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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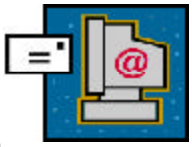

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From the Medical Director...

Robert Hoover, Jr., MD, MPH

CERT Errors And ICD-9 Codes

In a recent review of results from the Comprehensive Error Rate Testing (CERT) program, it was noted that several policy groups had errors related to ICD-9 diagnosis codes. Specifically, the payment errors were the result of CIGNA Medicare paying a claim that did not have the proper ICD-9 code as required by a local medical review policy (LMRP). As you are probably aware, certain DMERC LMRP have specific ICD-9 diagnosis code requirements. Following is a list of the LMRPs that have specific diagnosis code requirements for some or all items in the policy:

Ankle-Foot/Knee-Ankle-Foot Orthoses
Automatic External Defibrillators
High Frequency Chest Wall Oscillation
External Breast Prostheses
External Infusion Pumps
Glucose Monitors
Mechanical In-exsufflation Devices
Nebulizers
Oral Anticancer Drugs
Orthopedic Footwear
Osteogenesis Stimulators
Ostomy Supplies
Refractive Lenses
Therapeutic Shoes for Diabetics

Suppliers must adhere to the ICD-9 diagnosis code requirement(s) in the LMRP. For example, in the month of May 2003, 7% of all ostomy claims did not contain the diagnosis code(s) required by the LMRP. As CIGNA Medicare continues efforts to educate the supplier and physician communities, actions are also being taken to reduce these types of errors through claim editing and denial. To avoid having to file appeals, check your claims carefully to ensure that the item being billed to Medicare includes the correct ICD-9 diagnosis code for a covered diagnosis.

Additional information on proper ICD-9 coding is published in the Spring 2003 *DMERC Dialogue* article entitled "Diagnosis Codes" (page 7).

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Cont'd

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

MEDICAL POLICY

Cervical Traction Devices – Draft LMRP

The DMERCs have published a draft local medical review policy (LMRP) on cervical traction devices. The draft LMRP, as well as information about submitting comments to the draft policy, is available on our Web site at http://www.cignamedicare.com/dmerc/lmrp/draft/index.html.

RAD & CPAP Policy Revisions

HCPCS Codes:

Effective for dates of service on or after January 1, 2004, the following permanent codes replace temporary codes in the Continuous Positive Airway Pressure (CPAP) Devices and Respiratory Assist Devices (RAD) local medical review policies (LMRPs):

Policy Group	New Code	Replaces
RAD	E0470	K0532
RAD	E0471	K0533
RAD	E0472	K0534
CPAP & RAD	E0561	K0268
CPAP & RAD	E0562	K0531

The K codes will be discontinued for dates of service on or after January 1, 2004. Under the standard grace period, codes K0532, K0533, K0534, K0268 and K0531 will continue to be accepted on claims with dates of service on or after January 1, 2004 that are received by March 31, 2004. Claim lines for codes K0532, K0533,

K0534, K0268 and K0531 with dates of service on or after January 1, 2004 that are received after March 31, 2004 will be returned as unprocessable or denied as incorrectly coded. The K codes should continue to be used on claims for dates of service prior to January 1, 2004, regardless of the date of claim submission.

In addition, effective for dates of service on or after January 1, 2004, the following new HCPCS code is created:

A7046 - Replacement water chamber for humidifier, used with positive airway pressure device, each

These codes are incorporated in revisions of the RAD and CPAP LMRPs that are included in the Winter 2004 *DMERC Region D Supplier Manual* update.

Definitions:

In the LMRPs for CPAP and RAD, the Other Comments Section currently specifies that the diagnosis of obstructive sleep apnea requires that the apnea-hypopnea index (AHI) be calculated based on a minimum of two hours of sleep without the use of a positive airway pressure device. The LMRPs are revised, effective January 1, 2004, to delete the requirement that the polysomnogram demonstrate two hours of recorded sleep and will read as follows:

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected.

These revisions are made as a result of comments and suggestions from the clinical community in sleep medicine.

Wheelchair Options And Accessories

The 2004 Healthcare Common Procedure Coding System (HCPCS) update contains many new codes for wheelchair options and accessories which are effective for dates of service on or after January 1, 2004. A revision of the local medical review policy (LMRP) on Wheelchair Options and Accessories incorporating the changes is included in the Winter 2004 *DMERC Region D Supplier Manual* update. The Revision History section of the policy lists the codes that were changed. A number of codes will also be discontinued effective January 1, 2004. Under the standard grace period, these 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. Claim lines 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 as incorrect coding. The discontinued codes should continue to be used for claims with dates of service prior to January 1, 2004 regardless of the date of claim submission.

Detailed definitions for many of the new codes are included in the Coding Guidelines section of the policy. The definitions are meant to be broadly inclusive. All related components are included in the codes and should generally not be billed separately unless specifically allowed in the definition or description of a code. If the supplier chooses to bill separately for an included component, code A9900 (miscellaneous DME supply, accessory and/or service component of another HCPCS code) must be used and will be denied as not separately payable. If an included component is billed with the miscellaneous code K0108, that claim line will be rejected as incorrect coding.

Although the new HCPCS codes are only valid for dates of service on or after January 1, 2004, suppliers are encouraged to use the new categorization of accessories on claims for K0108 with dates of service in 2002 and 2003. Suppliers are encouraged, but not required, to use the narrative description of the new HCPCS code and/or enter the new HCPCS codes along with the narrative description of the item billed using K0108. This will result in more consistent processing and pricing of these accessories.

Example: Chin cups for use with a chin control interface are coded K0108 prior to January 1, 2004. For dates of service on or after January 1, 2004, these items are coded with the new code E2324 (power wheelchair accessory, chin cup for chin control interface). Although when billing for dates of service prior to January 1, 2004, the code K0108 must be used, the new code E2324 and/or the new narrative description may be listed in the narrative field.

The new codes revise the definition of nonstandard seat frame dimensions for adult manual and power wheelchairs. Codes E2201-E2204 and E2340-E2343 define nonstandard seat width and/or seat depth as being 20 inches or greater. As a result of this, effective for dates of service on or after January 1, 2004, the definitions of standard seat widths and depths for adult wheelchair bases in the Manual Wheelchairs and Motorized/Power Wheelchairs LMRPs are being revised. The new definitions are as follows:

Seat width: 15-19 inches
Seat depth: 15-19 inches

New codes E1019 and E1021 are invalid for claim submission to the DMERC.

Wheelchairs with seat widths and/or depths of 14 inches or less should be billed using codes E1231-E1238 for pediatric manual wheelchairs or code K0014 for pediatric power wheelchairs.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) with any questions concerning the correct coding of these items.

Refractive Lenses Local Medical Review Policy (LMRP) – New And Revised HCPCS Codes

Effective for dates of service on or after January 1, 2004, the following HCPCS code changes will apply to the Refractive Lenses LMRP:

Deleted Code	Crosswalk to New Code
V2116 V2117	V2121 (Lenticular lens, per lens, single)
V2216 V2217	V2221 (Lenticular lens, per lens, bifocal)
V2316 V2317	V2321 (Lenticular lens, per lens, trifocal)
V2740 V2741 V2742 V2743	V2745 (Addition to lens, tint, any color, solid, gradient or equal, glass, plastic or equal, excludes photochromatic, any lens material, per lens)

The following codes will be discontinued effective for dates of service on or after January 1, 2004: V2116, V2117, V2216, V2217, V2316, V2317, V2740 - V2743. Under the standard grace period, these 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. Claim lines with these codes with dates of service on or after January 1, 2004 that are received on or after April 1, 2004 will be returned as unprocessable or denied as incorrectly coded. These codes should continue to be used for claims with dates of service prior to January 1, 2004 regardless of the date of claim submission.

New Codes:

Effective for dates of service on or after January 1, 2004, the following new codes are included in the Refractive Lenses LMRP:

V2756 - Eye glass case
V2761 - Mirror coating, any type, solid, gradient or equal, any lens material, per lens
V2762 - Polarization, any lens material, per lens
V2782 - Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783 - Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2784 - Lens, polycarbonate or equal, any index, per lens
V2786 - Specialty occupational multifocal lens, per lens
V2797 - Vision supply, accessory and/or service component of another HCPCS vision code

A revision of the LMRP on Refractive Lenses is included in the Winter 2004 *DMERC Region D Supplier Manual* update. Refer to that policy for information concerning definitions, coverage criteria, and special documentation requirements for the new codes. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.

COVERAGE AND BILLING

Gait Trainers – Coding Guidelines

Gait trainer is a term used to describe certain devices that are used to support a patient during ambulation. The Centers for Medicare & Medicaid Services (CMS) has determined that gait trainers serve the same purpose as walkers. Therefore, when billing Medicare for a gait trainer, the appropriate walker code E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148 or E0149 must be used. If a gait trainer has a feature described by one of the walker attachment codes (E0154-E0157), that code may be separately billed. Other unique features of gait trainers are not separately payable and may not be billed with code E1399. If a supplier chooses to bill separately for a feature of a gait trainer that is not described by a specific Healthcare Common Procedure Coding System (HCPCS) code, then code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPCS code) must be used and the claim line will be denied as not separately payable.

Respiratory Assist Device/ Ventilator – Coding Clarification

Any product presented to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding as a respiratory assist device (RAD) will be coded to the product's highest capabilities. However, coverage by the Durable Medical Equipment Regional Carriers (DMERCs) will be determined by what is ordered and how the device is used. Similar principles also apply to coding and coverage of certain types of ventilators.

For details on billing these items, please see the Winter 2002 *DMERC Dialogue* article entitled "New Procedures to Use the ABN Form for DMEPOS Upgrades" (page 18).

2004 Annual Update For Skilled Nursing Facility (SNF) Consolidated Billing For The Common Working File (CWF) And Medicare Carriers

The coding files for skilled nursing facility consolidated billing will be updated effective January 1, 2004. These updates will appear on the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp on or about December 1, 2003. In order to correctly bill services, physicians, non-physician practitioners, and suppliers should carefully review the revised code files.

Annual Update Of HCPCS Codes Used For Home Health Consolidated Billing Enforcement

I. GENERAL INFORMATION

A. Background:

The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list which are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing. Medicare contractors include fiscal intermediaries (FIs), carriers, and durable medical equipment regional carriers (DMERCs).

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

B. Policy:

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is found in Medicare regulations at 42 CFR 409.100.

C. Code Changes for January 2004 Annual Update, effective for dates of service on or after January 1, 2004:

Added codes:

A4216, A4217, A4248, A4366, A4416, A4417, A4418, A4419, A4420, A4423, A4424, A4425, A4426, A4427, A4428, A4429, A4430, A4431, A4432, A4433, A4434, A4623, A6025, A6407, A6441, A6442, A6443, A6444, A6445, A6446, A6447, A6448, A6449, A6450, A6451, A6452, A6453, A6454, A6455, A6456, A7520, A7521, A7522, A7523, A7524, A7525, A7526, 97755

Deleted codes:

A4319, A4323, A4622, A4712, K0581, K0582, K0583, K0584, K0585, K0586, K0587, K0588, K0589, K0590, K0591, K0592, K0593, K0594, K0595, K0596, K0597, K0621

A complete list of HCPCS codes subject to Home Health Consolidated Billing may be found at the following internet address: www.cms.hhs.gov/providers/hhapps/#billing.

Are Your Claims Being Rejected?

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare *unless* you meet certain "exceptions" described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the guidelines below.

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. The following items from the CMS-1500 form have been identified as the items most likely to be completed inaccurately.

1. Item 1a and 2

The Beneficiary's Medicare number must be entered on the CMS-1500 form to insure proper processing of their claim. Always check the Medicare Insurance Card for beneficiary information.

a. Enter the number from this card in item 1a.
b. Enter the name as shown on this card in item 2.

2. Item 9

This item should only be completed if all of the following are true:

a. You are a participating provider.
b. The beneficiary has a Medigap company as their Medicare supplement.

If the above criteria are met, enter the following in item 9a-d:

a. Enter the word "Medigap", "MG" or "MGAP".
b. Enter either the OCNA number OR the Company name, address, city, state and zip code. A list of Medigap OCNA numbers can be found in the supplier manual, Chapter 7, pages 4-11.
c. Enter the policy number.
d. Item 13 must be signed by the beneficiary.

The claim will only crossover to the Medigap company if all the above criteria are met. Leave item 9 blank if any of the above information is not available.

3. Item 19

Specific information should be entered in item 19 or on an attachment. This includes:

a. A description of items billed using a not otherwise classified code (NOC), or
b. If more than 4 modifiers need to be billed on a line, enter KB for DME upgrades or 99 for other situations to the 4th modifier position in item 24D. Enter the line number and any modifier that the KB or 99 represent in block 19, or
c. Cataract surgery date, or
d. Dates needed for payment on the continuous passive motion (CPM) device.

4. Item 24D

This block should only include procedure codes and modifiers. Any code description or other needed information should be included in item 19 or on an attachment.

5. Item 33

The name and address of the company should be entered in this block. To ensure proper payment always include the provider identification number (PIN) also referred to as the supplier number. Failure to include the correct PIN could result in incorrect payment or the return of your claim.

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.

Remember, beginning October 16, 2003, all claims should be submitted electronically unless you met the criteria for exemption.

Billing Reminder

Proper identification of the beneficiary is essential when billing a claim. Please use the beneficiary's name and Health Insurance Claim Number (HICN) as it appears on the beneficiary's Medicare card. An incorrect or incomplete beneficiary name or HICN can cause delay in claim processing or return of the claim.

Correction To Quarterly Update Of HCPCS Codes Used For Home Health Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) Program Memorandum AB-03-096 listed HCPCS code A4421 as a deleted code from Home Health Consolidated Billing. The CMS has issued Program Memorandum AB-03-136 as notification that this code was deleted in error. Refer to the following Web site for a com-

plete listing of HCPCS codes subject to Home Health Consolidated Billing, http://cms.hhs.gov/providers/hhapps/.

Face Down Positioning Devices

Following vitrectomy and certain other eye surgery procedures, patients are instructed to position themselves with their face down through most of the day. There are certain devices that facilitate this positioning. Examples (not all-inclusive) are a face cushion that is attached to a frame that can rest on a table or be positioned on a bed, or a cushion pad that is attached to a chair-like device. The Centers for Medicare & Medicaid Services (CMS) has confirmed that these devices are statutorily noncovered because they do not fall within a Medicare benefit category.

The face cushion and frame should be coded as A9270 for dates of service prior to January 1, 2004 and as E0190 (positioning cushion/pillow/wedge, any shape or size) for dates of service on or after January 1, 2004. The chair-like device should be coded as A9270.

HCPCS Code Changes & Modifier AX Requirement On New Codes

Effective for dates of service on or after January 1, 2004, the following Healthcare Common Procedure Coding System (HCPCS) code additions, revisions and deletions apply to the Home Dialysis Supplies and Equipment local medical review policy (LMRP):

New HCPCS codes that require modifier AX:

A4216 - Sterile water/saline, 10 ml
A4217 - Sterile water/saline, 500 ml
A4248 - Chlorhexidine containing antiseptic, 1 ml

New HCPCS codes that do not require modifier AX:

A4671 - Disposable cycler set used with cycler dialysis machine, each
A4672 - Drainage extension line, sterile, for dialysis, each
A4673 - Extension line with easy lock connectors, used with dialysis
A4674 - Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz
A4728 - Dialysate solution, non-dextrose containing, 500 ml
E1634 - Peritoneal dialysis clamps, each

Deleted HCPCS Codes:

A4712 - Sterile saline or water 30 cc vial
K0610 - Peritoneal dialysis clamps, each
K0611 - Disposable cycler set used for dialysis, each
K0612 - Drainage extension line, sterile for dialysis, each
K0613 - Extension line with easy lock connectors, used with dialysis
K0614 - Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz

Under the standard grace period, the deleted HCPCS codes (A4712, K0610, K0611, K0612, K0613 and K0614) will continue to be accepted on claim lines with dates of service on or after January 1, 2004 that are received by March 31, 2004. Claim lines billed with dates of service on or after January 1, 2004 that are received on or after April 1, 2004 will be returned as unprocessable or denied as incorrect coding.

Providers are reminded that modifier AX must be used when specified items are furnished in conjunction with home dialysis supplies and equipment. Please refer to the Home Dialysis Supplies and Equipment LMRP for further details.

ICD-9 Coding Issues

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is not responsible for issuing ICD-9 diagnosis codes. Please contact the treating physician or consult an ICD-9 reference book for these codes.

For more information on ICD-9 coding, refer to the Spring 2003 *DMERC Dialogue* article entitled “Diagnosis Codes” (page 7).

New Requirements – Physician’s Order And CMNs For Repairs, Maintenance, Replacement & Delivery

The Centers for Medicare and Medicaid Services (CMS) has updated section 2100.4 through 2100.4.D of the *Medicare Carriers Manual* (MCM). The updates include explanations of repair and replacement and when a Certificate of Medical Necessity (CMN) and/or physician’s order are required. For information concerning claim submission, refer to articles entitled “Repairs/Replacement Chart” (upcoming Fall 2003 *DMERC Dialogue*) and “Billing for Replacement or Repairs of Du-

rable Medical Equipment (DME)" (Summer 2003 *DMERC Dialogue*).

Following is the updated verbiage for sections 2100.4 through 2100.4.D:

"2100.4Repairs, Maintenance, Replacement, and Delivery.— Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program. However, do not pay for repair, maintenance, or replacement of equipment in the frequent and substantial servicing or oxygen equipment payment categories. In addition, payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.

A. Repairs.— To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. However, do not pay for repair of previously denied equipment or equipment in the frequent and substantial servicing or oxygen equipment payment categories. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. (See subsection C where claims for repairs suggest malicious damage or culpable neglect.)

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental, and inexpensive or routinely purchased payment categories which are being rented.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

For replacement items, see Subsection C below.

B. Maintenance.— Routine periodic maintenance, such as testing, cleaning, regulating and checking of the beneficiary's equipment is not covered. Such routine maintenance is generally expected to be done by the owner rather than by a retailer or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered.

However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary. Do not pay for maintenance of purchased items that require frequent and substantial servicing or oxygen equipment. See §5102.2.G.

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for maintenance of rented equipment are generally not covered. Payment may not be made for maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items in §5102.1.E.4.

A new CMN and/or physician's order is not needed for covered maintenance.

C. Replacement.—Replacement refers to the provision of an identical or nearly identical item. Situations involving the provision of a different item because of a change in medical condition are not addressed in this section.

Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but

in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary. (See subsection A.)

Charges for the replacement of oxygen equipment, items that require frequent and substantial servicing or inexpensive or routinely purchased items which are being rented are not covered.

Cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment as discussed in §2100.6 should be investigated and denied where the DMERC/Carrier determines that it is unreasonable to make program payment under the circumstances.

D. Delivery.—Payment for delivery of DME whether rented or purchased is generally included in the fee schedule allowance for the item. See §5105 for the rules that apply to making reimbursement for exceptional cases."

(This information was previously published in the *Medicare Carriers Manual* (MCM). As explained in the article entitled "New Online CMS Manual System" in this issue, this information is now contained in the online CMS Manual System on the Internet, www.cms.hhs.gov/manuals.)

Notification Of Product Changes To The SADMERC

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is responsible for maintaining current and accurate product information. Therefore, if change(s) occur to a product that has undergone the formal Coding Verification Review process, the manufacturer or distributor is responsible for notifying the SADMERC. The following are situations where SADMERC notification is required:

• When a product has been discontinued - The SADMERC must be notified in writing of the discontinuance and the effective date of the discontinuance.

• When a change in the product name occurs - The manufacturer or distributor must notify the SADMERC of the name change and verify that the product itself has not been altered.

• If a manufacturer has sold the product line to another company - This information must be submitted to the SADMERC, along with appropriate documentation that the acquisition has been accomplished.

• If any of the components of a product have been changed - The product must be submitted to the SADMERC for a new verification review to ensure that the product still meets the definition and characteristics of the existing code. If the product change alters the product in such a way that it no longer meets the existing code, then the SADMERC will determine and assign a current code.

For questions, contact the SADMERC Product Review at 803-763-8114.

Knee Orthoses – Locking Mechanisms

Effective for dates of service on or after January 1, 2004, the description of code L2405 is revised as follows:

L2405 - Addition to knee joint, lock; drop, stance or swing phase, each joint

This code includes not only simple drop locks that the patient must lift to unlock the knee but also includes other manual locks, including but not limited to the Becker G-Knee and Becker Load Response Knee, as well as locks that automatically unlock in response to the patient's gait, including but not limited to the Basko (Fillauer) Swing Phase Lock, Becker UTX knee joint, Becker E-Knee, Horton Stance Control Orthotic Knee Joint, and Otto Bock Free Walk knee joint. Code L2999 must not be used to code these knee joints.

Knee Orthoses – New Code And Clarification Of Codes L1832 And L1845

Effective for dates of service on or after January 1, 2004, a new code has been established for a knee orthosis:

L1831 - Knee orthosis, locking joint(s), positional orthosis, prefabricated, includes fitting and adjustment

This code describes a knee orthosis which has double uprights and a locking joint for positioning the knee. This joint locks the knee into a particular position either in flexion or extension. This orthosis is designed for a patient who is nonambulatory. It is typically used to

treat a flexion contracture of the knee. It is important to distinguish this code from two other existing codes for knee orthoses, L1832 and L1845.

Code L1832 describes a prefabricated knee orthosis that has double uprights and adjustable flexion and extension joints. An adjustable flexion and extension joint is one which enables the practitioner to set limits on flexion and extension but allows the patient free motion of the knee within those limits. The joints can be unicentric or polycentric. Medial-lateral control of the knee is accomplished by way of the solid metal (or similar material) structure of the double uprights. It may have condylar pads. This orthosis is designed for a patient who can bear weight on the knee and is capable of some ambulation. It is typically used for early rehabilitation following knee surgery.

Code L1845 describes a prefabricated knee orthosis that has double uprights, condylar pads, and an adjustable flexion and extension joint (as described above) and provides both medial-lateral and rotation control. The joint can be unicentric or polycentric. The function of the joint is to control flexion and extension of the knee joint. Medial-lateral control of the knee is accomplished by the solid metal (or similar material) structure of the double uprights. Rotation control is accomplished by the combination of (1) solid metal (or similar material) in the anterior portion of the thigh and calf cuffs and (2) the condylar pads. Rotation of the knee joint occurs during weight bearing and ambulation. This orthosis is designed for a patient who is fully ambulatory.

Orthoses – Coding – Clarification

Orthoses are described by base codes that represent either prefabricated or custom fabricated braces. There are also codes that describe variations or modifications of base orthoses. These usually begin with the phrase "Addition to." Billing and reimbursement for variation/addition codes is limited to custom fabricated orthoses. If these add-on codes are billed with prefabricated orthoses, they will be denied as not separately payable. Questions concerning whether specific Healthcare Common Procedure Coding System (HCPCS) codes describe prefabricated or custom fabricated orthoses or additions to orthoses should be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Orthoses – Replacement of Components – Clarification

The allowance for a prefabricated orthosis includes all components provided at the time of initial issue including, but not limited to, soft interfaces, straps, and closures. Replacement of components of covered orthoses is covered if the original component is no longer functional (for example, due to wear and cannot be repaired). Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are not covered.

Some replacement items have unique Healthcare Common Procedure Coding System (HCPCS) codes. For example, replacement soft interfaces used with ankle contracture orthoses or foot drop splints are billed with codes L4392 and L4394, respectively. One unit of service of the replacement interface code is covered no more often than once every 6 months. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code – L1499, L2999, or L3999, whichever is applicable. The claim must include a description of the component provided, the reason for replacement, and the HCPCS code or narrative description of the base orthosis. Note: codes L4040-L4055 do not describe replacement soft interfaces used with contracture orthoses. Question concerning the coding of specific items should be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Saline And Water – Code Changes

The following codes will be discontinued effective January 1, 2004. The table shows the local medical review policy(s) (LMRP) in which each code is currently included:

Code	Description	Policy
A4214	Sterile saline or water, 30 cc vial	Suction Pumps
A4319	Sterile water irrigation solution, 1000 ml	Urological Supplies
A4323	Sterile saline irrigation solution, 1000 ml	Suction Pumps, Urological Supplies
A4712	Water, sterile, for injection, per 10 ml	Home Dialysis Supplies and Equipment
A7019	Saline solution, per 10 ml, metered dose dispenser, for use with inhalation drugs	Nebulizers
A7020	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer	Nebulizers

Under the standard grace period, these 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. Claim lines 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. These codes should continue to be used for claims with dates of service prior to January 1, 2004 regardless of the date of claim submission.

Effective for dates of service on or after January 1, 2004, the following new codes have been established for sterile saline or water for uses other than infusion:

A4216 - Sterile water/saline, 10 ml

A4217 - Sterile water/saline, 500ml

When code A4216 or A4217 is used as a dialysis supply, modifier AX must be added to the code. When code A4217 is used as a urological supply, modifier AU must be added to the code. These modifiers are not used when code A4216 or A4217 is used as a suction pump or nebulizer supply.

The following codes, which are included in the Nebulizers LMRP, remain valid:

A7018 - Water, distilled, used with large volume nebulizer, 1000 ml

J7051 - Sterile saline or water, up to 5 cc

These code changes will be incorporated into the relevant LMRPs in a future supplier manual update.

Surgical Dressings Containing Silver

If surgical dressings are impregnated with or otherwise incorporate drugs, coding of the dressing is based on the other materials and features of the product without regard to the drug(s). This same principle is applied to the coding of dressings containing silver. If the other material(s) meet the definition of a dressing (e.g., gauze, foam), the product must be billed using one of those codes. If the other material(s) serve only to deliver silver to the wound and do not meet the definition of a dressing, the product must be billed with code A9270, noncovered item or service. Code A4649 must not be used for silver-containing dressings. Questions concerning the coding of specific products should be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

APPEALS

Helpful Appeal Tips

At CIGNA Medicare, the DMERC Appeals Department does everything possible to effectively process appeal requests from Medicare suppliers and beneficiaries. However, we have found that many requests for appeals cannot be completed due to incomplete or missing information. Below are some helpful tips to assist you with appeal requests:

Review

- There are required elements that must be on every request for review (see *DMERC Dialogue*, Spring 2001). The easiest way to include all of these elements is to complete a Medicare Review Request Form for every review requested. This form can be found on our Web site at www.cignamedicare.com; select Durable Medical Equipment then Resource Center. A copy of the form is also included in the back of this issue.

- Be specific with your request. Please state what you are dissatisfied with and what you would like reviewed. It can be very helpful to include a copy of the remittance notice, as it contains the pertinent information needed to complete a review.

- At the claim filing level, a modifier can be appended to a code that indicates the supplier has the supporting documentation for submitting a claim. At the review level, a modifier is not sufficient. We require that the supporting documentation be sent in with the request.

  Our number one reason for not reversing a claim determination is missing or insufficient documentation. If sufficient documentation is not submitted, we may contact you and request the additional information. It is very important that you submit this information. If you do not submit this information, we will adjudicate the review based on the information submitted.

- Simple corrections to claims can be handled in the Adjustment Department. However, if you are dissatisfied with the claim decision or the denial involves medical necessity, you must request a review.

- A review request must be submitted within 120 days

of the initial determination date of the claim. The initial determination date can be found on the remittance notice.

Hearing

- Hearings must be submitted within 6 months of the date of the review decision letter, Recovery overpayment letter, Benefit Integrity Unit overpayment letter, or Medical Review overpayment letter.
- The amount in controversy for a hearing must be $100 or more.
- Use the attached hearing request form. This form contains all the pertinent information needed to process the hearing request.
- Specify the type of hearing requested: On the Record, Telephone, In Person.
- Include a copy of the remittance advice, the review decision letter, Recovery overpayment letter, Benefit Integrity Unit overpayment letter, or Medical Review overpayment letter.
- Include all supporting documentation that may help justify payment. This helps the process go faster once it gets to a hearing officer.
- Every hearing request receives an acknowledgement letter. This letter is mailed within 21 days of receipt of the hearing request.
- Payment for favorable decisions are processed within 30 days of the Hearing Officer's decision.

Administrative Law Judge (ALJ) Hearing

- ALJ hearings must be submitted within 60 days of the date of the hearing decision letter.
- The amount in controversy for an ALJ hearing must be $100 or more.
- Use the attached ALJ hearing request form. This form contains all the pertinent information needed to process the ALJ hearing request.
- Include a copy of the hearing decision letter.
- Include all supporting documentation that may help justify payment. This helps the process go faster once it gets to the ALJ.
- Every ALJ hearing request receives an acknowledgement letter. This letter is mailed within 21 days of receipt of the ALJ hearing request.
- Payment for favorable decisions are processed within 30 days of receiving the case file from the ALJ.

FEE SCHEDULE

2004 Reasonable Charge Codes

Payment for therapeutic shoes, dialysis equipment and dialysis supplies are made on a reasonable charge basis per regulations contained in 42 CFR §405.501. As part of the development of reasonable charge data, the DMERCs will compute 2004 customary and prevailing charges for the codes identified below using actual charge data from July 1, 2002 through June 30, 2003.

In addition, the DMERCs will compute the Inflation-Indexed Charge (IIC) amounts for 2004. The IIC update factor for 2004 is 2.1 percent.

Please refer to the *DMERC Region D Supplier Manual*, Chapter 12, page 2, for more information on how the reasonable charge is calculated.

Therapeutic Shoes

A5500, A5501, A5503, A5504, A5505, A5506, A5509, A5510, A5511

Dialysis Supplies Billed with AX Modifier

A4244, A4245, A4246, A4247, A4450, A4452, A6250, A6260, A4651, A4652, A4656, A4657, A4660, A4663, A4670, A4712, A4927, A4928, A4930, A4931

Dialysis Supplies Billed without AX Modifier

A4653, A4680, A4690, A4706, A4707, A4708, A4709, A4714, A4719, A4720, A4721, A4722, A4723, A4724, A4725, A4726, A4730, A4736, A4737, A4740, A4750, A4755, A4760, A4765, A4766, A4770, A4771, A4772, A4773, A4774, A4802, A4860, A4870, A4890, A4911, A4918, A4929

Dialysis Equipment Billed with AX Modifier

E0210NU, E1632, E1637, E1639

Dialysis Equipment Billed without AX Modifier

E1500, E1510, E1520, E1530, E1540, E1550, E1560, E1570, E1575, E1580, E1590, E1592, E1594, E1600, E1610, E1615, E1620, E1625, E1630, E1635, E1636

Dialysis Supplies (New Codes Added on January 1, 2004)

A4216AX - Sterile water/saline 10 ml
A4217AX - Sterile water/saline, 500 ml
A4248AX - Chlorhexidine containing antiseptic,1 ml
A4671 - Disposable cycler set used with cycler dialysis machine, each
A4672 - Drainage extension line, sterile, for dialysis, each
A4673 - Extension line with easy lock connectors, used with dialysis
A4674 - Chemicals/antiseptics solution used to clean/ sterilize dialysis equipment, per 8ounces
A4728 - Dialysate solution, non-dextrose containing, 500 ml
E1634 - Peritoneal dialysis clamps, each

Dialysis Codes Deleted as of January 1, 2004

The following codes will be deleted as of January 1, 2004. A three-month grace period will be allowed for the deleted code. Deleted codes received on or after April 1, 2004, with date of service on or after January 1, 2004, will be rejected or denied as incorrect coding.

Deleted Codes	New Crosswalk Codes
A4712	A4216AX
K0610	E1634
K0611	A4671
K0612	A4672
K0613	A4673
K0614	A4674

DMEPOS Fee Schedule Update for 2004

The 1st Quarter 2004 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule is available on our Web site at http://www.cignamedicare.com/dmerc/fsch/ index.html. Fees for the new 2004 HCPCS codes listed below are not yet available; therefore, they are not included in the 1st quarter fee schedule posted on the Web and are not included on the Winter 2004 publications CD-ROM. The 1st quarter fee schedule will be revised to include the new codes and posted on our Web site in mid-December 2003. The 1st Quarter 2004 DMEPOS fee schedule will apply to all claims with dates of service January 1, 2004 through December 31, 2004.

The 2004 fee schedule amounts for code L0486 have been revised as part of the January 2004 DMEPOS fee schedule update.

The 2004 DMEPOS update factor is 2.1 percent for all items except oxygen and oxygen equipment which was not updated. It is possible that the DMEPOS update factors could be changed through the legislative process.

The below list contains the new 2004 HCPCS codes and categories that will be added to the 2004 fee schedule posted in mid-December. Descriptions for the new HCPCS codes are provided in the article entitled "2004 HCPCS Updates" in this issue. Codes listed below fall into one of the following payment categories:

CR = Capped Rental
FS = Frequently Serviced DME
IN = Inexpensive or Routinely Purchased DME
OS = Ostomy, Tracheostomy, or Urological Supply
PO = Prosthetics and Orthotics
SD = Surgical Dressings
SU = DME Supplies

Code	Category	Code	Category
A4216	OS	E1006	IN
A4217	OS	E1007	IN
A4217AU	SU	E1008	IN
A4366	OS	E1009	IN
A4420	OS	E1010	IN
A4423	OS	E1028	IN
A4427	OS	E1029	IN
A4638	IN	E1030	IN
A6407	SD	E2120	CR
A6441	SD	E2201	IN
A6442	SD	E2202	IN
A6443	SD	E2203	IN
A6444	SD	E2204	IN
A6445	SD	E2310	IN
A6446	SD	E2311	IN
A6447	SD	E2320	IN
A6448	SD	E2321	IN
A6449	SD	E2322	IN
A6450	SD	E2323	IN
A6451	SD	E2324	IN
A6452	SD	E2325	IN
A6453	SD	E2326	IN
A6454	SD	E2327	IN
A6455	SD	E2328	IN
A6456	SD	E2329	IN
A7046	IN	E2330	IN
A7520	OS	E2340	IN

Code	Category	Code	Category
A7521	OS	E2341	IN
A7522	OS	E2342	IN
A7524	OS	E2343	IN
A7526	OS	E2351	IN
E0140	IN	L0112	PO
E0300	IN	L0861	PO
E0301	CR	L1831	PO
E0302	CR	L1907	PO
E0637	IN	L1951	PO
E0638	IN	L1971	PO
E0675	CR	L3917	PO
E0955	IN	L8511	PO
E0956	IN	L8512	PO
E0957	IN	L8513	PO
E0960	IN	L8514	PO
E0985	IN	V2762	PO
E0986	IN	V2782	PO
E1002	IN	V2783	PO
E1003	IN	V2784	PO
E1004	IN	V2786	PO
E1005	IN		

HCPCS UPDATES

2004 HCPCS Updates - New, Discontinued And Verbiage Changes

The following new codes are effective for dates of service on or after January 1, 2004. If billed before January 1, 2004, the claim will be returned as unprocessable or denied as an invalid code. The appearance of a HCPCS code in the list below does not necessarily indicate coverage.

New 2004 HCPCS Codes

A4216 - Sterile water/saline, 10 ml
A4217 - Sterile water/saline, 500 ml
A4248 - Chlorhexidine containing antiseptic, 1 ml
A4366 - Ostomy vent, any type, each
A4416 - Ostomy pouch, closed, with barrier attached, with filter (1 piece), each
A4417 - Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each
A4418 - Ostomy pouch, closed; without barrier attached, with filter (1 piece), each
A4419 - Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each
A4420 - Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each
A4423 - Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each
A4424 - Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each
A4425 - Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each
A4426 - Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each
A4427 - Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each
A4428 - Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each
A4429 - Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each
A4430 - Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each
A4431 - Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each
A4432 - Ostomy pouch, urinary; for use on barrier with non locking flange, with faucet-type tap with valve (2 piece), each
A4433 - Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each
A4434 - Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each
A4638 - Replacement battery for patient-owned ear pulse generator, each
A4671 - Disposable cycler set used with cycler dialysis machine, each
A4672 - Drainage extension line, sterile, for dialysis, each
A4673 - Extension line with easy lock connectors, used with dialysis
A4674 - Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 oz
A4728 - Dialysate solution, non-dextrose containing, 500 ml
A6407 - Packing strips, non-impregnated, up to 2 inches in width, per linear yard
A6441 - Padding bandage, non-elastic, non-woven/ non-knitted, width greater than or equal to three inches and less than five inches, per yard
A6442 - Conforming bandage, non-elastic, knitted/ woven, non-sterile, width less than three inches, per yard

A6443 - Conforming bandage, non-elastic, knitted/ woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard
A6444 - Conforming bandage, non-elastic, knitted/ woven, non-sterile, width greater than or equal 5 inches, per yard
A6445 - Conforming bandage, non-elastic, knitted/ woven, sterile, width less than three inches, per yard
A6446 - Conforming bandage, non-elastic, knitted/ woven, sterile, width greater than or equal to three inches and less than five inches, per yard
A6447 - Conforming bandage, non-elastic, knitted/ woven, sterile, width greater than or equal to five inches, per yard
A6448 - Light compression bandage, elastic, knitted/ woven, width less than three inches, per yard
A6449 - Light compression bandage, elastic, knitted/ woven, width greater than or equal to three inches and less than five inches, per yard
A6450 - Light compression bandage, elastic, knitted/ woven, width greater than or equal to five inches, per yard
A6451 - Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches or less than five inches, per yard
A6452 - High compression bandage, elastic, knitted/ woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard
A6453 - Self-adherent bandage, elastic, non-knitted/ non-woven, width less than three inches, per yard
A6454 - Self-adherent bandage, elastic, non-knitted/ non-woven, width greater than or equal to three inches and less than five inches, per yard
A6455 - Self-adherent bandage, elastic, non-knitted/ non-woven, width greater than or equal to five inches, per yard
A6456 - Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
A6550 - Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each
A6551 - Canister set for negative pressure wound therapy electrical pump, stationary or portable, each
A7046 - Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7520 - Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each
A7521 - Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each
A7522 - Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each
A7523 - Tracheostomy shower protector, each
A7524 - Tracheostoma stent/stud/button, each
A7525 - Tracheostomy mask, each
A7526 - Tracheostomy tube collar/holder, each
A9280 - Alert alarm or device, not otherwise classified
A9999 - Miscellaneous DME supply or accessory, not otherwise specified
E0118 - Crutch substitute, lower leg platform, with or without wheels, each
E0140 - Walker, with trunk support, adjustable or fixed height, any type
E0190 - Positioning cushion/pillow/wedge, any shape or size
E0240 - Bath/shower chair, with or without wheels, any size
E0247 - Transfer bench for tub or toilet with or without commode opening
E0248 - Transfer bench, heavy duty, for tub or toilet with or without commode opening
E0300 - Pediatric crib, hospital grade, fully enclosed
E0301 - Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302 - Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303 - Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304 - Hospital bed, extra heavy duty, extra wide, with weight capacity greater 600 pounds, with any type side rails, with mattress
E0470 - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471 - Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

E0472 - Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0561 - Humidifier, non-heated, used with positive airway pressure device
E0562 - Humidifier, heated, used with positive airway pressure device
E0637 - Combination sit to stand system, any size, with seat lift feature, with or without wheels
E0638 - Standing frame system, any size, with or without wheels
E0675 - Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)
E0955 - Wheelchair accessory, headrest, cushioned, prefabricated, including fixed mounting hardware, each
E0956 - Wheelchair accessory, lateral trunk or hip support, prefabricated, including fixed mounting hardware, each
E0957 - Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware, each
E0960 - Wheelchair accessory, shoulder harness/ straps or chest strap, including any type mounting hardware
E0981 - Wheelchair accessory, seat upholstery, replacement only, each
E0982 - Wheelchair accessory, back upholstery, replacement only, each
E0983 - Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control
E0984 - Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control
E0985 - Wheelchair accessory, seat lift mechanism
E0986 - Manual wheelchair accessory, push-rim activated power assist, each
E1002 - Wheelchair accessory, power seating system, tilt only
E1003 - Wheelchair accessory, power seating system, recline only, without shear reduction
E1004 - Wheelchair accessory, power seating system, recline only, with mechanical shear reduction
E1005 - Wheelchair accessory, power seating system, recline only, with power shear reduction
E1006 - Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction
E1007 - Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction
E1008 - Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction
E1009 - Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each
E1010 - Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, each
E1028 - Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E1029 - Wheelchair accessory, ventilator tray, fixed
E1030 - Wheelchair accessory, ventilator tray, gimbaled
E1391 - Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each
E1634 - Peritoneal dialysis clamps, each
E2120 - Pulse generator system for tympanic treatment of inner ear endolymphatic fluid
E2201 - Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches and less than 24 inches
E2202 - Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches
E2203 - Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches
E2204 - Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches
E2300 - Power wheelchair accessory, power seat elevation system
E2301 - Power wheelchair accessory, power standing system
E2310 - Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2311 - Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware
E2320 - Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related

electronics, and fixed mounting hardware
E2321 - Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2322 - Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware
E2323 - Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated
E2324 - Power wheelchair accessory, chin cup for chin control interface
E2325 - Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware
E2326 - Power wheelchair accessory, breath tube kit for sip and puff interface
E2327 - Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware
E2328 - Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware
E2329 - Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2330 - Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware
E2331 - Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
E2340 - Power wheelchair accessory, nonstandard seat frame width, 20-23 inches
E2341 - Power wheelchair accessory, nonstandard seat frame width, 24-27 inches
E2342 - Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches
E2343 - Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches
E2351 - Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface
E2360 - Power wheelchair accessory, 22 NF non-sealed lead acid battery, each
E2361 - Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
E2362 - Power wheelchair accessory, Group 24 non-sealed lead acid battery, each
E2363 - Power wheelchair accessory, Group 24 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
E2364 - Power wheelchair accessory, U-1 non-sealed lead acid battery, each
E2365 - Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat)
E2366 - Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each
E2367 - Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each
E2399 - Power wheelchair accessory, not otherwise classified interface, including all related electronics and any type mounting hardware
E2402 - Negative pressure wound therapy electrical pump, stationary or portable
E2500 - Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502 - Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504 - Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506 - Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508 - Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510 - Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511 - Speech generating software program, for personal computer or personal digital assistant
E2512 - Accessory for speech generating device, mounting system
E2599 - Accessory for speech generating device, not otherwise classified

J0215 - Injection, alefacept, 0.5 mg
J7621 - Albuterol, all formulations, including separated isomers, up to 5 mg (albuterol) or 2.5mg (levalbuterol) and ipratropium bromide, up to 1 mg, compounded inhalation solution, administered through DME
L0112 - Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated
L0861 - Addition to halo procedure, replacement liner/interface material
L1831 - Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1907 - AFO, supramalleolar with straps, with or without interface/pads, custom fabricated
L1951 - Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment
L1971 - Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L3031 - Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/ prepreg composite, each
L3917 - Hand orthosis, metacarpal fracture orthosis, prefabricated, includes fitting and adjustment
L5673 - Addition to lower extremity, below knee/ above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L5679 - Addition to lower extremity, below knee/ above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L5681 - Addition to lower extremity, below knee/ above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)
L5683 - Addition to lower extremity, below knee/ above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679)
L8511 - Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each
L8512 - Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10
L8513 - Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush or equal, replacement only, each
L8514 - Tracheoesophageal puncture dilator, replacement only, each
Q0137 - Injection, darbepoetin alpha, 1 mcg (non-ESRD use)
Q0182 - Dermal and epidermal, tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter
Q4054 - Injection, darbepoetin alpha, 1 mcg (For ESRD on dialysis)
Q4055 - Injection, epoetin alpha, 1,000 units (For ESRD on dialysis)
V2121 - Lenticular lens, per lens, single
V2221 - Lenticular lens, per lens, bifocal
V2321 - Lenticular lens, per lens, trifocal
V2745 - Addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens
V2756 - Eye glass case
V2761 - Mirror coating, any type, solid, gradient or equal, any lens material, per lens
V2762 - Polarization, any lens material, per lens
V2782 - Lens index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
V2783 - Lens index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
V2784 - Lens, polycarbonate or equal, any index, per lens
V2786 - Specialty occupational multifocal lens, per lens
V2797 - Vision supply, accessory and/or services component of another HCPCS vision code

Discontinued Codes and Replacement HCPCS Codes

The following codes will be deleted effective for dates of service on or after January 1, 2004. A three month grace period applies to discontinued HCPCS codes. We will accept claims for the discontinued codes with dates of service on or after January 1, 2004, with dates of receipt on or before March 31, 2004. Discontinued codes received on or after April 1, 2004, with a date of service on or after January 1, 2004 will be returned as unprocessable or denied as an invalid code.

Discontinued Codes with Replacement Codes

Discontinued Deleted Codes	Replacement Crosswalk Codes
A4621	A7525 or A7526
A4622	A7520, A7521,or A7522
K0016	E0973
K0022	E0982
K0025	E0966
K0026	E0982
K0027	E0982
K0028	E1226
K0029	E0981
K0030	E0992
K0031	E0978
K0032	E0981
K0033	E0981
K0035	E0951
K0036	E0952
K0048	E0990
K0049	E0995
K0062	E0967
K0063	E0967
K0079	E0961
K0080	E0974
K0082	E2360
K0083	E2361
K0084	E2362
K0085	E2363
K0086	E2364
K0087	E2365
K0088	E2366
K0089	E2367
K0100	E0959
K0103	E0972
K0107	E0950
K0268	E0561
K0460	E0983
K0461	E0984
K0531	E0562
K0532	E0470
K0533	E0471
K0534	E0472
K0538	E2402
K0539	A6550
K0540	A6551
K0541	E2500
K0543	E2508
K0544	E2510
K0545	E2511
K0546	E2512

Discontinued Deleted Codes	Replacement Crosswalk Codes
K0547	E2599
K0549	E0303
K0550	E0304
K0556	L5673
K0557	L5679
K0558	L5681
K0559	L5683
K0581	A4416
K0582	A4417
K0583	A4418
K0584	A4419
K0585	A4420
K0586	A4423
K0587	A4424
K0588	A4425
K0589	A4426
K0590	A4427
K0591	A4428
K0592	A4429
K0593	A4430
K0594	A4431
K0595	A4432
K0596	A4433
K0597	A4434
K0610	E1634
K0611	A4671
K0612	A4672
K0613	A4673
K0614	A4674
K0615	E2502
K0616	E2504
K0617	E2506
K0621	A6407
L1885	E1810RR
Q2010	J1595
Q4052	J2353
Q9920 – Q9940	Q0137 (Non-ESRD use), Q4055 (ESRD use)
V2116	V2121
V2117	V2121
V2216	V2221
V2217	V2221
V2316	V2321
V2317	V2321
V2740	V2745
V2741	V2745
V2742	V2745
V2743	V2745

Discontinued Codes with no Replacement Codes

A4214	A4319	A4323	A4631	A4712
A6421	A6422	A6424	A6426	A6428
A6430	A6432	A6434	A6436	A6438
A6440	A7019	A7020	E0142	E0145
E0146	E0943	J0151	J1910	J2000
J2352	J7508	K0054	K0055	K0057
K0058	K0542	K0622	K0623	K0624
K0625	K0626	Q4053		

Verbiage Changes for 2004

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2004. Refer to the *DMERC Region D Supplier Manual*, Chapter 16, HCPCS Coding section for the new verbiage.

A4326	A4538	A4623	A6025	E0141
E0143	E0144	E0147	E0149	E0950
E0951	E0952	E0958	E0959	E0961
E0966	E0967	E0972	E0973	E0974
E0978	E0990	E0992	E0995	E1225
E1226	E1390	L1843	L1844	L1950
L2405	L4350	L4360	L4386	L5646
L5648	L5848	L5984	L6620	L6675
L6676	L8658			

MEDICARE SECONDARY PAYER

Medicare Secondary Payer For Beneficiaries Entitled To Medicare Based On Age

Medicare pays secondary to Group Health Plan (GHP) coverage for individuals age 65 or over if the GHP coverage is by virtue of the individual's current employment status or the current employment status of the individual's spouse.

The Medicare secondary provision for individuals entitled to Medicare based on age 65 or over does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than an GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;
- Employees of employers of fewer than 20 employees who are covered by a single employer plan. Members of multi-employer plans, which have been approved by CMS for the "multi-employer exemption", whom the plan identified as employees of employers with fewer than 20 employees;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers of fewer than 20 employees; or
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus a domestic partner cannot be recognized as a spouse.

ELECTRONIC DATA INTERCHANGE (EDI)

Important Information About The EDI Enrollment Form

CIGNA Medicare will now accept a faxed copy of a signed EDI Enrollment form to begin the electronic billing set-up process. **The <u>original, signed EDI Enrollment form</u> must be sent <u>and</u> on file with CIGNA Medicare prior to any production claims being processed and eligible for payment.**

Medicare-Only EDI Enrollment Requirements

A signed CMS Medicare EDI Enrollment form is required whenever claims are sent to Medicare electronically. If a CMS Medicare EDI Enrollment form is on file for a provider/submitter, it is not necessary that a new CMS Medicare EDI Enrollment form be signed as a condition for submission of transactions in the HIPAA-standard format, or that the form be re-signed periodically as a condition for continued use of EDI. Changes such as

going from one format (National Standard Format), to another (ANSI X12N 4010A1) and/or changing billing services/clearinghouses, will not require CIGNA Medicare to obtain re-signed CMS Medicare EDI Enrollment forms.

The full Medicare requirements for EDI and the CMS Medicare EDI Enrollment language may be found in the online manual CMS Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 24, Section 20.1.

You may obtain a copy of the CMS Medicare EDI Enrollment form at *www.cignamedicare.com/edi/dmerc/forms.html*.

New Edits To Come In January 2004

Effective January 2004, diagnosis codes reported in the ANSI 4010 and 4010A1 formats will have a change in formatting requirements. Electronic claims transmitted in these formats will be rejected if received with a diagnosis code containing decimal points. As a reminder, you may send up to eight diagnosis codes per claim, but Medicare only processes the first four diagnoses. If you transmit eight diagnosis codes remember to only point to the first four diagnosis codes.

Claims will be rejected if the Employer Identification Number or the Social Security Number does not contain nine numeric-only characters.

When the ED (Electronic Data Interchange Access Number), FX (facsimile), or TE (telephone number), are transmitted, new edits will also be applied to certain elements of the Submitter EDI Contact Information. The new edits will ensure the elements contain a properly formatted telephone number. Special characters will not be allowed. All ten characters must be numeric and no more than ten digits will be allowed.

Revised NCPDP Companion Document Is Available

The original National Council for Prescription Drugs Program (NCPDP) Companion Document has been revised. You may access the most current NCPDP companion document at http://www.cignamedicare.com/hipaa/ncpcpcompaniondocumentrevision.pdf.

The revised companion document is based on the NCPDP protocol document for submitting retail pharmacy drug claims in the Telecommunication Standard Specifications and Implementation Guide (IG) Version 5.1 and Batch Standard 1.1. It clarifies the DMERC's expectations regarding data submission, processing, and adjudication.

The revisions made to the original companion document sections are as follows:

- NCPDP Implementation and Testing - Cost of NCPDP Implementation Guide - corrected
- NDC - Updated
- General Requirements - Sections 4, 7, 8, 10, 12 updated
- Compound Drugs - Value 11-Immunosuppressive Compounds - added, Section 2 updated
- End Stage Renal Disease - Updated
- Medigap - Updated
- Medicaid - Added
- MSP - Updated
- Partial Fills - Updated
- Prior Authorization Segment - Modifiers for Compound Drugs - added, *(This functionality is currently not available.)*
- DMERC Information Form (DIF) term added

In addition, the following fields have been updated, added or removed:

- Term "Not Used" - removed from table
- Group ID field (301-C1) -updated to accept "XXMEDICAID" when patient has Medicaid coverage and to specify the two position state alpha code. *(This functionality is currently not available.)*
- Plus:

880-K1-updated	880-K7-updated
332-CY-removed	339-8C-removed
336-8C-removed	303-C3-removed
405-D5-updated	498-PC-updated
498-PF-updated	498-PG-updated
498-PJ-updated	307-C7-added
462-EV-added	880-K5-updated
301-C1-updated	498-PM-updated
429-DT-removed	461-EU-removed
412-DC-updated	447-EC-updated
490-UE-updated	498-PB-updated
331-CX-removed	461-EU-updated
524-FO-removed	401-D1-updated
436-E1-updated	405-D5-removed
498-PE-updated	405-EV-removed
498-PH-updated	488-RE-updated

HIPAA

276/277 Companion Document – Now Available

The companion document to the implementation guide for the ANSI X12N 276/277 Health Care Claim Status Request and Response transaction is now available. You may access the companion document at www.cignamedicare.com/hipaa, under Tools and Resources.

This document is intended to serve only as a companion document to the HIPAA ANSI X12N 276/277 implementation guide. The use of this document is solely for the purpose of clarification. The information in this document is subject to change. Changes will be communicated in CIGNA Medicare's newsletters and/or on the CIGNA Medicare Web site at www.cignamedicare.com.

Additional Instructions For HIPAA Implementation Of NDCs

Currently the DMERCs only accept National Drug Codes (NDC) for oral anti-cancer drugs. Under HIPAA, any drug billed in the National Council for Prescription Drug Programs (NCPDP) format will require the National Drug Codes.

In addition:

- All claims for oral anti-cancer drugs must be billed with an NDC (including those claims sent in the ANSI X12N 837 format).
- NDCs other than oral anti-cancer drugs billed in the ANSI X12N 837 format will be rejected.
- Healthcare Common Procedure Coding System (HCPCS) codes must be used in the ANSI X12N 837 format (except for oral anti-cancer drugs billed with NDCs).
- HCPCS codes must be used on paper claims (except for oral anti-cancer drugs.)
- Oral anticancer drugs are always billed with NDCs.

Medicare Announces Plan To Accept HIPAA Non-Compliant Electronic Transactions After October 16 Compliance Deadline

FOR IMMEDIATE RELEASE - CMS Public Affairs Office - September 23, 2003

The Centers for Medicare & Medicaid Services (CMS) announced today that it will implement a contingency plan to accept non-compliant electronic transactions after the October 16, 2003 compliance deadline. This plan will ensure continued processing of claims from thousands of providers who will not be able to meet the deadline and otherwise would have had their Medicare claims rejected.

"*Implementing this contingency plan moves us toward the dual goals of achieving HIPAA compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need*," said CMS Administrator Tom Scully.

CMS made the decision to implement its contingency plan after reviewing statistics showing unacceptably low numbers of compliant claims being submitted.

"*Medicare is able to process HIPAA-compliant transactions*," said Tom Grissom,director of CMS' Center for Medicare Management, *"but we need to work with our trading partners to increase the percentage of claims in production*."

The contingency plan permits CMS to continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete the testing process. CMS will regularly reassess the readiness of its trading partners to determine how long the contingency plan will remain in effect.

The authority to implement a contingency plan was provided by guidance issued by the Health and Human Services (HHS) on July 24. CMS recognized that transactions often require the participation of two covered entities and that non-compliance by one covered entity may put the second covered entity in a difficult position. The guidance stated that covered entities that make a good faith effort to comply with HIPAA transactions and code set standards may implement contingencies to maintain operations and cash flow.

CMS announced its contingency plan on September 11, but at that time had not made a decision on whether the plan would be implemented. Today's announcement means the CMS plan will be implemented on October 16, 2003.

"*We encourage other plans to assess the readiness of their trading partners andimplement contingency plans if appropriate*," Grissom said.

MISCELLANEOUS

2004 Medicare Part B Deductible & Coinsurance Amounts For Beneficiaries

Most Supplementary Medical Insurance (SMI) services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. For 2004 the enrollee's (beneficiary's) Medicare Part B Deductible is $100.00 per year and the coinsurance amount is 20 percent.

The supplier who accepts assignment is precluded from charging the enrollee more than the $100 annual deductible and 20 percent coinsurance amount based on the approved payment amount determination. If dissatisfied with the amount of the Medicare allowed amount, the supplier may request a review.

Biller Purged Reports

Currently all CIGNA DMERC Biller Purged Reports are mailed from the Nashville, Tennessee office. These reports will soon be mailed from our Output Distribution office which is located in Easton, Pennsylvania. The new cover letters that will accompany the reports will have a new format; however, the information will be the same. Additional information regarding biller purged reports is available in the *DMERC Region D Supplier Manual*, Chapter 17.

DMERC Region D Publications

The National Supplier Clearinghouse (NSC) notifies the DMERC of new supplier number issuances. The DMERC mails a new supplier package to the new supplier which includes one hardcopy supplier manual and any applicable manual updates. Local Medical Review Policies (LMRPs) are included in Chapter 9 of the supplier manual. The new supplier will also receive the most current Region D publications CD-ROM that includes the DMEPOS Fee Schedule, current and previous *DMERC Dialogue* issues, Frequently Asked Questions, forms and information concerning HIPAA and EDI. Suppliers should allow approximately two to three weeks after issuance of a supplier number to receive their package.

Region D publications are issued quarterly, at no cost, to all suppliers with valid supplier numbers who have submitted claims in the previous twelve months. Publications are issued on CD-ROM unless the supplier chooses to opt out. Only the hardcopy *DMERC Dialogue* newsletter is mailed to suppliers that opt out. Suppliers may opt out by completing the "Request for CD-ROM Alternative DMERC Region D Publications" form included in this issue or by submitting a written request that includes the information on the form. Requests to opt out may be faxed or mailed as indicated on the form.

Suppliers must notify the NSC of any changes to their application including address changes to ensure they continue receiving Region D publications. (Refer to the article entitled "Reporting Address and Other Changes to the National Supplier Clearinghouse" published in the Summer 2003 *DMERC Dialogue*.)

Additional copies of publications may be obtained at a cost by completing the "DMERC Region D Publication Form" included in this issue. The form and payment must be submitted to the address indicated on the form. Region D also accepts publication orders from non-suppliers.

DMERC Region D publications and all other information included on the publications CD-ROM, including Local Medical Review Policies, may be downloaded from our Web site at http://www.cignamedicare.com/dmerc/.

Guidelines For Skilled Nursing Facility (SNF) Consolidated Billing

This article provides the background, regulations and services included and excluded from consolidated billing. In addition, there are resources for additional information on SNF Consolidated Billing.

Background

Skilled Nursing Facility (SNF) consolidated billing, which was effective for cost reporting periods beginning on or after July 1, 1998, states that SNFs must submit Medicare claims to the fiscal intermediary (FI) for all Part A and Part B services that its residents receive during the course of a covered Part A stay, except for a limited number of specifically excluded services. These ser-

vices must be furnished either directly or under arrangement with outside providers. Section 4432(b) of the Balanced Budget Act of 1997 (BBA, PL 105-33), mandated the exclusion of entire categories of services from SNF consolidated billing. These services are separately billable to the Part B Medicare carrier and include the services of physicians and certain other types of medical practitioners.

Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F), effective on April 1, 2000, enacted a second more targeted set of exclusions for high cost, low probability services within a number of broader service categories (e.g., chemotherapy services) that otherwise remained subject to consolidated billing.

Effective January 1, 2002, Section 313 of the Benefits Improvement and Protection Act restricted SNF consolidated billing to the majority of services provided to patients in a Medicare Part A covered stay and only to physical, occupational, and speech-language therapy services provided to patients in a noncovered stay.

For claims with dates of service on or after April 1, 2001, for those services and supplies that are not specifically excluded by law and furnished to a SNF resident covered under the Part A benefit, physicians must forward the technical portions of any services to the SNF to be billed by the SNF to the FI. The SNF cannot receive additional payment for these technical services and is to pay the physician for the technical portion of the service. Physical, occupational, and speech-language therapy services provided to patients in a non-covered stay must also be forwarded to the SNF to be billed by the SNF to the FI for payment. It is the responsibility of the rendering physician or non- physician practitioner to develop a business relationship with the SNF in order to receive payment from the SNF for services they render that are included in consolidated billing.

Services and Supplies Included in SNF Consolidated Billing

The SNF consolidated billing requirement confers on SNFs the billing responsibility for the entire package of services that residents receive including:

• All services and supplies received during the course of a Part A covered stay (including physical, occupational, and speech-language therapy services), with the exception of statutory exclusions; and

• For SNF residents in noncovered stays (e.g., Part A benefits exhausted or no prior qualifying hospital stay), physical, occupational, and speech-language therapy services.

Services and Supplies Excluded from SNF Consolidated Billing

A. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier:

• The professional component of physician services (see Section 1861(r) of the Social Security Act for the definition of a physician for Medicare purposes) except physical, occupational, and speech-language therapy services;

• Physician assistant services, when a physician assistant is working under a physician's supervision;

• Nurse practitioner services, when a nurse practitioner is working in collaboration with a physician;

• Clinical nurse specialists, when a clinical nurse specialist is working in collaboration with a physician;

• Certified mid-wife services;

• Qualified psychologist services; and

• Certified registered nurse anesthetist services.

NOTE: Physical, occupational, and speech-language therapy services included in SNF consolidated billing are subject to SNF consolidated billing regardless of who provides them, even if the services that type of practitioner normally provides are excluded from SNF consolidated billing.

B. The following are excluded from SNF consolidated billing and the institutional or technical component must be billed separately to the Medicare FI:

• The following services furnished on an outpatient basis by a hospital or critical access hospital (CAH):

- Cardiac catheterization services;
- Computerized axial tomography scans;
- Magnetic resonance imaging;
- Ambulatory surgery involving the use of an operating room;
- Radiation therapy;
- Emergency services;
- Angiography;
- Lymphatic and venous procedures; and
- Ambulance services furnished in connection with any of the above outpatient hospital services.

• Maintenance dialysis received in a Renal Dialysis Facility by an End Stage Renal Disease patient;

• Certain dialysis-related services including covered ambulance transportation to obtain dialysis services;

• Erythropoietin for certain dialysis patients when given along with dialysis; and

• Hospice care related to a patient's terminal condition;

C. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier or FI, as appropriate:

• Ambulance trips that transport a patient to the SNF for initial admission or from the SNF following a final discharge (see below for additional ambulance services information);

• Services to risk based HMO enrollees; and

• The following services for residents in a Part A covered stay (only certain services in these categories are excluded):

- Certain chemotherapy drugs;
- Certain chemotherapy administrative services;
- Certain radioisotope services; and
- Certain customized prosthetic devices.

Facilities Included in SNF Consolidated Billing

• Medicare participating SNFs, including Medicare-certified distinct part SNFs and swing beds in all hospitals except CAHs.

Facilities Excluded from SNF Consolidated Billing

• Nursing homes that have no Medicare certification (e.g., do not participate at all in either the Medicare or Medicaid program);

• Nursing homes that exclusively participate only in the Medicaid program as a nursing facility;

• The non-participating portion of a nursing home that also contains a Medicare-certified distinct part SNF; and

• Swing beds in CAHs.

Professional and Technical Components of Diagnostic Tests

The professional component, or the physician's interpretation of a diagnostic test, is considered a physician service and is separately billable to the Medicare carrier. The technical component, or the diagnostic test itself, is considered a diagnostic test and is subject to consolidated billing. As an example, for diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service. The technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to the Medicare FI by the SNF and is included in the SNF consolidated billing payment for covered Part A stays. Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would look to the SNF, rather than Part B, for payment.

Ambulance Services

Except for specific exclusions, SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a Part A stay. In most cases, ambulance trips are excluded from SNF consolidated billing when the covered Part A stay has ended, at which time the ambulance company must bill the Medicare carrier or FI directly for payment. The specific circumstances under which a patient may receive ambulance services that are covered by Medicare but excluded from SNF consolidated billing are:

• A medically necessary ambulance trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services;

• A medically necessary ambulance trip after a formal discharge or other departure from the SNF, **unless** the patient is readmitted or returns to that or another SNF before midnight of the same day;

• An ambulance trip to receive dialysis or dialysis-related services;

• An ambulance trip for an inpatient admission to a Medicare participating hospital or CAH; and

• After discharge from a SNF, a medically necessary ambulance trip to the patient's home where he/she will receive services from a Medicare participating home health agency under a plan of care.

NOTE: A patient's transfer from one SNF to another before midnight of the same day is not excluded from SNF consolidated billing. The first SNF is responsible for the ambulance services.

SNF Consolidated Billing Information Resources

• Consolidated Billing Web Site www.cms.hhs.gov/medlearn/snfcode.asp

- General SNF consolidated billing information.
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing).
- Therapy codes that must be consolidated in a non-covered stay.
- All code lists are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

• Program Memorandums www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

- Transmittal AB-03-094 dated July 3, 2003
- Transmittal AB-02-175 dated December 13, 2002
- Transmittal A-02-118 dated November 8, 2002

1) Updated codes for exclusions
2) SNF Help File
   a) HCPCS codes included in the SNF Part A payment.
   b) Codes that may be paid and on what basis to a SNF by the FI under Part B.

- Transmittal AB-02-038 dated March 27, 2002

• The SNF Help File will be available on a new CMS web site in the near future.

• Medicare Carriers Manual Part 3, Section 4210

Medicare + Choice Organizations And Hospice Election

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b).

A. Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an M+CO to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

B. Billing of Covered Services

M + C organizations may bill the Medicare carrier for non-hospice services provided to M + C enrollees who elect hospice benefits. These claims should be submitted with a GW (for services not related to the terminal condition) modifier as applicable. Carriers process these claims in accordance with regular claims processing rules.

Any covered Medicare services not related to the treatment of the terminal hospice condition, and which are furnished during a hospice election period, may be billed by the rendering provider to the Fiscal Intermediary (FI) or carrier for non-hospice Medicare payment. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition" when submitted to a carrier. Contractors process services coded with the GW modifier in the normal manner for coverage and payment determinations. If warranted, contractors may conduct prepayment development or post payment review to validate that services billed with the GW modifier are not related to the patient's terminal condition.

Medicare Program Integrity Manual Revised

The Medicare *Program Integrity Manual* (PIM) contains instructions from the Centers for Medicare & Medicaid Services (CMS) for contractor Medical Review, Benefit Integrity and Local Provider Education and Training programs. Six revisions have been published since the publication deadline of the Fall 2003 Region D *DMERC Dialogue*.

• Transmittal 48, released September 12, 2003, deletes the instruction that an item denied as not meeting the beneit category is not appealable by the supplier. The effective/implementation date is

10/1/03.

- Transmittal 49, released September 26, 2003, revises Chapter 3, Section 4.2.C, Denial Notices, to change the use of remittance advice code N109 from mandatory to contractor's discretion. It is effective October 10, 2003.

- Transmittal 50, released September 26, 2003, revises Chapter 5, Section 7.4, Instructions for Processing ADMC Requests, by instructing DMERCs to review medical documentation as well as the beneficiary claims history when processing Advance Determination of Medicare Coverage (ADMC) requests. It is effective October 10, 2003.
- Transmittal 52, released October 10, 2003, revises Chapter 7, Section 8, Report of Benefit Savings (RBS), to include the FY 2004 conversion factors, medical review codes, and categories. It requires Fiscal Intermediaries to use the FY 2004 conversion factors (found in the Program Integrity Manual, Chapter 7, Section 10) to determine Medicare Part A workload savings, in order to accommodate changes in home health and skilled nursing facility rates. It is effective October 1, 2003 and has an implementation date of January 1, 2004.

- Transmittal 53, released October 31, 2003, adds Section 5.1.1.C to Chapter 3, Prepayment Edits, to communicate initial requirements to shared systems and carriers so that beneficiaries will be notified as to the specific LMRP number(s) and/or NCD number(s) associated with their claim denial for Part B services. It is effective April 1, 2004 and has an implementation date of April 5, 2004.

- Transmittal 54, released October 31, 2003, revises Chapter 3, section 4.2.C, Denial Notices, to communicate initial requirements to shared systems and carriers so that beneficiaries will be notified as to the specific negotiated NCD number(s) associated with their claim denial for Part B services. It is effective April 1, 2004 and has an implementation date of April 5, 2004.

This manual is available on the Internet, HTML format. To access the PIM, go to http://www.cms.gov/manuals/PIM. CMS does not publish hard copies of this manual.

New Online CMS Manual System

Beginning October 1, 2003, CMS will transition from a paper-based manual system to a Web-based system. The process includes the streamlining, updating, and consolidating of CMS' various program instructions into an electronic Web-based manual system for all users. The new system is called the online CMS Manual System and is located at http://www.cms.hhs.gov/manuals.

The new online CMS Manual System will be organized by functional area, (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The functional orientation of the new manual will eliminate significant redundancy within the manuals and will streamline the updating process, thus making CMS program instructions available in a more timely and accessible fashion.

Specifically, the CMS Manual System will include the following functional areas:

Pub. 100-01—Medicare General Information, Eligibility, and Entitlement
Pub. 100-02—Medicare Benefit Policy
Pub. 100-03—Medicare National Coverage Determinations
Pub. 100-04—Medicare Claims Processing
Pub. 100-05—Medicare Secondary Payer
Pub. 100-06—Medicare Financial Management
Pub. 100-07—Medicare State Operations
Pub. 100-08—Medicare Program Integrity
Pub. 100-09—Medicare Contractor Beneficiary and Provider Communications
Pub. 100-10—Medicare Quality Improvement Organization
Pub. 100-11—Reserved
Pub. 100-12—State Medicaid
Pub. 100-13—Medicaid State Children's Health Insurance Program
Pub. 100-14—Medicare End Stage Renal Disease Network Organization
Pub. 100-15—Medicare State Buy-In
Pub. 100-16—Medicare Managed Care
Pub. 100-17—Medicare Business Partners Systems Security
Pub. 100-18—Medicare Business Partners Security Oversight
Pub. 100-19—Demonstrations
Pub. 100-20—One-Time Notification

Based on the reorganization of the CMS manuals, Region D will be updating previous publication references in all correspondence and the supplier manual. References in local medical review policies (LMRPs) will be updated as policies are revised.

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.

Claims Crossover Process Transition To Consolidated Contractor

CMS has decided to streamline the claims crossover process to better serve our customers. The claims crossover process provides for complementary insurers to receive claims payment information from Medicare contractors based on eligibility files they provide or on claims information (Medigap) that you submit as part of your claim to Medicare.

Medicare complementary insurers (i.e., non-Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans—collectively known as coordination of benefit (COB) trading partners—that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare contractors. Each COB trading partner will now enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC). Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers nor receive numerous crossover files. Medicare contractors will be testing the implementation of the new process over the next several months. The expected date for the phased-approach transition of this workload to the COB Contractor is between April 2004 and October 2004. The complementary insurer eligibility file based transfers will be the first workload in the transition.

CMS will provide generic Medicare Summary Notice (MSN) and Remittance Advice (RA) messages for claims transmitted to the COBC for crossover purposes and we will keep you informed of the changes to the current process. You will continue to contact the Medicare carrier Customer Service department for your questions about an individual's crossover status.

Please watch for future communication regarding this change.

Electronic Funds Transfer (EFT)

New Authorization Agreement For Electronic Funds Transfer Application

The Authorization Agreement For Electronic Funds Transfer (Form CMS-588 [09/03]) application has been revised to include privacy act information. This will help ensure that the information provided to us will be used to authorize electronic funds transfers from our bank to yours.

When the completed EFT Authorization form is submitted to CIGNA Medicare, electronic payments will begin within 10-15 business days assuming all information is accurate and complete.

Enroll in the EFT program by using the new form on the following page and available at www.cignamedicare.com/eft and on the CMS Web site at www.cms.hhs.gov/forms/cms588.pdf. The older forms will no be longer be accepted after January 1, 2004.

Stop waiting for your check to arrive in the mail - CIGNA Medicare can deposit your claims' payment for you!

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* ___ ___ ___ ___ ___ ___ ___ ___ ___

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature_____Date_____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Frequently Asked Questions

1. When the doctor's office is completing Section B of a Certificate of Medical Necessity (CMN), the nurse is completing the questions, the CMN is then sent to the medical records department for ICD-9 coding. Should the signatures of both people that complete portions of Section B be on the CMN or will one signature be sufficient?

   ANSWER: The back of the CMN says, "Name of Person Answering Section B Questions: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicted.

   The only person who fills out this information in Section B is the person who answers the questions.

2. The initial and recertification Certificate of Medical Necessity (CMN) were obtained by a prior company. There are corrections on the recertification CMN that were not initialed and dated by the physician. The company has been acquired. If the acquiring company obtained a revised CMN with initial, recertification and revised dates all listed on the top, would that CMN suffice as the recertification and revised CMN in an audit?

   ANSWER: This revised CMN will cover claims submitted from the time the CMN was corrected and forward but not claims submitted prior to the date the CMN was corrected. The CMN is a legal document and any changes made after it is signed by the treating physician must be initialed and dated by the treating physician before the claim is submitted. As instructed on the back of the CMN, when submitting a revised or recertified CMN, be sure to always furnish the initial date as well as the revised or recertification date.

3. If a patient has a Continuous Positive Airway Pressure (CPAP) device purchased by a commercial insurance, and the patient now has Medicare as their primary and is in need of replacement supplies, must the patient qualify under current CPAP guidelines (along with proof that the patient is still using the device) in order to append the modifier KX?

   ANSWER: The patient must meet the criteria in the current version of the local medical review policy (LMRP) for CPAP replacement supplies to be covered. There does not need to be a new sleep study, unless the old study does not have the information necessary to comply with the current requirements.

4. Most times, the old sleep studies were not interpreted by breaking down the information as to whether the patient's total sleep time off CPAP was a minimum of two hours and what the Apnea Hypopnea Index (AHI) was in those two hours. If we must prove that the patient qualifies under current CPAP guidelines, in some cases, repeat initial sleep studies will have to be scheduled, correct?

   ANSWER: Even before the new coverage criteria for CPAP were implemented, most sleep studies included an interpretation and documented the time the patient went to sleep and when the therapy with the device was initiated (split night study). In cases where the initial sleep study did not include information needed to show that the coverage criteria in the revised LMRP are met, the supplier may submit the claim with additional documentation and without the modifier KX for individual consideration. Otherwise a new sleep study may be performed to obtain the required documentation.

5. The initial and recertification CMN for oxygen was obtained by a prior company. The recertification CMN did not have the testing facility information completed. The company is now acquired. Acquiring company obtains a revised CMN with the testing facility completed. Will that stand up in an audit?

   ANSWER: It will stand up for claims from the revision date forward but not for previous claims. The CMN that was in the file at the time that the claims were billed should match what was submitted electronically.

Frequently Asked Questions (cont'd)

6. How does the acquiring company protect themselves on post-payment audits when the CMN on record with the DMERC contain problems? Would the acquiring provider need to submit the corrected CMNs? If so, can they be submitted electronically? Can both a recertification and revised CMN be submitted at the same time?

   ANSWER: The acquiring provider can verify the information with the physician and have a corrected CMN in the file but they cannot submit a recertification or revised CMN at the same time. There are numerous legal mechanisms to mitigate liability in the acquisition process. You should consult with an attorney knowledgeable in these types of transactions.

   If the information on the hard copy CMN does not match the information that was submitted electronically or is missing information, there is nothing that can be done to protect claims that were already paid but the purchasing supplier can get a revised or corrected CMN from the treating physician that will cover the claims from the revision or correction date and forward.

7. Could you please define the initial date on a Certificate of Medical Necessity?

   ANSWER: The "Initial Date" found in Section A of the CMN, is either the specific date that the treating physician gives as the start of medical necessity or, if the physician does not give a specific start date, the "Initial Date" is the date of the order. (CMS Pub. 100-08, Chapter 5 Section 1.1.4.2)

8. My patient has a portable oxygen system, the doctor has added a stationary system for this patient, is a new blood gas study required?

   ANSWER: For a patient with a portable oxygen system for whom a stationary oxygen system is subsequently added, the supplier must obtain a revised CMN but a new blood gas study is not required.

9. Are Certificates of Medical Necessity (CMNs) required for repairs?

   ANSWER: The chart on repair and replacement published in the Fall 2003 Region D *DMERC Dialogue*, pages 13 and 14, shows when new CMNs or orders are needed and when the original CMN or order will be adequate for repairing or replacing durable medical equipment.

10. What is the difference between a verbal order and a written order?

    ANSWER: Suppliers may dispense most items of DMEPOS based on a verbal order (except those items requiring a written order prior to delivery) from the treating physician. Suppliers must maintain documentation of the verbal order and this documentation must be available upon request.

    The verbal order must contain all the following elements:

    - Description of the item
    - Name of the beneficiary
    - Name of the physician
    - Start date of the order

    For any DMEPOS item to be covered by Medicare, the supplier must have a written order that has been both signed and dated by the treating physician before submitting a claim for the item to the DMERC. Written orders may take the form of a photocopy, facsimile image, electronically maintained or original "pen and ink" document.

Frequently Asked Questions (cont'd)

The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed. Medicare will not cover a DMEPOS item if the supplier only has a verbal order at the time that the claim is submitted.

Written orders for all items must include the following elements:

- Beneficiary's name and full address
- Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number
- All options or additional features which will be separately billed or which will require an upgraded code
- Signature of the treating physician and the date that the order is signed. Both the signature and date must be personally entered by the physician and may not be a stamp or other substitute.

Certain items require one or more of the following additional elements in the written order:

- For accessories or supplies that will be provided on a periodic basis:
  - o Quantity used
  - o Specific frequency of change or use - "as needed" or "prn" orders are not acceptable
  - o Length of need
    - Example: An order for surgical dressings might specify one 4" x 4" hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals.

- For drugs:
  - o Name of the drug
  - o Concentration (if applicable)
  - o Dosage
  - o Frequency of administration
  - o Route of administration
  - o Duration of infusion (if applicable)

- For orthoses:
  - o If a custom-fabricated orthosis is ordered by the physician, this must be clearly indicated on the written order that has been signed and dated by the treating physician. If the DMERC requests to see the order for a custom-fabricated orthosis and the order is not sufficiently specific, the claim may be denied or may be paid comparable to a prefabricated orthosis.

- Initial date:
  - o If the order is for an item that has been dispensed before the date that the detailed written order is signed (e.g., a written confirmation of a verbal order), then the order must clearly specify the initial date of need.

- Length of need:
  - o If the coverage criteria in a policy specify length of need; or,
  - o If the order is for a rental item.

- Diagnosis, if appropriate or required by policy or provider-specific mandate.

- Medical necessity information (e.g., an ICD-9 diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.), if appropriate or required by policy.

- Explanation of how the item(s) is to be used, if appropriate or required by policy.

Frequently Asked Questions (cont'd)

Although it is acceptable to submit a claim based on a facsimile image, electronically maintained or photo-copied order, it will be the supplier's responsibility to prove the authenticity/validity of the claim(s) under investigation. Suppliers must ensure the security and integrity of all electronically maintained orders and/or CMNs in accordance with any regulations published by CMS.

The detailed description of the item may be completed by someone other than the physician. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. Signature or date stamps are not allowed.

11. What date does the supplier list as a recertification date when a Group I oxygen patient who has been ordered oxygen for less than lifetime is not retested within 30 days of their recertification date?

    ANSWER: For a Group I patient with a less than lifetime length of need who is not retested within 30 days of their re-certification date, the initial date should be the date of the qualifying test. (This answer is a correction to the response provided for question 3 in the Frequently Asked Questions published in the Fall 2003 *DMERC Dialogue*.)

Completion of Medicare Certificates of Medical Necessity

Dear Physician:

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

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

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

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

Sincerely,

Robert D. Hoover, Jr., MD, MPH
Durable Medical Equipment Regional Carrier
Medical Director

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Filing The Request For Payment

The following text was previously published in the *Medicare Carriers Manual* (MCM). As explained in the article entitled "New Online CMS Manual System" in this issue, this information is now contained in the online CMS Manual System on the Internet, www.cms.hhs.gov/manuals.

"FILING THE REQUEST FOR PAYMENT - 3000. DEFINITION OF A CLAIM - A claim is a writing, identifying or permitting the identification of an enrollee, which requests payment for what appears to be Part B medical or other health services furnished by a physician or supplier. (See §5240, in MCM, Part 2 concerning process controls on claims.)

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

Under this definition, the following do not constitute claims:

- A claims form not containing sufficient information to permit you to identify the enrollee;

- Bills or claims forms referring only to services unrelated to medical or other health services;

- A writing not contained on a claims form and not accompanied by an itemized bill which does not permit you to identify the enrollee and to determine that the medical or other health services were apparently performed by a physician or supplier: and

- Claims forms, or that portion of a claims form, requesting a payment or coverage determination for services that are not within your claims processing jurisdiction (e.g., misdirected claims/services). Handle misdirected claims/services in accordance with §§3110 and 4267.1, as appropriate.

Under the foregoing definition, the following are examples of claims requiring control:

- A claim form containing full identifying information;

- A claim form giving sufficient information for basing requests for further identifying information;

- Bills for medical or other health services which permit you to identify the enrollee and to determine that the services for which you have claims processing jurisdiction were apparently performed by a physician or supplier. The bills need not be accompanied by a claim form. (See §3040.1.); and

- A writing not on a claims form or on a bill which requests payment, which permits identification of the enrollee, and which permits you to determine that the medical or other health services in question and for which you have claims processing jurisdiction were apparently performed by a physician or supplier. See §§33ll and 33l9 for the procedures where additional evidence or information is needed to complete the claim.

3. In Accordance with CMS Instructions.—CMS instructions for submitting claims to Medicare are contained in Chapter III, Claims, Filing, Jurisdiction and Development Procedures of the Medicare Carriers Manual (MCM), these instruction are supplemented by Program Memoranda which are published on the CMS Web site and are generally incorporated into the MCM within one year of publication. In order for a request for payment to be considered to have been filed timely in accordance with CMS instructions, the claim must not be considered to be unprocessable under the definition of an unprocessable claim found in MCM, Part 3, §§3005ff.

3000.1 CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES - Carriers use different processes for handling unprocessable claims. Some carrier's claims processing systems suspend and develop claims considered unprocessable because of incomplete or invalid information. Note that developed claims are not considered clean claims, and no Claims Processing Timeliness (CPT) interest is payable. If the corrections for a suspended claim are received by the carrier within the suspense period, the claim is considered to be timely, even if the corrections are submitted after the timely filing period has closed, provided the claim was filed timely. Other carrier's claims processing systems return unprocessable claims to the submitter, but do not suspend and develop to allow for corrections. Such returned requests for payment, do not constitute claims nor satisfy the timely filing requirement. In those instances, a processable claim that conforms to the requirements of MCM Part 3, §3005 as a minimum must be resubmitted within the timely filing period.

3000.1Splitting Claims for Processing.—There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

• Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs):
Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned "from" and "to" dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the "from" date, since that is the date when the item was furnished.

• A claim other than a DMERC claim that spans two calendar years where the "from" date of service is untimely but the "to" date of service is timely should be split and processed as follows:

1. Where the number of services on the claim is evenly divisible by the number of days spanned, assume that the number of services for each day is equal. Determine the number of services per day by dividing the number of services by the number of days spanned. Then split the claim into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

2. Where the number of services on the claim is not evenly divisible by the number of days spanned and it is not otherwise possible to determine from the claim the dates of services, suspend and develop the claim in order to determine the dates of services. After determining the dates of services, split the claim accordingly into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

• A claim containing both assigned and unassigned charges. Split assigned and unassigned services from non-participating physicians/suppliers into separate assigned and unassigned claims for workload counts and processing;

• Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). (See §§3060ff.) Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the services have reassigned their benefits in accordance with §§3060ff., process all of the services as a single claim;

• A claim where there is more than one beneficiary on a single claim. There can only be one beneficiary per claim; and

NOTE:Roster bills for covered immunization services furnished by mass immunizers may be submitted for mul

tiple beneficiaries. You must create individual claims for each Medicare beneficiary based on the roster bill information.

• Outpatient physical therapy services furnished on a cost basis by a physician-directed clinic cannot be processed when combined on the same claim with other charge-related services by the clinic. Process the cost related services as a separate claim.

If an unassigned claim includes services by an independent physical therapist together with other physician services, process the physical therapy services as a separate claim. Process an assigned claim from an independent physical therapist as a single claim.

• A claim that is a duplicate of a claim previously denied is treated as a new claim if there is no indication that the claim is a resubmittal of a previous claim with additional information, or there is no indication on the second claim that the beneficiary is protesting the previous determination.

• In a claim containing services from physicians/suppliers covering more than one carrier jurisdiction, the carrier receiving the claim must split off the services to be forwarded to another contractor and count the material within the local jurisdiction as a claim. The carrier receiving the transferred material must also count it as a separate claim.

• When services in a claim by the same physician/supplier can be identified as being both second/third opinion services and services not related to second/third opinion, the "opinion" services must be split off from the "non-opinion" services and counted as a separate claim. When one physician/supplier in an unassigned claim has provided the "opinion" service and another physician(s)/supplier(s) has provided the "non-opinion" services, the claim may not be split.

• Claims containing any combination of the following types of services must be split to process each type of service as a separate claim. These services are: Physical therapy by an independent practitioner, outpatient psychiatric, or any services paid at l00 percent of reasonable charges.

Any of these types of services may be combined on the same claim with any other type of service.

Do not deviate from defining claims as described above. Split claims in accordance with the appropriate definition. Throughout the claims process count each of the separate claims, resulting from the split, as an individual claim. See §§13310ff. for instructions on reporting claims.

3000.2Replicating Claims for Processing.—There are no prescribed reasons other than those listed in §3000.l for splitting claims and for counting additional claims into your workload. However, claims are frequently split for other reasons that are dictated by the systems or the methods of processing them. Such additional claims are labeled "Replicate Claims." Tally and report all replicate claims (claims created for any reasons other than those listed in §3000.l) separately. Identify replicate claims and report them in the appropriate categories for claims. (See §§l33l0ff.) Some examples of replicate claims are:

• Additional claims created because of a line item limitation (regardless of the methodology used for coding line items);

• Extra claims created in making partial payments;

• Claims created for carving out individual specialty types of services or for any other occurrence that is not provided for in §3000.l, e.g., unassigned claims containing both services of a podiatrist and services of a physician; and

• Extra claims created to apply special payment reductions (e.g., Gramm-Rudmann-Hollings) efficiently for applicable dates of service.

NOTE:For budget requests and cost reports (CMS-I524, CMS-I528, CMS-I6I6, and CMS-2599), the workload must exclude the number of replicate claims produced.

3001. FILING PART B CLAIMS FOR PHYSICIANS' AND SUPPLIERS' SERVICES

A. Methods of Claiming Benefits.—The method of claiming Part B benefits depends upon whether the patient is claiming payment or is assigning benefit payments to his/her source of medical treatment or services.

B. Itemized Claims by Patient.—As a rule, beneficiaries do not submit claims for reimbursement. However, if there is reason for a beneficiary to submit a claim for reimbursement, the beneficiary uses the Form CMS-1490S. For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit in accordance with SSA §1848(g)(4)(A) all Part B claims whether assigned or unassigned for beneficiaries who desire Medicare benefit payment determinations.

C. Assignment Method.—The physician/supplier (or the facility or organization to which the physician may reassign benefits (§§3060 - 3060.3)) claims the payment. The patient or his representative agrees to assign the benefits and the physician/supplier agreeing to the assignment accepts the Medicare reasonable charge determination as the full charge for the services. (See §§3045ff. about specific assignment procedures and the nature and effect of assignments.)

3002. CLAIMS FORMS - A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

• The reason or need for such reproduction;

• The intended user of the form;

• The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);

• The type of automatic data processing machinery, if any, for which the form is designed; and

• Estimates of printing quantity, cost per thousand, and annual usage.

NOTE:This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. Carriers, physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the American Medical Association.

A. General.—The Form CMS-I490 was formerly the basic Part B claims form. It was replaced by the Form CMS-I500 for claims completed by physicians and suppliers (except ambulance suppliers), and the Form CMS-I490S for claims from beneficiaries. You must, however, continue to accept and process claims received on the Form

CMS-1490 form after conversion to the Form CMS-I500 and Form CMS-I490S.

B. Form CMS-1500 (Health Insurance Claim Form).—Sometimes referred to as the AMA form, the Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. Instructions for completing Form CMS-1500 for Medicare claims are in §§4020ff.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

C. Form CMS-1490S (Patient's Request for Medicare Payment).—This form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so or if one of the situations in §7563 applies. Inasmuch as the Form CMS-1490S has no provision for an ICD-9 code, the ICD-9 code is not required at the time of claim submission.

D. Form CMS-I49l (Request for Medicare Payment-Ambulance).—This form used by suppliers of ambulance services for claiming this Part B benefit payment. The ambulance supplier uses this form to claim assigned Part B benefits or, when filing an unassigned claim for ambulance services.

For services furnished prior to September 1, 1990, if the ambulance supplier does not accept assignment or does not complete and submit the patient's claim, all essential data required on the Form CMS-I49l should be entered on the supplier's itemized statement to the patient.

Honor claims from ambulance suppliers that are submitted on forms other than the Form CMS-1491, (e.g. CMS-1500). Suppliers using the CMS-I49l may avoid delay in receiving payment as the Form CMS-I490 and Form CMS-1500 do not include all required information and further development may be necessary.

E. Form CMS-I490U.—Used by the entities listed in §7065.2 under the indirect payment provision. It contains a certification by the organization requesting payment that the conditions in §7065 are met. Make payment on the basis of a claim filed on this form only if the organization has paid the physician or supplier in full. (See §§4260 and 4265 for billing instructions.)

F. Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A Carrier).—Used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers. (See §4255 for billing instructions.)

3003. ACCEPTABILITY OF PHOTOCOPIES - Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration.

3004. TIME LIMITATION ON FILING PART B REASONABLE CHARGE AND FEE SCHEDULE CLAIMS

A. General.—Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished, except as follows:

- The time limit on filing claims for service furnished in the last 3 months of a year is the same as if the services

had been furnished in the subsequent year. Thus, the time limit on filing claims for services furnished in the last 3 months of the year is December 31 of the second year following the year in which the services were rendered.

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, Federal non-workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday. (See §4015.) Also note that a claim received by the contractor more than one year after the service has been rendered is subject to a 10 percent reduction. (Refer to MCM Part 3, §3041 and §7560).

EXAMPLE: An enrollee received surgery in August 2000. He must file a claim for payment for such services on or before December 31, 2001. Note also that a service provided in October 2000, must be filed on or before December 31, 2002.

The table that follows illustrates the timely filing limit for dates of service in each calendar month.

Table: Usual Time Limit

Date of service in:	Jan	Feb	Mar	Apr	May	June
Timely filing date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Months to file *	23	22	21	20	19	18

Date of service in:	July	Aug	Sep	Oct	Nov	Dec
Timely filing date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Months to file *	17	16	15	26	25	24

*The number specified in "Months to file" represents the number of full months remaining after the month in which the service was rendered.

See §3004.1 for the effect of administrative errors of SSA, CMS, intermediaries or carriers.

B. Provider Has Billed Improperly for Professional Component.—In some cases, a hospital or other provider may have incorrectly billed for a Part B professional component as a provider expense. For example, this might occur when physicians' services were erroneously considered entirely administrative in nature and the error might be discovered in connection with the final cost settlement. Where such billings have been filed with a Part A intermediary within the time limit, this establishes protective filing for a subsequent filing of a Part B claim.

Such claims will be considered filed timely as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., the Form CMS-1490S and itemized bill) is submitted within 6 months after the month in which the claimant is advised to furnish it or within the usual time limit, whichever is later.

The perfected claim may be filed by the physician on the basis of an assignment, or by the hospital (where the hospital has a contractual arrangement to bill and receive payment for the physician's services) or by the patient on the basis of an itemized bill. You and the intermediary should make your own arrangements regarding exchange of information and submission of the delayed claims. When there is more than one claim, it is preferable that they be submitted as a group.

A provider claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and hospital could not agree on the exact amount of the component charge or who would bill for it.

C. Penalty for Filing Claims After One Year (Effective September 1, 1990).—Section 1848(g)(4) of the Social Security Act requires that physicians and suppliers complete and submit Part B claims for medical services, equipment and supplies (furnished on or after September 1, 1990) within 12 months of the service date. Only assigned claims submitted more than 12 months after the service date will be subject to a 10 percent reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier 12 months or longer after the service is furnished, shall be reduced by 10 percent from the amount that would have otherwise been paid.

3004.1Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error.—Medicare law extends the time limitation for filing claims payable on a reasonable charge basis, if:

- The failure to submit the claim within the timeframes specified in §3004.A. was due to "administrative error" (i.e., misrepresentation, delay, mistake or other action) of an officer, employee, FI, carrier, or agent of the DHHS performing functions under the Medicare program, and acting within the scope of his/her authority; and

- The claim is filed promptly (see subsection B for definition) after the "error" is corrected.

The time limit provided by the law has been adequate for the great majority of claims. However, potential claimants (enrollees, their representatives or assignees) have failed to file timely claims due to an administrative error. For example, in some unusual cases the failure was caused by misinformation from an official source, a delay in establishing SMI entitlement, or some administrative action which appeared to be correct on the basis of information available at the time, but resulted in delaying the filing of a claim.

An extension of the time limits in §3004.A. applies only if the delay resulted primarily from some administrative error. The fact that the enrollee was "without fault" or otherwise showed "good cause" for his failure to submit a claim timely is not a basis for extending the time limits, in the absence of administrative error.

Relief may be given in any case which comes to light in the normal routine of work provided it meets the criteria outlined in subsection A. Neither you nor SSA will conduct a search for such claims.

A. When Delay Will Be Considered the Result of Administrative Error.—Situations in which failure to file within the normal time limit specified in §3004.A. will be considered to have been caused by administrative error include, but are not limited to, the following:

- The failure resulted from SSA's delay in establishing the individual's entitlement to SMI until many months after SMI coverage was effective. Until the enrollee's name is entered on the SMI rolls, he has no basis for claiming SMI benefits, since any SMI benefit claims made would have been disallowed;

- The failure to file resulted from SSA's failure to notify the individual that his enrollment application had been approved, or in giving him (or his representative or assignee) cause to believe that he was not entitled to SMI;

- The failure resulted from misinformation from you or SSA, e.g., that certain services were not covered under SMI

although in fact, they were covered; or

• Because of a policy or other issue, you advise the physician or supplier to hold his claims until further notice Filing The Request For Payment (cont'd)

and do not advise him timely to resume submitting them.

Submit any claim with a recommendation before payment involving situations other than those listed above in which it appears that an extension of the time limit might be justified on the basis of administrative error to your Regional Office for a particular situation. If the issue has a national implication the Regional Office will refer the matter to the Central Office.

B. Extension of Time Limit — Definition of "Filed Promptly".—Where failure to file a claim within the usual time limit results from an administrative error, the claim will be deemed filed promptly and timely if it is filed within 6 calendar months following the month in which the error is corrected. A claimant always has at least 6 calendar months after the month of correction in which to file. Correction of the error less than 6 full calendar months before expiration of the usual time limit will warrant an extension of time for the remainder of the 6 months.

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1989-September 1989, filed in March 1991, shows that the enrollee's request for enrollment in SMI was initially denied. He/she was first notified on January 15, 1991, that he/she had SMI effective May 1989. Under these circumstances, pay appropriate SMI benefits for the services. Although the usual time limit expired December 31, 1990, the error in this case - delay in establishing SMI entitlement - was not corrected until January 15, 1991, thus extending the time limit to July 31, 1991.

EXAMPLE 2: An individual requested enrollment in SMI in March 1989, the month before he attained age 65. He/she received covered services in July 1989, but filed no claim because he/she had received no notice of his/her SMI entitlement. Such notice was mailed to him/her on October 3, 1990. Although the regular time limit for the services in July 1989, expired on December 31, 1990, the claim will be considered promptly and timely filed if it is filed on or before April 30, 1991 (within the 6-month period following the month in which the notice was sent).

C. Basis for Initiating Development of Administrative Error.—Consider extending the time limit only if there is some reasonable basis for concluding that the claimant (the enrollee or his/her representative or assignee) was prevented from timely filing by administrative error, e.g., he/she states that official misinformation has caused late filing, or the Social Security office calls to your attention a situation in which such an error has caused late filing. Do not routinely initiate development for such a possibility. Make no search for possible administrative cause for delay in filing among cases previously denied because of the time limit. If a previously denied claim containing such an allegation or other basis for inferring such error comes to your attention, reexamine the case.

D. Evidence Necessary to Honor Late Claims.—Where administrative error is alleged to be responsible for late filing, the necessary evidence ordinarily includes:

• A statement from the claimant, his/her representative, or assignee regarding the nature and affect of the error, how he/she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed; and

• One of the following:

- A written report by the agency or other responsible party (SSA, CMS), based on its own records, describing how its error caused failure to file within the usual time limit;
- Copies of an official letter or written notice reflecting the error; or
- A written statement of an agency employee having personal knowledge of the error.

However, the statement of the claimant is not essential if the other evidence establishes that his failure to file within the usual time limit resulted from administrative error, and that he filed a claim within 6 months after the

month in which he was notified that the fault was corrected. There must be a clear and direct relationship between the administrative error and the late filing of the claim. Where the evidence is in the carrier's own records, it should annotate the claims file to this effect.

E. Responsibility for Decision on Extension of Time Limit.—The carrier has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The carrier will ordinarily accept a statement from some other component which shows that there was (not) error, as a result of which the claimant could reasonably have been prevented or deterred from filing his claim within the usual time limit. Similarly, the carrier will ordinarily accept a statement from the component which corrected the error as to whether and when this was done. However, where information submitted to the carrier by another component involved in SMI administration is incomplete or questionable, the carrier may request clarification. (See F below.)

F. Coordination of Development With Social Security Administration Carriers and Other Intermediaries.—Where the initial allegation of administrative error on the part of the Government is made to SSA, the servicing SSO will forward any necessary report, statement, and/or other evidence to the carrier.

There may be situations in which the enrollee still owes for services during a period for which the time limit has expired and it is clear that an extension of the time limit will apply on the basis of administrative error if a claim is now filed promptly. If the enrollee wishes to assign the claim and the enrollee or the SSO believes that the physician (or supplier) may be willing to accept assignment, the SSO will give the enrollee a report of the kind described above for the physician to attach to the assigned claim, and (when necessary) call the physician's office to explain both the time limit and the need for prompt filing of the claim.

If an allegation of administrative error by the SSA is made to the carrier or if the information furnished by the SSO is incomplete, the carrier will request the necessary evidence (see D above), from the SSO servicing the enrollee. Such request may be made on Form SSA-l980-Carrier or Intermediary Request for SSA Assistance (see §3999, Exhibit 7) and, unless RO instructions provide otherwise, will be made through the parallel SSO. Where allegedly another carrier or intermediary is involved in the delay, the request for and the furnishing of necessary information and evidence may be made by letter.

G. Statement of Intent (SOI). The purpose of an SOI is to extend the timely filing period for the submission of an initial claim. An SOI by itself does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. Detailed instructions regarding the submission requirements for SOIs are described in Medicare Program Memorandum Transmittal AB-03-061 dated May 2, 2003.

3004.2Time Limitation on Claims for Outpatient Physical Therapy or Speech Pathology Services Furnished by Clinic Providers.— Effective with respect to claims filed after December 3l, l974, claims for payment for services reimbursable on a reasonable cost basis are subject to the same limitation as claims for payments for services reimbursable on a reasonable charge basis (including a charge-related-to-cost basis). (The only Medicare claims for payments reimbursable strictly on a reasonable cost basis under the carriers' jurisdiction are those relating to outpatient physical therapy or speech pathology services furnished by clinic providers. There was no time limit on filing for such services for claims submitted before January l, l9975.) Most of the provisions in §§ 3004-3004.l concerning the time limitation are also applicable to reasonable cost claims. However, in the case of services reimbursable on a reasonable cost basis, administrative error of SSA or its agents will not ordinarily extend the time limit beyond the close of the third year following year in which the services were furnished (deeming services furnished in the last quarter of the year to have been furnished in the following year). Claims in which administrative error prevents timely payment until after the close of the third year following the year in which the services were furnished (fourth year, in the case of services furnished in the October-December quarter) should be submitted to the address shown in the last paragraph of § 3004.l for advice before a denial action. (See §§ 4l60ff. for billing for outpatient physical therapy services.)

EXAMPLE: Mr. G. receives outpatient physical therapy services on 0l/05/75 at Clinic X, a participating provider. For reimbursement for these services, the claim must be submitted to the carrier no later than l2/3l/76. If the services were furnished on l0/l5/75, the services would be deemed to be furnished in l976, and the claim would

have to be submitted by l2/3l/77. If the services were furnished on l0/l5/72, the claim must have been submitted by l2/3l/74, the effective date of the time limit. If administrative error prevents the claim for services furnished on l0/l5/72 from being filed until after l976, the fourth year after the fourth quarter of l972, the case should be submitted to BHI for advice.

If an enrollee request for payment is filed with the provider timely (or would have been filed timely had the provider taken action to obtain a request from a patient whom the provider knew or had good reason to believe was an enrollee) but the provider does not file a timely claim, the provider may not charge him for the services except for such deductible and/or coinsurance amounts and noncovered services as would be appropriate if Medicare payment were made."

Guidelines For Filing Paper Claims

**** Failure to follow these guidelines could cause a delay in processing, denial of the claim, or affect payment accuracy. ****

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless you meet certain "exceptions" described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the following guidelines.

1. Do not submit black CMS-1500 forms. This includes submitting copies or carbon copies. Always submit a RED CMS-1500 form.

2. Do not write or stamp information in RED ink. Information in red will not show up on the image and will not be available during processing.

3. Do not use light print or a Dot Matrix printer which causes broken lines. Check to make sure the ink is dark. Also, laser or inkjet printers are preferred.

4. Do not use small font type and size. For best processing results we recommend font type Lucida Console and size 10.

5. Do not use handwriting. It may be too light or simply unrecognizable.

6. Do not highlight items on the CMS-1500 form or attachments. This will cause the claim to be illegible which slows down the processing of the claim.

7. Do not use stamps or stickers within the body of the claim. If you must use a stamp or sticker, put it at the top of the claim within the blank area.

8. Do not leave block 11 blank. If no primary insurance exists, put NONE in the field.

9. Do not use extra verbiage within the body of the claim. If you must put extra verbiage on the claim, use block 19 or an attachment.

10. Do not put a description next to the diagnosis code in block 21. All that is needed is the ICD-9 alpha/numeric diagnosis code.

11. Do not submit more than four diagnosis codes within block 21.

12. Do not submit more than one diagnosis pointer in block 24e. Only the first pointer will be used for processing.

13. Do not submit more than six service lines within block 24.

14. Do not put a description of the procedure codes or times/units underneath the line item in blocks 24a – 24k. It is not needed and may cause processing errors.

15. Do not place the number of units/days in block 24g too close to the charges in 24f. This may cause the units/days to be read as a part of the submitted charges and the number of units/days to default to 1. Right justifying the days/units in block 24g will give more space between the two fields.

16. Do not put a phone number on the first line of block 33. Submit the phone number below the provider's name and address.

Guidelines For Filing Paper Claims (cont'd)

17. Do not omit the zip code in block 33. This block is used as the mailing address when a claim is returned.

18. Do not change the size of EOBs or copy them across to two pages. This may cause your EOB to be illegible.

19. Submit claims to P.O. Box 690 only.

As an alternative to paper claims, you may want to consider Electronic Media Claims (EMC). Electronic billers receive faster payment, save on postage, and have less paper shuffle, saving valuable time. For more information, contact our EDI department at 1-866-224-3094.

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 processsed 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
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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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CD-ROM 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.

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DMERC
REGION D

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FAX BACK SURVEY

NEW! CIGNA Medicare Project

CIGNA HealthCare Medicare Administration (CIGNA Medicare) is soliciting feedback from the provider/supplier community regarding an initiative it is considering implementing later this year. Your feedback and comments will help us determine whether or not the project will be feasible.

CIGNA Medicare is considering implementing a Fax-Back service, where providers/suppliers can call a toll-free phone number, request the documents, articles, and forms they need, and have them automatically faxed to their office free of charge. All providers/suppliers would receive an index of documents, articles, and forms, divided by specialty, on a quarterly basis from which to make their choices. This index would also be available on the CIGNA Medicare Web site.

In order to determine potential demand for these features, we are asking providers/suppliers to fill out the brief survey below and return it to CIGNA Medicare via fax or mail:

CIGNA HealthCare Medicare Administration
Communications - Fax-Back Survey
Two Vantage Way, Nashville, TN 37228
Fax: 615.782.4445

We appreciate your time, effort, and feedback on this potential service at CIGNA Medicare.

DMERC Fax Back Questionnaire

If articles from regular publications (DMERC Dialogue, EDI Manuals, etc.) and forms were available via a Fax-Back service at no cost to you, how likely would you be to utilize this feature?

- ○ Very Likely
- ○ Somewhat Likely
- ○ Neutral
- ○ Somewhat Unlikely
- ○ Extremely Unlikely

If you are likely to utilize a Fax-Back service for articles and forms, how often do you think you would use this service on a monthly basis?

- ○ 15+ times
- ○ 10-15 times
- ○ 5-10 times
- ○ Less than 5 times

With several options currently available, how do you primarily receive information and news from CIGNA Medicare?

- ○ Web site/ListServ notices
- ○ CD-ROM
- ○ Print Publications

How would you prefer to receive information from CIGNA Medicare?

- ○ Web site
- ○ CD-ROM
- ○ Print Publications
- ○ Fax-Back

How many publications do you think you would have faxed to you on a monthly basis?

- ○ 10+ documents
- ○ 5-10 documents
- ○ Less than 5 documents

Please share your comments regarding the proposed Fax-Back service:

_____

_____

_____

Note: *Fax-Back Survey is also available online at:*
http://www.cignamedicare.com/medicare_dynamic/survey/faxback/dmerc/form.asp

CIGNA HealthCare Medicare Administration

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DMERC

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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

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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.

CIGNA Medicare does not review or control the content and accuracy of Web sites referenced in this newsletter (except the CIGNA Medicare Web site) and is therefore not responsible for their content and accuracy.