DMERC Dialogue

Durable Medical Equipment Regional Carrier (DMERC) Region D

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A Medicare Newsletter for Region D DMEPOS Suppliers - A service of CIGNA HealthCare Medicare Administration

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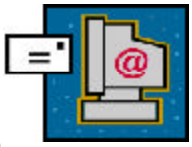

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From the Medical Director...

Robert Hoover, Jr., MD, MPH

Medical Review Web Page Up And Running!

CIGNA Medicare's Medical Review staff has created a Web site devoted to education about Medical Review related topics. Located at www.cignamedicare.com/dmerc/mr/index.html, it is a supplier's "one stop shop" for information about local medical review policies, Progressive Corrective Action (PCA) and the Comprehensive Error Rate Testing (CERT) program. In addition, the site includes Frequently Asked Questions on topics such as Power Mobility, Group 2 Support Surfaces, Oxygen and other Medicare policies.

Coming soon to the site – **Netcourses**. Netcourses are educational modules on popular topics like power mobility and enteral nutrition that are available 24 hours/day, 7 days per week. Suppliers can log onto the CIGNA Medicare Medical Review site and take the courses at their leisure. The courses will even include a pre- and post-test so suppliers can incorporate the education into any in-house training that might be required. CIGNA Medicare is excited to bring you these educational offerings. Visit the site often to stay up-to-date on Medical Review activities in Region D.

MEDICAL POLICY

Blood Gas Testing For Oxygen Qualification By Home Health Agencies Revisited

Recently, suppliers of home oxygen have again asked about home health nurses performing the blood gas test to qualify Medicare beneficiaries for home oxygen. According to suppliers, the confusion arises because of an article published in the Fall 2001 Durable Medical Equipment Regional Carrier (DMERC) bulletins (see Fall

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(Numbers have been appended to articles/forms in the index for future use.)

Cont'd

Blood Gas Testing For Oxygen Qualification By Home Health Agencies Revisited (cont'd)

2001 *DMERC Dialogue* article entitled "Oximetry Testing," page 3). The information in this article is intended to clarify the question of blood gas testing by home health agencies and reinforce the requirements of CMS Manual System, Pub. 100-3, *Medicare National Coverage Determinations Manual* (NCD), the CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual,* and the local medical review policy (LMRP) for oxygen and oxygen equipment.

CMS Manual System, Pub. 100-3, *Medicare National Coverage Determinations Manual,* § 240.2 states the Medicare coverage criteria for home oxygen and related equipment. Laboratory evidence for oxygen qualification requires measurement of arterial oxygen saturation by arterial blood gases or pulse oximetry. The requirements for qualification to perform this test are found in NCD 240.2, Section C which states:

....is also acceptable when ordered and evaluated by the attending physician and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services. [Emphasis in original text]

Therefore, the NCD provides for two sources for performance of a qualifying blood gas test - a qualified provider or supplier of laboratory services or under the supervision of the attending physician.

CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 13, § 20.2.4 defines the obligations of physicians who bill Medicare for services rendered by non-physicians under their supervision. 42

CFR § 410.32 defines the levels of physician supervision. For payment by Medicare, individuals supervised by a physician must be in the employ of the physician and "the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician." Supervision includes direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualification of non-physician personnel who use the equipment.

CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual,* Chapter 16, § 10.1 and CMS Manual System, Pub. 100-2, *Medicare Benefit Policy Manual*, Chapter 15, § 80 details the requirements for independent laboratory services. An independent laboratory is one that is independent of either an attending or consulting physician's office. Alternatively, laboratories operated by or under the supervision of a hospital also qualify. Unless the HHA qualifies as an independent laboratory as outlined in CMS Manual System, Pub. 100-4, *Medicare Claims Processing Manual,* Chapter 16, § 10.1 and CMS Manual System, Pub. 100-2, *Medicare Benefit Policy Manual,* Chapter 15, § 80, the agency (and its employees) would not meet the NCD requirement as a provider of blood gas testing for the purposes of Medicare oxygen coverage. Certificates of Medical Necessity (CMNs) indicating qualifying testing performed by HHA or an HHA employee will be denied because Medicare oxygen coverage requirements are not met.

Finally, the LMRP states that "The qualifying blood gas study must be one that complies with the Fiscal Intermediary or Local Carrier policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests."

In order to serve as a qualifying test for Medicare home oxygen, the home health agency must meet the requirements outlined above.

Cervical Traction Equipment – New Code And Policy

Effective for dates of service on or after April 1, 2004, the following new code has been established for cervical traction equipment:

K0627 - Traction equipment, cervical, free-standing, pneumatic, applying traction force to other than mandible

This code is in the Inexpensive or Routinely Purchased DME payment category.

Code K0627 describes cervical traction devices that provide traction on the cervical anatomy through the use of a free-standing frame. Traction force is applied by means of pneumatic displacement to anatomical areas other than the mandible – e.g., the occipital region of the skull. Devices described by code K0627 must be capable of generating traction forces greater than 20 pounds. In addition, code K0627 devices allow traction to be applied with alternative vectors of force (e.g., 15 degrees of lateral neck flexion).

Currently, the only product identified as included in this code is the Saunders Cervical Home Trac. Suppliers should contact the SADMERC with any questions concerning the correct coding of other devices.

A new medical policy on Cervical Traction Devices will be published in the April *DMERC Region D Supplier Manual* update. It includes coverage criteria for this new code and is effective for dates of service on or after July 1, 2004. This policy is being published in the new format mandated by CMS – i.e., two separate documents: a Local Coverage Determination (LCD) and a related Policy Article. (See the separate article on Medical Policies – New Format.) The combined information in both documents constitutes the "medical policy."

Power Wheelchairs And POVs – Policy Clarification And Medical Review Strategy

In a joint release by the Centers for Medicare & Medicaid Services (CMS) and the Office of the Inspector General (OIG) on September 9, 2003, the Department of Health and Human Services announced a 10 point initiative to address the explosive growth of Medicare payments for power wheelchairs over the past few years. Two of the points in the plan were a clarification of the local medical review policy (LMRP) for Power Wheelchairs and the adoption of a consistent approach to

medical review of power wheelchair claims by all four DMERCs. This article outlines steps that are being taken to address these two points.

The national policy on power wheelchairs and power operated vehicles (POVs) is found in the *Medicare Coverage Issues Manual* §60-9. It states that a wheelchair is covered "if the patient's condition is such that without the use of a wheelchair he would otherwise be bed or chair confined." A power wheelchair or power operated vehicle (POV) is covered if, in addition, "…the patient is unable to operate the wheelchair manually."

The following information is a clarification of national policy. All DMERCs are strictly enforcing these coverage criteria and applying them to all claims reviewed regardless of the date of service or date of submission. Power wheelchairs or POVs (hereafter referred to as just power wheelchairs) are covered only for patients who are nonambulatory. If a patient can only bear weight to transfer from a bed to a chair or wheelchair, the patient is considered nonambulatory. However, if the patient is able to walk either without any assistance or with the assistance of an ambulatory aid, such as a walker, the power wheelchair is denied as not medically necessary. If the patient is nonambulatory and qualifies for a wheelchair, a power wheelchair is covered only if the patient is unable to self-propel a manual wheelchair within their home. Medicare coverage of durable medical equipment is limited to items that are necessary for use within the home. Although a power wheelchair may be useful to allow the beneficiary to move extended distances, especially outside the home, Medicare statute and national policy do not currently provide coverage solely for those uses.

The DMERCs are pursuing an aggressive medical review strategy aimed at identifying suppliers who are providing power wheelchairs that do not meet Medicare coverage criteria. Through a variety of data analysis techniques, the DMERCs identify suppliers for medical review. Potential errors are validated through probe reviews. This review may be done on either a pre-pay basis (i.e., at the time of the initial claim determination) or a post-pay basis (i.e., after the claim has been paid). In accordance with the Progressive Corrective Action approach, the DMERCs will notify the supplier if a supplier-specific review is being conducted.

All claims for power wheelchairs must continue to include a Certificate of Medical Necessity (CMN). However, CMNs have never provided all of the information required to document that the coverage criteria for power wheelchairs have been met. Rather, they serve as medical review screening tools that allow the DMERCs to review some but not all of the coverage criteria for a particular item through automated edits. For claims that are subjected to manual medical review, the claims will be developed to the supplier asking for copies of the patient's medical record which contains information verifying that the coverage criteria have been met. Evaluations that are used to document coverage must have been performed and recorded prior to the delivery of the power wheelchair.

The information needed by the DMERCs to make a medical necessity determination includes, but is not limited to, the following elements:

- The distance that the patient can walk (a) independently and (b) with the assistance of a walker or other ambulatory aid;
- Strength and function of the upper and lower extremities (including tone, range of motion limitations, etc.);
- The diagnosis that is associated with the limitations.

If the power wheelchair is being provided to a patient who has received a Medicare-covered manual or power wheelchair within the past 5 years, the DMERCs will need information from the patient's medical record that documents that there has been a significant change in the patient's medical condition that necessitates the different type of equipment.

The following items must be submitted for all claims that are developed:

- Relevant portions of the patient's medical record containing evaluations performed and recorded prior to the delivery of the power wheelchair;
- A copy of the delivery slip;
- Product information including manufacturer, make, model, etc.;
- A photocopy of the original, signed CMN that was used to create the electronic CMN if it was transmitted electronically.

If the relevant portions of the patient's medical record are not provided, the claim will be denied as not medically necessary. Other than the CMN, there is no requirement that the documentation be received on any specific form.

For purposes of review of wheelchair claims, the patient's medical record consists of some or all of the following:

1) Physician notes from the office, inpatient or outpatient hospital, or nursing home;
2) Nonphysician clinician notes from the physician's office, inpatient or outpatient hospital, nursing

home, or Medicare-covered home health agency visit;

3) Nonphysician clinician (e.g., physical therapist or occupational therapist) evaluations that meet all of the following criteria:

   a) Performed on referral from the treating physician; and,
   b) Performed "in person" and not conducted by telephone; and
   c) Performed by a Medicare provider or employee of a Medicare provider; and,
   d) Clinicians are not employees of or otherwise paid by the wheelchair supplier.

Other types of information are not sufficient by themselves to document that the coverage criteria have been met, even if they are signed or initialed by the treating physician. That is because they are not considered to be part of the patient's medical record. However, the supplementary information that they contain will be given consideration if it is corroborated by the medical record. This applies to documents created either before or after delivery of the power wheelchair. Some examples, not all-inclusive, of these type documents are:

1) Evaluations performed by PTs, OTs, or other individuals employed by or otherwise paid by the supplier;
2) Forms (either narrative or check-off) devised by the supplier and completed by the physician;
3) Summaries of the patient's medical condition prepared by the supplier or physician;
4) Forms (either narrative or check-off) developed by suppliers and completed by the patient or caregiver.

These medical review guidelines will not only be applied to new reviews, but will also be applied to any provider-specific reviews that are currently being conducted by the DMERCs.

Depending on the extent of errors found on a probe review, the DMERCs have a number of options that may be used for follow-up, including but not limited to: supplier-specific education, conducting a follow-up audit, placing the supplier on 100% pre-pay review, conducting a statistically valid random sample post-pay review. Any evidence of fraud will be referred to the Benefit Integrity department. The DMERCs will be particularly on the alert for suppliers who switch their billing of power wheelchairs to another of their locations/supplier numbers when a probe or other medical review is conducted on a different office location.

The DMERCs will provide suppliers with additional updates and clarifications through our Web sites, ListServ, and bulletins. The DMERCs will also provide information to the local carriers for publication in their bulletins to help educate physicians on the coverage criteria for power wheelchairs.

Wheelchair Seating – New Policy

A new medical policy on Wheelchair Seating is included in the April *DMERC Region D Supplier Manual* update. The policy is effective for claims with dates of service on or after July 1, 2004, as are the following new codes which have been established for wheelchair seat and back cushions and related items:

K0650 - General use wheelchair seat cushion, width less than 22 inches, any depth
K0651 - General use wheelchair seat cushion, width 22 inches or greater, any depth
K0652 - Skin protection wheelchair seat cushion, width less than 22 inches, any depth
K0653 - Skin protection wheelchair seat cushion, width 22 inches or greater, any depth
K0654 - Positioning wheelchair seat cushion, width less than 22 inches, any depth
K0655 - Positioning wheelchair seat cushion, width 22 inches or greater, any depth
K0656 - Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth
K0657 - Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth
K0658 - Custom fabricated wheelchair seat cushion, any size
K0659 - Wheelchair seat cushion powered
K0660 - General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
K0661 - General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
K0662 - Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
K0663 - Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware
K0664 - Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
K0665 - Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware

K0666 - Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
K0668 - Replacement cover for wheelchair seat cushion or back cushion, each
K0669 - Wheelchair seat or back cushion, no written coding verification from SADMERC

Codes E0176-E0179, E0192, E0962-E0965, E1012, E1013, K0023, K0024, and K0114 will be invalid for claim submission to the DMERC for dates of service on or after July 1, 2004. Under the standard grace period, these codes will continue to be accepted on claims with dates of service on or after July 1, 2004 that are received by September 30, 2004. **The new policy will not be applied to claims for these codes.** Claim lines with these codes with dates of service on or after July 1, 2004 that are received on or after October 1, 2004 will be rejected or denied as incorrect coding. These codes should continue to be used for claims with dates of service prior to July 1, 2004 regardless of the date of claim submission.

Code K0667 (Mounting hardware, any type, for seat cushion or seat support base attached to a manual wheelchair or lightweight power wheelchair, per cushion/base) is not valid for claim submission to the DMERC. The Coding Guidelines section of the Policy Article provides instructions on billing for these items.

This policy is being published in the new format mandated by CMS – i.e., two separate documents: a Local Coverage Determination and a related Policy Article. (See separate article on Medical Policies – New Format.) The combined information in both documents constitutes the "medical policy."

The definitions of codes K0652-K0657 includes a requirement for documenting the pressure reduction capabilities of the seat cushion either by simulation testing or human subject testing. When a particular seat cushion model includes a range of sizes, only one cushion size needs to be tested and reported. The size tested should generally be within the "standard" adult range – i.e., width 15"-19" and depth 15"-19". If a particular model is not manufactured in a size within this range, testing should be done on a cushion that is closest to the range – e.g., 20" wide and 18" deep. Testing methodology and reporting requirements for these tests can be found in the Testing Methodology section of the Policy Article. In addition, manufacturers should refer to information on the Statistical Analysis DME Regional Carrier (SADMERC) Web site concerning the design specifications for the equipment used in performing simulation testing.

As stated in the Coding Guidelines section of the Policy Article, the only products which may be billed using codes K0650-K0657 and K0662-K0665 and the only brand name products that may be billed using codes K0658 or K0666 are those products for which a written coding verification has been made by the SADMERC. Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC Web site or by contacting the SADMERC.

A document summarizing the comments received on the draft policy and the DMERC response to the comments is posted on the draft policy page of the DMERC Web site (www.cignamedicare.com/dmerc/lmrp_lcd).

Medical Policies – New Format

The two new medical policies (Wheelchair Seating and Cervical Traction Devices) that are included in the April supplier manual update are published in a new format mandated by CMS. These policies are divided into two documents – a Local Coverage Determination (LCD) and a Policy Article – instead of the previous local medical review policy (LMRP) format.

An LCD, as established by section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular item or service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the item or service is reasonable and necessary) [Section 1869A(f)(2)(B) of the Social Security Act (42 U.S.C. §1395ff(f)(2)(B)]. The final rule establishing LCDs was published in the Federal Register in November 2003.

The major sections of the LCD are:

- Indications and Limitations of Coverage and/or Medical Necessity – This section defines coverage criteria based upon a determination of whether an item or service is reasonable and necessary. It includes information from National Coverage Determinations (NCDs) when applicable. When an item or service does not meet these criteria, it will be denied as "not medically necessary."
- HCPCS Codes and Modifiers
- ICD-9 Codes and Diagnoses That Support Medical Necessity
- Documentation Requirements
- Revision History

The major sections of the Policy Article are:

- Non-Medical Necessity Coverage and Payment Policy – This section identifies situations in which an item or service does not meet the statutory definition of a benefit category (e.g., durable medical equipment, prosthetic devices, etc.) or when it doesn't meet other requirements specified in Regulations. It also identifies situations in which an item or service is statutorily excluded from coverage for reasons other than medical necessity. In these situations, the policies will continue to identify the denial as "noncovered." This section may also include statements defining when an item or service will be denied as "not separately payable" or situations in which claim processing for the item or service is not DMERC jurisdiction.
- Coding Guidelines
- HCPCS Codes and Modifiers – these will be the same as in the LCD

Note that the term Policy Article will have a very specific meaning and will be used in the title of the article to define the document that is related to the LCD.

Both documents taken together will constitute the "medical policy." Both will be published in the Medical Policy section of the *DMERC Region D Supplier Manual* on our Web site. In the CMS database (http://cms.hhs.gov/mcd/indexes.asp), the Policy Article can be accessed both as an attachment to the LCD and also as a separate article in the Articles section of the database

Over the next two years the DMERCs will convert all existing LMRPs into LCDs and Policy Articles. Until the conversion is complete the term LCD will refer to both stand-alone LCDs and the "reasonable and necessary" provisions of an LMRP.

Intravenous Immune Globulin – New Benefit

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides a new benefit for intravenous immune globulin (IVIG) administered in the home setting effective for dates of service on or after January 1, 2004. In order for the IVIG to be covered, all of the following criteria must be met:

1) It is an approved pooled plasma derivative for the treatment of primary immune deficiency disease; and
2) The patient has a diagnosis of primary immune deficiency disease (ICD-9 codes 279.04, 279.05, 279.06, 279.12, 279.2); and
3) The IVIG is administered in the home; and
4) The treating physician has determined that administration of the IVIG in the patient's home is medically appropriate.

If all of the criteria are not met and the IVIG is not administered with an infusion pump, the IVIG will be denied as noncovered - no benefit category. If the criteria are not met and the IVIG is administered with an infusion pump, the general criteria in the External Infusion Pump local medical review policy (LMRP) will be applied. If it is determined that the criteria for an infusion pump are not met, the pump, related supplies, and the IVIG will be denied as not medically necessary.

Coverage under this benefit is limited to the IVIG itself, not to related supplies and services. If the IVIG is not administered with an infusion pump, related supplies will be denied as noncovered – no benefit category.

The IVIG must be dispensed and billed by a pharmacy or other entity licensed to dispense drugs. If the IVIG meets the coverage criteria for this benefit but it is not dispensed by an entity licensed to dispense drugs, it will be denied as not medically necessary. Suppliers must bill as an assigned claim. Beneficiaries are ineligible to receive payment for the drug.

HCPCS codes for IVIG are J1563 (Injection, immune globulin, intravenous, 1 gram) or J1564 (Injection, immune globulin, 10 mg). If the dose administered is 500 mg or more, code J1563 must be used. If the IVIG is not administered through an infusion pump and if supplies are billed, code A9270 (Noncovered item or service) must be used for the supplies. If the IVIG is administered through an infusion pump, then codes A4221 and A4222 are used for the related supplies.

Claims for IVIG administered in the home are DMERC jurisdiction with the following exception. Home health agencies dispensing IVIG would bill the fiscal intermediary.

Because of the need to make system changes, claims that qualify for coverage cannot be processed until on or after April 5, 2004. Claims received on or after April 5 for dates of service on or after January 1, 2004 will be processed based on the new coverage criteria.

Glucose Monitor Supplies - Medical Review

Comprehensive Error Rate Testing (CERT) shows glucose monitor supplies to be the third highest ranked DME category for paid claims errors in DMERC Region

D. Medicare contractors are required by the Centers for Medicare and Medicaid Services (CMS) to take appropriate actions to reduce the Medicare payment error rate.

To ensure that claims for quantities of supplies in excess of the amounts described in the Glucose Monitor local medical review policy (LMRP) meet applicable coverage criteria, DMERC Region D has increased its efforts to review claims on a prepayment basis. Such a review will require the supplier to provide additional documentation as described in the LMRP and shown below. In cases where documentation is not provided with the claim, the supplier will receive a letter requesting additional documentation.

The development letters have been revised as of January 3, 2004 to more specifically reflect the documentation requirements in the LMRP. Claims for which a timely response is not received are denied as not medically necessary. If the DMERC receives the documentation within 15 days after the date the claim is denied, the claim will be reopened and adjudicated according to the information provided.

Suppliers are reminded of the following requirements. Please be particularly aware of the requirement to document how many times per day the patient is actually testing (criterion (f)). Most documentation submitted by suppliers to the DMERC does not show how many times per day the beneficiary is testing. In most cases, only orders or instructions for the patient to test a specified number of times is provided, and there is no record indicating how often the beneficiary actually has been testing. The full text of the Glucose Monitor LMRP is available at www.cignamedicare.com/dmerc/lmrp/BGM.html, and in the *DMERC Region D Supplier Manual.*

For a patient who is not currently being treated with insulin injections, up to 100 test strips and up to 100 lancets or one lens shield cartridge every 3 months are covered if criteria (a)-(c) are met:

For a patient who is currently being treated with insulin injections, up to 100 test strips and up to 100 lancets or one lens shield cartridge every month are covered if criteria (a)-(c) are met:

For a patient who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets or one lens shield cartridge every 3 months are covered if criteria (a)-(f) are met:

For a patient who is currently being treated with insulin injections, more than 100 test strips and more than 100 lancets or one lens shield cartridge every month are covered if criteria (a)-(f) are met:

a) Coverage criteria (1)-(5) listed below for a glucose monitor are met.

1) The patient has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician; and

2) The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes and the treating physician maintains records reflecting the care provided including, but not limited to, evidence of medical necessity for the prescribed frequency of testing; and

3) The patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices; and

4) The patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control; and

5) The device is designed for home use.

b) The supplier of the test strips and lancets, or lens shield cartridge maintains in its records the order from the treating physician.

c) The beneficiary has nearly exhausted the supply of test strips and lancets, or useful life of one lens shield cartridge previously dispensed.

d) The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.

e) The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.

f) If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient

is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

If criteria (a)-(c) are not met, all testing supplies will be denied as not medically necessary. If quantities of test strips, lancets or lens shield cartridges that exceed the utilization guidelines are provided and criteria (d)-(f) are not met, the amount in excess will be denied as not medically necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted. Regardless of utilization, a supplier must not dispense more than a 3-month quantity of glucose testing supplies at a time.

COVERAGE AND BILLING

Automatic External Defibrillators – Correction

The narrative description for codes K0607 and K0609 should specify that they are only to be used for replacement batteries and electrodes, respectively, are used with a garment type (wearable) automatic external defibrillator (AED). The code narrative will be revised in the April *DMERC Region D Supplier Manual* update. Replacement supplies or accessories for nonwearable defibrillators must be billed with code A9999 (Miscellaneous DME supply or accessory, not otherwise specified). Replacement accessories (e.g., batteries, garment) are not separately payable if the device is rented. They are only separately payable when provided for a patient-owned device that meets Medicare coverage criteria. Replacement supplies (e.g., electrodes for a wearable defibrillator) are separately payable for a device that meets Medicare coverage criteria, even if the device is rented.

Power Operated Vehicles (POVs) - Options And Accessories

The Medicare allowance for a POV includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc. When these items are provided at the time of initial issue, they must not be billed separately. Medically necessary replacement accessories for beneficiary-owned POVs meeting Medicare coverage criteria are separately payable. Effective for claims with dates of service on or after January 1, 2002, a replacement item for a beneficiary-owned POV, including but not limited to replacement batteries, should be billed using the specific wheelchair option or HCPCS accessory HCPCS code if one exists and modifier RP. (Refer to the Wheelchair Options and Accessories local medical review policy in the *DMERC Region D Supplier Manual* for a list of specific HCPCS codes.) If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified). Do not use code E1399 for miscellaneous replacement POV accessories.

Correction To January 2004 Annual Update Of HCPCS Codes Used For Home Health Consolidated Billing Enforcement

This is a correction to the annual HH consolidated billing update for calendar year 2004 published in the Winter 2004 *DMERC Dialogue*, page 5. This update added HCPCS codes A7525 and A7526 to the list of supply codes subject to home health consolidated billing. These codes were added in error.

The following codes will **not** be added to home health consolidated billing enforcement:

A7525 - Tracheostomy mask, each
A7526 - Tracheostomy tube collar/holder, each

This correction is reflected in the HH consolidated billing master code list, which is available at the following Internet address: cms.hhs.gov/providers/hhapps/#billing.

Documentation Requirements – Signature Stamps

Effective January 1, 2004, all DMERCs began accepting stamped signatures when they are used by physicians on orders that are being reviewed for medical review purposes. (This does not apply to CMNs – see below.) Previously only personally handwritten or electronic signatures were accepted.

Physicians should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods. For example, a rubber stamped signature is much less secure than other modes of signature identification. The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information be-

ing attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All state licensure and state practice regulations continue to apply. Where state law is more restrictive than Medicare, the state law standard will be applied.

Note that there is no change in the prohibition of signature stamps in Section D of Certificates of Medical Necessity (CMNs). As stated on CMN forms, "Signature and date stamps are not acceptable."

These revisions will be incorporated in the upcoming *DMERC Region D Supplier Manual* update.

Ankle-Foot Orthoses - Walking Boots – Coverage And Coding Issues

Codes L4360 and L4386 are ankle-foot orthoses (AFOs) that are referred to as walking boots. Walking boots used to provide immobilization as treatment for an orthopedic condition or after orthopedic surgery are eligible for coverage under the Brace benefit. When walking boots are used primarily to relieve pressure, especially on the sole of the foot, or are used for patients with foot ulcers, they are noncovered – no Medicare benefit. Medicare covers therapeutic shoes, as described in the Therapeutic Shoes for Diabetics LMRP, for the prevention and treatment of diabetic foot ulcers.

For dates of service on or after April 1, 2004, suppliers must add modifier GY to codes L4360 and L4386 if the walking boot is only being used for the treatment or prevention of an ulcer. The absence of modifier GY indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery. Claims for L4360 and L4386 with modifier GY will be denied as noncovered.

Prefabricated walking boots must be billed with codes L4360 and L4386. Add-on codes must not be billed in addition to these codes. Custom fabricated walking boots must be billed with code L2999 and must be accompanied by information identifying the manufacturer and model name (if applicable), the indication(s) for use of the boot, and an explanation of why a prefabricated walking boot is not sufficient. Walking boots must not be billed with other AFO codes, including but not limited to L2106-L2116, or with codes for therapeutic shoes.

Suppliers should contact the SADMERC with any questions concerning the correct coding of specific devices. This information is incorporated in a revision of the Ankle-Foot/Knee-Ankle-Foot Orthoses local medical review policy in the April *DMERC Region D Supplier Manual* update.

Prefabricated Orthoses – Revised Coding Clarification

The article titled "Orthoses – Coding - Clarification" that was published in the January *DMERC Dialogue* is being rescinded. "Addition" codes may be used in conjunction with some prefabricated orthosis base codes when appropriate. Questions concerning the coding of specific items should be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Spinal Orthoses – New Codes

Effective for dates of service on or after April 1, 2004, the following new codes have been established for sacroiliac, lumbar, and lumbar-sacral orthoses:

K0630 - Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0631 - Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0632 - Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment

K0633 - Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated

K0634 - Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment

K0635 - Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebrae, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0636 - Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0637 - Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0638 - Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated

K0639 - Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0640 - Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0641 - Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0642 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0643 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated

K0644 - Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0645 - Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated

K0646 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0647 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from

sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/ panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

K0648 - Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment

K0649 - Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid plastic and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated

Codes L0476, L0478, L0500 – L0620, and L0960 will be invalid for claim submission to the DMERC effective for dates of service on or after April 1, 2004. Under the standard grace period, these codes will continue to be accepted on claims with dates of service on or after April 1, 2004 that are received by June 30, 2004. Claim lines with these codes with dates of service on or after April 1, 2004 that are received on or after July 1, 2004 will be rejected or denied as incorrect coding. These codes should continue to be used for claims with dates of service prior to April 1, 2004 regardless of the date of claim submission.

A revision of the LMRP on Spinal Orthoses incorporating these codes will be included in the upcoming *DMERC Region D Supplier Manual* update.

Albuterol And Ipratropium – Revised Coding Guidelines

This article contains a major revision to coding guidelines provided in an article posted to the DMERC Web site in December 2003.

Effective for dates of service on or after January 1, 2004, a new code was established for combinations of albuterol sulfate and ipratropium bromide inhalation solutions:

J7621 - Albuterol, all formulations, including separated isomers, up to 5 mg (albuterol) or 2.5 mg (levalbuterol), and ipratropium, up to 1 mg, compounded inhalation solution, administered through DME

This code may only be used when these drugs are provided in combination by a manufacturer or repackager in a vial with a single National Drug Code (NDC) number. DuoNeb is one example. Despite the narrative description of the code, J7621 must not be used for compounded inhalation solutions of these drugs. For compounded combination unit dose preparations and for situations in which these drugs are provided in separate unit dose vials, suppliers should continue to bill using code J7619 for albuterol and J7644 for ipratropium, each with its appropriate modifier – KO, KP, or KQ. For information on the correct use of these modifiers see the Nebulizers local medical review policy.

For DuoNeb and other products that meet the definition of J7621, suppliers must use code J7621 for all claims with dates of service on or after January 1, 2004. There is no grace period for continuing to use codes J7619 and J7644 for these products.

The KO, KP, and KQ modifiers should not be used with code J7621.

DuoNeb and currently available repackaged products contain 3.0 mg of albuterol sulfate (which is 2.5 mg of albuterol base) and 0.5 mg of ipratropium bromide in each unit dose vial. For these products, 1 unit of service of J7621 = 2 unit dose vials.

Epoetin And Darbepoetin – New Codes

Effective for dates of service on or after January 1, 2004, new codes were established for epoetin alfa (brand names Epogen and Procrit) and darbepoetin alfa (brand name Aranesp). The new codes are:

Q0137 - Injection, darbepoetin alfa, 1 mcg (non-ESRD use)

Q4054 - Injection, darbepoetin alfa, 1 mcg (for ESRD on dialysis)

Q4055 - Injection, epoetin alfa, 1,000 units (for ESRD on dialysis)

In addition, code Q0136 [Injection, epoetin alfa, (for non

ESRD use), per 1000 units] became valid for claim submission to the DMERC for dates of services on or after 1/1/04.

Codes Q9920-Q9940 for epoetin alfa were discontinued effective for dates of service on or after January 1, 2004. Under the standard grace period, the discontinued codes will continue to be accepted on claims with dates of service on or after January 1, 2004 that are received by March 31, 2004. Claims with these codes with dates of service on or after January 1, 2004 that are received on or after April 1, 2004 will be rejected or denied as incorrect coding. Codes Q9920-Q9940 should continue to be used on claims for epoetin alfa with dates of service prior to January 1, 2004 regardless of the date of claim submission.

Code J0880 (injection, darbepoetin alfa, 5 mcg) was made local carrier jurisdiction only for dates of service on or after January 1, 2004. There is no grace period for the use of J0880 for claims submitted to the DMERC with dates of service on or after January 1, 2004.

In this article, the term EPO applies to both epoetin alpha and darbepoetin alpha.

Codes Q4054 and Q4055 may only be used on claims for EPO that is administered to patients who are on dialysis. The only claims that are eligible for coverage by the DMERCs are those for patients who are on Method 2 home dialysis and that are submitted by the dialysis supplier. Therefore, claims for codes Q4054 and Q4055 that are submitted to the DMERC for home administration of EPO by patients who are on facility-based dialysis or Method 1 home dialysis will be denied as noncovered.

For electronic claims using the ANSI 837P HIPAA transaction, the units of service for codes Q4054 and Q4055 are entered in the 2400 SV104 with a qualifier of UN in 2400 SV103. Claims for EPO for patients who are on dialysis may not be submitted in the NCPDP format. For paper claims, the units of service are entered in Field 24G on Form CMS 1500.

Claims for Q4054 and Q4055 must include a hematocrit value that represents the most recent test result prior to the date of service on the claim. For electronic claims using the ANSI 837P HIPAA transaction, the hematocrit is entered in the 2400 MEA03 with a qualifier of R2 in 2400 MEA02. On paper claims, the hematocrit is entered in Field 19 on Form CMS 1500. Assigned claims that do not contain a hematocrit value will be rejected and returned to the supplier. Suppliers should resubmit those claims with the hematocrit value. Unassigned claims that do not contain a hematocrit value will be denied.

On electronic claims, the hematocrit must be entered as a three digit value with an implied single decimal point. For example, if the hematocrit is 30.4%, enter as 304; if it is 30% enter as 300. If the test report includes only a hemoglobin and not a hematocrit, multiply the hemoglobin by 3 to determine the value to enter as the hematocrit. For example, if the hemoglobin = 8.4 and no hematocrit is included on the test report, enter 252 as the hematocrit value on an electronic claim (8.4 x 3 = 25.2).

For dates of service on or after 1/1/04, claims that are submitted to the DMERC for EPO that is administered in the home to patients who are not on dialysis must be billed with the following codes:

Q0136 - Injection, epoetin alfa, (for non ESRD use), per 1000 units
Q0137 - Injection, darbepoetin alfa, 1 mcg (non-ESRD use)

Claims for codes Q0136 and Q0137 will be denied as noncovered.

A revision of the local medical review policy on Epoetin incorporating these changes will be included in the April 2004 supplier manual update.

Therapeutic Shoes – New Codes And Policy Revision

Effective for dates of service on or after April 1, 2004, the following HCPCS codes have been created:

K0628 - For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of Shore A 35 durometer or 3/16 inch material of Shore A 40 (or higher), prefabricated, each
K0629 - For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of Shore A 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

Codes A5509 and A5511 will be invalid for claim submission to the DMERC effective for dates of service on or after April 1, 2004. Under the standard grace period,

these codes will continue to be accepted on claims with dates of service on or after April 1, 2004 that are received by June 30, 2004. Claim lines with these codes with dates of service on or after April 1, 2004 that are received on or after July 1, 2004 will be rejected or denied as incorrect coding. These codes should continue to be used for claims with dates of service prior to April 1, 2004 regardless of the date of claim submission.

These new codes are incorporated into the Therapeutic Shoes for Persons with Diabetes local medical review policy published in the April 2004 *DMERC Region D Supplier Manual* update.

APPEALS

Appeals Reversal Rate

The DMERC Region D Appeals department continually monitors the reversal rate of review requests. We have found that many appeal requests cannot be completed because information needed is missing or incomplete. The review staff usually contacts suppliers to request additional information needed to properly adjudicate a particular case.

Submitting adequate documentation with your review request is the most efficient way to ensure that all information is available to us as we conduct a review of your claim. Refer to the local medical review policies, local coverage determinations, policy articles and Chapter 3-Documentation Requirements in the *DMERC Region D Supplier Manual* for information about the documentation needed for certain items. A review is the first level in the appeals process and must be filed within 120 days of the initial claim determination. All relevant material needed to make a review decision should be submitted with the review request.

In 2003, DMERC Region D received approximately 74,000 review requests. That year, the reversal rate averaged 52.5% with a high of 57.3% in October when additional emphasis was placed on contacting suppliers for additional or missing information. What this means to you is that providing the necessary information may result in a favorable decision without having to go to the next level of appeal.

Helpful Hearing Tips

At CIGNA Medicare the DMERC Hearing Department does everything possible to effectively process hearing requests from Medicare suppliers and beneficiaries. We have found that many requests for hearings do not indicate the type of hearing requested, which is important for expediting the hearing process. Specify one of the following types of hearings:

- On-the-Record Hearing (OTR) - The decision is based on the facts that are in the file, including any additional information obtained by, or furnished to, the hearing officer (HO). The major advantage is the speed with which an OTR hearing can be held and decision rendered versus the in-person and telephone hearing.

- Telephone Hearing - The appellant is afforded the opportunity to present both oral testimony and written evidence supporting the claim, and to refute or challenge the information used to deny the claim or prior payment determination. The hearing officer will contact the appellant by phone or mail to schedule the hearing. The HO provides notice of the hearing at least 14 calendar days prior to a scheduled date. The hearing officer issues a decision letter within thirty (30) days from the date of the hearing. Telephone hearings differ from in-person hearings by eliminating the need for the appellant to appear in-person.

- In-Person Hearing - The appellant is afforded the opportunity to present both oral testimony and written evidence supporting the claim, and to refute or challenge the information used to deny the claim or prior payment determination. The hearing officer will contact the appellant by phone or mail to schedule the hearing. The HO provides notice of the hearing at least 14 calendar days prior to a scheduled date. The hearing officer issues a decision letter within thirty (30) days from the date of the hearing.

FEE SCHEDULE

2004 DMEPOS Fee Schedule Update

This article outlines changes made to the 2004 DMEPOS fee schedule, in accordance with section 302(c) of the Medicare Prescription Drug, Improvement and Modernization Act (DIMA) of 2003.

- The 2004 payment limits for therapeutic shoes will be frozen at the 2003 amounts.

- The fee schedule update factor for 2004 for durable medical equipment (DME), other than items classified as class III devices by the Food and Drug Administration (FDA), prosthetic devices, prosthetics, orthotic and surgical dressings are equal to 0 percent.

• The following Healthcare Common Procedure Coding System (HCPCS) codes are classified as class III devices by the FDA, and will receive a covered item update of 2.1 percent for 2004: E0617, E0691, E0692, E0693, E0694, E0747, E0748, E0749, E0760, E0782, E0783, E0785, E0786, K0600, K0606, K0607, K0608 and K0609. These codes should be submitted with modifier "KF - Item Designated by FDA as Class III Device" effective for claims received on or after April 1, 2004, with dates of service on or after January 1, 2004. When billing for a class III device under a miscellaneous code, the "KF" modifier must be appended. Claims received without the "KF" modifier will be returned as unprocessable.

• Elevating, stair climbing power wheelchairs were recently cleared by the FDA for marketing and are considered class III devices. The base power wheelchair portion of this device would normally fall under HCPCS code K0011 (programmable power wheelchair base). However, because this device is not subject to the payment freeze, for claims received before April 1, 2004, with dates of service on or after January 1, 2004, the wheelchair base for this device should be billed under E1399. A wheelchair CMN is required for the wheelchair base.

Example of billing:

Claims received before April 1, 2004 – with dates of service on or after January 1, 2004

E1399 (RR, NU, UE) (Wheelchair base), E2300 and A9270

For claims received on or after April 1, 2004, with dates of service on or after January 1, 2004, modifier "KF" should be submitted along with HCPCS code K0011. For claims received on or after January 1, 2004, with dates of service on or after January 1, 2004, the elevation feature of this device should be billed under HCPCS code E2300 and the stair climbing feature for this device should be billed using HCPCS code A9270. A wheelchair CMN is required for the wheelchair base.

Example of billing:

Claims received on or after April 1, 2004 – with dates of service on or after January 1, 2004

K0011KF (RR, NU or NU with appropriate KH, KI, KJ modifiers), E2300 and A9270

The 2004 DMEPOS Fee Schedule Fees are now available on our Web site at http://www.cignamedicare.com/medicare_dynamic/fees/dmerc/search.asp.

April Quarterly Update DMEPOS Fee Schedule

The changes for the 2nd quarterly update of the 2004 DMEPOS Fee Schedule are listed below.

"Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage."

Corrections to the annual fee schedule are as follows:

States	A4366	E0301RR	E0302RR
AK	1.30	312.93	715.44
AZ	1.30	249.44	715.44
CA	1.30	256.93	715.44
HI	1.30	253.40	715.44
IA	1.30	270.72	715.44
ID	1.30	270.72	715.44
KS	1.30	270.72	608.12
MO	1.30	270.72	715.44
MT	1.30	241.39	715.44
ND	1.30	241.01	715.44
NE	1.30	270.72	715.44
NV	1.30	256.30	715.44
OR	1.30	270.72	715.44
SD	1.30	265.46	715.44
UT	1.30	270.72	715.44
WA	1.30	270.72	715.44
WY	1.30	264.53	715.44

Fees for new HCPCS codes effective April 1, 2004:

States	K0627NU	K0627RR	K0627UE
AK	515.31	51.53	386.46
AZ	515.31	51.53	386.46
CA	515.31	51.53	386.46
HI	515.31	51.53	386.46
IA	515.31	51.53	386.46
ID	515.31	51.53	386.46
KS	515.31	51.53	386.46
MO	515.31	51.53	386.46
MT	515.31	51.53	386.46
ND	515.31	51.53	386.46
NE	515.31	51.53	386.46
NV	515.31	51.53	386.46
OR	515.31	51.53	386.46
SD	515.31	51.53	386.46
UT	515.31	51.53	386.46
WA	515.31	51.53	386.46
WY	515.31	51.53	386.46

Additions to the fee schedule are as follows:

States	A4450AU	A4450AV	A4450AW	A4452AU	A4452AV	A4452AW	L3911
AK	.09	.09	.11	.36	.36	.40	17.71
AZ	.09	.09	.11	.36	.36	.40	17.71
CA	.09	.09	.11	.36	.36	.40	17.71
HI	.09	.09	.11	.36	.36	.40	17.71
IA	.09	.09	.11	.36	.36	.40	18.08
ID	.09	.09	.11	.36	.36	.40	17.71
KS	.09	.09	.11	.36	.36	.40	18.08
MO	.09	.09	.11	.36	.36	.40	18.08
MT	.09	.09	.11	.36	.36	.40	18.36
ND	.09	.09	.11	.36	.36	.40	18.36
NE	.09	.09	.11	.36	.36	.40	18.08
NV	.09	.09	.11	.36	.36	.40	17.71
OR	.09	.09	.11	.36	.36	.40	17.71
SD	.09	.09	.11	.36	.36	.40	18.36
UT	.09	.09	.11	.36	.36	.40	18.36
WA	.09	.09	.11	.36	.36	.40	17.71
WY	.09	.09	.11	.36	.36	.40	18.36

Fees for HCPCS codes K0630 – K0649 have not been established. The codes will be considered under individual consideration until enough pricing data can be collected to establish fees. Under individual consideration we will need the product information and suggested retail pricing for the item being billed.

New Basis For Medicare Drug Payment Amounts For Durable Medical Equipment Regional Carriers (DMERCs)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA) established a new basis for the upper payment limit for drugs and biologicals not paid on a cost or prospective payment basis.

The upper payment limit for drugs and biologicals not paid on a cost or prospective payment basis and furnished on or after January 1, 2004, is 85 percent of the April 1, 2003 Average Wholesale Price (AWP). Exceptions to this standard are listed below:

- The payment limit for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2004 will be 95 percent of the October 1, 2003 AWP.

- The payment limits for new drugs or biologicals is 95 percent of the AWP. For the purposes of this instruction, a new drug is defined as an unlisted drug (not currently covered by a HCPCS code) that was approved by the Food and Drug Administration (FDA) subsequent to April 1, 2003. A drug is not considered to be a new drug if: the brand or manufacturer of the drug changes; a new vial size is developed, or the drug receives a new indication.

- The payment limits for certain drugs studied by the Office of Inspector General and General Accounting Office are based on the percentages of the April 1, 2003 AWPs specified in Table 1 in §20 of Chapter 17 of the *Medicare Claims Processing Manual*, Pub. 100-21.

The Medicare payment limit for drugs and biologicals not paid on a cost or prospective payment basis and furnished prior to January 1, 2004, is 95 percent of AWP.

Payment limits determined under this instruction shall not be updated during 2004. Quarterly updates will not be made in 2004.

ELECTRONIC DATA INTERCHANGE (EDI)

ANSI 837 Narrative Fields

The ANSI X12N 837 v.4010 format allows for a narrative field at the claim level and one at the line level. Each narrative field (NTE segment) will be 80 characters long. We recommend placing the narrative information that applies to all of the lines on the claim in the claim NTE segment and put line specific information in each line NTE segment.

For example, when you are billing a Not Otherwise Classified (NOC) code you will want to indicate general information at the claim level narrative (NTE) and be very specific at the line level (NTE). If the specific information on the NOC code is placed at the claim level, we may not be able to identify which line item it is referring to and your claim will reject.

When entering the narrative information, please be as specific as possible and include only information required by the policy. A list of wheelchair abbreviations is available in the Jan – Mar (98-1) issue of the EDI Edge. This issue may be found on our Web site at www.cignamedicare.com/dmerc/edge.

Billing Electronically Makes "Cents"

Consider the following benefits of billing electronically:

You're paid faster. Upon receipt, claims are generally processed within a matter of days, but cannot be paid until they have met the federal payment floor. Payment is eligible for clean electronic claims in 14 days, compared to 27 days for paper claims (a "clean" claim is one that does not require further investigation before payment).

Early detection of errors. Electronic claims are checked for errors before entering our processing system. If a claim has errors it will be rejected and will be listed on the Electronic Report Package. Claims that receive errors can be corrected, and re-transmitted in less time than it takes to file a paper claim.

Simplify your billing. Building an electronic claim is easy. In most cases, once the software is setup, information such as patient's information, physician's information, and your business information will be available to select in the software. For example, you will just need to select the patient and then related information such as their address and Medicare number will be automatically entered into the claim. Unlike paper claims, this will eliminate the need to re-enter the same basic information for each claim.

EDI support available. There are many resources for electronic billers. When you begin billing you will receive your *EDI Manual* which will assist in billing electronically. If you still have questions, the EDI Department is available Monday through Friday, from 8 am to 5 pm Mountain Time. Resources are also available on our Web site at www.cignamedicare.com/edi/dmerc.

Improved accuracy. Electronic billing allows direct entry of claims into the CIGNA Medicare data processing system. Claims enter the system with the codes, charges, modifiers, etc., that are keyed by the supplier or billing service, or transmitted by a clearinghouse.

Increased tracking capability. Claims are tracked through such features as online receipt verification, 997 Functional Acknowledgement Report, Electronic Report Package and Claim Status Inquiry (CSI). In addition, Beneficiary Eligibility is available to check the eligibility status and deductible information of Medicare beneficiaries.

More value for the money spent. Electronic billing results in more efficient use of your office staff, freeing up time spent manually processing claims and transactions. Administrative, postage, and handling costs will be reduced. There is even Free Billing Software available through CIGNA Medicare.

To learn more about electronic billing including how to get started, visit the CIGNA Medicare Web site at www.cignamedicare.com/edi/dmerc/getstarted.html.

Check Your Data Type Before Sending Your ANSI Files

If you have migrated to ANSI then you have noticed that there are additional data types available to send or receive files in the Stratus Network. Please be aware of the data type selected when you dial in to send or receive your files. Verify the current settings box is displaying the correct upload or download option.

To change your data type:

1. At the Mailbox Access Facility menu, type "1", and press Enter.

2. The Data Type Value menu will appear. To select a data type, type the corresponding number and press Enter.
3. To return to the Mailbox Access Facility menu, type "99" and press Enter.

If your communications software is programmed to automatically send NSF files, then you will need to contact your software vendor.

Common Medicare Submitter Claim Testing Problems

The Centers for Medicare and Medicaid Services (CMS) has recently developed a list of issues encountered by Medicare contractors when submitters test. The Common Medicare Submitters Claim Testing Problems is included in the back of this newsletter.

DMERC EDI Customer Profile

The DMERC EDI Customer Profile form has been revised to include the most current EDI information. It is available exclusively on our Web site at www.cignamedicare.com/edi./edi_forms. This form changes periodically upon receipt of instructions from the Centers for Medicare & Medicaid Services (CMS) or for internal business needs. We recommend downloading the form from the Web site to ensure it is the most current version. ***As of February 2, 2004, we will only accept the most recent DMERC EDI Customer Profile form.***

Attention Billing Services or Clearinghouses: If you are adding new clients to your Submitter ID, you must send a DMERC EDI Customer Profile along with the EDI Enrollment Form. The forms will be returned if the EDI Customer Profile is not included with each EDI Enrollment Form.

It is very important that we have the most current information in our records. Invalid information may result in suspension of your Submitter or Stratus ID. If there are any changes in your business, please send the new information on the DMERC EDI Customer Profile to the EDI Department. Be sure to include your Submitter ID.

Information that may need updating:

- Address
- Phone Number
- Fax Number
- E-mail
- Contact Person
- Software

DMERC Region D Companion Document/Trading Partner Agreement

The DMERC Region D Companion Document/Trading Partner Agreement has been revised. This document is defined as a set of statements, which supplements the X12N 837 Professiona Implementation Guide and clarifies CIGNA Medicare's expectations regarding data submission, processing, and adjudication. To access the latest revision please visit http://www.cignamedicare.com/HIPAA/code_sets.html#3.

NCPDP Companion Document

The National Council for Prescription Drug Programs (NCPDP) Batch Transaction Standard 1.1 Billing Request Companion Document has been revised. The revised companion document clarifies the DMERC expectations regarding data submission, processing, and adjudication. This document is useful to retail pharmacy drug claim submitters (either suppliers, billing services, or clearinghouses) that will submit retail pharmacy drug claims to Medicare electronically.

The revised document is available on the CIGNA Medicare Web site at http://www.cignamedicare.com/HIPAA/code_sets.html#2.

Transmitting Decimals Within The 837 ANSI Transaction

Currently the NSF format implies decimals on all numeric fields including percentages and dollar amounts. By implying decimals, the software and user assumes the decimal is placed two positions from the right. For example, when "2500" is submitted for a dollar amount we assume it is "$25.00".

When users migrate to the ANSI X12N 837 version 4010 format they will need to send decimals where appropriate. As in the example above, when "2500" is submitted as a dollar amount we will assume it is "$2500.00".

To send $25.00 in the ANSI format, either manually insert the decimal or follow your software instructions for inserting decimals. If you are unsure how your software handles decimals, please contact your software vendor.

HIPAA

Requirements For Provider Submission Of Claims Under The Administrative Simplification Compliance Act (ASCA)

Section 3 of the ASCA, Pub.L. 107-105, and the implementing regulation at 42 CFR 424.32 requires that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions.

The following 12 point list provides an overview of important information and instructions found within the complete manual. You are encouraged to read the entire Mandatory Submission of Electronic Claims manual instruction located in the CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 24, Section 90 (http://www.cms.hhs.gov/manuals/). For your convenience, related sections of the complete manual are provided in the back of this newsletter.

1. Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically (section 90).

- Section 3 of the Administrative Simplification Compliance Act, Pub. L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 requires all initial claims to be submitted electronically as of October 16, 2003 (with limited exceptions).
- Medicare will not cover claims submitted on paper that do not meet the limited exception criteria.
- Electronic claims must be submitted in the appropriate national standards under HIPAA or those standards supported under the Medicare HIPAA contingency plan during the period that plan is in effect.

2. Small provider criteria. Small providers are encouraged to submit as many of their claims electronically as possible (section 90.1).

- Medicare will consider all providers that have fewer than 25 full-time equivalent employees (FTEs) and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.
- Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee.
- Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes.
- The small provider exception for submission of paper claims does not apply to health care claim clearinghouses that are agents for electronic claim submission for small providers.

3. FTE definition and calculation methodology (section 90.1).

- Part time employee hours must also be counted when determining the number of FTEs employed by a provider.
- In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider as identified by provider number, UPIN, or national provider identifier (NPI) when implemented to calculate the number of FTEs employed by that provider.
- Legal issues regarding the definition of providers, particularly when multiple providers have data reported under the same EIN, will be addressed in the NPI regulation when published in the Federal Register in final.

4. Exception criteria (section 90.2).

- In some cases, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At present, only the following claim types are considered to meet this condition:
  - Roster billing of vaccinations covered by Medicare
  - Claims for payment under a Medicare demonstration project that specifies paper submission

- o Medicare Secondary Payment Claims (MSP) when one or more payers are primary to Medicare
- o Claims submitted by beneficiaries.

5. Unusual circumstance criteria (section 90.3).

- CMS has delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. CMS will waive the electronic claim submission requirement for temporary or extended periods if the enforcement of the requirement would be against equity and good conscience as result of an "unusual circumstance".
- Providers who feel they qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims. DMERC Region D requests for waiver as a result of an "unusual circumstance" should be sent to CIGNA Medicare, PO Box 690, Nashville, TN 37202.
- Depending upon the nature of the "unusual circumstance" the requested waiver may be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically.
- Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

6. Self-assessment requirements (section 90.3.1).

- Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies:
  - o Dental Claims
  - o Disruption in electricity or phone/ communication services if such a disruption is expected to last more than 2 business days
  - o A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year).
  - o Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper.

7. Process for submission of an unusual circumstance waiver (section 90.3.2).

- Medicare contractors may at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considered there to be "good cause" that prevents a provider from submitting electronically for a temporary period.
- In the event a provider cites an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial HIPAA-compliant software to submit these claims, Medicare contractors may approve a single waiver for up to 180 days after the date of the decision notice.
- DMERC Region D requests for waiver as a result of an "unusual circumstance" should be sent to CIGNA Medicare, PO Box 690, Nashville, TN 37202.
- If the contractor determines an "unusual circumstance" applies, and an initial provider waiver of 90/180 days or less as described is not involved, CMS approval is required.

8. Additional claims, such as claims with attachments in some cases or certain claim types not supported by free billing software, that must continue to be submitted on paper pending any contractor or shared system modifications to enable those claims to be submitted electronically (90.3.3).

- Pending issuance of the future CMS instructions concerning submission of medical records for electronic claims, providers and Medicare contractors can continue current policies and practices regarding submission of attachments with claims.
- Suppliers billing DMERC Region D should continue with the current process of submitting claims with attachments on paper. This temporary exception does not apply to submission of paper EOBs or RAs for electronic claims when Medicare is secondary and there is only one primary payer.

9. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criterion applies at the time of submission (section 90.4).

10. Repercussions of submitting paper claims when ineligible for submission of paper claims (section 90.4).

- In the event contractor staff members realize that a particular provider does not meet any of the exception criteria, paper claims submitted by that provider may be rejected in the mailroom without entry of those claims.

11. Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation (section 90.5).

- Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims.
- If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that any paper claims submitted after a certain date (a reasonable period will be allowed for implementation of necessary provider changes) will be denied by Medicare.

12. Waiver requests submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.

MISCELLANEOUS

Are Your Claims Continuing To Be Rejected?

If you meet the exception criteria related to HIPAA compliance and will be submitting your claims on paper, please adhere to the following guidelines.

Medicare suppliers are encouraged to bill their claims electronically, but in cases where a paper claim needs to be filed, the CMS-1500 claim form should be completed accurately. Instructions for completing the entire claim form can be found in the *DMERC Region D Supplier Manual*, Chapter 6, pages 36 - 43. The following items from the CMS-1500 form have been identified as the items frequently completed inaccurately.

1. Item 17 and 17A - The referring/ordering physician name and Unique Provider Identification Number (UPIN) are required. Claims will be returned as unprocessable if:

a. These items are left blank.
b. The physician's name is present but the UPIN number is missing.
c. The UPIN is present but the physician's name is missing.
d. More than one physician and UPIN are entered.
e. The UPIN is invalid.

2. Item 21 - A valid ICD-9 code is required on all claims. Only four diagnosis codes may be entered on the CMS-1500 form. If an item is being billed for a diagnosis code not entered as one of the four, a new claim form should be filed for that item.

3. Item 24e - A diagnosis reference is required for each procedure billed on a claim line.

a. Only one reference number (1, 2, 3, or 4) should be entered for each procedure billed.
b. If multiple diagnoses relate to the procedure billed, only one diagnosis from item 21 should be referenced.
c. The ICD-9 code should be entered in item 21 not item 24e.

4. Item 28 - If submitting multiple CMS-1500 claim forms for the same beneficiary you must indicate "continued" in this field and put the total charge on the last page; otherwise, each form will be processed as an individual claim.

5. Item 29 - Only the total amount paid by the beneficiary on covered charges should be entered. Incorrect amounts entered in this item may cause the payment to be sent to the beneficiary instead of the provider. Do **not** include:

a. Amount paid on non covered charges.
b. Amount applied to the deductible.
c. Amount paid by the primary insurance.
d. Amount paid on charges billed on previous claims.

6. Item 31 - The signature of the practitioner or supplier, or his/her representative, and the date signed is required in this item. The signature may be computerized, a stamp or the actual signature. It may not be the company name, initials or blank. This will cause the claim to be returned as unprocessable.

Proper completion of the CMS-1500 form will help expedite the processing of your claim. If your claim is returned as unprocessable a new CMS-1500 form must be submitted for processing.

Clarification Of Proof Of Delivery Requirements

Suppliers are required to maintain documentation on file for seven (7) years and must make these records available to the Medicare contractor upon request. Included in the documentation file is proof of delivery that Durable Medical Equipment (DME) supplies and equipment were delivered to the beneficiary. Claims and services will be denied and overpayments recovered if proof of delivery is not provided.

Supplies must be delivered directly to the beneficiary or their designee (person authorized to sign and accept the delivery of DME on behalf of the beneficiary.) The designee's relationship to the beneficiary must be noted on the delivery slip and their signature legible. If it is not legible, the supplier should note the designee's name on the delivery slip. Suppliers, their employees, or anyone having financial interest in the items delivered are prohibited from signing and accepting items on behalf of beneficiaries. The delivery slip should include the patient's name, quantity delivered, detailed item description, brand name, and serial number. In addition, the delivery and signature dates must be the same.

The following are examples of proof of delivery if a delivery service is used.

- The delivery services tracking slip with the package identification number, delivery address, references to each individual package, and if possible, the actual date of delivery.
- The supplier's own shipping invoice
- Signed/dated return postage-paid delivery invoice with a description of the items shipped, patients, name, quantity, brand name, and serial number.

If items are shipped using a delivery service and the actual date of delivery is not available, the shipping date must be used as the date of service. Claims filed must reflect the initial delivery date as the date of service.

The supplier must contact the beneficiary no sooner than seven (7) days prior to shipping/delivering refill orders to verify the necessity of the item(s). The beneficiary cannot receive items (either shipped or delivered) sooner then five (5) days before the end of usage for the current product. The date of service on the claim should be the date of the new usage period and should not overlap the previous usage date. Claims should be filed on or after the new beginning usage period.

Anticipations for discharge from a hospital or nursing facility are exempt from the previously stated date of service requirements. The supplier may deliver the item to patient no sooner than two (2) days prior to the discharge date for training or fitting of the item. The date of service for these items is the discharge date from the hospital or nursing facility and the supplier should use the patient's home as the place of service. The supplier may not bill DMERC for any drugs or other DMEPOS items prior to the date of discharge as these items are payable under Medicare Part A; even if the patient wore the item home. The supplier cannot substitute billable DME items provided by the hospital or nursing facility.

Please refer to CMS Manual System, Pub 100-08, *Medicare Program Integrity Manual*, Chapter 5, Section 2.1.1 for additional information.

Crossover Claims

Crossover is the transfer of processed claim data from Medicare operations to other insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to the Medicaid (or state) agencies. The three types of crossovers that occur are: Medigap, Complementary, and Medicaid. A revised list of complementary companies and a revised Medigap Other Carrier Name and Address (OCNA) list is included in the April 2004 *DMERC Region D Supplier Manual* update, Chapter 7, which is available on the CD-ROM and at www.cignamedicare.com. Refer to Chapter 7 for additional information regarding crossover claims.

DMERC Region D Publications, Local Medical Review Policies, And Local Coverage Determinations – Official Notification Medium And Official Record Formats

The CIGNA Medicare Web site (www.cignamedicare.com) is the "official notification medium" for all notices developed and distributed by CIGNA Medicare, including the *DMERC Dialogue* and the *DMERC Region D Supplier Manual* update. Information posted to the Web is considered an "official record" the same as any printed material and CD-ROM material. Therefore, beginning May 1, 2004, DMERC Region D will no longer include the following disclaimer on the *DMERC Dialogue* and *DMERC Region D Supplier Manual* Web site pages:

"We have made every effort to ensure that the information on this Web site is an exact duplication of the printed material. However, should there be any discrepancy, the

printed material will always serve as the official record."

While the quarterly publications contain information that is current at the time of issuance, the Web site is utilized to communicate changes in Medicare regulations and updates that occur between quarterly publications. Suppliers are obligated and responsible for obtaining and using the most current information on Medicare issues and legislation as it is posted on the CIGNA Medicare Web site. The date a notice or publication is posted on the Web site is considered the "official notice date," regardless of the date publications are distributed via paper and CD-ROM.

The "official record" rule stated above does not pertain to local medical review policies (LMRPs) and local coverage determinations (LCDs). LMRPs and LCDs that appear on the contractor's Web site are the "official record" for legal purposes. The date a LMRP and LCD is posted to the Web site (www.cignamedicare.com/dmerc/ lmrp_lcd/index.html) is considered the "notice date" and may differ from the "start date of notice period" on the policy.

To ensure suppliers are kept informed of changes in Medicare rules and regulations, the Web site is updated frequently. Time-sensitive information is posted in the "What's New" section and distributed via the CIGNA Medicare ListServ (E-Mail Express Notification System). Suppliers are encouraged to subscribe to the ***ListServ*** (www.cignamedicare.com/mailer/subscribe.asp) to ensure they receive the most current information and notification of publication releases.

Have You Been Missing Your ListServ Messages?

Have you not been getting ListServ messages from CIGNA Medicare even though you are signed up to have the latest Medicare information e-mailed directly to you?

Last October, CIGNA Medicare updated its ListServ and sent out several notices to all ListServ subscribers informing them of the changes and what they needed to do to ensure they continued to receive these important e-mails.

Since October 1, 2003, ListServ messages are being identified and distributed by specialty area(s). The categories originally defined by CIGNA Medicare for sending ListServ messages have been updated to the new specialty categories required by CMS. There are now fewer categories than before, but these categories will be strictly followed by CIGNA Medicare when sending out messages to our ListServ members. If you are currently receiving messages from us (and we send out approximately 20 each month to both our Part B and DMERC subscribers) then no action is required on your part unless you want to update your profile.

ACTION REQUIRED – If you are not currently receiving ListServ messages even though you are signed up to receive them, please follow these steps to ensure you receive these messages and updates:

1. Visit http://www.cignamedicare.com/medicare_dynamic/mailer/reminder.asp, and enter the e-mail address where you normally receive the ListServ messages. Please note: If your e-mail address has changed, you will need to fill out a new form at http://www.cignamedicare.com/medicare_dynamic/mailer/subscribe.asp.

2. A personalized Web address will be emailed to you. Clicking on the link will take you to your ListServ information ready to be edited.

3. Be certain to go to the area of the form where you can "Select your specialty area(s) of interest" and click on "Choose Categories." All messages are sent to ListServ subscribers based upon the Medicare contract of interest and the specialty area(s) they choose.

4. Choose as many specialty areas of interest as you would like. **Please note**: About 80% of the ListServ messages are general in nature and sent out to subscribers who have chosen "General Part B" or "General DMERC" as their specialty area of interest. The other 20% of articles are targeted toward the more specific specialty areas. Please do not overlook choosing the "General Part B" or "General DMERC" categories for your specific contract.

Provider Alert: Stopping Abuse Of The Power Wheelchair Benefit

[From the Medicare Learning Network @ CMS]

Medicare providers need to be aware of new efforts recently announced by the Centers for Medicare & Medicaid Services (CMS) that are aimed at stopping abuse of the power wheelchair benefit in the Medicare Program. CMS will be taking immediate action to substantially curb abuse by unscrupulous providers who prey on Medicare beneficiaries. In addition, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) is investigating the proliferation of durable medical equipment (DME) fraud cases involving inflated billings to Medicare, charges for equipment and supplies not delivered, and the falsification of documents

to qualify beneficiaries for wheelchairs and other equipment that they often do not need.

CMS will begin aggressively reviewing applications from companies that seek to provide power wheelchairs to ensure that they meet reputable business standards of operation. CMS will also review its supplier enrollment standards, increase efforts to educate physicians and beneficiaries about the wheelchair benefit, and enhance current coverage and medical review policies to ensure that Medicare pays for wheelchairs when they are absolutely necessary.

Listed below are some of the immediate efforts that CMS is undertaking to stop the widespread and systemic fraud of this benefit:

- To prevent fraudulent suppliers from enrolling with Medicare for the sole purpose of receiving inappropriate payments, CMS will immediately begin aggressively scrutinizing all new applications for supplier numbers. Because of this increased scrutiny, new supplier numbers will not be issued until early 2004.
- CMS will be publishing regulations that will enhance the ability to screen new supplier applications to identify and prevent inappropriate enrollment of suppliers by providing a more detailed screening process, allowing CMS the time needed to properly review applications, and to provide sanctions against suppliers abusing the enrollment process.
- To quickly identify and punish fraudulent suppliers, CMS, Durable Medical Equipment Regional Carriers (DMERCs), and law enforcement agencies will collaborate to process fraud cases and assure aggressive, timely application of sanctions, and civil or criminal prosecutions. CMS will exercise one of its strongest administrative tools, payment suspensions, to stop the improper hemorrhaging of Medicare dollars.

CMS will finalize regulations revising coverage policy for motorized wheelchairs and scooters to assure that national policy accurately defines the conditions under which Medicare will cover mobility products. This policy will require, for the first time, that a medical provider see the patient before prescribing a wheelchair or scooter. This policy will allow the medical provider to prescribe either a motorized wheelchair or a power-operated vehicle (POV). Under existing policy, only a specialist may prescribe a POV.

- DMERCs will adopt local medical review policies (LMRPs) that accurately portray the clinical conditions for which mobility products are reasonable and necessary. This will educate suppliers and beneficiaries on when wheelchairs will be paid for by Medicare and will facilitate correct billing and payment for mobility products.
- DMERCs will also adopt a consistent approach to medical review so that when national billing and utilization trends are identified, Medicare knows that only claims that are reasonable and necessary are paid and that national billing problems are resolved in a consistent manner.
- CMS will work with physicians to clarify their prescribing responsibilities and Medicare coverage criteria.

A brochure titled ***"Medicare Coverage of Power Wheelchairs and Other Power Operated Vehicles"*** that outlines the current Medicare coverage information is available on the Medlearn Web site at: http://www.cms.hhs.gov/medlearn/PowerWheelchair.pdf.

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update ListServ (electronic mailing list) at http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

Update To The American National Standard Institute (ANSI) Codes

New Remittance Advice Remark Codes

N202 Additional information/explanation will be sent separately.
N203 Missing/incomplete/invalid anesthesia time/units.
N204 Services under review for possible pre-existing condition. Send medical records for prior 12 months.
N205 Information provided was illegible.
N206 The supporting documentation does not match the claim.
N207 Missing/incomplete/invalid birth weight.
N208 Missing/incomplete/invalid DRG code.
N209 Missing/invalid/incomplete taxpayer identification number (TIN).
N210 You may appeal this decision.
N211 You may not appeal this decision.

Revised Remittance Advice Remark Codes

M13 Only one initial visit is covered per specialty per medical group.
M18 Certain services may be approved for home use. Neither a hospital nor a skilled nursing facility (SNF) is considered to be a patient's home.
M25 Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
M26 Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service/any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
- If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Contact this office if you have any questions about this notice.

M60 Missing/incomplete/invalid Certificate of Medical Necessity.
M86 Service denied because payment already made for some/similar procedure within set time frame.
M117 Not covered unless submitted via electronic claim.
M129 Missing/incomplete/invalid indicator of x-ray availability for review.
M134 Performed by a facility/supplier in which the provider has a financial interest.
MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.

If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.

MA02 If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.

MA03 If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.

MA20 Skilled nursing facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA24 Christian science sanitarium/skilled nursing facility (SNF) bill in the same benefit period.
MA93 Non-PIP (Periodic Interim Payment) Claim.
MA101 A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
MA106 PIP (Periodic Interim Payment) claim.
MA121 Missing/incomplete/invalid date the x-ray was performed.
N30 Patient ineligible for this service.
N32 Claim must be submitted by the provider who rendered the service.
N40 Missing/incomplete/invalid x-ray.
N69 PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.
N71 Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
N72 PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
N100 PPS (Prospect Payment System) code corrected during adjudication.
N103 Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
N106 Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
N107 Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
N113 Only one initial visit is covered per physician, group practice or provider.
N115 This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP.
N117 This service is paid only once in a patient's lifetime.
N119 This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or skilled nursing facility (SNF) within those 28 days.
N120 Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
N121 No coverage for items or services provided by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay.
N177 We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.

Retired Remittance Advice Remark Codes

M43 Payment for this service previously issued to you or another provider by another carrier/intermediary.
M48 Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M63 We do not pay for more than one of these on the same day.
M98 Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M101 Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.

M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
M140 Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday.
MA11 Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources.
MA78 The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
MA104 Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
MA124 Processed for IME only.
MA129 This provider was not certified for this procedure on this date of service.
N18 Payment based on the Medicare allowed amount.
N60 A valid NDC is required for payment of drug claims effective October 02.
N73 A skilled nursing facility is responsible for payment of outside providers who furnish these services/ supplies under arrangement to its residents.
N101 Additional information is needed in order to process this claim. Resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.
N164 Transportation to/from this destination is not covered.
N165 Transportation in a vehicle other than an ambulance is not covered.
N166 Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N168 The patient must choose an option before a payment can be made for this procedure/equipment/ supply/service.
N169 This drug/service/supply is covered only when the associated service is covered.

New Health Care Claim Adjustment Reason Codes

155 This claim is denied because the patient refused the service/procedure.

Modified Health Care Claim Adjustment Reason Codes

38 Services not provided or authorized by designated (network/primary care) providers.

107 Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.

Retired Health Care Claim Adjustment Reason Codes

28 Coverage not in effect at the time the service was provided.
36 Balance does not exceed co-payment amount.
37 Balance does not exceed deductible.
41 Discount agreed to in Preferred Provider contract.
46 This (these) service(s) is (are) not covered.
48 This (these) procedure(s) is (are) not covered.
57 Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
63 Correction to a prior claim.
64 Denial reversed per medical review.
65 Procedure code was incorrect. This payment reflects the correct code.
67 Lifetime reserve days. (Handled in QTY, QTY01=LA)
68 DRG weight. (Handled in CLP12)

71 Primary payer amount.
72 Coinsurance day. (Handled in QTY, QTY01=CD)
73 Administrative days.
77 Covered days. (Handled in QTY, QTY01=CA)
79 Cost Report days. (Handled in MIA15)
80 Outlier days. (Handled in QTY, QTY01=OU)
81 Discharges.
82 PIP days.
83 Total visits.
84 Capital Adjustment. (Handled in MIA)
86 Statutory Adjustment.
88 Adjustment amount represents collection against receivable created in prior overpayment.
92 Claim paid in full.
93 No claim level adjustments.
98 The hospital must file the Medicare claim for this inpatient non-physician service.
99 Medicare Secondary Payer Adjustment Amount.
120 Patient is covered by a managed care plan.
123 Payer refund due to overpayment.
124 Payer refund amount - not our patient.
A3 Medicare Secondary Payer liability met.
B2 Covered visits.
B3 Covered charges.
B19 Claim/service adjusted because of the finding of a Review Organization.
B21 The charges were reduced because the service/care was partially furnished by another physician.
D1 Claim/service denied. Level of subluxation is missing or inadequate.
D2 Claim lacks the name, strength, or dosage of the drug furnished.
D3 Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4 Claim/service does not indicate the period of time for which this will be needed.
D5 Claim/service denied. Claim lacks individual lab codes included in the test.
D6 Claim/service denied. Claim did not include patient's medical record for the service.
D7 Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8 Claim/service denied. Claim lacks indicator that 'x-ray is available for review.
D9 Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
D10 Claim/service denied. Completed physician financial relationship form not on file.
D11 Claim lacks completed pacemaker registration form.
D12 Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13 Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14 Claim lacks indication that plan of treatment is on file.
D15 Claim lacks indication that service was supervised or evaluated by a physician.

Frequently Asked Questions

1. My claim denied for an invalid ICD-9 diagnosis code. This is the diagnosis code that the doctor gave me, what do I need to do to get this paid?

   ANSWER: Obtain the correct diagnosis code(s) and resubmit the claim. ICD-9-CM is composed with three, four, or five digits. Some three-digit codes stand alone. Other three-digit codes are further subdivided by the addition of fourth or fifth digits, which provide greater specificity. Therefore, code as follows:

   - Use three-digit codes only if there are no four or five-digit codes within that code category.
   - Use four-digit codes only if there are no five-digit codes for that category.
   - Use five-digit codes when they exist in a code category.
   - Sometimes fourth and fifth digits are not available. In these cases, do not add fourth and fifth digits to valid three-digit codes (i.e., do not add zeros to valid three-digit codes).

   It is important for providers to use the most recent version of the ICD-9 coding book and that they code to the highest level of specificity.

   The most recent version may be obtained through the following sources:

   - Ingenix – 800.999.4600
   - CMS's Web site – www.cms.hhs.gov/medlearn/icd9code.asp
   - American Medical Association (AMA) – 800.621.8335 or www.ama-assn.org
   - National Center for Health Statistics (NCHS) – www.cdc.gov/nchs/icd9.htm

   (Region D *DMERC Dialogue,* Fall 2003, pages 11 - 12)

2. My claim denied for "same or similar "equipment. How does the supplier resolve this issue?

   ANSWER: Though suppliers should always try to determine whether a beneficiary has had the same or related equipment before, there are situations in which a supplier may submit an initial claim for a capped rental not knowing that another supplier has previously been approved for the same or related code. If the DMERC does not receive narrative documentation justifying the start of a new capped rental period, we will presume that there has been no substantial change in the medical necessity for the item. If the claims are denied as same or similar and the new supplier disagrees with this determination, they can obtain the information described below and request an appeal.

   1. A description of the patient's prior medical condition that necessitated the previous item;

   2. A statement explaining when and why the medical necessity for the previous item ended; and

   3. A statement explaining the patient's new or changed medical condition and when the new capped rental period began.

   A CSR can verify the previous provider's information, such as the name and phone number of the company on a post-claim basis.

3. I received a denial because the Medicare records indicate the beneficiary was in a Skilled Nursing Facility (SNF). Can Medicare's Customer Service Representatives (CSRs) verify the inpatient dates and the name of the facility?

   ANSWER: A CSR cannot verify the dates the beneficiary was in a SNF or the name of the facility. Try contacting the beneficiary or family member for verification of SNF information.

Frequently Asked Questions (cont'd)

4. I sent the Certificate of Medical Necessity (CMN) with my claim, however Medicare records indicate no CMN was received. What should I do?

   ANSWER: Claims denied for no CMN must be resubmitted with the CMN. If you sent your CMN electronically, please check your CMN reject report at the end of your Electronic Receipt Listing (ERL) to see if the CMN was rejected. It is possible a claim will be accepted into our system but the CMN may still be rejected.

   If you are submitting several paper claims for one beneficiary, make sure the CMN is submitted with the first claim in your batch.

5. The supplier's records indicate oxygen was prescribed for the beneficiary for a need of lifetime. Why did I receive a denial for needing a recertification?

   ANSWER: Lifetime length of need on an initial CMN is not sufficient for continuation of oxygen coverage. A recertification is required three months after the initial certification if oxygen tests results on the initial certification are in Group II. If the oxygen test results on the initial certification are in Group I, a recertification is required twelve months after the initial certification.

6. Lately, we have had claims deny because the beneficiary does not live in Region D. How do we find out what region the beneficiary resides in?

   ANSWER: First, check your records to see if the beneficiary's address that you have on file should be billed to Region D. If so, contact the beneficiary to verify the correct address. If you need further assistance, contact a CSR to verify what region the claim should be sent to and resubmit the claim to the correct DMERC region.

7. How does the supplier check Medicare eligibility for new customers?

   ANSWER: Eligibility inquiries must be made through the Interactive Voice Response (IVR) system at 877.320.0390. Suppliers contacting a CSR for inquiries that can be handled through the IVR will be instructed to disconnect and call the IVR. Inquiries that must be made through the IVR include:

   - Claim Status – pending, denied, paid
   - Outstanding Check Information
   - Current Deductible Information
   - Allowable Information
   - Duplicate Payment Reports
   - Ordering Publications
   - New Legislation, Supplier Issues and Educational Seminar information
   - Information about the appeal process

   The Direct Data Entry (DDE) of the 270/271 Version ANSI 4010A1 transaction set allows the supplier to check beneficiary eligibility. The user inputs data into predefined field and instantaneously is provided with an eligibility response. The beneficiary eligibility system is available for use Monday – Friday, excluding holidays. Hours of operation 7 A.M. – 6 P.M. Central Time.

8. I need to find out the status of a particular claim. How do I get this information?

   ANSWER: These inquiries must be made through the Interactive Voice Response (IVR) system at 877.320.0390. Suppliers contacting a CSR for inquiries that can be handled through the IVR will be instructed to disconnect and call the IVR.

Frequently Asked Questions (cont'd)

Claim Status Inquiry (CSI) allows you to electronically check the status of production claims after they have passed the front-end edits and received Claim Control Numbers (CCNs).

At least three working days after you successfully file an electronic claim, you will be able to locate your claim in the processing cycle. Through CSI, you will know if your claim has been paid, denied, or still pending. If you are checking the status of pending claims, there are additional screens available which contain more detailed status information. CSI is available for both electronic and paper claims.

9. How do I verify the allowable on a specific procedure code?

   ANSWER: These inquiries must be made to the Interactive Voice Response (IVR) system at 877.320.0390. Allowable information is also available on the CIGNA Medicare Web site at www.cignamedicare/dmerc. Suppliers contacting a CSR for inquiries that can be handled through the IVR will be instructed to disconnect and call the IVR.

10. My remittance advice notice shows an offset amount with a Financial Claim Number (FCN). How do I find out what beneficiary the overpayment was on, as well as the date of service?

    ANSWER: Suppliers are notified by letter when an overpayment has been identified and a refund is requested. A second request is made in 30 days if no response has been received. If after 10 additional days the supplier has not contacted our office regarding the overpayment, offset withholdings are initiated.

    Before calling customer service, we recommend that you refer to the offset letter. If your mail is sent to an address separate from your location, please attempt to contact that office for offset information (i.e., mail that goes to the corporate office). If you are unable to locate the letter, contact our customer service toll free line at 866.243.7272, to verify the information or request a duplicate letter.

Appendix

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Announcing the New *Medlearn Matters...Information for Medicare Providers*

The Centers for Medicare & Medicaid Services (CMS) and your Medicare Learning Network introduces *Medlearn Matters…Information for Medicare Providers,* a new educational resource for Medicare Providers. *Medlearn Matters…Information for Medicare Providers* is designed to inform you of important changes to the Medicare system in a user-friendly format that will accommodate your busy schedule.

Please let us know if these articles help you understand these changes more readily. Provide us with suggestions for improvements to articles. If there is a special topic of interest that you believe warrants an article, let us know and we will consider a special edition for that topic. To provide feedback, please go to: http://www.cms.hhs.gov/medlearn/suggestform.asp

Bookmark this page, use it frequently, and let us know how best to continue providing good service to you.

Background

CMS is committed to partnering with the Medicare physician, provider, and supplier communities so services to Medicare beneficiaries can be timely and of the highest quality. One way of providing the best services to Medicare patients is assuring that the providers of care have ready access to Medicare's latest coverage and reimbursement rules and policies in a brief, accurate, and easy-to-understand format.

CMS recognizes that the Medicare provider communities have been hampered by the number, frequency, and complexity of Medicare changes. CMS also appreciates the feedback from those same providers who indicate that Medicare rules and changes are not always relayed to them in an easy, timely, and consistent manner.

To address those issues, CMS has implemented a new initiative — "Consistency in Medicare Contractor Outreach Material" or CMCOM, designed to provide more timely information on Medicare changes. The product of this effort, *Medlearn Matters…Information for Medicare Providers,* is a series of articles prepared by actual clinicians and billing experts. *Medlearn Matters…Information for Medicare Providers* articles are tailored, in content and language, to the specific provider types who are affected by Medicare changes.

Previously, each Medicare carrier and intermediary was responsible for crafting educational articles within days of release of the related Medicare change. With this new effort, the Medicare carrier or fiscal intermediary will still be responsible for local provider education. However, they will benefit from the availability of *Medlearn Matters…Information for Medicare Providers* articles to support their efforts. These articles are easily accessible from the Medlearn Web site, which providers already access for other Medicare information.

Enlisting the expertise of medical professionals to develop these articles and providing them from a single location will result in more consistent, accurate, and timely information than in the past. This initiative supplements and should improve the ability of your carrier or intermediary to provide better service to you.

Those of you who have relied on Medicare Program Memorandums or Manual Transmittals on the Web, may be familiar with the Change Request (CR) documents and their accompanying CR numbers. Since you may have used the original CRs to get early information on upcoming changes, we think you will agree that those documents were not always clear as to provider impact and action needed.

Announcing the New *Medlearn Matters...Information for Medicare Providers (cont'd)*

One reason is that those CRs were written to provide instructions to Medicare carriers, intermediaries, and Medicare system maintainers. Thus, the focus of the message was quite different and probably contained more information than providers needed to know. The intent of *Medlearn Matters…Information for Medicare Providers* articles is to help focus the information more toward providers, to give you only the information you need and thus reduce the amount of time you need to spend on that information.

The articles will be placed on the Medlearn Web site on the new *Medlearn Matters…Information for Medicare Providers* page. Each article's number will usually correspond to the number of the Change Request (CR) that officially announced the change, but the number will be preceded by MM to show it is a related *Medlearn Matters…Information for Medicare Providers* article. There are exceptions, designated as Special Editions. These articles will be numbered in a distinctive manner, as "SEyynn" where "SE" stands for Special Edition, the "yy" is the two-digit year the article was released, and "nn" is the number of the special edition for that year. Thus, this first Special Edition article is numbered as SE0301.

To view all the articles available, please visit: **http://www.cms.hhs.gov/medlearn/matters**

We hope you find this new vehicle of assistance to you and we invite your feedback.

Common Medicare Submitter Claim Testing Problems

Listed below is a list of technical and non-technical issues that Medicare contractors have encountered that are preventing submitters from moving into production on the 837 claim:

1. Errors in data element **NM109**

   Submitters are placing the Medicare provider number or UPIN in NM109 instead of the REF (secondary identification number) segment.

   CMS Guidance: NM109 must contain the provider SSN or EIN. Medicare provider numbers must be submitted in the REF02 with the appropriate qualifier in REF01 (1C for Medicare provider number or 1G for the Medicare UPIN).

2. Enveloping issues – **ISA and GS** segments

   GS02 and 03 – invalid submitter codes and receiver codes
   ISA06 and 08 – contractor codes are being omitted
   Invalid lengths in the data elements contained in the envelopes
   ISA15 contains the value "P" when testing

3. CMS Guidance: ISA06 and GS02 must contain the submitter code that is agreed to or assigned by the Medicare contractor. ISA08 and GS03 must contain the Medicare contractor receiver number.

   The ISA and ISE are fixed length segments. The length defined in the implementation guide must be followed.

   When testing, the ISA15 must have a value of "T".

4. Invalid taxonomy codes

   CMS Guidance: Although CMS does not require a taxonomy code; it must be a valid code if submitted. A list of the approved codes is posted at the Washington Publishing Company (WPC) Web site www.wpc-edi.com/codes.

Common Medicare Submitter Claim Testing Problems (cont'd)

5. Invalid characters in the data stream.

   CMS Guidance: The basic character set as defined in Appendix A of the 837 Implementation Guide must be used. In addition, certain characters from the extended character set may be used. Contact your Medicare contractor for a copy of their companion document for further guidance.

6. **SBR** (subscriber) data elements missing, such as date of birth and gender. **SBR09** identifies the incorrect payer.

   CMS Guidance: SBR09 must equal "MB" for Medicare Part B or "MA" for Medicare Part A. All required data elements in the SBR segment must be submitted per the implementation guide.

7. Missing/out of order **N3** and **N4** segments

   CMS Guidance: When address information is submitted, the N3 (street address information) and N4 (city, state and zip code information) must be submitted. State codes and zip codes must be valid codes based on the code source in the 837 implementation guide.

8. Submitter's contact phone number missing

   CMS Guidance: Loop 1000A is always required. The submitter's communications number (fax, email, telephone, etc.) must be provided in this loop.

9. Sending both billing provider loop and rendering provider loop when they are the same entity.

   CMS Guidance: When the billing provider is the same as the rendering provider, loop 2310B is not submitted. In this case the rendering provider is identified in loop 2000A.

10. Invalid date formats.

    CMS Guidance: When dates are submitted, they must be formatted in accordance with the value in DTP02.

Requirements for Provider Submission of Claims under the Administrative Simplification Compliance Act (ASCA)

The following information regarding Mandatory Submission of Electronic Claims may be found in the CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24, Section 90, http://w.cms.hhs. gov/manuals/.

90 – Mandatory Electronic Submission of Medicare Claims

Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32 require that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, Durable Medical Equipment Regional Carrier (DMERC), or intermediary for the first time, including resubmitted previously refected claims, claims with paper attachments, demand bills, claims where Medicare is secondary and there is only one primary payer, and non-payment claims. Initial cliams do not include adjustments submitted to intermediaries on previously submitted claims or appeal requests.

Medicare will not cover claims submitted on paper that do not meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (Non-covered charge(s)) and remark code M117 (Not covered unless submitted via electronic claim.)

Claims required to be submitted electronically effective October 16, 2003 and later must comply with the appropriate claim standards adopted for national use under HIPAA or with standards supported under the Medicare HIPAA contingency plan during the period that plan is in effect. The mandatory electronic claim submission requirement does not apply to claims submitted by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, or to health plans other than Medicare.

90.1– Small Providers and Full-Time Equivalent Employee Assessments

A “small provider” is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare will consider all providers that have fewer than 25 FTEs and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider’s staff for FTE calculation purposes when determining whether a provider can be considered as “small” for electronic billing waiver purposes.

Requirements for Provider Submission of Claims under the Administrative Simplification Compliance Act (ASCA) *(cont'd)*

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider as identified by provider number, UPIN, or national provider identifier (NPI) when implemented to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill intermediaries and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part time hours a week worked on average by all staff who furnished services for the provider on a less than full time basis. Divide that total by 40 hours to determine their full time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents.

Legal issues regarding the definition of providers, particularly when multiple providers have data reported under the same EIN, will be addressed in the NPI regulation when published in the Federal Register in final. For FTE calculation purposes in the interim, it is acceptable to include only those staff of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply. This process will be modified if warranted by the definitions established in the NPI final rule.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records,or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare

Requirements for Provider Submission of Claims under the Administrative Simplification Compliance Act (ASCA) (cont'd)

electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

The small provider exception for submission of paper claims does not apply to health care claim clearinghouses that are agents for electronic claim submission for small providers. HIPAA defines a clearinghouse as an entity that translates data to or from a standard format for electronic transmission. As such, HIPAA requires that clearinghouses submit claims electronically effective October 16, 2003 without exception.

90.2 – Exceptions

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition:

1. Roster billing of vaccinations covered by Medicare—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some suppliers have been allowed to submit a single claim on paper with the basic provider and service data to which was attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim implementation guides adopted under HIPAA can submit single claims to payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

Flu shots are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations. In some cases, a single nurse who is not accompanied by support staff might conduct mass immunizations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

It is in the interest of Medicare and public health to make it as simple as possible for mass immunization activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for vaccinations. Providers or suppliers that furnish vaccinations and other medical services or supplies must bill those other medical services or supplies to Medicare electronically though unless the provider qualifies as "small" or meets other exception criteria.

This vaccinations waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections furnished in a traditional medical setting such as a doctor's office or an outpatient clinic when supplied as a component of other medical care or examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, the flu shot or other vaccination is also to be included in the electronic claim sent to Medicare for the patient.

2. Claims for payment under a Medicare demonstration project that specifies paper submission—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) previously adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims

for a demonstration project. Demonstrations typically involve a limited number of providers and limited geographic areas. Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper. Non-demonstration claims will continue to be submitted electronically, unless another exception or waiver condition applies.

3. Medicare Secondary Payment Claims (MSP)-MSP claims occur when one or more payers are primary to Medicare. The claim formats adopted for national use under HIPAA include segments for provider or payer use to submit secondary claims as well as initial claims. Since a patient rarely has more than two insurers in total, t he formats were designed for a provider to bill a payer secondarily and include payment data from one primary in the claim. In actuality, there may have been more than one primary payer. The claim formats adopted under HIPAA do not currently contain the ability to report individual service level payments made by more than one primary payer.

The paper claim format has no fields for reporting of any primary payment data when Medicare is secondary. When paper claims are submitted, a copy of the primary plan's explanation of benefits (EOB) must always be attached if there is one or more payers that pay prior to Medicare. Since the HIPAA claim formats do allow service level data to be submitted electronically when there is only one payer primary to Medicare, those claims can be sent to Medicare electronically. When more than one payer is primary, the formats cannot accommodate this additional reporting and the only alternative is for providers to submit those claims to Medicare on paper with copies of the EOBs/remittance advices (RAs).

The payment segments of the claim formats adopted under HIPAA include fields for reporting of the identity of the primary payer, service procedure code, allowed amount, payment amount, and claim adjustment reason codes and amounts applied by the other payer when the billed amount of the service was not paid in full. These segments correspond to segments reported in the X12 835 remittance advice format. Since the HIPAA requirements apply only to electronic transactions, and not to paper transactions such as paper EOBs or RA notices, there is no requirement that payers use the same codes in their paper EOBs or RAs as in their electronic RAs. Medicare uses the same code set in both paper and electronic RAs, but other payers may not. Payers can elect to use different code sets in their paper transactions than their electronic transactions, or to use text messages in their paper transactions and not use codes at all. Payers that do not use the standard claim adjustment reason codes in their paper EOBs or RAs, generally use proprietary codes or massages for which there is no standard crosswalk to the 835 claim adjustment reason codes.

Providers that receive those paper EOBs/RAs cannot reasonably furnish standard claim adjustment reason codes for use in the HIPAA claim and COB formats. As a result, when there is only one payer primary to Medicare and those claims must be sent to Medicare electronically, those providers cannot complete the situational CAS segment for those claims. The coordination of benefits implementation guide adopted under HIPAA does not require that this segment be completed in this situation. Although this will prevent the primary payer data in the claim from balancing, akin to balancing when the data is reported in an 835 transaction, that is acceptable. There is no requirement in the implementation guide that these payment segments balance in a claim transaction. Providers should not try to convert non-standard messages or codes to standard claim adjustment reason codes to submit these claims to Medicare electronically. Medicare does not use the CAS segment data elements to calculate the Medicare payment in any case. Providers must, however, still report the primary's allowed, contract amount when Obligation to Accept in Full (OTAF) applies, and payment amounts for the individual services to enable Medicare to calculate payment.

4. Claims submitted by Medicare beneficiaries.

90.3 – "Unusual Circumstance" Waivers

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a waiver of the electronic claim submission requirement would be appropriate.

Requirements for Provider Submission of Claims under the Administrative Simplification Compliance Act (ASCA) (cont'd)

The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims.

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as secondary claims when more than one other payer is primary. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

Providers who feel they should qualify for a waiver as a result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims. DMERC Region D requests for waiver as a result of an "unusual circumstance" should be sent to CIGNA Medicare, PO Box 690, Nashville, TN 37202.

90.3.1—Unusual Circumstance Waivers Subject to Provider Self-Assessment

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may continue to submit claims to Medicare on paper when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor(s) that one of the circumstances applies as a condition of paper submission.

1. Dental claims—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data that not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically. They can continue to submit claims, when appropriate, to Medicare on paper.

2. Disruption in electricity or phone/communication services—In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.

3. A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.

4. Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper. These claims are not processable by the MSPPay module and must be manually adjudicated by Medicare contractors.

90.3.2—Unusual Circumstance Waivers Subject to Medicare Contractor Approval

Medicare contractors may at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considers there to be "good cause" that prevents a provider to submit claims electronically for a temporary period. "Good cause" would apply if a provider has made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider is making reasonable efforts to rectify, the provider is not initially able to submit all affected claims electronically effective October 16, 2003.

In the event that a provider cites an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial HIPAA-compliant software to submit these claims, Medicare contractors may approve a single waiver for up to 180 days after the date of the decision notice to allow adequate time for the provider to obtain and install an upgrade from their vendor, or to transition to software from another vendor that can submit these claims electronically.

DMERC Region D requests for waiver as a result of an "unusual circumstance" should be sent to CIGNA Medicare, PO Box 690, Nashville, TN 37202.

If the contractor determines an "unusual circumstance" applies, and an initial provider waiver of 90/180-days or less as described above is not involved, CMS approval is required.

90.3.3—Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision

A provider may submit a waiver request to their Medicare contractor in the following "unusual circumstances." It is the responsibility of the provider to submit documentation appropriate to establish the validity of the waiver request in these situations. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied.

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication may request a waiver. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the implementation guides deficiency.)

Contractor Note: Pending issuance of the future CMS instructions concerning submission of medical records for electronic claims, providers and Medicare contractors can continue current policies and practices regarding submission of attachments with claims.

Suppliers billing DMERC Region D should continue with the current process of submitting claims with attachments on paper. This temporary exception does not apply to submission of paper EOBs or RAs for electronic claims when Medicare is secondary and there is only one primary payer.

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims.

3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience.

Requirements for Provider Submission of Claims under the Administrative Simplification Compliance Act (ASCA) (cont'd)

90.4 – Electronic and Paper Claims Implications of Mandatory Electronic Submission

Claims providers submit via a direct data entry screen maintained by a Medicare contractor or transmitted to a Medicare contractor using the free/low cost claims software issued by Medicare are considered electronic. When enforcing the electronic claim submission requirement, CMS will take into account those limited situations where a provider submitted paper claims because the free billing software they were issued was temporarily unable to accommodate submission of a secondary or other particular type of claim.

Medicare contractors are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

Medicare carriers, DMERCs, and intermediaries are to assume for processing purposes that claims submitted by a provider on paper October 16, 2003 and later are submitted by providers that are small or that do meet exception criteria, barring information received from other sources to the contrary. Submission of a paper claim October 16,2003 or later will be considered an attestation by a provider that waiver criteria are met at the time of submission.

In the event contractor staff members realize that a particular provider does not meet any of the exception criteria, paper claims submitted by that provider may be rejected in the mailroom without entry of those claims.

90.5 – Enforcement

Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims. If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that any paper claims submitted after a certain date (a reasonable period will be allowed for implementation of necessary provider changes) will be denied by Medicare. Further Medicare contractor instructions are forthcoming.

For reference purposes, each contractor will maintain a record of "unusual situation" waivers aproved or denied.

Contractor Note: Waiver requests submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.

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DMERC Region D

Spring 2004 Seminars

Your mission, should you choose to accept it, is to learn all about the processes involved with submitting a DMERC claim. Let the DMERC Region D Provider Education and Training "agents" lead you to greater accuracy in your claims and your documentation with the following topics:

To Register (Accept the mission):

Go to www.cignamedicare.com or fill out the registration form on the reverse side, and send with your check for $25.00 (per attendee), payable to: CIGNA Medicare.

Note: Cash and Credit Cards will not be accepted.

Your Assignment Information:

All attendees must be preregistered. Walk-ins will not be accepted. Due to the space limitations, registration is on a first-come, first-serve basis. Registrations must be received by the registration date listed below the seminar location. Don't wait to send your registration and payment in as the location you are interested in could fill up faster. Registrations, refund requests, and cancellations will not be accepted any later than two weeks prior to the date of the seminar. Please do not wait to send in your registration, space is limited.

Please bring a jacket. Meeting room temperatures can be difficult to control.

www.cignamedicare.com

BEFORE SUBMITTING YOUR CLAIM:

- **Intake Process** . . . . . The first step in submitting a Medicare claim.
- **One-Time Authorization** . . . . . Why you need one.
- **Orders** . . . . . Find out what Medicare requires and when they are needed.
- **Documentation** . . . . . The evidence you need to substantiate your claims.
- **Fee Schedule Payment Categories** . . . . . The rules that apply to your equipment.
- **Modifiers** . . . . . Your best defense, find out when and how to use them.

SUBMITTING YOUR CLAIM:

- **HIPAA** . . . . . Does it really apply to you? We'll show you how to learn more.
- **Crossovers** . . . . . Identify how your claim crosses to other carriers.
- **Duplicate Claims** . . . . . How to avoid duplicates and save the Medicare Trust Fund.

AFTER SUBMITTING YOUR CLAIM:

- **Proof of Delivery** . . Taking the doubt out of whether or not the equipment has been received.
- **Repairs** . . . . . How to get repairs paid for the first time.
- **Medicare Remittance Notice** . . . . . Decoding your claim determination.
- **Overpayments and Refunds** . . . . . The protocol to follow.
- **Appeals** . . . . . Choosing the correct direction and navigating the levels.

Mission Day Schedule:

Workshop Check-in	8:00a.m. to 8:30a.m.
Workshop	8:30a.m. to 4:00p.m.
Lunch *(on your own)*	11:45a.m. to 1:00p.m.

CIGNA HealthCare
Medicare Administration

DMERC REGION D

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DMERC Region D: Spring 2004 Seminars

When reserving seminar facilities, we do our best to choose locations with ample, cost-free parking. Unfortunately, cost-free parking is not always available. Please call the meeting facility for specific information regarding parking and directions, or if you have special accessibility needs.

LOCATIONS:

Arizona

Phoenix - April 1, 2004
Embassy Suites Phoenix Biltmore
2630 E. Camelback Road
Phoenix, AZ 85016
602.955.3992
Registration Deadline: March 18, 2004

California

San Diego - March 30, 2004
Holiday Inn on the Bay
1355 N. Harbor Drive
San Diego, CA 92101
619.232.3861
Registration Deadline: March 16, 2004

Fresno - April 15, 2004
Holiday Inn Fresno Airport
5090 E. Clinton Way
Fresno, CA 93727
559.252.3611
Registration Deadline: April 1, 2004

Torrance - May 11, 2004
Holiday Inn Torrance
19800 S. Vermont Avenue
Torrance, CA 90502
310.781.9100
Registration Deadline: April 27, 2004

Anaheim - May 13, 2004
Sheraton Anaheim Hotel
900 South Disneyland Drive
Anaheim, CA 92802
714.778.1700
Registration Deadline: April 29, 2004

Idaho

Boise - March 24, 2004
MK Plaza
720 Park Boulevard
Boise, ID 83712
866.224.3094, option 3
Registration Deadline: March 10, 2004

Iowa

Des Moines - May 6, 2004
Holiday Inn Merle Hay
5000 Merle Hay Road
Des Moines, IA 50322
515.278.0271
Registration Deadline: April 22, 2004

Kansas

Overland Park - April 6, 2004
Marriott Overland Park
1000 Metcalf Avenue
Overland Park, KS 66210
913.451.8000
Registration Deadline: March 23, 2004

Wichita - April 8, 2004
Holiday Inn Select
549 S. Rock Road
Wichita, KS 67207
316.686.7131
Registration Deadline: March 25, 2004

Missouri

Clayton - April 20, 2004
Ritz Carlton St. Louis
100 Carondelet Plaza
Clayton, MO 63105
314.863.6300
Registration Deadline: April 6, 2004

Springfield - April 22, 2004
University Plaza Hotel
333 John Q Hammonds Parkway
Springfield, MO 65806
417.864.7333
Registration Deadline: April 8, 2004

Nebraska

Omaha - May 4, 2004
Sheraton Omaha Hotel
1615 Howard Street
Omaha, NE 68102
402.342.6040
Registration Deadline: April 20, 2004

Oregon

Portland - April 29, 2004
Sheraton Portland Airport
8235 Northeast Airport Way
Portland, OR 97220
503.281.2500
Registration Deadline: April 15, 2004

Utah

Salt Lake City - April 13, 2004
Marriott Downtown
75 South West Temple
Salt Lake City, UT 84101
801.531.0800
Registration Deadline: March 30, 2004

Washington

Seattle - April 27, 2004
Hilton Seattle Airport
17620 Pacific Highway South
Seattle, WA 98188
206.244.4800
Registration Deadline: April 13, 2004

Questions?

Call the DMERC Provider Education & Training Team at:
866.224.3094, ext. 3

DMERC Region D: Spring 2004 Seminars

Please submit one registration form per attendee. Please print information in black or blue ink.

Check #:
($25.00 per attendee)

Seminar Location (City): _____

Attendee Name: _____

Company Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

Please pay careful attention to the registration deadlines listed under each site. Registrations received after the cutoff date will not be accepted. Confirmations will be sent via e-mail only.

CIGNA HealthCare
Medicare Administration

DMERC
REGION D

Mail your registration and check to:
CIGNA Medicare Administration
Attn: DMERC Spring 2004 Seminars - 7N12
P.O. Box 360295
Pittsburgh, PA 15251-0295

MEDICARE REVIEW REQUEST FORM

DATE _____

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22995
Nashville, TN 37202

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐ DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

Service Date	HCPCS	Charge(s)	Internal Control Number (ICN)	Denial Reason/ ANSI Code	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

Please see the Summer 2000 *DMERC Dialogue* for additional documentation requirements.

_____ CMS 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name - Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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Medicare Hearing Request Form

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22263
Nashville TN 37202

Date _____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

Type Of Hearing _____ On the Record _____ Telephone _____ Inperson

CLAIM INFORMATION _____ Assigned _____ Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Review DCN	Date of Review Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ HCFA 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Review Letter
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Other _____

CONTACT INFORMATION

PROVIDER: Contact Name and Signature)	Beneficiary: (Contact Name – Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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Medicare Administrative Law Judge Request Form

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22263
Nashville TN 37202

Date _____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

Type Of Hearing **On the Record** **Inperson**

CLAIM INFORMATION Assigned Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Hearing Case Number	Date of Hearing Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ HCFA 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Review Letter
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Hearing Letter

CONTACT INFORMATION

PROVIDER: Contact Name and Signature)	Beneficiary: (Contact Name – Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

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REQUEST FOR CD-ROM ALTERNATIVE DMERC REGION D PUBLICATIONS

Effective August 1, 2003, the CIGNA Medicare Web site (www.cignamedicare.com) will provide formal notification for all notices developed and distributed by CIGNA Medicare, including the *DMERC Dialogue* and the *DMERC Region D Supplier Manual*. Suppliers are obligated and responsible for remaining updated on current Medicare issues and legislation as it is posted on the Web site. The date a notice or publication is posted on the Web site will be considered the "official notice date." Suppliers are encouraged to subscribe to the *ListServ* (www.cignamedicare.com/mailer/subscribe.asp) to ensure they receive the most current information and notification of publication releases.

Beginning with publications scheduled to be distributed in September, DMERC Region D quarterly publications will be distributed in a new format – CD-ROM.

With the conversion of DMERC Region D publications to CD-ROM format, paper copies of the *DMERC Region D Supplier Manual* and quarterly updates are no longer distributed. The supplier manual and updates are available to view and download on the CIGNA Medicare Web site at www.cignamedicare.com/dmerc/dmsm/index.html.

The *DMERC Dialogue* only will be available to suppliers who choose to continue to receive paper copies in lieu of a CD-ROM. To receive paper copies of the *DMERC Dialogue*, suppliers must "opt out" of the CD-ROM distribution by completing this form. The form must be returned to the following address or fax number no later than August 15th to "opt out" beginning with the Fall 2003 *DMERC Dialogue*. Requests received after that date will be honored beginning with the next scheduled publication.

CIGNA Medicare
ATTN: Communications Dept.
Two Vantage Way
Nashville, TN 37228
FAX: 615.782.4445

Provider/Supplier Number **(This form cannot be processed without this number)**

Provider/Supplier Name

Address

City State Zip

Reason for requesting paper version (select one):

- ☐ No Personal Computer
- ☐ No CD-ROM Drive
- ☐ Prefer Paper Copy
- ☐ Other _____

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The privacy of our customers is important to CIGNA Medicare. Personally identifying information that is being collected will be used only in connection with the purpose of removing you from the CD-ROM distribution list and adding you to the list of providers/suppliers requesting paper copies. CIGNA will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

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for DMERC Dialogue

REQUEST

Publication of the *DMERC Dialogue* is a service of CIGNA HealthCare Medicare Administration (CIGNA Medicare) to its supplier community. The *DMERC Dialogue* is published quarterly online at www.cignamedicare.com and contains current information regarding Medicare issues and legislation. The *DMERC Dialogue* is also published quarterly in CD-ROM format and mailed to the supplier community. A printed version is available for those without access to a computer or CD-ROM drive.

Why should I choose the CD-ROM instead of print?

There are many benefits to receiving the *DMERC Dialogue* on CD-ROM. The CD-ROM is easy to use, and you do not need Internet access to use it. Also, the CD-ROM contains many other documents such as:

- Previous *DMERC Dialogues*
- DMEPOS Fee Schedule
- EDI information and resources
- HIPAA information and resources
- *DMERC Region D Supplier Manual* & quarterly update
- Frequently Asked Questions
- Resource Lists
- Forms

If you would like to be included on the list of suppliers receiving the *DMERC Dialogue* on CD-ROM instead of the paper version, please fill out the form below or submit a written request that includes the below information and mail or fax to:

CIGNA Medicare
Communications Dept.
Two Vantage Way
Nashville, TN 37228
Fax: 615.782.4445

Supplier Number (required)

Supplier Name

Address

City State Zip

The privacy of our customers is important to CIGNA Medicare. Personally identifying information that is being collected will be used only in connection with the purpose of adding you to the CD-ROM distribution list and removing you from the list of suppliers requesting paper copies. CIGNA will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

CIGNA HealthCare
Medicare Administration

CMS
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DMERC
REGION D

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DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue** **($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

DMERC Region D Supplier Manual Update* **($10.00 each)** (*Previous updates may include the *DMERC Dialogue.)*

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignamedicare.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment Information

Checks or money orders should be made payable to CIGNA HealthCare Medicare Administration. Send completed order form and payment (if applicable) to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If you have not billed CIGNA Medicare within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue.* Region D publications are available at http://www.cignamedicare.com/dmerc/index.html.

(Rev. 10/2003)

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Suggested Intake Form

Order taken by:	Date:
Telephone:	Referral Person Calling in Order:

BENEFICIARY INFORMATION

Name:	Date of Birth:
Street Address:	Gender: ☐ Male ☐ Female
City, State, Zip:	Weight: / Height:
Telephone:	Medicare Number:

Name of Legally Responsible Representative:

Relationship to beneficiary:

Street Address:

City, State, Zip: / Telephone:

ORDERING PHYSICIAN INFORMATION

Name:	UPIN #:
Street Address:	
City, State, Zip:	Telephone:
Specialty:	

QUESTIONS FOR THE BENEFICIARY

Has the beneficiary ever received the same or similar supplies/equipment? ☐ Yes ☐ No

If yes, list equipment/supplies:

Who was it purchased or rented from?

Date purchased or if rented, how many months? / Date of past setup: / Date equipment was returned:

Was item returned to original supplier? ☐ Yes ☐ No

Why was the item returned?

Is the item being replaced? ☐ Yes ☐ No

Is there a new medical necessity? ☐ Yes ☐ No

Describe condition for previous need:

Describe new/changed condition:

Is the beneficiary enrolled in a Medicare HMO/managed care program? ☐ Yes ☐ No

Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)? ☐ Yes ☐ No

QUESTIONS FOR THE SUPPLIER

If providing repairs on equipment obtain the following information for the item being repaired:

Manufacturer: / Model Name or Number: / Serial Number: / Purchase Date:

Reason or nature of repairs:

Do you have medical necessity to file for repairs?

Does beneficiary meet criteria for item being repaired? ☐ Yes ☐ No / Where will the item be used?

Did I photocopy the Medicare card and/or other insurance cards? ☐ Yes ☐ No

Do I have a dispensing order and/or a detailed written order? ☐ Yes ☐ No

Will I need a Certificate of Medical Necessity (CMN)? ☐ Yes ☐ No

Do I have supporting documentation on file to meet medical necessity? ☐ Yes ☐ No

Should I obtain an Advanced Beneficiary Notice (ABN)? ☐ Yes ☐ No

What is the primary diagnosis? / List any other diagnoses if applicable:

Is Medicare the beneficiary's ☐ primary or ☐ secondary insurer?

Is the beneficiary or beneficiary's spouse employed? ☐ Yes ☐ No

Is the current condition related to employment, auto or other accident? ☐ Yes ☐ No

Is the beneficiary nearing Medicare eligibility? ☐ Yes ☐ No If yes, give eligibility date:

Do I need to obtain a one-time authorization form? ☐ Yes ☐ No

Did the beneficiary sign and date this intake form? ☐ Yes ☐ No

Beneficiary Signature: / Date Signed:

This is just a **suggested** intake form and suppliers can model one to fit their particular type of business. For example if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advanced Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.

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Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 6:00 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System: 877.320.0390 ***Supplier Help Line***: 866.243.7272 ***Beneficiary Help Line***: 800.899.7095

Paper Claim Submission & Written Inquiries:
CIGNA Medicare
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Medicare
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Medicare
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs)

LMRPs are available to view and download on the CIGNA Medicare Web site (http://www.cignamedicare.com/dmerc/lmrp/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired LMRPs. Paper copies of LMRPs are available upon request by writing to: CIGNA Medicare, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Medicare Online Help Center at http://www.cignamedicare.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Medicare regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignamedicare.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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CIGNA Medicare
DMERC Region D
PO Box 690
Nashville TN 37202

Region D DMERC Serves. . .

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

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