
Senior Services News

A Newsletter
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TO: Providers of Pharmaceutical Services,
Physicians, Dentists, Podiatrists, Certified Nurse
Practitioners/Clinical Nurse Specialists and Optometrists – **For Action**
Independent Clinics and Health Maintenance Organizations – **For
Information**

SUBJECT: **Enactment of the Pharmaceutical Assistance to the Aged and
Disabled Medicare Recovery Initiative With Regard to Participating
Pharmacy Providers and Prescribers**

EFFECTIVE: For claims with service dates on or after April 2, 2002

PURPOSE: To inform providers of pharmaceutical services to Pharmaceutical
Assistance to the Aged and Disabled (PAAD) beneficiaries of changes
concerning PAAD's Medicare Recovery Initiative pursuant to P.L.2001,
c. 130.

ACTION: Pharmacy providers must comply with the Medicare Reimbursement
requirements of Medicare Part B (DMEPOS) suppliers and submit a
completed EDI enrollment form in order to continue their participation in
the PAAD and Senior Gold Programs. Please note that pharmacies not
complying with the above noted provisions will be suspended as
participating providers in the PAAD and Senior Gold programs.

Medicare recovery procedure:

PAAD will act as the billing agent of its pharmacy providers and bill Medicare for dually eligible claims so that PAAD may recover the cost of claims that are covered under both PAAD and Medicare Part B. PAAD will satisfy the beneficiary's co-insurance and Medicare deductible.

1. The prescription claim will be sent electronically to PAAD by the pharmacy in accordance with the standards established by PAAD and in a manner similar to any other PAAD on-line prescription. Only the \$5.00 PAAD copayment will be collected from the beneficiary.
2. PAAD will process the claim and make payment to the pharmacy in accordance with the usual PAAD procedures.
3. EDI enrollment will allow PAAD to act as the billing agent for its pharmacy providers to bill Medicare for dually eligible claims covered under both PAAD and Medicare Part B.

4. PAAD will translate the claim information from the National Council for Prescription Drug Programs' (NCPDP) format used by Unisys into the National Standard Format (NSF) and forward the claim electronically to the Durable Medical Equipment Regional Carrier (DMERC) Region A for processing and payment by Medicare.
5. Medicare will make payment of its allowable amount to the pharmacy, minus any applicable co-insurance payment, and will send a copy of the remittance advice to PAAD.
6. Based upon the Medicare remittance advice, PAAD will recapture the Medicare payment from the pharmacy on subsequent billing cycle(s) and provide claim-specific recapture information on subsequent remittance advice statements with EOB '879' (Medicare/PAAD claim adjustment).

Obligations of the pharmacy supplier:

1. Medicare regulations require a diagnosis code on the original order from the physician. The only permissible representation of diagnosis is an ICD-9 code. You can obtain a telephone prescription with verbal diagnosis but this must be followed up with a written order form from the doctor for you to maintain on file in case of a Medicare audit. A sample of each type is attached for your information. These forms include all necessary information required by Medicare for documentation purposes. Please refer to the DMERC's web site at www.umd.nycpic.com/rev15mrover.html#12.0 under section 12.4 entitled Documentation for additional information.
2. If the order indicates that the patient is being treated *with insulin injections*, the ZX modifier must be added to the ICD-9 code for diabetic testing supplies on every claim submitted. The ZX modifier must *not* be used for a patient who is not treated with insulin injections.
3. If the order indicates that the patient is *not* being treated with insulin injections, the KS modifier must be added to the ICD-9 code for diabetic testing supplies on every claim submitted.
4. Medicare regulations require a new written order every six months for diabetic testing supplies indicating the diagnosis as an ICD-9 code with the appropriate modifier. If the modifier is absent, the physician should be contacted to obtain this information.
5. Medicare regulations require a Drug Information Form (DIF) for any immunosuppressive drugs covered by Medicare. The DIF *may* be completed by the supplier and must be kept on file under Medicare's documentation requirements. A copy of this form is attached for your information. The form also can be obtained at DMERC's web site at www.umd.nycpic.com/rev15Immuno.pdf.
6. Medicare regulations require that an authorization of assignment of benefits and a release of medical information documentation be kept on file for each beneficiary using PAAD/Medicare dually eligible drugs. Please refer to the DMERC's web site at www.umd.nycpic.com/rev15mrover.html#12.0 under section 12.4, entitled

"Documentation for Additional Information" or the sample form attached to this newsletter.

7. It is the responsibility of all PAAD pharmacy providers to be knowledgeable and comply with Medicare rules and regulations.

Billing Procedure:

1. When a pharmacist processes a claim for a Medicare covered drug, the point of sale (POS) system will post edit '444' along with edit '423' (short description of edit '444' is "Medicare covered drug diagnosis code required", edit '423' reads "Prior authorization required call FHS") prompting the pharmacist to contact First Health Services to get the prior authorization number.
See attachment for the list of Medicare covered drugs, which will deny with error code 444/423.
2. First Health Services will request the ICD-9 code (diagnosis code) from the pharmacist as written on the prescription.
3. If the ICD-9 is not available, FHS will call the prescriber and request the physician's office to mail a new written order with the diagnosis code or a complete physician's written order form back to the pharmacy. FHS will call the pharmacy back with the PA number and ICD-9 code received from the prescriber.

PAAD and its contract vendors maintain strict confidentiality measures with regard to beneficiary and claims records. These measures will continue for the Medicare recovery program as for all other PAAD operations.

For further information:

Any questions or comments concerning these requirements may be directed to the Medicare Reimbursement Unit (MRU) at 609-588-7146 or email us at www.medicarerecoveryunit@doh.state.nj.us.

Check the Department of Health and Senior Services' web site at www.state.nj.us/health/seniorbenefits/index.html or www.NJMMIS.com for information concerning the Medicare recovery initiative - including copies of PAAD regulations, past newsletter editions, and links to Medicare forms and resources.

Pharmacies may also refer to the following newsletter editions for further information on the Medicare recovery program: *Senior Services News*, July 2000 (Volume 4, Number 2); *Senior Services News*, August 2000 (Volume 4, Number 4); *Joint Newsletter* of the Division of Medical Assistance and Health Services (NJ Dept. of Human Services) and the Division of Senior Affairs (NJ Dept. of Health and Senior Services), October 2000 (Volume 10, Number 79); *Senior Services News*, May 2001 (Volume 5, Number 2), *Senior Services News*, August 2001 (Volume 5, Number 8).

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")**

**Medicare-Covered Drugs for PAAD Reimbursement Program
November 2001**

Oral Cancer Drugs

ALKERAN 2 MG TABLET
CYTOXAN 25MG TABLET
CYTOXAN 50 MG TABLET
METHOTREXATE 2.5 MG TABLET
MYLERAN 2MG TABLET
NEOSAR 100MG VIAL
NEOSAR 1GM VIAL
NEOSAR 200MG VIAL
NEOSAR 2GM VIAL
NEOSAR 500MG VIAL
VEPESID 50MG CAPSULE
XELODA 150MG TABLET
XELODA 500MG TABLET
ZENAPAX 5MG/ML VIAL

Diabetic Supplies

DIABETIC TEST STRIPS
LANCETS

Ant-Emetic Drugs

KYTRIL 1MG TABLET

Immunosuppressive Drugs

AZATHIOPRINE 50MG TABLET
CYCLOSPORIN 100MG SOFTGEL
CYCLOSPORIN 25MG SOFTGEL
CYCLOSPORIN 50MG/ML VIAL
IMURAN 100MG VIAL
IMURAN 50MG TABLET
NEORAL 100MG/ML SOLUTION
PROGRAF 1MG CAPSULE
PROGRAF 5MG CAPSULE
PROGRAF 5MG/ML AMPULE
RAPAMUNE 1MG/ML ORAL SOLUTION

Solutions for Nebulizers

ALBUTEROL 0.83MG/ML SOLUTION
ALUPENT 4% SOLUTION
ALUPENT 5% SOLUTION
ATROVENT 0.02% SOLUTION
IPRATROPIUM BR 0.02% SOLUTION
METAPROTERENOL 4% SOLUTION
METAPROTERENOL 5% SOLUTION

Physician's Written Order

NOTE TO THE PHYSICIAN:
NOTE TO THE PHARMACY:

*Complete the sections below and fax it to the pharmacy and mail original to pharmacy.
Retain the original form for your records.*

Patient Name _____

This section to be completed by the pharmacy

Address _____

Pharmacy Name _____

City/State _____

Pharmacy Address _____

Phone _____

City/State _____

Medicare # _____

Phone _____

Original Order Date _____

Fax Number _____

ICD-9 DIAGNOSIS CODES :

- | | | |
|--------------------------|------------------------------------|----------------|
| <input type="checkbox"/> | NIDDM WITHOUT COMPLICATIONS | #250.00 |
| <input type="checkbox"/> | NIDDM WITH COMPLICATIONS | #250.80 |
| <input type="checkbox"/> | IDDM WITHOUT COMPLICATIONS | #250.01 |
| <input type="checkbox"/> | IDDM WITH COMPLICATIONS | #250.80 |
| <input type="checkbox"/> | HYPOGLYCEMIA (not reactive) | #251.00 |
| <input type="checkbox"/> | HYPERGLYCEMIA | #790.9 |
| <input type="checkbox"/> | GESTATIONAL | #648.8 |

modifier (KS) (ZX)
modifier (KS) (ZX)
modifier (ZX)
modifier (ZX)

*Please circle one
to all listed*

- | | | | |
|--------------------------|-------------------------------------|---|-------------------------|
| <input type="checkbox"/> | Patient is not using insulin | } | Please check off |
| <input type="checkbox"/> | Patient is using insulin | | |

Specific Diabetic Supply requested: *please check off one to all listed*

- | | | |
|--------------------------|---|-----------|
| <input type="checkbox"/> | Lancets (specify brand) _____ | Qty _____ |
| | Specific directions for use with frequency _____ | |
| | Specific # of Refills _____ max 6 months | |
| <input type="checkbox"/> | Blood Glucose Strips (specify brand) _____ | Qty _____ |
| | Specific directions for use with frequency _____ | |
| | Specific # of Refills _____ max 6 months | |
| <input type="checkbox"/> | Blood Glucose Monitor (specify brand) _____ | Qty _____ |
| | Specific directions for use with frequency _____ | |
| <input type="checkbox"/> | Blood Glucose Control Solutions (specify brand) _____ | Qty _____ |
| <input type="checkbox"/> | Replacement Battery for Monitor (specify brand) _____ | Qty _____ |

Please complete the following:

Physician's Name (Print) : _____

Physician's Signature : _____ Date _____

Address : _____

City/State/Zip : _____

Physician's UPIN # : _____

Physician's DEA # : _____

Physician's Written Order

NOTE TO THE PHYSICIAN:
NOTE TO THE PHARMACY:

*Complete the sections below and fax it to the pharmacy and mail original to pharmacy.
Retain the original form for your records.*

Patient Name _____

This section is to be completed by the pharmacy

Address _____

Pharmacy Name _____

City/State _____

Pharmacy Address _____

Phone _____

City/State _____

Medicare # _____

Phone _____

Original Order Date _____

Fax Number _____

ICD-9 DIAGNOSIS CODES : ICD-9 # and Narrative Description _____

MEDICATIONS PRESCRIBED

Drug or Supply Name _____

Quantity Ordered _____

Specific Directions for use _____

*as directed unacceptable

Specific # of Refills _____ max 6 months Date _____

Drug or Supply Name _____

Quantity Ordered _____

Specific Directions for use _____

*as directed unacceptable

Specific # of Refills _____ max 6 months Date _____

Drug or Supply Name _____

Quantity Ordered _____

Specific Directions for use _____

*as directed unacceptable

Specific # of Refills _____ max 6 months Date _____

Physician's Name (Print) : _____

Physician's Signature : _____ Date _____

Address : _____

City/State/Zip : _____

Physician's UPIN # : _____

Physician's DEA # : _____

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS &
RELEASE OF MEDICAL INFORMATION**

PLEASE
PRINT

Patient Name _____ Date: _____
Address _____ City _____ State ___ Zip ____
Health Insurance ID Number _____

I am the Patient, Parent or Guardian or Designee and hereby request that payment or authorized Medicare benefits be made on my behalf to _____ PHARMACY for any services furnished me by _____ PHARMACY.

I authorize any holder of medical information about me to release to _____ PHARMACY, the Centers for Medicare & Medicaid Services and its agents, and any secondary insurance companies any information needed to determine these benefits or the benefits payable for related services.

Beneficiary acknowledges responsibility for co-insurance amount and deductibles, if beneficiary has no secondary insurance, or it co-insurance and deductibles are not paid by beneficiary's secondary insurance. Beneficiary agrees to be fully responsible if Medicare denies payment.

Beneficiary acknowledges receipt of Centers for Medicare & Medicaid Services DMEPOS Supplier Standards.

This authorization is valid for current and future services provided by:

_____ PHARMACY

Patient, Parent or Guardian or Designee

Signature: _____ Date: _____