Spring

DMERC Dialogue

April 2003 | **DMERC Region D** | **General Release 03-2**

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

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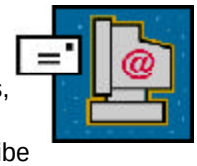

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From the Medical Director...

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Support Surfaces – Lessons Learned

CIGNA Medicare's Medical Review staff recently conducted a Progressive Corrective Action widespread probe review involving group 2 support surfaces (HCPCS Codes E0193, E0277, E0371, E0372 and E0373). Coverage, coding and documentation guidelines for these devices are found in the Pressure Reducing Support Surfaces – Group 2 local medical review policy (LMRP).

This review was prompted by data indicating that the utilization of support surfaces in Region D has increased over the past several years, rising 32% by paid amount from 1999 to 2002. In addition, we wished to examine a sample of claims to determine if there were distinguishing factors associated with support surfaces ordered for patients with and without a diagnosis of decubitus ulcer (ICD-9 code 707.0). One hundred claims were selected from the universe of initial rental month claims paid between the dates of April 1, 2002 and August 31, 2002. This encompassed 100 beneficiaries and 75 unique suppliers. Most of the claims in the sample were for code E0277 (powered pressure-reducing air mattress). The results of this review revealed that 78% of the claims in the sample did not meet Medicare coverage criteria for a group 2 support surface. The following points summarize the types of errors found and emphasize the rules and regulations regarding the billing of group 2 support surfaces.

1. Support Surfaces for Prevention: Group 2 support surfaces are not covered for decubitus ulcer prevention, beneficiaries who only have stage I pressure ulcers or beneficiaries with ulcers located just on the extremities. In order to qualify for coverage, the beneficiary must actually have stage II-IV decubitus ulcers on the trunk or pelvis.

2. Location and Number of Ulcers: One stage II decubitus ulcer on the trunk or pelvis does not meet coverage criteria. Group 2 support surface LMRP criterion

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Support Surfaces - Lessons Learned (cont'd)

one states that there must be **multiple** stage II pressure ulcers located on the trunk or pelvis.

3. Trial of Conservative Therapy: LMRP criterion two specifies that a comprehensive ulcer treatment program must be at least one month (not less than 30 days). The comprehensive ulcer treatment program must include documented use of a group 1 support surface for a minimum of one month (at least 30 days) immediately prior to beginning group 2 therapy. This criterion applies to patients attempting to qualify for the treatment of multiple stage II ulcers.

4. Size of Ulcer: While one stage III or IV pressure ulcer on the trunk or pelvis can qualify a beneficiary for group 2 support surface coverage, coverage criterion four states that this must be a "large ulcer". The carrier, when reviewing medical records, generally considers any wound of 8 square centimeters (length x width) or more as meeting the definition of "large". Individual patient circumstances, however, are weighed. We also take into account whether undermining and/or tunneling are present, the anatomic location on the body and the size of the patient.

5. Statement of Ordering Physician: Suppliers are required to obtain information concerning which coverage criteria the beneficiary meets and obtain a signed and dated statement from the treating physician. Suppliers should not use the Support Surface Certificate of Medical Necessity (CMN); rather, the carrier encourages suppliers to use the Group 2 Support Surface Statement of Ordering Physician (SOP). The Support Surface CMN is only intended for group 3 support surfaces and does not contain all the information required to determine if beneficiaries meet group 2 coverage criteria.

6. Source of Medical Documentation: The medical information on the Statement of Ordering Physician cannot be completed by suppliers or anyone in a financial relationship with a supplier. Additionally, suppliers should ascertain that actual medical records exist that support the information on the SOP. Suppliers are not required to keep copies of these medical records in the beneficiary's file but must, if requested by the carrier, be able to supply them in a timely manner upon request.

7. Written Order Prior to Delivery: Suppliers must have a written signed and dated order prior to delivering a group 2 support surface. If the supplier delivers the item prior to receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage (*Medicare Carriers Manual,* Section 5102.2D).

Although not encompassed by the timelines for this probe review, effective for dates of service on or after April 1, 2003, claims without a written order prior to delivery must append modifier EY (No physician or other health care provider order for this item or service) to the HCPCS code.

8. Orders Must be Complete and Sufficiently Detailed: The written order should contain sufficient detail to establish that the ordering physician's intent is to prescribe a group 2 support surface. For example, an order that simply states "air mattress" or "pressure pad" can be interpreted to mean a variety of group 1 or group

2 products. It should also be noted that the Statement of Ordering Physician example in the *DMERC Region D Supplier Manual* cannot, as printed, serve as a substitute for a written order. If a supplier chooses to use this form as a written order, modifications are required to make sure all elements of a detailed written order are included.

9. Continued Use for Capped Rental Items: Suppliers are strongly encouraged to perform monthly beneficiary status checks in order to lessen the chance of billing for a date of service that does not meet Medicare coverage criteria. Suppliers should make certain that the beneficiary is still using the mattress and has not been moved to a noncovered place of service (acute care hospital, SNF, etc.) or died. If the beneficiary is not in a covered place of service on the usual date of service billed, claim submissions should be discontinued until the day the beneficiary returns to a covered place of service and resumes use of the device. Additionally, if suppliers have knowledge that payment was received for a date of service not meeting coverage criteria, it is their responsibility to voluntarily refund the money.

10. Use After Wound is Healed: Continued use of a group 2 support surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management. Once the wound is healed, group 2 support surfaces are no longer covered.

Finally, a significant number of suppliers failed to provide medical records (35%). Although the purpose of these wide-spread error validation probe reviews is to gather information about claims payment errors and educational topics, they do fall under post-payment review activities and are subject to overpayment recoupment. Suppliers are strongly encouraged to respond to record requests from the DMERC in a timely manner when notified of a provider review.

MEDICAL POLICY

CPAP And Respiratory Assist Devices – Apnea/Hypopnea Index

Changes in the Continuous Positive Airway Pressure (CPAP) and Respiratory Assist Devices local medical review policies (LMRPs), effective July 1, 2002, represented significant liberalizations in the criteria for qualification for these devices when used in the treatment of obstructive sleep apnea. However, based upon inquiries from suppliers, there are several basic points that merit emphasis.

The Apnea/Hypopnea Index (AHI) refers to the average number of apneas and hypopneas per hour and must be based on a minimum of 2 hours of sleep off a positive pressure device, recorded by polysomnography using actual recorded hours of sleep. The definition for apnea and hypopnea are included in the policies. Leg movement, snoring, respiratory event related arousals (RERAs), and other sleep disturbances that may be included by some polysomnographic facilities are not considered to meet the AHI definition in the LMRPs. Some facilities use the term Respiratory Disturbance Index (RDI) to describe a calculation that includes these other sleep disturbances. For that reason, the term RDI is being removed from the two policies. Claims for items based upon an index that does not score apneas and hypopneas separately from other sleep disturbance events, will be denied as not medically necessary. Only an Apnea/Hypopnea Index as defined in the policy and that meets coverage criteria qualifies for use of a KX modifier.

Polysomnography studies often take the form of split night studies in which a diagnostic portion of the study with the patient not on any device is followed by a therapeutic portion of the study in which a CPAP device is used to determine the response to treatment and to help select optimal pressure settings. Qualification for a CPAP device must be calculated based on a minimum of 2 hours of sleep without a device being worn. In other words, there must be a minimum of 2 hours of recorded sleep off CPAP in order to calculate the AHI and make the diagnosis of obstructive sleep apnea. The AHI may not be extrapolated or projected.

If the date of service (DOS) is for the fourth month or after in the capped rental cycle, compliance information must be obtained. For CPAP devices, this requirement was effective with the effective date of the policy, July 1, 2002, and applies to all beneficiaries on a CPAP device as of that date. Should suppliers choose to obtain this information via telephone, suppliers must document, at a minimum, the date of the call and to whom they spoke. For respiratory assist devices (RADs), the compliance requirements differ significantly from those for CPAP devices. Refer to the RAD policy for information on coverage criteria and documentation requirements for those devices.

Suppliers are reminded that polysomnographic studies must be performed in a facility based sleep study laboratory. These facilities must be qualified suppliers of

Medicare services, or a hospital certified to do such tests and must comply with all applicable state regulatory requirements. Durable Medical Equipment suppliers may NOT perform the sleep studies.

Functional Electrical Stimulation (FES) – New Coverage And Coding

Effective for dates of service on or after April 1, 2003, the Centers for Medicare & Medicaid Services (CMS) has issued a National Coverage Determination (NCD) establishing coverage for functional electrical stimulation (FES) to enable spinal cord injured (SCI) patients to walk. *Coverage Issues Manual* (CIM), Section 35-77, has been revised to reflect the new NCD. Details of the NCD can be found at http://www.cms.hhs.gov/coverage/.

FES is a technique that uses electrical impulses to activate paralyzed or weak muscles in precise sequence. The FES device transmits these electrical impulses via surface electrodes in the same manner as neuromuscular electrical stimulation (NMES). For example, through selective and sequential stimulation of various lower extremity muscle groups, FES can enable spinal cord injured (SCI) patients to walk.

Coverage of NMES (other than FES) to treat muscle atrophy is limited to the treatment of patients with disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and other non-neurological reasons for disuse atrophy. There has been no change in coverage criteria when NMES is used to treat disuse atrophy.

Coverage of FES

Medicare will consider coverage of FES for SCI patients who have completed a training program consisting of at least 32 physical therapy sessions with the device, over a period of 3 months.

Coverage for FES to enhance walking will be limited to SCI patients with an ICD-9 diagnosis of 344.1 (paraplegia – paralysis of both lower limbs) and with all of the following characteristics:

1) Persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve); and,

2) Persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently; and,

3) Persons that demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction; and,

4) Persons that possess high motivation, commitment and cognitive ability to use such devices for walking; and,

5) Persons that can transfer independently and can demonstrate standing independently for at least 3 minutes; and,

6) Persons that can demonstrate hand and finger function to manipulate controls; and,

7) Persons with at least 6-month post recovery spinal cord injury and restorative surgery; and,

8) Persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and,

9) Persons who have demonstrated a willingness to use the device long-term.

FES to enhance walking for SCI patients will not be covered for SCI patients with any of the following:

1) presence of cardiac pacemakers;
2) severe scoliosis or severe osteoporosis;
3) irreversible contracture;
4) autonomic dysreflexia; or
5) skin disease or cancer at area of stimulation.

Indications for FES other than to enable SCI patients to walk will be denied as not medically necessary.

Coding of FES

For dates of service on or after April 1, 2003, a new HCPCS code must be used when billing for FES:

K0600 - Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program

Note that code K0600 represents the "entire system" for the FES device. Therefore, individual components such as walkers, crutches or other supplies must not be billed separately.

One such device meeting the definition of code K0600 is the Parastep I System, manufactured by Sigmedics, Inc. Manufacturers or suppliers should contact the

SADMERC for guidance on whether a particular device meets the definition of this HCPCS code.

K0600 must not be used for dates of service prior to April 1, 2003. Use HCPCS code E1399 and submit documentation of the manufacturer, name, model and description of the device being billed, and how it is being used. Claims for FES for dates of service prior to April 1, 2003 will be denied as not medically necessary.

Documentation of FES

For this item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DMERC. This order must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request. If the supplier bills for this item without first receiving the completed order, the item will be denied as not medically necessary. Items billed to the DMERC before a signed and dated order has been received by the supplier must be submitted with an EY modifier (No physician or other health care provider order for this item or service) added to each affected HCPCS code.

For dates of service on or after April 1, 2003, if all the above criteria for coverage are met, HCPCS code K0600 must be billed with a KX modifier (Specific required documentation on file). If ICD-9 diagnosis code 344.1 is applicable, it must be added to the claim. If all the coverage criteria listed above are not present, a KX modifier must not be added to the code.

Please refer to the Supplier Manual for more information on orders, medical records, and supplier documentation.

Home Blood Glucose Monitors - Coverage Issues Manual Update

The *Coverage Issues Manual* (CIM) § 60-11 has been updated to implement the National Coverage Determination (NCD) for home blood glucose monitors under §1862(a)(1)(A) and §1861(n) of the Social Security Act (the Act). This NCD is a technical correction to §60-11 that changes one condition for coverage from insulin-treated diabetes to diabetes. This section of the CIM is a NCD under §1869(f)(1)(B) of the Act. The NCDs are binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256(b), a NCD that expands coverage is also binding on a Medicare + Choice Organization. In addition, an administrative law judge may not review a NCD (see §1869(f)(1)(A)(I) of the Act). This CIM revision was published on November 29, 2002; there is no effective date. Transmittal 163, Change Request 2445, can be found on the CMS Web site at http://www.cms.gov/manuals/pm_trans/R163CIM.pdf. See also Chapter 10 of the *DMERC Region D Supplier Manual*.

Local Medical Review Policy Revisions - Medicare Policy Database

The Centers for Medicare & Medicaid Services (CMS) has mandated that the Local Medical Review Policies (LMRPs) for all contractors be put into a standard format that can be incorporated into a Web-based national database. As a result, all of the DMERC policies have been revised and are replacing the existing policies. The newly revised policies will have an effective date of April 1, 2003. As part of this revision, additions, changes, and deletions of HCPCS codes and modifiers that were included in the 2003 HCPCS Update have been incorporated into the policies.

The changes made to each policy are indicated in a section titled Revision History Explanation. This section provides detailed information on the changes that have been made. Suppliers are encouraged to review this section in each policy. Selected changes from some of the policies are presented in articles either in the January 2003 Region D *DMERC Dialogue* or in this bulletin. Medical policies will continue to be posted on the Region D DMERC Web site (www.cignamedicare.com/dmerc).

The Medicare National Coverage Database can be found at http://cms.hhs.gov/coverage/. Included in this database are National Coverage Determinations, National Coverage Analyses, and Local Medical Review Policies from the DMERCs, local carriers, fiscal intermediaries, and Regional Home Health Intermediaries (RHHIs). Though the policies for all the DMERCs are currently included in the database, the transition of policies from the other contractors is not yet complete. CMS expects to have the policies of all contractors transitioned by late spring 2003. A future enhancement will incorporate bulletin articles into this searchable database.

The new database allows users to search policies for single contractors or multiple contractors. When entering the Geographical Area of the search, selecting any state in Region D will result in the same policy being displayed. Users can search by key words in the entire document or just in the title or by HCPCS code. Users

can also search by contractor type and effective date of the policy. When searching by effective date, the only policies that are included in the database are the policies with effective dates of April 1, 2003, and the policies which were in effect immediately prior to those revisions.

Respiratory Assist Devices – Lessons Learned

CIGNA Medicare recently completed a Progressive Corrective Action widespread probe of HCPCS code K0533 (Respiratory assist device, bi-level pressure capability, with backup rate feature). Coverage, coding and documentation guidelines for this device are found in the Respiratory Assist Device (RAD) local medical review policy (LMRP).

This code was selected for review because the policy was recently introduced and enough time has passed to allow CIGNA Medicare to assess compliance with the policy requirements. Specifically, the policy includes the use of the ZX (now KX) modifier when required documentation is on file. Part of the purpose of the probe was to determine if this documentation was maintained by the supplier. The probe encompassed 100 claims from 79 unique suppliers for dates of service from January 1, 2001 through June 30, 2001. The following points address the 10 most common errors found in this review.

1. "Grandfathered Beneficiaries" and Use of KX Modifier: Suppliers billing claims for beneficiaries who began using the device prior to October 1, 1999, are reminded that they should not use the KX (formerly ZX) modifier unless their files include completed and signed Beneficiary and Physician statements. This applies to patients in Groups I-III. A KX modifier must not be added to claims for a K0533 used to treat Group IV patients (obstructive sleep apnea). (Also see #10)

2. KX Modifier: The KX modifier indicates that all the criteria for coverage and payment in Groups I, II or III have been met. After the first three months of coverage, the requirements include completed and signed Beneficiary and Physician statements. If these statements are not in the supplier's files in time for submission of the fourth or succeeding months' claims, the supplier may still submit the claims, but a KX modifier must not be added. The supplier can alternately choose to hold claims for the fourth and succeeding months until the completed and signed forms are obtained. Then, according to the Coverage and Payment Rules section of the RAD LMRP, claims may then be submitted with the KX modifier, assuming the answers indicate continued compliant use of and benefit from the therapy.

3. K0532 Trial: A K0533 device is not covered for the first two months of therapy for beneficiaries in Group II (severe chronic obstructive pulmonary disease). Group II beneficiaries must first compliantly use a K0532 device for a minimum of 60 days.

4. Diagnostic Tests: The supplier's file should contain copies of any diagnostic tests (sleep studies, blood gas studies, pulmonary function tests, etc.) that support that the beneficiary meets coverage and payment requirements in one of the qualifying groups. The supplier must make these results available to the carrier upon request. Also, someone other than the supplier must perform the qualifying test(s).

5. Restrictive Thoracic Disorders: Restrictive Thoracic Disorders and Restrictive Lung Diseases (pulmonary fibrosis, etc.) are not synonymous. To qualify under Group I, the beneficiary must suffer from a progressive neuromuscular condition such as amyotrophic lateral sclerosis, or post-polio syndrome or have a severe thoracic cage abnormality (for example, post-thoracoplasty for *M. tuberculosis* or severe kyphosis).

6. Written Order: The written order should be sufficiently detailed to support that the physician's intent was to order a K0533. A written order that merely includes the notation "BiPap" could mean the physician is ordering a K0532 or a K0533. To allow the carrier medical review clinicians to determine that the physician's intent was to order a K0533 device, written orders for HCPCS code K0533 should include a precise description of the item being ordered and specify the desired inspiratory and expiratory pressure settings plus the backup rate.

7. Proof of Delivery: The delivery slip should be sufficiently detailed to support that the item the beneficiary received was a respiratory assist device with backup rate. This document should include the device's manufacturer, the model number/name and the serial number.

8. Compliant Utilization: For continued coverage beyond the initial three month's of therapy, the supplier must obtain signed Beneficiary and Physician statements. These statements however must be supported by supplier and physician records. There must be documentation in the patient's actual medical record about the progress of relevant symptoms and patient usage of the device up to that time.

9. Re-evaluation: Patients covered for the first 3 months must be re-evaluated to establish the medical necessity of continued coverage. The Physician's signed statement is not sufficient documentation of this re-evalu-

ation. There should be detailed documentation in the patient's medical record that is available to the carrier upon request.

10. Obstructive Sleep Apnea: Beneficiaries in Group IV (primary diagnosis is obstructive sleep apnea) do not qualify for K0533 coverage. If HCPCS code K0533 is billed, since the K0533 is in a different payment category than K0532 and E0601 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.

For more information on the coverage, coding and documentation guidelines for codes K0532 and K0533, please refer to the *DMERC Region D Supplier Manual*, Chapter 9, Respiratory Assist Device LMRP.

COVERAGE AND BILLING

Diagnosis Codes

As directed by the Centers for Medicare & Medicaid Services (CMS), on April 1, 2003, the DMERCs will implement new edits relating to diagnosis codes. These edits represent a major change from the diagnosis edits that have been in effect in the past.

ICD-9-CM (hereafter referred to as ICD-9) diagnosis codes that are entered on claims and referenced on individual claim lines must be valid for the date of service on the claim and must be the highest level of specificity for that range of diagnosis codes. Effective for claims that are received on or after January 1, 2003, and that are processed on or after April 1, 2003, if these requirements are not met, on assigned claims, the claim line(s) will be rejected and returned to the supplier as unprocessable. If this occurs, the supplier should make the necessary corrections and resubmit the claim. Assigned claims returned to the supplier for this reason may not be sent in as an appeal. On nonassigned claims that are processed by the DMERC, if the requirements are not met, the claim will be denied for incorrect coding. Nonassigned claims that have been denied for these reasons may be resubmitted with the necessary corrections or may be sent in as an appeal.

Concerning valid dates of service, ICD-9 codes are updated yearly with codes being added, revised, and deleted. The update becomes effective for dates of service on or after October 1 of a given year. Under a grace period, codes from the prior year's update will continue to be valid on claims with dates of service October 1 through December 31 of the new update year that are received on or before December 31 of that year. For claim lines in which a date span is entered, the diagnosis code must be valid on the "From" date of the date span (the edits do not require that the diagnosis code be valid on the "To" date). Books and other references containing the complete listing of ICD-9 codes can be obtained from a variety of commercial sources. A list of the ICD-9 code changes that were included in the October 1, 2002 update can be found on the CMS Web site at http://www.cms.hhs.gov/medlearn/icd9code.asp.

Concerning level of specificity, ICD-9 codes contain either 3, 4, or 5 digits. If a 3 digit code has 4 digit codes which further describe it, then the 3 digit code is not acceptable for claim submission. If a 4 digit code has 5 digit codes which further describe it, then the 4 digit code is not acceptable for claim submission. For example, the ICD-9 codes describing diabetes mellitus (250.00-250.93) require 5 digits. The 3 digit code (250) and the 4 digit codes (for example, 250.0, 250.1, etc.) in this range are not acceptable for claim submission.

All electronic claims submitted to the DMERC must contain a diagnosis code and each line on the claim must reference a valid diagnosis code. For paper claims, a diagnosis code is not required in order for the claim to be processed by the DMERCs. However, these edits will be applied to each claim line on a paper claim which references a diagnosis. In addition, there are some DMERC medical policies that require use of specific ICD-9 codes in order for the item to be covered.

ICD-9 codes are entered in Field 21 of CMS Form 1500 or the electronic equivalent. Up to four ICD-9 diagnosis codes may be entered in Field 21. For each claim line, one of the ICD-9 codes listed in Field 21 may be referenced in Field 24E or the electronic equivalent. Only a single ICD-9 diagnosis code can be referenced for an individual claim line.

Suppliers determine the ICD-9 codes to submit on a claim from a variety of sources including, but not limited to: ICD-9 codes on a written order, narrative diagnoses on a written order, ICD-9 codes entered on a Certificate of Medical Necessity (CMN) (where applicable), information obtained in other written forms or verbally from physicians or other healthcare professionals involved in the care of the patient, information obtained from the beneficiary, coding books and resources. If an ICD-9 code entered on an order or CMN is not valid for the date of service on the claim or is not the highest level specificity, suppliers are not required to obtain a new/revised order and/or CMN. Suppliers may instead use other sources of information described above to determine the appropriate ICD-9 codes to enter on the claim. However, suppliers are reminded that ICD-9 diagnosis codes that are entered on a claim must be supported by information in the patient's medical record

and that this information must be available to the DMERC on request.

Suppliers are prohibited from entering diagnosis information (including ICD-9 codes) on Certificates of Medical Necessity (CMNs). However, a CMN will be accepted even if the ICD-9 code entered by the physician is not valid on the date of service of the claim and/or is not the highest level of specificity as long as the ICD-9 diagnosis codes **on the claim** are valid on the date of service and are the highest level specificity. Once a CMN has been accepted into the DMERC system, there is no requirement to update the ICD-9 diagnosis code on the CMN if there is no other need to revise the CMN. The only requirement is that a valid ICD-9 diagnosis code be submitted on each claim.

External Infusion Pump Policy - HCPCS Coding Changes

Effective for dates of service on or after April 1, 2003, the following HCPCS code changes are applicable to the External Infusion Pump local medical review policy (LMRP).

- HCPCS code A4232 (Syringe with needle for external insulin pump, sterile, 3 cc), will no longer be valid for claim submission to the DMERCs and will be replaced by a new HCPCS code, K0552 (Supplies for external infusion pump, syringe type cartridge, sterile, each). Under the standard grace period, code A4232 will continue to be accepted on claims with dates of service on or after April 1, 2003, that are received by June 30, 2003. Claims for code A4232 with dates of service on or after April 1, 2003, that are received on or after July 1, 2003, will be returned as unprocessable or denied for incorrect coding.

- HCPCS code K0455 is changed to read as follows: "Infusion pump used for uninterrupted parenteral administration of medication, epoprostenol or treprostinil."

- HCPCS code A4632 (Replacement battery for external infusion pump, any type, each), will no longer be valid for claim submission to the DMERCs. Code A4632 will be replaced with the following codes:

K0601 - Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602 - Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603 - Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604 - Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605 - Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each

Under the standard grace period, code A4632 will continue to be accepted on claims with dates of service on or after April 1, 2003, that are received by June 30, 2003. Claims for code A4632 with dates of service on or after April 1, 2003, that are received on or after July 1, 2003, will be returned as unprocessable or denied for incorrect coding.

Providers should refer to the External Infusion Pumps LMRP for additional information on the coverage, coding, and documentation requirements for these items.

Insulin For Use In Durable Medical Equipment – New Code

Effective for dates of service on or after January 1, 2003, code K0548 (Injection, insulin Lispro, up to 50 units) is being crosswalked to a permanent code established for insulin used in conjunction with durable medical equipment (DME) (e.g., an insulin infusion pump).

J1817 - Insulin for administration through DME (i.e., insulin pump) per 50 units

Also effective for dates of service on or after January 1, 2003, code J1820 (Injection, insulin, up to 100 units) is being discontinued and a new code created for self-administered insulin.

J1815 - Injection, insulin, per 5 units

Code J1815 must not be used for insulin administered through DME. Suppliers should use the J code that corresponds to the specific route of administration being used. Claims submitted for J1815 when administered through DME will be denied as not reasonable and necessary.

Under the standard grace period, codes K0548 and J1820 will continue to be accepted on claims with dates of service on or after January 1, 2003, that are received by March 31, 2003. Claims with codes K0548 and J1820 with dates of service on or after January 1, 2003, that are received on or after April 1, 2003, will be returned as unprocessable or denied for incorrect coding. Codes K0548 and J1820 should continue to be used for claims with dates of service prior to January 1, 2003, regard-

less of the date of claim submission.

For beneficiaries with a covered pump and Certificate of Medical Necessity (CMN) on file, no new CMN or revised CMN is required for this coding change.

For more information on the coverage, coding, and documentation requirements for these codes, please refer to the External Infusion Pump local medical review policy in the Supplier Manual.

Modifiers KB And 99

The DMERC claims processing system accommodates up to 4 modifiers per line item. Because the DMERC recognizes there are some claim situations when more than 4 modifiers may be required on a given claim line, effective for claims processed on or after July 1, 2003, two new modifiers have been created and must be used according to the following instructions:

Beneficiary-Requested DME Upgrade: Aside from modifiers required for proper billing, suppliers must also use two of three modifiers (either GZ or GA, and GK) with a beneficiary-requested DME upgrade. (See the *Winter 2002 DMERC Dialogue*, page 18, for more information on correct usage of these modifiers.) In cases when billing for a beneficiary-requested upgrade and more than four modifiers are necessary the following new modifier must be used:

KB - Beneficiary requested upgrade for ABN, more than 4 modifiers identified on claim

All Other Situations: For any other situation where more than four modifiers are needed, suppliers must use the following new modifier:

99 - Modifier overflow

- For paper claims, when a supplier must use more than 4 modifiers, the supplier must append modifier KB or 99 to the HCPCS code following the required modifiers for the code.

Example: Supplier needs to bill E0277RRKJKXBPGA

On the claim line the supplier should enter E0277RRKJKXKB or E0277RRKJKX99 (whichever is applicable). Modifiers BP and GA should be entered in block 19 of the CMS-1500 claim form.

- For electronic claims in the National Standard Format (NSF), when a supplier must use more than 4 modifiers, the supplier must append modifier KB or 99 to the HCPCS code following the required modifiers for the code.

Example: Supplier needs to bill E0277RRKJKXBPGA

On the claim line the supplier should enter E0277RRKJKXKB or E0277RRKJKX99 (whichever is applicable). Modifiers BP and GA should be entered in the Narrative Record (HA0) per claim line.

- For electronic claims in the American National Standards Institute (ANSI) X12N format, when a supplier must use more than 4 modifiers, the supplier must append modifier KB or 99 to the HCPCS code following the required modifiers for the code.

Example: Supplier needs to bill E0277RRKJKXBPGA

On the claim line the supplier should enter E0277RRKJKXKB or E0277RRKJKX99 (whichever is applicable). Modifiers BP and GA should be entered in the Narrative Segment (2400-NTE).

Quarterly HCPCS Update For Home Health Consolidated Billing (CB)

The following HCPCS code is being added to the editing for Home Health CB this quarter. This code will be included in the Home Health CB editing for claims with dates of service on or after April 1, 2003.

A6440 - Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 10 yards, unstretched)

A complete list of HCPCS codes subject to Home Health CB can be found on the CMS Web Site: www.cms.hhs.gov/medlearn/refhha.asp.

Reminder - Home Prothrombin Time Monitoring For Anticoagulation Management - Not Covered By The DMERC

Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management has been added to the Diagnostic Services section of the *Coverage Issues Manual* (http://www.cms.gov/manuals) as Section 50-56. Use of the International Normalized Ratio (INR) allows physicians to determine the level of

anticoagulation in a patient independent of the laboratory reagents used.

This test is not covered as durable medical equipment; therefore, claims submitted to the DMERCs will be denied for incorrect jurisdiction. Contact your local Part B carrier for information about the coverage of this diagnostic service.

Update To article Entitled "New Modifier – AX"

Two codes, A4651 and A4652, were inadvertently omitted from the list of codes that may require the AX modifier in the article entitled "New Modifier – AX" published in the Winter 2003 Region D *DMERC Dialogue*. **REMINDER: The AX modifier must not be used with any HCPCS codes other than those listed below. Also, the AX modifier must not be used with the HCPCS listed unless furnished in conjunction with dialysis services.**

The article is reprinted below and includes codes A4651 and A4652.

New Modifier – AX

A new HCPCS modifier has been established for use when items are furnished in conjunction with home dialysis supplies and equipment. This modifier is effective for dates of service on or after January 1, 2003.

AX - Items furnished in conjunction with dialysis services

The DMERCs have specified the codes that may require use of the AX modifier. The AX modifier must not be used with any HCPCS codes other than those listed below. In addition, the AX modifier must not be used with these items unless furnished in conjunction with dialysis services:

A4244 - Alcohol or peroxide, per pint
A4245 - Alcohol wipes, per box
A4246 - Betadine or phisohex solution, per pint
A4247 - Betadine or iodine swabs/wipes, per box
A4450 - Tape, non-waterproof, per 18 square inches
A4452 - Tape, waterproof, per 18 square inches
A4651 - Calibrated microcapillary tube, each
A4652 - Microcapillary tube sealant
A4656 - Needles, any size, each
A4657 - Syringe, with or without needle, each
A4660 - Sphygmomanometer/blood pressure apparatus with cuff and stethoscope
A4663 - Blood Pressure cuff, only
A4670 - Automatic Blood pressure monitor
A4712 - Water, sterile, for injection, per 10ml
A4927 - Gloves, non-sterile, per 100
A4928 - Surgical mask, per 20
A4930 - Gloves, sterile, pair
A4931 - Oral thermometer, reusable, any type, each
A6250 - Skin sealants
A6260 - Wound cleansers
E0210 - Electric heat pad, standard
E1632 - Wearable artificial kidney, each
E1637 - Hemostats, each
E1639 - Scale, each
J1644 - Injection, heparin sodium, 1,000 units

Many of these codes have had changes in their descriptor to remove the words "for dialysis" so that these codes can also be used for purposes other than dialysis. However, with the exception of the tape codes (A4450 and A4452) and the heating pad (E0210), the DMERC will consider reimbursement for these codes only on claims for patients eligible for coverage under the DMERC policy on Home Dialysis Supplies and Equipment.

Under the standard grace period, all codes listed above will continue to be accepted without these modifiers on claims with dates of service on or after January 1, 2003, that are received by March 31, 2003. Claims for these codes (except for the tape codes A4450 and A4452 and the heating pad code E0210) submitted *without* an AX modifier with dates of service on or after January 1, 2003, that are received on or after April 1, 2003, will be denied as noncovered (no benefit). These modifiers are effective for claims with dates of service on or after January 1, 2003, and must not be used for claims with dates of service before January 1, 2003. Use of the AX modifier on claims with dates of service before January 1, 2003, will be returned as unprocessable or denied for incorrect coding.

Wheelchairs – New Codes

Effective for dates of service on or after January 1, 2003, new codes were established for adult manual tilt-in-space wheelchairs (E1161) and for pediatric manual wheelchairs (E1231-E1238). Refer to the HCPCS chapter or to the April 2003 revision of the Manual Wheelchairs policy in the *DMERC Region D Supplier Manual* and on our Web site for code descriptions. These items were previously billed with code K0009. All of these codes require use of the Manual Wheelchairs Certificate of Medical Necessity, HCFA Form 844.

Codes for adult manual tilt-in-space wheelchairs (E1161) and for pediatric manual tilt-in-space wheelchairs (E1231-E1234) are eligible for Advance Determination of Medicare Coverage (ADMC). Refer to Chapter 9 of the *DMERC Region D Supplier Manual* for details of the process.

FEE SCHEDULE

2003 DMEPOS Fee Schedule April Quarterly Update

Revised Fees

The following are revised fees for thoracic-lumbar-sacral-orthoses (TLSO) which will be implemented on April 1, 2003 for dates of service on or after January 1, 2003.

States	L0452	L0454	L0456	L0458	L0460	L0462	L0464	L0486	L0488	L0490
AK	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
AZ	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
CA	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
HI	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
IA	1,122.29	1,139.39	968.07	389.51	696.14	313.55	321.15	802.91	1,204.35	226.61
ID	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
KS	1,122.29	1,139.39	968.07	389.51	696.14	313.55	321.15	802.91	1,204.35	226.61
MO	1,122.29	1,139.39	968.07	389.51	696.14	313.55	321.15	802.91	1,204.35	226.61
MT	1,140.20	1,157.56	983.53	395.74	707.27	318.56	326.28	815.71	1,223.58	230.20
ND	1,140.20	1,157.56	983.53	395.74	707.27	318.56	326.28	815.71	1,223.58	230.20
NE	1,122.29	1,139.39	968.07	389.51	696.14	313.55	321.15	802.91	1,204.35	226.61
NV	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
OR	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
SD	1,140.20	1,157.56	983.53	395.74	707.27	318.56	326.28	815.71	1,223.58	230.20
UT	1,140.20	1,157.56	983.53	395.74	707.27	318.56	326.28	815.71	1,223.58	230.20
WA	1,100.78	1,117.55	949.54	382.05	682.82	307.58	315.02	787.52	1,181.30	222.28
WY	1,140.20	1,157.56	983.53	395.74	707.27	318.56	326.28	815.71	1,223.58	230.20

New HCPCS Codes

The following new fees will be effective for dates of service on or after April 1, 2003.

State	K0552	K0600NU	K0600RR	K0600UE	K0601	K0602	K0603	K0604	K0605
AK	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
AZ	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
CA	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
HI	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
IA	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
ID	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
KS	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
MO	2.65	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
MT	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
ND	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
NE	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
NV	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
OR	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
SD	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
UT	2.65	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
WA	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60
WY	2.61	9,967.86	996.79	7,475.91	1.10	7.65	.57	8.11	14.60

Revised Ostomy Fees

The following are revised Ostomy fees that were updated in the April Quarterly update. These fees will be implemented on April 1, 2003 for dates of service on or after January 1, 2003.

State	A4392	A4393	A5051	A5052	A5054	A5061	A5071	K0592	K0594
AK	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
AZ	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
CA	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
HI	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
IA	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
ID	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
KS	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
MO	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
MT	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
ND	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
NE	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
NV	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
OR	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
SD	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
UT	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
WA	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22
WY	8.18	9.04	2.07	1.49	1.79	3.52	6.01	8.25	6.22

Ostomy Codes

The list below has three codes that were inadvertently deleted from the annual fee schedule. These fees are effective for dates of service on or after January 1, 2003.

State	A4391	A5063	A5073
AK	7.13	2.19	3.34
AZ	7.07	2.17	3.03
CA	7.07	2.17	3.18
HI	7.66	2.33	3.55
IA	7.07	2.17	3.13
ID	7.07	2.17	2.90
KS	7.07	2.17	3.18
MO	7.07	2.23	3.18
MT	7.07	2.17	2.71
ND	7.07	2.17	3.13
NE	7.07	2.17	3.18
NV	7.07	2.17	3.18
OR	7.07	2.17	3.18
SD	7.07	2.17	3.13
UT	7.07	2.23	3.10
WA	7.07	2.17	3.13
WY	7.07	2.17	3.13

Individual Consideration Code

Currently, we have no fee set for code A4387 – Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each. When billing for this code we will need the following: manufacturer name, product name, product number, suggested retail price.

Additional Fees

The fees listed below are effective for dates of service on or after January 1, 2003.

	E0636RR	E1012NU	E1012RR	E1012UE	E1013NU	E1013RR	E1013UE
All States	1,054.56	507.05	50.70	380.30	837.93	83.80	628.46

	E1014NU	E1014RR	E1014UE	E1025NU	E1025RR	E1025UE	E1026NU
All States	365.14	36.52	273.85	125.35	12.55	94.02	192.90

	E1026RR	E1026UE	E1027NU	E1027RR	E1027UE	E1035RR	E1037RR
All States	19.29	144.67	275.06	27.49	206.28	613.20	108.49

	E1232RR	E1233RR	E1234RR	E1235RR	E1236RR	E1237RR	E1238RR
All States	213.42	220.85	192.32	185.19	163.34	164.81	171.86

HCPCS UPDATES

2003 HCPCS Updates For Non-Covered Items

In addition to the changes detailed in the Winter 2003 *DMERC Dialogue* article entitled "2003 HCPCS Changes - Added, Deleted and Description Changes," the following codes for non-covered items are effective for dates of service on or after January 1, 2003.

A4521 - Adult-sized incontinence product, diaper, small size, each
A4522 - Adult-sized incontinence product, diaper, medium size, each
A4523 - Adult-sized incontinence product, diaper, large size, each
A4524 - Adult-sized incontinence product, diaper, extra large size, each
A4525 - Adult-sized incontinence product, brief, small size, each
A4526 - Adult-sized incontinence product, brief, medium size, each
A4527 - Adult-sized incontinence product, brief, large size, each
A4528 - Adult-sized incontinence product, brief, extra-large size, each
A4529 - Child-sized incontinence product, diaper, small/medium size, each
A4530 - Child-sized incontinence product, diaper, large size, each
A4531 - Child-sized incontinence product, brief, small/medium size, each
A4532 - Child-sized incontinence product, brief, large size, each
A4533 - Youth-sized incontinence product, diaper, each
A4534 - Youth-sized incontinence product, brief, each
A4535 - Disposable liner/shield for incontinence, each
A4536 - Protective underwear, washable, any size, each
A4537 - Under pad, reusable/washable, any size, each
A4538 - Diaper service, reusable diaper, each diaper
B4100 - Food thickener, administered orally, per ounce

HCPCS Updates

In addition to the changes detailed in the Winter 2003 *DMERC Dialogue* article entitled "2003 HCPCS Changes - Added, Deleted and Description Changes," the following codes were deleted effective for dates of service on or after January 1, 2003.

Deleted Code	Replacement (Crosswalk Code)
K0548	J1817
L3218	L3260
L3223	L3260

A 3-month grace period applies to discontinued Level I and Level II HCPCS codes. We will accept claims for deleted codes with dates of service on or after January 1, 2003, with dates of receipt on or before March 31, 2002. Deleted codes received on or after April 1, 2003, with a date of service on or after January 1, 2003, will be returned as unprocessable.

ELECTRONIC DATA INTERCHANGE (EDI)

Are You Using The Right Version Of ANSI?

As the health care industry began implementing the ANSI 4010 version it was realized that changes needed to be made to the format requirements.. As a result, addenda pages to the existing ANSI 4010 version were developed and a final rule was published in the Federal Register on February 20, 2003. You may access the final rule at http://edocket.access.gpo.gov/2003/pdf/03-3876.pdf.

The updated version of ANSI is referred to as ANSI 4010A1. **ANSI 4010A1 is the HIPAA-ready electronic version that is mandated for use by October 16, 2003.** The addenda pages may be found at http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp.

Medicare will switch to exclusive use of version 4010A1 by October 16, 2003. At that time, providers/suppliers must submit all of their electronic claims, claim status inquiries, and eligibility inquiries in compliance with the requirements in the ANSI X12N 4010A1 version. In addition, each trading partner that receives remittance, claim status response and eligibility response electronically must accept version 4010A1 by October 16, 2003.

CIGNA Medicare is scheduled to begin testing and transitioning of EDI trading partners to version 4010A1 on April 1, 2003. We will provide more information on our Web site as it becomes available. More details and instructions for testing and implementation of the ANSI 4010A1 version will be provided through the CIGNA Medicare Web site. Please be sure to sign-up to receive automatic notification of updates through our **E-Mail Express Notification System.**

If you have already migrated to the ANSI 4010 format, then you may continue to use that format until October 16, 2003. Even though the ANSI 4010A1 format is not mandated until October 16, 2003, **we highly encourage you to update to the ANSI 4010A1 version as soon as possible after April 1, 2003. This will ensure that you will be fully migrated by October 16, 2003.**

If you are a new electronic submitter, then you must use either the 4010A1 or the 4010 format. The NSF 3.01 version will not be an available format option for new submitters after April 16, 2003.

If you will be migrating to the ANSI version of DMACS, DMACS-837, the software is being developed based on the requirements for the ANSI 4010A1 version. For additional information on the DMACS software, please refer to the article entitled **"Update on DMACS-837"** in this section.

Misdirected Claims

As a benefit of electronic billing, claims submitted by suppliers for beneficiaries residing in a state outside of the DMERC for which the claim was billed, are forwarded to the appropriate DMERC for processing. This allows submitters to transmit all of their claims in one batch to one place without having to separate their claims or submit multiple files to different payors. As of July 1, 2003, we will, in coordination with the other DMERCS, change the way we currently adjudicate these types of claims.

Instead of processing claims based on the date the original DMERC received the claim, the claims will be processed based on the date the receiving DMERC receives the claim. For example, Region A receives a claim on July 1, 2003 that needs to be transferred to Region B. Region B receives the claim from Region A on July 2, 2003. The payment floor will begin July 2nd rather than July 1st. This will allow Region B to have the same amount of time to process transferred claims as they process other electronic claims.

Remember you have the option to transmit your electronic claims directly to any DMERC as long as you have signed-up with that DMERC. All DMERCs require a signed-original EDI Enrollment form on file (and may possibly require testing) before they will accept electronic claims either directly or by transfer from another DMERC.

Update On *DMACS-837*

As per CMS instruction, the release of *DMACS-837*, the ANSI version of DMACS (DMERC Medicare Automated Claims System) has been delayed. Originally scheduled for release in December 2002, *DMACS-837* is now scheduled to be available this spring. Once the software is available for release, we will notify you via our **E-mail Express Notification System** and on the "What's New" section of the Web site. At that time, we will provide the necessary information for applying for the software.

DMACS-837, a software program designed to build your Region D Medicare claims in the ANSI X12N 837 4010A1, is a basic claim submission program which

we offer free of charge*. The ANSI version of DMACS is being developed based on requirements set forth in the addenda to the 4010 format. For more information on the addenda, please refer to the article entitled **"Are You Using the Right Version of ANSI"** in this section.

DMACS32, the NSF 3.01 version, may be used to transmit your claims to Medicare until October 16, 2003. Once *DMACS-837*, the ANSI X12N 837 4010A1version, is made available, we will only distribute the 4010A1 version; however, we will continue to support both the NSF and ANSI versions of DMACS until October 16, 2003. Please note, according to CMS, all Medicare contractors are to begin phasing out their free billing software effective October 2003.

As a means of utilizing technology to its potential, the ***DMACS-837 User Manual*** will be offered exclusively in an electronic format, and will be included on the CD-ROM along with the software program. By including the manual on CD, the shipping and handling fee will be decreased to $5.00.

We will continue to provide information and keep you updated on the status of *DMACS-837* through the ***DMERC Dialogue***, our Web site (www.cignamedicare.com) and our **E-Mail Express Notification System**. If you are not currently enrolled and receiving e-mail notifications, you may sign up for the notification system through our Web site.

Please direct any questions and/or concerns regarding *DMACS-837* to the EDI Department at 866.224.3094, option 1 or 2.

** A $5.00 shipping and handling fee will apply.*

Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) Claims For Multiple Primary Payers

There are situations where more than one primary payer pays on a Medicare Part B claim and Medicare may still make a secondary payment on the claim. Physician and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Professional Implementation Guide regarding the submission of Medicare beneficiary claims to multiple payers for payment. Providers must follow model 1 in section 1.4.2.1 that discusses the provider to payer to provider methodology of submitting electronic claims. When there are multiple primary payers to Medicare you must follow the instructions cited below when sending the claim to Medicare for secondary payment.

Submission of Electronic MSP Claims With Multiple Primary Payers, but With Only One Insurance Type Code

Where there is more than one primary payer on a MSP claim and the primary payers identify the same insurance type code (e.g., the claims show two employer group health plans made payment on the claim which is identified as insurance type code 12), physicians and suppliers can send these claims electronically using the 837 version 4010 claim submission format. When sending these types of claims, you must do the following:

Primary Payer Paid Amounts: For line level services claims, physicians and suppliers must add all primary payer paid amounts for that service line and put the total amount in loop ID 2430 SVD02 of the 837. If only claim level information is sent to Medicare, providers and suppliers must add all other payer paid amounts for that claim and place the total amount in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount: For line level services, physicians and suppliers must take the higher of the allowed amount for that service line, or the total of the other payer paid amounts, whichever is higher, and put the amount in loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837. If only claim level information is sent to Medicare, take the higher of the claim level allowed amount, or the total of the other payer paid amounts, whichever is higher, and put the amount in Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF): For line level services, physicians and suppliers must take the lowest OTAF amount for that service line, which must be greater than zero, and put the amount in loop 2400 CN102 CN 101 = 09. If only claim level information is sent to Medicare, take the lowest claim level OTAF amount, which must be greater than zero, and put this information in loop 2300 CN102 CN101 = 9.

Submission of Hardcopy MSP Claims With Multiple Primary Payers, but With More Than One Insurance Type Involvement

There may be situations where two or more insurer types make payment on a claim; for example, an auto insurer

makes a primary payment on a line of service and, subsequently, a group health plan also makes a primary payment for the same line of service. Claims with more than one insurance type involvement cannot be sent electronically to Medicare. A hardcopy claim must be submitted. Use the current Form CMS-1500 when submitting Part B hard copy claims. Physicians and suppliers must attach the other payers EOB, or remittance advice, to the incoming claim when sending it to Medicare for processing.

Miscellaneous

Changes To A Completed Certificate Of Medical Necessity (CMN) – Reminder

If there is a change made to any section of the CMN, the physician must signify approval of the change by making a line through the error, inserting the corrected information, and then initialing and dating the correction. As an alternative method of change approval, the supplier may choose to have the physician complete, sign, and date a new CMN.

Illegible Documentation Submitted With Claims And Review Requests

We have noticed an increase in illegible documentation submitted with claims and review requests. This appears to be mostly related to documents that have been faxed between the supplier and the physician multiple times. When documents are faxed multiple times, the print may become very faint and hard to read. Sending poor quality documents can delay the completion of your claim and review request. Before mailing your documentation, please take a few minutes to make sure it is legible.

Limitation On Liability And Refund Requirements – Implementation Of Form CMS-R-131, Advance Beneficiary Notice (ABN)

Per the Centers for Medicare & Medicaid Services (CMS) Program Memorandum AB-02-168, Change Request 2415, for items and/or services furnished on or after January 1, 2003, suppliers must use the OMB-approved Advance Beneficiary Notice form CMS-R-131 (ABN-G) for use with DMEPOS items and services.

CMS guidelines regarding ABN standards are included in Chapter 6 of the accompanying supplier manual update. Per CMS Program Memorandum B-03-003, Change Request 2416, instructions provided in Section II.8, Processing Initial Denials, will be implemented by the DMERCs effective as of July 1, 2003.

Advance Beneficiary Notices (ABNs) advise beneficiaries, before items or services are actually furnished, when Medicare is likely to deny payment for them. Several statutory provisions limit beneficiaries' financial liability for certain denied claims. The ABN is implemented per the Limitation On Liability provisions in § 1879(a)-(c) of the Social Security Act (the Act) and the Refund Requirements provisions in §§ 1834(a)(18), 1834(j)(4), 1842(l), and 1879(h) of the Act.

Limitation On Liability (LOL) applies to assigned claims for DMEPOS items/services for which Medicare payment is denied as not reasonable and necessary under § 1862(a)(1) of the Act.

Refund Requirements (RR) applies to claims for DMEPOS items/services for which Medicare payment is denied as explained below:

Assigned & Nonassigned Claims

- The supplier did not meet the supplier number requirements under § 1834(j)(1) of the Act;

- The item/service is denied in advance (Advance Determination of Medicare Coverage) under § 1834(a)(15) of the Act; and

- The supplier violated the prohibition on unsolicited telephone contacts under § 1834(a)(17)(B) of the Act.

Nonassigned Claims

- Payment is denied as not reasonable and necessary under § 1862(a)(1) of the Act.

When the supplier is held liable under the LOL or RR provisions, a refund of any amounts collected must be made to the beneficiary on a timely basis as explained below:

- If the supplier does not request review of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the supplier receives the Medicare Remittance Notice (MRN).

• If the supplier requests review within 30 days of receipt of the MRN of the initial determination, the refund must be made to the beneficiary within 15 days after the date the supplier receives the notice of the contractor's determination of the supplier's appeal.

If a supplier makes proper refund, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or rerentable. (Details are provided in Section II.15 of the ABN standards.)

(Also, see articles entitled "New Procedures to Use the ABN Form for DMEPOS Upgrades" and "Noncovered Items, Not Medically Necessary Items, and Advance Beneficiary Notices – New Modifiers" previously published in the Winter 2002 *DMERC Dialogue*.)

Medicare Program Integrity Manual Revised

The Medicare *Program Integrity Manual* (PIM) contains the medical review and fraud and abuse instructions from the Centers for Medicare & Medicaid Services (CMS). Five revisions have been published since the publication deadline of the Winter 2003 Region D *DMERC Dialogue*.

• Transmittal 34, released November 22, 2002, revises Chapter 13, section 11.E.2 to correct a Web site address and a grammatical error. Under the LMRP reconsideration request requirements, if modification of an LMRP would conflict with a national coverage determination (NCD), the requestor can be referred to www.cms.hhs.gov/coverage/8a1.asp or www.access.gpo.gov/nara/index.html. The notice was posted on Thursday, August, 22, 2002. There is no effective or implementation date for these changes.

• Transmittal 35, released November 29, 2002, revises Chapter 3, §4.5 to clarify the circumstances under which contractors may use health care professionals other than a physician or nurse (RN/LPN) during the review of claims. The effective/implementation date is January 1, 2003.

• Transmittal 36, released December 27, 2002, revises Chapter 11 (Fiscal Administration), section 3 - Local Provider Education and Training (LPET) Workload, Cost and Savings Allocation. The effective/implementation date is December 27, 2002.

• Transmittal 37, released January 17, 2002, revises Chapter 5, sections 1.1.2 and 1.1.2.1 to indicate claims submitted without obtaining an order shall be denied as not reasonable and necessary, and that claims billed without obtaining a written order, when required, shall be denied as not covered. The effective/implementation date is February 1, 2003.

• Transmittal 38, released February 3, 2003, revises Chapter 3, section 3.2 to clarify when contractors may publish coverage/coding articles in their bulletins and Web sites. Chapter 13, Section 2 (Articles) is deleted. The effective date for this PIM revision is January 31, 2003. The implementation date is February 14, 2003.

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.

Utilizing Your Automated Options

Although suppliers may require the assistance of a DMERC Customer Service Representative for certain claim issues, often times the information that a supplier seeks is available through other avenues, such as electronic or paper Medicare Remittance Notices (MRNs), electronic Claim Status Inquiry (CSI), and the Interactive Voice Response (IVR) system.

Suppliers receive MRNs that provide claim determinations on all assigned claims. Notices are sent daily; therefore, you should receive notification shortly after your claims are processed. All original MRNs should be kept in your records as they provide valuable facts regarding your claims. There may be occasions in the future when you will need to refer to an earlier MRN. Special attention should be made to the claim remarks and ANSI codes (AC). The codes will explain the basis for payment, reason(s) for denial, and other pertinent claim information.

Claim Status Inquiry (CSI) allows suppliers who bill electronically to check the status of claims after they have passed the front-end edits and received Claim Control Numbers (CCNs). At least three working days after you successfully file an electronic claim, you will be able to locate your claim in the processing cycle. Through CSI, you will know if your claim has been paid, was denied, or is still pending. If you are checking the status of pending claims, there are additional screens available which contain more detailed status information. CSI is available to electronic billers for both their electronic and paper claims. Information on billing electronically is available at www.cignamedicare.com/edi.

Electronic Beneficiary Eligibility is an option available to suppliers who bill electronically. This function allows

electronic billers to send CIGNA Medicare a file containing beneficiary information, and approximately 48 hours later, CIGNA Medicare will return a file including beneficiary eligibility dates and deductible information.

These options allow suppliers to increase productivity and avoid the Customer Service line busy signals and hold time. For more complete information about MRNs, CSI and Electronic Beneficiary Eligibility, please refer to your *DMERC Region D Supplier Manual*, or visit our Web site at www.cignamedicare.com.

The DMERC Region D IVR system is also available for supplier usage as long as our mainframe is up and running, and is available beyond the Customer Service hours of 8:00 am to 6:00 pm (Central Standard Time). Suppliers can utilize the IVR to check claim status, get a list of outstanding checks, order duplicate MRNs, get Medicare fee schedule information, check a beneficiary's Medicare eligibility, and check deductible information (participating suppliers only). You may refer to the Fall 2002 *DMERC Dialogue* for a guide to the IVR. Additional IVR enhancements will be coming soon!

CIGNA Medicare encourages suppliers to utilize these options for their claim and billing questions, and contact Customer Service only for more complex issues that cannot be addressed by other means.

Keys To Successful Claims Filing

Verify if the beneficiary has had same or similar equipment.

Asking all the right questions during the intake process can help you build clean claims and complete files. An intake form can assist you in accomplishing this task. A Suggested Intake Form is published in the *DMERC Region D Supplier Manual*, Chapter 15, page 6. The Suggested Intake Form is intended only as a tool to assist suppliers in obtaining information, at the time of patient intake, regarding same/similar equipment, Medicare eligibility, or other information the supplier may need for their particular type of business. Suppliers may use this form or model a similar form to fit their needs. This form is not required for claim submission and does not replace obtaining an Advance Beneficiary Notice (ABN) when there is reason to believe the item(s) may be denied as not medically necessary. Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, for information about same or similar equipment and ABNs, and the Limitation on Liability section in Chapter 6 for more information.

(Region D *DMERC Dialogue*, Spring 2002, page 19.)

Verify proper completion of Field 12 (signature on file) of the CMS-1500 form on a non-assigned claim.

A signature on file (SOF) indicates the supplier has obtained the beneficiary's one time authorization on assigned and/or non-assigned claims; future claims for those services can be filed without obtaining an additional signature. The exception is durable medial equipment (DME) rentals. The one time authorization for DME rental claims is limited to assigned claims. If you bill non-assigned for DME rentals, you will need to obtain the beneficiary's authorization every month.

(Region D *DMERC Dialogue*, December 1996, page 14.)

Verify the HCPCS code before using a Not Otherwise Classified (NOC) code.

If you are uncertain which procedure code to use, you should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding verification. When you call make sure to have the product information available. Remember, the appearance of a code does not necessarily indicate coverage.

(*DMERC Region D Supplier Manual*, Chapter 16, page 1, Region D *DMERC Dialogue*, Fall 2000, page 8.)

Verify the amount entered in Field 29 of the CMS-1500 form to ensure accuracy.

Enter the amount the beneficiary paid on covered services only in Field 29 of the CMS-1500 form. Do not enter a primary insurer payment amount in Field 29 on a Medicare secondary claim.

(DMERC Region D Supplier Manual, Chapter 16.)

Verify that six months has passed from the end of the final paid rental month before submitting a claim for maintenance and servicing.

DMEPOS suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six months has passed from the end of the final paid rental month. Furthermore, DMEPOS suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself.

(*DMERC Region D Supplier Manual*, Chapter 5, page 3.)

Update To The American National Standard Institute (ANSI) Codes

Revised Reason Codes:

35 Lifetime benefit maximum has been reached.

N22 This procedure code was changed because it more accurately describes the services rendered.

Revised Remittance Advice Remark Codes:

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

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

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

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

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

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

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.
The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

M27 The patient has been relieved of liability of payment of these items and services under the limitation of

liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.

M80 Not covered when performed during the same session/date as a previously processed service for the patient.

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

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

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

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

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

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

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

N103 Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody

under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

N104 This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov.

New Reason Codes:

149 Lifetime benefit maximum has been reached for this service/benefit category.

150 Payment adjusted because the payer deems the information submitted does not support this level of service.

151 Payment adjusted because the payer deems the information submitted does not support this many services.

152 Payment adjusted because the payer deems the information submitted does not support this length of service.

153 Payment adjusted because the payer deems the information submitted does not support this dosage.

154 Payment adjusted because the payer deems the information submitted does not support this day's supply.

New Remark Codes:

N117 This service is paid only once in a lifetime per beneficiary.

N118 This service is not paid if billed more than once every 28 days.

N119 This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or SNF (Part B) facility within those 28 days.

N120 Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/readmitted during payment episode.

N121 Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.

N122 Mammography add-on code can not be billed by itself.

N123 This is a split service and represents a portion of the units from the originally submitted service.

N124 Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

N125 Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice.
The law permits exceptions to this refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or

• If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within 30-days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision.

You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

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

The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.

N126 Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.

N127 This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.

N128 This amount represents the prior to coverage portion of the allowance.

N129 This amount represents the dollar amount not eligible due to the patient's age.

N130 Consult plan benefit documents for information about restrictions for this service.

N131 Total payments under multiple contracts cannot exceed the allowance for this service.

N132 Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.

N133 Services for predetermination and services requesting payment are being processed separately.

N134 This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service. (New Code 10/31/02)

N135 Record fees are the patient's responsibility and limited to the specified co-payment.

N136 To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.

N137 You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The

Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.

N138 In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.

N139 Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.

N140 You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.

N141 The patient was not residing in a long-term care facility during all or part of the service dates billed.

N142 The original claim was denied. Resubmit a new claim, not a replacement claim.

N143 The patient was not in a hospice program during all or part of the service dates billed.

N144 The rate changed during the dates of service billed.

N145 Missing/incomplete/invalid provider identifier for this place of service.

N146 Missing/incomplete/invalid/not approved screening document.

N147 Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.

N148 Missing/incomplete/invalid date of last menstrual period.

N149 Rebill all applicable services on a single claim.

N150 Missing/incomplete/invalid model number.

N151 Telephone contact services will not be paid until the face-to-face contact requirement has been met.

N152 Missing/incomplete/invalid replacement claim information

N153 Missing/incomplete/invalid room and board rate

N154 This payment was delayed for correction of provider's mailing address.

N155 Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.

N156 The patient is responsible for the difference between the approved treatment and the elective treatment.

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Frequently Asked Questions

1. What is the supplier's responsibility in obtaining a Certificate of Medical Necessity (CMN) for a non-assigned claim?

   ANSWER: Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, page 1, under Supplier Documentation. This information applies to both assigned and non-assigned claims. It states, "Before submitting a claim to the DMERC, the supplier must have on file a dispensing order (verbal, faxed, original or electronic), the written order (electronic, faxed or original), the CMN, (electronic, faxed or original, if applicable), information from the treating physician concerning the patients diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DMERC local medical review policies (LMRPs).

2. Now that faxed or electronically transmitted orders and Certificates of Medical Necessity (CMNs) are accepted for both billing and auditing purposes, in what form does the Written Order Prior to Delivery (WOPD) need to be submitted to the DMERC?

   ANSWER: Written orders for those items that require a written order prior to delivery may take the form of a photocopy, facsimile image, electronically maintained document or original "pen and ink" document.

   (*DMERC Region D Supplier Manual*, Chapter 3, pages 3 & 4)

3. According to the Winter 2003 Region D *DMERC Dialogue*, we now have a new modifier for no order on file. Do I now have to send in all my claims using the modifier EY if I do not obtain a prescription (order) from the beneficiary and provide a DMEPOS item?

   ANSWER: No. You do not have to submit a claim to the DMERC if you did not obtain a prescription (order) for the item. However, if you choose to do so, then you must append the modifier EY to the claim.

   (*DMERC Region D Supplier Manual*, Chapter 3, page 1)

4. If I submit a claim to the DMERC using the modifier EY, is the patient or supplier responsible financially?

   ANSWER: For dates of service on or after January 1, 2003, claim lines with the modifier EY will be denied as not reasonable and necessary unless an order is specifically required by statute. Suppliers are held financially responsible unless they have a valid Advance Beneficiary Notice (ABN) on file in which case they should bill the code with modifier EY and modifier GA. For items requiring an order by statute, failure to obtain an order will result in the claim being denied as noncovered (no benefit) and an ABN is not required in these circumstances.

5. If a patient has a continuous positive airway pressure (CPAP) device that was purchased by a commercial insurance, do we still need to have proof that the beneficiary is still using the equipment before we can bill with the modifier KX for supplies and repairs?

   ANSWER: Yes. To append the modifier KX to the claim, continued use of the device must be confirmed.

   (*DMERC Region D Supplier Manual*, Chapter 9, CPAP)

Frequently Asked Questions (cont'd)

6. When an item reaches the 15th month cap and then a free upgrade is provided (e.g., K0001 wheelchair is upgraded to a K0003 but there is no break in service or change in the patient's condition) how do you bill? Would you bill the K0001 or the K0003? Would you use the modifier MS and the upgrade modifier?

   ANSWER: Suppliers should bill the claim with K0001MSGL. In addition, the following information must be sent in the narrative for electronic claims or in field 19 of a paper claim:

   - Make and model of upgraded item
   - Why the item is an upgrade.

   When billing free upgrades, remember to only charge for the ordered item.

7. If a patient gets their refill of home blood glucose supplies a few days early, do we bill it when they receive the supplies as the DMERC suggests? Are we risking a denial since supplies were already billed for that period? We have heard that some DMERCs are allowing a 10 day grace period. What is the standard in Region D?

   ANSWER: For claims billed for blood glucose monitor supplies that are refilled early, the date of service on the claim must be the same as the date the supplies were provided to the beneficiary (e.g., beneficiary goes to drug store and buys supplies), or the date sent if the supplies are mailed or shipped to the beneficiary. This is the same as for supplies that are not refilled early. There is minimal risk that supplies will be denied due to early billing, since Region D DMERC takes the possibility of early delivery into consideration when reviewing claims; the degree of risk would primarily depend upon the quantity billed and how many days early they are billed. Region D does not use a standard grace period, but takes into consideration the beneficiary's historical billing pattern, the number of days by which the dates of service precede the usual billing date, and additional information provided by the supplier. An explanation included with the claim in situations where a quantity that is greater than usual is provided, and/or supplies are provided more than a few days early, should mitigate any risk associated with this situation.

8. When replacing an external breast prosthesis, is a new order required?

   ANSWER: The useful lifetime expectancy for silicone breast prostheses is 2 years. For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is 6 months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as noncovered. An external breast prosthesis of the same type can be replaced at any time if it is lost or is irreparably damaged (this does not include ordinary wear and tear). An external breast prosthesis of a different type can be covered at any time if there is a change in the patient's medical condition necessitating a different type of item. (*DMERC Region D Supplier Manual*, Chapter 9, EBP) A new order is required when an item is being replaced because the item is irreparably worn or the patient's condition has changed. The supplier's records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in the supplier's files and be available to the DMERC on request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in claim(s) denial.

   (*DMERC Region D Supplier Manual*, Chapter 3, page 3)

9. Can a beneficiary call CIGNA Medicare after the 12th month of a capped rental period to change their mind regarding their decision to purchase or rent the equipment? Is the supplier required to use a B modifier and when?

   ANSWER: According to the *DMERC Region D Supplier Manual*, Chapter 5, page 4, beneficiaries have one month from the date the supplier makes the offer to accept the purchase option. Suppliers must use one of

Frequently Asked Questions (cont'd)

three modifiers; BR, BP, or BU to notify the carrier of the beneficiary's decision. Once the carrier has been notified of the decision, it is considered final.

10. Why would a supplier want to use the modifier GY?

    ANSWER: Use of the modifier GY is usually limited to situations in which there is a specific HCPCS code to describe the item or service. If there is no specific HCPCS code to describe the item or service, then A9270 (Noncovered item or service) is usually used. The GY modifier should generally not be used with a "miscellaneous" or "not otherwise classified" code – e.g., E1399. The modifier GY is not needed with code A9270.

    GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit.

    (Region D *DMERC Dialogue*, Winter 2002, page 20 and *DMERC Region Supplier Manual*, Chapter 16, MOD)

11. Can respiratory disturbance index or respiratory related arousals be used with or in lieu of Apnea Hypopnea Index (AHI) in regards to claims for the Continuous Positive Airway Pressure (CPAP) device?

    ANSWER: There are no considerations for "respiratory disturbance index" or "respiratory related arousals" or other terms in the national policy. Coverage is established by the AHI, which is defined as the average number of episodes of apnea and hypopnea per hour (i.e., apneas plus hypopneas divided by hours of sleep). If that is not how the sleep laboratory reports it, the supplier needs to contact the sleep laboratory to get them to break those values out and calculate an AHI.

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DMERC Region D Publication Order Form

Name: _____

Company Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

Email: _____

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

Subscription (12 months) $50.00/year per publication

Region D *DMERC Dialogue* _____ (Qty.) **Includes (if applicable) supplier manual update.**

Subtotal **$**_____

DMERC Individual Requests

Region D *DMERC Dialogue $10.00 Each Issue**

	Quantity	Year		Quantity	Year
Spring	_____	_____	**Fall**	_____	_____
Summer	_____	_____	**Winter**	_____	_____

*Includes (if applicable) the supplier manual update.

Subtotal **$**_____

DMERC Region D Supplier Manual _____ (Qty.) **$**_____
($50.00/Manual)

DMERC DMEPOS Fee Schedule _____(Qty.) _____ (Year) **$**_____
($10.00/Schedule)

Note: DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.

Subtotal **$**_____

Total Amount Due **$**_____

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

ATTN: DMERC Publication Fulfillment Center
Connecticut General Life Insurance Company
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 copy of the Region D *DMERC Dialogue* and supplier manual update.

DMERC Region D publications are also available on our Web site at www.cignamedicare.com.

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Instructions for completing the *Region D DMERC EDI Customer Profile*

IMPORTANT: Read this page before completing your application.

Application Processing

Completed applications are processed within 21 business days from the date the application is received. **Failure to properly complete the form may result in a delay in the processing of your application.** Please note that applications with 100 or more supplier numbers will require an additional 10 business days for processing.

Sections 1, 2, 3, and **4: Required for all applications.**

Section 5: Use to note your software vendor's information. If you will be transmitting claims using the ANSI X12N v. 4010 format, or if you will be using software programmed in the NSF 3.01, you must complete this section.

Section 6: Use to note any special instructions; use to note address changes; and use for documenting the transfer of claims from region to region. Please state: *I am currently transmitting claims directly to Region _____ and I am requesting they transfer into Region D.*

Section 7: For existing submitters only. If you are currently submitting production claims to Region D, you may apply for additional electronic features.

Section 7a: For existing submitters only. If you are currently submitting production claims to Region D, you may apply for additional features (for ANSI format). Please check the appropriate box, test or production.

Section 8: For existing submitters only. Used to authorize a billing service or clearinghouse to add features on the supplier's behalf and to authorize CIGNA Medicare to release patient and/or supplier information electronically to the billing service or clearinghouse.

Section 9: Required for all applications. Mail the completed form(s) to the appropriate address indicated in this section. If ordering *DMACS-837* or CSI (online version), payment may be required.

New Submitter – Enrolling

To enroll in EDI, you must complete both the DMERC EDI Customer Profile (see attached) and the EDI Enrollment Form. You may access the EDI Enrollment Form at ***www.cignamedicare.com/edi*, select EDI Forms and Applications.**

If you want to:	*You must complete sections:*								
	1	***2***	***3***	***4***	***5***	***6***	***7& 7a***	***8***	***9***
Enroll in EDI	X	X	X	X	A	A			X

Existing Submitter – Making a Change/Addition or Migrating to ANSI X12N 837 v. 4010

If you want to:	*You must complete sections:*								
	1	***2***	***3***	***4***	***5***	***6***	***7 & 7a***	***8***	***9***
Change address, phone, or contact information	X	X	X	X		X			X
Change software and/or transmission information	X	X	X	X	A				X
Add electronic features (ERN, Beneficiary Eligibility, CSI)	X	X	X	X			X	A	X
Add ANSI electronic features (835 ERAs, 276/277 Batch CSI)	X	X	X	X			X		X
Change vendor	X	X	X	X	X				X
Add new supplier to existing profile	X	X	X	X					X
Begin transmitting claims in ANSI X12N 837 version 4010	X	X	X	X	A				X
Transferring from another region	X	X	X	X		X*			X

A = Complete this section when applicable
X* = Complete this section with the following sentence: *I am currently transmitting claims directly to Region _____ and I am requesting they transfer into Region D.*

Questions?

Please direct all questions about the DMERC EDI Customer Profile to the EDI Department at 866.224.3094, option 1.

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➔ ALL BILLERS BEGIN HERE ←

Complete this form in its entirety. Incomplete applications may be returned.

(1) General Information

I am a (*select one*)	❑ Supplier	❑ Billing service	❑ Clearinghouse	❑ Software vendor
I am a	❑ New biller	❑ Existing biller (if submitting production claims to Region D)		
I would like to	❑ Enroll in EDI ❑ Change or add to my existing profile ❑ Begin using an **ANSI X12N v. 4010** transaction ❑ Test ❑ Production			

(2) Customer Information

Submitter ID # ***(required for existing billers)***			
Company Name			
Mailing Address			
City, State, Zip			
Phone #	( )	Fax #	( )
Contact Name		E-mail	

(3) Supplier Number(s) - *Please list each individual supplier number for which this application applies. Additional supplier numbers may be added to section #6, or you may attach a separate page to this form.*

Supplier #		Supplier #		Supplier #	
Supplier #		Supplier #		Supplier #	
Supplier #		Supplier #		Supplier #	

(4) Claim Transmission Information (direct communication only)

Format	❑ ANSI X12N 837 v. 4010	❑ NSF 3.01		
Operating System	❑ Windows® Version ( )	❑ UNIX	❑ Other ( )	
Billing Software	❑ Vendor Software *(See # 5)*	❑ Program-In-House	❑ *DMACS-837* ($5.00 S & H)**	
Communications Software	❑ HyperTerminal ®	❑ ProComm Plus®	❑ pcAnywhere®	❑ Other ( )

(5) Software Vendor Information - *If you marked "Vendor Software" in the section above, please complete the fields below.* **This section must be completed if transmitting claims in the ANSI format and using vendor software.**

Company Name			
Mailing Address			
Phone #	( )	Fax #	( )
Contact Name		E-mail	
Software Name		Software Version	

DMERC EDI Customer Profile

(6) Special Instructions

➔ NEW BILLERS STOP HERE – Go to Step #9 ←

If you are currently submitting production claims to Region D, you may apply for additional electronic features and/or you may submit test *or* production claims for ANSI transactions. Continue onto Step #7 for a list of available electronic features.

For more information on available electronic features, please visit the CIGNA Medicare Web site at *www.cignamedicare.com/edi*, select EDI Products and Services.

(7) Additional Features *NOTE: If you want to apply for ANSI transactions, see #7a below.*

❑	Electronic Remittance Notice* (ERN)
	Suppliers must purchase an ERN software program or develop their own software in order to convert the file into a readable format. If a supplier has both Electronic Funds Transfer (EFTs) and ERNs, the supplier will no longer receive paper remittance notices.
	1. What version of NSF is your ERN software program? ❑ NSF 1.04 ❑ NSF 2.00 ❑ NSF 2.01
	2. Would you like to download your file ❑ Daily or ❑ Weekly ?
	3. What is the name of your ERN software program or from whom did you purchase the software?
❑	Beneficiary Eligibility* ***(Available to Participating Suppliers Only)***
	Suppliers must purchase a Beneficiary Eligibility software program or develop their own in order to create and read the files. Please contact the EDI Department for a programming matrix.
	1. EMC Logon ID#: _MB_____
❑	Claim Status Inquiry**(CSI)
	CSI is only available on the AT&T Network (formerly IBM) using the communication software that CIGNA provides. The software, Passport for Windows, can be issued to you upon receipt of $25.00 to cover shipping and handling costs.**
	1. EMC Logon ID#: _MB_____
	2. RCD #_____ (to be completed by CIGNA Medicare)

(7a) Additional Features (for ANSI format)

❑	ANSI X12N 835 (Electronic Remittance Advice) ❑ Test ❑ Production
	Suppliers must purchase an a reader program or develop their own software in order to convert the file into a readable format. If a supplier has both Electronic Funds Transfer (EFT) and electronic remittance advices, the supplier will no longer receive paper remittance notices.
	1. Would you like to download your file ❑ Daily or ❑ Weekly ?
	2. What is the name of your ANSI 835 software program or from whom did you purchase the software?

DMERC EDI Customer Profile

	ANSI X12N 270/271 (Beneficiary Eligibility) – **Currently not available.**
❑	ANSI X12N 276/277 (Batch Claim Status Inquiry) ❑ Test ❑ Production

(8) Third-Party Authorization for Additional Features

** If applying for additional features and using the services of a **billing service, clearinghouse, or for suppliers billing for multiple supplier numbers,** the following authorization must be completed by each supplier.*

I hereby authorize _____

Billing Service/Clearinghouse/Supplier Billing for Multiple Numbers

Check all that apply:

❑ to receive **Electronic Remittance Notices (ERNs)** and/or **ANSI 835 Electronic Remittance Advices** on my behalf. I understand that these transactions contain payment information concerning my processed DMEPOS claims. I also understand that if I am receiving Electronic Funds Transfer (EFTs), my paper remits will be discontinued.

❑ to perform any and all functions of **Beneficiary Eligibility** on my behalf. I understand that this allows access to information regarding patient eligibility.

❑ to perform any and all functions of **Claims Status Inquiry (CSI)** and/or **ANSI 276/277 Batch Claim Status Inquiry** on my behalf. I understand that these transactions allow access to information on both pending and processed DMEPOS claims.

I am authorized to endorse this Third-Party Authorization on behalf of the supplier; and acknowledge that it is my responsibility to notify CIGNA Medicare in advance and in writing if I wish to make any changes or revoke this authorization.

The supplier or a representative from each supplier's office must sign this form. Other signatures may result in a delay in processing this application.	*Supplier or Authorized Signature* / ***Supplier #*** / ***Date***

(9) Form Submission

All applications are processed within 21 business days from the date the application is received. Please note that applications with 100 or more supplier numbers will require an additional 10 business days for processing.

Mail the completed form to: CIGNA Medicare ***Attn: EDI Department*** PO Box 49 Boise, ID 83707 **Please do not fax this form.**	****If applying for *DMACS-837* or CSI (online version) please send both the completed EDI Customer Profile and your check to:** Connecticut General Life Insurance Company PO Box 360295 Pittsburgh, PA 15251-0295 ***Please make check payable to CIGNA***

Incomplete forms may be returned and may result in a delay in the processing of your application.

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Customer Service Available

Telephone Inquiries—Service Representatives are available to answer your questions regarding Region D. For your convenience, our phone lines are open from 8:00 am to 6:00 pm CST, Monday through Friday.

Supplier Help Line: 877.320.0390 ***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

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).

National Supplier Clearinghouse
PO Box 100142
Columbia SC 29202-3142
866.238.9652
www.palmettogba.com

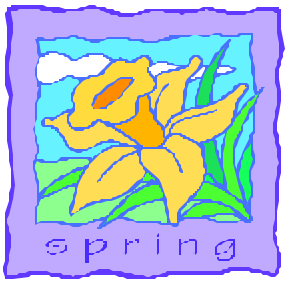
Also, remember that no checks or Medicare Remittance Notices will be issued/mailed if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

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
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Nashville TN 37202
877.320.0390

Region D DMERC Serves. . .

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

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

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