

*The staff of the DMERC Region A extends heartfelt sympathy and support to those whose lives have been touched by the tragic events of September 11, 2001. We are especially sensitive to our colleagues at Empire Blue Cross and Blue Shield in New York City, and offer our deepest condolences to those who have lost friends, coworkers, and loved-ones. We are thankful for the many, many lives that were spared, including the entire staff of the New York Regional Office of the Centers For Medicare & Medicaid Services (CMS). We are grateful to all who have served so bravely and tirelessly, and to all of you who have given generously to the ongoing recovery efforts in New York and Washington. May the unity and good will toward our fellow Americans engendered by these events live on as testaments to the lives which were lost.*

### 2002 DMERC A Holiday Schedule

The DMERC A announces its 2002 Holiday Schedule:

New Year's Day:	Tuesday, January 1, 2002	Thanksgiving Day	Thursday, November 28, 2002
Martin Luther King, Jr. Day	Monday, January 21, 2002	Day after Thanksgiving	Friday, November 29, 2002
Memorial Day	Monday, May 27, 2002	Christmas Eve	Tuesday, December 24, 2002
Independence Day	Thursday, July 4, 2002	Christmas Day	Wednesday, December 25, 2002
Labor Day	Monday, September 2, 2002		

#### DMERC A Contacts

Supplier Caller Information Network	866-419-9458	Medicare Secondary Payer	570-740-9001
Beneficiary Caller Information Network	800-842-2052	National Supplier Clearinghouse	866-238-9652
(In Pennsylvania only, 1-800-MEDICARE)			
Check Control/MSP Fax	570-735-9594	Program Education & Training	570-735-9666
EDI Fax	570-735-9510	Program Education & Training Fax	570-735-9442
EDI Helpdesk	570-735-9429	Program Inquiries Fax (Hearings & Reconsiderations)	570-735-9599
Hearings Voice Mail	570-735-9513	SADMERC	877-735-1326

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# Billing

## New Procedures to Use the ABN Form for DMEPOS Upgrades

An Advance Beneficiary Notice (ABN) is a written notice you can give to a Medicare beneficiary before you provide a beneficiary an item or service that you expect Medicare will deny for the following reasons:

- lack of medical necessity;
- prohibited, unsolicited telephone contacts;
- no supplier number;
- an item that you submitted for an advanced determination of Medicare coverage (ADMC) where the DMERC denied the ADCM request.

The purpose of an ABN is to inform the beneficiary that Medicare will probably not pay for a certain item or service on a certain occasion, even if Medicare might pay for the item or service under different circumstances. This allows the beneficiary to make an informed consumer decision on whether or not to receive the items or services, for which s/he may have to pay out of pocket or through other insurance.

DMEPOS suppliers have been using an ABN form (HCFA-R-131) when they expect that Medicare may not pay for an item. The Office of Management and Budget (OMB) recently cleared a new, optional ABN form (CMS-R-131-G) that you can also use for the same purpose. You can get copies of this form online at: <http://www.hcfa.gov/medicare/bni/>.

For example, you may think that the DMERC will determine that the item is not medically necessary, or that the quantities of an item exceed the quantity that Medicare allows. On the ABN, you must specify the item in sufficient detail, so the beneficiary can understand what Medicare will not pay for and the reason Medicare won't pay for it. You may not simply give ABNs to every Medicare beneficiary you serve, unless there is a specific reason (e.g., you only sell items that Medicare never covers) why you feel Medicare will deny payment. Statements such as "I never know when Medicare will pay" are not acceptable on ABNs.

## Upgrades

Medicare will accept ABNs on upgrades. For Medicare purposes, CMS defines an upgrade as an item that is more expensive, deluxe, or containing excess components, quantity, or features than what the physician ordered.

The upgraded item may be from one HCPCS code to another, or within the same HCPCS code. However, the upgraded item must be within the range of services that are appropriate for the beneficiary's medical condition. For example, the beneficiary can upgrade from a standard manual wheelchair to an ultralight wheelchair, but not from a cane to a wheelchair. The choice to upgrade lies with the beneficiary.

CMS is not including items that a physician ordered, but which the supplier believes to be more than what Medicare considers medically necessary. You may still use an ABN in this situation, but must continue to follow the current operating procedures for ABNs that are already in place, and bill them as you have billed them in the past (i.e. bill the item that the physician ordered on one line with the GA modifier).

If a beneficiary signs an ABN, you may collect the difference between the charges for the upgraded item and the charges for the non-upgraded item from the beneficiary.

In some cases, you may choose to provide an upgrade for a beneficiary for free (e.g. to lower costs by maintaining an inventory of only one type of manual wheelchair that can supply all of your manual wheelchair needs). When providing a free upgrade, you do not need to have the beneficiary sign an ABN, because you will not be charging them for anything above their normal deductible and co-payment for the non-upgraded item.

ABNs for upgrades can apply to both assigned and unassigned claims.

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## Billing Claims for Dates of Service Before April 1, 2002

**To provide a free upgrade:** Bill for the non-upgraded item. You don't need to use any modifiers, but you need to describe the upgraded item in Line 19 of the HCFA-1500/CMS-1500, or the HA0 record on an electronic claim.

**To charge for the difference between the Medicare allowed for a non-upgraded item and an upgrade:** Bill for the upgraded item with a GA modifier.

## Billing Claims for Dates of Service April 1, 2002 and Later

**To provide a free upgrade:** Use the correct HCPCS code for the non-upgraded item that the physician ordered. You must only charge for the non-upgraded item. Use a GL modifier with the code. In item 19 of the claim, or as an attachment to the claim, specify the make and model of the upgraded item you actually furnished, and describe why this item is an upgrade (e.g. you provided an ultralight wheelchair when the physician ordered a standard wheelchair).

**To charge for the difference between the Medicare allowed for a non-upgraded item and an upgrade:** You need to bill two lines on your claim. You must bill the upgraded item that you provided to the beneficiary on the first line, with a GA or GZ modifier. Use the GA modifier if the beneficiary signed the form, and the GZ if you did not get an ABN that the beneficiary signed.

On the next line, bill for the item the physician ordered. Use a GK modifier on this line. If you are upgrading from one item to another within the same HCPCS code, this will be the same code you put on line 1, but with a different charge amount.

You must bill both lines sequentially and on the same claim. You may include more than one upgraded item on a claim, as well as any other items for which you use an ABN. However, for items where you provide an upgrade, you must bill the non-upgraded item on the line immediately following the upgraded item.

You must use the full charge on the claim for both the non-upgraded and the upgraded items. Do not calculate the difference between the non-upgraded item and the upgrade yourself.

## Mandatory Claim Submission

**All assigned and non-assigned claims must be submitted on the HCFA-1500 form.** The HCFA-1500 form is the basic form prescribed by HCFA for the Medicare program for claims from physicians and suppliers, with the exception of ambulance services. The HCFA-1500 has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

The HCFA-1500 form has space allocated for physicians and suppliers to provide information on other health insurance. This information should be used in determining whether the Medicare patient has other coverage which should be billed prior to Medicare payment, or whether there is a Medigap or supplemental policy for which payments are to be made to a participating physician or supplier.

The Omnibus Budget Reconciliation Act of 1980 (P.L. 101-239) includes a requirement that physicians and suppliers complete and submit Part B claims for services furnished to Medicare beneficiaries on or after September 1, 1990. The requirement that physicians and suppliers submit all Part B claims was included in Public Law 101-239 as an aid to Medicare beneficiaries, and to improve the completeness and timeliness of claims processed by Medicare carriers. The law specifically forbids you from charging patients for completing or submitting Medicare claims on their behalf.

Please note that as a supplier participating in the Medicare program, ALL claims must be submitted on HCFA 1500 claim forms. The beneficiary should not be submitting with the 1490 forms for items that you are supplying.

## Billing Reminder for External Infusion Pumps and Drugs

A recent audit has been completed on the E0781, ambulatory infusion pump, single or multiple channels, electric or battery operated, with administration equipment worn by patient, and E0791, parenteral infusion pump, stationary single or multi-channel.

The audit findings concluded that infusion drugs have been billed to the local carrier. Drugs put into an infusion pump in the physicians office for use in the patient home must be billed to the DMERC if the pump is billed to the DMERC. Injectable drugs administered in a physician office, whether with or without a pump must be billed to the local carrier and not the DMERC. Please reference the policy on External Infusion Pumps in the Region A DMERC Supplier Manual.

## Suction Catheters - Oropharyngeal vs. Tracheoesophageal

Claims data analysis in Region A indicates that some suppliers are incorrectly coding suction catheters. HCPCS code A4624 describes a tracheal suction catheter. These are long, flexible catheters typically contained in a sterile package. Suppliers should distinguish code A4624 from an oropharyngeal suction catheter (HCPCS code A4628), commonly referred to as a Yankauer suction tube. These are short, rigid, plastic suction instruments of durable construction. For additional information on the coverage and payment rules, coding and documentation guidelines, suppliers should consult the local medical review policy on Suction Pumps in the DMERC Region A Supplier Manual.

## Reminder 2002 Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

As mandated by the Balanced Budget Refinement Act of 1999, the fee schedule for DME will be receiving a temporary increase of 0.6 percent for 2002. In accordance with § 1833 (o)(2) of the Social Security Act, this 0.6 percent temporary increase for 2002 also applies to the national limit for therapeutic shoes. Because this 0.6 percent increase applies only to 2002, it is not to be carried over into future years (e.g., 2003, 2004). As mandated by the Balanced Budget Act of 1997, the fee schedule for surgical dressings, ostomy supplies, tracheostomy supplies, and urologicals are to be frozen for 2002. The fee schedule for prosthetic and orthotic devices (excluding ostomy supplies, tracheostomy supplies and urologicals) will be increased by 1 percent for 2002.

The fee schedule for 2002 will be available on the DMERC web site at [www.umd.nycpic.com](http://www.umd.nycpic.com). If you do not have access to the web site, you may request a copy from our Freedom of Information (FOI) Unit:

HealthNow DMERC A  
Attention: FOI  
60 East Main Street  
Nanticoke, PA 18634  
Fax: 570-735-9422

## Clinical Trials Routine Care Services - Diagnosis Coding Instructions

Effective for dates of service on or after January 1, 2002, providers must use the procedure code modifier "QV" to identify and report routine care for Medicare qualifying clinical trial services. The use of the "QV" modifier serves as the provider's attestation that a service, supply or equipment meets the Medicare qualifying coverage criteria for clinical trial services. In addition, the reporting of diagnosis code V70.5 as a secondary diagnosis will no longer be required as of this date.

One exception to this billing requirement is for items or services rendered on or after January 1, 2002 to healthy, control group volunteers as part of a qualifying diagnostic clinical trial. Routine care of healthy, control group, volunteers enrolled in a qualifying diagnostic clinical trial must be coded and billed in the following manner:

1. The "QV" modifier must be reported at the line item level; and
2. Diagnosis code V70.7 (Examination of participant in clinical trial) must be reported as the primary diagnosis for applicable line items on the HCFA - 1500 form or electronic claim equivalent.

Only claims utilizing the "QV" modifier and the diagnosis code V70.7 as the primary diagnosis will be considered as services or items rendered to healthy, control group, diagnostic trial volunteers.

Providers submitting claims for routine items and services furnished to beneficiaries in qualifying clinical trials should include information in the beneficiary's medical record about the clinical trial such as: the trial name, sponsor and sponsor-assigned protocol number. This information should not be routinely submitted with the claim but should be provided upon request for medical review. A copy of routine items and services provided should also be maintained and provided to medical review upon request.

Reference: Transmittal AB-01-03 (CR 1637) - Revised Guidelines for Processing Claims for Clinical Trial Routine Care Services.

## Parenteral and Enteral Nutrition (PEN) Items and Services are Now Included in Fee Schedule

The Secretary, as authorized by §4315 of the Balanced Budget Act of 1997, has implemented a fee schedule for parenteral and enteral nutrition (PEN) items and services. These items and services were previously paid on a reasonable charge basis. The 2002 fee schedule for PEN codes will be available through the DMERC website at [www.umd.nycpic.com](http://www.umd.nycpic.com). If you do not have access to the internet, you can request a hard copy by writing to:

HealthNow DMERC A  
Attention: FOI  
60 East Main Street  
Nanticoke, PA 18634  
Fax: 570-735-9422

## New Modifier for Rental Items

Effective for dates of service on or after April 1, 2002, a new modifier has been established to indicate billing of durable medical equipment for a partial month of service.

KR Rental Item - billing for partial month

The KR modifier is for use by suppliers who wish to exercise the option of billing Medicare for a partial month(s) of rental on DME. Although suppliers are entitled to bill and receive a full month's reimbursement for rented DME provided to qualifying beneficiaries, suppliers now have the option of billing for a partial month of service and receiving reimbursement on a prorated basis by using the KR modifier.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the HCFA-1500 claim form, or electronic equivalent, for each partial month of billing. The modifier "RR," indicating rental, must also be appended to the claim line for the partial month rental item(s).

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# Non-Routine Medical Supplies Subject to Home Health Consolidated Billing

The non-routine medical supplies subject to Home Health Consolidated Billing (CB) for dates of services January 1, 2002 through December 31, 2002 are as follows:

A4212 A4310 A4311 A4312 A4313 A4314 A4315 A4316 A4319 A4320 A4321 A4322 A4323 A4324 A4325 A4326 A4327  
A4328 A4330 A4331 A4332 A4333 A4334 A4335 A4338 A4340 A4344 A4346 A4347 A4348 A4351 A4352 A4353 A4354  
A4355 A4356 A4357 A4358 A4359 A4361 A4362 A4364 A4365 A4367 A4368 A4369 A4370 A4371 A4372 A4373 A4374  
A4375 A4376 A4377 A4378 A4379 A4380 A4381 A4382 A4383 A4384 A4385 A4386 A4387 A4388 A4389 A4390 A4391  
A4392 A4393 A4394 A4395 A4396 A4397 A4398 A4399 A4400 A4402 A4404 A4421 A4455 A4460 A4462 A4481 A4622  
A4623 A4625 A4626 A4649 A5051 A5052 A5053 A5054 A5055 A5061 A5062 A5063 A5071 A5072 A5073 A5081 A5082  
A5093 A5102 A5105 A5112 A5113 A5114 A5119 A5121 A5122 A5123 A5126 A5131 A6010 A6020 A6021 A6022 A6023  
A6024 A6154 A6196 A6197 A6198 A6199 A6200 A6201 A6202 A6203 A6204 A6205 A6206 A6207 A6208 A6209 A6210  
A6211 A6212 A6213 A6214 A6215 A6219 A6220 A6221 A6222 A6223 A6224 A6228 A6229 A6230 A6231 A6232 A6233  
A6234 A6235 A6236 A6237 A6238 A6239 A6240 A6241 A6242 A6243 A6244 A6245 A6246 A6247 A6248 A6251 A6252  
A6253 A6254 A6255 A6256 A6257 A6258 A6259 A6261 A6262 A6266 A6402 A6403 A6404 A6405 A6406 A7501 A7502  
A7503 A7504 A7505 A7506 A7507 A7508 A7509

## New code subject to CB for 2002:

A6010: Collagen based wound filler, dry foam

## Discontinued code for 2002, no longer subject to CB:

A4329: External catheter start set

Reimbursement for these codes is included in the home health claim billed by the home health agency to the Regional Home Health Intermediary (RHHI) if the beneficiary has a home health plan of care episode. The DMERC will deny these codes if the date of service is within the home health claim dates. If the home health claim has not been billed, the DMERC will pay these codes conditionally. Once the home health claim is billed, a request will be sent to recover any money paid with dates of service within the RHHI claim dates.

## Tracheo-Esophageal Voice Prosthesis - New Codes

Two new codes have been established for tracheo-esophageal voice prostheses:

L8507 Tracheo-esophageal voice prosthesis, patient inserted, any type, each

L8509 Tracheo-esophageal voice prosthesis, inserted by licensed health care provider, any type, each

These codes are effective for dates of service on or after January 1, 2002. Claims for these items with dates of service prior to January 1, 2002 must continue to be submitted with the miscellaneous code L8499. The new codes are in the prosthetic devices for payment category.

The new codes describe small tubes that are placed in a surgically created opening between the trachea and esophagus in selected patients who have had a laryngectomy. The tubes have a one-way valve that allow the flow of air from the trachea, through the tube, and into the esophagus, enabling the patient to speak.

Code L8509 describes a device that is designed to be removed and replaced only by a physician or other health care provider. Examples, not all-inclusive, of products and manufacturers described by this code are: Blom-Singer Indwelling Low Pressure Voice Prosthesis (InHealth Technologies).

Code L8507 describes a device that is designed to be removed and replaced by the patient for cleaning. Even if this type of device is inserted by a physician, code L8507 must be used. Examples, not all-inclusive, of products and manufacturers described by this code are: Blom-Singer Duckbill Voice Prosthesis (InHealth Technologies), Blom-Singer Low Pressure Voice Prosthesis (InHealth Technologies), Ultra Low Resistance Voice Prosthesis (Bivona), Duckbill Voice Prosthesis (Bivona).

## Gastrostomy Tubes - New Code

A new HCPCS code has been created for use with gastrostomy and jejunostomy tubes.

B4086 Gastrostomy / jejunostomy tube, any material, any type, (standard or low profile), each

This HCPCS code is effective for claims with dates of service on or after January 1, 2002. This HCPCS code replaces HCPCS codes B4084 (Gastrostomy / jejunostomy tubing) and B4085 (Gastrostomy tube, silicone with sliding ring, each).

Under the standard grace period, HCPCS codes B4084 and B4085 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with HCPCS codes B4084 and B4085 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Enteral Nutrition in the Supplier Manual.



## Year 2002 HCPCS Codes

Due to the volume of new, modified, or discontinued HCPCS codes, only a list of HCPCS codes is being published in this newsletter. The Region A DMERC Supplier Manual, Chapter 5, has been updated to indicate all Year 2001 and 2002 code activity and can be referenced for all HCPCS descriptors. This update is included in the accompanying Region A DMERC Supplier Manual revision. Please utilize the table in Chapter 5, Section 5.6 to determine the action taken with each HCPCS code (i.e., A=Add, C=Change, D=Discontinued, etc.)

Procedure codes that have been added, changed, or discontinued are listed below, and are effective for dates of service on or after January 1, 2002.

New Codes	E0481 E0482 E0603 E0604 E0620 E0752 E0754 E0759 E1500 E1637 E1638 E1639 E1801 E1806 E1811 E1816 E1818 E1821 E1840 E1902 E2000 E2100 E2101 J0587 J0692 J0706 J0744 J1056 J1270 J1590 J1655 J1755 J1835 J2020 J2940 J2941 J3100 J3395 J7193 J7195	J7302 J7308 J7316 J7340 J7511 J7622 J7624 J7626 J7641 J9017 J9300 K0548 L0321 L0331 L0391 L0561 L0986 L1005 L2768 L3677 L5301 L5311 L5321 L5331 L5341 L5671 L5847 L5989 L5990 L6881 L6882 L8001 L8002 L8505 L8507 L8509 L8510	<b>Discontinued Codes</b>	<b>The following deleted codes have no crosswalk codes:</b>	<b>Modified Codes; Descriptor Changes</b>		
			Reminder - There is a 3-month grace period for discontinued codes. This grace period applies to claims received by the DMERC before April 1, 2002, which include Year 2001 discontinued codes for dates of service January 1, 2002 to March 31, 2002.	A4329 A4650 A4655 A4700 A4705 A4735 A4780 A4790 A4820 A4880 A4900 A4901 A4905 A4910 A4914 A4919 A4920 A4921 A5064 A5065 A5074 A5075 A5502 A9160 A9170 A9190 B4084 B4085 E0753 E1640 E1900 J0340	J0400 J0510 J0590 J0695 J0730 J0810 J1090 J1362 J1690 J1739 J1741 J1930 J1970 J2240 J2330 J2350 J2480 J2512 J2640 J2675 J2860 J2970 J3080 J3270 J3390 J3450 J7315 L5667	A4300 A4301 A4351 A4352 A4358 A4660 A4663 A4670 A4680 A4690 A4712 A4714 A4730 A4740 A4750 A4755 A4760 A4765 A4770 A4771 A4772 A4773 A4774 A4860 A4870 A4890 A4913 A4918 A4927 A6196 A6197 A6198 A6199 E0600 E0602 E1520 E1530 E1540	E1550 E1560 E1575 E1580 E1600 E1610 E1615 E1620 E1625 E1632 E1636 E1699 E1800 E1805 E1810 E1815 E1820 E1825 E1830 J2993 J7504 J7618 J7619 K0184 L0100 L0110 L0515 L1510 L1930 L1940 L2415 L2755 L4000 L4396 L5704 L5705 L5706 L5707
			The following table indicates deleted codes and the corresponding crosswalk code:				
			<b>Old Codes</b>	<b>New Codes</b>			
			A4800 A4850 A4912 E0298 E0609 L5300 L5310 L5320 L5330 L5340 L5669	A4801 E1637 A4911 K0549 E2100 - E2101 L5301 L5311 L5321 L5331 L5341 L5660, L5662, L5663, L5664			

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## Joint Contracture Devices - New and Revised Codes

Several new codes have been established for devices used in the management of joint contractures:

- E1801 Bi-directional static progressive elbow stretch device with range of motion adjustment, includes cuffs
- E1806 Bi-directional static progressive wrist stretch device with range of motion adjustment, includes cuffs
- E1811 Bi-directional static progressive knee stretch device with range of motion adjustment, includes cuffs
- E1816 Bi-directional static progressive ankle stretch device with range of motion adjustment, includes cuffs
- E1818 Bi-directional static progressive pronation/supination stretch device with range of motion adjustment, includes cuffs
- E1821 Replacement soft interface material/ cuffs for bi-directional static progressive stretch device

These codes are effective for dates of service on or after January 1, 2002. Claims for these items for date of service prior to January 1, 2002 will continue to be billed using code E1800 (elbow), E1805 (wrist), E1810 (knee), E1815 (ankle), E1399 (forearm pronation/ supination), E1820 (replacement cuffs). The new codes are considered durable medical equipment and are in the capped rental payment category (except for code E1821 which is in the inexpensive or routinely purchased category). The rental allowance for codes E1801, E1806, E1811, E1816, and E1818 includes cuffs and any other interface material that is needed. Code E1821 would be payable only in situations in which a medically necessary device is owned by the patient. Examples of products billed using these codes are the JAS devices by Joint Active Systems. For coding verification of other devices that may be billed using these codes, manufacturers or suppliers should contact the SADMERC. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage or full payment.

Changes have also been made in the related series of codes describing dynamic adjustable extension/ flexion devices - E1800, E1805, E1810, E1815, E1825, and E1830. Effective for dates of service on or after January 1, 2002, the phrase "or equal" has been removed from the code narrative and the phrase "includes soft materials" has been added to each code. In addition a new code has been added, effective for dates of service on or after January 1, 2002:

- E1840 Dynamic adjustable shoulder flexion/extension/rotation device, includes soft interface material

Beginning with dates of service on or after January 1, 2002, the rental allowance for all these codes includes the soft interface material. Code E1825 (replacement soft interface material, dynamic adjustable extension/flexion device) would be payable only in situations in which a medically necessary device is owned by the patient. Examples (not all-inclusive) of products billed using these codes are joint contracture devices manufactured by Dynasplint Systems, Ultraflex, and Empi. For coding verification of devices that are billed using these codes, manufacturers or suppliers should contact the SADMERC.

## Gastric Suction Pump - New Code

A new HCPCS code has been established for gastric suction pumps.

- E2000 Gastric suction pump, home model, portable or stationary, electric.

This pump is used to suction gastrointestinal secretions. The gastric suction pump has been billed using HCPCS code E1399 (Durable medical equipment, miscellaneous). Under the standard grace period, HCPCS code E1399 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. For claims received on or after April 1, 2002, E1399 will no longer be accepted when billing for gastric suction pump. A gastric suction pump is covered if medically necessary and ordered by a physician.

Tracheal suction pumps must continue to be billed with HCPCS code E0600.

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## Home Blood Glucose Monitors and Supplies - New Codes

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for laser skin lancing devices.

A4257 Replacement lens shield cartridge for use with laser skin piercing device, each

E0620 Skin piercing device for collection of capillary blood, laser, each

Laser skin lancing devices use laser technology to pierce the skin in order to obtain capillary blood for use in home blood glucose monitors. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.

Also effective for dates of service on or after January 1, 2002, code E0609 (blood glucose monitor with special features (e.g. voice synthesizers, automatic timers, etc.)) is discontinued and crosswalked to the following codes:

E2100 Blood glucose monitor with integrated voice synthesizer

E2101 Blood glucose monitor with integrated lancing/blood sample collection

Home blood glucose monitors previously meeting the description of code E0609 must be coded E2100 or E2101, whichever is applicable. The coverage and payment rules associated with code E0609 will also apply to codes E2100 and E2101. Under the standard grace period, code E0609 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with code E0609 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Home Blood Glucose Monitors in the DMERC Region A Supplier Manual.

## Non-Contact Wound Warming System - New Codes

Effective for dates of service on or after January 1, 2002, new HCPCS codes have been established for a non-contact wound warming system.

E0231 Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover

E0232 Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover

A6000 Non-contact wound warming cover for use with the non-contact wound warming device and warming card

Code E0231 is in the capped rental payment category. Codes E0232 and A6000 are in the miscellaneous durable medical equipment payment category. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

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## New HCPCS Codes for Home Dialysis Supplies and Equipment

Effective January 1, 2002 suppliers will be required to separately identify the supplies and equipment which they are furnishing to the patient. Suppliers have been billing for dialysis supplies using codes describing "kits" of supplies. The use of kit codes such as A4820, A4900, A4901, A4905 and A4914 allows suppliers to bill for supply items without separately identifying the supplies that are being furnished to the patient. The use of kit codes A4820, A4900, A4901, A4905, and A4914 may continue to be used until March 31, 2002.

For dates of service on or after January 1, 2002 suppliers will be required to bill for dialysis supplies using existing and newly developed HCPCS codes for individual dialysis supplies. The following HCPCS codes for dialysis supplies and equipment will be effective for claims received on or after January 1, 2002:

- A4651 Calibrated microcapillary tube, each
- A4652 Microcapillary tube sealant
- A4656 Needle, any size, for dialysis, each
- A4657 Syringe, with or without needle, for dialysis, each
- A4660 Sphygmomanometer/blood pressure apparatus with cuff and stethoscope for Dialysis
- A4663 Blood pressure cuff only, for dialysis
- A4670 Automatic blood pressure monitor, for dialysis
- A4680 Activated carbon filter for hemodialysis, each
- A4690 Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each
- A4706 Bicarbonate concentrate, solution, for hemodialysis, per gallon
- A4707 Bicarbonate concentrate, powder, for hemodialysis, per packet
- A4708 Acetate concentrate, solution, for hemodialysis, per gallon
- A4709 Acid concentrate, solution, for hemodialysis, per gallon
- A4712 Water, sterile, for injection, for dialysis, per 10 ml
- A4714 Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon
- A4719 Y set tubing for peritoneal dialysis
- A4720 Dialysate solution, any concentration of dextrose, fluid volume of greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis
- A4721 Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc but less than or equal to 1999 cc, for peritoneal dialysis
- A4722 Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc but less than or equal to 2999 cc, for peritoneal dialysis
- A4723 Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc but less than or equal to 3999 cc, for peritoneal dialysis
- A4724 Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc but less than or equal to 4999 cc, for peritoneal dialysis
- A4725 Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc but less than or equal to 5999 cc, for peritoneal dialysis
- A4726 Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis
- A4730 Fistula cannulation set for hemodialysis, each
- A4736 Topical anesthetic, for dialysis, per gram
- A4737 Injectable anesthetic, for dialysis, per 10 ml
- A4740 Shunt accessory, for hemodialysis, any type, each
- A4750 Blood tubing, arterial or venous, for hemodialysis, each
- A4755 Blood tubing, arterial and venous combined, for hemodialysis, each
- A4760 Dialysate solution test kit, for peritoneal dialysis, any type, each
- A4765 Dialysate concentrate, powder, additive for peritoneal dialysis, per packet
- A4766 Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml
- A4770 Blood collection tube, vacuum, for dialysis, per 50
- A4771 Serum clotting time tube, for dialysis, per 50
- A4772 Blood glucose test strips, for dialysis, per 50
- A4773 Occult blood test strips, for dialysis, per 50
- A4774 Ammonia test strips, for dialysis, per 50
- A4801 Heparin, any type for hemodialysis, per 1,000 units
- A4802 Protamine sulfate, for hemodialysis, per 50 mg
- A4860 Disposable catheter tips for peritoneal dialysis, per 10
- A4870 Plumbing and/or electrical work for home hemodialysis equipment
- A4890 Contracts, repair and maintenance, for hemodialysis equipment
- A4911 Drain bag/bottle, for dialysis, each
- A4913 Miscellaneous dialysis supplies, not otherwise specified

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- A4918 Venous pressure clamps, for hemodialysis, each
- A4927 Gloves, non-sterile, for dialysis, per 100
- A4928 Surgical mask, for dialysis, per 20
- A4929 Tourniquet, for dialysis, each
- E1500 Centrifuge, for dialysis
- E1510 Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container
- E1520 Heparin infusion pump for hemodialysis
- E1530 Air bubble detector for hemodialysis, each, replacement
- E1540 Pressure alarm for hemodialysis, each, replacement
- E1550 Bath conductivity meter for hemodialysis, each
- E1560 Blood leak detector for hemodialysis, each, replacement
- E1575 Transducer protectors/fluid barriers, for hemodialysis, any size, per 10
- E1580 Unipuncture control system for hemodialysis
- E1600 Delivery and/or installation charges for hemodialysis equipment
- E1610 Reverse osmosis water purification system, for hemodialysis
- E1615 Deionizer water purification system, for hemodialysis
- E1620 Blood pump for hemodialysis, replacement
- E1625 Water softening system, for hemodialysis
- E1632 Wearable artificial kidney, each
- E1636 Sorbent cartridges, for hemodialysis, per 10
- E1637 Hemostats, for dialysis, each
- E1638 Heating pad, for peritoneal dialysis, any size, each
- E1639 Scale, for dialysis, each
- E1699 Dialysis equipment, not otherwise specified

#### **Deletion of Codes**

- A4650 Centrifuge (includes microcapillary tubes and sealase)
- A4655 Needles and syringes for dialysis
- A4700 Standard dialysate solution, each
- A4705 Bicarbonate dialysate solution, each
- A4735 Local/topical anesthetic for dialysis only
- A4780 Sterilizing agent for dialysis equipment, per gallon
- A4790 Cleansing agent for equipment for dialysis only
- A4800 Heparin for dialysis and antidote, any strength, porcine or beef, up 1,000 units, 10-30 ml (for parenteral use, see code B4216)
- A4820 Hemodialysis kit supply
- A4850 Hemostats with rubber tips for dialysis

- A4880 Storage tank utilized in connection with water purification system, replacement tank for dialysis
- A4900 Continuous ambulatory peritoneal dialysis (CAPD) supply kit
- A4901 Continuous cycling peritoneal dialysis (CCPD) supply kit
- A4905 Intermittent peritoneal dialysis (IPD) supply kit
- A4910 Non-medical supplies for dialysis (i.e., scale, scissors, stop-watch, etc.)
- A4912 Gomco drain bottle
- A4914 Preparation kit
- A4919 Dialyzer holder, each
- A4920 Harvard pressure clamp, each
- A4921 Measuring cylinder, any size, each
- E1640 Reciprocating peritoneal dialysis system

## **Speech Generating Devices - New Code**

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been created for non-electronic augmentative or alternative communication devices.

E1902 Communication board, non-electronic augmentative or alternative communication device

This code describes devices that are typically constructed of multiple pictures or symbols representing words, phrases or actions. Patients point to the picture or symbol to express their communication statement. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for information on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Speech Generating Devices (SGDs) in the DMERC Region A Supplier Manual.

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## Multiple Density Shoe Inserts - New Codes

Effective for dates of service on or after January 1, 2002, HCPCS code A5502 (For diabetics only, multiple density insert(s), per shoe) is discontinued and the following HCPCS codes are established for multi-density inserts covered under the Therapeutic Shoes for Diabetics benefit category:

- A5509 For diabetics only, direct formed, molded to foot with external heat source (i.e. heat gun) multiple density insert(s), prefabricated, per shoe
- A5510 For diabetics only, direct formed, compression molded to foot without external heat source, multiple density insert(s), prefabricated, per shoe
- A5511 For diabetics only, custom molded from model of patient's foot, multiple density insert(s), custom fabricated, per shoe

Suppliers are reminded that for a multi-density insert to qualify for this benefit, the insert must be in total contact with the foot, meaning the insert must cover the heel, ball and toe. In addition, all inserts must have a minimum of two layers of material with differing density with the top layer consisting of a softer material to provide protection for the patient's foot and to redistribute pressure. The bottom layer should be designed of a density that provides stability and durability. All inserts must retain the shape of the foot for the life of the insert and must be removable.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Therapeutic Shoes for Diabetics in the DMERC Region A Supplier Manual.

## Lower Extremity Prosthetics - Coding Changes

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for suspension socket locking mechanisms.

- L5671 Addition to lower extremity, below the knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert

Also effective for dates of service on or after January 1, 2002, code L5669 (addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism) is discontinued. Items previously coded L5669 should be coded L5660, L5662, L5663 and L5664, whichever is applicable. Under the standard grace period, code L5669 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with code L5669 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

Code L5667 (addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism) is also discontinued effective for dates of service on or after January 1, 2002. Items previously coded L5667 should be coded with the combination of L5671 and the HCPCS code describing the applicable suspension socket insert. Under the standard grace period, code L5667 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with code L5667 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for information on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Lower Extremity Prosthetics in the DMERC Region A Supplier Manual.

## Spinal Orthoses - Coding Changes

Effective for dates of service on or after January 1, 2002, several new codes are established for prefabricated spinal orthoses and one existing code (L0515) is being revised. The new/revised codes are:

- L0321 Thoracic-lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
- L0331 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
- L0391 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral-rotary control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
- L0515 Lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
- L0561 Lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
- L0986 Addition to spinal orthosis, rigid or semi-rigid abdominal panel, prefabricated

In the codes listed above, anterior-posterior control is achieved by a rigid or semi-rigid posterior panel. Lateral control is achieved by a rigid or semi-rigid panel in the mid-axillary line which is either an integral part of a posterior panel or a separate panel. Rotary control is achieved by a rigid or semi-rigid panel in the upper chest area which is attached by a rigid connection to a posterior, lateral, or abdominal panel.

Code L0986 would be used in addition to any of the other codes listed if the prefabricated orthosis had a rigid or semi-rigid abdominal panel.

Also effective for dates of service on or after January 1, 2002, the following codes will be invalid for claim submission to the DMERC:

- L0315 TLSO, flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel
- L0317 TLSO, flexible dorso-lumbar surgical support, hyperextension, elastic type, with rigid posterior panel

Code L0321 should be used instead. In accordance with the standard grace period, codes L0315 and L0317 will be accepted for claims with dates of service on or after January 1, 2002 that are received by March 31, 2002.

As defined in the Spinal Orthoses policy, codes L0320-L0340 and codes L0520-L0540 may only be used for custom fabricated spinal orthoses.

Refer to the Spinal Orthoses medical policy for definitions of prefabricated and custom fabricated orthoses.

Codes L0300 and L0310 (Thoracic-lumbar-sacral orthosis, flexible), L0500 and L0510 (Lumbar-sacral orthosis, flexible), and L0600 and L0610 (Sacroiliac flexible support) are used for spinal orthoses which do not have rigid or semi-rigid panels. Sacroiliac orthoses encompass the pelvis and extend from the pubic symphysis to the waist anteriorly. Flexible spinal orthoses may be made of cloth, elastic, or other stretchable material. They may have vertical stays made of flexible metal or other material. Codes L0300, L0500, and L0600 are for prefabricated orthoses; codes L0310, L0510 and L0610 are for custom fabricated orthoses.

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# New/Revised Codes for Nebulizer Drugs (Inhaled Steroids and Levalbuterol)

## New Codes:

Effective for claims with dates of service on or after January 1, 2002 new HCPCS codes have been established:

J7622 Beclomethasone, inhalation solution administered through DME form, unit dose, per milligram

J7624 Betamethasone, inhalation solution administered through DME, unit dose form, per milligram

J7626 Budesonide, inhalation solution administered through DME, unit dose form, 0.25 mg

J7641 Flunisolide, inhalation solution administered through DME, unit dose, per milligram

These medications are currently billed using HCPCS code J7699. For dates of service on or after January 1, 2002, they should be billed using the new codes.

## Revised Code:

Effective for claims with dates of service on or after January 1, 2002 the HCPCS code for unit dose albuterol has been revised:

J7619 Albuterol, all formulations, including separated isomers, inhalation solution administered through DME, unit dose, per 1 mg. (albuterol) or per 0.5 mg (levalbuterol)

This code revision was made to accommodate billing for levalbuterol (Xopenex®), a separated isomer of albuterol. Note the change in billing units for code J7619 and levalbuterol before and after the January 1, 2002 effective date.

### DOS prior to January 1, 2002

1 mg. levalbuterol = 1 unit J7619

### DOS on or after January 1, 2002

1 mg. levalbuterol = 2 units J7619

The billing for the standard formulation of albuterol is not affected by this change in code J7619.

Under the standard grace period, HCPCS code J7699 (used to bill for the steroid drugs), will continue to be accepted on claims with dates of service on or after January 1, 2002, that are received by March 31, 2002. However, use of HCPCS code J7699 to describe these drugs, received on claims on or after April 1, 2002, will be rejected as invalid coding. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these supply items.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Nebulizers and Nebulizer Drugs in the Supplier Manual.



## Revised Insulin Pump Requirements

An external insulin infusion pump is now covered for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus, (ICD-9 CM codes 250.00-250.93), which has been documented by a fasting serum C-peptide level that is less than or equal to 110 percent of the lower limit of normal of a particular laboratory's measurement method. This represents an increase in the allowable amount of C-peptide found in the patient's blood, and will result in more beneficiaries having access to Medicare coverage of the insulin infusion pump.

For patients who have obtained an external insulin infusion pump that was not eligible for reimbursement by Medicare prior to January 1, 2002, insulin and supplies used with the pump are covered for dates of service on or after January 1, 2002 provided the patient has a fasting C-peptide level that is less than or equal to 110 percent of the lower limit of normal of a laboratory's measurement method.

For all claims for external insulin infusion pumps, insulin and/or supplies, if the results of the patient's C-peptide level meet the requirements outlined above, a ZX modifier should be added to the HCPCS code.

The External Infusion Pump Policy will be revised and republished in the near future.

These revised criteria are effective for claims with dates of service on or after January 1, 2002.

## Heating Pad - New Code

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for an infrared heating pad.

E0221 Infrared heating pad system

Code E0221 is in the inexpensive or routinely purchased payment category. This code includes both the power source and the infrared therapy pads. Manufacturers or suppliers should contact the SADMERC for guidance on whether a particular device meets the definition of this code.

Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.

# Medical Policy

## National Coverage Decision

On June 7, 2000, the President of the United States issued an executive memorandum directing the The Centers for Medicare & Medicaid Services (CMS) to "explicitly authorize [Medicare] payment for routine patient care costs...and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, this National Coverage Decision (NCD) serves to define the routine costs of clinical trials and identify the clinical trials for which payment for such routine costs should be made for eligible services furnished on or after September 19, 2000.

CMS has developed a National Coverage Determination (NCD) which can be accessed and downloaded from the CMS webpage at [www.cms.hhs.gov/quality/8d.htm](http://www.cms.hhs.gov/quality/8d.htm). This NCD states that Medicare covers: 1) the routine costs of qualifying clinical trials as well as, 2) reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. This instruction addresses routine costs of qualifying clinical trials including complications resulting from qualifying clinical trials. All other Medicare rules apply.

### Clinical Trial Services That Qualify for Coverage

Clinical trial services covered by Medicare must meet both the following requirements:

**1. Qualifying Trial.** In order to be covered, the service must be part of a trial that meets all of the following criteria in order to be considered a qualifying trial:

a) Evaluates a Medicare Benefit. The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).

b) Has a Therapeutic Intent. The trial must have a therapeutic intent (i.e., is not designed exclusively to test toxicity or disease pathophysiology).

c) Enrolls Diagnosed Beneficiaries. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

d) Has Desirable Characteristics. The desirable characteristics are listed in the NCD.

Deemed Trials. Some trials are considered automatically deemed as having desirable characteristics. They include:

Effective September 19, 2000

Trials funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), CMS, Department of Defense (DOD), and Department of Veterans Affairs (VA);

Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD and VA;

Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drugs Administration (FDA); and drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) are deemed until the qualifying criteria are developed and the certification process is in place. At time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status.

Until the Medicare clinical trials registry is established, the sponsors of both IND trials and IND-exempt trials must identify themselves by e-mail to:

**[clinicaltrials@cms.hhs.gov](mailto:clinicaltrials@cms.hhs.gov)** for administration, payment and program integrity purposes.

Self-Certified Trials. In the future, a multi-agency Federal panel (see NCD for further details) will develop qualifying criteria that will indicate a strong probability that a trial exhibits the desirable characteristics as stated in the NCD. No trials are covered based upon self-certification at this time.

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**2. Routine Costs.** Routine costs of a clinical trial include all items and services that are provided in either the experimental or the control arms of a trial except those listed below as not covered. Services provided to Medicare beneficiaries in both the experimental group and the control group are eligible for coverage provided that all other criteria in this instruction are met.

Routine costs do NOT include (and are therefore not covered):

The investigational item or service, itself;

Items and services:

For which there is no Medicare benefit category; or

Which are statutorily excluded; or

That fall under a national noncoverage policy;

Items and services furnished solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);

Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

Items and services provided solely to determine trial eligibility.

Routine costs DO include (and are therefore covered):

Items or services that are typically provided absent a clinical trial (e.g., medically necessary conventional care);

Items and services required for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent);

Items and services required for the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.

This national coverage policy is based upon the authority found in §1862(a)(1)(E) of the Social Security Act (Act). It is binding on all Medicare carriers, intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, Health Care Prepayment Plans, and Medicare+Choice organizations (§1852 (a)(1)(A) of the Act)."

Effective for dates of service on or after September 19, 2000, when submitting claims for services or items that meet the requirements as outlined in the final National Coverage Decision you must identify these services with the "QV" procedure code modifier. "QV" - "Item or service provided as routine care in an approved clinical trial" (The full coverage policy regarding clinical trials may be accessed at [www.cms.hhs.gov/quality/8d.htm](http://www.cms.hhs.gov/quality/8d.htm)).

The modifier is line item specific and must be used to identify items and services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary's participation in a Medicare covered clinical trial. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the clinical management of the patient are not covered and may not be billed using the QV modifier. Items and services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category also may not be billed using the QV modifier. Finally, items and services customarily provided by the research sponsor free of charge for any enrollee in the trial may not be billed.

In addition to the QV modifier, providers must also report diagnosis code V70.5 (Health Examination of Defined Subpopulations) as a secondary diagnosis for patients participating in Medicare covered clinical trials.

The QV modifier and V70.5 diagnosis code will serve as your attestation that the service meets the Medicare coverage criteria (i.e., was furnished to a beneficiary who is participating in a Medicare qualifying clinical trial and represents routine patient care, including complications associated with qualifying trial participation.)

Submit separate line items for clinical trial services when billing other covered services not directly related to a Medicare qualifying clinical trial on the same claim.

When submitting claims with the QV procedure code modifier and V70.5 diagnosis code, the billing provider must include in the beneficiary's medical record the following information: trial name, sponsor, and sponsor-assigned protocol number. This information should not be submitted with the claim but must be provided if requested for medical review. A copy of the signed informed consent document must also be made readily available if requested for medical review

Payment for these qualifying clinical trial services furnished on or after September 19, 2000, will be made based on the payment methodology applicable for the service that was furnished (e.g., physician fee schedule, lab fee schedule, DME fee schedule, reasonable charge). All applicable deductible and coinsurance rules apply to these services with one exception. Managed care enrollees will not be responsible for the Part A and Part B deductibles for covered clinical trial services billed as fee for service.

If you have a claim for a Medicare qualifying clinical trial service that has been denied for a date of service on or after September 19, 2000, the action you take to get the claim paid will depend on whether the service was initially submitted with the QV modifier and ICD-9 code.

**Initial Claim Did Not Include the QV Modifier and ICD-9 Code V70.5.**--If clinical trial routine care services on a claim are denied and were not identified as clinical trial services (i.e., the clinical trial modifier and ICD-9 code was not included), resubmit the services on a new claim with the QV modifier and ICD-9 code V70.5 for the care or medical complications arising from a Medicare qualifying clinical trial.

**Denied Service Included the QV Modifier and ICD-9 Code.**--If a service Medicare covers is billed with the QV modifier and ICD-9 code and initially denied (e.g., for medical necessity or utilization) contact us (insert the phone number for providers) and request an adjustment to the claim. If appropriate, we will adjust and pay the claim."

**Payment Of Clinical Trial Services For Managed Care Enrollees.**-- Until Medicare capitation rates are adjusted to account for clinical trials, payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans will be made on a fee for service basis by the Medicare contractors that process fee for service claims. Providers will need to submit fee for

service bills for Medicare covered clinical trial services furnished to managed care enrollees. The payment amounts will be based on the applicable Medicare fee schedules for such services. In addition, the Part A and Part B deductibles are assumed to be met for covered clinical trial services billed as fee for service for managed care enrollees.

## Walkers - Policy Revision

Revision of the medical policy on Walkers is included in the accompanying Region A DMERC Supplier Manual update. The revision incorporates the new codes for heavy duty walkers which were established in January 2001.

## Regional Medical Review Policies (RMRPs) Have A New Name

The Center for Medicare and Medicaid Services (CMS), formerly HCFA, has instructed the durable medical equipment regional carriers (DMERCs) to change the name of their policies. Local Medical Review Policies (LMRPs), formerly RMRPs, will now be used when referring to policies published by the DMERCs.

## Neuromuscular Electrical Stimulator

A recent audit of the Neuromuscular Electrical Stimulator has identified that beneficiaries are receiving treatment for medical conditions other than disuse atrophy, or the selected muscle group for stimulation was unable to be identified from the medical documentation. The Neuromuscular Electrical Stimulation (NMES) involves the use of a device which transmits an electrical impulse to the skin over selected muscle groups by the way of electrodes. Coverage of NMES is limited to the treatment of disuse atrophy where nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse causing atrophy. (Coverage Issues Manual, Section 35-77)

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## Useful Lifetime for External Breast Prosthesis

The Center for Medicare and Medicaid Services (CMS) has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for an external breast prosthesis.

The useful lifetime expectancy for silicone breast prostheses is 2 years. For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is 6 months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as noncovered.

An external breast prosthesis of the same type can be replaced at any time if it is lost or is irreparably damaged (this does not include ordinary wear and tear). An external breast prosthesis of a different type can be covered at any time if there is a change in the patient's medical condition necessitating a different type of item.

The Medicare program will pay for only one breast prosthesis per side at any one time. More than one external breast prosthesis per side at any one time will be denied as not medically necessary.

Suppliers must use the RT and LT modifiers to delineate the side or sides being billed.

This is effective for claims with dates of service on or after April 1, 2002.

## Manual and Power Wheelchairs, POVs - Policy Revisions

Revisions of the medical policies on Manual Wheelchair Bases, Motorized/Power Wheelchair Bases, and Power Operated Vehicles (POVs) are included in the accompanying Region A DMERC Supplier Manual update. The revisions include changes in codes, coverage and payment rules, coding guidelines, and documentation requirements, including Advance Determination of Medicare Coverage (ADMC), which have occurred since the policies were last published.

### TENS Policy Revised

A revised Transcutaneous Electrical Nerve Stimulation (TENS) policy is included in the accompanying Supplier Manual Update. The revisions include changes in coverage and payment rules, coding guidelines, and documentation requirements, as well as elimination of availability for prior authorization for this item.

# EDI - HIPAA

## Elimination of CMS Free Billing Software

Since the late 1980s, the Centers for Medicare & Medicaid Services (CMS) has required DMERC A to offer free electronic billing software to our suppliers upon request. These generally simple pieces of software allowed our suppliers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format (NSF), the UB-92, or the X12N 837 format. DMERC A was required to offer this software in order to increase electronic claim submissions. The software gave our suppliers an opportunity to try electronic billing at low cost, with the expectation that suppliers would experience the benefits and procure or develop more sophisticated practice management or billing software that would do additional functions. Additionally, use of this software reduced processing costs to the Medicare program as suppliers switch from paper to electronic claims.

With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare specific electronic formats. The same format will be used by suppliers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for suppliers, and should encourage more suppliers to use electronic transactions. These changes have prompted CMS to assess whether or not to continue offering the free billing software in the post-HIPAA environment. CMS will require DMERC A to begin phasing out the free billing software requirement effective fiscal year 2004, approximately one year after HIPAA standards are implemented. This will give our suppliers enough time to find substitute software that can work with all payers. You will be notified when the transition period will begin to phase out the free billing software.

## EDI Extra Documentation Reminder

Following is a brief review of the Extra Documentation Policy for electronic claims.

1. Extra documentation must be faxed at least 48 hours prior to transmitting the claim electronically to allow for proper processing.
2. You must indicate in the HA0 record (narrative) the date the documentation was faxed for easier routing.
3. We will only accept up to 10 pages of faxed extra documentation. Therefore, be concise and submit only pertinent documentation. Faxes over 10 pages will not be accepted. Should you need to submit more than 10 pages, you will need to mail the information, and indicate the mail date information in the HA0 record.
4. CMNs (Certificates of Medical Necessity) must be submitted with the initial claim transmission. CMNs are not considered "extra documentation." If submitted separate from the initial claim transmission, they will not be sent on to be matched to the claim. They will be destroyed without notification to you.

NOTE: This article was previously published as Supplier Notice 2001-27.

## HIPAA: What's Next?

The Implementation of HIPAA required electronic transactions are progressing, and with that progression comes the need to pass on some additional information to the provider/supplier/vendor community. Currently we are working on the Health Care Claim Status Request and Response, also known as the ANSI X12N 276/277 version 4010. EDI queries for health care claim status must be submitted with software based on the ANSI X12N 276 v. 4010 effective October 2002. For every valid 276 request received a responding 277 will be created. Claim Status responses may be available within 24 hours if made within normal business hours. The status response will be delivered electronically to your directory on our Bulletin Board System. Prior claim status versions and formats will be discontinued beginning October, 2002, although claim status information may continue to be available via VPIQ, ARU, or some other non-EDI method, if that method is currently supported.

If you are a provider/supplier who prefers to obtain claim status data in an EDI format but you don't have a vendor that supports the 276/277 transactions, you have the option of contracting with a clearinghouse to translate the information on your behalf. However you will be liable for any charges the clearinghouse bills you for these services.

Unlike other transactions, providers, vendors, and clearinghouses are NOT REQUIRED (in most cases) to test the 276/277 claim status request and response prior to "going live," but they MUST notify their Medicare contractor when they plan to begin using the transactions. Although not required, some providers, vendors or clearinghouses may request to test the transactions just to be on the safe side! If your vendor or clearinghouse wishes to test the 276/277 v. 4010 status query and response it must be scheduled with your Medicare carrier beginning April 2002. There is no charge for this testing but appointments are made on a "first come first serve basis". Due to the high volume of testing that each Medicare carrier must accomplish for all of the HIPAA compliant transactions, if you delay scheduling your testing the DMERC may not be able to accommodate you before October 2002. Therefore it is best to plan ahead!

Since Medicare will not be furnishing any in-depth training on the use and interpretation of the HIPAA

standard implementation guides, providers who feel they need more in-depth training for their staff are expected to obtain training from commercial vendors, their clearinghouse, or through standards development organizations. Any provider/supplier who wishes to familiarize themselves with the 276/277 implementation guide can download the guide from the [www.wpc-edi.com/HIPAA](http://www.wpc-edi.com/HIPAA) web site.

## HIPAA Testing Date Postponed

Effective immediately, the testing for 837 inbound, 837 outbound and 835 remittance transactions has been postponed from October 16, 2001 to January 2nd, 2002. You or your software vendor will be able to schedule testing on or after January 2nd, 2002. Testing can be scheduled by appointment only. If you would like further information you may contact the Region A DMERC EDI Help Desk at 570-735-9429.

Due to the high volume of testing that each Medicare Carrier must accommodate for all of the HIPAA compliant transactions, waiting to schedule a test very late in the transition period may not enable your carrier to accommodate you before October 2002. Therefore, it is best to plan ahead!

NOTE: This article was previously published as Supplier Notice 2001-29.

## Bulletin Board Systems Equipment Move

In order to improve the connectivity options and reliability of our Bulletin Board Systems, the DMERC A will be moving the Bulletin Board Systems telecommunications equipment to its home office in Binghamton, NY. The move will take place during the weekend of January 19, 20, and 21, 2002.

Our Bulletin Board Systems will be unavailable to accept claims submissions or retrieve electronic remittance notices from 6:00 PM Friday, January 18, 2002 through 8:00 AM Tuesday, January 22, 2002.

Please watch for another Supplier Notice in January 2002 to inform you of the new dial-in telephone numbers for both claims submissions and retrieval of electronic remittance notices through the Bulletin Board Systems.

NOTE: This article was previously published as Supplier Notice 2001-28.

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# ANSI X12N 837 Professional Health Care Claim Companion Document

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at [www.wpc-edi.com](http://www.wpc-edi.com).

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the ViPS Medicare System (VMS) by HealthNow New York Inc. Region A DMERC, Contractor number 00811. The information in this document is subject to change. Changes will be communicated in the standard "DMERC Medicare News" quarterly news bulletin and on HealthNow New York Inc.'s Web site: [www.umd.nycpic.com](http://www.umd.nycpic.com). This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

## LANGUAGE

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.
- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.
- Data submitted in CLM20 (Delay Reason Code) will not be used for processing.
- HealthNow New York Inc. Region A DMERC will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- Currency code (CUR02) must equal 'USA'.
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).

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- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
- For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data may not be sent for processing consideration.
- Any data submitted in the PWK (Paperwork) segment may not be considered for processing.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
- HealthNow New York Inc. Region A DMERC will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides. Invalid header and trailer segments (ISA, GS, ST, SE, GE and/or IEA) could result in an unexpected outcome during translation.
- HealthNow New York Inc. Region A DMERC may reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) submitted with more than 9,999 loops.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) submitted with more than 9,999 segments per loop.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
- You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes will not be considered in processing.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last modifier may not be considered.
- HealthNow New York Inc. Region A DMERC will return the first 6-digits of the inbound version as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
- Compression of files using the .zip format is supported for transmissions between the submitter and HealthNow New York Inc. Region A DMERC.

NOTE: This article was previously published as Supplier Notice 2001-30.

# Miscellaneous

## A Reminder: Items Covered In A Skilled Nursing Facility

Reimbursable items in a Skilled Nursing Facility include:

- Parenteral and Enteral Nutrition
- Ostomy Supplies
- Incontinence Supplies
- Prosthetics and Orthotics
- Surgical Dressings
- Immunosuppressive and Oral Anti-Cancer Drugs

NOTE: Durable medical equipment is not covered in a skilled nursing facility.

## Frequently Asked Questions (FAQs) Fiscal Year 2001, Quarter 4

### 1. What information is needed when repairing a patient-owned wheelchair and for billing a K0108?

If a part is being replaced and the HCPCS code being billed requires a CMN, a CMN should accompany the claim.

Documentation must accompany the claim that describes the nature and medical necessity of the repair and an itemization of the parts and labor time involved with the repair for each individual item or part. The claim must document the date the equipment was purchased and the make/model/serial number of the equipment/item. Labor is billed using code E1340 in 15 minute increments. Parts should be billed using the appropriate HCPCS code. If no HCPCS code is available, use K0108 and give a complete description of the part/item/equipment along with part number/serial number and catalog pricing information. Refer to DME Medicare News June 1996, page 19.

### 2. What modifiers are necessary when billing for repairs? Are the RP and NU or RR modifiers needed?

The RR modifier does not apply. RR is only used for rented equipment. NURP must be used, in that order. Refer to Supplier Notice 98-16.

### 3. What type of documentation is required to submit when the patient is going from a manual to a power wheelchair?

Documentation should include medical necessity for the power wheelchair, and options and accessories that are ordered. Documentation must indicate the reason the patient can no longer use the manual wheelchair. Documentation requirements for power wheelchairs are in the medical policy. Documentation requirements for options and accessories are in the wheelchair option and accessory policy.

### 4. Does an E0434 need to have its own CMN or can it be included on the CMN for the stationary?

E0434 can be included on the CMN for the stationary system.

### 5. When a patient has a stationary oxygen system, and the physician then adds a portable oxygen system, do I need a new initial CMN?

When a portable oxygen system is added subsequent to initial certification of a stationary system, a revised CMN is required.

### 6. When billing for therapeutic shoes for diabetics, explain how many inserts and modifications are covered. Can the patient be allowed more with added documentation?

For patients meeting the coverage criteria, coverage is limited to one of the following within one calendar year (Jan. 1- Dec. 31):

1. One pair of custom-molded shoes, A5501 (which includes inserts provided with the shoes); and, 2 additional pairs of inserts, A5502.
2. One pair of depth shoes, A5500; and, 3 pairs of inserts, A5502 (not including the non-customized removable inserts provided with such shoes).

Additional inserts will be considered if additional documentation is provided.

A modification of a custom-molded or depth shoe will be covered as a substitute for the insert. Follow the utilization parameters, as outlined above, for inserts.

Refer to the Supplier Manual for this information.

### **7. Why is a hospital bed downcoded?**

A hospital bed will be downcoded if a total electric bed, which is not covered by Medicare, is billed. If the CMN grid is not properly answered to support the need for an E0260, it will be downcoded to an E0255.

### **8. Can we bill the patient the difference between an E0265 and an E0260 on an assigned claim?**

An E0265, a total electric hospital bed, is a non-covered item by Medicare; therefore, any claim submitted for an E0265 will be automatically down coded to an E0260. A provider is unable to bill the patient the difference on an assigned claim.

### **9. Why are all of my nutrient claims being downcoded?**

The medical necessity for special enteral formulas (B4151, B4153-B4156) will need to be justified in each patient. If the medical necessity for these formulas is not substantiated, the nutrient will be down coded to B4150.

### **10. How do I calculate the units and calories for nutrients?**

All Enteral Nutrient HCPCS codes are established in 100 calorie increments. Therefore, they must always be billed and processed in 100 calorie increments - one unit of service for every 100 calories supplied. Always indicate the number of units supplied for Enteral Nutrients.

Calculate as follows:

Calories prescribed per day, divided by 100, multiplied by the number of days in billing period, equals the total number of units supplied.

## **Home Prothrombin Time Monitors (INR)**

In a September 18, 2001 Decision Memorandum, the Centers for Medicare and Medicaid Services stated that home prothrombin time monitors (INR) used to manage anticoagulation are only eligible for coverage under the Diagnostic Services benefit. That is to say that individual tests performed by the patient or caregiver using the device can be considered for coverage. However, these tests must be billed by a laboratory to the local carrier or local intermediary. There is no coverage for the monitor or related supplies under the Durable Medical Equipment benefit or any other benefit administered by the DMERC. If claims for these items are received by the DMERC, they will be rejected as incorrect billing jurisdiction. Claims rejected for this reason are not eligible for appeal through the DMERC.

## **New DMERC A ListServe**

The Region A DMERC ListServe is a new feature on the DMERC A website. The Listserve will be used to notify subscribers via email of important and time-sensitive Medicare program information, upcoming provider education and training events, and other important announcements or messages. Subscribers will also receive notice of the availability of newsletters, Supplier Alerts, and Supplier Notices on our Web site.

### **To Subscribe**

To receive reminders and announcements via email, you may join the ListServe by visiting:  
[www.umd.nycpic.com](http://www.umd.nycpic.com).

Subscribe to the Region A DMERC ListServe by typing your email address in the box provided at the ListServe page.

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## Completion of Certificates of Medical Necessity

Dear Physician:

Certificates of medical necessity, commonly known as CMNs, are documents used by the DMERCs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both the medical need for, and the utilization of, all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are *your partners* in caring for *your patient*. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act provides that:

*[i]n case of an item or service...ordered by a physician or a practitioner...but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.*

Remember, everyone has tight cashflow these days - help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Paul J. Hughes, MD  
Medical Director, DMERC Region A, PSC

## Product Classification Lists Have a New Look

You will notice the Product Classification Listings in the Appendices are set up differently than in the past. In order to be consistent with the SADMERC, we are publishing these lists in the same format as they appear on the SADMERC website. There are also more product types being published by Region A this year. In addition to the listings we have published in the past, this year we are including Rollabout Chairs (on the Power Operated Vehicle list), C-Pap Systems and Respiratory Assist Devices, External Infusion Pumps, Orthotics and Prosthetics, Wheelchair Accessories, and Wheelchair Cushions.

## Pessary Codes - Change in Jurisdiction

Effective for dates of service on or after January 1, 2002, jurisdiction for processing claims for the following pessary codes will change from the Durable Medical Equipment Regional Carriers (DMERCs) to the local carriers:

- A4561 - Pessary, rubber, any type
- A4562 - Pessary, non rubber, any type

Suppliers and physicians should contact the local carrier in their area for instructions on how to submit claims for these items.

# Noncovered Items, Not Medically Necessary Items, and Advance Beneficiary Notices - New Modifiers

## Noncovered items

Effective for dates of service on or after January 1, 2002, a new modifier has been established to describe situations in which an item or service with a specific code is noncovered.

GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit

The GY modifier replaces the current ZY modifier for dates of service on or after January 1, 2002. The ZY modifier should continue to be used for claims with dates of service on or before December 31, 2001, regardless of the date of submission. Under the standard grace period, the ZY modifier will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with the ZY modifier with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

It is important to distinguish situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit from those situations in which an item is denied because it is not reasonable and necessary (see below). Some examples of statutorily excluded items or situations include, but are not limited to:

- Hearing aids
- Eyeglasses or contact lenses - except those provided following cataract removal or other cause of aphakia
- Durable medical equipment and related accessories and supplies provided to patients in nursing facilities
- Dental items
- Personal comfort items
- Orthopedic shoes or shoe inserts - other than those covered under the Therapeutic Shoes for Diabetics benefit or those that are attached to a covered leg brace
- Replacement of items that have not reached their useful lifetime and were not lost, stolen, or irreparably damaged (not including ordinary wear and tear)

A description of the statutory benefits whose items are processed by the DMERC can be found in the Region A DMERC Supplier Manual. Some examples of items or situations which do not meet the definition of a Medicare benefit include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition
- Enteral nutrients that are administered orally
- Infusion drugs that are not administered through a durable infusion pump
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin
- Irrigation supplies that are used to irrigate the skin or wounds
- Immunosuppressive drugs when they are used for conditions other than following organ transplants
- Most oral drugs
- Oral anti-cancer drugs when there is no injectable or infusion form of the drug
- Nondurable items (that are not covered under any other benefit category) - e.g., compression stockings and sleeves
- Durable items that are not primarily designed to serve a medical purpose - e.g., exercise equipment

Use of the GY modifier is limited to situations in which there is a specific HCPCS code to describe the item or service. If there is no specific HCPCS code to describe the item or service, then code A9270 (Noncovered item or service) is used. The GY modifier should generally not be used with a "miscellaneous" or "not otherwise classified" code - e.g., E1399. The GY modifier is not needed with code A9270. Code A9270 must not be used in situations in which an item is expected to be denied as not reasonable and necessary (see below).

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An Advance Beneficiary Notice (ABN) is not required for items that are statutorily excluded from coverage or that do not meet the definition of any Medicare benefit category since the DMERC does not make limitation of liability determinations for these types of denials.

### **Not medically necessary items**

Effective for dates of service on or after January 1, 2002 a new modifier, GZ, has been established to describe certain situations in which an item or service is expected to be denied as not medically necessary. The new modifier will complement the existing GA modifier which is used in other situations in which an item or service is expected to be denied as not medically necessary.

**GZ** Item or service expected to be denied as not reasonable and necessary (Used when an Advance Beneficiary Notice is not on file)

**GA** Waiver of liability statement on file (Used when an item or service is expected to be denied as not reasonable and necessary and an Advance Beneficiary Notice is on file)

It is important to distinguish situations in which an item is denied because it is not reasonable and necessary from those situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit (see above). Some example of items or situations which are medical necessity denials include, but are not limited to:

- Items which are not ordered by a physician or qualified nurse practitioner, clinical nurse specialist, or physician assistant
- Items which do not meet medical necessity coverage criteria or frequency guidelines specified in national or DMERC medical policies
- Items which are the same as or similar to covered items that the beneficiary is already using
- Items whose safety and effectiveness in the home setting has not been established
- Experimental or investigational items - other than Category B IDE devices

A GZ or GA modifier can be used on either a specific or miscellaneous HCPCS code. It would never be correct to place both modifiers on the same claim line. If both modifiers are used on the same claim line, it will be denied as invalid coding.

Refer to the Region A DMERC Supplier Manual for information concerning Advance Beneficiary Notices (ABNs).

## **Home Blood Glucose Supplies**

Manufacturers of home blood glucose monitors often sell monitoring "kits" which include the home blood glucose monitor and small quantities of starter supplies (e.g., test strips, lancet device with lancets, etc.). Both the monitor and starter supplies are included in the manufacturer's price for these kits. If these monitoring "kits" are provided to Medicare beneficiaries, the starter supplies are considered part of the service of furnishing the monitor. They are not separately payable and should not be billed separately.

Additionally, many manufacturers provide free monitors or free supplies of test strips in return for purchasing their brand of monitor and test strips. This practice is potentially a violation of the Medicare and Medicaid anti-kickback statute. This statute makes it illegal to offer or

pay anything of value to induce a person to order any item or service for which payment may be made under the Medicare or Medicaid program. If a supplier receives test strips or monitors for free from the manufacturer and provides those items to a Medicare beneficiary, then only those items the supplier paid for can be billed to Medicare and the beneficiary. There cannot be a charge for the item that was provided free of charge by the manufacturer.

A supplier may bill for test strips and other supplies that they themselves package together with the monitor and ship to the beneficiary. However, if any of the items shipped were received by the supplier free of charge they may not be billed.

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## Prostheses and Orthoses Related to a Hospital Stay

The DMERC has identified a number of problems with suppliers submitting claims to the DMERC for items related to an inpatient hospital stay. Hospitals are required to provide whatever equipment or other items are needed by a patient during a Part A covered inpatient hospitalization. Hospitals may either provide the item directly or under arrangement with a supplier. This includes items which are provided prior to hospital admission but whose medical necessity begins during the hospital stay. One example is a custom fabricated spinal orthosis which is needed following spinal surgery. Even if this item is fabricated prior to hospital admission and is given to the patient to take to the hospital, the hospital must be the one to reimburse the orthotist for the item. In this situation, the orthotist is not permitted to submit a claim to the DMERC for that item.

Similarly, if an item is needed during an inpatient stay, it must be provided and paid for by the hospital either directly or under arrangement - even if the patient will continue to use the item at home. A supplier may deliver an item to an inpatient during the two days prior to discharge to home and bill the DMERC for the item only if the patient does not use the item in the hospital. For example, if a patient needs a brace following discharge, the orthotist may come to the hospital, do any fitting or custom fabrication that is needed, and leave the brace with the patient to take home. Or a supplier may bring an item which will be needed at home to the hospital to show the patient how to use it and then leave the item with the patient to take home. If the patient does not wear or use the item in the hospital, the supplier may submit a claim to the DMERC for the item. However, if the patient wears or uses the item in the hospital - indicating that the item was a necessary part of treatment or rehabilitation during the hospital stay - then reimbursement is included in the hospital's payment for the inpatient admission, even if the patient will continue to use the item following discharge. When the patient wears or uses the item in the hospital, the hospital must pay the supplier for the item; the supplier may not submit a claim to the DMERC for the item.

## Update to Coordination of Benefits (COB) Contractor

NOTE: This article was received after publication of Supplier Notice 2001-25 (found on page 38).

Service provided by the Coordination of Benefits (COB) Contractor was affected by the disaster to the World Trade Center on September 11, 2001. As previously reported, the COB Contractor moved its operations to the corporate office of Group Health Incorporated in an effort to minimize disruption to service.

After city officials inspected the lower Manhattan facility and found the building to be sound and air quality within standards, the COB Contractor staff immediately began migrating back to the lower Manhattan facility. As of October 22, 2001, all COB activities have returned to normal at that facility. All systems continue to be operational and the COB Call Center is available Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Standard Time.

Continue to mail questionnaires and correspondence to:

Medicare-COB  
Data Match Project  
P.O. Box 125  
New York, N.Y. 10274-0125

Medicare-COB  
MSP Claims Investigation Project  
P.O. Box 5041  
New York, N.Y. 10274-5041

Medicare-COB  
Voluntary Agreement Project  
P.O. Box 660  
New York, N.Y. 10274-0660

Medicare-COB  
Initial Enrollment Questionnaire Project  
P.O. Box 17521  
Baltimore, MD 21203-7521

Your assistance during this period has truly been appreciated. Without your understanding and cooperation, Medicare's customers could have experienced major inconveniences. Please continue to visit the COB Web site at [www.hcfa.gov/medicare/cob](http://www.hcfa.gov/medicare/cob) so you will be kept abreast of all future COB developments.

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## Comprehensive Error Rate Testing (CERT)

To improve the processing and medical decision-making involved with payment of Medicare claims, CMS began a new program effective August 2000. This program is called Comprehensive Error Rate Testing (CERT) and is being implemented to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (DynCorp of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. DynCorp's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. CMS will use the DynCorp findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. On a monthly basis, DynCorp will request a small sample of claims, approximately 200, from each contractor, as the claims are entered into their system. DynCorp will follow the claims until they're adjudicated, and then compare the contractor's final claims decision with its own. Instances of incorrect processing (e.g., due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement. Consequently, it is CMS's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How else are providers and suppliers impacted by CERT?

Providers and suppliers of the sampled claims will be asked during the course of the DynCorp review, to provide additional information (e.g., medical records, certificates of medical necessity, etc.) for DynCorp staff to verify services billed were delivered, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information and the name of a contact person.

General questions regarding the CERT initiative may be directed to Laura Castelli, DynCorp Project Director for

the CERT Program, at 804-264-1778. Otherwise, providers and suppliers will be contacted ONLY if their claim(s) is selected and DynCorp requires additional information.

## Supplier Notices

*The information contained in the Supplier Notices was accurate at the time of original publication. Some of the content may have since been updated or changed.*

### DMERC Email Inquiries - New Address

**Supplier Notice 2001-20  
August 24, 2001**

The DMERC A has established a new email address for suppliers to send their inquiries; the new address is [dmerc.pr@healthnow.org](mailto:dmerc.pr@healthnow.org).

Please remember that email messages sent to the DMERC are considered written correspondence and the DMERC has up to 45 calendar days to respond to these inquiries.

When sending email messages, the supplier's name is required in addition to the name of the person submitting the inquiry. If we are unable to determine the source of the inquiry, we will send a return message requesting the identity of the inquirer. Our responses must follow the provisions of the Privacy Act. Please do not include Medicare numbers, Social Security numbers, personal medical information, or other confidential items in your email inquiry. If you have a question about a specific claim, please contact our Supplier Service Unit by calling 866-419-9458 between the hours of 7:30 a.m. and 4:30 p.m.

Requests for information covered under the Freedom of Information Act must be submitted to our office in writing with the signature of the requestor. Requests sent via email will be returned to the sender with instructions for submitting the request in writing.

As of Tuesday, August 28, 2001, email inquiries sent to the [mailto.dmerca@healthnow.org](mailto:mailto.dmerca@healthnow.org) address will be returned to the sender with instructions to forward the message to the new address. Please remember to update your email address book.

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# Program Safeguard Contractor Supplier Hotline Discontinued

**Supplier Notice 2001-21**  
**September 27, 2001**

The DMERC A will be discontinuing the Program Safeguard Contractor (PSC) Supplier Hotline (570-735-9424) that was used for the supplier community to contact the DMERC A regarding the PSC. The hotline will be discontinued as of October 1, 2001.

Please direct inquiries to the Caller Information Network at 866-419-9458.

## Denial Code Change for DME Furnished in SNFs

**Supplier Notice 2001-22**  
**September 28, 2001**

The use of the Contractual Obligation (CO) denial code indicates that the beneficiary cannot be charged for denied services. Previously, DME provided in a SNF was denied with a CO denial code. However, it has been determined that DME provided in a SNF setting is a noncovered service under Part B and the use of the CO denial code is not appropriate in this situation.

Effective October 2001, claims for DME provided in a SNF setting will be denied with a Patient Responsibility (PR) 58 denial code, making it permissible to charge the beneficiary for these types of services. Claims previously denied as CO rather than PR may be re-submitted for services if a corrected remittance advice is required to obtain payment from a secondary payer.

## Revision of Existing Home Health Prospective Payment System (HH PPS) Consolidated Billing Edits

**Supplier Notice 2001-23**  
**September 28, 2001**

Providers will receive the following alert when a Request for Anticipated Payment (RAP) for the episode has been received and the incoming therapy or supply claim contains dates of service within the full 60 day home health episode period.

This code is important to the provider because it will indicate that the services may be denied and claim payment may be recouped if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing.

**N88 - This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under and HHA episode of care.**

This remark will be applied at the line level on the electronic remittance advice.

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## 4th Quarter Update: Drug Fees

**Supplier Notice 2001-24**  
**October 1, 2001**

The fees listed below are effective October 1, 2001.

### DRUG FEES

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J0285	AMPHOTERICIN B	50MG	\$ 10.28
J0286	AMPHOTERICIN B, ANY LIPID FORMULATION	50MG	\$ 88.66
J0895	DEFEROXAMINE MESYLATE	500MG/5CC	\$ 13.50
J1170	HYDROMORPHONE	4MG	\$ 1.50
J1250	DOBUTAMINE HYDROCHLORIDE	250MG	\$ 2.97
J1325	EPOPROSTENAL	.5MG	\$ 12.04
J1455	FOSCARNET SODIUM	1000MG	\$ 11.99
J1570	GANCICLOVIR SODIUM	500MG	\$ 33.89
J1820	INSULIN, INJECTION	UP TO 100UNITS	\$ 2.29
J2175	MEPERIDINE HYDROCHLORIDE	100MG	\$ 0.56
J2260	MILRINONE LACTATE	5ML	\$ 46.34
J2270	MORPHINE SULFATE	10MG	\$ 0.62
J2271	MORPHINE SULFATE	100MG	\$ 13.85
J2275	MORPHINE SULFATE, PF, STERILE SOL	10MG	\$ 2.00
J2545	PENTAMIDINE FOR AEROSOL INHALER	300MG	\$ 93.81
J2920	METHYLPREDNISOLONE SODIUM SUCCINATE	40MG	\$ 1.58
J2930	METHYLPREDNISOLONE SODIUM SUCCINATE	125MG	\$ 1.92
J3010	FENTANYL CITRATE	2ML	\$ 1.96
J3370	VANCOMYCIN HCL	500MG	\$ 5.20
J7500	AZATHIOPRINE, ORAL, TAB	50MG	\$ 1.25
J7501	AZATHIOPRINE, PARENTERAL	100MG	\$ 118.95
J7502	CYCLOSPORINE, ORAL	100MG	\$ 5.23
J7506	PREDNISONE, ORAL	5 MG	\$ 0.02
J7507	TACROLIMUS, ORAL	1 MG	\$ 2.91
J7508	TACROLIMUS, ORAL	5 MG	\$ 14.55
J7509	METHYLPREDNISOLONE, ORAL	4 MG	\$ 0.51
J7510	PREDNISOLONE, ORAL	5 MG	\$ 0.03
J7513	DACLIZUMAB, PARENTERAL	25MG	\$ 397.29
J7515	CYCLOSPORINE, ORAL	25MG	\$ 1.31
J7517	MYCOPHENOLATE MOFETIL, ORAL	250MG	\$ 2.40

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**HCPCS**

<b>CODE</b>	<b>DESCRIPTION</b>	<b>DOSAGE</b>	<b>FEE</b>
J7520	SIROLIMUS, ORAL	1MG	\$ 6.51
J8700	TEMOZOLMIDE,ORAL	5MG	\$ 6.17
J9000	DOXORUBICIN HCL	10MG	\$ 50.96
J9001	DOXARUBICIN HCL ALL LIPID FORMS.	10MG	\$ 358.96
J9040	BLEOMYCIN SULFATE	15UNITS	\$ 289.37
J9065	CLADRIBINE	1MG	\$ 56.09
J9100	CYTARABINE	100MG	\$ 5.94
J9110	CYTARABINE	500MG	\$ 23.75
J9190	FLUOROURACIL	500MG	\$ 2.47
J9200	FLOXURIDINE	500MG	\$ 129.56
J9208	IFOSFAMIDE	1GM	\$ 156.65
J9265	PACLITAXEL	30MG	\$ 162.17
J9280	MITOMYCIN	5MG	\$ 127.40
J9290	MITOMYCIN	20MG	\$ 421.99
J9360	VINBLASTINE SULFATE	1MG	\$ 4.10
J9370	VINCRISTINE SULFATE	1MG	\$ 33.98
J9375	VINCRISTINE SULFATE	2MG	\$ 67.96
J9380	VINCRISTINE SULFATE	5MG	\$ 169.91
J9390	VINORELBINE TARTRATE	10MG	\$ 90.73
K0548	LISPRO		\$ 2.27

**NEBULIZER DRUG FEES****HCPCS**

<b>CODE</b>	<b>MOD</b>	<b>DESCRIPTION</b>	<b>FEE</b>
J7051		STERILE SALINE OR WATER	\$ 0.21
J7608	KO	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	\$ 5.06
J7608	KP	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	\$ 5.06
J7608	KQ	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	\$ 4.53
J7618		ALBUTEROL, CONCENTRATED FORM	\$ 0.14
J7619	KO	ALBUTEROL, UNIT DOSE FORM	\$ 0.47
J7619	KP	ALBUTEROL, UNIT DOSE FORM	\$ 0.47
J7619	KQ	ALBUTEROL, UNIT DOSE FORM	\$ 0.14
J7628		BITOLTEROL MESYLATE, CONCENTRATED FORM	\$ 0.25
J7629	KO	BITOLTEROL MESYLATE, UNIT DOSE FORM	\$ 0.33
J7629	KP	BITOLTEROL MESYLATE, UNIT DOSE FORM	\$ 0.33
J7629	KQ	BITOLTEROL MESYLATE, UNIT DOSE FORM	\$ 0.25

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HCPCS CODE	MOD	DESCRIPTION	FEE
J7631	KO	CROMOLYN SODIUM, UNIT DOSE FORM	\$ 0.27
J7631	KP	CROMOLYN SODIUM, UNIT DOSE FORM	\$ 0.27
J7631	KQ	CROMOLYN SODIUM, UNIT DOSE FORM	\$ 0.17
J7635		ATROPINE, CONCENTRATED FORM	\$ 0.16
J7636	KO	ATROPINE, UNIT DOSE FORM	\$ 0.37
J7636	KP	ATROPINE, UNIT DOSE FORM	\$ 0.37
J7636	KQ	ATROPINE, UNIT DOSE FORM	\$ 0.16
J7637		DEXAMETHASONE, CONCENTRATED FORM	\$ 0.10
J7638	KO	DEXAMETHASONE, UNIT DOSE FORM	\$ 0.21
J7638	KP	DEXAMETHASONE, UNIT DOSE FORM	\$ 0.21
J7638	KQ	DEXAMETHASONE, UNIT DOSE FORM	\$ 0.10
J7639	KO	DORNASE ALPHA, UNIT DOSE FORM	\$ 15.87
J7639	KP	DORNASE ALPHA, UNIT DOSE FORM	\$ 15.87
J7639	KQ	DORNASE ALPHA, UNIT DOSE FORM	\$ 15.79
J7642		GLYCOPYRROLATE, CONCENTRATED FORM	\$ 0.31
J7643	KO	GLYCOPYRROLATE, UNIT DOSE FORM	\$ 0.83
J7643	KP	GLYCOPYRROLATE, UNIT DOSE FORM	\$ 0.83
J7643	KQ	GLYCOPYRROLATE, UNIT DOSE FORM	\$ 0.31
J7644	KO	IPRATROPIUM BROMIDE, UNIT DOSE FORM	\$ 3.34
J7644	KP	IPRATROPIUM BROMIDE, UNIT DOSE FORM	\$ 3.34
J7644	KQ	IPRATROPIUM BROMIDE, UNIT DOSE FORM	\$ 2.92
J7648		ISOETHARINE HCL, CONCENTRATED FORM	\$ 0.17
J7649	KO	ISOETHARINE HCL, UNIT DOSE FORM	\$ 0.21
J7649	KP	ISOETHARINE HCL, UNIT DOSE FORM	\$ 0.21
J7649	KQ	ISOETHARINE HCL, UNIT DOSE FORM	\$ 0.17
J7658		ISOPROTERENOL HCL, CONCENTRATED FORM	*IC
J7659	KO	ISOPROTERENOL HCL, UNIT DOSE FORM	*IC
J7659	KP	ISOPROTERENOL HCL, UNIT DOSE FORM	*IC
J7659	KQ	ISOPROTERENOL HCL, UNIT DOSE FORM	*IC
J7668		METAPROTERENOL SULFATE, CONCENTRATED FORM	\$ 0.25
J7669	KO	METAPROTERENOL SULFATE, UNIT DOSE FORM	\$ 1.09
J7669	KP	METAPROTERENOL SULFATE, UNIT DOSE FORM	\$ 1.09
J7669	KQ	METAPROTERENOL SULFATE, UNIT DOSE FORM	\$ 0.25
J7680		TERBUTALINE SULFATE, CONCENTRATED FORM	\$ 2.13
J7681	KO	TERBUTALINE SULFATE, UNIT DOSE FORM	\$ 2.34
J7681	KP	TERBUTALINE SULFATE, UNIT DOSE FORM	\$ 2.34
J7681	KQ	TERBUTALINE SULFATE, UNIT DOSE FORM	\$ 2.13

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HCPCS CODE	MOD	DESCRIPTION	FEE
J7682	KO	TOBRAMYCINE, UNIT DOSE FORM, 300MG	\$ 44.69
J7682	KP	TOBRAMYCINE, UNIT DOSE FORM, 300MG	\$ 44.69
J7682	KQ	TOBRAMYCINE, UNIT DOSE FORM, 300MG	*IC
J7683		TRIAMCINOLONE, CONCENTRATED FORM	\$ 0.04
J7684	KO	TRIAMCINOLONE, UNIT DOSE FORM	\$ 0.15
J7684	KP	TRIAMCINOLONE, UNIT DOSE FORM	\$ 0.15
J7684	KQ	TRIAMCINOLONE, UNIT DOSE FORM	\$ 0.04
Q0163		DIPHENHYDRAMINE HYDROCHLORIDE, 50MG	\$ 0.02
Q0164		PROCHLORPERAZINE MALEATE, 5MG	\$ 0.57
Q0165		PROCHLORPERAZIEN MALEATE, 10MG	\$ 0.86
Q0166		GRANISETRON HYDROCHLORIDE, 1MG	\$ 44.69
Q0167		DRONABINOL, 2.5MG, ORAL	\$ 3.28
Q0168		DRONABINOL, 5MG, ORAL	\$ 7.66
Q0169		PROMETHAZINE HYDROCHLORIDE, 12.5MG, ORAL	\$ 0.26
Q0170		PROMETHAZINE HYDROCHLORIDE, 25MG, ORAL	\$ 0.02
Q0171		CHLORPROMAZINE HYDROCHLORIDE, 10MG, ORAL	\$ 0.07
Q0172		CHLORPROMAZINE HYDROCHLORIDE, 25MG, ORAL	\$ 0.09
Q0173		TRIMETHOBENZAMIDE HYDROCHLORIDE, 250MG, ORAL	\$ 0.43
Q0174		THIETHYLPERAZINE MALEATE, 10MG, ORAL	\$ 0.56
Q0175		PERPHENAZINE, 4MG, ORAL	\$ 0.57
Q0176		PERPHENAZIEN, 8MG, ORAL	\$ 0.93
Q0177		HYDROXYZINE PAMOATE, 25MG, ORAL	\$ 0.33
Q0178		HYDROXYZINE PAMOATE, 50MG, ORAL	\$ 0.29
Q0179		ONDANSETRON HYDROCHLORIDE, 8MG, ORAL	\$ 25.15
Q0180		DOLASETRON MESYLATE, 100MG, ORAL	\$ 69.64
Q9920		EPOETIN	\$ 10.00

\* IC (INDIVIDUAL CONSIDERATION)

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# Coordination of Benefits (COB) Contractor Operations Status

**Supplier Notice 2001-25**  
**October 12, 2001**

The following statement is provided on behalf of the Coordination of Benefits Contractor:

Service provided by the Coordination of Benefits (COB) Contractor was affected by the disaster to the World Trade Center. On Monday, September 17, 2001, the COB Contractor began moving its operations to the corporate office of Group Health Incorporated. The COB Contractor's call center has since been restored to 80 percent of capacity and, although the call center is not fully staffed, there are no reports of lengthy wait time. The Electronic Correspondence Referral System (ECRS) continues to be up and fully operational.

City officials have inspected the lower Manhattan facility and have found the building to be structurally sound. The air has also been tested and has passed the quality standards. Currently, a skeletal staff made up of the executive and technical support individuals are occupying the building. Full electric power was restored on Tuesday, September 25, 2001. The COB Contractor will relocate staff back to the lower Manhattan facility using a phased-in approach, over a several week period, to guard against the potential for interrupted customer service. Telephone service is available Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time.

Questionnaires and correspondence should continue to be mailed to:

Medicare-COB  
Data Match Project  
P.O. Box 125  
New York, NY 10274-0125

Medicare-COB  
MSP Claims Investigation Project  
P.O. Box 5041  
New York, NY 10274-5041

Medicare-COB  
Voluntary Agreement Project  
P.O. Box 660  
New York, NY 10274-0660

Medicare-COB  
Initial Enrollment Questionnaire Project  
P.O. Box 17521  
Baltimore, MD 21203-7521

We appreciate your understanding and cooperation during this difficult time and assure you that we are making every effort to resume full service and minimize your inconvenience. Please continue to visit the COB Web site at [www.hcfa.gov/medicare/cob](http://www.hcfa.gov/medicare/cob) so we may keep you abreast of all future developments.

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## Fourth Quarter Update: Oral Anti-Cancer Drug Fees

### Supplier Notice 2001-26 October 25, 2001

The fees listed below were effective October 1, 2001.

Manufacturers	Descriptors	Dosage	NDC Number/Code	Fee
GLAXO- WELLCOME ROCHE LABORATORIES ROCHE LABORATORIES	BUSULFAN	2 mg Oral 1 Tab, per unit	000173-0713-25	\$1.91
BRISTOL-MYERS BRISTOL-MYERS BRISTOL-MYERS BRISTOL-MYERS	CAPECITABINE	150 mg, Oral, 1 Tab per unit	00004-1100-51	\$2.43
GLAXO- WELLCOME	CAPECITABINE	500 mg, Oral, 1 Tab per unit	00004-1101-16	\$8.11
LEDERLE LABS	CYCLOPHOSPHAMIDE	25 mg Oral 1 Tab, per unit	00015-0504-01	\$1.98
ROXANE	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-01	\$3.64
ROXANE	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-02	\$3.64
ROXANE	ETOPOSIDE	50 mg Oral 1 Tab, per unit	00015-3091-45	\$52.43
LEDERLE LABS	MELPHALAN	2 mg 1 Tab, per unit	00173-0045-35	\$2.29
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00005-4507-23	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-4550-15	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-4550-25	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-03	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-05	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-06	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-07	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-10	\$2.92
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-25	\$2.92
MYLAN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00378-0014-01	\$2.92
MYLAN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00378-0014-50	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-02	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-35	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-45	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-46	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-47	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-48	\$2.92
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-49	\$2.92
UDL	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	51079-0670-05	\$2.92
DURAMED	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	51285-0509-02	\$2.92
ESI LEDERLE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	59911-5874-01	\$2.92
SCHERING	TEMOZOLOMIDE	5mg Oral 1 Tab, per unit	00085-1248-01	\$6.17
SCHERING	TEMOZOLOMIDE	5mg Oral 1 Tab, per unit	00085-1248-02	\$6.17
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-01	\$24.68
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-02	\$24.68
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-01	\$123.40
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-02	\$123.40
SCHERING	TEMOZOLOMIDE	250mg Oral 1 Tab, per unit	00085-1252-01	\$308.49
SCHERING	TEMOZOLOMIDE	250mg Oral 1 Tab, per unit	00085-1252-02	\$308.49

This bulletin should be shared with all health care practitioners and managerial members of the supplier staff. All bulletins are available at no cost from our Web site at [www.umd.nycpic.com](http://www.umd.nycpic.com).

## NEW Beneficiary 800# in PA

The Centers for Medicare and Medicaid Services (CMS) are changing the Medicare Customer Service 800 telephone numbers of our three largest contractors serving beneficiaries in Pennsylvania on November 29, 2001. This is a pilot to test the value of having a single 800 number for beneficiaries and the public to call with questions on any Medicare issue. CMS's goal is to improve existing telephone customer service by: 1) providing a single point of access and easy-to-remember number; 2) getting callers to the correct contractor as quickly as possible; and, 3) reducing the number of calls and transfers the Medicare community now experiences (i.e., no "hang up and dial...").

Beginning November 29, callers in PA dialing 1-800-MEDICARE (or, still dialing the "old" HGSAdministrators, Veritus, and HealthNow 800 lines) will receive this enhanced service. All of these callers will be routed to 1-800-MEDICARE and hear the same script choices found on pages 6 & 7 of the Medicare and You 2002 Handbook. Though initially reaching the 1-800-MEDICARE center, the caller can get directly to a specific Medicare contractor by use of a new Service Code, located on each Medicare Summary Notice. These codes are:

1.) Veritus -----#00363;                      2.) HealthNow -- #00811;                      3.) HGSA ----- #00865.

Beneficiary and general public calls to 1-800-MEDICARE for claims and/or detailed coverage information should continue to be made during regular business hours. General information or requests for items such as new Medicare cards, publications, etc., can be made at any time.

**NOTE: This pilot does NOT affect our PROVIDER call lines in any way. Providers should continue to reach us at 866-419-9458.**

## DMERC Medicare News

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Suppliers: This newsletter should be directed to your billing manager.