DMERC Medicare News

DMERC Region A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone (866) 419-9458 ◆ www.umd.nycpic.com
Number 57 ◆ March 2001

To the DMERC A Supplier Community:

There have been some changes at the Region A DMERC and I would like to share them with you. I have been appointed as the Senior Director, DMERC site. Vikki Menichillo has been appointed to my former position as Director, Public Relations and Marketing, Upstate Medicare Division and DMERC A. Replacing Vikki's position as Manager, Professional Relations, is Tom O'Connor. Andrea Vasil has been appointed as the HealthNow Director, Program Safeguard Contract. Replacing Andrea's position as Manager, Systems and Business Support, is Karen Furman. Mary Shubzda has been appointed as the Manager of Hearings and Appeals.

Position changes are not the only activity at the DMERC. Recovering from our recent call center incidents has been our priority. The DMERC staff has been diligently working extra hours to process claims, correspondence, and return calls. Providing quality customer service is important to us and we look forward to enhancing that service so that all your needs can be met. In the coming months, offers of new and additional educational programs and services will be implemented. I am interested in your feedback, please let me know your ideas and suggestions regarding services that you could benefit from. I can be reached via e-mail at dhcupina@nycpic.com.

Sincerely,

Donna Cupina
Senior Director, HealthNow, NY Inc. DMERC A

Table of Contents

Region A DMERC Contacts

HealthNow DMERC A	570-735-9400	Hearings Voice Mail	570-735-9513
HealthNow DMERC A Fax	570-735-9402	Medicare Secondary Payer	570-740-9001
Accounting	570-740-9002	National Supplier Clearinghouse	866-238-9652
Accounting/MSP Fax	570-735-9594	Professional Relations	570-735-9666
Beneficiary Help Line	570-735-7383	Professional Relations Fax	570-735-9442
Beneficiary Toll-Free Help Line	800-842-2052	Reconsiderations Fax	570-735-9599
EDI Fax	570-735-9510	SADMERC	877-735-1326
EDI Helpdesk	570-735-9429	Supplier Toll-Free Help Line	866-419-9458*
Hearings Fax	570-735-9599 *(new)*	* *New toll-free number*	

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.

Billing

Mandatory Assignment On All Drugs

Under Section 114 of the Benefits Improvement and Protection Act of 2000, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.

For claims with dates of service on or after February 1, 2001, suppliers must accept assignment on all claims for drugs.

This notice was posted on the Region A DMERC Web site, www.umd.nycpic.com in February.⌘

Vision Billing Reminder

Vision claims that are submitted to the DMERC must have the proper ICD-9-CM diagnosis code and HCPCS modifiers included. All vision codes with the exception of V2020 and V2025 require the LT and/or RT modifier(s). Claims submitted without the required HCPCS modifier will be denied as return/reject. Claims submitted for a diagnosis other than the covered ICD-9-CM diagnosis code will be denied as noncovered. Also, claims submitted without both the LT and/or RT modifier(s) AND the ICD-9-CM diagnosis code may be denied as return/reject. If tints, anti-reflective coating, U-V lenses or oversized lenses are specifically ordered by the treating physician and are NOT only a patient preference item, the ZX modifier should be added to the code.

For additional information, please refer to the Refractive Lenses policy, Chapter 16.7, in the supplier manual.⌘

Accessories Billing Reminders

CPAP Accessories

When CPAP accessories are billed alone with no record of CPAP in the patient's history, the accessories will be denied. If the patient owns a CPAP, the date of purchase is required along with the make and model of the CPAP. Please refer to Supplier Notices 98-41 "CPAP Coverage Criteria" and 99-21 "Date of Purchase."

Wheelchair Accessories

K0108-Other Accessories

Miscellaneous options, accessories or replacement parts for the wheelchairs that do not have a specific HCPCS code should be coded K0108. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108, ensure the additional information can be matched to the appropriate line item on the claim. It is also helpful to reference the line item to the submitted charge. Claims must include:

1. a narrative description of the item
2. the brand name and model name/number of the item
3. a statement defining medical need for the item for the patient

Documentation might include:

- information on patient's diagnosis, abilities, and limitations as related to the equipment
- duration of the condition, expected prognosis, and past experience using similar equipment

Supplying all the appropriate information when submitting the claim or when requesting a review is very helpful in adjudicating the claim process.

Please refer to the Wheelchair Options/Accessories policy, Chapter 14.20, in the supplier manual. ⌘

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.

Medicare's Licensure Requirement for Suppliers of Drugs

Medicare's licensure requirement for suppliers and physicians who bill for Medicare-covered drugs has been expanded. Effective for dates of service on or after December 11, 2000, suppliers and physicians who desire to bill the DMERC for any Medicare-covered drug (prescription or non-prescription) must have a state license to dispense the drug. Previously the licensure requirement had applied only to Medicare-covered prescription drugs used in conjunction with durable medical equipment or prosthetic devices. This included drugs addressed in the regional medical review policies (RMRPs) for External Infusion Pumps, Parenteral Nutrition, and Nebulizers. The new requirement expands the list to include drugs addressed in the RMRPs for Immunosuppressive Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) *and*, Oral Anticancer Drugs (including the oral antiemetics covered in this policy). There is no pharmacy licensure requirement for oxygen, enteral nutrients, *and erythropoetin*.

When Medicare-covered prescription or non-prescription drugs are dispensed by an entity not qualified as described above, the drugs are considered to be not reasonable and necessary because HCFA cannot be assured of the drug's safety and effectiveness. Similarly, equipment used to administer drugs dispensed by a non-licensed entity is also considered to be not reasonable and necessary because of the related safety and effectiveness concerns. Therefore, claims for drugs submitted by entities not licensed to dispense drugs and claims for related equipment will be denied for lack of medical necessity. ⌘

Blood Glucose Test Strips – Marketing to Medicare Beneficiaries

Marketing practices may influence Medicare beneficiaries who utilize medical supplies, such as blood glucose strips, on a repeated basis.

The Medicare program advises beneficiaries to report any instances of fraudulent or abusive practices, such as misleading advertising and excessive or non-requested deliveries of test strips, to their Durable Medical Equipment Regional Carrier. **Suppliers are reminded that beneficiaries must specifically request refills of supplies before they are dispensed.**

Advertising incentives that indicate or imply a routine waiver of coinsurance or deductibles could be in violation of 42 United States Code (U.S.C.) 1320a-7b(b). Routine waivers of coinsurance or deductibles are unlawful because they could result in (1) false claims, (2) violation of the anti-kickback statute, and/or (3) excessive utilization of items and services paid for by Medicare.

In addition, 42 U.S.C. 1320a-7a(a) (5) prohibits a person from offering or transferring remuneration. Remuneration is a waiver of coinsurance and deductible amounts with exceptions for certain financial hardship waivers that are not prohibited.

Suppliers should seek legal counsel if they have any questions or concerns regarding waivers of deductibles and/or coinsurance of the propriety of marketing or advertising material. **Any supplier who routinely waives coinsurance or deductibles can be criminally prosecuted and excluded from participating in Federal health care programs.**⌘

DMEPOS Pricing Updates

Based on changes made by the Benefits Improvement and Protection Act (BIPA) of 2000, the Balanced Budget Refinement Act of 1999, and the Balanced Budget Act of 1997, the DMEPOS pricing updates (percentage increases) for the pricing periods beginning January 2001, July 2001 (where applicable), and January 2002 are as follows:

Category	***January 1, 2001***	***July 1, 2001***	***January 1, 2002***
DME	0.3*	3.7 + 3.28*	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
Other Reasonable Charge Items**	3.7	n/a	CPI-U

* Temporary increase not to be carried over into future periods

** Other than ambulance services

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.

EDI

Elimination of HCFA Free Billing Software

Since the late 1980s, the Health Care Financing Administration (HCFA) has required the Region A DMERC 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. The Region A DMERC 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 Region A DMERC 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. ⌘

Bulletin Board Times

The Bulletin Board System is available for transmission of claims 7 days a week with the following exceptions:

- 12 midnight to approximately 6:00 AM ET (This time may vary due to maintenance needs.)
- 1:00 PM to approximately 2:oo PM
- 6:00 PM to approximately 6:30 PM⌘

Want To Save Some Money????

The following are tips for improving transmission times to the Region A DMERC:

- increase modem speeds – DMERC A uses 28.8 kbps modems
- use Z modem as your transfer protocol
- use PKzip or WinZip to compress files before transmission (this reduces the size of the file by more than 90%). Please call the EDI Helpdesk at 570-735-9429 if you plan to use this feature.

The following table compares upload times for the same file using common protocols – the file used for the test was about 2MB (approximately 980 claims)

Protocol	Upload Time in Minutes
Z modem	6
Y modem Batch	18
X modem	126
Zipped file with Z modem	Less than 1 minute⌘

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.

EDI Software Order Form

Dear Supplier,

The Region A DMERC charges for the cost of materials and shipping for each Accelerate software package. We also offer a communication package called Procomm Connections which is compatible with the Accelerate software. The total charge for the software package is $25. If either the Accelerate software or the Procomm Connections are ordered separately, the cost is $15.00 each.

To order, complete the order form below. Checks are made payable to Region A DMERC. The Region A DMERC will not issue any software without payment and no refunds will be issued. Questions regarding this information may be directed to the EDI Helpdesk at 570-735-9429.

ACCELERATE ORDER FORM ONLY*: (3.5 diskette only)

Company Name: _____

Address: _____

_____

Contact Person: _____

Phone Number: _____

Fax Number: _____

EMAIL Address: _____

NSC Number: _____

Submitter Number: _____
(Please put in your current submitter number, if you have one. If you are a new submitter put in the word NEW.)

Mail to:

HealthNow NY INC
DMERC A
Attn: EDI Unit
PO Box 5251
Binghamton, NY 13902

Amount enclosed: $_____

Circle One: (Both Procomms come in CD-ROM only)

Accelerate and Procomm Connections
(for Win 95, 98 or NT only)
$25.00

Accelerate and Procomm Plus
(for Win 3.1 only)
$25.00

Procomm Connections
(for Win 95, 98 or NT only)
$15.00

Procomm Plus
(for Win 3.1 only)
$15.00

Accelerate Software

$15.00

HCPCS

New HCPCS Code for Insulin Lispro

Effective for claims with dates of service on or after April 1, 2001, a new HCPCS code has been established for insulin lispro: K0548 (Injection, insulin lispro, up to 50 units). For dates of service prior to April 1, 2001, this form of insulin should be coded as J1820 (Injection, insulin, up to 100 units). After April 1, 2001, all forms of insulin other than lispro must continue to be coded as J1820. Insulin is only covered by Medicare if administered through an insulin pump, and in accordance with the coverage and payment rules of the External Infusion Pump Policy, Chapter 14.27, in the supplier manual.⌘

Cervical and Lumbar Traction

The recent audit of cervical and lumbar traction has identified the need for a reminder of HCPCS coding issues. A previously published article in the March 1998 *DMERC Medicare News* outlines products, a new HCPCS code established, and known products coded and to be billed with the E0855 HCPCS code. The known products that should be coded using E0855, cervical traction equipment, not requiring additional frame or stand, are the Pronex Pneumatic Traction device, manufactured by Glacier Cross, and the Saunders Cervical HomeTrac, manufactured by the Saunders Group. Additional products coded for the E0855 include the CycleTrac, manufactured by PT Products, LLC, and Cervico 2000, manufactured by Meditrac Medical Equipment.

The Lossing 90/90 BackTrac has been coded in 1994 as the E0900, traction stand, freestanding pelvic traction with the E0944, pelvic belt/harness/boot for the polar pelvic belt.

If a supplier or manufacturer thinks another product meets the description of the above codes, they may contact the Statistical Analysis DME Regional Carrier (SADMERC) toll-free at 877-735-1326 for a written coding determination.⌘

Correction: PPS Crosswalked Codes Listing

The following is a correction to the Home Health Prospective Payment System (PPS) article on page 4 of the December 2000 *DMERC Medicare News.* Listed below are codes that were deleted on December 31, 1999 and crosswalked to new codes on January 1, 2000:

Old Code	New Code
K0428	A4384
K0429	A4385
K0430	A4386
K0431	A4387
K0432	A4388
K0433	A4389
K0434	A4390
K0435	A4391
K0436	A4392
K0437	A4393
K0438	A4394
K0439	A4395

Please refer to the December 2000 newsletter for any new crosswalked codes for the year 2001.

A4396 was a new code effective January 1, 2001. ⌘

Medical Policy

Trapeze Bars Versus Traction Equipment

A trapeze bar is covered when a patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in and out of bed. An E0910, trapeze bars, also known as Patient Helper, attached to a bed, with grab bar, is covered when it is either an integral part of or used on a hospital bed and the hospital bed and trapeze bar are medically necessary. This item is not covered when used on a non-hospital bed. The E0940, trapeze bar, freestanding, complete with grab bar, must meet the same criteria as attached equipment and the patient must not be renting or own a hospital bed. Please reference the Trapeze Bars and Other Bed Accessories policy, Chapter 14.17, in the Region A Durable Medical Equipment supplier manual.

Traction equipment is covered if the patient has an orthopedic impairment requiring traction, which prevents ambulation during the period of use. Please reference the Durable Medical Equipment Reference List, Section 12.6, in the Region A DMERC supplier manual.

For all of the above items, the supplier must maintain on file an order, which has been signed and dated by the physician. Please reference Documentation, Section 12.4, in the Region A DMERC supplier manual for additional information on prescriptions and/or orders.

Although an item may be classified as DME, it may not be covered in every instance. Coverage is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury or to improve the functioning of a malformed body member. These considerations will bar payment for equipment furnished that substantially exceeds the requirement for the treatment of the illness or injury involved. Please reference Coverage Issues, Section 12.2, in the Region A DMERC supplier manual. If a supplier or manufacturer thinks another product meets the description of the above codes, they may contact the Statistical Analysis DME Regional Carrier (SADMERC) toll-free at 877-735-1326 for a written coding determinations.⌘

Certificates of Medical Necessity (CMNs) – New Instructions for Corrections

In the June 1999 *DMERC Medicare News* (pg. 16), information was provided on how to correctly identify changes on a CMN once the physician had signed Section D. In that article, instructions for corrections indicated that the physician should draw a line through the erroneous information, sign in full, and provide the date of the change.

Effective for dates of service on or after November 22, 2000, physicians may indicate changes to information on the CMN by drawing a line through the erroneous information, initialing the change, and providing the date of the change. Suppliers also have the option of having the physician complete a new CMN.⌘

Oral Antiemetic Drug Policy

The regional medical review policy on Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) is published in the accompanying Region A supplier manual revision. The revision language reflects a change in jurisdiction for claim submission by physicians who are also DMEPOS suppliers. In addition, the policy incorporates instructions from the Health Care Financing Administration (HCFA) regarding entities qualified to dispense and bill for Medicare-covered drugs (see accompanying article on page 11 of this *DMERC Medicare News* entitled Medicare's Licensure Requirement for Suppliers of Drugs). The revised policy is effective for dates of service on or after April 1, 2001.⌘

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.

Immunosuppressive Drugs Following Intestinal Transplantation – Coverage and DMERC Information Form (DIF)

Effective April 1, 2001, Medicare covers intestinal transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Coverage of immunosuppressive drugs is being extended to include patients who meet *all* of the following criteria:

- The patient receives a Medicare-covered intestinal transplant on or after April 1, 2001; and,
- The patient was enrolled in Medicare Part A at the time of the transplant and is enrolled in Medicare Part B at the time that the drugs are dispensed; and,
- The drugs are medically necessary to prevent or treat rejection of the organ transplant in the particular patient; and,
- The drugs are furnished on or after discharge from the hospital following the intestinal transplant.

Suppliers billing for immunosuppressive drug(s) related to an intestinal transplant must, for question #5 on the DIF, answer "7" (Reserved For Future Use) if this correctly identifies the patient's situation. For hard copy claims, enter the statement "Intestinal Transplant" in the blank space on the DIF next to Item 7 in question #5. If the claim is filed electronically, enter "intestinal transplant" in the HA0 record.

Refer to the Immunosuppressive Drugs policy in Chapter 19.01 of the DMERC supplier manual for more information on Coverage and Payment Rules, Coding Guidelines, and Documentation requirements. ⌘

Immunosuppressive Drugs Following Transplant – Coverage Change

Effective for immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for this Medicare benefit. This policy applies to all Medicare beneficiaries who meet all of the other program requirements for coverage under this benefit. Beneficiaries who satisfy all eligibility requirements for immunosuppressive drug coverage but for whom coverage expired prior to December 21, 2000 due to time limitations imposed by Medicare statute may have immunosuppressive drug coverage reinstated on or after December 21, 2000. However, there is no provision for coverage between the time of previous benefit expiration and the resumption of the benefit on or after December 21, 2000. Therefore, claims for dates of service after expiration of benefits but prior to December 21, 2000 will be denied as noncovered.

A new DMERC Information Form (DIF) for Immunosuppressive Drugs is not required for beneficiaries who had previously received coverage for immunosuppressive drugs and are now resuming coverage under this benefit extension *unless* there has been a change in the drug regimen since the initial DIF was filed. If there has been a change in the drug regimen, a new initial DMERC Information Form (DIF) for Immunosuppressive Drugs must be completed when claim submission resumes for these beneficiaries.

In the accompanying Region A supplier manual revision, the regional medical review policy on Immunosuppressive Drugs has been updated to reflect this change in coverage time limits. ⌘

Speech Generating Devices (SGD) – New Policy

The Speech Generating Devices final policy is published in the accompanying Region A supplier manual revision and posted on the Region A DMERC Web site at www.umd.nycpic.com. In addition, the Web site posting also includes a "Response to Comments" document that summarizes the comments received from clinical organizations, suppliers, manufacturers, and beneficiary organizations during the 60-day public comment period that ended on December 19, 2000. The DMERC medical directors' response to each comment is also detailed in this document. The final SGD policy reflects changes adopted by the DMERCs in response to comments and is effective for dates of service on or after July 1, 2001.

As noted in the December 2000 *DMERC Medicare News* (page 14), the development of this policy reflects a change in HCFA's national coverage of "communicators" and HCFA's issuance of Coverage Issues Manual 60-23 which was effective for dates of service on or after January 1, 2001. Therefore, claims submitted for these devices between January 1, 2001 and June 30, 2001 will be adjudicated based on individual consideration.⌘

Non-Implantable Pelvic Floor Electrical Stimulation (PFES) – National Coverage Determination

Effective for dates of service on or after April 1, 2001, the Coverage Issues Manual (CIM) is being revised to permit coverage for non-implantable pelvic floor electrical stimulators. Reference to non-implantable pelvic floor electrical stimulators has been moved from CIM §65-9 (incontinence control devices) to CIM §60-24 (Non-Implantable Pelvic Floor Electrical Stimulator).

Section 60-24, Non-Implantable Pelvic Floor Electrical Stimulator, permits coverage for non-implantable pelvic floor electrical stimulators for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Suppliers submitting claims to the DMERC for PFES should use HCPCS code E0740 (Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer). This code is in the Inexpensive or Routinely Purchased (IRP) reimbursement category. Suppliers are reminded that there must be documentation in the patient's medical record that the coverage criteria outlined in the national policy have been met. This documentation does not have to be routinely sent with the claim but must be available to the DMERC upon request.⌘

Osteogenesis Stimulators – Policy Revision

A revision of the Osteogenesis Stimulators medical policy is included in the accompanying Region A DMERC supplier manual revision. The major changes are:

1. Coverage of ultrasonic osteogenesis stimulators (E0760) as specified in the recent revision to Medicare Coverage Issues Manual, Section 35-48.
2. Use of a ZX modifier to indicate that coverage criteria for an ultrasonic osteogenesis stimulator are met. (The ZX modifier will not be used with electrical osteogenesis stimulators – E0747 and E0748.) The Certificate of Medical Necessity (CMN) will not be used for ultrasonic osteogenesis stimulators, but will continue to be used for electrical osteogenesis stimulators.
3. New requirements for diagnosis coding for **all** osteogenesis stimulators, electrical and ultrasonic. For nonunions of fractures, in addition to the generic code for nonunion (733.82), the policy also requires the ICD-9 code specifying the fracture site.

Coverage for ultrasonic osteogenesis stimulators became effective for claims with dates of service on or after January 1, 2001. The revised documentation requirements for all osteogenesis stimulators are effective for claims with dates of service on or after July 1, 2001.

The ultrasonic osteogenesis stimulator is in the Inexpensive or Routinely Purchased (IRP) payment cat-

Miscellaneous

Reminder for Prior Authorization Requests

When a prior authorization request has been denied you will receive a denial letter. This letter will outline your appeal rights. If you wish to appeal this initial decision, you have the right to request a review. Refer to Chapter 8 in the Region A DMERC supplier manual for information on the review process. Resubmission of this prior authorization will be denied as a duplicate.⌘

Appendices Publication Change

In the past, the classification list was published quarterly in the Appendices of the supplier manual revision. Effective for the June 2001 revision, the Appendices will no longer be published quarterly. The Appendices will only be published annually in the December revisions. Suppliers can access quarterly updates to the classification lists by visiting the SADMERC Web site www.pgba.com/palmetto/main.nsf/allframesets/oth_sadm.html.⌘

Helpful Hearings Reminders

Suppliers are reminded of the following:

- The amount in controversy for a Fair Hearing must be at least $100.00. The amount in controversy for an Administrative Law Judge (ALJ) hearing must be at least $500.00. *(Please refer to pages 16 and 17 of the September 1999 edition of the DMERC Medicare News for more information.)*
- The amount in controversy is calculated by taking the submitted charge and subtracting any amount that has been paid (and any deductible not met for the year); 80% of this amount is the amount in controversy. It is not calculated based on the allowable.
- A Fair Hearing must be requested within 180 days of the Review denial. An ALJ Hearing must be requested within 60 days of the Fair Hearing denial.
- All Fair Hearing and ALJ Hearing requests must be in writing. All Fair Hearing requests must specify what type of hearing is being requested: Telephone, On-the-Record, or In-Person.
- On-the-Record Hearings will be initially completed on all denials that are not medical necessity denials. This is a requirement of the MCM.
- The Hearings Department new fax number is (570) 735-9599.⌘

Debt Collection Improvement Act of 1996 "Intent to Refer Letter"

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to transfer/refer debt that is 180 days delinquent to a Department of Treasury Debt Collection Center for cross servicing.

Prior to debt transfer, the DCIA requires agencies to inform the debtor of the agency's intent to refer the debt, and to provide debtor information regarding the referral process.

Medical suppliers will now receive second demand letters on outstanding overpayments with the Debt Collection Improvement Act of 1996 required language. A sample of this letter will appear in the June 2001 edition of the *DMERC Medicare News*.⌘

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.

A New Member of the Region A DMERC Team for Program Safeguard Activities

Soon there will be a new member of the Region A DMERC team. While HealthNow NY, Inc. will continue to process your DMEPOS claims – in fact, nearly every aspect of your day-to-day relationship with HealthNow will remain the same – beginning in May, a new partner, TriCenturion, LLC, will begin to assume responsibility for Program Safeguard activities.

On November 7th, 2000, HCFA awarded a Medicare Program Safeguard Task Order to TriCenturion, LLC. As the Program Safeguard Contractor (PSC) for Region A, TriCenturion will assume responsibility for medical policy development, medical review, and Benefit Integrity for Region A DMEPOS claims. HealthNow will continue to process claims, provide customer service, address Medicare Secondary Payer issues (in conjunction with the Coordination Of Benefits, or "COB" Contractor), administer the appeals process, and provide education to the beneficiary and supplier communities. TriCenturion and HealthNow are fully committed to coordinating our efforts in working for you. This transition will be completed by October 1, 2001.

HealthNow remains your primary resource for all Medicare DMEPOS customer service matters. Your points of contact to inquire about the status of your Medicare claims remain the same. TriCenturion, as the new PSC, will contact you directly in the event that it requires information from you in carrying out its activities, and any such request will contain explicit instructions on when, where, and how to respond.

You will be provided with additional information about the PSC in coming months; look to the HealthNow DMERC A Web site, www.umd.nycpic.com, and to upcoming issues of the *DMERC Medicare News*. For additional information about the Program Safeguard Contractor effort, a part of the Medicare Integrity Program (MIP), visit HCFA's MIP Web site at www.hcfa.gov/medicare/mip/. ⌘

Questions regarding the Program Safeguard Contract (PSC) can be directed to telephone number 570-735-9424.

This article was contributed by TriCenturion, LLC.

Toll-Free Supplier Number Established for Region A

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.

Suppliers can continue to contact the other DMERC Departments at the telephone numbers listed on page 2 of this newsletter.

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.

Reconsiderations Update

To improve the quality of the affirmation letters, the Reconsideration Unit has re-evaluated the letters that are affirming or upholding the original denial for lack of medical necessity. Additional paragraphs have been added to better inform the supplier or beneficiary as to why the equipment or supplies are affirmed as not medically necessary. The appeals process is still to be utilized upon receiving the affirmation of the denial. Any additional documentation can be submitted with your request for a Fair Hearing.⌘

Appeals of Medicare Part B Coverage Determinations

A beneficiary's right to appeal a Part B coverage determination is afforded by statute (see §1869, 1842(b)(3)(c) of the Social Security Act (the Act)). The Act provides for a hearing where a beneficiary is dissatisfied with the determination of the amount of benefits payable under Part B (including a determination where such amount is determined to be zero). The statute also provides for appeal rights for providers and suppliers in certain circumstances (see §1879(d) of the Act). By regulation, HCFA has further established administrative appeals remedies for resolving such disputes that must be exhausted prior to securing a right to a hearing. The regulations governing administrative appeals for Part B coverage determinations are found at 42 CFR Part 405, Subpart H (Appeals Under the Medicare Part B program). These regulations also provide for appeal rights with respect to determinations that a beneficiary, provider, or supplier was not without fault regarding an overpayment under §1870 of the Act; or knew or reasonably could be expected to know that the item or service was not covered, under §1879 of the Act.

Development of Requests for Provider/Supplier-Initiated Appeals

If additional documentation is needed to process an appeal, the DMERC will request that the submitter of the appeal (i.e., the provider/supplier) obtain and submit it within the prescribed time period following notification of an initial determination. Providers or suppliers may request a review by filing a written review request within the timely filing period.

Contents of a Written Request for Reconsideration or Review

For Part A appeals, the Medicare regulation at 42 CFR 405.710 states that a party that is dissatisfied with the initial determination may request a reconsideration of such determination. It is clear that the request for reconsideration must be tied to a specific, identifiable initial determination. However, it is not sufficient to simply identify a beneficiary, or a certain time period, for example. The appeal must not only identify the initial determination with which the party is dissatisfied, but must also meet the requirements for the contents of an appeal request outlined below.

For Part B appeals, the Medicare regulation at 42 CFR 405.807 states that a party who is dissatisfied with an initial determination may request that the carrier review such determination. Again, the request for review must not only identify the initial determination with which the party is dissatisfied, but must also meet the requirements for the contents of an appeal request outlined below.

If a fully-completed Form HCFA-2649, Request for Reconsideration of Part A Health Insurance Benefits, or Form HCFA-1964, Request for Review of Part B Medicare Claim, is not used to express disagreement with the initial determination, then the appeal request must contain the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and
- Which item(s), if any, and/or service(s) are at issue in the appeal.

Providers/suppliers, Medicaid State agencies or the party authorized to act on behalf of the Medicaid State agency are responsible for submitting documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies. This documentation may be supplied with the appeal request or at the request of the contractor. Failure to submit requested documentation in a timely manner may result in processing delays.⌘

In an effort to manage incoming appeals in FY 2001 with the given resources, HCFA has provided guidance relative to processing appeals. Incoming appeal requests submitted without necessary supporting documentation will be given secondary priority to appeal requests submitted with appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possible be delayed.

Product/Process Focus Groups

Please refer to the Product/Process Focus Group assignments listed below when calling the Professional Relations telephone number 570-735-9666. The Secondary Ombudsman serves as backup/support to the Primary Ombudsman for the product category.

Respiratory
Laurie Kulak-Ombudsman-Primary
Mary Jo George Roue-Ombudsman-Secondary

Oxygen Supplies/Equipment
Tracheostomy Supplies
Nebulizers
IPPB
CPAP/BIPAP
Ventilators
Suction Pumps

Mobility
Suzanne Smetana Paul-Ombudsman-Primary
Jean Gober-Ombudsman-Secondary

Wheelchairs
Seat Lift Mechanisms
Walkers
Power Operated Vehicle
Canes/Crutches
Seating Systems
Repairs/DME

Orthotics & Prosthetics
Mary Jo George Roue-Ombudsman-Primary
Laurie Kulak-Ombudsman-Secondary

Lower/Upper Limb Orthosis
Diabetic Shoes
Spinal Orthosis
Orthotic/Prosthetic Repairs
Lower/Upper Limb Prosthesis
Dynamic Splints
Orthopedic Footwear

Beneficiary Ombudsman
Jennifer Lorang
MA, CT, ME, RI, and NY City and Long Island

Supports
TBA-Ombudsman-Primary
Cheri Cross-Ombudsman-Secondary

Hospital Beds/Accessories
Support Surfaces
Trapeze Bars
Patient Lifts
Commodes/Bed Pans/Urinals
Traction

Nutrition/Pharmacy
Cheri Cross-Ombudsman-Primary
TBA-Ombudsman-Secondary

Enteral Nutrition
Dialysis Equipment/Supplies/EPO
Infusion Pumps
Oral Anti-Cancer Drugs
Immunosuppressive Drugs
Oral Antiemetic
Parenteral Nutrition

Specialized DME
Jean Gober-Ombudsman-Primary
Suzanne Smetana Paul-Ombudsman-Secondary

Heat/Cold Application & IDE
Lymphedema Pumps
CPM & Neuromuscular
Ostomy & Urologicals
TENS & Osteogenic Bone Stimulator
Surgical Dressings
Vision- Lenses & Prosthesis
Breast Prosthesis
Impotence
Diabetic Supplies
Voice Prosthesis
Maxillofacial/Miscellaneous DME

Beneficiary Ombudsman
Kim Hollis
PA, NJ, DE, VT, NH, and Upstate NY

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.

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.

Payment for Method II Dialysis Claims

Supplier Notice 2000-34
November 29, 2000

As of December 1, 2000, in compliance with MCM reference section B3 4270, HealthNow NY Inc. DMERC A will be implementing methodology for accurate payment of Method II Dialysis claims.

The allowance per month under Method II for home dialysis equipment and supplies may NOT exceed $1,409.85 per month for all forms of dialysis except continuous cycling peritoneal dialysis (CCPD). For CCPD, the allowance may not exceed $1,974.45 per month.

In the past, dialysis codes were paid at the "actual charge" but not to exceed the monthly cap.

As of December 1, 2000, the amount paid per dialysis code will be based on the "usual reasonable charge rules" but not to exceed the monthly cap.

This could result, at times, in the provider receiving less than the monthly cap based on the "reasonable fees".

If you have any questions, please contact the Customer Service Department at telephone number 570-735-9445.

Crossover Update

Supplier Notice 2000-35
December 1, 2000

The Region A DMERC is providing an update on processing issues of crossover claims during the period of September 22 through November 24, 2000. Written and verbal contact has been made to all of our trading partners to determine an efficient resolution. Based on our findings, files are currently being recreated and resent to those trading partners who reported non-receipt of crossover claims.

The following trading partners have acknowledged receipt of recreated crossover claim files:

- AFLAC
- Pennsylvania Department of Income Maintenance
- Peoples Benefit Life Insurance
- Special Agents Mutual Benefit Association (SAMBA)
- United American Insurance Company

The Region A DMERC is currently recreating files and continues to work with the following trading partners to resolve all outstanding issues:

- Bankers Life and Casualty
- BC/BS of New Hampshire
- Empire BC/BS
- Government Employees Hospital Association (GEHA)
- New Hampshire Department of Income Maintenance
- Pioneer Life Insurance Company
- Maine Medicaid

The DMERC will continue to provide updates as the crossover issues are resolved.

Correction: December 2000 Newsletter

Supplier Notice 2001-01
January 17, 2001

The following are corrections to the December 2000 edition of the Region A DMERC newsletter:

Page 2, Table of Contents:
The listing of "Stump Support System K0048" on page 16 was inadvertently included in the Table of Contents. This article was not included in the newsletter.

Page 21, "Offset Information Requests":
The last sentence of the article should read:

> "To appeal an overpayment request, please follow the instructions in your overpayment letter received from the Region A DMERC."

The Region A DMERC December 2000 edition of the *DMERC Medicare News* was mailed to suppliers at the end of December. We apologize for any inconvenience the above may have caused.

MSP Amounts at the Line Level

Supplier Notice 2001-02
January 17, 2001

HealthNow Medicare's claim processing system was modified to allow Medicare Secondary Payer (MSP) claim payment information to be processed at the line level. Currently, all MSP information is reported at the claim level. Beginning January 6, 2001 an electronic submitter can report information from the primary payer's Explanation of Benefits (EOB) for line level paid amounts, if available, as well as claim level paid amounts. If payment information from the primary EOB is reported at a claim level ONLY, electronic submitters will ONLY report claim level information. The NSF fields that are to be used in providing MSP line level information are:

FA0 – 35.0 (positions 179-185) Primary Paid Amount
The actual amount paid by the payer under the provisions of the contract. **Zero fill**.

FB0 – 6.0 (positions 47-53) Allowed Amount
Derived from the Primary Payer EOB. Right justify. **Zero fill**. If value is 0000000 for an MSP claim, explain reason in HA0 – 5.0

FA0 – 48.0 (positions 224-230) Obligated to Accept Amount.
The amount the provider agreed to accept as payment in full under the provisions of the contract. **Zero fill**. May not be blank.

Some of your users may have had claims reject on January 6 & 9, 2001 with an edit indicating the obligated to accept amount was invalid. This edit hit because FA0 – 48 was coming in as spaces. Although the edit checking this field is new, the requirement to zero fill that field is not. An interim solution has been found and will allow these claims into the processing system. Effective April 2, 2001, the edit will be set to reject claims that do not contain a positive, unsigned, numeric value. We apologize for any inconvenience this may have caused. If you have any questions regarding this change, please contact the EDI Department at 570-735-9429.

1st Quarter Update: Drug Fees

Supplier Notice 2001-03
January 29, 2001

The fees listed below were effective January 1, 2001.

DRUG FEES

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J0285	AMPHOTERICIN B	50 MG	$16.95
J0286	AMPHOTERICIN B, ANY LIPID FORMULATION	50 MG	$88.66
J0895	DEFEROXAMINE MESYLATE	500 MG/5CC	$12.62
J1170	HYDROMORPHONE	4 MG	$1.01
J1250	DOBUTAMINE HYDROCHLORIDE	250 MG	$4.28
J1325	EPOPROSTENAL	0.5 MG	$11.02
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	$42.85
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	$2.75
J7508	TACROLIMUS, ORAL	5 MG	$13.72
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
J7517	MYCOPHENOLATE MOFETIL, ORAL	250 MG	$2.29
J9000	DOXORUBICIN HCL	10 MG	$50.96
J9001	DOXARUBICIN HCL ALL LIPID FORMS.	10 MG	$335.47
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	$149.19
J9265	PACLITAXEL	30 MG	$170.90
J9280	MITOMYCIN	5 MG	$127.40
J9290	MITOMYCIN	20 MG	$421.99

(Continued on page 18.)

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.

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	$75.51

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
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

(Continued on page 19.)

J7680		TERBUTALINE SULFATE, CONCENTRATED FORM	$1.96
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	$40.51
J7682	KP	TOBRAMYCINE, UNIT DOSE FORM, 300MG	$40.51
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	$0.26
Q0178		HYDROXYZINE PAMOATE, 50MG, ORAL	$0.26
Q0179		ONDANSETRON HYDROCHLORIDE, 8MG, ORAL	$25.15
Q0180		DOLASETRON MESYLATE, 100MG, ORAL	$69.64
Q9920		EPOETIN	$10.00

*INDIVIDUAL CONSIDERATION

2001 Cap Fees for Therapeutic Shoes

Supplier Notice 2001-04
February 2, 2001

Listed below is the 2001 Special Limitation for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes **A5500 – A5506**. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the cap amount. The current cap breakdown for 2001, which is the same for all states, is as follows:

Code	Cap
A5500	$63.00
A5501	$189.00
A5502	$32.00
A5503	$32.00
A5504	$32.00
A5505	$32.00
A5506	$32.00

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.