DMERC Medicare News

DMERC A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone (866) 419-9458 ◆ www.umd.nycpic.com
Number 58 ◆ June 2001

DMERC A Summer 2001 Education Schedule

Mark your calendars – the Summer 2001 seminar and workshop schedules are set! Region A is holding DMERC 101 seminars and respiratory workshops for our summer sessions.

Locations	*Dates/Sessions Available*	*Registration Deadlines*
Marriott Boston-Peabody 8A Centennial Drive Peabody, MA 01960 PH: 978-977-9700	August 15, 2001 - DMERC 101 August 16, 2001 - Respiratory	Tuesday, July 31, 2001 Tuesday, July 31, 2001
Marriott Philadelphia West 111 Crawford Avenue Philadelphia, PA 19107 PH: 610-941-5600	August 22, 2001 - DMERC 101 August 23, 2001 - Respiratory	Tuesday, July 31, 2001 Tuesday, July 31, 2001
Marriott Pittsburgh 112 Washington Street Pittsburgh, PA 15219 PH: 412-471-4000	August 29, 2001 - Respiratory	Tuesday, July 31, 2001
Sheraton – Burlington, VT 870 Williston Road Burlington, VT 05403 PH: 802-865-6600	September 11, 2001 - Respiratory	Friday, August 31, 2001
Marriott New York LaGuardia 102-05 Ditmars Boulevard East Elmhurst, NY 11369 PH: 718-565-8900	September 13, 2001 - Respiratory	Friday, August 31, 2001
DoubleTree Portland 1230 Congress Avenue Portland, ME 04102 PH: 207-774-5611	September 17, 2001 - Respiratory	Friday, August 31, 2001

Contact the hotels for overnight accommodations, parking, parking fees, and driving directions.

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DMERC A Contacts

Supplier Toll-Free Help Line	866-419-9458	Hearings Voice Mail	570-735-9513
Beneficiary Toll-Free Help Line	800-842-2052	Medicare Secondary Payer	570-740-9001
Beneficiary Help Line	570-735-7383	National Supplier Clearinghouse	866-238-9652
Check Control	570-740-9002	Program Education & Training	570-735-9666
Check Control/MSP Fax	570-735-9594	Program Education & Training Fax	570-735-9442
EDI Fax	570-735-9510	Reconsiderations Fax	570-735-9599
EDI Helpdesk	570-735-9429	SADMERC	877-735-1326
Hearings Fax	570-735-9599		

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DMERC 101 Seminar Agenda		*Respiratory Workshop Agenda*	
8:30 AM – 9:00 AM	Registration	8:30 AM – 9:00 AM	Registration
9:00 AM – 12:00 PM	DMERC 101	9:00 AM – 9:15 AM	Welcome and Introduction
12:00 PM – 1:00 PM	Lunch *(Will not provided)*	9:15 AM – 11:30 AM	Educational Forum: Oxygen, Nebulizers, CPAP, RAD, Ventilators, IPPB
1:00 PM – 3:00 PM	DMERC 101	11:30 AM – 12:00 PM	Questions and Answers

How to Register

Complete a registration form below for each attendee. **There is a $20 fee per person, per session.** Credit cards and cash are not accepted. **Make checks payable to HealthNow NY, Inc.** Mail the registration form(s) and check(s) to the address listed below. The fee is non-refundable. Registrations **will not** be accepted by telephone. All attendees must be pre-registered and registrations must be paid in advance. Due to limited space, registration is on a first-come, first-served basis. In the event that a particular session is filled to capacity, you will be notified by telephone.

Address:

HealthNow NY, Inc DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Seminar Registration

For more information on these events, visit our Web site at www.umd.nycpic.com or contact us at 570-735-9406.

Note: If you do not receive your confirmation within five days of the event you have registered for, please call our Program Education & Training Department at 570-735-9406.

The DMERC reserves the right to cancel any seminar or workshop. If this occurs, attendees who have received confirmations will be notified by telephone and the fees will be refunded.

Please contact the hotels for information regarding overnight accommodations, parking, parking fees, and driving directions.

Complete a registration form for each person attending. Please type or print clearly.

Company Name: _____Supplier Number:_____

Address _____

_____

Phone: _____ Fax: _____

Name of Attendee:_____Contact Name: _____

Events- *Check the date(s) you wish to attend***:**

DMERC 101 Seminars:

- ❑ August 15, 2001 ($20)
- ❑ August 22, 2001 ($20)

Respiratory Workshops:

- ❑ August 16, 2001 ($20)
- ❑ August 23, 2001 ($20)
- ❑ August 29, 2001 ($20)
- ❑ September 11, 2001 ($20)
- ❑ September 13, 2001 ($20)
- ❑ September 17, 2001 ($20)

Total Amount Enclosed: _____

Mail to: HealthNow NY, Inc. DMERC A , P.O. Box 6800, Wilkes-Barre, PA 18773-6800, Attn: Seminar Registration

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Billing

Group 1 and 2 Pressure Reducing Support Surfaces Reminder

Group 1 and 2 pressure reducing support surface claims that are submitted to the DMERC must include the ZX modifier as stated per the policies. Claims submitted without the ZX modifier will be denied as not medically necessary on assigned claims. For additional information, please refer to the Group 1 and 2 pressure reducing support surface policies, Chapters 14.22 and 14.23, in the DMERC A Supplier Manual.⌘

Billing Reminder for Rapamune (Sirolimus)

HCPCS code J7520 (Sirolimus, oral, 1 mg) became effective January 1, 2001 as published in the December 2000 *DMERC Medicare News* and in the March 2001 Immunosuppressive Drugs policy revision in the DMERC A Supplier Manual. Previously, this drug had been billed using code J7599 (Immunosuppressive drug, not otherwise classified).

Refer to the Immunosuppressive Drugs policy in Chapter 19.01 of the DMERC A Supplier Manual for more information on immunosuppressive drug billing requirements.⌘

EDI

Elimination of HCFA Free Billing Software

Since the late 1980s, the Health Care Financing Administration (HCFA) has required DMERC A to offer free electronic billing software to our providers upon request. These generally simple pieces of software allowed our providers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format, 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 providers an opportunity to try electronic billing at low cost, with the expectation that providers 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 providers 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 providers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for providers, and should encourage more providers to use electronic transactions. These changes have prompted HCFA to assess whether or not to continue offering the free billing software in the post-HIPAA environment. HCFA will require DMERC A to begin phasing out the free billing software requirement effective fiscal year 2004, approximately 1 year after HIPAA standards are implemented. This will give our providers 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.⌘

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HIPAA Fast Facts

What is HIPAA? The Health Insurance Portability and Accountability Act, or HIPAA, is a law that was enacted by Congress in 1996. This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. This law was enacted by the federal government on August 21, 1996 with the intent to assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information.

What is the purpose of HIPAA? The purpose of HIPAA is to improve the efficiency and effectiveness of the health care system through the establishment of standards and to protect the security and privacy of health care information. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for the automated transfer of health care data between health care payers and providers. This will enable the communication of electronic data between many different entities, using a single set of transaction standards.

Who will be affected by HIPAA? All health plans, all clearinghouses, and those providers who choose to conduct these transactions electronically will be affected.

What transactions are covered by HIPAA? The standard chosen for electronic claim submissions is the American National Standards Institute (ANSI) X12 837 health care claim transaction set version 4010. The standard chosen for remittance retrieval is the Accredited Standards Committee (ASC) X12N 835 health care claim payment/advice version 4010. All other nonstandard formats that are currently in use will be eliminated, including the National Standard Format (NSF). When fully implemented, Medicare and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards. Under HIPAA, the Secretary of Health and Human Services is proposing standards for the following administrative and financial health care transactions:

1. Health claims or equivalent encounter information (ASC X12N 837)
2. Enrollment/disenrollment in a health plan (ASC X12N 834)
3. Eligibility for a health plan (ASC X12N 270/271)
4. Health care payment/remittance advice (ASC X12N 835)
5. Health plan premium payments (ASC X12N 820)
6. Health claim status (ASC X12N 276/277)
7. Referral certification and authorization (ASC X12N 278)
8. Coordination of Benefits (COB) (ASC X12N 837)

When will the standards become effective? All health plans, all health care clearinghouses, and any health care provider that chooses to transmit any of the transactions in electronic format must comply within 24 months after adoption of the standard (36 months for small health plans). The 24-month transition period will not be shortened by delays in adoption of the standards.

What is the implementation schedule for Medicare electronic submitters? The current federal schedule requires the adoptions of the standard by those conducting health care electronic transactions within two years and 60 days from the issuance of the final rule for that transaction. The final rule for claims, remittance, and COB was issued on August 17, 2000. All affected parties must be in compliance by October 16, 2002. However, Medicare electronic submitters will be able to begin testing or using version 4010 of the claims or remittance transactions until the VIPS Medicare System (VMS) has the changes installed in the VIPS system. The current proposed time frame for VMS implementation of the 4010 standard is:

ASC X12N 837 (claims) - April 2001 release (in production July 2001)
ASC X12N 837 (COB) - July 2001 release (in production October 2001)
ASC X12N 835 (electronic remittance) – July 2001 release (in production October 2001)
ASC X12N 270/271 (eligibility) - January 2002 release
ASC X12N 276/277 (status request/response) - January 2002 release

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What does this mean for providers? Once HIPAA is implemented nationally, a provider will be able to submit the same transaction in the same format to ANY health plan equipped for the receipt of electronic transactions. HIPAA will reduce the need for manual processing of patient account information.

What can Medicare providers do now to prepare for HIPAA? Medicare Providers and health care clearinghouses may wish to consider upgrading to the latest X12 claim and/or remittance advice version by October 1, 2001. You can also contact software vendors and billing services to assess plans for HIPAA implementation.

How can I get more information on HIPAA? The following helpful Web sites can give you the information you will need:

http://www.wpc-edi.com/hipaa - this site includes a posting of the X12N implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards.

http://www.wedi.org - this site contains postings of information on EDI in the healthcare industry and availability of resources for standard transactions.

If you need additional information regarding HIPAA, please read our quarterly newsletters for up-to-date information or call our EDI Helpdesk at 570-735-9429.⌘

HCPCS

Status of Codes for Heavy Duty Hospital Beds

The following table is a summary of the codes for heavy duty and extra heavy duty hospital beds and a history of their previous or current valid dates for billing to the DMERC. A revision of the Hospital Beds policy will be published in the future to reflect these changes.

Codes	Description	Effective date	Invalid date
K0456	Hospital bed, heavy duty, extra wide, with any type side rails with mattress	July 1, 1998	January 1, 2001
E0298	Hospital bed, heavy duty, extra wide, with any type side rails with mattress	January 1, 2001	April 1, 2001 (with a grace period until July 1, 2001)
K0549	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	July 1, 2001	N/A
K0550	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	July 1, 2001	N/A

Clarification:
E1399 (Durable medical equipment, miscellaneous): For dates of service prior to July 1, 2001, E1399 was used to bill for an extra heavy duty hospital bed (now billed using K0550 on or after July 1). For dates of service on or after July 1, 2001, E1399 may still be used to bill for beds not described by any of the above codes (i.e., if a heavy duty or extra heavy duty hospital bed is provided without a mattress, as when used with a support surface for treatment of pressure ulcers).⌘

Level III HCPCS Codes

The Consolidated Appropriations Act of 2001 instructs the continuation of the use of the Level III HCPCS coding system through December 31, 2003. No new Level III HCPCS codes or modifiers will be created.

HCPCS code ZZ010 (Transtracheal oxygen catheter for patient owned equipment) will be reinstated by DMERC A. However, ZZ010 was crosswalked to HCPCS code A4608 effective for dates of service on or after January 1, 2001 and A4608 should continue to be used when submitting claims for this item.

Also remember that oxygen accessories are separately payable only when they are used with a patient owned system that was purchased prior to June 1, 1989. Accessories used with a patient owned system that was purchased on or after June 1, 1989 will be denied as noncovered.⌘

Wheelchairs – K0008, K0013 – Code Deletion

Codes K0008 (Custom manual wheelchair base) and K0013 (Custom motorized wheelchair base) will be discontinued and rejected as invalid codes for dates of service on or after October 1, 2001.

These codes are being deleted because they do not reflect the way that wheelchairs with individualized features should be billed. In order to meet the needs of a particular beneficiary, various options or accessories are typically selected. In some situations, the frame of the wheelchair base is modified in order to accommodate the beneficiary. In all these situations, the wheelchair is correctly billed by selecting the appropriate code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. If there isn't a specific code for a wheelchair option, accessory, or modification, code K0108 (Wheelchair component or accessory, not otherwise specified) is used.

A Product Classification List including many wheelchair bases can be found on the SADMERC Web site at www.pgba.com/palmetto/Other.nsf/(Home)/Other+Medicare+Partners+SADMERC+Home?OpenDocument. Questions concerning the proper coding of wheelchair bases not on this list, or of wheelchair accessories, should be directed to the SADMERC.⌘

Product Classification Lists - Notice and Reminder

The Product Classification List for Thoracic Lumbar Sacral Orthosis-L0430 was published in error in the Appendices of the March 2001 Supplier Manual Revision. Please disregard this listing.

Also as a reminder, as published in the March 2001 *DMERC Medicare News*, all quarterly Appendices updates are to be referenced on the SADMERC's Web site at www.pgba.com/palmetto/Other.nsf/(Home)/Other+Medicare+Partners+SADMERC+Home?OpenDocument. The DMERC will no longer publish updates in the quarterly Supplier Manual revisions.⌘

Residual Limb Support System - New "K" Code

Effective for dates of service on or after July 1, 2001, a new "K" code has been established for residual limb support systems (stump support systems).

K0551 -Residual limb support system, solid base with adjustable drop hooks, mounts to wheelchair frame, each

The new code describes residual limb supports that have adjustable drop hooks, a solid base that mounts on a wheelchair frame, and an adjustable bracket that attaches to the base with a contoured pad to support the stump of a below knee amputee.

Suppliers should be aware that not all stump support systems meet the description of this new code. For example, if billing for a plastic or covered board, which is placed under the weight of the buttocks and is non-adjustable, this device should be billed as HCPCS code K0108. Similarly, if the stump support system does not have adjustable drop hooks, it should be coded with HCPCS code K0108.

Suppliers with questions concerning the proper coding of a specific stump support system should contact the SADMERC at telephone number 877-735-1326.⌘

Please see page 16, "Coding Verifications" for more information on the SADMERC.

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Casts and Splints – Codes A4570, L2102, L2104, L2122, L2124

Effective for dates of services on or after October 1, 2001, claims for casts and splint materials will be in the jurisdiction of the local carriers and intermediaries. Codes A4570 (Splint), L2102 (Ankle foot orthosis, tibial fracture cast orthosis, plaster type casting material), L2104 (Ankle foot orthosis, tibial fracture cast orthosis, synthetic type casting material), L2122 (Knee ankle foot orthosis, femoral fracture cast orthosis, plaster type casting material), and L2124 (Knee ankle foot orthosis, femoral fracture cast orthosis, synthetic type casting material) will be invalid for Medicare for dates of service on or after October 1, 2001. Claims received with dates of service on or after this date will be rejected. A new series of HCPCS codes, Q4001-Q4051, has been established to describe cast and splint supplies. Physicians and suppliers should refer to information published by their local carriers and intermediaries for details concerning coding and coverage of these items.⌘

Tracheoesophageal Voice Prostheses

Tracheoesophageal voice prostheses are devices that are used by laryngectomy patients who have had a tracheoesophageal puncture procedure to enable them to speak. There are two broad types of devices: one type is removed and reinserted by the patient on a daily basis and the other "indwelling" type is inserted by the physician on a periodic basis. As of July 1, 2001, both types of devices should currently be billed using code L8499 (Unlisted procedure for miscellaneous prosthetic services). The claim must be accompanied by information that clearly describes whether the item is a patient-inserted or physician-inserted device, including the manufacturer and model name/number of the device. This information may be entered in the HA0 record of an electronic claim or attached to a hard copy claim. Questions concerning the proper coding of specific products should be directed to the SADMERC at 877-735-1326.⌘

Temporary Replacement Equipment – Documentation Requirement

This is a revision of an article previously published in the June 1999 DMERC Medicare News.

Code K0462 (Temporary replacement equipment for patient owned equipment being repaired, any type) should be used to bill for the temporary replacement of patient owned equipment such as a wheelchair, which is being repaired. Coverage consideration will be given if the patient owned equipment is covered by Medicare and will not be available for use for more than one day (e. g., if the repair took over one day).

Effective for dates of service on or after July 1, 1999, a claim for code K0462 representing replacement equipment must include:

- Narrative description, manufacturer, and brand name/number of equipment being repaired, **and**
- Date of purchase of the equipment being repaired, **and**
- Narrative description, manufacturer, and brand name/number of the equipment provided as a temporary replacement, **and**
- Description of what was repaired, **and**
- Explanation of why the repair took longer than one day.

If all of the above information is not included, the claim will be denied **for lack of information**. If coverage is approved for the replacement equipment, one month's rental will be reimbursed at the level of either 1) the equipment provided, or 2) the equipment being repaired, whichever is the least costly medically appropriate alternative.⌘

HCPCS Coding Reminder

HCPCS code XX001 (Sterile saline, unit dose, up to 5 ml, each) and XX011 (Nonadhesive appliance disc, each) are discontinued codes and should no longer be billed to the DMERC. Code XX001 crosswalked to J7051, effective January 1, 1997. Code XX011 crosswalked to A5126 effective January 1, 2000.⌘

Walkers-E0147

The only products that may be billed as code E0147 (Heavy duty, multiple breaking system, variable wheel resistance walker) are those for which a written coding determination dated on or after April 1, 1998, specifying use of this code, has been made by the SADMERC. At the present time, there are five products known to be described by code E0147, which are as follows:

- Buddy Safety Roller by White Cap Enterprises, Corp.
- Wizard by Essential Medical Supply
- U-Step Walking Stabilizer (Model US-PC) by In-Step Mobility
- Wenzelite Navi/Gator Safety Roller by Wenzelite Medical Supply
- Dannie Rollator by WINMED

Providers can access the SADMERC Web site at www.pgba.com/palmetto/Other.nsf/(Home)/Other+Medicare+Partners+SADMERC+Home?OpenDocument for the most current walker product classification list. If a supplier or manufacturer thinks that another product meets the definition of this code, they should contact the SADMERC for a coding determination.

If billing with code E0147, submit the claim hard copy and include the manufacturer's name, the model name/number, and a copy of a note or other documentation from the treating physician giving a detailed description of the functional limitations which preclude the patient from using another type of wheeled walker and the diagnosis causing this limitation.

Please refer to the Walkers policy, Chapter 14.2, in the DMERC A Supplier Manual for any further coverage criteria and documentation requirements.⌘

Medical Policy

Prior Authorization Eliminated for POVs, TENS, and Seat Lift Mechanisms

Effective September 1, 2001, prior authorization will no longer be available for power operated vehicles (POVs), seat lift mechanisms, and transcutaneous electrical nerve stimulators (TENS). Prior authorization requests for these items received on or after that date will be returned to the requester.

Advance Determination of Medicare Coverage for Wheelchairs

Advance Determination of Medicare Coverage (ADMC) is a process by which the DMERC will provide the supplier and beneficiary with a coverage decision prior to delivery of an item. Effective October 1, 2001, an ADMC will be available as an option only for the following wheelchair base HCPCS codes and related options and accessories:

K0005
K0009
K0011 –only when a power tilt and/or power recline seating system or non-joystick control device (e.g., head control, sip and puff, switch control) is ordered
K0014 – only when a power tilt and/or power recline seating system or non-joystick control device (e.g., head control, sip and puff, switch control) is ordered

Note that only a limited subset of K0011 and K0014 wheelchairs (as described above) are eligible for ADMC. When a particular wheelchair base is eligible for ADMC, all wheelchair options and accessories ordered by the physician for that patient along with the base HCPCS code will be eligible for ADMC.

ADMC requests may either be mailed to:

DMERC A, Attn: ADMC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800 ,

or be sent via fax to 570-735-9402, Attn: ADMC. ADMC requests cannot be submitted electronically.

ADMC requests must be accompanied by a copy of the appropriate Certificate(s) of Medical Necessity (CMN) – HCFA Form 844 for manual wheelchairs or HCFA Form 843 for power wheelchairs, plus HCFA Form 854 if

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more space is needed in Section C to list options and accessories. Completion of the CMN should follow all the standard rules – refer to Chapter 12 of the DMERC Supplier Manual. The manufacturer and model name of the wheelchair base must be listed in Section C. For items billed with HCPCS code K0108 (Miscellaneous wheelchair accessory), the narrative in Section C of the CMN must clearly identify the item. (HCPCS code E1399 is not used for wheelchair options or accessories.)

ADMC requests must also be accompanied by information which documents the medical condition of the patient that necessitates the use of the wheelchair, options, and accessories that are ordered. Special attention should be given to any item billed with HCPCS code K0108. Examples (not all-inclusive) of the types of information which will assist the DMERC in making a determination are: the patient's medical records with dated entries; identification of person(s) performing evaluations; date of onset of the condition; strength of the extremities and function of the extremities (including tone, ROM limitations, etc.); the distance that the patient can walk (a) independently and (b) with the assistance of a cane, crutch, or walker; how the patient transfers from bed/chair to a wheelchair; cognitive abilities; visual impairments; current activity level; and whether the patient is expected to be fully independent in the use of the wheelchair. Objective measurements should be reported whenever possible.

If the patient currently has a wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

Upon receipt of an ADMC request, the DMERC will make a determination within 30 calendar days. The DMERC will provide the supplier and beneficiary with its determination, either affirmative or negative, in writing. If it is a negative determination, the letter will indicate why the request was denied – e.g., not medically necessary, insufficient information submitted to determine coverage, statutorily noncovered.

If a wheelchair base receives a negative determination, all accessories will also receive a negative determination. If a wheelchair base receives an affirmative determination, each accessory will receive an individual determination.

An affirmative determination only relates to whether the item is reasonable and necessary based on the information submitted. An affirmative determination does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it provide assurance that any other Medicare requirements (e.g., place of service, Medicare Secondary Payer) have been met. Only upon submission of a complete claim can the DMERC make a full and complete determination. An affirmative determination does not extend to the price that Medicare will pay for the item. Finally the DMERC may review selected claims on a pre-payment or post-payment basis and may deny a claim or request an overpayment if it determines that an affirmative determination was made based on incorrect information.

A negative ADMC may not be appealed because it does not meet the regulatory definition of an initial determination since no request for payment is being made. However, if the ADMC request for the wheelchair base is denied and if the supplier obtains additional medical documentation, an ADMC request may be resubmitted. ADMC requests may only be resubmitted once during the 6-month period following a negative determination. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories. If a supplier provides a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted. If new information is provided with the claim, coverage will be considered. If the claim is denied, it may be appealed through the usual process.

An affirmative ADMC is only valid for items delivered within 6 months following the date of the determination. If the wheelchair is not delivered within that time, the supplier has the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item).

If the item is provided within six months following an affirmative determination and if the claim is for all the same items which were listed on the ADMC request, the CMN does not need to be submitted with the claim. If any of the items on the ADMC request were described by HCPCS code K0108 and if those items were provided, the supplier must ensure that the narrative description used on the claim matches the narrative description used on the ADMC determination letter. If a wheelchair base receives an affirmative determination, the supplier may not submit a separate ADMC request for additional accessories. If options or accessories are provided that were not listed on the ADMC request, a revised CMN must be submitted with the claim and the supplier should also submit whatever information is appropriate to document the medical necessity for the new item(s).⌘

Protective Body Socks

Code L0984 (Protective body sock, each) describes a garment made of cloth or similar material that is worn under a spinal orthosis. There is no Medicare benefit category for products coded L0984. Therefore, effective for dates of service on or after October 1, 2001, claims for HCPCS code L0984 will be denied as non-covered.⌘

Humidifiers Used with Ventilators and Oxygen Therapy

Humidifiers (E0550, E0555, E0560) billed separately when used with a rented ventilator (E0450) or rented oxygen equipment will be denied as unbundled.

Separate reimbursement for accessories such as humidifiers may be considered when the beneficiary purchased the ventilator (E0450) or oxygen equipment before 1989 or before Medicare eligibility.⌘

Physician Assistants May Sign Orders and Certificates of Medical Necessity

In the latest revision of the Program Integrity Manual (PIM), the Health Care Financing Administration (HCFA) added the provision that physician assistants may write and sign detailed written orders for durable medical equipment, prosthetics, orthotics and supplies (DME-POS). In addition, physician assistants may complete Section B and sign Section D of a Certificate of Medical Necessity (CMN). This is effective for dates of service on or after July 1, 2001.

In order to complete CMNs and sign orders, physician assistants must meet the following criteria:

- They meet the definition of physician assistant found in §1861(aa)(5) of the Act or §2156(A) of the Medicare Carriers Manual; and,
- They are treating the beneficiary for the condition for which the item is needed; and,
- They are practicing under the supervision of an MD or DO; and,
- They have their own UPIN; and,
- They are permitted to do all of the above in the state in

Replacements of Prosthetic Devices and Parts

Effective April 1, 2001, payment may be made for the replacement of a prosthetic device which is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of:

1. a change in the physiological condition of the patient;
2. an irreparable change in the condition of the device, or in a part of the device; or
3. the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or as the case may be, of the part being replaced.⌘

Revised CMNs for Capped Rental Items

This is a revision to an article previously published in the June 1998 DMERC Medicare News and is being republished as a reminder.

If a patient requires a capped rental item for less than 15 months, the number of months ordered should be listed on the initial CMN. If subsequent to the initial CMN the doctor orders additional months of need for the patient, the supplier must obtain and submit a revised CMN to the DMERC. This revised CMN must indicate a revised length of need which includes the number of months originally notated on the initial CMN.

For example, the initial CMN documents the length of need as 3 months. After 3 months have passed the physician orders the item for an additional 6 months. The revised CMN must indicate the length of need as 9 months.

Parenteral and enteral nutrition and oxygen are not capped rental items. Please refer to recertification schedules in Chapters 13 and 18 of the DMERC A Supplier Manual and newsletters for instructions on these items.

Incorrect submissions of CMNs may result in claim denials.⌘

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Oxygen CMN Length of Need

DMERCs use the physician's stated estimated length of need indicated on the Initial, Revised or Recertification CMN in determining the period of covered oxygen services. For beneficiaries for whom oxygen coverage criteria are met, the covered period for oxygen equipment is from the Initial Date plus the length of need or the next scheduled recertification date (if applicable), whichever occurs first.

The length of need may have to be changed (e.g., extended) when the scheduled Recertification CMN is completed or when completing a Revised CMN. Physicians should be reminded that the number of months listed on the CMN must be the total number of months counted from the Initial Date listed in Section A of the CMN.

The Initial Date found in Section A of the CMN should be either the specific date that the physician gives as the start date of the medical necessity or, if the physician does not give a specific start date, the Initial Date would be the date that the order is received (not necessarily the date of delivery).

Please refer to Chapters 12 and 13 of the DMERC A Supplier Manual for additional information about the oxy-

Sheepskin Pads - Group 1 Pressure Reducing Support Surfaces

In a recent coverage determination by the Health Care Financing Administration (HCFA) (Transmittal AB-01-53), synthetic sheepskin pads and lambswool sheepskin pads (HCPCS codes E0188 and E0189, respectively) were re-classified as durable medical equipment and placed in the inexpensive or routinely purchased payment category. Effective for dates of service on or after January 1, 2001, codes E0188 and E0189 will be given coverage consideration by the DMERC. The Group 1 Pressure Reducing Support Surfaces policy will be updated in a future DMERC A Supplier Manual revision to reflect this coverage change.

Suppliers should note that the HCFA instructions included a directive to the DMERC not to process previously denied claims unless requested by the supplier. Therefore, suppliers with claims for codes E0188 and E0189 with dates of service on or after January 1, 2001 that have previously been denied should request adjustments in writing for those claims. Claims submitted for adjustment must comply with the requirements outlined in the Group 1 Pressure Reducing Support Surfaces policy. *Do not simply resubmit the claim.* Claims resubmitted will be denied as duplicates. ⌘

Miscellaneous

Customer Service Options Unchanged by PSC Transition

You learned in the March 2001 issue of the *DMERC Medicare News* that a new contractor, TriCenturion, LLC, will perform program safeguard functions in DMERC A. HealthNow NY, Inc. and TriCenturion, LLC are working very closely together to ensure a smooth transition of these activities.

Both contractors want to remind you that HealthNow continues to serve as your customer service team. HealthNow provides suppliers with several options to access DMERC claim-specific or general information. To help suppliers make the most of the tools available, a few of the options for getting this needed information are listed below:

Supplier Manual

Many answers to the questions frequently addressed to the DMERC Caller Information Network can be found in the Supplier Manual. The Supplier Manual contains information on:

- ♦ Supplier enrollment and standards
- ♦ Completing the HCFA-1500 form
- ♦ Claim crossover and OCNA listing
- ♦ HCPCS codes
- ♦ Fee schedule
- ♦ Hearings and appeals
- ♦ Medicare secondary payer
- ♦ Fraud and abuse
- ♦ Electronic Data Interchange (EDI)
- ♦ Medical overview/documentation
- ♦ Medical policies

(Continued on page 13.)

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The DMERC publishes quarterly revisions to the Supplier Manual to keep suppliers up to date on information that has changed. It is very important that revisions be incorporated into the Supplier Manual upon receipt. The Manual is a very useful tool that should be the first stop for information.

Web Site (www.umd.nycpic.com)

The DMERC A Web site contains:

- Supplier notices and alerts
- Billing information and updates
- EDI information
- Medical policy
- Newsletters, supplier manual and revisions
- CMN information

Caller Information Network (CIN)
866-419-9458

Monday through Friday (7:30 AM - 4:30PM ET)
Contact the CIN for:

- Coverage issues
- Policy coverage information
- General DMERC information

The DMERC CIN staff will coordinate with the Program Safeguard Contractor (PSC) to respond to issues requiring additional information from the PSC. The DMERC continues to be your primary resource for all Medicare DMEPOS customer service matters.

Program Education & Training (PET)
570-735-9666

Monday through Friday (8:00 AM - 4:00 PM ET)
Ombudsman category defines contact.
Categories:

Mobility	Respiratory
Nutrition & Pharmacy	Specialized DME
Orthotics & Prosthetics	Supports

Contact PET For:

- Educational seminars/workshops
- Trade shows/association meetings
- Issues affecting multiple suppliers
- Broad product-related issues

Suppliers who bill electronically have these additional resources available:

VIPS Provider Inquiry System (VPIQ)

VPIQ is a subsystem of the VIPS Medicare System (VMS) that allows suppliers to obtain information on:

- Summaries and listings of all pending claims
- Claim status by HICN and date of service
- Paid/denied claim information
- Information on completed claims awaiting payment floor clearance
- Estimated mail of EFT date on completed claims
- Participating suppliers have the advantage of obtaining beneficiary eligibility information such as:
  - Entitlement/termination dates
  - Deductibles met for the current year
  - Medicare Secondary Payer (indicates any activity in the past year)
  - HMO membership

Bulletin Board System (BBS)

The BBS allows suppliers to access various forms of information and interactive inquiries. The BBS functions give suppliers the ability to view:

- Newsletters
- Supplier notices and alerts
- Fee schedules
- OCNA (crossover) listings
- Accelerate updates
- Seminar registration form
- Additional documentation form
- Medical policies

The BBS also has a message system that allows suppliers to direct questions to selected departments within the DMERC:

- Program Education & Training
- Check Control/Medicare Secondary Payer
- EDI
- General inquiries
- Returned/pick-up equipment⌘

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Correction: DMEPOS Pricing Updates

On page 4 of the March 2001 *DMERC Medicare News*, we published the fee schedule update factors for 2001 for both durable medical equipment (DME) and prosthetics and orthotics, in accordance with the Benefits Improvement and Protection Act (BIPA) of 2000. The DMEPOS Pricing Updates published in March did not include oxygen and oxygen equipment because oxygen and oxygen equipment are not affected by §425 of BIPA of 2000. Therefore, in accordance with §228 of the Balanced Budget Refinement Act (BBRA) of 1999, the fees for oxygen and oxygen equipment are to be increased by 0.3 percent for items furnished on or after January 1, 2001, and before January 1, 2002, and 0.6 percent for items furnished on or after January 1, 2002, and before January 1, 2003. A revised chart is published below with the revisions in bold.

Category	***January 1, 2001***	***July 1, 2001***	***January 1, 2002***
DME **(other than oxygen)**	0.3*	3.7 + 3.28*	0.6*
Oxygen and Oxygen Equipment	**0.3***	**see below***	**0.6***
Prosthetics & Orthotics	1.0*	3.7 + 2.6*	1.0
Ostomy/Tracheostomy/Urologicals	0.0	3.7 + 3.28*	0.0
Surgical Dressings	0.0	3.7 + 3.28*	0.0
Therapeutic Shoes	0.3*	3.7 + 3.28*	0.6*
Parenteral & Enteral Nutrition	0.0	n/a	0.0
Reasonable Charge (other than ambulance)	3.7	n/a	CPI-U

* Temporary increase not to be carried over into future periods, except in the case of oxygen and oxygen equipment,

DMERC A Restructures Departments

There have been many changes at the DMERC since the transition to HealthNow. Some of them are very noticeable, such as the new logo and newsletter colors. Others, you may not be aware of, such as changes within the DMERC organizational structure. The DMERC is pleased to announce restructuring and changes in the title of many of its departments.

The Professional Relations (PR) Department has been renamed the Program Education & Training (PET) Department. We believe that the new title more accurately represents the primary responsibilities of the department, which are to assure that suppliers are fully knowledgeable about Medicare provisions impacting them and to conduct and support the ongoing education of beneficiaries concerning the Medicare program.

The Public Relations (PR) Department was established in April and is responsible for the DMERC media and public relations activities. The PR Department continues to be an integral part of the overall PET initiative. All issues related to media and public relations should be directed to the attention of Jacqueline E. Burress, Manager of PR. Please note that inquiries regarding claims should be directed to the DMERC Caller Information Network (CIN) or Program Inquiries (PI) departments, not Public Relations.

The Hearings Department, Review Department and Correspondence Unit are now all one department – Program Inquiries. As a reminder, when submitting requests to Program Inquiries, please be sure to include your name and telephone number with your request.

Below is a list of all of the departments that have had name changes:

Old Names	**New Names**
Accounting	Check Control
Customer Service Unit	Caller Information Network (CIN)
Systems and Business Support (SBS)	Technical Services
Professional Relations (PR)	Program Education & Training (PET) and Public Relations (PR)
Hearings, Review and Correspondence	Program Inquiries (PI)
Fraud and Abuse	Benefit Integrity (BI)⌘

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Assignment of Case to Lead Contractor

Claims for services related to an accident or injury may be processed by more than one Medicare contractor. Prior to January 8, 2001, the identifying contractor coordinated with other Medicare contractors that may have paid for services related to the accident. The contractor that paid the highest dollar amount for accident-related charges was usually designated as the lead contractor.

After January 8, 2001, designation of lead contractors for liability or no fault recoveries is generally an intermediary for the state of the beneficiary's residence. National intermediaries may be assigned a state(s) where they have significant workload. Beneficiary residence is determined by the existing Common Working File (CWF) rules for beneficiary residence. The lead remains with the initial lead contractor even if the beneficiary subsequently changes his/her permanent address.

For worker's compensation recoveries, the lead contractor is the same as the lead contractor would be for a liability or no-fault recovery except where venue for the workers' compensation claim is in a different state. In this situation, if the beneficiary and/or his or her attorney or other representative identifies the state of venue at the time of the original inquiry or other notification, the Coordination of Benefits (COB) contractor will forward the lead to the designated intermediary for the state of venue. If a contractor has the lead based upon the state of the beneficiary's residence and it is subsequently determined that the state of venue is a different state, the initial lead intermediary will transfer the lead to the designated intermediary for the state of venue.

Note: The state of venue is the state under whose rules the workers' compensation case is being adjudicated. After the lead contractor is determined, all documentation related to the case will be forwarded to that contractor.

The lead contractor is responsible for coordinating all other contractors' charges and compiling a list for the attorney. The attorney will be notified of the contractor responsible for the case until settlement is concluded. The attorney should direct all inquiries and information to the lead contractor for coordination with the other contractors.⌘

Medicare Secondary Payer Program

Under the Medicare Secondary Payer (MSP) program, Medicare is the secondary payer to group health insurance provided for employees; Medicare pays after the employer-sponsored health insurance pays the claim. The MSP program applies to:

- Health plans offered by an employer to current employees (where the employer has 20 or more full or part-time employees or belongs to a multi-employer group plan) that cover workers and their spouse age 65 and older.
- Large group health plans (LGHP) offered by an employer to current employees (where the employer has 100 or more full or part-time employees or belongs to a multi-employer group plan) that cover an employee or family member who is disabled.
- Health plans offered by an employer, which cover an individual with end-stage renal disease (ESRD). In the MSP program, Medicare is the secondary insurance for the first 30 months(18 months if coordination of benefits was prior to 3/01/1996) of the employee's Medicare eligibility based on ESRD, regardless of the number of employees that sponsoring employer has, and regardless of whether the individual is eligible for insurance based on current employment.

When an employer-sponsored health insurance plan is covered by the MSP rules and Medicare is the secondary payer, Medicare will not pay more than the amount it would have paid if had been primary.

When MSP Rules Do Not Apply

If the MSP rules do not apply, Medicare pays first – not the employer sponsored health plan. In other words, the private health insurance becomes secondary to Medicare. The additional coverage an employer-sponsored health insurance will provide varies from plan to plan. The MSP rules do not apply to insurance:

- That covers workers or their spouses on Medicare due to age when an employer has fewer than 20 employees.
- That covers workers or their spouses on Medicare due to disability when an employer has fewer than 100 employees.
- That is offered by an employer after someone with ESRD has been on Medicare for first 30 months (18 months if coordination of benefits was prior to 3/01/1996).
- That is offered by an employer for their nonactive employees. This includes retiree health insurance and COBRA insurance (this does not apply to ESRD).

Coding Verifications

This article was submitted by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC); all questions pertaining to this article should be directed to the SADMERC at 877-735-1326.

One of the functions of the SADMERC is to ensure uniform coding by all suppliers nationally. The mechanism for facilitating this action is the application for HCPCS coding verification submitted by the manufacturers. A preliminary step in the process for requesting a coding verification is submitting the request in the correct format. When submitting the request, identify one coding verification per request. Provide five original verification information packets for each coding request. The specified product literature submitted by the manufacturer will be reviewed by the SADMERC HCPCS Medical Analyst and a coding recommendation will be made. The information submitted by the manufacturer and the SADMERC coding recommendation are then disseminated to the four DMERCs for a consensus coding decision. Once this consensus coding decision has been reached, the applicant is notified in writing of the coding decision. This code is to be used to bill the four DMERCs for the product reviewed. The assignment of a HCPCS code to the product should in no way be construed as an approval or endorsement of the product by SADMERC or Medicare, nor does it imply or guarantee reimbursement or coverage. The following is a step-by-step procedural map of the previously identified process:

1. The applicant submits a request for HCPCS coding verification. The application and required documentation are submitted to the HCPCS Coordinator at SADMERC. The required documentation is identified on the Required Documentation Necessary for HCPCS Coding Verification Reviews list (copies of this list can be obtained via the SADMERC Web site or fax request).

2. Once all of the required documentation is received by the HCPCS Coordinator at the SADMERC, the applicant is notified in writing that the review has been initiated. A product review may take up to 90 days to complete.

3. The information submitted to the SADMERC is provided to one of the SADMERC HCPCS Medical Analysts for the purpose of conducting a product review.

4. Once the review has been completed by the Medical Analyst and endorsed by the SADMERC Medical Advisor, the reviewer's evaluation, coding recommendation and the product package are disseminated to the four regional DMERCs for the purpose of achieving a consensus coding decision. When a consensus coding decision is reached, the applicant is notified via written notification from the SADMERC of this decision.

Please visit the SADMERC Web site at www.pgba.com/palmetto/Other.nsf/(Home)/Other+Medicare+Partners+SADMERC+Home?OpenDocument for the SADMERC Coding Verification Application Format.⌘

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.

Toll-Free Supplier Number Established

Supplier Notice 2001-05
March 7, 2001

The Region A DMERC has established a toll-free telephone number, 866-419-9458, for the supplier community to contact the Region A DMERC Customer Service Department.

Suppliers may continue to call the 570-735-9445 number through March 16, 2001. The 570-735-9445 number will be disconnected on March 16, 2001.

Electronic submitters should continue to use the 570-735-9515 to transmit claims electronically to the DMERC.

Please remember to have your supplier (NSC) number and information related to your questions ready when you call the DMERC Customer Service Department.

Correction: Supplier Notice 2000-05

Supplier Notice 2001-06
March 14, 2001

The following is a correction to Supplier Notice 2000-05, "Region A DMERC Parenteral and Enteral Nutrient Fees," published on February 22, 2000.

Supplier Notice 2000-05 stated that the Region A DMERC would publish quarterly updates to the parenteral and enteral nutrient fees via supplier notices. The Notice also labeled the listed fees as being effective for January 1, 2000 - March 31, 2000.

According to the Balanced Budget Act of 1997, the fees for parenteral and enteral nutrients were frozen in 1998 through 2002 at the 1995 reasonable charge. The fees listed in Supplier Notice 2000-05 are correct and are effective through 2002. The DMERC will not be publishing updates to the parenteral and

Prospective Payment System (PPS) Updates

Supplier Notice 2001-07
March 14, 2001

Home Health PPS (HH PPS)
As of October 1, 2000, Medicare payment for home health services transitioned from a reasonable charge methodology to a prospective payment system (PPS). Common Working File (CWF) system changes to process Part B and DMERC claims under the new Home Health PPS (HH PPS) were implemented in a staggered process. This process began in October 2000 and was completed in January 2001. These changes required two new edits be added. These new edits were added to detect the following:

- Duplicate DME billing for home health claims, DMERC claims, and Part B claims with the same HCPCS code and date of service of October 1, 2000 and after; **and**
- A detail line item date of service falls within the start and end date of a HH PPS episode when a non-routine medical supplies HCPCS code is present.

SNF PPS
Part B Consolidated Billing, delayed repeatedly since July 1998, has been rescinded per the Benefits Improvement and Protection Act of 2000 (BIPA) except for Therapy Services.

A new Program Memorandum will be issued by HCFA for Part B consolidated billing. Suppliers will be notified when this

Clarification: Medicare HMOs

Supplier Notice 2001-08
March 26, 2001

In 1997, Congress established the Balanced Budget Act which allowed the federal government to contract with a variety of entities, called Medicare Plus Choice Organizations (M+COs), to provide Medicare coverage to beneficiaries. M+COs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Private Fee for Service (PFFS) plans. The Health Care Financing Administration (HCFA) contracts with M+COs to provide Medicare benefits through a contracted network of providers. These M+COs are reimbursed several different ways, but the one that causes the most confusion involves those entities reimbursed under the "risk" methodology - Medicare HMOs. The following is a brief explanation of how Medicare HMOs can impact your business as a supplier:

Medicare beneficiaries enrolling in a Medicare HMO must meet the following requirements:
1. Continue payment of their Medicare Part B premiums
2. Live in the HMO service network
3. Cannot have End Stage Renal Disease

Medicare HMOs do not replace Medicare benefits. A Medicare beneficiary electing a Medicare HMO still has Medicare; he/she is just receiving his/her benefits through an alternative delivery system. Enrollment in a Medicare HMO is voluntary, and there is no need for a Medicare supplemental plan when a Medicare HMO is elected. The HMO is not a supplemental plan nor is Medicare a secondary payer to the HMO.

Medicare HMO members must go to an authorized HMO provider for coverage of supplies under the HMO plan, with the exception of an emergency or urgently needed care situation. Any other care by a non-plan provider will not be covered by the HMO plan or by Medicare. Always check with the beneficiary for Medicare HMO coverage before providing any supplies.

Suppliers cannot bill Medicare for a beneficiary enrolled as a member of a Medicare HMO. Claims will be denied with action code OA-B11. Claims denied for this reason should be submitted to the beneficiary's Medicare HMO; Medicare does not transfer the claim to the HMO.

Same - Similar Equipment Reminder

Supplier Notice 2001-09
March 26, 2001

Two recent audits of the walker and cane policies have identified that some beneficiaries are receiving multiple walkers or canes within a short time frame. Medicare does not pay for same or similar equipment without identifying a change in medical necessity. Please reference Chapter 14.1, Canes and Crutches, and Chapter 14.2, Walkers, of the Region A DMERC Supplier Manual, the March 1998 *DMERC Medicare News*, and Supplier Notice 98-03, *Same - Similar Equipment*.

Second Quarter Update: Drug Fees

Supplier Notice 2001-10
April 24, 2001

The fees listed below were effective April 1, 2001.

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J0285	AMPHOTERICIN B	50 MG	$11.06
J0286	AMPHOTERICIN B, ANY LIPID FORMULATION	50 MG	$88.66
J0895	DEFEROXAMINE MESYLATE	500 MG/5CC	$12.62
J1170	HYDROMORPHONE	4 MG	$1.50
J1250	DOBUTAMINE HYDROCHLORIDE	250 MG	$2.97
J1325	EPOPROSTENAL	0.5 MG	$11.57
J1455	FOSCARNET SODIUM	1000 MG	$11.99
J1570	GANCICLOVIR SODIUM	500 MG	$33.89
J1820	INSULIN, INJECTION	UP TO 100 UNITS	$2.29
J2175	MEPERIDINE HYDROCHLORIDE	100 MG	$0.60
J2260	MILRINONE LACTATE	5 ML	$44.13
J2270	MORPHINE SULFATE	10 MG	$0.62
J2271	MORPHINE SULFATE	100 MG	$13.85
J2275	MORPHINE SULFATE, PF, STERILE SOL	10 MG	$2.38
J2545	PENTAMIDINE FOR AEROSOL INHALER	300 MG	$106.51
J2920	METHYLPREDNISOLONE SODIUM SUCCINATE	40 MG	$1.92
J2930	METHYLPREDNISOLONE SODIUM SUCCINATE	125 MG	$3.10
J3010	FENTANYL CITRATE	2 ML	$1.04
J3370	VANCOMYCIN HCL	500 MG	$5.20
J7500	AZATHIOPRINE, ORAL, TAB	50 MG	$1.25
J7501	AZATHIOPRINE, PARENTERAL	100 MG	$107.91
J7502	CYCLOSPORINE, ORAL	100 MG	$5.23
J7506	PREDNISONE,ORAL	5 MG	$0.02
J7507	TACROLIMUS, ORAL	1 MG	$2.80
J7508	TACROLIMUS, ORAL	5 MG	$13.99
J7509	METHYLPREDNISOLONE, ORAL	4 MG	$0.51
J7510	PREDNISOLONE, ORAL	5 MG	$0.03
J7513	DACLIZUMAB, PARENTERAL	25 MG	$397.29
J7515	CYCLOSPORINE, ORAL	25 MG	$1.31

(Continued on page 19.)

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HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J7517	MYCOPHENOLATE MOFETIL, ORAL	250 MG	$2.40
J7520	SIROLIMUS, ORAL	1 MG	$6.51
J9000	DOXORUBICIN HCL	10 MG	$50.96
J9001	DOXARUBICIN HCL ALL LIPID FORMS	10 MG	$358.96
J9040	BLEOMYCIN SULFATE	15 UNITS	$289.37
J9065	CLADRIBINE	1 MG	$53.47
J9100	CYTARABINE	100 MG	$5.94
J9110	CYTARABINE	500 MG	$23.75
J9190	FLUOROURACIL	500 MG	$2.73
J9200	FLOXURIDINE	500 MG	$129.56
J9208	IFOSFAMIDE	1 GM	$156.65
J9265	PACLITAXEL	30 MG	$164.08
J9280	MITOMYCIN	5 MG	$127.40
J9290	MITOMYCIN	20 MG	$421.99
J9360	VINBLASTINE SULFATE	1 MG	$4.10
J9370	VINCRISTINE SULFATE	1 MG	$33.98
J9375	VINCRISTINE SULFATE	2 MG	$67.96
J9380	VINCRISTINE SULFATE	5 MG	$154.57
J9390	VINORELBINE TARTRATE	10 MG	$79.28
K0548	LISPRO		$1.99

Nebulizer Drug Fees

HCPCS CODE	MOD	DESCRIPTION	FEE
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
J7631	KO	CROMOLYN SODIUM, UNIT DOSE FORM	$0.24
J7631	KP	CROMOLYN SODIUM, UNIT DOSE FORM	$0.24
J7631	KQ	CROMOLYN SODIUM, UNIT DOSE FORM	$0.14
J7635		ATROPINE, CONCENTRATED FORM	$0.15
J7636	KO	ATROPINE, UNIT DOSE FORM	$0.36
J7636	KP	ATROPINE, UNIT DOSE FORM	$0.36
J7636	KQ	ATROPINE, UNIT DOSE FORM	$0.15
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

(Continued on page 20.)

HCPCS CODE	MOD	DESCRIPTION	FEE
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	$0.31
J7659	KO	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KP	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KQ	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.31
J7668		METAPROTERENOL SULFATE, CONCENTRATED FORM	$0.25
J7669	KO	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.37
J7669	KP	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.37
J7669	KQ	METAPROTERENOL SULFATE, UNIT DOSE FORM	$0.25
J7680		TERBUTALINE SULFATE, CONCENTRATED FORM	$2.13
J7681	KO	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.17
J7681	KP	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.17
J7681	KQ	TERBUTALINE SULFATE, UNIT DOSE FORM	$1.96
J7682	KO	TOBRAMYCINE, UNIT DOSE FORM, 300MG	$42.55
J7682	KP	TOBRAMYCINE, UNIT DOSE FORM, 300MG	$42.55
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	$3.18
Q0168		DRONABINOL, 5MG, ORAL	$6.30
Q0169		PROMETHAZINE HYDROCHLORIDE, 12.5MG, ORAL	$0.24
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	$0.45
Q0174		THIETHYLPERAZINE MALEATE, 10MG, ORAL	$0.54
Q0175		PERPHENAZINE, 4MG, ORAL	$0.57
Q0176		PERPHENAZIEN, 8MG, ORAL	$0.93
Q0177		HYDROXYZINE PAMOATE, 25MG, ORAL	$0.29
Q0178		HYDROXYZINE PAMOATE, 50MG, ORAL	$0.30
Q0179		ONDANSETRON HYDROCHLORIDE, 8MG, ORAL	$25.15
Q0180		DOLASETRON MESYLATE, 100MG, ORAL	$69.64
Q9920		EPOETIN	$10.00

* INDIVIDUAL CONSIDERATION

Second Quarter Update: Oral Anticancer Drug Fees

Supplier Notice 2001-11
April 24, 2001

The fees listed below were effective April 1, 2001.

Manufacturers	Descriptors	Dosage	NDC Number/Code	Fee
GLAXO-WELLCOME	BUSULFAN	2 mg Oral 1 Tab, per unit	000173-0713-25	$1.81
ROCHE LABORATORIES	CAPECITABINE	150 mg, Oral, 1 Tab per unit	00004-1100-51	$2.43
ROCHE LABORATORIES	CAPECITABINE	500 mg, Oral, 1 Tab per unit	00004-1101-16	$8.11
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	25 mg Oral 1 Tab, per unit	00015-0504-01	$1.98
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-01	$3.64
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-02	$3.64
BRISTOL-MYERS	ETOPOSIDE	50 mg Oral 1 Tab, per unit	00015-3091-45	$50.90
GLAXO-WELLCOME	MELPHALAN	2 mg 1 Tab, per unit	00173-0045-35	$2.18
LEDERLE LABS	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	$5.93
SCHERING	TEMOZOLOMIDE	5mg Oral 1 Tab, per unit	00085-1248-02	$5.93
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-01	$23.72
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-02	$23.72
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-01	$118.61
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-02	$118.61
SCHERING	TEMOZOLOMIDE	250mg Oral 1 Tab, per unit	00085-1252-01	$296.51

Attention: Electronic Billers - Password Resets

Supplier Notice 2001-12
April 26, 2001

This form must be completed for VPIQ password resets due to new security procedures at the Region A DMERC.

Please reset my password on the:

_____ A T & T screen

_____ HCFA Southbury Data Center Screen

This form must be signed and dated by the authorized agent that we have on file. Also please include the printed name of the authorized agent and a return fax number. If the authorized agent on this form does not match the authorized agent we have on file, we will not reset the password(s) requested.

Please fax this form to 570-735-9510; remember password resets may take up to two weeks to process. We will not accept any requests via phone after May 7, 2001; there will be no exceptions.

Submitter Number: _____

Authorized Signature: _____

Printed name: _____

Date: _____

Return fax number: _____

EFFECTIVE MAY 7, 2001

DMERC Supplier Manuals

DMERC A provides one Supplier Manual free of charge to each new supplier who has received a new supplier number from the National Supplier Clearinghouse (NSC) and is located within Region A. The DMERC mails the Manual to the mailing address the supplier has on file with the NSC approximately six to eight weeks after the DMERC receives notification from the NSC of the new supplier number.

Please note that DMERC A does not provide back issues of the DMERC newsletters or supplier notices to new suppliers; these publications can be accessed on the DMERC web site at www.umd.nycpic.com.

The DMERC charges a $50 fee to all suppliers who wish to receive an extra or replacement copy of the Supplier Manual or are located outside of Region A. Companies or organizations that do not have a supplier number (i.e,. billing clearinghouses, associations, etc.) are also charged a $50 fee for a copy of the Supplier Manual.

To order a copy of the DMERC A Supplier Manual, complete the form below and mail the form and a check for $50 made payable to HealthNow NY, Inc. to the address listed below.

When completing the form, do not provide a post office box or bank box for the mailing address. The DMERC will mail Supplier Manuals to street addresses only.

- -

Company Name: ____________________

NSC Number: ____________________

Mailing Address:(street addresses only) ____________________

____

Contact Name: ____________________

Telephone Number: ____________________

Quantity: ____________________ Amount Enclosed ____________________:

Mail this form and payment in full (no cash) to:

HealthNow NY, Inc. DMERC A
P.O. Box 5251
Binghamton, NY 13902
Attn: Program Education & Training

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.

DMERC Medicare News

HealthNow NY, Inc. DMERC A ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800

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