Summer

DMERC Dialogue

July 2003

DMERC Region D

General Release 03-3

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

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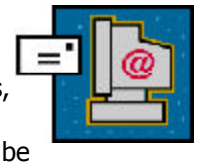

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Important Announcement Regarding DMERC Region D Publications!

CIGNA Medicare DMERC Region D is making significant changes in the official notification and distribution of information to suppliers.

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

Important Change - Also, effective August 1, 2003, the date a local medical review policy (LMRP) is posted to the Web site (www.cignamedicare.com/dmerc/lmrp/index.html) will be considered the "notice date" and may differ from the "start date of notice period" on the policy.

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

Publications Distributions - Beginning with publications scheduled to be distributed in September, DMERC Region D quarterly publications will be distributed in a new format – CD-ROM. The new CD-ROM electronic format will be an easy and effective way to receive important Medicare publications.

The CD-ROM will utilize the following format:

- Portable Document Format (PDF) - PDF allows the user to view and print the printable version of a document. Users will need Adobe Acrobat Reader version

In This Issue *(Cont'd)*

Important Announcement Regarding DMERC Region D Publications! (cont'd)

4.0 or higher to view PDF files on the CD-ROM. A free download of Adobe Acrobat is available at www.adobe.com.

One of the most important features of the CD-ROM format is the ability to place many publications and announcements on one convenient and easy-to-use disc. The CD-ROM will contain the following publications:

- *DMERC Dialogue* (including archived issues)
- *DMERC Region D Supplier Manual* (including quarterly updates)

In addition to the above publications, the CD-ROM will also include other valuable documents such as the *EDI Manual*, Webinar/Seminar information, Frequently Asked Questions, DMERC Region D Fee Schedules, etc. The CD-ROM will contain hyperlinks to the Centers for Medicare & Medicaid Services (CMS) Web site and the CIGNA Medicare Web site. Users must have Internet access to utilize the hyperlinks, although Internet access is not required to view the contents of the CD-ROM. The entire contents of the CD-ROM will also be available to view and download on the CIGNA Medicare Web site.

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

The *DMERC Dialogue* will be available to suppliers who choose to continue to receive paper copies in lieu of a CD-ROM. To receive paper copies of the *DMERC Dialogue*, suppliers must "opt out" of the CD-ROM distribution by completing the "Request for CD-ROM Alternative" form on page A-1 in the back of this issue. Suppliers must return the form to the following address or fax number no later than August 15th to "opt out" beginning with the Fall 2003 *DMERC Dialogue*. Requests received after that date will be honored beginning with the next scheduled publication.

CIGNA Medicare
Attn: Communications Department
Two Vantage Way
Nashville, TN 37228
Fax Number: 615.782.4445

The "Request for CD-ROM Alternative" form will also be available on the CD-ROM. Suppliers receiving a CD-ROM may return to receiving paper copies of the *DMERC Dialogue* at any time by completing and returning the form to the address or fax number above.

From the Medical Director...

Robert Hoover, Jr., MD, MPH

CERT Revisited

As I wrote in the Winter 2000 *DMERC Dialogue*, the Comprehensive Error Rate Testing program (CERT) was implemented to allow the Centers for Medicare & Medicaid Services (CMS) to monitor claims payment accuracy. Each month, a sample of claims is examined by an independent auditor (AdvanceMed) and the results reviewed to determine if claims were paid in accordance with Medicare guidelines. Region D claims paid in error are referred back to CIGNA Medicare for collection of an overpayment or refund for underpayment. Now almost three years into the program, the DMERCs continue to track the types of errors and provide education to the supplier and physician community. By far, the most common CERT error is related to documentation. Below are some tips to avoid documentation errors and subsequent overpayment requests.

1. **Respond to the documentation request from AdvanceMed.**

   Should you receive a letter from AdvanceMed asking for your records pertaining to a claim(s), please respond promptly and provide the information requested in the letter. Even though you may have initially been paid for the claim, failure to respond to the documentation request will result in denial of the claim and a request for an overpayment refund to Medicare.

   (Documentation information is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

2. **Maintain complete and accurate records.**

   The *DMERC Region D Supplier Manual*, available online at www.cignamedicare.com/dmsm/index.html, has details about orders and documentation that must be present in a supplier's files, including which items must be in a supplier's files before a claim can even be submitted to Medicare.

   (Refer to Chapter 3 of the *DMERC Region D Supplier Manual* for information about documentation and Chapter 9 regarding requirements detailed in the local medical review policies.)

3. **Ensure orders contain all the required elements, including a signature and date from the treating physician.**

   As noted in the Winter 2003 *DMERC Dialogue*, incomplete orders are one of the top errors noted by the CERT program, particularly in the policy groups of glucose monitors, ostomy supplies, urological supplies and nebulizer drugs. For these policy groups, remember to ensure that the order contains the following elements:

   - Quantity to be dispensed;
   - Frequency of use;
   - ICD-9 diagnosis code or narrative diagnosis;
   - Treating physician's signature and date;
   - Specific type of supply ordered.

   (Documentation information is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

4. **For items requiring a written order prior to delivery, HAVE A WRITTEN ORDER PRIOR TO DELIVERY!**

   Very few items in Medicare have this requirement. Below is the list:

   - Support Surfaces
   - Transcutaneous Nerve Stimulators (TENS)
   - Seat Lift Mechanisms
   - Negative Pressure Wound Therapy (NPWT)
   - Power Operated Vehicles (POV)

   (Information regarding orders is published in Chapter 3 of the *DMERC Region D Supplier Manual*.)

5. **For items requiring a Certificate of Medical Necessity (CMN), ensure that the form is signed AND dated by the treating physician.**

   In addition, if there are any corrections necessary, make sure that the corrections are initialed and dated by the treating physician.
   (Information regarding CMNs is published in Chapter 4 of the *DMERC Region D Supplier Manual*.)

As always, CIGNA Medicare's goal is to help suppliers get their claims processed in an accurate and timely manner. Remembering these documentation tips will help prevent claim errors and claim denials.

MEDICAL POLICY

Coding Instructions – Otto Bock C-Leg®

Recently during a claim review, it was noted that suppliers were billing the miscellaneous code L5999 for the "on-board, real-time gait analysis" function on the Otto Bock C-Leg® product. Although the suppliers were billing this code based on instructions from the manufacturer, this coding advice is not correct. The on-board, real-time gait analysis is accomplished by the microprocessors in the Otto Bock knee (codes L5846 and L5847) and pylon sensors (L5989). There is no separate billing and reimbursement for this function since the allowance for this function is included in the reimbursement for code L5847.

Suppliers are reminded that if there are any questions regarding the correct coding of durable medical equipment, orthotics, prosthetics or supplies (DMEPOS) to contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Dual Oxygen Concentrators

When stationary oxygen concentrators that provide supplemental oxygen from more than one port are furnished, the total unit must be billed as only one unit of E1390 (Oxygen concentrator, capable of delivering 85 percent or greater oxygen), and must only be claimed for use by one beneficiary. Medicare pays for only one unit of equipment, when only one piece of equipment is delivered.

Example: Two beneficiaries living together require home oxygen therapy. One stationary oxygen concentrator (E1390), configured with two ports, is provided. Even though both beneficiaries use the concentrator, the supplier must only bill for one beneficiary and one unit of service.

Suppliers should obtain a completed CMN for both beneficiaries. However, only the CMN for the beneficiary whose name is on the submitted claim should be sent to the DMERC. The CMN for the second beneficiary should be kept in the supplier's files for later use if needed. The supplier should submit a completed CMN and claim to the DMERC for the second beneficiary only if necessary if the supplier can no longer file a claim for the first beneficiary (e.g., the first beneficiary dies), the first beneficiary no longer qualifies for supplemental oxygen, the second beneficiary needs a higher rate of oxygen delivery that would result in additional reimbursement, or later requires a different type of oxygen delivery system.

Enteral Nutrition – Coverage Reminder

Suppliers are reminded that enteral nutrition products that are administered orally are noncovered. Coverage of enteral nutrition is through the prosthetic benefit category. In order to qualify for the prosthetic benefit, beneficiaries must have one of the following conditions:

- Permanent non-function or disease of the structures that normally permit food to reach the small bowel; or,
- A disease of the small bowel which impairs digestion and absorption of an oral diet.

For either of the above situations, the beneficiary must require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with their overall health status.

Suppliers should ensure that claims and Certificates of Medical Necessity (CMNs) for enteral nutrition are submitted accurately and reflect the beneficiary's situation. For example, if the nutrient is administered orally, the answer to Question 13 on the CMN must be answered "4" (Does Not Apply) and the BO modifier (Orally administered nutrition, not by feeding tube) must be added to the claim line.

Local Medical Review Policies Finalized

The following local medical review policies are being published in final form, effective for dates of service on or after October 1, 2003.

- Infrared Heating Pad Systems (IHS)
- High Frequency Chest Wall Oscillation Devices (CWO)
- Mechanical In-exsufflation Devices (MIX)

These may be viewed either on our contractor Web site at www.cignamedicare.com/dmerc/lmrp or at the CMS Contractor LMRP Database at www.cms.gov/medcov/. *Response to Comments* documents for all three policies are also available on the Web sites.

Local Medical Review Policy (LMRP) Revisions

Effective for dates of service on or after July 1, 2003, the following LMRPs are revised:

- Ankle Foot/Knee-Ankle-Foot Orthoses
- Home Dialysis Supplies and Equipment
- Immunosuppressive Drugs
- Oral Antiemetic Drugs
- Ostomy Supplies
- Refractive Lenses
- Speech Generating Devices
- Spinal Orthoses: TLSO and LSO
- Surgical Dressings

The changes made to each policy are indicated in the LMRP section entitled "Revision History Explanation." LMRPs are located on the CIGNA Medicare Web site at www.cignamedicare.com/dmerc/lmrp.

COVERAGE AND BILLING

Advance Determination Of Medicare Coverage (ADMC) - Claim Submission Instructions

Suppliers are reminded that the ADMC process allows DMERC medical review staff to render a decision with respect to the medical necessity of customized wheelchairs and accessories. Medical review does not decide reimbursement. Reimbursement is determined at the time of claim submission.

At the time of claim submission, regardless of the wheelchair base (E1161, E1231 - E1234, K0005, K0009, K0011 or K0014), CIGNA Medicare staff needs the following information:

• Wheelchair Base: Manufacturer, Model Name or Number, Suggested Retail Price

• Miscellaneous Accessories (HCPCS code K0108): Manufacturer, Part Number, Description and Suggested Retail Price

This information must be provided at the time of claim submission, even if it was provided as part of the ADMC documentation for medical necessity determination. If this information is not provided at the time of claim submission, the item(s) lacking the information will be denied. Suppliers billing in the ANSI format are reminded that 80 characters are available on the claim narrative and the line narrative to send the necessary information.

In addition, suppliers should be aware that to qualify for ADMC consideration, there must be submission of a customized wheelchair base. There is no provision for ADMC on accessories billed with beneficiary-owned equipment.

Automatic External Defibrillator And Supplies

Effective for dates of service on or after July 1, 2003, four new HCPCS codes have been established for billing the automatic external defibrillators and supplies.

K0606 - Automatic external defibrillator with integrated electrocardiogram analysis, garment type
K0607 - Replacement battery for automatic external defibrillator, each
K0608 - Replacement garment for use with automatic external defibrillator, each
K0609 - Replacement electrodes for use with automatic external defibrillator, each

Manufacturers or suppliers should contact the SADMERC for guidance on whether a particular device meets the definition of these HCPCS codes. Suppliers are reminded that the establishment of a unique HCPCS code for a particular product does not necessarily indicate coverage.

Billing For Replacement Or Repairs Of Durable Medical Equipment (DME)

When billing for replacement of an item and there is an appropriate HCPCS code for that item, use the HCPCS code with the RP modifier. The RP modifier indicates that this is a replacement item. Any existing criteria based on the LMRP will be required (e.g., KX modifier).

When billing for the repair of a DME item, use the appropriate labor code (E1340) and the appropriate miscellaneous HCPCS codes (E1399, K0108) for parts. Itemize repairs with one claim line billed for the labor and a separate claim line for each part.

The following information is required when billing for replacement or repairs for durable medical equipment:

- Manufacturer's name (if billing for parts, give manufacturer's name for each part)
- Product name
- Part number
- Suggested retail price or manufacturer's invoice price
- Date of purchase
- Justification of patient's medical necessity for the item

Continuous Passive Motion (CPM) Devices

All claims for Continuous Passive Motion (CPM) devices must include the surgery performed, described either by narrative description, a Current Procedural Terminology (CPT) code or ICD-9 diagnosis code.
Each claim for CPM rental must include:

- a narrative description of the surgery, CPT code, or ICD-9 diagnosis code for the surgery performed
- surgical procedure date
- date CPM use began
- beneficiary's discharge date from hospital or nursing home

This information should either be attached to a hard copy claim or entered into the HA0 record of an electronic claim.

CPM devices, E0935, are covered following total knee replacement/arthroplasty (ICD-9 diagnosis code V43.65 or CPT code 27447) or revision of a total knee replacement/arthroplasty (CPT code 27486 or 27487) when the onset of use is within two days following the surgical procedure. Coverage is limited to the three-week period following the surgical procedure where the device is used in the beneficiary's home. Use of the device for longer than the three-week post-operative period or use for other than total knee replacement/revision will be denied as not medically necessary.

Calculation of covered days: The maximum number of covered days for CPM device rental is twenty-one. However, it is unlikely that the full twenty-one days will ever be allowed, since the DMERC does not pay for CPM use while the beneficiary is hospitalized.

Example: Date of total knee replacement/revision is July 14, 1998. Date of total knee replacement/revision plus two days is July 16, 1998.

- Criteria are met if the onset date of CPM is July 14, 15, or 16, 1998.
- Criteria are not met if the onset date of CPM use was July 17, 1998, or after.

Payment for rental of CPM devices is on a per diem basis. When billing for CPM devices, the "from" and "to" dates on the claim line should reflect the actual days the CPM device was used in the home. The units of service (item 24G) should be the number of days in the date span, including the first and last day. If the beneficiary has surgery for a total knee replacement or revision of the opposite knee, another rental period may be allowed. If the beneficiary has a bilateral total knee replacement, two CPM devices may be allowed concurrently. A statement describing the need for the additional rental period or additional device should either be attached to a hard copy claim or entered into the HA0 record of an electronic claim.

EY Modifier Use – Clarification

Effective for dates of service on or after January 1, 2003, a new modifier (EY) was created for use when billing claims for items provided without a physician's order. Items commonly sold without a physician's order include canes, crutches, walkers and commode chairs. Questions have arisen about how to complete the CMS-1500 form in these situations and others where no physician order is received.

UPIN and Ordering Physician Name – Fields 17, 17a: In situations where suppliers are billing, on the same claim, a mix of items with and without orders, suppliers should list the name and UPIN of the physician associated with those items with orders in Fields 17 and 17a, respectively. For those claim lines where the item does not have an order, the modifier EY must be appended. Do not use modifier EY on lines for which the item billed does have a physician's order.

For claims where there is no order for <u>any</u> of the items billed, suppliers should use "No Physician" for the ordering physician's name in Field 17 and use the surrogate UPIN OTH000 in Field 17a. Modifier EY is then appended to the procedure code for each item. Claim lines for items without a physician's order, as indicated by the use of modifier EY, will be denied as not medically necessary, except where an order is required by statute or information on the claim indicates the proper denial is a coverage denial.

For an ANSI claim, Loop 2420E must be completed. This loop contains the ordering provider's name, address, UPIN and phone number. Suppliers filing electronically in the ANSI format should use the following surrogate information:

√ Physician Name – No Physician
√ Physician Address – 555 Anywhere
Anytown, TN 55555
√ UPIN – OTH000
√ Physician Phone Number – 555-555-5555

ICD-9 Diagnosis Code – Field 21: For claim lines of items for which no order is received but the supplier is aware of a valid ICD-9 diagnosis, suppliers should list the valid diagnosis. For example, claims for vision add-on codes without an order where the supplier knows the beneficiary has undergone cataract surgery with insertion of an intraocular lens should use V43.1. When no

valid diagnosis is available, suppliers should use the ICD-9 code 799.9 (Other unknown and unspecified cause) in Field 21.

Certificates of Medical Necessity (CMN): Several fields on the Certificate of Medical Necessity (CMN), including Sections B & D, require input from the treating physician or information from the treating physician's order. For those items where there is no order and a CMN is required, suppliers should follow the instructions above for the CMS-1500 form but a CMN does not have to be sent to the DMERC.

Grace Period For Code Changes

A standard grace period is applied to HCPCS codes that have been discontinued or made invalid for claim submission to the DMERC. The standard grace period applies to claims submitted within three calendar months after the HCPCS code is discontinued. This allows the supplier community to make the appropriate changes to their systems. Example of the grace period: If a code is discontinued as of January 1, the DMERCs would accept claims with dates of service from January 1 to March 31 that are received by March 31. Claims for dates of service on or after January 1 that are received on or after April 1 would be rejected or denied as incorrect coding. The discontinued code should continue to be used for claims with dates of service prior to January 1, regardless of the date of claim submission.

The standard grace period does not apply to items of DMEPOS previously billed using not-otherwise-classified (NOC) HCPCS codes (e.g., E1399, K0009, K0108, etc.). That is because the NOC codes themselves have not been discontinued. When a new specific code is established for an item that was previously billed with an NOC code, the new code must be used when it becomes effective. Claims submitted using the NOC code instead of the newly established code will be denied for incorrect coding.

The grace period also does not apply to codes whose narrative description is changed. If the code narrative is changed, items billed using that code must meet the revised description of the code as of the effective date of the change.

Home Dialysis – New HCPCS Codes

Effective for dates of service on or after July 1, 2003, five new codes have been added to the Home Dialysis Supplies and Equipment local medical review policy (LMRP):

K0610 - Peritoneal dialysis clamp, each
K0611 - Disposable cycler set used with cycler dialysis machine, each
K0612 - Drainage extension line, sterile, for dialysis, each
K0613 - Extension line with easy lock connectors, used with dialysis
K0614 - Chemicals/antiseptics solutions used to clean/sterilize dialysis equipment, per 8 ounces

A revision of the local medical review policy (LMRP) on Dialysis Equipment and Supplies which incorporates these changes is included in the *DMERC Region D Supplier Manual* update and is posted on our Web site. Suppliers are reminded to review the LMRP for more details on the coverage, coding and documentation requirements for these items.

Independent Therapists And DME Suppliers - Billing For Therapy Services Or Supplies That May Be Part Of A Home Health Stay

Before you provide therapy services or medical supplies to a Medicare beneficiary, you need to be certain whether or not a home health episode of care exists for that beneficiary, and whether or not an actual home health discharge date exists. This article provides information that will help you determine whether Medicare will pay separately for your service or whether payment for the services are consolidated into Medicare's payment to a home health agency (HHA). Claims consolidated in the HHA's payment will continue to be denied and you will not receive payment! Medicare adjusts claims for services already consolidated into the HHA's payment and will recover your payment for these services. You will receive a remittance advice on any denied claim which will read as follows: reason code B15: "Payment adjusted because this procedure/service is not paid separately", and remark code N70: "Home health consolidated billing and payment applies."

To help you determine whether the beneficiary is in a home health episode of care, CMS will, in the future, make home health inquiry information available to you electronically, through the Eligibility Benefit Inquiry/Response (270/271) Transaction System. Until and unless you have access to this system, it is your responsibility to simply ask the beneficiary (or his/her authorized representative) if he/she is presently under a home health plan of care. Payment for the services denied by Medicare may be sought from the beneficiary, but you should advise them of their obligation for payment prior to delivering the service.

Remember, you are responsible for determining if the beneficiary you wish to serve is eligible to receive additional Medicare payment for your services. Services provided to a beneficiary who is not eligible to receive those services because they are already in a home health plan of care, are not payable.

A complete list of HCPCS codes subject to Home Health Consolidated Billing can be found on the CMS Web site at www.cms.hhs.gov/medlearn/refhha.asp.

Medicare Carriers Manual Rules For Maintenance And Servicing Claims

The *Medicare Carriers Manual* §3010.D states:

"DMEPOS suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six months have passed from the end of the final paid rental month. (See §5102.1.E.4.) Furthermore, DMEPOS suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself."

Maintenance and servicing for an item billed on the same claim with the rental of the same item will be denied. A claim must be resubmitted for the maintenance and servicing fee only.

Rollabout And Transport Chairs

Rollabout and transport chairs billed using the following HCPCS codes are not included in the local medical review policy (LMRP) for wheelchairs.

E1031 - Rollabout chair, any and all types with castors 5" or greater
E1037 - Transport chair, pediatric size
E1038 - Transport chair, adult size

Add-on features/accessories provided for the above items are not covered. Although, rollabout and transport chairs are not included in the LMRP, they are considered similar to wheelchairs. Therefore, documentation will be required if a patient has a wheelchair and now needs a rollabout or transport chair.

Speech Generating Devices – New HCPCS Codes

Effective for dates of service on or after July 1, 2003, the following codes have been added to the Speech Generating Devices local medical review policy:

K0615 - Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
K0616 - Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
K0617 - Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time

These codes replace code K0542 which will become invalid for submission to Medicare for dates of service on or after July 1, 2003. Under the standard grace period, code K0542 will continue to be accepted on claims with dates of service on or after July 1, 2003 that are received by September 30, 2003. Claim lines for code K0542 with dates of service on or after July 1, 2003 that are received after September 30, 2003 will be returned as unprocessable or denied as incorrectly coded.

Spinal Orthoses – New Codes

Effective for dates of service on or after July 1, 2003, two new codes for spinal orthoses have been established:

K0618 - TLSO, sagittal-coronal 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 and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
K0619 - TLSO, sagittal-coronal 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 xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment

A revision of the local medical review policy (LMRP) on Spinal Orthoses, which incorporates these changes, is

included in the *DMERC Region D Supplier Manual* update and posted on our Web site. Suppliers are reminded to review the LMRP for more details on the coverage, coding and documentation requirements for these items.

Surgical Dressings – New Codes

Effective for dates of service on or after July 1, 2003, two new codes for surgical dressings have been established:

K0620 - Tubular elastic dressing, any width, per linear yard
K0621 - Gauze, packing strips, non-impregnated, less than or equal to 2 inches, per linear yard

A revision of the local medical review policy (LMRP) on Surgical Dressings, which incorporates these changes, is included in the *DMERC Region D Supplier Manual* update and posted on our Web site. Suppliers are reminded to review the LMRP for more details on the coverage, coding and documentation requirements for these items.

APPEALS

Helpful Review Tips

At CIGNA Medicare the DMERC Review Department does everything possible to effectively process review requests from Medicare suppliers and beneficiaries. However, we have found that many requests for review cannot be completed due to incomplete or missing information. It is important to note that there are significant documentation differences when it comes to filing a request for review as compared to filing a claim for initial payment. Below are some helpful tips to assist you with review requests.

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

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

· At the claim filing level, a modifier can be appended to a code that indicates the supplier has the supporting documentation for submitting a claim. At the review level, a modifier is not sufficient. We require that the supporting documentation be sent in with the request. Our number one reason for not reversing a claim determination is missing or insufficient documentation. If sufficient documentation is not submitted, we may contact you and request the additional information. It is very important that you submit this information. If you do not submit this information, we will adjudicate the review based on the information submitted.

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

· A review request must be submitted within 120 days of the initial determination date of the claim. The initial determination date can be found on the remittance notice.

Managing Medicare Appeals Workload In FY 2003

In an effort to manage incoming appeal requests in FY 2003 with the given resources, the Centers for Medicare & Medicaid Services (CMS) has provided guidance relative to processing appeals. Incoming appeal requests submitted **without** necessary supporting documentation will be given secondary priority to appeal requests submitted **with** appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.

HCPCS UPDATES

Coding Assistance From The SADMERC

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) provides HCPCS Level II coding assistance for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The coding advice given by the SADMERC is accepted and effective for all of the four DMERCs. While the SADMERC responds to anyone that requests DMEPOS HCPCS coding assistance, those that primarily seek SADMERC advice are providers and manufacturers of DMEPOS. Some confusion seems to exist as to the types of as-

sistance available and the documentation needed for each type. There are three methods by which coding assistance can be obtained.

1) Coding Verification Review
2) Telephone Inquiry to the SADMERC Helpline
3) Written Inquiry

Coding Verification Review

The Coding Verification Review process is typically used by manufacturers or distributors to determine the proper HCPCS Level II code for billing their product. Per instructions found on the SADMERC Web site, the manufacturer submits the appropriate application to the SADMERC along with other required documentation and a product sample if applicable. Information submitted may include certain proprietary and privileged information and is kept strictly confidential.

There are two types of Coding Verification Reviews:

Type I Review: The SADMERC performs the Coding Verification Review and obtains agreement from the four DMERCs on the coding decision. The four DMERCs require that coding requests received for the following categories of products undergo a Type I Coding Verification Review:

- Enteral Nutrition
- Support Surfaces
- Wheelchair Cushions
- Wheelchairs
- Surgical Dressings
- TLSOs
- LSOs*
- Knee Orthotics**
- Nebulizer Compressors
- Pneumatic Compression Devices (used for Lymphedema)
- CPAP Systems
- BiPAP Systems and Respiratory Assist Devices (including Ventilators)
- Diabetic Shoes and Inserts
- Walkers (that may fall under E0147)

*LSOs - Except those LSOs that are made of elastic or elastic with stays which are coded L0500 and those made of elastic with a rigid or semi-rigid posterior panel which are coded L0515.

**Knee Orthotics - Except those Knee Orthotics that are made of elastic which are coded L1825, those made of elastic with stays which are coded L1800 or those made of elastic with condylar pads which are coded L1815.

Type I reviews require five copies of information for distribution to the DMERCs. The completion of a Type I review is typically 90 days after the receipt of all information required to perform the review.

Type II Review: The SADMERC performs the review based on DMERC guidelines; however, the DMERCs do not participate in the review. If desired, the manufacturer may request a Type I review. Type II reviews require one copy of information. The completion of a Type II review is typically 60 days after the receipt of all information required to perform the review.

Results of Coding Verification Reviews are found in the SADMERC Classification Lists, which are updated daily on the SADMERC Web site. View SADMERC information at www.palmettogba.com (select SADMERC from the Palmetto GBA home page).

Telephone Inquiry to the SADMERC Helpline

The SADMERC operates a HCPCS Coding Helpline that provides DMEPOS coding advice and national fee schedule prices for codes listed on the national schedule. The SADMERC responds to anyone who calls the Helpline. Suppliers of DMEPOS are the most frequent callers.

For the coding of products, callers are asked to provide the product name, manufacturer, and model number and a description of the product for which they need coding advice. The Helpline Customer Service Representative (CSR) determines the proper HCPCS code based on the information provided. In some cases, the information needed to code the product is not easily obtained from a telephone call. In those cases the CSR will request that the caller send a written inquiry to the SADMERC with copies of product literature and if possible, a sample of the product.

Callers should be prepared to provide the following information:

- company name and address
- supplier number (if applicable)
- caller's name
- telephone number
- product name and model number
- manufacturer
- full description of the product

If the caller wants a fee schedule amount for a HCPCS code, the caller should be prepared to provide the following:

- HCPCS code

- pricing modifier (if applicable)
- beneficiary state of residence

The Helpline telephone number is 877.735.1326. The hours of operation are Monday through Friday, 9:00 a.m. to 4:00 p.m. EST, with extended hours, 9:00 a.m. to 6:00 p.m. EST, on Wednesday.

Written Inquiry

The SADMERC accepts written inquiries received by mail and the SADMERC Web site. If insufficient or illegible information is provided in the written inquiry, the response will contain a request for more information. The proper HCPCS code is determined based on the information provided. The following should be included in a written inquiry to the SADMERC:

- company name and address
- supplier number (if applicable)
- requester's name and telephone number
- product name and model number
- manufacturer name
- description of the product
- product literature
- sample of the product (if possible)

Written inquires are typically completed within 45 days of receipt of the inquiry.

Written inquiries may be sent via the following:

- Mailing Address:
  Palmetto GBA, SADMERC
  P. O. Box 100143
  Mail Code AG-370
  Columbia, SC 29202

- Mailing Address for Fed X:
  Palmetto GBA, SADMERC
  2300 Springdale Drive
  Building One
  Camden, SC 29020

- Email: via the SADMERC Web site.

Notice To K0009 Manufacturers

Manufacturers of any products currently coded as K0009 (Other manual wheelchair/base), or accompanying accessories, are urged to contact the SADMERC within 60 days of receipt of this notification. Changes in the current coding structure are underway. These changes will simplify the coding process of the K0009 manual wheelchair base and many of the accessories used on them. This simplification will benefit manufacturers, providers, and claims processing entities alike, and enhance your ability to continue to provide quality products for beneficiaries as well.

Some products currently coded as K0009 may meet the newly established codes effective January 1, 2003. These newly established codes are for pediatric wheelchairs, tilt-in-space manual wheelchairs and transport chairs.

All products currently on the Wheelchair Product Classification List coded as K0009 will receive assignment of an end date along with the new code and effective date. If there is no response from a manufacturer of product(s) currently coded as K0009, the code K0009 will only be valid for that product until the specified end date. The product would then need to be submitted to the SADMERC for coding verification before a HCPCS code will be recommended.

For instructions on submitting an application for HCPCS Coding Verification Review, please contact Shana Sanders, SADMERC HCPCS Coordinator, at 803.763.8114 between 8:00 a.m. and 4:00 p.m. EST. You may also visit the SADMERC Web site at www.PalmettoGBA.com/Other_Partners/SADMERC/HCPCS Coding Verification Reviews.

Wheelchair Payment Category Changes

Effective for claims with dates of service on or after January 1, 2003, processed on or after July 1, 2003, the following HCPCS codes will be moved from payment category capped rental durable medical equipment (DME) to inexpensive or routinely purchased DME.

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 system

FEE SCHEDULE

Important Information About The TLSO Fee Schedule

(Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.)

Recalled – TLSO April 2003 Quarterly Fee Schedule Update

The thoracic-lumbar-sacral-orthoses (TLSO) fees recently published in the article entitled "2003 DMEPOS Fee Schedule April Quarterly Update," with an implementation date of April 1, 2003, for dates of service on or after January 1, 2003, have been recalled. Therefore, the following fees published in the 2003 annual fee schedule update will continue to be effective for dates of service on or after January 1, 2003.

States	L0452	L0454	L0456	L0458	L0460	L0462	L0464	L0486	L0488	L0490
AK	364.83	358.79	358.79	585.28	585.28	585.28	585.28	1760.08	1240.67	1393.21
AZ	330.85	350.83	350.83	547.13	547.13	547.13	547.13	1692.61	1212.41	1124.43
CA	330.85	350.83	350.83	547.13	547.13	547.13	547.13	1692.61	1212.41	1124.43
HI	390.10	429.26	429.26	585.28	585.28	585.28	585.28	1882.07	1326.65	1489.79
IA	298.64	309.06	309.06	632.01	632.01	632.01	632.01	1419.28	1051.16	1083.72
ID	287.20	366.83	366.83	557.71	557.71	557.71	557.71	1419.28	1008.64	843.32
KS	298.64	309.06	309.06	632.01	632.01	632.01	632.01	1419.28	1051.16	1083.72
MO	298.64	309.06	309.06	632.01	632.01	632.01	632.01	1419.28	1051.16	1083.72
MT	248.14	366.83	366.83	606.25	606.25	606.25	606.25	1628.69	1140.86	843.32
ND	248.14	366.83	366.83	606.25	606.25	606.25	606.25	1628.69	1140.86	843.32
NE	298.64	309.06	309.06	632.01	632.01	632.01	632.01	1419.28	1051.16	1083.72
NV	330.85	350.83	350.83	547.13	547.13	547.13	547.13	1692.61	1212.41	1124.43
OR	287.20	366.83	366.83	557.71	557.71	557.71	557.71	1419.28	1008.64	843.32
SD	248.14	366.83	366.83	606.25	606.25	606.25	606.25	1628.69	1140.86	843.32
UT	248.14	366.83	366.83	606.25	606.25	606.25	606.25	1628.69	1140.86	843.32
WA	287.20	366.83	366.83	557.71	557.71	557.71	557.71	1419.28	1008.64	843.32
WY	248.14	366.83	366.83	606.25	606.25	606.25	606.25	1628.69	1140.86	843.32

The above article was posted to our Web site on March 26, 2003. After this article was posted, it was determined that the following fees published in the April quarterly update for the codes listed below were correct and therefore implemented on April 1, 2003, for dates of service on or after January 1, 2003.

States	L0462	L0464	L0490
AK	307.58	315.02	222.28
AZ	307.58	315.02	222.28
CA	307.58	315.02	222.28
HI	307.58	315.02	222.28
IA	313.55	321.15	226.61
ID	307.58	315.02	222.28
KS	313.55	321.15	226.61
MO	313.55	321.15	226.61
MT	318.56	326.28	230.20
ND	318.56	326.28	230.20
NE	313.55	321.15	226.61
NV	307.58	315.02	222.28
OR	307.58	315.02	222.28
SD	318.56	326.28	230.20
UT	318.56	326.28	230.20
WA	307.58	315.02	222.28
WY	318.56	326.28	230.20

Claims received on or after June 1, 2003, with dates of service on or after January 1, 2003, will be paid based on the following local gap-filled fee schedule amounts until the July quarterly update is implemented. Please note code L0464 is included in the below gap-filled fees and replaces the fee listed above. Code L0452 will be considered as individual consideration (IC) due to a lack of product information.

States	L0452	L0454	L0456	L0458	L0460	L0464	L0486	L0488
AK	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
AZ	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
CA	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
HI	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
IA	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
ID	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
KS	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
MO	IC	284.03	814.53	730.37	822.10	1217.31	951.55	822.10
MT	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
ND	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
NE	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
NV	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
OR	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
SD	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
UT	IC	288.18	826.44	741.06	834.12	1235.14	965.47	834.12
WA	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
WY	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75

Revised TLSO fees – Effective July 1, 2003

The fees listed below are the final fee schedule for the TLSO codes. These fees will be effective for claims processed on or after July 1, 2003, for dates of service on or after January 1, 2003.

States	L0452	L0454	L0456	L0458	L0460	L0464	L0486	L0488
AK	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
AZ	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
CA	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
HI	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
IA	IC	277.85	796.76	714.45	804.16	1190.76	930.80	804.16
ID	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
KS	IC	277.85	796.76	714.45	804.16	1190.76	930.80	804.16
MO	IC	277.85	796.76	714.45	804.16	1190.76	930.80	804.16
MT	IC	282.27	809.47	725.85	817.01	1209.77	945.64	817.01
ND	IC	282.27	809.47	725.85	817.01	1209.77	945.64	817.01
NE	IC	277.85	796.76	714.45	804.16	1190.76	930.80	804.16
NV	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
OR	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
SD	IC	282.27	809.47	725.85	817.01	1209.77	945.64	817.01
UT	IC	282.27	809.47	725.85	817.01	1209.77	945.64	817.01
WA	IC	272.52	781.51	700.77	788.75	1167.97	912.96	788.75
WY	IC	282.27	809.47	725.85	817.01	1209.77	945.64	817.01

2003 DMEPOS Fee Schedule July Quarterly Update

Listed below are the changes to the DMEPOS Fee Schedule for the 2003 third quarterly update.

Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage. Please refer to the individual bulletin articles in this issue for the description of the new HCPCS codes and coverage guidelines.

New HCPCS Codes

Listed below are the fee schedule amounts for the new HCPCS codes. These codes are valid for dates of service on or after July 1, 2003.

External Defibrillator and Supplies

States	K0606	K0607NU	K0607RR	E0607UE	K0608NU	K0608RR	K0608UE	K0609
AK	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
AZ	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
CA	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
HI	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
IA	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
ID	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
KS	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
MO	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
MT	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
ND	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
NE	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
NV	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
OR	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
SD	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
UT	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
WA	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09
WY	IC	194.23	19.43	145.67	121.21	12.14	90.91	806.09

Speech Generating Devices

States	K0615NU	K0615RR	K0615UE	K0616NU	K0616RR	K0616UE	K0617NU	K0617RR	K0617UE
AK	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
AZ	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
CA	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
HI	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
IA	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
ID	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
KS	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
MO	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
MT	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
ND	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
NE	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
NV	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
OR	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
SD	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
UT	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
WA	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69
WY	1,195.80	119.59	896.86	1,577.42	157.76	1,183.05	2,312.96	231.29	1,734.69

Thoracic-lumbar-sacral-orthoses (TLSO)

States	K0618	K0619
AK	603.47	411.25
AZ	603.47	416.43
CA	603.47	416.43
HI	603.47	411.25
IA	615.24	378.25
ID	603.47	396.93
KS	615.24	378.25
MO	615.24	378.25
MT	625.06	393.91
ND	625.06	393.91
NE	615.24	378.25
NV	603.47	416.43
OR	603.47	396.93
SD	625.06	393.91
UT	625.06	393.91
WA	603.47	396.93
WY	625.06	393.61

Surgical Dressings

States	K0620	K0621
AK	1.14	1.88
AZ	1.14	1.88
CA	1.14	1.88
HI	1.14	1.88
IA	1.14	1.88
ID	1.14	1.88
KS	1.14	1.88
MO	1.14	1.88
MT	1.14	1.88
ND	1.14	1.88
NE	1.14	1.88
NV	1.14	1.88
OR	1.14	1.88
SD	1.14	1.88
UT	1.14	1.88
WA	1.14	1.88
WY	1.14	1.88

Revised Fees

Wheelchair Fees – Payment Category Changes

The following fee schedule changes are due to the payment category moving from capped rental to inexpensive and routinely purchased. These fees will be effective July 1, 2003, for claims with dates of service on or after January 1, 2003.

States	E1161NU	E1161RR	E1161UE	E1231NU	E1231RR	E1231UE	E1232NU	E1232RR	E1232UE
AK	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
AZ	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
CA	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
HI	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
IA	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
ID	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
KS	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
MO	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
MT	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
ND	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
NE	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
NV	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
OR	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
SD	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
UT	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
WA	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82
WY	2,366.09	236.61	1,774.59	IC	IC	IC	2,138.41	213.85	1,603.82

Wheelchair Fees – Payment Category Changes (cont'd)

States	E1233NU	E1233RR	E1233UE	E1234NU	E1234RR	E1234UE	E1235NU	E1235RR	E1235UE
AK	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
AZ	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
CA	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
HI	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
IA	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
ID	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
KS	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
MO	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
MT	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
ND	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
NE	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
NV	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
OR	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
SD	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
UT	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
WA	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07
WY	2,215.73	221.57	1,661.79	1,928.95	192.91	1,446.70	1,857.43	185.75	1,393.07

States	E1236NU	E1236RR	E1236UE	E1237NU	E1237RR	E1237UE	E1238NU	E1238RR	E1238UE
AK	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
AZ	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
CA	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
HI	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
IA	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
ID	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
KS	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
MO	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
MT	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
ND	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
NE	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
NV	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
OR	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
SD	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
UT	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
WA	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64
WY	1,638.73	163.87	1,229.05	1,653.05	165.30	1,239.80	1,723.55	172.37	1,292.64

Infusion Pump Battery Codes

These fees will be effective for claims processed on or after July 1, 2003, with dates of service on or after January 1, 2003.

States	K0602	K0604
AK	6.36	6.09
AZ	6.36	6.09
CA	6.36	6.09
HI	6.36	6.09
IA	6.36	6.09
ID	6.36	6.09
KS	6.36	6.09
MO	6.36	6.09
MT	6.36	6.09
ND	6.36	6.09
NE	6.36	6.09
NV	6.36	6.09
OR	6.36	6.09
SD	6.36	6.09
UT	6.36	6.09
WA	6.36	6.09
WY	6.36	6.09

ELECTRONIC DATA INTERCHANGE (EDI)

Changes In Boise's Toll-Free Menu Options

Effective March 11, 2003, the menu options for Boise's toll-free line (866.224.3094), which supports both DMERC EDI and the DMERC Provider Education and Training (PET) Departments, have changed.

- Option 1 is the only available option to use for both EDI-related customer service and technical support calls.
- The designated option for ANSI testing has changed to option 2.
- The Provider Education and Training Department (formerly referred to as Public Relations) may still be contacted by selecting option 3.

The Provider Education and Training (PET) Department should only be contacted for issues relating to educational outreach or complex claim issues. Callers choosing Option 3 must leave a message; the PET Department no longer takes "live" telephone calls. The DMERC PET Department's primary and most vital focus is supplier education and outreach. The PET Department will only return calls related to seminars, webinars, trade shows, association meetings and complex claim issues that are unable to be resolved through the normal channels. Suppliers should expect a return call within 24-48 hours. Messages unrelated to these PET issues will be routed back to customer service or other resource avenues as appropriate.

The Interactive Voice Response Unit (877.320.0390) or the Nashville Customer Service Department (866.243.7272) should always be contacted initially for all other claim related issues. For complete information on which resource to use, please refer to the article entitled "DMERC Region D Unique Toll-Free Lines For Supplier Inquiries" located on page 26 of this newsletter.

Claim Status Inquiry (CSI) Code Updates

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee. These codes are currently updated on a quarterly basis and may be found at www.wpc-edi.com.

Effective July 1, 2003, our claims system will be updated to include the most current health care claim status category codes and health care claim status codes used with the HIPAA-ready Healthcare Claim Status Request and Response ASC X12N 276/277 batch transaction. This will also be applicable to the online feature which uses the AT&T Passport for Windows software to access CSI. Future code changes and/or updates applicable to both the online feature and/or batch transaction will be communicated to you via our E-Mail Express Notification System.

EDI Forms Available Exclusively On Web

Effective May 12, 2003, EDI (Electronic Data Interchange) forms are available exclusively via the CIGNA Medicare Web site. We will no longer incorporate these forms into user manuals or future supplier manual updates. To access the current DMERC EDI Customer Profile and EDI Enrollment Form, go to: www.cignamedicare.com/edi/EDI_Forms.

Fixing Errors On Your CMN Reject Listing

The Certificate of Medical Necessity (CMN) reject listing appears at the end of the Electronic Receipt Listing (ERL) for NSF (National Standard Format) users or the Electronic Report Package (Report 7I6006) for ANSI (American National Standards Institute) users. This listing identifies any claims with rejected CMNs by assigning the CMN a four-digit reject code. It is possible that a claim will be accepted into CIGNA Medicare's system for processing, although the CMN may still be rejected. The rejection codes and their corresponding explanations may be found in Chapter 15 of the *EDI Manual* (for NSF users) or Chapter 6 of the *Region D DMERC EDI Manual* (for ANSI users). Please update your manual with the information contained in this article.

Transmitting in the ANSI format makes it easier to resolve these CMN rejections. With the ANSI format, the CMN Reject Listing now includes the original initial date Region D DMERC has on file. This date can be very useful in determining and correcting the CMN rejects.

Many CMNs are rejected simply because they are not completed properly. Here are two helpful tips to ensure proper CMN completion. In addition, these simple guide-

lines may help prevent ANSI Code B17 claim denials.

Tip #1: These CMN rejections occur when another CMN is on file in our system for the same procedure code and beneficiary. Remember that duplicate CMNs will be rejected. In addition, if another supplier has provided same or similar equipment previously, a current CMN may already be on file in our system.

Tip #2: Review CMNs before transmitting with any claims. CMNs should only be transmitted when needed and not with every claim. Consider the following questions before transmitting claims:

- Is the correct type of CMN being transmitted according to the documentation requirements in the various policies: initial, revision, or recertification?
- Are all the sections of the CMN completed?
- Is the correct CMN being sent with the first claim that will be affected?
- Does the date on the CMN you are transmitting overlap that of a CMN already transmitted to CIGNA Medicare?

The following definitions of the CMN reject error codes explain what causes the rejection. Suggestions are also provided for resolving each rejection. CIGNA Medicare is unable to release specific information to a supplier until they have filed a claim. Once a claim has been received for the item indicated on the CMN reject report, the supplier may contact the Customer Service Department toll-free at 866.243.7272.

In order to obtain information regarding CMNs on file and the dates listed, CIGNA Medicare suggests contacting the beneficiary, the ordering physician, and/or the previous supplier. A final option is to have the beneficiary utilize the Customer Service Department toll-free line (800.899.7095) to inquire about previous services.

For questions concerning claim related issues, please contact the Customer Service Department toll-free at 866.243.7272. The Customer Service Department should always be a supplier's initial contact for claim related issues. For a complete guide to CIGNA Medicare's toll-free resources, please refer to the What's New article, "Unique Toll-Free Lines for Supplier Inquiries," located at www.cignamedicare.com.

CMN Reject Error Codes & Explanations

ERROR CODE	EDIT DESCRIPTION	EDIT EXPLANATION
3030	INIT DATE DUP	The initial CMN being transmitted electronically has the same initial date as the original CMN on file for this procedure code. This error occurs when a duplicate initial CMN was transmitted. An initial CMN should be transmitted only with the initial claim for that item. For example, a claim is transmitted for a semi-electric hospital bed with a date of service of 01/15/03, along with an initial CMN with an initial date of 01/15/03. The following month a claim is transmitted with the date of service 02/15/03, along with the same CMN previously transmitted with an initial date of 01/15/03. Since CIGNA Medicare already has the first initial CMN with an initial date of 01/15/03, the second (duplicate) CMN would be rejected with error code 3030. ***Resolution:*** Suppliers should check their software to make sure that a CMN will be transmitted only when necessary. Remember to only transmit a CMN when necessary and not with every subsequent claim. This rejection would also occur if a supplier tried to correct and/or change information on a CMN, different from the CMN already transmitted and on file with the DMERC.

CMN Reject Error Codes & Explanations (cont'd)

ERROR CODE	EDIT DESCRIPTION	EDIT EXPLANATION
3031	INIT DATE< PREV END DATE	The initial CMN transmitted electronically has an initial date that is prior to the end date of the original CMN on file for the same procedure code. This error most often occurs when a beneficiary changes suppliers for rental equipment. The initial CMN was already on file from the original supplier and then another initial CMN was transmitted either by the same supplier or subsequent supplier. CMNs are categorized in our system by beneficiary not supplier. For example, *Fresher Oxygen* transmits a claim for a portable system with a date of service of 04/03/02, along with an initial oxygen CMN for Jane Doe with an initial date of 04/03/02 for a lifetime (99) length of need. In May, Jane injures her hip and enters a nursing facility, but continues to need and use oxygen. In June, Jane returns home after her hip has improved. *Fresher Oxygen* transmits the next rental month's claim with an initial oxygen CMN with an initial date of 06/03/02. The CMN would be rejected with error code 3031 because the initial oxygen CMN is already on file. ***Resolution:*** In the example above, the therapy for the oxygen starts with the initial date the beneficiary needed the oxygen, or 04/03/02. A break in billing is not considered a change in medical need, therefore, no new CMN should be submitted. A break in billing would result when the patient is into a hospital, nursing facility, hospice care, skilled nursing facility, or Medicare HMO. If a change occurred in the medical condition of the beneficiary that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended, the supplier should obtain a new initial CMN. An explanation is needed to document this change in medical condition stating why a new medical need is being established. This CMN would need to be submitted on paper with the documentation for the break of medical necessity. In this case, the CMN cannot be transmitted electronically.
3032	CUR REC/REV DATE <= PREV	The recertification or revised CMN being transmitted electronically has a recertification or revised date that is prior to or the same as the recertification or revised date on the CMN on file for this procedure code for this beneficiary. This error most often occurs when duplicate recertification or revised CMNs are transmitted, or when recertification or revised CMNs are transmitted out of order. For example, *Beds 'R Us* transmits a claim for a hospital bed with a revised CMN with a revised date of 02/01/03, for procedure code E0260. The CMN is transmitted electronically and posted to CIGNA Medicare's CMN files. Later, *Beds 'R Us* realizes they have a revised CMN with a date of 01/08/03, for E0260. *Beds 'R Us* transmits the second revised CMN and it rejects with edit 3032 because CIGNA Medicare has already posted the first revised CMN with the revised date of 02/01/03. ***Resolution*:** Make sure CMNs are transmitted in sequence. If you receive this error and the claim was processed and paid incorrectly due to the wrong CMN for that date of service, follow the guidance in the supplier manual for requesting a review. If the claim was processed and payment was not made, submit the claim and recertification or revised CMN to Nashville on paper for processing. CMNs cannot be transmitted electronically once the recertification or revised CMN has been transmitted out of sequence.

CMN Reject Error Codes & Explanations (cont'd)

ERROR CODE	EDIT DESCRIPTION	EDIT EXPLANATION
3047	RCT/REV INIT DATE	The recertification or revised CMN being transmitted electronically has an initial date that is not the same as the initial date on the initial CMN currently on file for the same procedure code. For example, CIGNA Medicare already has an initial CMN on file for enteral nutrition with an initial date of 03/29/02, sent by *Good Nutrition.* A revised CMN for 03/29/03, is transmitted by *Better Nutrition* with an initial date of 05/29/02. The CMN would reject with error code 3047 because CIGNA Medicare already has an initial date of 03/29/02 on file. ***Resolution:*** Compare the initial date on the CMN you're transmitting with the initial date on the CMN you have in your files. A change in suppliers does not require a new initial CMN. If the order for the nutrition is the same (no change in medical need), a revised CMN should be obtained and kept in the supplier's files and made available to the DMERC upon request. Contact the beneficiary, physician, and/or other supplier to determine if the need has changed.
3048	CANNOT REC/REV DISC	The recertification or revised CMN being transmitted electronically cannot be accepted for this procedure code. The initial CMN on file for this procedure code has been discontinued. Any CMN in a discontinued status cannot be recertified or revised. For example, a beneficiary with a progressive degenerative neurological disorder rents a K0001 wheelchair from *Speedy Wheels*, which transmits a claim with an initial CMN dated 07/13/02 indicating a 6-month length of need. Later, the beneficiary's condition progresses and they can no longer self-propel. The beneficiary's physician orders a K0011 wheelchair and the beneficiary receives the chair from *Rolling Right,* which transmits a CMN for the K0011 with an initial date of 10/20/02. Upon receipt of the K0011 CMN, CIGNA Medicare would discontinue the CMN on file for the K0001 because the need has changed. Next, *Speedy Wheels* transmits the next rental month's claim for the K0001 with a revised CMN to extend the length of need and receives a CMN rejection with error code 3048. ***Resolution:*** Remember to verify every rental month that the beneficiary is continuing to use the item. Contact the beneficiary, physician, and/or other supplier to determine the beneficiary's current medical need.
3052	CMN CLSD-NO REV	The revision CMN that was transmitted electronically cannot be accepted for this procedure code. The CMN on file for this procedure code has been closed. Any CMN in a closed status cannot be revised. For example, if the item was an inexpensive or routinely purchased piece of durable medical equipment such as a Power Operated Vehicle (POV) and it had reached the purchased price, CIGNA Medicare would close the CMN since the maximum allowed had been paid. Another example would be if a beneficiary chose the purchase option for a capped rental item. In this instance, the equipment would belong to the beneficiary in the 14th month and further payment would not be due. ***Resolution:*** Contact the beneficiary, physician, and/or other supplier to determine the status of the equipment. Check your files to see how many months the beneficiary rented the item, or if the beneficiary purchased at initial issuance.

Free Billing Software Will Not Be Phased Out

The Centers for Medicare & Medicaid Services (CMS) has notified Medicare carriers (including the CIGNA Medicare Region D DMERC and Part B) to continue offering the Health Insurance Portability and Accountability Act (HIPAA) free billing software. Previously, CMS instructed Medicare carriers to discontinue the software later this year. This change is good news for health care providers who are required under federal law to send electronic Medicare claims by October 16, 2003.

DMACS-837, the Region D DMERC's free billing software, will be released May 2003. This software will allow electronic billers to submit their claims in the ANSI 4010A1 format, which is the format required by HIPAA. If you currently use DMACS32, programmed in the NSF 3.01 format, you may use this until October 16, 2003 when the HIPAA requirements to use the ANSI 4010A1 will go into effect. Beginning April 1, 2003, we will no longer offer DMACS32. However, we will continue to support both the NSF and ANSI versions of DMACS until October 16, 2003. To apply for DMACS-837, please complete the DMERC EDI Customer Profile or the DMACS Application (for brand new electronic billers) located at www.cignamedicare.com/edi/edi_forms. Be sure to include a check for $5.00 to cover the shipping and handling costs. While at our Web site, be sure to sign up for our E-mail Express Notification System. We'll send you regular Medicare news, updates and information via e-mail, and – don't forget to check out our complete list of upcoming workshops and seminars!

New Options For Beneficiary Eligibility

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions, CIGNA Medicare will be implementing the 270/271 Version 4010A1 transaction set for beneficiary eligibility. Medicare will implement the 270/271 Version 4010A1, using Direct Data Entry (DDE), or Real-Time mode by July 11, 2003.

With the DDE option users will input requests one at a time and then receive an instant response. With Real-Time mode you will build a file for each request using separate software. Once you send your request you will receive an instant response file back that your software will need to interpret. To apply for either of these options, please complete the DMERC EDI Customer Profile located on our Web site.

All other EDI formats for this transaction will become obsolete on October 16, 2003. For more detailed information regarding beneficiary eligibility please read the article "Implementation of the HIPAA Health Care Eligibility Benefit Inquiry and Response (270/271 Version 4010A1) Transaction" that can be found at the EDI What's New section of our Web site at www.cignamedicare.com/edi.

NSF Format Discontinued

In an effort to facilitate the transition to the HIPAA Standard ANSI 837 4010A1 format, CIGNA Medicare DMERC Region D has determined it is counter-productive to set up new submitters in the NSF 3.01 format. Effective May 6, 2003, we discontinued offering NSF as a format option for new electronic billers. This decision was difficult as we considered the impact to our submitters, but we feel it provides the best service to our users. Full migration and implementation to the ANSI format is mandated by the HIPAA Transaction and Code Set Final Rule and Administrative Simplification Compliance Act by October 16, 2003 for all covered entities (including Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies).

We encourage all submitters to consider their options and capitalize on the benefits of electronic billing and achieve compliance with the Transaction and Code Set Final Rule. These options include obtaining ANSI 837 4010A1 software, contracting with a billing service, or contracting with a clearinghouse to support the submission of claims to Medicare.

Suppliers And The 4010A1

Effective April 7, 2003, there has been a change to the outbound files. If you receive the 835 (ANSI Electronic Remittance Notices) or 277 (Claims Status Inquiry Responses) files from CIGNA Medicare and are having problems with your reader or translator after this date please contact your software vendor to verify the software you are using has the ability to accept the ANSI X12N 4010A1 version. This change will not impact your Electronic Receipt Listings or Electronic Reports Package.

Time For Testing

The EDI Department has been accepting the 837 claim version 4010A1 transaction since April 7, 2003. If you have not tested, now is the time to begin.

Here are some clarifications regarding testing as provided by the Centers for Medicare & Medicaid Services (CMS):

• The Administrative Simplification Compliance Act or ASCA requires entities who requested a one-year extension to start testing their systems no later than April 16, 2003. This requirement relates to their own internal testing, not testing with Medicare.

• CMS contractors will continue to accept claims sent on non-4010 formats regardless of whether a provider had submitted an ASCA extension form to CMS by October 16, 2002.

• Submitters of electronic (EDI) claims who have successfully tested with the 837 claim version 4010 do not need to be retested on 4010A1 unless they wish to retest. If you are currently sending in 4010 transactions and would like to test or move directly into production in the 4010A1 format, you will need to complete the DMERC EDI Customer Profile (www.cignamedicare.com/edi/edi_forms) and indicate either test or production. We recommend existing billers test five claims. If you are a new electronic biller, and would like to start sending transmissions in the 4010A1 format, the original testing instructions need to be followed. These can be accessed at www.cignamedicare.com/hipaa/testingpackets.html.

• By October 16, 2003, each EDI submitter must submit all of their electronic claims, claim status inquiries, and eligibility inquiries in compliance with the requirements in the X12N 837 version 4010A1.

• A provider or submitter who does not know who to contact at the contractor to schedule testing should visit: http://cms.hhs.gov/providers/edi/anum.asp (for Part A) and http://cms.hhs.gov/providers/edi/bnum.asp (for Part B).

Update On The National Council For Prescription Drug Programs (NCPDP) Standards

General Information

• Each provider that submits retail pharmacy drug claims electronically must submit all of their retail pharmacy drug claims in compliance with the requirements in the NCPDP format (telecommunications standard version 5.1 and batch version 1.1).

Testing

• CIGNA Medicare is scheduled to be ready for testing of the NCPDP format by August 1, 2003.

• If an EDI submitter is using a vendor, clearinghouse, or billing service to generate a certain transaction and that entity has passed testing requirements for the NCPDP transaction and is using the same program to generate the transaction for all of their clients, then all clients of the vendor/clearinghouse/billing service will not be required to test prior to DMERC acceptance of production data.

• There is no Medicare charge for this system testing. In order to begin the testing process or migrate to the NCPDP format, you must complete the DMERC EDI Customer Profile available on our Web site at www.cignamedicare.com/edi/edi_forms. Be sure to indicate if you would like to test or start production. Additional testing requirements will be posted to the Web site.

Claim Submission

• Several situations have been identified where Medicare requires narrative information for processing certain NDCs. The NCPDP format contains a 500-position field in the Prior Authorization segment where retail pharmacists will be required to submit formatted information relating to a Certificate of Medical Necessity (CMN). In addition, this field will be used to submit the facility name and address information. The NCPDP companion document will provide specific instructions.

• There has been more clarification on when to use the NCPDP format versus the ANSI 837 transaction:

  o The following should be billed using the ANSI 837 transaction using HCPCS codes.

    • Parenteral nutrition claims
    • Enteral nutrition claims
    • End Stage Renal Disease (ESRD) claims

  o Home infusion pharmacies are professional pharmacies and must bill on the ANSI X12N 837 format. Home infusion drugs and associated supplies submitted by these pharmacies must be billed on the X12N 837 using the HCPCS codes to identify the drug and related supply.

• The NCPDP implementation guide allows for up to 4 transactions (line items) per transmission (claim). This means that each claim can have up to 4 line items.

Therefore, if one transaction (line item) rejects, the entire transmission (claim) will be returned. Each NCPDP batch can have up to 9,999,999,997 transmissions (claims).

Coordination of Benefits (COB)

• Each trading partner that has elected to exchange COB electronically must accept the NCPDP format for retail pharmacy drug claims originally sent in this format by providers.

• COB trading partners must either request system compatibility testing for use of the NCPDP COB format prior to Medicare's full implementation, or be confident that they have completed system changes as required to accept production NCPDP COB transactions. Any trading partner that prefers to have COB testing conducted prior to transmission of production data must schedule testing with CIGNA Medicare as soon as possible to assure testing will be completed before Medicare's full implementation.

Resources

• CIGNA Medicare is working with CMS to provide an NCPDP Companion Document. This will be posted on the Web site at www.cignamedicare.com/hipaa as soon as it becomes available.

• More information on the NCPDP format can be found at www.ncpdp.org. In addition, sign-up to receive automatic notification of updates through our E-mail Express Notification System.

HIPAA

CMS Introduces A New HIPAA Information Resource

You can now access a new document-on-request service to help you toward HIPAA transactions compliance. Have your fax number handy and call this toll-free number - 800.874.5894. Select option 1 for the starter set - which includes HIPAA information, resources, and transactions checklist - then follow the prompts. The information will then be delivered to you via your fax machine. It's that easy! Other documents are also available for example information on Medicare's free billing software and a HIPAA glossary. Comments and suggestions may be sent to Sharon Vogt at svogt@cms.hhs.gov (e-mail) or 404.562.7377 (telephone).

HIPAA …It's Not Just For Electronic Billers

The April 14, 2003 HIPAA privacy deadline and the April 16, 2003 testing deadline, have passed, and the October 16, 2003 deadline for compliance with the HIPAA electronic transactions and code set standards is approaching quickly. Many providers are only now starting to think about what they need to do to become HIPAA compliant. To avoid being a HIPAA covered entity, some consultants are suggesting that providers consider switching from electronic transmission to paper claims. Their advice is extremely shortsighted and certainly not a panacea, especially for Medicare providers. Consider the following:

Requirement to go to electronic claims: Medicare will not accept paper claims, effective October 16, 2003. There will be exceptions for small providers and under other limited situations. Regulations are expected soon.

Negative fiscal impact of paper claims: Processing paper claims takes longer than electronic claims and has an increased rate of error. Faster payment can be made for electronic claims submitted to Medicare. Electronic Medicare claims can be paid 14 days after they are received while paper claims cannot be paid before 28 days after receipt. In addition, processing paper claims has increased administrative, postage and handling costs.

Changes to business processes: Switching from electronic transmission to paper claims would have numerous repercussions on the business processes of your office. Remember that HIPAA transactions include more than just claims submission. Providers often conduct eligibility queries, claim status queries, and referral transmission electronically. All of these would have to be done on paper to avoid being a HIPAA covered entity, ultimately leaving less time for patient care and more time devoted to administration. However, you could decide to do some paper transactions and some electronic transactions, but remember that the electronic transactions must be HIPAA compliant.

The following is a basic overview of HIPAA, and some general information related to the law.

What is HIPAA? Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. There are four main areas that comprise administrative simplification:

1. Electronic Transactions and Code Sets
2. Unique Identifiers

3. Privacy
4. Security

What are the HIPAA transactions? Electronic Transaction Standards have been developed for the following exchanges of information that providers conduct:

1. Health care claims or equivalent encounter information;
2. Health care payment and remittance advice;
3. Health care claims status
4. Eligibility inquiry
5. Referral certification and authorization
6. Claims attachment (standards forthcoming)
7. First report of injury (standards forthcoming)

What is a HIPAA covered entity? Under HIPAA, all health care clearinghouses, all health plans, and those health care providers that conduct certain transactions in electronic form or who use a billing service to conduct transactions on their behalf are considered covered entities.

What is "electronic"? The term "electronic" is used to describe moving health care data via the Internet, an extranet, leased lines, dial-up lines such as for "direct data entry", or DDE, private networks, point of service, and health data that is physically moved from one location to another using magnetic tape, disk or CD media. For example, if a provider transmits information electronically by transmitting claims, conducting eligibility queries, conducting claim status queries or referrals, they would be considered a covered entity under HIPAA.

A benefit to consider: HIPAA efficiencies include using the same format for all payers rather than separate formats for each payer, as is often done today.

HIPAA Deadlines:

APRIL 14, 2003	PRIVACY - ALL COVERED ENTITIES EXCEPT SMALL HEALTH PLANS.
April 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities must have started internal software and systems testing.
October 16, 2003	Electronic Health Care Transactions and Code Sets - all covered entities that filed for an extension and small health plans.
April 14, 2004	Privacy - small health plans.
April 21, 2005	Security - all covered entities except small health plans.
April 21, 2006	Security - small health plans.

Where to go for help:

CMS Web site: http://www.cms.hhs.gov/hipaa/hipaa2

HIPAA hotline: 1-866-282-0659

AskHIPAA mailbox: Send an email to: askhipaa@cms.hhs.gov

For more information on privacy, visit http://www.hhs.gov/ocr/hipaa.

For privacy questions, call 1-866-627-7748.

MISCELLANEOUS

CIGNA Medicare Prepares Menu For On-Site Seminars

Do you have a craving for more Medicare knowledge? CIGNA Medicare's Provider Education and Training (PET) Department will host on-site seminars this fall in over 20 different locations throughout the region. Topics will include Certificates of Medical Necessity (CMNs), Advance Beneficiary Notices (ABNs), Repairs, HIPAA, Medicare Updates, and more! Please visit the *Medicare Learning On Demand* Web site for a list of locations and to register online: www.cignamedicare.com/wrkshp/dm. Bring your appetite for learning!

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). One revision has been published since the publication deadline of the Spring 2003 Region D *DMERC Dialogue*.

- Transmittal 39, released March 14, 2003, revises sections 4, 5, and 6 of Chapter 3 to clarify or revise various aspects of MR prepayment and postpayment editing, development and review procedures. The effective/implementation date 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.

Overpayment Refund Checks

DMERC overpayment refund checks sent to us for any reason should be sent to the following address:

CIGNA FEDERAL INSURANCE BENEFITS
P. O. Box 10927
Newark, NJ 07193-0927

Checks should never be sent to our Nashville operations, as this will create delays in the process. In situations where you have received a letter of notification regarding a Medicare overpayment, these delays can result in payment offset. If you are responding to a particular person or department, include that information on the envelope or correspondence. CIGNA Medicare DMERC Region D checks that need to be returned to us should be sent to the following address:

CIGNA HealthCare Medicare Administration
P. O. Box 690
Nashville, TN 37202-0690

Reporting Address And Other Changes To The National Supplier Clearinghouse (NSC)

Suppliers must notify the National Supplier Clearinghouse (NSC) of any changes that occur after the initial

application is filed, including changes to their street, "Mail to," and "Pay to" addresses. Changes must be submitted on the CMS-855S Application Form which can be obtained by contacting a NSC representative toll-free at 866.238.9652 or downloaded from www.palmettogba.com. The form must be mailed to:

National Supplier Clearinghouse
P. O. Box 100142
Columbia, SC 29202-3142

Previously, the DMERC used "return service requested" envelopes only when mailing checks to suppliers allowing the U.S. Postal Service to return undeliverable Medicare checks. Because some suppliers get paid through electronic funds transfer (EFT), there may be cases where a supplier does not have a correct address on file, but continues to receive payments through EFT. Beginning October 1, 2002, the DMERC uses "return service requested" envelopes for all hardcopy Medicare Remittance Notices (MRNs) in addition to using them for hardcopy checks.

When the post office returns an MRN, the DMERC will follow the same procedure as with returned checks. The DMERC will notify the NSC and cease generating any more payments to the supplier until the supplier furnishes a new address and that address is verified by the NSC. The NSC maintains/updates the supplier's records and provides the information to the DMERC.

DMERC Region D Unique Toll-Free Lines For Supplier Inquiries

DMERC Region D is taking action to respond to an increase in calls to our Customer Service Department. This increase in call volume has generated busy signals when calling our current toll-free number. To address this issue, we have taken the following actions to enhance customer service while simultaneously providing more efficient resolution of your inquiries.

On April 28, 2003, we implemented the use of two toll-free lines dedicated to ensure that the supplier community has better access to our office. The existing toll-free line, 877.320.0390, is dedicated exclusively to the Interactive Voice Response Unit (IVR). When accessing this toll-free number, suppliers will not be able to transfer to a customer service agent. To speak to a customer service agent, suppliers will be required to disconnect from the IVR and contact the new Customer Service toll-free number. DMEPOS suppliers can benefit by accessing the IVR to obtain information because it can be accessed outside of normal business hours, 8:00 am - 6:00 pm (CST) as long as the mainframe system is functional.

Suppliers who need to speak with a customer service agent about complex inquiries that cannot be handled via the IVR can call the new toll-free number, 866.243.7272. Suppliers who call a customer service agent regarding inquiries that can be handled by using the IVR will be asked to disconnect and call the toll-free IVR line. Customer service agents cannot route or transfer callers from the new toll-free number to the IVR line. Also note, the beneficiary toll-free line must not be used for supplier inquiries. Suppliers calling on the beneficiary toll-free line will be instructed to call the appropriate number.

Based on supplier feedback, we have enhanced our eligibility option to provide Medicare Secondary Payer eligibility information. We have also expanded the types of Health Insurance Claim Number (HICN) suffixes and prefixes that can be accessed. Please refer to the Supplier Interactive Voice Response (IVR) System article in this issue for IVR navigation tips.

We have developed a Supplier Resource Sheet that includes numerous resources available via the Web, print, in person or via the IVR. These key resources should be recognized as an asset to the DMEPOS supplier community and used regularly before contacting a customer service agent, who is responsible only for addressing complex inquiries that cannot be handled through other means identified in this document. To access the Supplier Resource Sheet and Frequently Asked Questions about this change, please visit our Web site at www.cignamedicare.com/articles/march03/ws0544.html.

Supplier Interactive Voice Response (IVR) System

CIGNA Medicare DMERC Region D has an Interactive Voice Response (IVR) System (formerly known as the ARU) with multiple options to assist you. Claim status, outstanding checks, beneficiary Medicare eligibility, deductible and allowed amount inquiries must be conducted through our IVR system. Our customer service representatives are available at 866.243.7272 Monday - Friday from 8:00 AM - 6:00 PM (CST) for more complex inquiries.

Following is a Supplier Guide to the Interactive Voice Response (IVR) System that contains features, detailed instructions, and tips.

Supplier Guide to the Interactive Voice Response (IVR) System

Current features of the IVR:

- Claim Status Inquiry - pending, denied, paid and/or applied to deductible
  - Line by line explanation of the payment/denial
  - Appeal rights on denied claims
  - Multiple Medicare numbers
  - Multiple provider numbers
- Outstanding Check Information
- Current Deductible Information (available to participating suppliers)
- Beneficiary Medicare Eligibility Information
  - Part B entitlement date
  - Medicare HMO information
  - MSP information
- Allowable Information
- Duplicate Payment Reports
- Ordering Publications
- New Legislation, Supplier Issues and Educational Seminar Information
- Information About Appeal Rights

There is no limit to the number of claims you can check in the IVR!!

Quick tips on accessing information through the IVR:

To enter a supplier number:

- If the supplier number contains a letter, press 1. Enter the supplier number excluding the C followed by the "#" key.
- If the supplier number does not contain a letter, press 2. Enter the 10-digit number followed by the "#" key.
- The IVR will repeat the number entered. Press 1 if the number entered is correct. If you would like to reenter the number, press 2.

To enter a beneficiary's Medicare number:
If the Medicare number begins with a letter, press 1 and:

- If the prefix letter is A, press 1
- If the prefix letters are CA, press 2
- If the prefix letters are MA, press 3
- If the prefix letters are PA, press 4
- If the prefix letters are WA, press 5
- If the prefix letters are WD, press 6
- If the prefix letters are WCA, press 7
- If the prefix letters are WCD, press 8

If it is any other letter(s) press 9

- If the prefix letter is H, press 1
- If the prefix letters are JA, press 2
- If the prefix letters are MH, press 3
- If the prefix letters are PD, press 4
- If the prefix letters are PH, press 5
- If the prefix letters are WH, press 6
- If the prefix letters are WCH, press 7

Enter the 6 or 9 numbers following the prefix followed by the # key.

If the Medicare number begins with a number, press 2; then enter the nine-digit Medicare number. The system will then prompt you to enter the alpha character at the end of the Medicare number.

- If the letter is A, press 1
- If the letter is B, press 2
- If the letter is C, press 3
- If the letter is D, press 4
- If the letter is M, press 5
- If the letter is T, press 6
- If the letter is W, press 7
- If it is any other letter(s) press 8

To enter a letter you will need to press 2 keys. Press the key that contains the letter on your telephone key pad. Then press 1, 2 or 3 depending on the position of the letter on the telephone key pad (i.e., to enter the letter A press 2 1). Assume letters Q and Z are located on the 1 key. The Q is in the first position and the Z is in the second position (i.e., to enter the letter Z press 1 2).

If the letter is followed by a number, press 1. If the letter is followed by another letter, press 2. If no number or letter follows the letter, press the # key.

The IVR will repeat the Medicare number entered and will provide the first three letters of the beneficiary's last name. If correct, press 1. If you would like to reenter the Medicare number, press 2.

To enter a date of service: Use MM/DD/YY format (e.g., 01/01/03).

The IVR Menu

Claim Status (Option 1) - To receive claim status you must enter your supplier number, the HICN of the beneficiary and the date of service. After getting the status of a claim, you may choose from the following:

- For line by line information on the claim, press 1 (Appeal rights and denial information on non-covered claims will be given.)
- To continue, press 2
- To order a duplicate remittance notice on the claim, press 1
- To continue, press 2
- To receive claim information on another claim for the same date of service, press 1
- To receive claim information on this Medicare number for a different date of service, press 2
- To receive claim information on a different Medicare number, press 3
- To have this information repeated, press 7
- To return to the main menu, press 8
- To receive information on a different provider number, press 9

Outstanding checks issued to your supplier number (Option 2) - Enter your supplier number. Outstanding checks on file for the last month will be provided.

Deductible information (Option 3) - Enter your supplier number and the beneficiary's Medicare number. If you are a participating provider, you will receive the current year deductible remaining for the Medicare number you entered.

Eligibility information (Option 4) - To verify Medicare eligibility for a beneficiary you must enter your supplier number, the beneficiary's HICN, date of birth and gender (press 1 for M or 2 for F). This option will provide the Medicare Part B entitlement date and term date, if applicable.

An option is also provided to verify if the beneficiary is enrolled in a Medicare HMO. This option will provide the type of HMO (Risk or cost), the enrollment date and term date, if applicable.

After Medicare HMO enrollment is verified you have the option to verify if Medicare is secondary payer. If there is a Medicare secondary record on file, you are instructed to contact the beneficiary for more information.

Current Medicare allowed amount on a specific procedure code (Option 5) - Specify the state where the beneficiary resides, the HCPCS code and modifiers.

To enter letters for a state code:
1. Using the letters on your touchtone telephone, enter the first letter of the state where the beneficiary resides. For example: If the beneficiary resides in California, press the 2 key.

2. Select the state desired by entering the number provided by the IVR. For example: For Alaska, press 1; for American Samoa, press 2; for Arizona, press 3; for California, press 4. (only the states serviced by Region D will be available)

To enter the HCPCS code you're looking for:

- If the procedure code begins with an A, press 1
- If the procedure code begins with a B, press 2
- If the procedure code begins with an E, press 3
- If the procedure code begins with a K, press 4
- If the procedure code begins with a L, press 5
- If the procedure code begins with a J, press 6
- If the procedure code begins with a Q, press 7
- If the procedure code begins with a V, press 8

Enter the next 4 digits of the procedure code. If there is a modifier at the end of the procedure code, press 1, otherwise press 2.

If the procedure code is followed by a modifier:
- If the modifier is NU, press 1
- If the modifier is RR, press 2
- If the modifier is UE, press 3
- If the modifier is RRKH or RRKI, press 4
- If the modifier is RRKJ, press 5

Other Inquiries (Option 6) - For a duplicate Remittance Notice, press 1: Enter your supplier number, the beneficiary's Medicare number, and the payment report date. You will receive a duplicate remittance notice in the mail.

To Order a *DMERC Region D Supplier Manual*, *DMERC Dialogue*, or Region D Fee Schedule, press 2: The address is given to send written requests for publications.

For new legislation, supplier issues, and educational seminars, press 3:

- For new legislation, press 1
- For supplier issues, press 2
- For Webinar information, press 3
- For onsite seminar information, press 4
- For Provider Communication Advisory Group information, press 5

For information about your appeal rights, press 4: Information about what services are eligible for a review, the elements that should be included in a review request and the proper party to a review is provided.

To repeat these choices, press 7

Frequently Asked Questions

1. When filling out the units in milligrams on the DMERC Informational Form (DIF), should the supplier be filling out the units for a single dose, or the total number of units a beneficiary takes a day, which can be more than one dose?

   ANSWER: The units in milligrams should be filled out for each dose.

2. What can a supplier do if the Certificate of Medical Necessity (CMN) or the written order signed by the physician has an ICD-9 diagnosis code that is not the highest level of specificity?

   ANSWER: Suppliers are prohibited from entering diagnosis information (including ICD-9 codes) on Certificates of Medical Necessity (CMNs). However, a CMN will be accepted even if the ICD-9 code entered by the physician is not valid on the date of service of the claim and/or is not the highest level of specificity as long as the ICD-9 diagnosis code(s) on the claim are valid on the date of service and are the highest level of specificity. Once a CMN has been accepted into the DMERC system, there is no requirement to update the ICD-9 diagnosis code on the CMN if there is no other need to revise the CMN. The only requirement is that a valid ICD-9 diagnosis code be submitted on each claim. Suppliers determine the ICD-9 codes to submit on a claim from a variety of sources including, but not limited to: ICD-9 codes on the written order, narrative diagnoses on a written order, ICD-9 codes entered on a CMN (where applicable), information obtained in written form or verbally from physicians or other healthcare professionals involved in the care of the patient, information obtained from the beneficiary, coding books and other resources. However, suppliers are reminded that ICD-9 diagnosis codes that are entered on a claim must be supported by information in the patient's medical record and this information must be available to the DMERC on request.

   (Region D *DMERC Dialogue*, Spring 2003, page 7)

3. Can a supplier provide more than a 30-day supply to a beneficiary, regardless of place of service, if the applicable local medical review policy (LMRP) in question does not include any specific restrictions?

   ANSWER: According to the *Medicare Carriers Manual § 3010*, "For efficient and effective use of Medicare operational and program resources, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should submit their claims on a monthly basis. Suppliers should bill no more or less frequently than monthly, for a month's worth of DMEPOS, unless another policy that allows billing at a different frequency applies (e.g., diabetic test strips). In the case of continuous periods of service, suppliers should submit their claims in sequence. Suppliers may not automatically mail or deliver durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Inform suppliers of DMEPOS about these preferred billing procedures."

4. Does the supplier need to append the modifier KX when submitting a claim for continuous positive airway pressure supplies?

   ANSWER: The supplier must add the modifier KX (for dates of service on or after 7/1/02) to codes for CPAP (E0601) and accessories only if both the Initial Coverage criteria and the Continued Coverage criteria in the Indications and Limitations of Coverage and/or Medical Necessity section of the policy are met.

   (*DMERC Region D Supplier Manual*, Chapter 9, CPAP, page 4)

Frequently Asked Questions (cont'd)

5. How does the supplier determine whether or not to append the NU modifier?

   ANSWER: Use all resources available, including the following, to determine appropriate modifier(s).

   • Chapter 5, *DMERC Region D Supplier Manual* – lists the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) payment categories and modifier requirements per category.

   • Chapter 16, *DMERC Region D Supplier Manual* – includes a list of HCPCS codes and payment categories and a list of modifiers with definitions.

   • Chapter 9, *DMERC Region D Supplier Manual* – local medical review policies (LMRPs) may contain instructions regarding the use of modifiers.

   • DMERC Fee Schedule at http://www.cignamedicare.com/dmerc/fsch/index.html - modifiers are included on the fee schedule table.

6. The supplier has received an affirmative Advance Determination of Medicare Coverage (ADMC) on a K0014 power wheelchair base, but two of the K0108 Not Otherwise Classified (NOC) codes received negative determinations. What are the supplier's options?

   ANSWER: If the supplier chooses to provide a wheelchair base and/or accessories following a negative ADMC determination, a claim for the item must be submitted. If new information is provided with the claim, coverage will be considered. If the claim is denied, it may be appealed through the usual process. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories.

   (*DMERC Region D Supplier Manual*, Chapter 9, page 2)

7. When does the supplier request a review, an adjustment or resubmit the claims?

   ANSWER: When a claim is denied, analyze all denial codes carefully. If the claim is denied due to a billing error such as invalid procedure code, modifier, or place of service code, resubmit the claim. Claim denials occurring due to lack of an attached Certificate of Medical Necessity (CMN) or Explanation of Benefits (EOB) from the primary insurer must be resubmitted with proper attachment(s). Claims denied for missing information can generally be resubmitted. When resubmitting a claim on paper, do not make unnecessary notations.

   If a claim may be resubmitted as indicated above, do not request an adjustment. Adjustments may be made to correct claims with billing errors that have been fully or partially paid. Resubmitting a corrected claim as a new one may result in a duplicate denial. When requesting an adjustment for a corrected claim, such as a change in unit of services or in a submitted charge, do not use bold, red ink, or circle items on the claim form. A narrative explanation for the changes/corrections may be submitted as an attachment.

   If a denied claim may be resubmitted or adjusted as described above, do not request a review. A review is the first level of the appeals process, and may be requested when an item is fully or partially denied for coverage or medical necessity reasons. Claim denials resulting from the absence of a coverage or medical necessity modifier (such as KX) may neither be resubmitted nor sent for adjustment; they must be resubmitted for review.

   (Region D *DMERC Dialogue*, Spring 1999, page 9)

Frequently Asked Questions (cont'd)

8. In a post-payment audit, is the original physician's signature still required on the Certificate of Medical Necessity (CMN) or will a faxed CMN be accepted?

   ANSWER: When reviewing claims where the medical record contains a copied, faxed or electronically maintained CMN (any CMN created, modified, and stored via electronic means such as commercially available software packages and servers), the DMERC must accept the copied, faxed or electronic document as fulfilling the requirements for these documents.

   When a DMERC is investigating potentially fraudulent behavior by a supplier, it will be the supplier's responsibility to prove the authenticity/validity of the claim(s) under investigation. A DMERC may require the supplier to prove the authenticity/validity of the signature on the CMN or order, or any other questionable portion of the claim(s) under investigation.

   Upon request by the DMERCs, suppliers must provide the CMN in a format that the DMERCs can accept in a timely manner. Upon medical review, the DMERCs should not deny claims solely because the CMN is faxed, copied, or electronic. The DMERC may request the supplier to download and print a hard copy of an electronic order or CMN if the DMERC cannot access it electronically.

   (*Program Integrity Manual*, Chapter 5, Section 1.1.4)

9. What information is required when submitting a claim including a Not Otherwise Classified (NOC) code?

   ANSWER: When a NOC code is billed, the claim must include a narrative description of the item, the manufacturer and/or product name, the model name or number (if applicable), and suggested retail or manufacturer's invoice price, information justifying the patient's medical necessity for the item. This information is required for each NOC code on the claim.

10. Does the supplier have to obtain all of the required documentation when they are only submitting a claim for a denial?

    ANSWER: Claims submitted to Medicare must be complete, including all required CMNs and/or documentation. If the claim is lacking the required documentation, the claim denies as incomplete or missing information.

    (Region D *DMERC Dialogue*, Winter 2000, page 2)

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REQUEST FOR CD-ROM ALTERNATIVE DMERC REGION D PUBLICATIONS

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

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

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

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

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

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

Provider/Supplier Name

Address

City State Zip

Reason for requesting paper version (select one):

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

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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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 # Area Code ( )	Phone # Area Code ( )

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

CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

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

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

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

_____ 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 # Area Code ( )	Phone # Area Code ( )

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Customer Service Available

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

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

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

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

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

Local Medical Review Policies (LMRPs)

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

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

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

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

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

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

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

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

July 4th

America - Celebrating 227 Years of Freedom

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

Region D DMERC Serves. . .

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

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

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