Winter

# DMERC Dialogue

**DMERC Region D**

**January 2003** **General Release 03-1**

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

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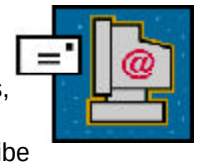

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# *From the Medical Director...*

*Robert Hoover, Jr., MD, MPH*

## Documentation Errors

Results from a recent review of claim errors by the Contractor Error Rate Testing (CERT) program found that over half of the errors were related to documentation. Moreover, in Region D, four policy groups – Home Blood Glucose Monitors, Nebulizers and Nebulizer Drugs, Urological Supplies and Ostomy Supplies – accounted for 70% of the documentation errors. Almost exclusively, the problem is related to lack of orders or incomplete orders. Here are some tips for reducing your claim errors related to orders for these policy items.

**Home Blood Glucose Monitors** – The top errors in this group were for orders that were missing information or orders that were not renewed in a timely manner. To avoid these types of errors, remember to screen your orders for supplies to ensure they contain all of the elements required for a valid Medicare order including:

1. The item(s) to be dispensed;
2. The quantity of item(s) to be dispensed;
3. The specific frequency of testing ("as needed" or "prn" orders are not acceptable);
4. Whether the patient has insulin-treated or non-insulin treated diabetes;
5. The treating physician's signature and date of the treating physician's signature; and
6. The start date of the order – only required if the start date is different than the signature date.

Monitor orders to ensure they are renewed timely and are not refilled until a valid renewal order is on file. Orders for home blood glucose monitor supplies must be renewed every 12 months, even if there is no change in the order.

**Nebulizers and Nebulizer Drugs** – Similar to glucose monitors, no order and information missing from the order were responsible for the bulk of the errors in this group. The most common claim type for items in this policy is drugs used with nebulizer equipment. Orders

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## Documentation Errors (cont'd)

for nebulizer drugs billed to Medicare must include:

1. The name of the drug;
2. The concentration;
3. The dosage;
4. The frequency of administration ("as needed" or "prn" orders are not acceptable);
5. The route of administration; and
6. The narrative diagnosis and/or ICD-9 diagnosis code describing the condition for which the drug is being prescribed.

For all inhalation drugs used in nebulizers, a new order is required every 12 months even if the order does not change. In addition, a new order is required if there is a change in the type of solution dispensed or the administration instructions such as dosing frequency.

**Urological and Ostomy Supplies** – Both of these policies have items that are needed on a recurring basis. For accessories or supplies that will be provided on a periodic basis, the order must contain:

1. The item dispensed;
2. The quantity to be dispensed;
3. The specific frequency of change or use ("as needed" or "prn" orders are not acceptable); and
4. The length of need.

For ostomy supply orders, an ICD-9 diagnosis code describing the type of ostomy must be included on the initial order to the supplier. Also, a new order is required when there is an increase in the quantity of the supply used per month and/or the type of supply used.

For urological supply orders, there must be a statement indicating whether the patient has permanent or temporary urinary incontinence or retention or other indication for the use of a catheter or urinary collection device.

Remember, a thorough intake process can prevent many of these errors. All items require an order if Medicare will be billed. All orders must be signed and dated by the treating physician (stamps are not acceptable). Physicians should be contacted to complete any missing information. In addition, CIGNA will be sending information to physicians reminding them of the Medicare order requirements. For more details about these and other Medicare documentation requirements, consult the *DMERC Region D Supplier Manual.* The supplier manual can also be found online at the CIGNA Medicare Web site at www.cignamedicare.com/dmerc/dmsm.

CIGNA Medicare's primary goal is to pay claims correctly. Your attention to these simple details can make the difference between claim payment and denial.

# *MEDICAL POLICY*

## Electrical Stimulation For The Treatment Of Wounds CIM Revision

*Coverage Issues Manual* (CIM), Section 35-98 Electrical Stimulation for the Treatment of Wounds - pursuant to court's decision Aitken v Shalala, the court ordered an injunction to the national non-coverage policy on the use of electrical stimulation for the treatment of wounds.

The court has enjoined CMS and its agents from enforcing or giving effect to the CIM §35-98. The court's preliminary injunction continues to be in effect. Therefore, contractors must continue to adjudicate all claims for electrical stimulation without regard to the national policy, described in CIM §35-98. This includes all claims for services performed after July 14, 1997. A new policy on electrical stimulation for the treatment of wounds can be found in CIM §35-102 and will be effective for claims with dates of service on or after April 1, 2003. We will delete the outdated reference from the CIM as soon as the court injunction has been lifted.

CIM, Section 35-102 Electrical Stimulation for the Treatment of Wounds - electrical stimulation for the treatment of wounds is the application of electrical current through electrodes placed directly on the skin in close proximity to the wound. Based on evidence that we have reviewed, we are issuing a coverage decision on the use of electrical stimulation only for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers. Electrical stimulation will not be covered as an initial treatment modality. The use of electrical stimulation will be covered only after standard wound therapy has been tried for at least 30 days and there are no measurable signs of healing. Medicare will not cover any form of electromagnetic therapy for the treatment of chronic wounds.

CIM, Section 60-9 Durable Medical Equipment - Reference List - revised to include Electrical Stimulation for Wounds. Unsupervised home use of electrical stimulation for wounds will not be covered, as unsupervised home use has not been found to be medically reasonable and necessary.

This revision to the *Coverage Issues Manual* is a national coverage decision (NCD). NCDs are binding on all carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256 (b), an NCD that expands coverage is also binding on a Medicare + Choice Organization. In addition, an administrative law judge may not review an NCD. (See §1869 (f)(1)(A)( i ) of the Social Security Act.)

This policy revision is effective April 1, 2003. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy.

## Electrical Stimulation For Wound Healing – New National Coverage Decision

The Centers for Medicare and Medicaid Services (CMS) has issued a national coverage decision (NCD) in the Medicare *Coverage Issues Manual*, Section 60-9, stating that, effective for dates of service on or after April 1, 2003, electrical stimulation devices used for the treatment of wounds in the home setting will not be covered. Use of these devices in the home setting will be denied as not medically necessary.

Effective for dates of service on or after January 1, 2003, a new code has been created for a particular type of electrical stimulation device used for wound healing.

> E0761 - Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device

Diapulse® is an example of a device described by this code. As addressed in the NCD, "Medicare will not cover any form of electromagnetic therapy for the treatment of chronic wounds." Manufacturers or suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on whether other devices meet the definition of this code.

Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage. Until the national policy on electrical stimulation of wounds takes effect, the DMERCs will make individual consideration claim determinations based on the related decision memorandum (CAG #00032) which is posted at www.cms.hhs.gov/coverage.

## Home Dialysis Supplies & Equipment - Code Changes

Effective for dates of service on or after January 01, 2003, the following code changes, revisions and deletions are implemented for the Home Dialysis Supplies and Equipment local medical review policy (LMRP):

New Codes:

A4450 Tape, non-waterproof, per 18 square inches
A4452 Tape, waterproof, per 18 square inches
A4653 Peritoneal dialysis catheter anchoring device, belt, each
A4930 Gloves sterile, per pair
A4931 Oral thermometer, reusable, any type, each

Existing Codes Added to Home Dialysis Policy:

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
A6250 Skin sealants
A6260 Wound cleansers
E0210 Electric heat pad, standard
J1644 Injection, heparin sodium, 1,000 units

Verbiage Changes to Existing Codes Within Home Dialysis Policy:

A4656 Needle, 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, per 10 ml
A4927 Gloves, non-sterile, per 100
A4928 Surgical mask, per 20
E1637 Hemostats, each
E1639 Scale, each

Discontinued Codes:

A4801 Heparin, any type, for hemodialysis, per 1000 units
E1638 Heating pad, for peritoneal dialysis, any size, each

Under the standard grace period, the deleted codes (A4801 and E1638) 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 billed 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 A4801 and E1638 should continue to be used on claims with dates of service prior to January 1, 2003, regardless of the date of claim submission.

Providers are reminded that the KX and EM modifiers must also be added to claims with dialysis codes, according to the coverage and payment rules and documentation sections of the DMERC Home Dialysis Supplies and Equipment LMRP. The LMRP may be accessed online at www.cignamedicare.com/dmerc/dmsm.

(Also, see the article in this edition of the *DMERC Dialogue* entitled "New Modifier – AX" for additional information on billing dialysis supplies and equipment.)

## Lower Limb Prostheses – Coverage In SNFs

As described in previous DMERC bulletins, for patients who are in a Medicare Part A covered skilled nursing facility (SNF) stay, lower limb prostheses described by codes L5000-L5020 and L5400-L5460 must be billed by the SNF to the intermediary. Claims for other lower limb prostheses provided to patients in Part A covered stays are submitted to the DMERC. For additional information on Consolidated Billing for Skilled Nursing Facility Residents, refer to the CMS Web site at: http://cms.hhs.gov/medlearn/snfcode.asp.

In the Lower Limb Prostheses local medical review policy (LMRP) in Chapter 9 of the *DMERC Region D Supplier Manual*, page 5, the third paragraph under the heading "General" is being corrected by splitting it into two paragraphs as follows:

Payment for a prosthesis is included in the payment to a hospital if:

1) The prosthesis is provided to a patient during an inpatient hospital stay prior to the day of discharge; and
2) The patient uses the prosthesis for medically necessary inpatient treatment or rehabilitation.

A claim must not be submitted to the DMERC in this situation.

Payment for a prosthesis described by codes L5000-L5020 and L5400-L5460 is included in the payment to a SNF if:

1) The prosthesis is provided to a patient during a

Medicare Part A covered SNF stay prior to the day of discharge; and

2) The patient uses the prosthesis for medically necessary inpatient treatment or rehabilitation.

A claim must not be submitted to the DMERC in this situation. Claims for other lower limb prostheses provided to a patient in a Part A covered SNF stay and claims for any lower limb prosthesis provided in a SNF when the stay is not covered by Part A are submitted to the DMERC.

## Multipositional Patient Support System - New Code

Effective for dates of service on or after January 1, 2003, a new HCPCS code has been established for a multipositional patient support system.

E0636 - Multipositional patient support system, with integrated lift, patient accessible controls

An example of a product that is described by this code is the Arycare Patient Support System.

This HCPCS code is in the capped rental payment category.

If coverage criteria for a patient lift are met, payment for E0636 is based on the least costly alternative, E0630.

For additional information on the coverage, coding, and documentation requirements for this code and other lifts, please refer to the Patient Lifts local medical review policy.

## Nebulizer Local Medical Review Policy – New And Revised Codes

For dates of service on or after January 1, 2003, the following new and revised codes are effective for the Nebulizer and Nebulizer Drugs local medical review policy (LMRP):

New Code:

J7633 Budesonide, inhalation solution administered through DME, concentrated form, per 0.25 milligram

Revised codes:

J7626 Budesonide inhalation solution, administered through DME, unit dose form, 0.25 to 0.5 mg

E0574 Ultrasonic/electronic aerosol generator with small volume nebulizer

When billing code J7626 for dates of service prior to January 1, 2003, 0.5 mg is billed as 2 units of service. For dates of service on or after January 1, 2003, 0.5 mg is billed as *one* unit of service.

Coverage and payment rules for the E0574 continue unchanged. Refer to the *DMERC Region D Supplier Manual* for the LMRP on Nebulizers and Nebulizer Drugs for information on the coverage and payment rules, coding and documentation requirements for these items. The Supplier Manual can be accessed online at www.cignamedicare.com/dmerc/dmsm.

## Neuromuscular Electrical Stimulation (NMES) CIM Revision

*Coverage Issues Manual* (CIM), Section 35-77, Neuromuscular Electrical Stimulation (NMES), is revised to add a new section - Use for Walking in Patients with Spinal Cord Injury (SCI). There are two broad categories of NMES. One type stimulates the muscle when the patient is in a resting state to treat patients with muscle atrophy. A second type is used to enhance functional activity in neurologically impaired patients. These devices use electrical impulses to activate paralyzed or weak muscles in precise sequence and have been utilized to provide the SCI patients with the ability to walk. Based on the evidence they have reviewed, CMS has issued a positive national coverage determination for the use of NMES for walking, but is maintaining the existing national noncoverage policy for the treatment of disuse atrophy in SCI patients.

This revision is a national coverage decision (NCD). The NCDs are binding on all carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare + Choice Organization. In addition, an administrative law judge may not review an NCD. (See §1869(f)(1)(A)(I) of the Social Security Act.)

This policy revision is effective April 1, 2003. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy.

# Ostomy Supplies Local Medical Review Policy – Code Changes

The local medical review policy (LMRP) on Ostomy Supplies will soon be updated to reflect changes in the ostomy HCPCS codes. These include code revisions, additions, deletions, and reinstatement of some previously deleted codes. These code changes are effective for claims with dates of service (DOS) on or after January 1, 2003.

The ostomy HCPCS codes changes are as follows:

**Reinstatements:**

A4368 Ostomy filter, any type, each
A5061 Ostomy pouch, drainable; with barrier attached (1 piece), each

**Revisions:** (See Chapter 16 of the *DMERC Region D Supplier Manual* for code verbiage)

A4372, A4373, A4387, A4388, A4389, A4391, A5051, A5052, A5053, A5054, A5062, A5063, A5071, A5072, A5073

**Added Codes:**

K0581 Ostomy pouch, closed; with barrier attached, with filter (1 piece), each
K0582 Ostomy pouch, closed; with barrier attached, with built-in convexity, with filter (1 piece), each
K0583 Ostomy pouch, closed; without barrier attached, with filter (1 piece), each
K0584 Ostomy pouch, closed; for use on barrier with flange, with filter (2 piece), each
K0585 Ostomy pouch, closed; for use on barrier with locking flange (2piece), each
K0586 Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each
K0587 Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each
K0588 Ostomy pouch, drainable, for use on barrier with flange, with filter (2 piece system), each
K0589 Ostomy pouch, drainable, for use on barrier with locking flange, (2 piece system), each
K0590 Ostomy pouch, drainable, for use on barrier with locking flange, with filter (2 piece system), each
K0591 Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each
K0592 Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each
K0593 Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each
K0594 Ostomy pouch, urinary, with barrier attached, with faucet-type tap with valve (1 piece), each
K0595 Ostomy pouch, urinary, for use on barrier with flange, with faucet-type tap with valve (2 piece), each
K0596 Ostomy pouch, urinary, for use on barrier with locking flange (2 piece), each
K0597 Ostomy pouch, urinary, for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each

The following HCPCS ostomy codes have also been added and are included in the crosswalk table below, where they correspond to deleted codes: A4405, A4406, A4407, A4408, A4409, A4410, A4413, A4414, A4415, A4450, A4452, A4422.

**Deleted Codes:** (See Chapter 16 of the *DMERC Region D Supplier Manual* for code verbiage)

| Deleted Code | New Code for DOS on or after January 1, 2003 |
|---|---|
| K0561 | A4405 |
| K0562 | A4406 |
| K0563 | A4407 |
| K0564 | A4408 |
| K0565 | A4409 |
| K0566 | A4410 |
| K0569 | A4413 |
| K0570 | A4414 |
| K0571 | A4415 |
| K0572 | A4450 |
| K0573 | A4452 |
| K0579 | A4422 |

Other deleted codes include: K0567, K0568, K0574, K0575, K0576, K0577, K0578, K0580

Under the standard grace period, the deleted ostomy codes will continue to be accepted for claims with dates of service on or after January 1, 2003 that are received by March 31, 2003. Claim lines 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. These codes should continue to be used for claims with dates of service prior to January 1, 2003, regardless of the date of claim submission.

Usual Maximum Quantity of Supplies in the LMRP on Ostomy Supplies will be updated to reflect the deleted, new or reinstated HCPCS code(s). In addition, refer-

ences to the add-on feature HCPCS codes will be removed. These changes will be incorporated into the LMRP in an upcoming revision of the *DMERC Region D Supplier Manual*.

In addition, a new HCPCS modifier has been established for use when items are furnished in conjunction with a urological, ostomy or tracheostomy supply.

> AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

This modifier is effective for dates of service on or after January 1, 2003 (See accompanying article in this *DMERC Dialogue* entitled "New Modifier – AU, AV, AW" for further details on which codes must have the AU modifier appended to the claim line(s).)

## Oxygen Qualification With Exercise Testing – Reminder

During a recent review of claims associated with the Comprehensive Error Rate Testing (CERT) program, it was noted that documentation did not support the medical necessity of oxygen provided for patients who qualified on the basis of testing during exercise. National Coverage Policy, outlined in the *Coverage Issues Manual* 60-4, specifies coverage is considered when:

> *An arterial $PO_2$ at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial $PO_2$ at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise* ***if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.*** [emphasis added]

Consequently, qualification for oxygen therapy when testing is performed during exercise requires documentation of 3 measurements of oxygen saturation: 1) testing at rest without oxygen; 2) testing with exercise, but without oxygen, to demonstrate hypoxemia; 3) testing with exercise, with oxygen applied, to demonstrate improvement of the hypoxemia.

Failure to obtain and document test results under all 3 conditions for patients attempting to qualify for oxygen therapy under the exercise category may result in denial of the claim and any subsequent claims that relied upon this testing result. However, only the qualifying test value must be reported on the Certificate of Medical Necessity (CMN). The other test results do not have to be routinely submitted with the claim but must be made available by the supplier to the DMERC upon request.

## Pneumatic Compression Devices - Documentation Reminder

Overall DMERC denials for pneumatic compression pumps have dropped in each of the last three years; however, the percentage of claims denied as a proportion of all claims processed remains unusually high. We have noted that many of the current denials occur when the devices are used for the treatment of chronic venous insufficiency, as opposed to primary or secondary lymphedema.

If a patient suffers from chronic venous insufficiency, suppliers must answer "Y" to question #3 on the CMN. According to the DMERC LMRP on pneumatic compression devices, "If question #3 on the CMN ("Does the patient have chronic venous sufficiency with venous stasis ulcers?") is answered "Yes," documentation supporting the medical necessity for the device should include a signed and dated statement from the treating physician indicating:

1. The location and size of venous stasis ulcer(s);
2. How long each ulcer has been continuously present;
3. Whether the patient has been treated with a compression bandage system or compression garment, appropriate dressings for the ulcer(s), exercise and limb elevation for the past 6 months; and
4. Whether the patient has been seen regularly by a physician for treatment of venous stasis ulcer(s) during the past 6 months.

If the ulcer has healed after the requisite 6 months of treatment, the device will not be covered. An ulcer must still be present when the device is first applied.

If E0652 is billed, additional documentation supporting the medical necessity for this device should include a signed and dated statement from the ordering physician indicating:

1. The treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode;
2. Whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented appliance (E0671-E0673) had been tried and the

results;
3. Why the features of the system that was provided are needed for this patient; and
4. The name, model number, and manufacturer of the device.

In analyzing denied claims for chronic venous insufficiency, common deficiencies include absent or poor description of the location and size of the ulcers being treated, indication of how long conservative treatment measures have been tried and (for E0652) an adequate description of the distinct lesion causing pain in a discrete area to be bypassed by the preprogrammed pressure available in an E0651. Providers are reminded of the importance of this information and of their responsibility to provide this supporting information when required.

Refer to the Supplier Manual for more information on orders, CMNs, medical records, and supplier documentation. The *DMERC Region D Supplier Manual* can be accessed online at www.cignamedicare.com/dmerc/dmsm/.

## Reasonable Useful Lifetime – Clarification

In a Summer 2001 *DMERC Dialogue* article (pg. 5), Medicare coverage of replacement durable medical equipment (DME) was discussed. The article stated that replacement of DME may be covered when an item is "worn beyond repair." This statement was only partially correct.

Medicare guidelines governing the replacement of DME, orthotics, and certain prosthetics (see exceptions below) specify that the reasonable, useful lifetime is determined by the Carrier, but in no case, can it be less than five (5) years. Replacement during the first five years of use, during the "reasonable useful lifetime," is covered if the item is lost, irreparably damaged or the patient's medical condition changes such that the current equipment no longer meets the patient's needs. Replacement due to irreparable wear during the period of reasonable useful lifetime is not covered.

The term "irreparable damage" is often confused with "irreparable wear." Irreparable damage, like loss or theft, is a rare, unexpected event that is an exception to the reasonable useful lifetime rule. Medicare considers irreparable damage to have occurred when an item is damaged beyond repair by a specific incident or accident. For example, a power wheelchair falls off of a van while traveling down the highway. If the cost to repair the wheelchair exceeds the cost of a new wheelchair, Medicare would cover the replacement.

Accidental damage must be distinguished from wear. Wear is deterioration sustained from day-to-day usage over time and a specific event cannot be identified that caused the deterioration. For example, the drive motor in a power wheelchair breaks down after 3 years of use because the patient uses the power wheelchair on a daily basis to go to work and school and for mobility in their home environment. There is no specific incident that can be identified that caused the motor to stop other than the daily "wear" on the motor. In this example, Medicare would not cover a replacement wheelchair because the statutory 5-year period of useful lifetime has not expired. However, Medicare would cover repair of the wheelchair up to but not exceeding the cost of replacement of the wheelchair.

There are two exceptions to the above guidance that apply to limb prostheses and external breast prostheses. For limb prostheses, a recent change to the reasonable useful lifetime rule was made when the Benefits Improvement and Protection Act of 2000 amended §1834(h)(1) of the Social Security Act by adding a provision (1834 (h)(1)(G)(i)) that requires Medicare payment to be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.

Payment may be made for the replacement of a prosthetic device which is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device, or in a part of the device; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

This provision supersedes the 5-year replacement rule with regard to prosthetic devices and applies to items replaced on or after April 1, 2001.

External breast prostheses represent the other exception to the 5-year rule. The Centers for Medicare and Medicaid Services (CMS) Transmittal AB-01-123 instructs the Durable Medical Equipment Regional Carri-

ers to consider the useful lifetime of silicone breast prostheses to be 2 years, and for fabric, foam or fiber-filled breast prostheses, to be 6 months. However, a breast prosthesis may be replaced at any time if it is lost, irreparably damaged (this does not include ordinary wear and tear), or if there is a change in the patient's medical condition requiring a different type of item.

## Spinal Orthoses - New Codes

In September 1999, the Office of Inspector General (OIG) released to the Centers for Medicare & Medicaid Services (CMS) a report entitled Medicare Payments for Orthotic Body Jackets (available on the OIG web site http://oig.hhs.gov/oas/reading/cms0100.html.). As a result of the report findings, CMS instructed the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) to conduct Coding Verification Reviews on the Thoracic Lumbar Sacral Spinal Orthoses (TLSOs).

Upon review of the TLSO codes, SADMERC found that some of the codes were outdated and others contained vague descriptors. As the SADMERC attempted to assign HCPCS codes using the system L0300 through L0440, it became apparent that many of the products on the market today did not meet the existing codes and manufacturers were being instructed to use the L1499, a miscellaneous code for billing Medicare. Manufacturers complained to the SADMERC that using L1499 was not a solution.

In an attempt to update the codes for spinal orthoses, the SADMERC and CMS worked with consultants and experts in the field of orthotics. The results of this collaborative effort are the new TLSO codes presented below. These codes are valid for dates of service on or after January 1, 2003.

**L0450** TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment

**L0452** TLSO, flexible**,** provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures**,** custom fabricated

**L0454** TLSO flexible**,** provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures**,** prefabricated, includes fitting and adjustment

**L0456** TLSO, flexible**,** provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures**,** prefabricated, includes fitting and adjustment

**L0458** TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures**,** prefabricated, includes fitting and adjustment

**L0460** TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures**,** prefabricated, includes fitting and adjustment

**L0462** TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures**,** prefabricated, includes fitting and adjustment

**L0464** TLSO, triplanar control, modular segmented spinal system**,** four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures prefabricated, includes fitting and adjustment

**L0466** TLSO, sagittal control**,** rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame**,** prefabricated, includes fitting and adjustment

**L0468** TLSO, sagittal-coronal control**,** rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame**,** prefabricated, includes fitting and adjustment

**L0470** TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame**,** prefabricated, includes fitting and adjustment

**L0472** TLSO, triplanar control, hyperextension**,** rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame**,** prefabricated, includes fitting and adjustment

**L0476** TLSO, sagittal-coronal control, flexion compression jacket**,** two rigid plastic shells with soft liner, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of the LS region, includes straps and closures, prefabricated, includes fitting and adjustment

**L0478** TLSO, sagittal-coronal control, flexion compression jacket, two rigid plastic shells with soft liner, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of LS region, includes straps and closures**,** custom fabricated

**L0480** TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model**,** custom fabricated

**L0482** TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model**,** custom fabricated

**L0484** TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model**,** custom fabricated

**L0486** TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or CAD-CAM model**,** custom fabricated

**L0488** TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment.

**L0490** TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from

sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes**,** prefabricated, includes fitting and adjustment

The following codes are discontinued effective for dates of service on or after January 1, 2003: L0300, L0310, L0315, L0317, L0320, L0321, L0330, L0331, L0340, L0350, L0360, L0370, L0380, L0390, L0391, L0400, L0410, L0420, L0430, L0440, and L0986. Under the standard grace period, these codes 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 these codes with dates of service on or after January 1, 2003 that are received on or after April 1, 2003 will be returned or denied as invalid coding. These codes should continue to be used on claims with dates of service prior to January 1, 2003 regardless of the date of claim submission.

Definitions:

A prefabricated orthosis is one that is manufactured in quantity without a specific patient in mind. It is preformed with a shape that generally conforms to the body part. A prefabricated orthosis may be trimmed, bent, molded (with or without heat) or otherwise modified for use by a specific patient (i.e., custom fitted). A preformed orthosis is considered prefabricated even if it requires the attachment of straps and/or the addition of a lining and/or other finishing work. Multiple measurements may be taken of the body part to determine which stock size of a prefabricated orthosis will provide the best fit. An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom fabricated orthosis is considered prefabricated.

A custom fabricated orthosis is one that is individually made for a specific patient (no other patient would be able to use this orthosis) starting with basic materials including, but not limited to, plastic, metal, leather or cloth in the form of flat sheets, bars, etc. It involves substantial work such as vacuum forming, cutting, bending, molding, sewing, etc. It requires more than just trimming, bending or making other modifications to a significantly prefabricated manufactured item. This item is not made in quantity but is made for one person only.

A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis that describes the way the orthosis is formed. A positive model of the specific body part may be produced from a three-dimensional negative impression which is made using plaster or fiberglass casting material or a CAD-CAM digital scanning model. Detailed measurements of the patient's torso may also be used to modify a positive model (which has been selected from a large library of models) to make it conform to the patient's body shape and dimensions. The orthosis is then individually fabricated and molded over the positive model of the patient.

## Surgical Dressings – New Codes

New codes are being established for roll bandages that are used as secondary dressings including items that are components of multi-layer compression bandage systems. The new codes are effective for dates of service on or after January 1, 2003.

**A6421** Padding bandage, non-elastic, non-woven/ non-knitted, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6422** Conforming bandage, non-elastic, knitted/ woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6424** Conforming bandage, non-elastic, knitted/ woven, non-sterile, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)

**A6426** Conforming bandage, non-elastic, knitted/ woven, sterile, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6428** Conforming bandage, non-elastic, knitted/ woven, sterile, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)

**A6430** Light compression bandage, elastic, knitted/ woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6432** Light compression bandage, elastic, knitted/ woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)

**A6434** Moderate compression bandage, elastic, knitted/ woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6436** High compression bandage, elastic, knitted/ woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

**A6438** Self-adherent bandage, elastic, non-knitted/ non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 5 yards, unstretched)

**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)

The following codes are discontinued effective for dates of service on or after January 1, 2003:

**A4460** Elastic bandage, per roll, (e.g. compression bandage)

**A6263** Gauze, elastic, non-sterile, per linear yard

**A6264** Gauze, non-elastic, non-sterile, per linear yard

**A6405** Gauze, elastic, sterile, per linear yard

**A6406** Gauze, non-elastic, sterile, per linear yard

Under the standard grace period, these codes 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 these codes 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. These codes should continue to be used on claims with dates of service prior to January 1, 2003 regardless of the date of claim submission.

Note that the unit of service for all the new codes is "per roll" rather than "per linear yard."

One major distinguishing feature between different products is whether they are elastic or non-elastic. In the new codes, elastic bandages are those that contain fibers of rubber (latex, neoprene), spandex, or elastane. Roll bandages that do not contain these fibers are considered non-elastic bandages even though many of them (e.g., gauze bandages) are stretchable.

Code A6421 describes a padding layer that is included in some multi-layer compression bandage systems. There is currently no specific code to describe these products.

Codes A6422-A6428 describe roll gauze-type bandages made either of cotton or of synthetic materials such as nylon, viscose, polyester, rayon, polyamide. These bandages are stretchable, but do not contain elastic fibers. Roll bandages previously coded as A6263 or A6264 are now coded as A6422 or A6424, depending on the width of the roll. Roll bandages previously coded as A6405 or A6406 are now coded as A6426 or A6428, depending on the width of the roll. These codes include short-stretch bandages. Roll bandages described by code A6422 are included in some multi-layer compression bandage systems.

Codes A6430 and A6432 describe ACE type elastic bandages that were previously billed with code A4460.

Codes A6434 and A6436 describe elastic bandages that produce moderate or high compression that is sustained typically for one week. They are commonly included in multi-layer compression bandage systems. These items were previously billed with code A4460. Suppliers billing these new codes must be able to provide, on request from the DMERC, documentation from the manufacturer verifying that the product meets the performance characteristics specified in the code narratives. Manufacturers of these products are encouraged to seek a Coding Verification Review from the SADMERC.

Code A6438 describes an elastic bandage that adheres to itself but not to skin. These bandages serve as the top layer of some multi-layer compression bandage systems and are also used over zinc paste roll bandages (A6440). These items were previously billed with code A4460.

Code A6440 describes a bandage commonly referred to as an Unna Boot. These items were previously billed with code A6266 (gauze, impregnated, other than water or normal saline, any width, per linear yard). Code A6266 may not be used for zinc paste bandages for dates of service on or after April 1, 2002.

As noted in the Surgical Dressings policy, multi-layer compression bandage systems are covered when they are used in the treatment of venous stasis ulcers. Compression bandage systems are noncovered if a wound is not present. It is understood that products described by multiple codes are often packaged together because they work synergistically.

Multi-layer compression bandage systems used for the treatment of venous stasis ulcers are applied by clinicians. If they are applied in an office or other outpatient facility, claims should not be submitted to the DMERC.

Similarly, when they are applied in the hospital, in a Part A covered skilled nursing facility stay, or to a patient covered by the Medicare home health benefit, claims should not be submitted to the DMERC. Claims for compression bandage systems submitted to the DMERC would be those that will be applied by clinicians in the home setting when the patient is not covered by the Medicare home health benefit or in a nursing facility when the stay is not covered by Medicare Part A.

Compression stockings are noncovered when used as part of the treatment of venous stasis ulcers.

## Surgical Dressings, PEN – New Modifiers

New modifiers have been established for use with surgical dressing codes. A new modifier has also been established for use in conjunction with parenteral or enteral nutrition (PEN).

| | |
|---|---|
| A1 | Dressing for one wound |
| A2 | Dressing for two wounds |
| A3 | Dressing for three wounds |
| A4 | Dressing for four wounds |
| A5 | Dressing for five wounds |
| A6 | Dressing for six wounds |
| A7 | Dressing for seven wounds |
| A8 | Dressing for eight wounds |
| A9 | Dressing for nine wounds (This modifier should be used if there are 9 or more wounds.) |
| BA | Item furnished in conjunction with parenteral enteral nutrition (PEN) services |

Modifiers A1-A9 replace modifiers X1-X9 and must be used according to the instructions in the Surgical Dressings local medical review policy (LMRP).

Modifier BA replaces modifier XA and must be used for the IV pole (E0776) according to the instructions in the Parenteral Nutrition and Enteral Nutrition LMRPs.

Modifiers A1-A9 and BA are effective for claims with dates of service on or after January 1, 2003. Modifiers A1-A9 and BA must not be used for claims with dates of service prior to January 1, 2003. Use for dates of service prior to January 1, 2003 will be returned as unprocessable or denied for incorrect coding.

**There is no grace period for the use of the X1-X9 and XA modifiers.** Modifiers X1-X9 and XA must not be used for claims with dates of service on or after January 1, 2003. Use for dates of service on or after January 1, 2003 will be returned as unprocessable or denied for incorrect coding. Modifiers X1-X9 and XA must continue to be used for claims with dates of service prior to January 1, 2003, regardless of the date of claim submission.

If you have already sent the DMERC a CMN for the IV pole with an XA modifier, no new CMN is required to change the modifier.

Refer to the local medical review policy on Surgical Dressings in the *DMERC Region D Supplier Manual* for additional information on the appropriate use of surgical dressing modifiers. The *DMERC Region D Supplier Manual* may be accessed online at www.cignamedicare.com/dmerc/dmsm.

# *COVERAGE AND BILLING*

## Amphotericin B - New HCPCS Codes

Effective for dates of service on or after January 1, 2003, three new HCPCS codes have been established.

| | |
|---|---|
| J0287 | Amphotericin B lipid complex, injection, 10 mg |
| J0288 | Amphotericin B cholesteryl sulfate complex, injection, 10 mg |
| J0289 | Amphotericin B liposome, injection, 10 mg |

These new codes will replace code J0286 (Injection, amphotericin B, any lipid formulation, 50 mg) which is discontinued. Suppliers should use the J code that corresponds to the specific product being used.

Under the standard grace period, code J0286 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 code J0286 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. Code J0286 should continue to be used for claims with dates of service prior to January 1, 2003, regardless of the date of claim submission.

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.

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

The following changes apply to claims processed for Home Health Consolidated Billing with dates of service on or after January 1, 2003. These non-routine medical supply codes are included in the Medicare payment made to the Home Health agency.

The following new codes replace the corresponding deleted codes:

| New Code and Description | Deleted Code and Description |
|---|---|
| A4405 Non-pectin based ostomy paste | K0561 Non-pectin based ostomy paste |
| A4406 Pectin based ostomy paste | K0562 Pectin based ostomy paste |
| A4407 Ext wear ost skn barr <4sq" | K0563 Ext wear ost skn barr <4sq" |
| A4408 Ext wear ost skn barr >4sq" | K0564 Ext wear ost skn barr >4sq" |
| A4409 Ost skn barr w flng <4sq" | K0565 Ost skn barr w flng <4sq" |
| A4410 Ost skn barr w flng >4sq" | K0566 Ost skn barr w flng >4sq" |
| A5061 Pouch drainable w barrier at | K0567 1 pc drainable ost pouch |
| A5061 Pouch drainable w barrier at | K0568 1 pc cnvx drainabl ost pouch |
| A4413 2 pc drainable ost pouch | K0569 2 pc drainable ost pouch |
| A4414 Ostomy skn barr w flng <4sq" | K0570 Ostomy skn barr w flng <4sq" |
| A4415 Ostomy skn barr w flng >4sq" | K0571 Ostomy skn barr w flng >4sq" |
| A4368 Ostomy filter | K0574 Ostomy pouch filter |
| A4422 Ost pouch absorbent material | K0579 Ost pouch absorbent material |

Additional deleted codes without replacement:

| |
|---|
| K0575 Ost pouch rustle free material |
| K0576 Ostomy pouch comfort panel |
| K0577 Ostomy pouch odor barrier |
| K0578 Urinary pouch faucet/drain |
| K0580 Ost pouch locking flange |

The following codes are added to the Home Health Consolidated Billing code list:

| | |
|---|---|
| A4458 Reusable enema bag | A4656 Needle, any size, each |
| A4657 Syringe, with or without needle, each | A4712 Sterile water inj per 10 ml |
| A4930 Sterile, gloves per pair | A6011 Collagen gel/paste wound fil |
| A6410 Sterile eye pad | A7043 Vacuum drainage bottle/tubing |
| K0581 Ost pch clsd w barrier/filtr | K0582 Ost pch w bar/bltinconv/fltr |
| K0583 Ost pch clsd w/o bar w filtr | K0584 Ost pch for bar w flange/flt |
| K0585 Ost pch clsd for bar w lk fl | K0586 Ost pch for bar w lk fl/fltr |
| K0587 Ost pch drain w bar & filter | K0588 Ost pch drain for barrier fl |
| K0589 Ost pch drain 2 piece system | K0590 Ost pch drain/barr lk flng/f |
| K0591 Urine ost pouch w faucet/tap | K0592 Urine ost pouch w bltinconv |
| K0593 Ost urine pch w b/bltin conv | K0594 Ost pch urine w barrier/tapv |
| K0595 Os pch urine w bar/fange/tap | K0596 Urine ost pch bar w lock fln |
| K0597 Ost pch urine w lock flng/ft | |

The following is a complete list of HCPCS codes subject to Home Health Consolidated Billing for dates of service on or after January 1, 2003. This list will be updated on a quarterly basis:

A4212 A4310 A4311 A4312 A4313 A4314 A4315 A4316 A4319 A4320 A4321 A4322 A4323 A4324
A4325 A4326 A4327 A4328 A4330 A4331 A4332 A4333 A4334 A4335 A4338 A4340 A4344 A4346
A4347 A4348 A4351 A4352 A4353 A4354 A4355 A4356 A4357 A4358 A4359 A4361 A4362 A4364
A4365 A4367 A4368 A4369 A4371 A4372 A4373 A4375 A4376 A4377 A4378 A4379 A4380 A4381
A4382 A4383 A4384 A4385 A4387 A4388 A4389 A4390 A4391 A4392 A4393 A4394 A4395 A4396
A4397 A4398 A4399 A4400 A4402 A4404 A4405 A4406 A4407 A4408 A4409 A4410 A4413 A4414
A4415 A4421 A4422 A4455 A4458 A4460 A4462 A4481 A4622 A4623 A4625 A4626 A4649 A4656
A4657 A4712 A4930 A5051 A5052 A5053 A5054 A5055 A5061 A5062 A5063 A5071 A5072 A5073
A5081 A5082 A5093 A5102 A5105 A5112 A5113 A5114 A5119 A5121 A5122 A5126 A5131 A6010
A6011 A6020 A6021 A6022 A6023 A6024 A6154 A6196 A6197 A6198 A6199 A6200 A6201 A6202
A6203 A6204 A6205 A6206 A6207 A6208 A6209 A6210 A6211 A6212 A6213 A6214 A6215 A6219
A6220 A6221 A6222 A6223 A6224 A6228 A6229 A6230 A6231 A6232 A6233 A6234 A6235 A6236
A6237 A6238 A6239 A6240 A6241 A6242 A6243 A6244 A6245 A6246 A6247 A6248 A6251 A6252
A6253 A6254 A6255 A6256 A6257 A6258 A6259 A6261 A6262 A6266 A6402 A6403 A6404 A6405
A6406 A6410 A7043 A7501 A7502 A7503 A7504 A7505 A7506 A7507 A7508 A7509 K0581 K0582
K0583 K0584 K0585 K0586 K0587 K0588 K0589 K0590 K0591 K0592 K0593 K0594 K0595 K0596
K0597

## Appropriate UPIN Usage

CIGNA DMERC has identified that claims are being submitted with an incorrect Unique Physician Identification Number (UPIN). The UPIN A11111 should only be used to reference the physician to whom this UPIN is actually assigned. This is not a surrogate UPIN or a "wild card" to be used when the UPIN of the referring physician is not known.

Incorrect use of UPIN A11111 will result in denial. Refer to the article in this *DMERC Dialogue* entitled "Durable Medical Equipment Ordered with Surrogate Unique Physician Identification Numbers (UPINs)" for instructions on the use of surrogate UPINs.

## Charges Imposed By Family Members Of Patient

According to the *Medicare Carriers Manual*, section 2332, Medicare will not pay for items billed by immediate relatives of beneficiaries or by immediate members of their household. This exclusion applies to items and services rendered by a related physician or supplier, even if the bill or claim is submitted by an unrelated individual or by a partnership or a professional corporation. The following degrees of relationship are included in the definition of immediate relative:

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

Note: A brother-in-law or sister-in-law relationship does not exist between a physician (or supplier) and the spouse of his wife's (her husband's) brother or sister. A father-in-law or mother-in-law relationship does not exist between a physician and his/her spouse's stepfather or stepmother.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or through the death of one of the parties. For example, if a physician treats his stepfather after the death of his natural mother or after the stepfather and natural mother are divorced or if he treats his father-in-law or mother-in-law after the death of his wife, the services are considered to have been furnished to an immediate relative and are excluded from coverage.

Members of a patient's household are considered to be persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage, or adoption, domestic employees, and others who live together as part of a single family unit. A mere roomer or boarder is not included.

This exclusion applies to physician services, including services of a physician who belongs to a professional corporation and services furnished by the physician's nurse or technician if the physician who ordered or supervised services has an excluded relationship to the beneficiary. This exclusion also applies to items or services furnished by a nonphysician supplier that is not incorporated, whether the supplier is owned by a sole proprietor who is related to the patient or by a partnership in which even one of the partners is related to the patient.

## Correct Billing Of Vision Codes

When billing for lenses with add-on features, the specific eyeglass lens as well as the add-on feature of the lens must be billed. For example, if billing for a progressive lens feature for a bifocal spherocylinder lens, the specific eyeglass lens code (i.e., V2200) must be billed as well as the code for the progressive lens add-on feature (V2781). The Coding Guidelines portion of the Refractive Lenses policy in the *DMERC Region D Supplier Manual* contains additional information on correctly coding and billing these vision codes.

## Deported Medicare Beneficiaries

Sections 226 and 226(A) of the Social Security Act (the Act) provide that no payments may be made for benefits under Part A of Title XVIII of the Act if there is no monthly benefit payable under Title II. Section 1836 of the Act limits Part B benefits to those who are either entitled to Part A benefits or who are age 65 and a United States (U.S.) resident, U.S. citizen or a lawfully admitted alien residing permanently in the U.S. Finally, a deported beneficiary is not allowed to enter the U.S. and cannot be lawfully present in the United States to receive Medicare-covered services.

Effective for claims processed on or after April 1, 2003 the Common Working File (CWF) will edit for claims processed for deported beneficiaries. Claims submitted for payment with dates of service on or after the

effective date of the CWF record will be denied with the following messages:

> ANSI reason code 96 – Non-covered charges
>
> ANSI remark code N126 - Social Security records indicate that this beneficiary has been deported. The payer does not cover items and services furnished to individuals that have been deported.

A party to a claim denied in whole or in part under this policy may appeal the initial determination only on the basis of deportation status.

## Durable Medical Equipment Ordered With Surrogate Unique Physician Identification Numbers (UPINs)

Section 1833(q) of the Social Security Act requires that all physicians who meet the §1861(r) definition of a physician must have a UPIN. All claims for services ordered or referred by a physician must include the name and UPIN of the ordering/referring physician.

A physician or supplier who bills Medicare for a service or item must show the name and UPIN of the ordering/referring physician on the claim form, if that service or item was the result of an order or referral from a physician. If the ordering physician is also the performing physician, the physician must enter his/her name and assigned UPIN as the ordering physician. If the ordering/referring physician is not assigned a UPIN, the biller may use a surrogate UPIN.

A physician or supplier who submits a claim for a service or item is responsible for ensuring that the name and UPIN of the ordering/referring physician is obtained and submitted on Form CMS-1500. Physician names and UPINs can be found in the UPIN directory. If the physician's UPIN has not yet been issued, a surrogate UPIN is to be used only until an individual UPIN has been assigned. Surrogate UPINs are used under these conditions:

- OTH000: To be used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs. If a UPIN has been assigned, the physician will be notified of the assigned UPIN. If a UPIN has not been assigned, the physician will be notified of the need to file an application for a UPIN and sent an application form.
- RES000: To be used by physicians meeting the description of "intern," "resident," or "fellow."
- VAD000: To be used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.
- PHS000: To be used by physicians serving in the Public Health Service, including the Indian Health Service.
- RET000: To be used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

It is the goal of the Centers for Medicare & Medicaid Services to assign a UPIN to every physician/health care practitioner and group practice that meets the Medicare definition.

## HCPCS Codes Excluded From Consolidated Billing (CB) For Skilled Nursing Facility (SNF) Residents

Section 4432(b) of the Balanced Budget Act (BBA) requires Consolidated Billing for the SNF. The SNF bills Medicare for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

Effective 04/01/01, services and supplies furnished to a SNF resident covered under the Part A benefit must be furnished by the SNF either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare carrier, for payment.

It is the supplier's responsibility to check with the facility to see if their patient is a resident in a covered Part A stay. If so, all services must be sent to Medicare by the SNF. Services billed to the DMERC for a beneficiary in a covered Part A stay will be denied with the following messages.

> ANSI reason code 109 – Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor; and
>
> Remark code N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

**DMERC Services excluded from Consolidated Billing in a SNF:**

Erythropoietin (EPO) Services - These services are not included in the SNF Part A PPS rate and are excluded from CB. EPO services are identified by the following HCPCS codes:

Q9920 - Injection of EPO, per l,000 units, at patient HCT of 20 or less;

Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 2l through 39; or

Q9940 - Injection of EPO, per l,000 units at patient HCT of 40 or above.

Dialysis **-** Home dialysis equipment, home dialysis support services, institutional dialysis services and supplies are excluded from CB and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment.

Customized Prosthetic Devices

| | | | | | | |
|---|---|---|---|---|---|---|
| L5050 | L5060 | L5100 | L5105 | L5150 | L5160 | L5200 |
| L5210 | L5220 | L5230 | L5250 | L5270 | L5280 | L5300 |
| L5301 | L5310 | L5311 | L5320 | L5321 | L5330 | L5331 |
| L5340 | L5341 | L5500 | L5505 | L5510 | L5520 | L5530 |
| L5535 | L5540 | L5560 | L5570 | L5580 | L5585 | L5590 |
| L5595 | L5600 | L5610 | L5611 | L5613 | L5614 | L5616 |
| L5617 | L5618 | L5620 | L5622 | L5624 | L5626 | L5628 |
| L5629 | L5630 | L5631 | L5632 | L5634 | L5636 | L5637 |
| L5638 | L5639 | L5640 | L5642 | L5643 | L5644 | L5645 |
| L5646 | L5647 | L5648 | L5649 | L5650 | L5651 | L5652 |
| L5653 | L5654 | L5655 | L5656 | L5658 | L5660 | L5661 |
| L5662 | L5663 | L5664 | L5665 | L5666 | L5667 | L5668 |
| L5669 | L5670 | L5671 | L5672 | L5674 | L5675 | L5676 |
| L5677 | L5678 | L5680 | L5682 | L5684 | L5686 | L5688 |
| L5690 | L5692 | L5694 | L5695 | L5696 | L5697 | L5698 |
| L5699 | L5700 | L5701 | L5702 | L5704 | L5705 | L5706 |
| L5707 | L5710 | L5711 | L5712 | L5714 | L5716 | L5718 |
| L5722 | L5724 | L5726 | L5728 | L5780 | L5782 | L5785 |
| L5790 | L5795 | L5810 | L5811 | L5812 | L5814 | L5816 |
| L5818 | L5822 | L5824 | L5826 | L5828 | L5830 | L5840 |
| L5845 | L5846 | L5847 | L5848 | L5850 | L5855 | L5910 |
| L5920 | L5925 | L5930 | L5940 | L5950 | L5960 | L5962 |
| L5964 | L5966 | L5968 | L5970 | L5972 | L5974 | L5975 |
| L5976 | L5978 | L5979 | L5980 | L5981 | L5982 | L5984 |
| L5985 | L5986 | L5988 | L5989 | L5990 | L5995 | L6050 |
| L6055 | L6100 | L6110 | L6120 | L6130 | L6200 | L6205 |
| L6250 | L6300 | L6310 | L6320 | L6350 | L6360 | L6370 |
| L6400 | L6450 | L6500 | L6550 | L6570 | L6580 | L6582 |
| L6584 | L6586 | L6588 | L6590 | L6600 | L6605 | L6610 |
| L6615 | L6616 | L6620 | L6623 | L6625 | L6628 | L6629 |
| L6630 | L6632 | L6635 | L6637 | L6638 | L6640 | L6641 |
| L6642 | L6645 | L6646 | L6647 | L6648 | L6650 | L6655 |
| L6660 | L6665 | L6670 | L6672 | L6675 | L6676 | L6680 |
| L6682 | L6684 | L6686 | L6687 | L6688 | L6689 | L6690 |
| L6691 | L6692 | L6693 | L6700 | L6705 | L6710 | L6715 |
| L6720 | L6725 | L6730 | L6735 | L6740 | L6745 | L6750 |
| L6755 | L6765 | L6770 | L6775 | L6780 | L6790 | L6795 |
| L6800 | L6805 | L6806 | L6807 | L6808 | L6809 | L6810 |
| L6825 | L6830 | L6835 | L6840 | L6845 | L6850 | L6855 |
| L6860 | L6865 | L6867 | L6868 | L6870 | L6872 | L6873 |
| L6875 | L6880 | L6881 | L6882 | L6920 | L6925 | L6930 |
| L6935 | L6940 | L6945 | L6950 | L6955 | L6960 | L6965 |
| L6970 | L6975 | L7010 | L7015 | L7020 | L7025 | L7030 |
| L7035 | L7040 | L7045 | L7170 | L7180 | L7185 | L7186 |
| L7190 | L7191 | L7260 | L7261 | L7266 | L7272 | L7274 |
| L7362 | L7364 | L7366 | | | | |

## ICD-9 Diagnosis Codes Must Be Valid

The *Medicare Carriers Manual* (Part 3, Section 3005.4) and Program Memorandum Transmittal B-02-064 (CR 2209) instruct carriers to begin editing for the validity of diagnosis codes based on the date of service (DOS) of the procedure code to which the diagnosis code is correlated. Beginning in April 2003, claims submitted with invalid or truncated ICD-9 diagnosis codes, for the DOS on the claim, will be returned as unprocessable. The most specific ICD-9 diagnosis code must be used. For example, a diagnosis of adult onset type diabetes mellitus without mention of complication should be coded 250.00. Diagnosis code 250 (diabetes mellitus) will not be accepted since a more specific code exists.

These claims will be returned with ANSI messages 16 and M81. ANSI message 16 states, "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate." ANSI message M81 states, "Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity."

Providers and their billing staff will need to know which diagnosis code is in effect at the time the service was rendered. Refer to articles included in the Fall 2002 *DMERC Dialogue* entitled "ICD-9-CM Coding Update" and "ICD-9 Codes Will Be Date of Service Driven" for more information.

## New Codes For Prosthetic Socket Inserts

Effective for dates of service on or after October 1, 2002, new codes have been created for prefabricated and custom fabricated socket inserts for lower limb prostheses. These codes replace codes L5660, L5662, L5663, and L5664.

**K0556** Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

**K0557** Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

**K0558** Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital

or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

**K0559** Addition to lower extremity, below knee/ above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

Codes L5660, L5662, L5663 and L5664 are invalid for Medicare use after October 1, 2002. Under the standard grace period, codes L5660, L5662, L5663 and L5664 will continue to be accepted on claims with dates of service on or after October 1, 2002 that are received by December 31, 2002. Claim lines for codes L5660, L5662, L5663 and L5664 with dates of service on or after October 1, 2002 that are received after December 31, 2002 will be returned or denied as invalid coding. Codes L5660, L5662, L5663, and L5664 should continue to be used for claims with dates of service prior to October 1, 2002, regardless of the date of claim submission.

Codes K0556 and K0557 represent socket inserts that are either prefabricated or are custom fabricated from a patient's existing mold. Custom fabricated socket inserts created from a new mold are coded K0558 or K0559.

Note that two of the new codes, K0558 and K0559, are for use only with the initial issue of a custom fabricated socket insert. Additional inserts (either custom fabricated or prefabricated) provided at the time of initial issue or replacement socket inserts are coded K0556 and K0557, whichever is applicable.

Codes L5647 (addition to lower extremity, below knee, suction socket) and L5652 (addition to lower extremity, suction suspension, above knee or knee disarticulation socket) describe modifications to the prosthetic socket itself and may be billed only when a new prosthesis or a replacement socket is being constructed or an existing socket is being modified. Codes L5647 and L5652 must not be billed when only a socket insert is provided and no modification is made to the socket itself.

The same coverage and payment rules, coding guidelines, and documentation requirements apply to codes K0556 – K0559 as apply to L5660 and L5662 – L5664.

The local medical review policy on Lower Limb Prostheses will be revised to reflect these new codes in a future edition of the *DMERC Region D Supplier Manual* update.

## 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
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.

## New Modifier For No Order On File

Effective for dates of service on or after January 1, 2003, a new modifier has been created for use when an item of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) is dispensed without an order from the treating physician.

> EY - No physician or other licensed health care provider order for this item or service

This modifier is effective for claims with dates of service on or after January 1, 2003 and must not be used for claims with dates of service on or before December 31, 2002. Use of the EY modifier on claims with dates of service prior to January 1, 2003 will be returned as unprocessable or denied for incorrect coding. For dates of service on or after January 1, 2003, claim lines with the EY modifier will be denied as not reasonable and necessary unless an order is specifically required by statute. For items requiring an order by statute, failure to obtain an order will result in the claim line(s) being denied as noncovered (no benefit). Those items for which an order is required by statute include:

Three Policy groups with HCPCS or NDC codes:

- Oral Anticancer Drugs
- Oral Antiemetics (Full Replacement for Intravenous Antiemetics)
- Therapeutic Shoes for Diabetics

Items specified as requiring a written order prior to delivery (WOPD):

- Power Operated Vehicles (POV)
- Seat Lift Mechanisms
- TENS Units
- Support Surfaces
- Negative Pressure Wound Therapy

All DMEPOS items require an order prior to dispensing EXCEPT when an item is being replaced due to loss or irreparable damage. In those cases, according to the *Medicare Carriers Manual* §2100.4(C):

> "Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when, in the judgement of the carrier the equipment as originally ordered, considering the age of the order, still fills the patient's medical needs."

In other words, the EY modifier should be used in situations where an order is required but was not provided by the treating physician. The EY modifier should not be used when the item is being replaced due to loss or irreparable damage because no order is necessary.

Refer to the Documentation section of individual local medical review policies (LMRPs) or the *DMERC Region D Supplier Manual,* Chapter 3, for those items requiring a WOPD.

## New Modifiers – AU, AV, AW

New HCPCS modifiers have been established for use when items are furnished in conjunction with various orthoses, prostheses, ostomies and surgical dressings. These modifiers are effective for dates of service (DOS) on or after January 1, 2003.

> AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
>
> AV - Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
>
> AW - Item furnished in conjunction with a surgical dressing

These modifiers identify items that are eligible for reimbursement under multiple benefit or payment categories. At this time, the only codes with which these modifiers may be used are:

A4450 Tape, non-waterproof, per 18 square inches
A4452 Tape, waterproof, per 18 square inches
K0572 Tape, non-waterproof, per 18 square inches (for DOS prior to March 31, 2003)
K0573 Tape, waterproof, per 18 square inches (for DOS prior to March 31, 2003)

For example, tape used with a facial prosthesis must be billed using the AV modifier. Tape used with an ostomy pouch must be billed with the AU modifier. Tape used with a surgical dressing must be billed using the AW modifier.

**At the present time, these modifiers must not be used with any other codes. Use of these modifiers with other codes may result in the return or denial of the claim line(s) for incorrect modifier use.**

Under the standard grace period, codes A4450 and A4452 will 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 codes A4450 and A4452 *without* an AU, AV or AW 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 on or before December 31, 2002. Use of the AU, AV or AW modifier on claims with dates of service prior to January 1, 2003 will be returned as unprocessable or denied for incorrect coding.

Codes K0572 and K0573 crosswalk to codes A4450 and A4452. As with codes A4450 and A4452, codes K0572 and K0573 will be accepted without the use of the AU, AV and AW modifiers for claims with dates of service on or after January 1, 2003 that are received by March 31, 2003.

## New National Drug Codes (NDCs) for Etoposide

Suppliers are instructed to bill oral anti-cancer drugs to the DMERCs using the appropriate National Drug Code (NDC) number. Two additional NDC numbers have been added for etoposide products:

| |
|---|
| Etoposide, 50mg, oral NDC #00378-3266-94, (Mylan) |
| Etoposide, 50mg, oral NDC #51079-0965-05, (UDL) |

The approval dates of Medicare coverage for the above sources of the drug etoposide are October 29, 2001 for UDL and November 15, 2001 for Mylan.

## Orders And CMNs – Facsimile Image, Electronic, Or Photocopy – Clarification

In a recent revision of the *Program Integrity Manual* (PIM), effective October 15, 2002, CMS clarified its position on the acceptability of facsimile image, photocopy, and electronically maintained orders or CMNs. When a claim is reviewed by the Medical Review Unit, the DMERC will accept any of the following forms of orders and CMNs: an original "pen and ink" document, a photocopy, a facsimile image, or an electronically maintained document. An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers.

When a claim is reviewed by the Benefit Integrity Unit as part of an investigation of potentially fraudulent behavior by a provider, it will be the provider's responsibility to prove the authenticity/validity of the claim(s) under investigation. The DMERC may require the provider to prove the authenticity/validity of the signature on the CMN or order, or any other questionable portion of the claim(s) under investigation. Proof of the authenticity/validity of a signature may take a variety of forms. The Benefit Integrity Unit will determine the appropriate level of proof needed.

## Skilled Nursing Facility (SNF) Consolidated Billing – Capped Rental DME

Medicare pays for durable medical equipment (DME) when it is medically necessary for use in a patient's home.

For capped rental items of DME where the supplier submits a monthly bill, the date of delivery on the first claim must be the "from" or anniversary date on all subsequent claims for the item.

**Example:** If the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.).

The DME benefit is only meant for items a beneficiary is using in his or her home. For a beneficiary in a Part A stay, a SNF is not defined as a beneficiary's home. Medicare does not make separate payment for DME when a beneficiary is in a SNF. The SNF is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

However, in accordance with DMEPOS payment policy, Medicare will make a separate payment for a full month of rental for DME items, provided the beneficiary was in the home on the "from" date or anniversary date defined above. Medicare will make payment for the entire month, even if the "from" date is the date of discharge from the SNF.

**Example:** A beneficiary rents a wheelchair beginning on January 1. The beneficiary enters a covered Part A stay in a SNF on January 15 and is discharged on Feb-

ruary 1. The February 1 claim can be submitted for payment consideration.

If a beneficiary using DME is in a covered Part A stay in a SNF for a full month, Medicare will not make payment for the DME for that month.

**Example:** A beneficiary rents a wheelchair beginning on January 1. The beneficiary enters a covered Part A stay in a SNF on January 15 and is discharged on March 1. The February 1 rental cannot be considered for payment.

If the beneficiary is in a Part A covered stay, but not for the entire month, the discharge date becomes the new anniversary date for subsequent claims. In this situation, the supplier must submit a new claim using the date of discharge as the "from" date. Suppliers should note in the HA0 record (field 19 for paper claims) that the patient was in a SNF, resulting in the need to establish a new anniversary date.

**Example:** A beneficiary receives oxygen on January 1. On February 28 the patient enters a covered Part A stay in a SNF and is discharged on March 15. The DMERC would deny a claim dated March 1. The supplier would submit a new claim dated March 15, which would then become the anniversary date for future billing purposes. On this first claim with the new anniversary date, the supplier should annotate the HAO record (field 19 for paper claims) to indicate that the patient was in a covered Part A stay in a SNF.

Scheduled maintenance and servicing claims should be allowed once 15 rental months have been paid, regardless of whether the patient is in a covered Part A stay in the SNF on the date of service of the maintenance and servicing claim.

## Tips For Filing Paper Claims

Although we encourage all providers to submit their Medicare claims electronically, we understand that we will continue to receive some paper claims. In our endeavor to process paper claims accurately, timely, and efficiently, we are using an Intelligent Character Recognition (ICR) system. In order to utilize this technology to its full potential, the guidelines listed below should be followed when filing paper claims.

Failure to follow these guidelines will result in increased manual handling of the claim which delays processing and may also affect accuracy.

1. Please send claims in an 8 ½ x 11 envelope so that the claims do not have to be folded.
2. Machine print claims in a clear typeset using black ink. Laser or inkjet printers are preferred. If using a dot matrix printer, please check that it is not printing light or broken lines.
3. Handwriting may be too light or simply unrecognizable. If a manual correction must be made, print the correction clearly using dark ink.
4. Do not put any red writing or red marks on the claims. Information in red will not show up on the image and would not be available during processing.
5. Do not add extra verbiage or stamps in block 24.
6. All data should be properly aligned in the appropriate box on the claim form.
7. Highlighters should not be used to bring attention to certain information. As the image is similar to a photocopy, the highlighting may cover the information to where it is unrecognizable. If you must use a highlighter, use only yellow or pink.
8. Do not circle items on the claim form.
9. Do not staple, tape or glue attachments to the CMS-1500 claim form.
10. Do not include descriptions of the diagnosis codes in Item 21.
11. Only one diagnosis pointer per line should be given in block 24e.
12. Please do not enter a phone number on the first line of block 33. Please submit the phone number below the provider's name and address.
13. If the required information is missing from the CMS-1500 claim form, the claim may be returned to you requesting the appropriate documentation. Always submit a "New" Red CMS-1500 claim form, with a disclaimer on the back. (Note: We are also still accepting the HCFA-1500 form.)

## Use Of National Drug Codes (NDCs) For Claims Submitted To The DMERC

On August 17, 2000, the Centers for Medicare & Medicaid Services (CMS) published a final rule (65 FR 50311) that implements standards for electronic transactions in accordance with the administrative simplification pro-

visions of HIPAA. This rule became effective on October 16, 2000. HIPAA required Medicare and other insurers to be capable of processing claims using NDCs for drugs within 24 months (by no later than October 1, 2002) after the effective date of the final rule. A subsequent law, the Administrative Simplification Compliance Act (ASCA) of December 2001, allowed covered entities to request an extension until October 16, 2003.

For claims processing purposes, CMS considers any entity billing the DMERCs for a drug to be a retail pharmacy.

Although HIPAA applies to electronic transactions, which includes electronic claims, the ruling pertaining to NDCs for drugs is extended to include paper claims. Electronic and paper claims for all drugs submitted to the DMERCs on or after April 1, 2003, must be identified by the NDC number, unless an ASCA extension has been requested. Claims for drugs submitted with HCPCS codes will be returned as unprocessable.

Drug information, including the NDC Directory, can be obtained from the FDA by accessing its Web site at www.fda.gov. The FDA can be contacted by e-mail at DRUGPRODUCTS@CDER.FDA.GOV or by writing to the following address:

Food and Drug Administration
Information Management Team HFD-095
5600 Fishers Lane
Rockville, Maryland 20857

## Ventilator - New HCPCS Codes

Effective for dates of service on or after January 1, 2003, two new HCPCS codes have been established for ventilators.

E0454 Pressure ventilator with pressure control, pressure support and flow triggering features
E0461 Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface

Both of these new codes are in the frequent and substantial service payment category. With the introduction of code E0461, suppliers must no longer use code E1399 for dates of service after December 31, 2002 to describe using a volume ventilator with a non-invasive interface. Also, this code should not be used when billing for a volume ventilator used with an invasive interface (E0450).

# HCPCS UPDATES

## 2003 HCPCS Changes - Added, Deleted and Description Changes

### Deleted and Crosswalked HCPCS Codes

The following codes will be deleted effective for dates of service on or after January 1, 2003. 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 date 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.

Deleted Codes with Replacement Codes

| Deleted Code | Replacement (Crosswalk) Code |
|---|---|
| A4460 | A6430 – A6436 |
| A4464 | L1901, L3651, L3652, L3701, L3909, L3911 |
| A4572 | L0210 |
| A4801 | J1644 |
| E0608 | E0618 |
| E0690 | E0691 – E0694 |
| E1638 | E0210NUAX |
| J1820 | J1815 |
| K0021 | E0971 |
| K0034 | E0951 |
| K0101 | E0958 |
| K0183 | A7034 |
| K0184 | A7032, A7033 |
| K0185 | A7035 |
| K0186 | A7036 |
| K0187 | A7037 |
| K0188 | A7038 |
| K0189 | A7039 |
| K0561 | A4405 |
| K0562 | A4406 |
| K0563 | A4407 |
| K0564 | A4408 |
| K0565 | A4409 |
| K0566 | A4410 |
| K0569 | A4413 |
| K0570 | A4414 |
| K0571 | A4415 |
| K0572 | A4450 |
| K0573 | A4452 |
| K0579 | A4422 |
| L0900 | L0500 |
| L0910 | L0510 |
| L0920 | L0500 |
| L0930 | L0510 |
| L0940 | L0500 |
| L0950 | L0510 |

Deleted Codes no Crosswalk

| | | | | |
|---|---|---|---|---|
| A4360 | A6263 | A6264 | A6405 | A6406 |
| J0286 | J0635 | J1050 | J1095 | J1561 |
| J1755 | J2500 | J2915 | J7316 | K0551 |
| K0567 | K0568 | K0574 | K0575 | K0576 |
| K0577 | K0578 | K0580 | L0300 | L0310 |
| L0320 | L0321 | L0330 | L0331 | L0340 |
| L0350 | L0360 | L0370 | L0380 | L0390 |
| L0391 | L0400 | L0410 | L0420 | L0430 |
| L0440 | L0986 | L3218 | L3223 | |

## New Codes for 2003

The following new codes are effective for dates of services on or after January 1, 2003. If you bill these codes for dates of service prior to January 1, 2003, the claim will be returned as unprocessable.

A4405 Ostomy skin barrier, non-pectin based, paste, per ounce
A4406 Ostomy skin barrier, pectin based, paste, per ounce
A4407 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each
A4408 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
A4409 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
A4410 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
A4413 Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each
A4414 Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
A4415 Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, larger than 4 x 4 inches, each
A4422 Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each
A4450 Tape, non-waterproof, per 18 square inches
A4452 Tape, waterproof, per 18 square inches
A4458 Enema bag with tubing, reusable
A4606 Oxygen probe for use with oximeter device, replacement
A4609 Tracheal suction catheter, closed system, for less than 72 hours of use, each
A4610 Tracheal suction catheter, closed system, for 72 or more hours of use, each
A4632 Replacement battery for external infusion pump, any type, each
A4633 Replacement bulb/lamp for ultraviolet light therapy system, each
A4634 Replacement bulb for therapeutic light box, tabletop model
A4639 Replacement pad for infrared heating pad system, each
A4653 Peritoneal dialysis catheter anchoring device, belt, each
A4930 Gloves, sterile, per pair
A4931 Oral thermometer, reusable, any type, each
A4932 Rectal thermometer, reusable, any type, each
A6011 Collagen based wound filler, gel/paste, per gram of collagen
A6410 Eye pad, sterile, each
A6411 Eye pad, non-sterile, each
A6412 Eye patch, occlusive, each
A6421 Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)
A6422 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)
A6424 Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)
A6426 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)
A6428 Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)
A6430 Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)
A6432 Light compression bandage, elastic, knitted/woven, load resistance less than 1.25 foot pounds at 50% maximum stretch, width greater than or equal to 5 inches, per roll (at least 3 yards, unstretched)

A6434 Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches or less than 5 inches, per roll (at least 3 yards, unstretched)

A6436 High compression bandage, elastic, knitted/ woven, load resistance greater than 1.35 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 3 yards, unstretched)

A6438 Self-adherent bandage, elastic, non-knitted/ non-woven, load resistance great than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to 3 inches and less than 5 inches, per roll (at least 5 yards, unstretched)

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)

A6501 Compression Burn garment, bodysuit (head to foot), custom fabricated

A6502 Compression Burn garment, chin strap, custom fabricated

A6503 Compression Burn garment, facial hood, custom fabricated

A6504 Compression Burn garment, glove to wrist, custom fabricated

A6505 Compression Burn garment, glove to elbow, custom fabricated

A6506 Compression Burn garment, glove to axilla, custom fabricated

A6507 Compression Burn garment, foot to knee length, custom fabricated

A6508 Compression Burn garment, foot to thigh length, custom fabricated

A6509 Compression Burn garment, upper trunk to waist including arm openings (vest), custom fabricated

A6510 Compression Burn garment, trunk, including arms down to leg openings (leotard), custom fabricated

A6511 Compression Burn garment, lower trunk including leg openings (panty), custom fabricated

A6512 Compression Burn garment, not otherwise classified

A7025 High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each

A7026 High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each

A7030 Full face mask used with positive airway pressure device, each

A7031 Face mask interface, replacement for full face mask, each

A7032 Replacement cushion for nasal application device, each

A7033 Replacement pillows for nasal application device, pair

A7034 Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap

A7035 Headgear used with positive airway pressure device

A7036 Chinstrap used with positive airway pressure device

A7037 Tubing used with positive airway pressure device

A7038 Filter, disposable, used with positive airway pressure device

A7039 Filter, non disposable, used with positive airway pressure device

A7044 Oral interface used with positive airway pressure device, each

E0117 Crutch, underarm, articulating, spring assisted, each

E0203 Therapeutic lightbox, minimum 10,000 LUX, table top model

E0445 Oximeter device for measuring blood oxygen levels non-invasively

E0454 Pressure ventilator with pressure control, pressure support and flow triggering features

E0461 Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface

E0483 High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each

E0484 Oscillatory positive expiratory pressure device, non-electric, any type, each

E0618 Apnea monitor, without recording feature

E0619 Apnea monitor, with recording feature

E0636 Multipositional patient support system, with integrated lift, patient accessible controls

E0691 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less

E0692 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; 4 foot panel

E0693 Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; 6 foot panel

E0694 Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulbs/lamps, timer and eye protection
E0701 Helmet with face guard and soft interface material, prefabricated
E0761 Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device
E0951 Loop heel, each
E0958 Wheelchair attachment to convert any wheelchair to one arm drive
E0971 Anti-tipping device wheelchair
E1011 Modification to pediatric wheelchair, with adjustment package (not to be dispensed with initial chair)
E1012 Integrated seating system, planar, for pediatric wheelchair
E1013 Integrated seating system, contoured, for pediatric wheelchair
E1014 Reclining back, addition to pediatric wheelchair
E1015 Shock absorber for manual wheelchair, each
E1016 Shock absorber for power wheelchair, each
E1017 Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each
E1018 Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each
E1020 Residual limb support system for wheelchair
E1025 Lateral thoracic support, non-contoured, for pediatric wheelchair, each (includes hardware)
E1026 Lateral thoracic support, contoured, for pediatric wheelchair, each (includes hardware)
E1027 Lateral/anterior support, for pediatric wheelchair, each (includes hardware)
E1037 Transport chair, pediatric size
E1038 Transport chair, adult size
E1161 Manual adult size wheelchair, includes tilt in space
E1231 Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
E1232 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system
E1233 Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system
E1234 Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
E1235 Wheelchair, pediatric size, rigid, adjustable, with seating system
E1236 Wheelchair, pediatric size, folding adjustable with seating system
E1237 Wheelchair, pediatric size, rigid, adjustable, without seating system
E1238 Wheelchair, pediatric size, folding, adjustable, without seating
E1802 Dynamic adjustable forearm pronation/ supination device, includes soft interface material
J0287 Injection, amphotericin B lipid complex, 10 mg
J0288 Injection, amphotericin B cholesteryl sulfate complex, 10 mg
J0289 Injection, amphotericin B liposome, 10 mg
J0592 Injection, buprenorphine hydrochloride, 0.1 mg
J0636 Injection, calcitriol, 0.1 mcg
J0637 Injection, caspofungin acetate, 5 mg
J0880 Injection, darbepoetin alfa, 5 mcg
J1051 Injection, medroxyprogesterone acetate, 50 mg
J1094 Injection, dexamethasone acetate, 1 mg
J1564 Injection, immune globulin, 10 mg
J1652 Injection, fondaparinux sodium, 0.5 mg
J1756 Injection, iron sucrose, 1 mg
J1815 Injection, insulin, per 5 units
J1817 Insulin for administration through DME (i.e., insulin pump) per 50 units
J2324 Injection, nesiritide, 0.5 mg
J2501 Injection, paricalcitol, 1 mcg
J2788 Injection, rho d immune globulin, human, minidose, 50 mcg
J2916 Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg
J3315 Injection, triptorelin pamoate, 3.75 mg
J3487 Injection, zoledronic acid, 1 mg
J3590 Unclassified biologics
J7317 Sodium hyaluronate, 20-25 mg dose for intra-articular injection
J7633 Budesonide, inhalation solution administered through DME, concentrated form, per 0.25 milligram
J9010 Alemtuzumab, 10 mg
K0581 Ostomy pouch, closed, with barrier attached, with filter (1 piece), each
K0582 Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each
K0583 Ostomy pouch, closed; without barrier attached, with filter (1 piece), each
K0584 Ostomy pouch, closed; for use on barrier with flange, with filter (2 piece), each
K0585 Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each
K0586 Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each
K0587 Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each
K0588 Ostomy pouch, drainable; for use on barrier with flange, with filter (2 piece system), each
K0589 Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each
K0590 Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each
K0591 Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each

K0592 Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each

K0593 Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each

K0594 Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each

K0595 Ostomy pouch, urinary; for use on barrier with flange, with faucet-type tap with valve (2 piece), each

K0596 Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each

K0597 Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each

L0450 TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment

L0452 TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated

L0454 TLSO flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment

L0456 TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacro-coccygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, includes fitting and adjustment

L0458 TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0460 TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0462 TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

L0464 TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures prefabricated, includes fitting and adjustment

L0466 TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavi-tary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0468 TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, in

cludes fitting and adjustment

L0470 TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacro-coccygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0472 TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment

L0476 TLSO, sagittal-coronal control, flexion compression jacket, two rigid plastic shells with soft liner, posterior extends from sacro-coccygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of the LS region, includes straps and closures, prefabricated, includes fitting and adjustment

L0478 TLSO, sagittal-coronal control, flexion compression jacket, two rigid plastic shells with soft liner, posterior extends from sacro-coccygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, usually laced together on one side, restricts gross trunk motion in sagittal and coronal planes, allows free flexion and compression of LS region, includes straps and closures, custom fabricated

L0480 TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and trans-verse planes, includes a carved plaster or Cad-Cam model, custom fabricated

L0482 TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococ-cygeal junction and ter-minates just inferior to scapular spine, anterior extends from sym-physis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated

L0484 TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated

L0486 TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacro-coccygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated

L0488 TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacro-coccygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in the sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment

L0490 TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment

L1652 Hip orthosis, bilateral thigh cuffs with adjust able abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type

L1836 Knee orthosis, rigid, without joint(s), includes

soft interface material, prefabricated, includes fitting and adjustment

L1901 Ankle orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L3651 Shoulder orthosis, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L3652 Shoulder orthosis, double shoulder, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L3701 Elbow orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L3762 Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, includes fitting and adjustment

L3909 Wrist orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L3911 Wrist Hand Finger orthosis, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, lycra)

L4386 Non-pneumatic walking splint, with or without joints, prefabricated, includes fitting and adjustment

L5781 Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system.

L5782 Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty

L5848 Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, adjustable

L5995 Addition to lower extremity prosthesis, heavy duty feature (for patient weight >300 lbs)

L6025 Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device

L6638 Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow

L6646 Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system

L6647 Upper extremity addition, shoulder lock mechanism, body powered actuator

L6648 Upper extremity addition, shoulder lock mechanism, external powered actuator

L7367 Lithium ion battery, replacement

L7368 Lithium ion battery charger

### Verbiage Changes for 2003

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2003. Refer to the *DMERC Region D Supplier Manual,* Chapter 16, HCPCS Coding section for the new verbiage.

| | | | | |
|---|---|---|---|---|
| A4372 | A4373 | A4387 | A4388 | A4389 |
| A4391 | A4462 | A4595 | A4624 | A4656 |
| A4657 | A4660 | A4663 | A4670 | A4712 |
| A4927 | A4928 | A5051 | A5052 | A5053 |
| A5054 | A5062 | A5063 | A5071 | A5072 |
| A5073 | E0441 | E0442 | E0443 | E0444 |
| E0574 | E0730 | E0782 | E1637 | E1639 |
| J2790 | J3070 | J3240 | J7626 | K0082 |
| K0083 | K0084 | K0085 | K0086 | K0087 |
| K0088 | K0089 | L0500 | L0510 | L1843 |
| L1844 | L3260 | L4350 | L4360 | L4370 |
| L4380 | L7510 | | | |

# *FEE SCHEDULE*

## Fee Schedule Update For 2003 For Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

The 2003 DMEPOS fee schedule update for DMERC Region D states will be posted by January 1, 2003 on our Web site at http://www.cignamedicare.com/dmerc/fsch/index.html. The 2003 fee schedule for all states will be available on the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.hhs.gov/.

If you're unable to access the Internet, you may request a hardcopy fee schedule by submitting the DMERC Region D Publication Order Form included at the back of this newsletter.

The 2003 fee schedule amounts will be implemented on January 1, 2003, for items furnished on dates of service January 1, 2003 through December 31, 2003. Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

# *ELECTRONIC DATA INTERCHANGE (EDI)*

(The following articles were derived from the DMERC Region D Fall 2002 *EDI Edge*. The entire publication can be accessed at www.cignamedicare.com/dmerc/edge/index.html.)

## All about the NCPDP (National Council for Prescription Drug Programs) standards

If you are a retail pharmacy and bill CIGNA Medicare for retail pharmacy drug claims electronically, then you need to learn about the NCPDP format. CIGNA Medicare uses the following NCPDP definition of a retail pharmacy to determine who must use this format:

> "Any duly licensed entities that deliver pharmaceutical goods or services for sale to or use by the final consumer."

The Secretary of Health and Human Services (HHS) established the NCPDP Telecommunications Standard Version 5.1 and Batch Standard 1.1 as the standard for electronic retail pharmacy drug claims and coordination of benefits (COB). This standard will be used by all health plans, including durable medical equipment regional carriers (DMERCs) that process retail pharmacy drug transactions. Each pharmacy that has elected to transmit retail drug claims electronically must begin using the NCPDP format by October 16, 2003.

All other claims submitted to Medicare by pharmacies, other than retail pharmacy drug claims, must be sent in the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837 version 4010 Health Care Claim format. In addition, the NDCs (National Drug Codes) will replace HCPCS (Healthcare Common Procedure Coding System) codes for all drugs and biologics. Although Medicare will accept the NCPDP formats, the Medicare retail drug payment policies have not been changed. Very few categories of self-administered drugs are covered by Medicare.

**NCPDP Testing**

- Pharmacies, agents, and clearinghouses planning to transmit retail pharmacy drug claims data to Medicare electronically by October 16, 2003 must schedule testing with their DMERC by April 1, 2003.
- There is no Medicare charge for this system testing.
- Testing information, including the testing procedures, will be located on our Web site at www.cignamedicare.com when it becomes available.

**Other Important Information**

- The X12N 835 version 4010 transaction set will be the only remittance advice format used for NCPDP standard claims as of October 16, 2003.
- The Certificate of Medical Necessity (CMN) for Parenteral Nutrition (HCFA Form 852) and the DMERC Information Form for Immunosuppressive Drugs (DMERC Form 08.02) will continue to be required. As with other electronic formats, CMN data must be submitted within the NCPDP transaction. For claims submitted on the CMS-1500, retail pharmacies will continue to supply hard copies of CMNs when required.
- A pharmacy that elects to use a clearinghouse for translation services is responsible for associated costs.
- We are not implementing the NCPDP standard for eligibility at this time. Nor do we expect to begin to prior authorize retail drugs.
- CIGNA Medicare will not be issuing free billing software programmed in the NCPDP format.
- CIGNA Medicare will continue to forward claims to the appropriate DME regional carrier for processing when it is determined that the claim submitted is for a beneficiary that resides in a state that is outside the DMERC's processing area.
- Although Medicare will furnish pharmacies with basic information on the HIPAA standard transaction requirements to make them aware of the changes to be made, Medicare will not furnish in-depth training on the use of the NCPDP standard implementation guides.

**Resources**

- Individuals who want to review the NCPDP standard implementation guides can become members, for a fee of $450.00, by contacting them at www.ncpdp.org.
- Further information on the HIPAA standards requirements in general may be obtained at http://aspe.hhs.gov/admnsimp.

## Announcing The ANSI Version Of DMACS … *DMACS-837*

*DMACS-837*, the ANSI version of DMACS (DMERC Medicare Automated Claims System) is scheduled for release in December 2002. *DMACS-837* is designed to build your Region D DMERC Medicare claims in the ANSI X12N 837 version 4010 format. This version is *in addition to* the existing *DMACS32*, the NSF (National Standard Format) version.

**Important Items to Note About *DMACS-837*:**

- *DMACS-837* will be available only on CD-ROM.
- Your stored data from the *DMACS32* (NSF version) will not function in the new *DMACS-837* software. After installing the new program, please re-enter your data.
- Windows 95 will not be supported with this version.
- Unlike previous versions of *DMACS, DMACS - 837* does not include a data backup or restore feature.
- **Important Note for Retail Pharmacies Who Bill for Drugs:**

  *DMACS-837* does not have the capability to transmit claims in the NCPDP format. It is your responsibility to obtain software designed to transmit claims in the NCPDP format.

**If you are an existing DMACS user:**

You may choose to use either the NSF* or the ANSI version of DMACS.

**If you are a new DMACS user**:

The ANSI version of DMACS is the only format that will be available for new DMACS users. Effective October 1, 2002, we discontinued the acceptance of *DMACS32* applications for the NSF version. The ANSI version is the only format available for new DMACS users whose application was received after October 1, 2002.

**How to Apply for *DMACS-837***

Please complete the enclosed application. All applications for *DMACS-837* will be held until December 3, 2002 at which time the software will be available for release.

If you have any questions, please contact the EDI Department.

*** Note**: In order to continue to transmit electronically in the NSF, you must have submitted a compliance plan to the Department of Health and Human Services (DHHS) by October 16, 2002.

## Element REF02 (prior to 1000A loop)

Until April 1, 2003, your transactions may reject unless you enter the value "004010X098" in REF02. CIGNA Medicare will accept either "004010X098" or "004010X098D" in test files, but only "004010X098" will be accepted in production files.

## October 2002 Changes For X12N 835 Remittance Advice

Beginning October 7, 2002 X12N 835 (4010) Remittance Advice transactions will be updated to meet specific HIPAA data requirements. As a result of this upgrade the X12N 835 (4010) Remittance Advice transactions are to be generated with complete, HIPAA compliant data elements.

There are situations when an inbound claim received on paper, in a pre-4010 electronic format or 837 (4010) format will lack data elements, or contain data that do not meet the data attribute (alphanumeric, numeric, minimum and maximum lengths, etc) requirements to create a compliant outbound file. In most cases, claims with invalid data are rejected. However, in limited cases, a claim could be accepted and adjudicated by Medicare. It is also possible to receive data from the Common Working File that may not meet the X12N 837 (4010) Implementation Guide requirements. The Common Working File is where master data files are kept and shared by all Medicare contractors. These master files provide items like Certificates of Medical Necessity data and patient eligibility information. CMS requires that the file created by our system for the Remittance Advice have all of the requirements and applicable conditional data elements for generating a HIPAA-compliant X12N 835 transaction.

Whenever possible, we will use the data in our history files, store and forward repository (SFR) or reference files to provide accurate and complete information in the X12N 835 (4010) remittance. In those situations when the information is not available, our system will "gap fill" the required data elements with one of the following values: "UNKNOWN", "FC", zeros, or nines.

# *MISCELLANEOUS*

## American National Standard Institute (ANSI) Codes

New ANSI Reason Codes:

145 Premium payment withholding.
146 Payment denied because the diagnosis was invalid for the date(s) of service reported.
147 Provider contracted/negotiated rate expired or not on file.
148 Claim/service rejected at this time because the information from another provider was not provided or was insufficient/incomplete.

Revised ANSI Reason Codes:

6 The procedure/revenue code is inconsistent with the patient's age.
7 The procedure/revenue code is inconsistent with the patient's gender.
8 The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108 Payment adjusted because rent/purchase guidelines were not met.

New Remittance Advice Remark Codes:

N73 A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to it's residents.
N113 You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.
N114 During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115 This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at www.LMRP.net.
N116 This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
N126 Social Security records indicate that this beneficiary has been deported. The payer does not cover items and services furnished to individuals that have been deported.

Revised Remittance Advice Remark Codes:

MA49 Missing/incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA82 Did not complete or enter the correct physician/physician assistant/ nurse practitioner/clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.
MA112 Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthestist/anesthesia assistant/supplier/ nurse practitioner is a member of a group practice; however, you did not complete or enter accurately the group's name, address, zip code and their carrier assigned individual and group PINs.

## Billing Reminder

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

## CERT Program – Reminder

In the Winter 2000 *DMERC Dialogue* (pg. 7), the DMERCs introduced the Comprehensive Error Rate Testing (CERT) program. Under CERT, an independent contractor, AdvanceMed, selects a random sample of claims paid by the DMERC to determine if the claims were paid accurately. As noted in the "From the Medical Director" article in this issue, the majority of CERT errors are related to incomplete documentation or failure to provide documentation.

Providers should be aware that when the CERT contractor determines that a claim previously paid by CIGNA Medicare was paid in error, an overpayment (or underpayment) will be assessed. Consequently, providers should respond to AdvanceMed CERT record requests. Requests for records in conjunction with the CERT program will be clearly identified with the AdvanceMed letterhead and will contain details about the specific documentation needed. Failure to provide all of the documentation requested may result in denial of your claim and the assessment of an overpayment.

## 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). Four revisions have been published since the publication deadline of the Fall 2002 Region D *DMERC Dialogue.*

- Transmittal 30, released September 27, revises Chapter 5, sections 1 and 2 to provide guidance, clarification and revised instructions regarding orders for DMEPOS items. The effective/implementation date is October 15, 2002.
- Transmittal 31, released October 23, revises Chapter 3, section 5.1.1 to instruct contractors not to install edits that result in the automatic denial of services based solely on the diagnosis of progressively debilitating disease where treatment in the early stages may be reasonable and necessary. The effective/implementation date is September 1, 2002.
- Transmittal 32, released October 23, revises Chapter 2, sections 4.1, 4.5 and 6 and adds sections 7 – 7.4, revises Chapter 3, sections 8.3.3, 12.2.1, and 12.3.2, revises Exhibits 27 and 28 and adds Exhibits 32 and 33. These sections address a variety of fraud issues. The effective/implementation date is October 25, 2002.
- Transmittal 33, released October 31, 2002, revises Chapters 1, 3, and 11 to include language from the FY 2003 Budget and Performance Requirements. The effective date for these changes is October 1, 2002. The implementation date for non-system changes is November 1, 2002. The implementation date for system changes is April 1, 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.

## Region D Wants YOU!


In the coming months, you may receive a *Durable Medical Equipment Supplier Satisfaction Survey* asking you to rate the performance of CIGNA Medicare as your Durable Medical Equipment Regional Carrier (DMERC). CIGNA Medicare, in cooperation with Scarlett Associates International and the Centers for Medicare & Medicaid Services (CMS), developed this survey so that suppliers in Region D can provide feedback to CIGNA on our performance as your DMERC.

The supplier satisfaction survey requests responses to questions in the areas of claim processing performance, medical policy development, supplier education, customer service, the appeals process, and over all performance. In addition, there is space to provide comments in each area for issues that are not addressed by the specific questions. You are asked to think about your experiences with CIGNA Medicare over the past 12 months and to consider the administration of Region D only, not other government or private insurance programs involving CIGNA. Finally, please make a mental distinction between the performance of CIGNA Medicare in administering the DMERC program and the rules and regulations of the Medicare program itself.

If you receive a survey, please have it completed by someone knowledgeable about CIGNA Medicare's performance. Your feedback is invaluable in assisting CIGNA Medicare in improving the quality of the services we provide to the supplier and beneficiary community.

## *Frequently Asked Questions*

1. When will Medicare pay for repairs?

   **ANSWER:** Medicare may pay for repair of covered DME which the beneficiary owns or is purchasing, including equipment that the beneficiary was using before becoming enrolled in Part B. If Medicare paid for the equipment, repairs will be considered on an individual basis. If Medicare did not pay for the equipment, we will need to have the following documentation attached to the claim to consider coverage of repairs:

   1) A statement explaining why Medicare did not pay for the equipment repaired (e.g., purchased before Part B entitlement, primary insurance paid 100%, etc);

   2) For items that require a Certificate of Medical Necessity (CMN), the CMN must be provided to determine whether the beneficiary meets Medicare's coverage and payment rules for the equipment being repaired;

   3) Date of purchase; and

   4) Type of equipment being repaired, including the brand name of model (e.g., Quickie P300 motorized wheelchair)

   *(Region D DMERC Dialogue Fall 2000, page 8)*

2. In the Fall 2002 (October) Region D *DMERC Dialogue* in the article, "New Medicare Medical Review Guidelines for Claims For Diabetic Testing Supplies," the example states that testing once a day would require approximately 100 strips in a 3 month period. Using this example, if a beneficiary testing once a day ordered 50 test strips would the date span be 45 days (one half of a 3 month period) or would the date span be 50 days (one strip per day)?

   **ANSWER:** The span date should reflect the physician's order and what was dispensed.

3. If a beneficiary is testing 2 –3 times per week (26 – 39 times in a 3 month period) and 50 strips are shipped, should these test strips be date spanned for a 3 month period? If not, what period should they be date spanned for?

   **ANSWER:** They should be spanned for a 3 month period, but the supplier should not dispense again until the beneficiary requires additional supplies.

4. What is the grace period for shipping the second order. For example, if the first order ends on the 30th, on what date can the second order be shipped?

   **ANSWER:** 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. Please refer to the Region D *DMERC Dialogue*, Summer 2002, pages 2-3, to the article titled "Home Blood Glucose Monitor Supply Claims and Spanned Dates" which states in the last sentence, "Suppliers should not refuse to provide supplies merely on the basis that the beneficiary's stock is not completely exhausted."

## *Frequently Asked Questions (cont'd)*

5. For purposes of date spanning a 3 month order, if the date span begins on the 15th of month one, should the date span end on the 14th of month four? Or, is the 3 month date spanning based on a certain number of days?

   **ANSWER:** This would be based on what the doctor ordered and what was dispensed. The date span for 3 months based on the example above should end on the 14th of month four.

6. If a beneficiary requiring diabetic testing supplies tests more than what the doctor ordered can the supplier get an Advance Beneficiary Notice (ABN) on the additional supplies?

   **ANSWER:** Yes, for the added items and the related charges. Remember that the ABN must be signed and dated prior to the dispensing of any of these supplies.

7. If the doctor ordered a certain amount of test strips over the utilization guidelines of the Home Blood Glucose Policy but refuses to give the supplier documentation to support the over utilization, can the supplier get an Advance Beneficiary Notice (ABN) from the beneficiary for the additional supplies?

   **ANSWER:** Yes, but the supplier should attempt to get the cooperation of the doctor first. If there is no cooperation, advise the beneficiary in the *Because* box of the ABN that the physician did not furnish a justification for the added strips.

8. If the doctor ordered more test strips than what the Home Blood Glucose Policy guidelines call for and provides the additional documentation but the claim is still denied, can the supplier get an Advance Beneficiary Notice (ABN) on future claims?

   **ANSWER:** Yes, on the basis that they reasonably expect a denial.

9. Does Medicare replace glasses if they are lost, stolen or irreparably damaged?

   **ANSWER:** Medicare will make payment for no more than one pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery with the insertion of an intra-ocular lens. For a beneficiary who is aphakic, (has no natural or artificial lens of any kind) whose eyeglasses are covered under the prosthetic benefit, if the patient's medical need (prescription) changed, or if the lenses were lost, stolen or irreparably damaged Medicare will cover a replacement.

10. Is the RP modifier required on the replacement of accessories?

    **ANSWER:** The RP modifier is required on any DME accessory that was replaced after the initial issuance.

11. After July 1, 2002, is the KX modifier required on continuous positive airway pressure devices (CPAP) claims for a beneficiary whose E0601 is in maintenance and service?

    **ANSWER:** The policy stipulates that in order to use the KX modifier for the fourth month's claim and any month thereafter, evidence of the continued use of the E0601 device must be obtained from either the beneficiary or the treating physician. This also applies to claims for maintenance and service. *(Region D DMERC Dialogue Fall 2002, page 3)*

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# Application for *DMACS-837*

Yes, I would like to order ***DMACS-837***, ANSI 4010 version**.** If you are applying for the software prior to December 3, 2002, please be aware that all applications will be held until December 3, 2002, when the new software will be available for release.

If you are an existing *DMACS32* user, your data will not remain intact and you will need to re-enter the data upon the installation of the new software. *DMACS-837* has been developed specifically for the ANSI 4010 version and is not compatible with the NSF version.

***Retail Pharmacies Who Bill for Drugs:*** *DMACS-837does not have the capability to transmit claims in the NCPDP (National Council for Prescription Drug Program) format. According to HIPAA requirements, if you bill for retail pharmacy drug claims, you must transmit those claims in the NCPDP format. You are responsible for obtaining NCPDP software from another source.*

## Customer Information

| | | | |
|---|---|---|---|
| Supplier # | | | |
| Submitter ID # | | | |
| Company Name | | | |
| Mailing Address | | | |
| | | | |
| City, State, Zip | | | |
| Phone # | (  ) | Fax # | (  ) |
| Email | | Contact | |

## Application Submission

If you have paid for *DMACS32* since 12/03/2001, it is not necessary to send payment and you may **fax this application to 208.333.2192.** If our records indicate you need to pay and we do not receive a check from you, we will contact your office directly. If you do not have access to a fax machine, please mail the application to:

**CIGNA Medicare**
**Attn: DMERC EDI**
**PO Box 49**
**Boise, ID 83707**

If you have not paid for *DMACS32* since 12/03/2001, please return this application to the address listed below, along with a check or money order (payable to CIGNA Medicare) for $25 to cover the shipping and handling fees. We must receive the check with your application by mail in order to process your request.

**Please mail to:**

**Connecticut General Life Insurance Company**
**Attn: DMERC EDI**
**PO Box 360295**
**Pittsburgh, PA 15251-0295**

***Please Note – Incomplete Applications May Be Returned***

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Clip and Save for Physician Education

## *Completion of Medicare Certificates of Medical Necessity*

Dear Physician:

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

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

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

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

Sincerely,

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

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# *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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# MEDICARE REVIEW REQUEST FORM

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

**DATE** _____

| PROVIDER INFORMATION | BENEFICIARY INFORMATION |
|---|---|
| Name | Name |
| Provider # | Medicare # |
| Address | Address |
| | |
| | |
| Phone #<br>Area Code ( ) | Phone #<br>Area Code ( ) |

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

## CLAIM INFORMATION

□ Assigned □ Non-Assigned

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

## REASON FOR REQUEST

## SUPPORTING DOCUMENTATION

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

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

## CONTACT INFORMATION

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

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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. This section may be used 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 forms 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 |
| 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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CIGNA HealthCare
Medicare Administration

# DMERC EDI Customer Profile

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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<br>❑ Change or add to my existing profile<br>❑ Begin using an **ANSI X12N v. 4010** transaction<br>❑ Test<br>❑ 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* ($25.00 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 (Continued)

**(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 the next steps 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)<br>❑ Test<br>❑ 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 (Continued)

| | |
|---|---|
| | ANSI X12N 270/271 (Beneficiary Eligibility) – **Not available until April 2003.** |
| ❑ | ANSI X12N 276/277 (Batch Claim Status Inquiry)<br>❑ Test<br>❑ 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*<br><br>***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*

| | |
|---|---|
| **Return the completed form to:**<br>CIGNA Medicare<br>***Attn: EDI Department***<br>PO Box 49<br>Boise, ID 83707<br><br>**Or you may fax this form to:**<br>208.333.2192<br>***Attn: EDI Department*** | ****If applying for *DMACS-837* or CSI (online version) please send both the completed EDI Customer Profile and your check to:**<br>Connecticut General Life Insurance Company<br>PO Box 360295<br>Pittsburgh, PA 15251-0295<br><br>***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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## Electronic Data Interchange (EDI) Enrollment Form
## CIGNA Medicare, Region D DMERC

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' contractors.

**A. The Provider Agrees:**

1. That it will be responsible for all Medicare claims submitted to CMS by itself, its employees, or its agents.

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary, to Medicare, or as required by State or Federal law.

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file.

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

   - X Beneficiary's name,
   - X Beneficiary's health insurance claim number,
   - X date(s) of service,
   - X Diagnosis/nature of illness, and
   - X Procedure/service performed.

5. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines.

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer.

7. That it will submit claims that are accurate, complete, and truthful.

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid.

9. That it will affix the CMS-assigned unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the CMS-assigned unique identifier number constitutes the provider's legal electronic signature and an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

## EDI Enrollment Form (cont'd)

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified and record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law.

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with S1106 (a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or CMS within 2 business days if any transmitted data are received (by the provider) in an unintelligible or garbled form.

**B. The Centers for Medicare & Medicaid Services (CMS) Agree To:**

1. Transmit to the provider an acknowledgment of claim receipt.

2. Affix the carrier number, as its electronic signature, on each remittance advice sent to the provider.

3. Ensure that payments to providers are in accordance with CMS' policies.

4. Ensure that no contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor will make alternative means available to any electronic biller to obtain such services.

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare contractors to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

**Notice:**

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

**EDI Enrollment Form (cont'd)**

**C. Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name/title:_____

Phone:_____

Address:_____

_____

City/State/Zip:_____

Supplier ID #:_____

_____
By

_____
Title

_____
Date

Please fill in **ALL** the blank lines above and **mail** the completed form to the following:

**CIGNA DMERC**
**EDI Department**
**P.O. Box 49**
**Boise, ID 83707**

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CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

# *Application for Replacement of EDI Manuals/Diskette*

## Customer Information

| | | | |
|---|---|---|---|
| Submitter ID # | | | |
| Supplier # | | | |
| Company Name | | | |
| Mailing Address | | | |
| | | | |
| City, State, Zip | | | |
| Phone # | (  ) | Fax # | (  ) |
| Contact Name | | E-mail | |

## Order Replacement Items

Please indicate which of the following items you would like to order. The cost is indicated by each item.

| | MANUAL/DISKETTE | COST/per item |
|---|---|---|
| ❑ | ***EDI Manual (Stratus Network Users)*** (NSF version) | $15.00 |
| ❑ | ***Region D DMERC EDI Manual*** (ANSI version) | $20.00 |
| ❑ | ***DMACS32 User Guide*** (NSF version) | $ 5.00 |
| ❑ | ***DMACS-837 Users Manual*** (ANSI version) | $ 5.00 |
| ❑ | DMACS-837 CD (ANSI version) | $ 5.00 |
| ❑ | Passport for Windows Diskette – *used for on-line CSI only* | $ 5.00 |
| ❑ | ***IBM Passport for Claim Status Inquiry: Installation and User Guide*** (On-line CSI User Manual) | $ 6.00 |
| ❑ | ***ANSI X12N 276/277 v. 4010 Health Care Claim Status Inquiry/Response Transaction*** (Batch CSI Manual) | $ 6.00 |
| ❑ | ***Beneficiary Eligibility Manual*** | $ 6.00 |

## Form Submission

Completed applications are processed within 21 business days from the date the application is received. Please return this application with your check made payable to **CIGNA Medicare** and mail to:

**Connecticut General Life Insurance Company**
***Attn: DMERC EDI Department***
**PO Box 360295**
**Pittsburgh, PA 15251-0295**

**Incomplete applications 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 will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

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

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

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

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

**Let It Snow!**

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

***DMERC Dialogue*** *...a service of*

CIGNA Medicare
DMERC Region D
PO Box 690
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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