Fall

# DMERC Dialogue

October 2003

DMERC Region D

General Release 03-4

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

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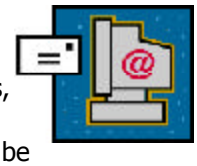

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## In This Issue



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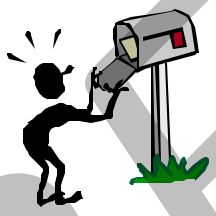
## *From the Medical Director...*

*Robert Hoover, Jr., MD, MPH*



### DO NOT BE AFRAID!!!

Some of you know the feeling. The fluttering in your chest, the cold sweat that breaks out when you go through your mail and you see a letter with a return address marked "CIGNA Medicare." Your hands shake as you rip open the letter, already wondering how many records you'll have to collect and how long the audit will take.

However, a more likely scenario is the letter will contain educational information from CIGNA Medicare. In recent months, targeted mailing has resulted in thousands of letters being sent to providers in Region D. Providers are selected based on claim volume, denial percentage and the type of item provided, primarily in the policy groups of ostomy and urological supplies, nebulizer drugs and blood glucose monitors. The letters contain tips for reducing claim denials for these policy groups.

CIGNA Medicare monitors the types of denials received by providers and strives to provide educational material to help reduce claim denials. The educational materials distributed over the past several months are an effort to assist providers in submitting correct claims. They are not intended as a "warning" or notice that an audit is impending. They are purely educational in nature and more will be forthcoming as CIGNA Medicare identifies areas where education is necessary.

So rejoice, catch your breath, and take a moment to read the contents of the letter. Hopefully the information will help you with future claims to CIGNA Medicare.

**In This Issue** *(Cont'd)*



# MEDICAL POLICY

## Coverage Of Compression Garments In The Treatment Of Venous Stasis Ulcers

Effective for dates of service on or after October 1, 2003, a gradient compression stocking described by the HCPCS codes listed below may be covered under the surgical dressing benefit when it is used to secure a primary dressing over an open venous stasis ulcer that has been treated by a physician or other healthcare professional requiring medically necessary debridement, and when the gradient stocking can be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg. As noted in the Surgical Dressings local medical review policy (LMRP), debridement of a wound may include: surgical (e.g., sharp instrument or laser), mechanical (e.g., irrigation or wet-to-dry dressings), chemical (e.g., topical application of enzymes), or autolytic (e.g., application of occlusive dressings to an open wound).

In the past, gradient compression stockings have not been covered for these conditions and will continue to be denied as noncovered if billed with dates of service prior to October 1, 2003. In addition, there are a number of medical conditions for which gradient compression stockings are considered standard of practice but for which there is no Medicare benefit. Those conditions include:

1. Venous insufficiency without stasis ulcers;
2. Prevention of stasis ulcers;
3. Prevention of the reoccurrence of stasis ulcers that have healed; or,
4. Treatment of lymphedema.

If claims for gradient compression stockings are submitted for these indications, modifier AW (see below) must not be added to the code.

Coding

The following codes describe the gradient compression stockings that are eligible for coverage:

L8110 - Gradient compression stocking, below knee, 30-40 mmHg, each
L8120 - Gradient compression stocking, below knee, 40-50 mmHg, each

For these codes, one unit of service is generally for one stocking. However, if a manufacturer has a product con-

sisting of two components which are designed to be worn simultaneously on the same leg, the two components must be billed as one claim line with one unit of service. An example is the UlcerCare® stocking by Jobst which consists of an unzippered liner and a zippered stocking.

Modifier Usage

When a gradient compression stocking described by code L8110 or L8120 is provided for a patient with an open venous stasis ulcer, the modifier AW (Item furnished in conjunction with a surgical dressing) must be appended. Modifier AW must only be used with these codes when the above requirements have been met. Claims for L8110 and L8120 submitted without modifier AW will be denied as noncovered (no Medicare benefit).

Modifiers RT (Right) and LT (Left) must be used with HCPCS codes L8110 and L8120. When a gradient compression garment is provided bilaterally and the same code is used for both garments, bill both on the same claim line using modifier LTRT and 2 units of service.

Reusable nonelastic binders, A4465, (e.g., Circaid®) are sometimes used to treat venous stasis ulcers; however, these devices are not considered gradient compression stockings. Under the Surgical Dressing benefit category, only gradient compression stockings are covered. Therefore, claims for code A4465 are denied as noncovered (no Medicare benefit).

A revision to the Surgical Dressings LMRP is published in this edition of the *DMERC Region D Supplier Manual* update. Please refer to the LMRP for additional information about the coverage, coding, and documentation for these items.

## Dialysis LMRP – Modifier KX Change

Effective for dates of service on or after July 1, 2003, the meaning and use of modifier KX in the Home Dialysis Supplies and Equipment LMRP has been changed. Modifier KX must only be used to indicate that a Method II supplier has a written agreement with a Medicare-certified support service facility within a reasonable distance from the beneficiary's home. If such an agreement is lacking, claims must not be submitted with modifier KX. Claims submitted without modifier KX will be denied as noncovered.

Modifier KX must not be used to indicate that any other coverage criteria listed in the LMRP has been met.

## Local Medical Review Policy (LMRP) Publications

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

- Ostomy Supplies
- Home Dialysis Supplies and Equipment
- Surgical Dressings
- External Infusion Pumps
- Power Wheelchairs

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.

In addition, the Oxygen LMRP has been revised with changes effective for dates of service on or after January 1, 2004. See the accompanying article in this edition of the *DMERC Dialogue* for more details.

The final Automatic External Defibrillators LMRP is included in the accompanying supplier manual update. This new LMRP is effective for dates of service on or after January 1, 2004. The policy and Response to Comments document are located on the CIGNA Medicare Web site for LMRPs listed above. Also see the accompanying article in this edition of the *DMERC Dialogue* for more details.

## Negative Pressure Wound Therapy Pumps

Recently, the Durable Medical Equipment Regional Carrier (DMERC) medical directors were asked by Kinetic Concepts, Inc., manufacturer and supplier of the V.A.C.® wound therapy system, to clarify several aspects of the Negative Pressure Wound Therapy (NPWT) local medical review policy. The following is a summary of the answers to their inquiry.

The medical policy says that coverage of an NPWT pump ends if wound healing has failed to occur over the prior month. Healing of a wound is assessed by comparing measured wound volumes. It is therefore important that the length, width, and depth of the wound be recorded during each evaluation performed to document continued medical necessity for the NPWT pump. If one of these values is not recorded, then healing of the wound will not have been adequately documented and coverage for that wound will end. Changes in undermining or tunneling around the wound will not be considered in the determination of wound healing because the dimen-

sions cannot be quantitated and because it is expected that changes in measured wound volume will correlate with other aspects of wound healing.

If healing of a wound fails to occur in a particular month, then there will be no further coverage for that wound – even if treatment with the pump continues and subsequent improvement occurs. If healing of a wound fails to occur in a particular month, then the KX modifier must not be added to claims for any subsequent months for use of the pump on that particular wound. (If other wounds are being treated and improvement is continuing on one or more of those wounds, the KX modifier may continue to be used.) If it is determined on review that claims were paid after a month in which no improvement occurred, overpayments will be collected.

NPWT pumps are used to initiate the healing of wounds. It is not necessary to continue to use a pump until a wound is completely healed. For example, if the depth of a wound is less than 0.5 cm, then it would generally not be appropriate to continue use of the device. Also, if improvement of a wound has steadily occurred during four months treatment with the pump, then continued use of the pump on that wound would very rarely be medically necessary. An exception might be a very large open sternotomy or abdominal wound which had improved but was still quite large after four months of treatment.

If multiple wounds are being treated and there is no improvement in one wound but improvement is noted in the other wound(s), then coverage could continue for those wounds. The four month time frame for coverage would apply to each wound being treated. If treatment of a new wound was started after treatment for an initial wound was begun, this would not generally start a new capped rental period for the device. However, it may extend the total months in which we cover the device – if there was continual improvement of the wound(s) being treated. A new capped rental period would only begin if the device had not been used on any wound for at least 2 months and treatment was then begun on a completely new wound which met coverage criteria.

## New Local Medical Review Policy – Automatic External Defibrillators

Effective for dates of service on or after January 1, 2004, a new LMRP entitled "Automatic External Defibrillators" is being published with this edition of the *DMERC Region D Supplier Manual*. It may be viewed either on our contractor Web site at www.cignamedicare.com/dmerc/lmrp/index.html or on the CMS Contractor LMRP Database at www.cms.hhs.gov/coverage/.

## Oxygen – Policy Revision

A revision of the Oxygen policy is included in the accompanying *DMERC Region D Supplier Manual* update. The changes are effective for claims related to CMNs with initial dates on or after January 1, 2004. A document providing a partial response to comments received relating to the draft policy is posted on the CIGNA Medicare local medical review policy Web site at www.cignamedicare.com/dmerc/lmrp.

The draft revision of the LMRP on Oxygen and Oxygen Equipment was initially released for comment in July 2001. Two major changes were proposed. First, a proposal to change the criteria for patients who qualify for oxygen based only on a sleep study to require that the qualifying test value be present for at least 5 minutes. Currently no minimum length of time is specified. This change has been incorporated into the final LMRP.

Second, the draft LMRP proposed to change the recertification of Group I patients from the current 12 months to 3 months and to require retesting prior to recertification. Due to technical considerations relating to policy implementation, revisions to the LMRP dealing with the recertification requirements for Group I patients are not included in the current revision. They will be included in a future revision of the policy. Response to comments relating to those changes will be published at that time.

Finally, the final policy incorporates additional guidance on CMNs that is also included in a separate article in this bulletin (See "CMN Table", page 7).

## Oxygen - Lessons Learned

In 2002, CIGNA Medicare received 2,050,580 claims for HCPCS code E1390 and paid suppliers a total of $306,868,809.39. The Medical Review Department recently completed a postpayment widespread probe review of this high volume, high dollar item. The sample reviewed represented claims from 93 suppliers on behalf of 100 beneficiaries. CIGNA Medicare determined that the error ratio (total amount overpaid divided by total amount paid) was 34.72%.

The number one error found in this review occurred in instances where the qualifying test was performed during exercise. According to the National Coverage Determination concerning coverage criteria for home oxygen therapy (*Coverage Issues Manual*, 60-4), there must be demonstration that the hypoxia, exhibited with exercise while breathing room air, improves with the application of oxygen therapy. Typically, this involves three separate blood gas measurements (at rest on room air,

exercising on room air and exercising with oxygen). Please refer to page 7 of Region D's Winter 2003 *DMERC Dialogue* for a detailed discussion of this requirement.

The LMRP covering oxygen therapy instructs suppliers that information submitted by the supplier must be corroborated by documentation in the patient's medical records. This information must be available to the DMERC upon request. A significant number of the suppliers in this review, however, were unable to obtain supporting documentation from the beneficiary's prescribing physician. CIGNA Medicare suggests that suppliers protect themselves by verifying the availability of corroborating medical records prior to dispensing oxygen.

Another error that occurred in multiple instances concerned qualifying tests taken while the beneficiary was in the hospital. In this situation, the qualifying value cannot be taken more than 2 days prior to discharge **and** must be the value on room air closest to discharge. For example, the beneficiary ***does not*** qualify for home oxygen therapy if a room air saturation of 87% is recorded on the day before discharge but the medical record documents the last room air saturation value as 90%.

An additional finding of the review concerns portable oxygen systems. A coverage criterion for portable oxygen is that the beneficiary be mobile (ambulatory or wheelchair) within the home. In situations where the medical records did not support that this criterion was met, CIGNA Medicare denied the portable system. Medical Review personnel also found instances where the CMN listed the testing condition as "at rest" but the medical records showed the testing condition was actually "during sleep." The beneficiary therefore did not qualify for a portable system.

Finally, CIGNA Medicare would like to remind suppliers that the blood gas study reported on the Initial CMN must be the most recent study obtained prior to the Initial Date and this study must be obtained within 30 days prior to that Initial Date.

## Seat Lift Mechanism And Power Wheelchair - Lessons Learned

Recently CIGNA Medicare's Medical review staff conducted a Progressive Corrective Action widespread probe to examine the provision of both a seat lift mechanism and a power/motorized wheelchair to a beneficiary within a 60 day timeframe. The Medicare coverage criteria for these two items are in conflict. Ambulatory patients who are unable to rise from any chair without assistance may qualify for a seat lift mechanism. The motorized wheelchair is a covered Medicare item for patients who are unable to ambulate within the home and cannot propel any type of manual wheelchair.

Data analysis of claims between November 1, 2001 and October 31, 2002 revealed a potential overpayment involving seat lift mechanism and power wheelchairs with 131 beneficiaries receiving both items within a 60 day or less time frame. Seventy-seven suppliers were identified as having provided one or both of these items.

The percent of error was 89%. All of the denials were medical necessity denials. Of these, 22% of the suppliers did not respond to the records request, 36% responded but provided no medical records, and 41% provided medical records which did not support the provision of the seat lift mechanism and/or power wheelchair. The medical records which were provided often produced information that specifically contraindicated the need for one or both of these items (e.g., "patient tires after walking more than one block"). Other records did not mention the need for either item.

In order to provide coverage for a power wheelchair, information should be present in the beneficiary's medical record which describes their ambulatory ability within the home and the reason that a manual wheelchair would not be usable. This estimate should be quantitative, not qualitative. For a seat lift mechanism to be covered, information should be in the records to indicate that the patient is unable to rise from any chair in his house and is able to walk once standing. A statement such as "the patient would benefit from the seat lift mechanism" is not adequate justification for why the equipment is medically necessary.

For the provision of all DMEPOS items, medical documentation should be available to the DMERC upon request to support the medical necessity of the item billed. CIGNA Medicare suggests that suppliers discuss with the treating physician, in advance of providing these items, the need for documentation, especially when there is a history of use by the beneficiary of other items with conflicting coverage criteria. This information can often be obtained by a thorough intake data collection procedure.

For further information, please refer to the Winter 2003 *DMERC Dialogue* article entitled "Provision of Items with Conflicting Coverage Criteria."

## Surgical Dressings – New Codes

Effective for dates of service on or after October 1, 2003, the following codes for surgical dressings have been

established:

K0622 - Conforming bandage, non-elastic, knitted/ woven, non-sterile width less than three inches, per roll
K0623 - Conforming bandage, non-elastic, knitted/ woven, sterile width less than three inches, per roll
K0624 - Light compression bandage, elastic, knitted/ woven width less than 3 inches, per roll (at least 3 yards unstretched)
K0625 - Self adherent bandage, elastic, non-knitted/ non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width less than 3 inches, per roll.
K0626 - Self-adherent bandage, elastic, non-knitted/ non-woven, load resistance greater than or equal to 0.55 foot pounds at 50% maximum stretch, width greater than or equal to 5 inches, per roll

A revision of the LMRP on Surgical Dressings which incorporates these changes is included in the *DMERC Region D Supplier Manual* update and is posted on our Web site at www.cignamedicare.com/dmerc/lmrp.

# *COVERAGE AND BILLING*

## Addition Of Temporary Codes Q4052 And Q4053

Effective July 1, 2003, two new "Q" codes have been established for billing for octreotide and pegfilgrastim.

The code descriptions are as follows:

Q4052 - Injection, octreotide, depot form for intramuscular injection, 1 mg
Q4053 - Injection, pegfilgrastim, 1 mg

***NOTE: The HCPCS code J2352 may no longer be used to report the depot form of octreotide.***

These codes are not covered by the DMERC.

## Addition Of Temporary Codes Q4075, Q4076 And Q4077

Effective October 1, 2003, three new HCPCS "Q" codes have been established.

Q4075 - Injection, acyclovir, 5 mg
Q4076 - Injection, dopamine hydrochloride, 40 mg
Q4077 - Injection, treprostinil, 1 mg

These HCPCS codes are incorporated into the External Infusion Pump local medical review policy in the accompanying *DMERC Region D Supplier Manual* update.

## DMERC Place Of Service (POS) Code Update

In terms of HIPAA compliance, Medicare must recognize and accept place of service (POS) codes from the National POS Code Set, currently maintained by the Centers for Medicare & Medicaid Services (CMS). Therefore, DMERC Region D is adding the following codes to the current list of place of service codes valid for claim submission for durable medical equipment, prosthetics, orthotics and supplies.

**04 Homeless Shelter** - A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (For the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home.)

**13 Assisted Living Facility** - Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.

**14 Group Home** - Congregate residential foster care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community.

Effective October 1, 2003, the above listed POS codes will be valid for paper and electronic claims submitted to the DMERC. These codes will be added to the Place of Service section in Chapter 5 of the *DMERC Region D Supplier Manual* with the October update. The supplier manual can be accessed at http://www.cignamedicare.com/dmerc/dmsm/index.html. For a complete list of place of service codes visit www.cms.hhs.gov/states/poshome.asp.

## Certificates Of Medical Necessity – Common Scenarios

Suppliers frequently approach the DMERCs with questions about what CMN type should be submitted for a given situation. All CMN requirements detailed below are based on assumptions about what are the most common scenarios seen by the DMERCs. The facts of

any individual supplier's claim may result in an alternate requirement. Suppliers should use this information only as general guidance and should consult with the appropriate contractor as necessary.

## Certificates of Medical Necessity – Common Scenarios

| # | Oxygen | Certification Required | Notes | Comments |
|---|---|---|---|---|
| 1 | Break in service > 60 days (change in medical condition) | initial | 1, 2 | |
| 2 | Break in service > 60 days (no change in medical condition) | none | 1, 2 | |
| 3 | Break in service < 60 days (change in medical condition) | none | 1, 2 | |
| 4 | Break in service < 60 days (no change in medical condition) | none | 1, 2 | |
| 5 | Change in supplier (no break in service) | revised in supplier's files | 1, 3 | In an acquisition, the original may be used if it is available. |
| 6 | Initial CMN did not qualify, patient retested and now qualifies | initial | 1 | The initial date should be the date of the qualifying test |
| 7 | Group II patient not retested within 61-90th day | initial | 1 | The initial date should be the date of the qualifying test |
| 8 | Group I patient with a length of need less than or equal to 12 months (but not lifetime) and not retested 30 days prior to revision | initial | | The initial date should be the date of the qualifying test |
| 9 | Group I patient with lifetime length of need, not seen and evaluated by the physician within 90 days prior to the 12 month recert but subsequently seen | recertification | 1 | The recertification date should be the date of the physician visit. |
| 10 | Change in supplier due to acquisition. Previous supplier did not file recert when it was due. All requirements for recert were met when it was due. | recertification | 1,3 | Recert date would be 12 or 3 months after initial date depending on whether initial cert was group 1 or group 2. |
| 11 | Change in supplier due to acquisition. Previous supplier did not file recert when it was due. Not all requirements for recert were met when it was due. | initial | 1,3 | The initial date would be the date of the qualifying test. |
| 12 | Portable was added after stationary | revised | | |
| 13 | Stationary was added after portable | revised | | |
| 14 | Change in modality | none | | |
| 15 | Changed billing assignment (non-assigned to assigned) | none | | |
| 16 | Change in doctor | revised in supplier's files | | |



*(cont'd next page)*

## Certificates of Medical Necessity – Common Scenarios (cont'd)

| # | Oxygen | Certification Required | Notes | Comments |
|---|---|---|---|---|
| 17 | Change in liter flow | revised if change in payment category, e.g., from 4 lpm to 5 lpm. None if payment category does not change | | |
| 18 | Change from Medicare secondary to Medicare primary | none | | |
| 19 | Change from non-Medicare insurance to Medicare | initial | | The initial date should be the date of Medicare eligibility if the patient has a Medicare qualifying test within 30 days before their eligibility. If they do not get the qualifying test until after they become Medicare eligible, then the initial date should be the date of the qualifying test. |

| | Capped Rental Equipment | Certification Required | Notes | |
|---|---|---|---|---|
| 20 | Break in service > 60 days (change in medical condition) No change in HCPCS | initial | 2 | |
| 21 | Break in service > 60 days (no change in medical condition) No change in HCPCS | none | 2 | |
| 22 | Break in service < 60 days (change in medical condition) No change in HCPCS | none | 2 | |
| 23 | Break in service < 60 days (no change in medical condition) No change in HCPCS | none | 2 | |
| 24 | Break in service > 60 days (change in medical condition) Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial | 2, 4 | |
| 25 | Break in service > 60 days (no change in medical condition) Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial | 2, 4 | |
| 26 | Break in service < 60 days (change in medical condition) Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial | 2, 4 | |
| 27 | Break in service < 60 days (no change in medical condition) Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial | 2, 4 | |

*(cont'd next page)*

**Certificates of Medical Necessity – Common Scenarios (cont'd)**

| # | Capped Rental Equipment | Certification Required | Notes | |
|---|---|---|---|---|
| 28 | Change in supplier (no break in service, no change in HCPCS) | revised in supplier's files | 2, 3 | |
| 29 | Change in supplier (no break in service, HCPCS changed e.g., K1 to K3) | initial | 2, 3, 4 | |
| 30 | Initial CMN did not qualify, patient re-evaluated and now qualifies | initial | | |
| 31 | Change in doctor | revised in supplier's files | | |
| 32 | Added elevating leg rests after wheelchair provided | initial for elevating leg rests | | |
| 33 | Changed billing assignment (non-assigned to assigned) | none | | |
| 34 | Change from Medicare secondary to Medicare primary | none | | |
| 35 | Change from non-Medicare insurance to Medicare | initial | | |

Notes

1. Assumes lifetime length of need. If the length of need is less than lifetime, different guidelines may apply.

2. "Break in service", for the purpose of this table, is defined as break in monthly billing.

   "Change in medical condition" means that the patient's condition changed to the point that they no longer needed the original device. The patient's condition then changed again and the patient needed to resume using the original item. It could be for the same or different diagnosis.

   "No change in medical condition" means that there is a break in billing but the patient still needed the same equipment. For example, the patient was in a SNF, hospital, Medicare HMO, or hospice and the DMERC was not being billed during this time. This could also include situations in which the patient continued to need the equipment, but it was removed from the patient's home.

3. Requirement is for the new supplier.

4. Submission of a new Initial CMN does not guarantee that a new capped rental period will be started.

# Durable Medical Equipment, Prosthetics, Orthotics And Supplies (DMEPOS) Claims During An Inpatient Stay

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

However, there is an exception to the general rule above. In accordance with DMEPOS payment policy, Medicare will make a separate payment for a full month for DMEPOS items, provided the beneficiary was in the home on the "from" date or anniversary date defined below.

For DME items where the supplier submits a monthly bill, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.).

If a beneficiary using DME is at home on the "from" date or anniversary date, Medicare will make payment for the item for the entire month, even if the "from" date is the date of discharge from the institution.

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

When the "from" date on the DMEPOS claim falls within an inpatient stay and the beneficiary returns home within the same calendar month, the supplier must submit a new claim on the date of discharge from the institutional provider and the date of discharge will become the "from" (anniversary) date for all subsequent claims.

Suppliers should annotate the HAO record in NSF claims, 2300 NTE and 2400 NTE for ANSI claims, or field 19 for paper claims, to indicate that the patient was in an institution, resulting in the need to establish a new anniversary date.

**Example 1:**

A beneficiary rents a wheelchair beginning on January 1. The Durable Medical Equipment Regional Carrier (DMERC) determines that the wheelchair is medically necessary and that the beneficiary meets all coverage criteria, and so begins to make payment on the wheelchair. The beneficiary enters a hospital on February 15 and is discharged on April 5.

In this example, Medicare will make payment for the entire month of February, because the patient was in the home for part of the month. However, the DMERC will deny the claim for March, because the patient was in a covered hospital stay for the entire month.

Because the anniversary date ("from" date) of the monthly bill was April 1, and the patient was still in the covered hospital stay on that date, the DME supplier must not submit another claim until April 5 (the date of discharge). April 5 becomes the new anniversary date ("from" date) for billing purposes, so the supplier would now bill on the 5th of the month rather than the 1st of the month for the remainder of the capped rental period.

**Example 2:**

A beneficiary receives oxygen on January 1. On February 28, the patient enters a hospital and is discharged on March 15.

In this example, the DMERC would deny a claim dated March 1. The supplier would submit a new claim dated March 15, which would then become the anniversary date for billing purposes.

**Example 3:**

A beneficiary rents a hospital bed beginning on January 1. On March 15, the patient enters a hospital and is discharged on March 25.

In this example, the DMERC will make payment for the entire month of March.

**Example 4:**

A beneficiary rents a wheelchair beginning December 15. On January 1, the patient enters a hospital and is discharged on January 31.

In this example, the DMERC will deny the claim dated January 15. The supplier would submit a new claim dated January 31, which would then become the anniversary date for billing purposes. The February claim would be dated February 28 because there is no 31st day in February.

## Early Delivery Of Immunosuppressive Drugs

The DMERCs make payment for immunosuppressive drugs for beneficiaries who receive a covered organ transplant and who meet all other Medicare coverage criteria for immunosuppressive drugs once the patient has returned to their home. Suppliers are required to complete a DMERC Information Form (DIF) prior to submission of claims for immunosuppressive drugs for use in the home.

For a pharmacy that delivers by shipment, it is reasonable to expect that it may need to ship medication to the patient up to 2 days prior to the date the patient will be discharged so that the drugs will arrive at the patient's home when they return.

Under normal circumstances, the date of service listed on the claim must be the date the supplier actually delivered or shipped the item. However, under the circumstance described above, the DMERC claim processing systems will, appropriately, reject the claim with a date of service listed as being prior to the patient's date of discharge, because the hospital remains responsible for the provision of immunosuppressive drugs while the beneficiary is still an inpatient.

Therefore, for a pharmacy that delivers medication by shipment, the pharmacy may enter the date of discharge as both the initial date on the DIF form and as the date of service on the first claim it submits for the beneficiary after the beneficiary is discharged. Note that this is an optional, not mandatory, process. If the pharmacy does not want to ship the immunosuppressive drugs prior to the beneficiary's date of discharge from the hospital, they may wait for the beneficiary to be discharged before doing so, and follow all applicable Medicare and DMERC rules for immunosuppressive drug billing (e.g., the date of service will be the date of delivery/shipping).

Note that the following conditions apply:

1. The facility remains responsible for all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay. The pharmacy must not receive separate payment for immunosuppressive drugs prior to the date the beneficiary is discharged.

2. The pharmacy must not ship or otherwise dispense the drugs any earlier than 2 days before the patient is discharged. It is the pharmacy's responsibility to confirm the patient's discharge date if they choose to take advantage of this option.

3. The pharmacy must not submit a claim for payment prior to the beneficiary's date of discharge.

4. The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility, skilled nursing facility – if not during Medicare Part A covered stay), but not to a facility that does not qualify as the beneficiary's home (e.g., inpatient hospital or skilled nursing facility – during Medicare Part A covered portion of stay).

## ESRD Claim Processing Procedures

Method II suppliers must maintain documentation to support the existence of a written agreement with a Medicare certified support service facility within a reasonable distance from the beneficiary's home. The supplier may not provide supplies or services to the beneficiary, or submit a claim to the DMERC, until they have a valid written support service facility agreement for that beneficiary.

Suppliers must use the KX modifier on the line item level for all Method II home dialysis claims to indicate they have this documentation on file, and must provide it to the DMERC upon request. As previously published in the Spring 2002 *DMERC Dialogue*, page 9, effective July 1, 2002, claims submitted without a KX modifier would be rejected back to the supplier as unprocessable.

Effective with claims processed on or after October 1, 2003, DMERCs will deny any Method II claims that do not have the KX modifier at the line item level. The supplier may correct and resubmit the claim with the appropriate modifier.

## ICD-9-CM Coding Update

Beginning October 1, 2003, providers/suppliers may begin using the 2004 ICD-9-CM codes. There will be a grace period from October 1, 2003 through December 31, 2003. For claims received on or after January 1, 2004, the latest version of the ICD-9 codes must be used by providers.

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

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

- Ingenix - 800.999.4600

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

ICD-9-CM is composed of codes with three, four, or five digits. Some three-digit codes stand alone. Other three-digit codes are further subdivided by the addition of fourth or fifth digits, which provide greater specificity. Therefore, code as follows:

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

## New Requirements For ICD-9 Coding On Claims Submitted To Medicare Carriers

Effective for dates of service on or after October 1, 2003, ICD-9-CM diagnosis codes must be included on all Medicare paper and electronic claims billed to Part B carriers.

The Region D DMERC previously published an article in the Spring 2003 *DMERC Dialogue*, page 7, based on Program Memorandum (PM) B-03-028 (CR2672), implementing requirements for submittal of a diagnosis code for electronic claims. PM B-03-045 (CR2725) expands the requirement to include the submittal of a diagnosis code on paper claims and that invalid ICD-9-CM codes on claims will not be allowed. If there is an invalid ICD-9-CM code in the header or on the service line, the claim will be returned as unprocessable to the supplier.

## Medicare Beneficiaries In State Or Local Custody Under A Penal Authority

**I. GENERAL INFORMATION**

**A. Background:**

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

A recent Office of Inspector General audit of Medicare payments identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified payments for beneficiaries who, on the date of service on the claim, were in state or local custody under the authority of a penal statute. To address this vulnerability, CMS is establishing claim level editing using data received from the Social Security Administration (SSA).

Specifically, the data will contain the names of the Medicare beneficiaries and time periods where the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered.

**B. Policy:**

Exclusion from Coverage - Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way and with the same vigor as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services.

Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. Denial messages are:

ANSI Reason code: CO 96 - Non covered charges.

Remark code: N103 - Social Security records indicate that this beneficiary was in the custody of a state or local government when theservice was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact by appending the modifier referenced in section C below to the procedure code when submitting a claim.

Appeals - A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

**C. Implementation:**

Providers that render services to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the following modifier:

> QJ - Services/items provided to a prisoner or patient in State or local custody, however, the Stateor local government, as applicable, meets the requirements in 42 CFR 411.4(b).

This modifier indicates that the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner or patient is responsible to repay the cost of medical services, and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

## Options, Accessories And Supplies For Equipment Owned By Patient

Beginning September 1, 2003, claims for options, accessories and supplies that are denied because there is no information about related equipment cannot be resubmitted as new claims. They may be submitted with additional information as a request for adjustment or submitted to the Review Department. If the denied claim is resubmitted, it will be denied as a duplicate claim. These claims will be identified by the following Remittance Advice messages:

ANSI Healthcare Claim Adjustment Reason Code 96 - Non-covered services

ANSI Remittance Advice Remark Code M124 - Information to indicate if the patient owns the equipment that requires the part or supply is missing.

## Quarterly Update For Home Health Consolidated Billing (CB)

The Centers for Medicare & Medicaid Services (CMS) has issued the third quarterly Home Health consolidated billing update for calendar year 2003 effective October 1, 2003. The second update occurred in April 2003. There was no update in July 2003. This update adds the following three non-routine supply codes to the list of codes subject to consolidated billing.

K0614 - Chemicals/antiseptics solution used to clean/ sterilize dialysis equipment per 8 ounces
K0620 - Tubular elastic dressing, any width, per linear yard
K0621 - Gauze, packing strips, non-impregnated, up to 2 inches in width, per linear yard

A complete list of HCPCS code subject to Home Health Consolidated Billing can be found on the CMS website: www.cms.hhs.gov/medlearn/refhha.asp.

## Repairs/Replacement Chart

The accompanying chart on Repairs and Replacements indicates when original or new suppliers need new Certificates of Medical Necessity (CMNs) or orders, or when the original CMN or order will be adequate for repairing or replacing durable medical equipment.

# CMNs & ORDERS FOR REPAIRS OR REPLACEMENT OF DME

**CAPPED RENTAL (Rented)**
**Equipment/ Durable Accessories**

| Original Item Requires CMN | | | | Original Item Requires Only Order | | | |
|---|---|---|---|---|---|---|---|
| Repair before or after 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years | Repair before or after 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years |
| N/A because covered by rental or M/S | N/A because covered by rental or M/S | N-CMN plus doc of why replace-ment necessary | N-CMN | N/A because covered by rental or M/S | N/A because covered by rental or M/S | N-ORD plus doc of why replace-ment necessary | N-ORD |

**INEXPENSIVE/ ROUTINELY PURCHASED (IRP) (Rented)**
**Equipment/ Durable Accessories**

| Original Item Requires CMN | | | | Original Item Requires Only Order | | | |
|---|---|---|---|---|---|---|---|
| Repair before 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years | Repair before 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years |
| N/A because covered by rental | N/A because covered by rental | N/A because covered by rental | N/A because not rented for 5 years | N/A because covered by rental | N/A because covered by rental | N/A because covered by rental | N/A because not rented for 5 years |

**CAPPED RENTAL (Purchased) or IRP (Purchased)**
**Equipment/ Durable Accessories**

| Original Item Requires CMN | | | | Original Item Requires Only Order | | | |
|---|---|---|---|---|---|---|---|
| Repair before or after 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years | Repair before or after 5 years | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years |
| Doc of why repair, but no order for actual repair; Repair up to $Replacement | N/A - Only Cover Repair | N-CMN and doc of why replacement | N-CMN | Doc of why repair, but no order for actual repair; Repair up to $Replacement | N/A - Only Cover Repair | N-ORD and doc of why replacement | N-ORD |

**ACCESSORIES for DME**
**Accessories Requiring More Frequent Replacement**

| Original Item Requires CMN | | Original Item Requires Only Order | |
|---|---|---|---|
| Repair before or after 5 years | Replacement before or after 5 years | Repair before or after 5 years | Replacement before or after 5 years |
| Doc of why repair, but no order for actual repair; Repair up to $Replacement | O-CMN or N-CMN stating frequency of replacement; Frequency of replacement at discretion of DMERC | Doc of why repair, but no order for actual repair; Repair up to $Replacement | O-ORD or N-ORD stating frequency of replacement; Frequency of replacement at discretion of DMERC |

N-CMN = New Initial CMN; O-CMN = Original CMN; N-ORD = New Order; O-ORD = Original Order; "Doc" = Statement submitted by supplier

Same requirements apply regardless of whether the same supplier or a new supplier is providing the repair or replacement.

## Tape Modifiers AU, AV, AW, And AX – Sticky Billing Situations (Billing Clarifications)

Effective October 1, 2003:

Claim lines for tape having more than one of the required modifiers AU, AV, AW, or AX will be returned as unprocessable or denied for incorrect coding. To avoid this, when providing tape to be used for purposes covered under multiple medical policies, bill only one modifier per claim line. For example, units of tape provided for use as a urological must be billed on one claim line with modifier AU; additional units of tape provided for use with surgical dressings must be billed on a separate claim line with modifier AW, even if the HCPCS code is the same.

Currently In Effect:

Conversely, if more than one claim line is billed having the same tape code, modifier, and date of service, the additional lines will deny as duplicates. Instead, combine and bill these units on one claim line. For example, the AU modifier represents tape used as a urological, ostomy, and/or tracheostomy supply. Therefore, if units of tape described by the same HCPCS code are dispensed on the same day for more than one of these purposes, add the number of units provided and bill them on one claim line with modifier AU.

Claims for tape dispensed on or after January 1, 2003 are adjudicated based on the presence of one of these modifiers and whether other information on the claim indicates the requirements of the applicable local medical review policy (LMRP) are met. Claims submitted without the coverage and/or medical necessity information required by the LMRP are denied accordingly.

For more information on modifiers AU, AV, and AW see the Winter 2003 *DMERC Dialogue* article entitled "New Modifiers – AU, AV, AW" on page 19. Tape (codes A4450 and A4452 only) supplied in conjunction with dialysis services is also covered and must have the modifier AX added. See the Winter 2003 *DMERC Dialogue* article entitled "New Modifier – AX" on page 18 for more information on use of the AX modifier.

## Time Limit for Filing Claims

Claims for services provided between October 1, 2001 and September 30, 2002 must be received at the carrier by December 31, 2003. Claims that are not submitted within these time limits will be denied. The timely filing period may be extended by submitting a written Statement of Intent (SOI) to claim Medicare benefits. Refer to the *DMERC Region D Supplier Manual* (Chapter 6, pages 48-50) for information about the SOI.

## United Mine Workers (UMWA) Claims-Effective July 1, 2003

The *Medicare Carriers Manual* (MCM), Section 3110, Disposition of Misdirected Claims, is revised to include information on UMWA claims. Effective July 1, 2003, carriers will return UMWA claims as unprocessable to the provider to resubmit to the UMWA for processing.

Providers will see the following remittance advice messages:

Claim adjustment reason code 109-Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

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

## Use Of HCPCS Code L5647 And L5652 – Clarification

In Winter 2002, CIGNA Medicare published a *DMERC Dialogue* article entitled "New Codes for Prosthetic Socket Inserts" (pg. 10). In that article, guidance was provided about the billing of codes L5647 and L5652 (addition to lower extremity, below knee and above knee suction socket, respectively); however, some practitioners have questioned when it is appropriate to bill these codes in light of the new socket insert codes. Others have asked if these codes are appropriate to bill with the new locking and non-locking liner codes (K0556 – K0559) and/or code L5671 (addition to lower extremity, below knee/above knee suspension locking mechanism [shuttle, lanyard or equal], excludes socket insert). The following information serves as clarification of this issue.

Code L5647 describes a type of suspension system and is intended for use with sockets that incorporate a suction valve in their design. The parallel code for above knee prostheses is code L5652 (addition to lower extremity, suction suspension, above knee or knee disarticulation socket). The reimbursement for codes L5647

and L5652, takes into account the time and labor to incorporate this suction valve into the socket suspension system.

It is not appropriate to bill codes L5647/L5652 with code L5671 since code L5671 was created specifically to address suspension sockets using mechanical locking mechanisms, not as an "add on" for suction suspension. In addition, L5647 and L5652 are not the appropriate codes to use for gel liners. Although a gel liner, by partial vacuum, draws in the residual limb, this is not the same as the suction valve design intended for use with codes L5647 or L5652. The appropriate gel liner code should be used (K0556 – K0559).

# *FEE SCHEDULE*

## Correction - 2003 DMEPOS Fee Schedule July Quarterly Update

There was an error in the External Defibrillator and Supplies fee schedule chart published in the Summer 2003 *DMERC Dialogue.* HCPCS code E0607UE should be corrected to K0607UE. The fee schedule amounts listed in that chart are correct.

## October Quarterly Update For 2003 DMEPOS Fee Schedule

The changes to the DMEPOS Fee Schedule for the 2003 4th quarterly update are listed below.

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

**Gradient Compression Stocking**

| States | L8110AW | L8120AW |
|---|---|---|
| AK | $43.27 | $60.96 |
| AZ | $43.27 | $60.96 |
| CA | $43.27 | $60.96 |
| HI | $43.27 | $60.96 |
| IA | $43.27 | $60.96 |
| ID | $43.27 | $60.96 |
| KS | $43.27 | $60.96 |
| MO | $43.27 | $60.96 |
| MT | $43.27 | $60.96 |
| ND | $43.27 | $60.96 |
| NE | $43.27 | $60.96 |
| NV | $43.27 | $60.96 |
| OR | $43.27 | $60.96 |
| SD | $43.27 | $60.96 |
| UT | $43.27 | $60.96 |
| WA | $43.27 | $60.96 |
| WY | $43.27 | $60.96 |

**Revised TLSO Code**

| States | L0462 |
|---|---|
| AK | $981.08 |
| AZ | $981.08 |
| CA | $981.08 |
| HI | $981.08 |
| IA | $1,000.25 |
| ID | $981.08 |
| KS | $1,000.25 |
| MO | $1,000.25 |
| MT | $1,016.20 |
| ND | $1,016.20 |
| NE | $1,000.25 |
| NV | $981.08 |
| OR | $981.08 |
| SD | $1,016.20 |
| UT | $1,016.20 |
| WA | $981.08 |
| WY | $1,016.20 |

**Revised Surgical Dressing Code**

| States | A6440 |
|---|---|
| AK | $12.69 |
| AZ | $12.69 |
| CA | $12.69 |
| HI | $12.69 |
| IA | $12.69 |
| ID | $12.69 |
| KS | $12.69 |
| MO | $12.69 |
| MT | $12.69 |
| ND | $12.69 |
| NE | $12.69 |
| NV | $12.69 |
| OR | $12.69 |
| SD | $12.69 |
| UT | $12.69 |
| WA | $12.69 |
| WY | $12.69 |

**New Surgical Dressings Codes**

| States | K0622 | K0623 | K0624 | K0625 | K0626 |
|---|---|---|---|---|---|
| AK | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| AZ | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| CA | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| HI | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| IA | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| ID | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| KS | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| MO | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| MT | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| ND | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| NE | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| NV | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| OR | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| SD | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| UT | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| WA | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |
| WY | $0.67 | $1.40 | $5.82 | $2.93 | $7.13 |

**Additional Surgical Dressing Codes**

| States | A6421 | A6422 | A6424 | A6426 | A6428 | A6430 | A6436 |
|---|---|---|---|---|---|---|---|
| AK | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| AZ | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| CA | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| HI | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| IA | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| ID | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| KS | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| MO | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| MT | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| ND | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| NE | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| NV | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| OR | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| SD | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| UT | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| WA | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |
| WY | $2.09 | $1.17 | $2.05 | $1.88 | $3.04 | $8.76 | $19.08 |

# MEDICARE SECONDARY PAYER (MSP)

## Medicare Secondary Payer (MSP) With One Or Multiple Primary Payers

Program Memorandum (PM) B-03-050 is a revision to instructions published in the April 2003 DMERC Dialogue based on PM AB-03-011. The previous memorandum included instructions for billing MSP claims with multiple primary payers electronically. After the PM was published, concerns were raised as to whether the 837 was able to support all the MSP data necessary for Medicare carriers to process claims with multiple primary payers. PM B-03-050 instructs physicians and suppliers that MSP claims with multiple primary payers should be submitted on paper with the appropriate explanation of benefits, or remittance advice, and should not be submitted electronically.

**1. When Medicare is the Secondary Payer Following One Primary Payer**

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at http://hipaa.wpc-edi.com/HIPAA_40.asp). Providers must follow model 1 in section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Providers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837.

**Primary Payer Paid Amount:** For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

**Primary Payer Allowed Amount:** For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

**Obligated to Accept as Payment in Full Amount (OTAF):** For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero.

For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero.

**2. When Medicare is the Secondary Payer Following Two primary Payers**

**Submission of Hardcopy MSP Claims with Multiple Primary Payers**

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and suppliers must attach the other payers' EOB, or remittance advice, to the claim when sending it to Medicare for processing.

# ELECTRONIC DATA INTERCHANGE (EDI)

## DMACS-837 Is Here And It's Here To Stay

We are pleased to announce the release of *DMACS-837*, Region D DMERC's free billing software. DMACS-837, which stands for DMERC Medicare Automated Claims System, is specifically designed for building and transmitting your health care claims (ANSI X12N 837) to Region D DMERC in the HIPAA-required 4010A1 format.

*If you are familiar with previous versions of DMACS, DMACS-837* contains the same basic information, however, here are just a few items that you may want to know:

• DMACS-837 is available only on CD-ROM. The CD-ROM contains both the software program and an electronic copy of the ***DMACS-837 User Guide***.

• Your stored data from the *DMACS32* (NSF version) will not function in the new *DMACS-837* software. After installing the new program, you will need to re-enter your data.

• Windows 95 is not supported with this software.

• Important Note for Retail Pharmacies Who Bill Drugs: *DMACS-837* **does not** have the capability to build and/or transmit claims in the NCPDP format.

**If you are an existing *DMACS32* user,** we will continue to support both versions of DMACS until October 16, 2003. However, effective October 16, 2003, DMACS-837 version 2.26 will be the only version supported by the Region D DMERC EDI Department due to the HIPAA requirements. If you currently use DMACS32, you may bypass the testing process and move directly into transmitting your production claims. However, we encourage you to test to become familiar with the new program and electronic reports prior to transmitting production claims.

**If you are a brand new DMACS user,** DMACS-837 is the only version of the free billing software available for Region D DMERC submitters. Testing is required for all new electronic billers.

**DMACS-837 Is Here To Stay** - DMACS-837 is available and is here to stay. Recent CMS (Centers for Medicare and Medicaid Services) instruction states that Medicare contractors are to continue offering the HIPAA free billing software from now through fiscal year 2004 and beyond.

**How to Apply for DMACS-837 -** To apply for *DMACS-837*, complete the *DMERC EDI Customer Profile*. You may access this form via the CIGNA Medicare Web site, under EDI Forms. The software is free, with a $5.00 shipping and handling fee.

## EDI Manuals Distributed On CD-ROM

Effective August 1, 2003, the Region D DMERC EDI manuals will be distributed in a CD-ROM format. Paper manuals will no longer be distributed. These manuals are distributed to new or existing electronic billers migrating to the ANSI 4010A1 format upon receipt of application.

The CD-ROM will utilize the following format: Portable Document Format (PDF) – PDF allows the user to view and print the document. Users will need Adobe Acrobat Reader to view the PDF file on the CD-ROM. A free download of Adobe Acrobat is available at www.adobe.com.

With the conversion of the EDI manuals to CD-ROM format, paper copies will no longer be distributed. In addition, the manuals will also be available on the Web site at www.cignamedicare.com. The *Region D DMERC EDI Manual* is updated quarterly. The updates are available on the Web site. Please note that there was not an update in July 2003. The next update is expected in October 2003.

## NSF And ANSI Formats 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 or the ANSI 4010 format. Effective May 6, 2003, we discontinued offering NSF as a format option for new electronic billers. Effective June 16, 2003, we discontinued offering the ANSI 4010 format as a valid option for new electronic billers. Effective June 16, 2003, the only format available for new electronic billers is ANSI 4010A1. These decisions were difficult as we considered the impact to our submitters, but we feel it provides the best service to our users. The HIPAA Transaction and Code Set Final Rule has mandated full migration to the ANSI 4010A1 format 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 electronic transmission of claims to Medicare.

# *HIPAA*

## Guidance On The HIPAA Privacy Rule Business Associate Provisions

By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individu-

ally identifiable health information on behalf of a covered entity (45 CFR §164.103).

Medicare contractors that perform health care activities involving the use of protected health information on behalf of the Medicare Fee-for-Service (FFS) health plan are not business associates of providers, physicians, suppliers or other health plans. Likewise, providers, physicians, suppliers, or other health plans are not business associates of the Medicare contractor, unless the provider, physician, supplier or other health plan is doing work on behalf of the Medicare contractor.

## Law Requires Medicare Claims To Be Submitted Electronically After October 2003

Administrative Simplification Compliance Act (ASCA) prohibits Health and Human Services (HHS) from paying Medicare claims that are not submitted electronically according to HIPAA requirements after October 16, 2003, unless the Secretary grants a waiver from this requirement. It further provides that the Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies. Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances. More information on ASCA may be found at www.cms.hhs.gov/hipaa/hipaa2.

## NCPDP Companion Document

The Centers for Medicare & Medicaid Services (CMS) has released a National Council for Prescription Drug Programs (NCPDP) Companion Document. The companion document is based on the NCPDP protocol document for submitting retail pharmacy drug claims in the Telecommunications Standard Specifications and Implementation Guide (IG) version 5.1 and Batch Standard 1.1. NCPDP is the electronic format defined by HIPAA for retail pharmacy drug claims. The companion document clarifies the DMERC expectations regarding data submission, processing, and adjudication. This document and further information on NCPDP is available on our Web site at www.cignamedicare.com/hipaa/code_sets.html#3.

## Ten Steps To HIPAA Compliance

There is only a few months left for you to comply with the HIPAA standards. At this late date, anything you can do to familiarize yourself with your compliance obligations under the law will help you avoid potentially catastrophic business implications as a result of non-compliance and may help you avoid penalties for failing to comply with federal regulations. Those implications can include your inability to submit claims to any insurer and delays in your payments as a result of non-compliance. Quite simply – if you cannot submit a claim, you will not get paid for services provided.

The following ten steps are part of a much larger educational tool currently available on the SHARP (Southern HIPAA Administrative Regional Process) Web site at www.sharpworkgroup.com – These steps are not-inclusive of all your obligations under the law but they will certainly help you advance toward HIPAA compliance. HIPAA workshops, seminars, and other educational opportunities exist. Visit www.cignamedicare.com for detailed information.

***Ten Steps to HIPAA Compliance***

1. Appoint someone to be the Transactions Point Person.
2. Determine how you interact with health plans and trading partners for administrative transactions.
3. Contact your health plans and vendors, technology and billing services vendors and clearinghouses.
4. Determine how the new claim formats will affect your operations.
5. Determine how the HIPAA code sets will affect you.
6. Make compliance pay for itself – use the EDI ROI (Return on Investment) tool to see how HIPAA can save your office money (available at www.sharpworkgroup.com).
7. Start testing with payers and clearinghouses as soon as you can and test with each payer or clearinghouse.
8. Establish a contingency plan for getting claims paid.
9. Document and train staff for new content changes – establish crosswalks from the old information to the new required information.
10. Leverage HIPAA transactions for a more efficient operation.

Comprehensive HIPAA information is available at the following internet locations:

www.cignamedicare.com/hipaa
www.cms.hhs.gov/hipaa/
www.SHARPworkgroup.com
www.aspe.hhs.gov/admnsimp/

# Testing And Other Help Available Before the October 16, 2003 Compliance Date For Health Insurance Portability And Accountability Act (HIPAA) Transaction And Code Set Standards

*Dear Medicare Provider,*

Will you be ready to bill Medicare effective October 16?

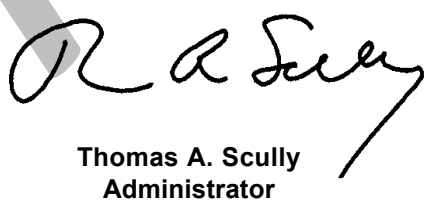
Should you be concerned about getting your Medicare claims paid starting October 16? If you are not ready to use the HIPAA standard transaction and code sets by October 16, you may not get paid!

HIPAA is more than a privacy law; it touches many aspects of health care, including the bills you submit to all health insurers, not just Medicare. Effective October 16, 2003, all electronic transactions covered by HIPAA must comply with these standards for format and content. For example, the electronic claim that a physician or hospital sends to a health plan must be compliant and health plans are only allowed to process compliant transactions. Any non- compliant claims submitted after the October deadline will be returned to you, unpaid.

You may have thought that you can still submit paper bills to Medicare, but in many cases, this is not true. The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003, with a few exceptions[1].

CMS and its contractors are eager to help you through this transition. Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. Medicare contractors are ready to test with you now! To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information, please review the helpful HIPAA resources, shown below.

Although we have all been working hard to achieve HIPAA compliance and the benefits it will bring, there is still much to be done. Time is growing short; please be sure to test and start sending and receiving HIPAA compliant transactions as early as possible to avoid any last- minute problems.



**Thomas A. Scully**
**Administrator**
**Centers for Medicare & Medicaid Services**

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[1]One of the major exceptions is for claims submitted by “a small provider of services or supplier.” The term “small provider of services or supplier” is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions.

## HELPFUL HIPAA RESOURCES

### Upcoming Satellite Broadcasts

HIPAA 101 - The Basics of Administrative Simplification

July 16, 2003
2:00 - 3:00 p.m. ET

July 30, 2003
2:00 - 3:00 p.m. ET

**www.cms.hhs.gov/medlearn**

Register to be a Host Site for Satellite Broadcasts

**www.cms.hhs.gov/hipaa/hipaa2**

General HIPAA Information
Educational Materials
Frequently Asked Questions
HIPAA Administrative Simplification Information Series for Providers
Links to Additional HIPAA Web Pages

**www.eventstreams.com/cms/tm_001**

View HIPAA Educational Webcast
Topics:
HIPAA Basics
Provider Steps for Getting Paid Under HIPAA

**askHIPAA@cms.hhs.gov**

Request Answers to Your HIPAA Administrative Simplification Questions

**1-866-282-0659**

HIPAA Hotline Staff Will Answer Your HIPAA Administrative Simplification Questions or Direct You to the Appropriate Resources

### Local Carriers and Fiscal Intermediaries

HIPAA Scheduling and Testing information is available at www.cignamedicare.com/hipaa.

***Region D DMERC Contact:***

If you have further questions, please call our Region D DMERC EDI department at 866.224.3094.

***Part B Contacts:***

| | |
|---|---|
| NC testing assistance: | 866.352.1608 |
| TN/ID testing assistance: | 866.520.4023, Option #1 |
| Information on HIPAA legislation and EDI Benefits: | 866.794.0674 |

# MISCELLANEOUS

## CMS Quarterly Provider Update

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

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

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

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

## Collection Of Fee-For-Service Payments Made During Periods Of Managed Care Enrollment

This article provides guidance for physicians, providers, and suppliers regarding overpayment recovery activities that the Centers for Medicare & Medicaid Services (CMS) will undertake connected to erroneous approvals for payment of fee-for-service (FFS) claims during periods of Managed Care enrollment.

The 1999 Balanced Budget Reconciliation Act (BBRA) requires "current month enrollment," which means that the effective date of enrollment is based upon the date a beneficiary signs an application for enrollment in a Medicare + Choice Organization (M+CO). The effective date of enrollment, as well as the date the M+CO is responsible for providing Medicare services to the beneficiary, is the first day of the month following receipt of the beneficiary's completed, signed application for enrollment in the M+CO.

The CMS electronic data systems may experience time lags, during which time Medicare services and items are paid twice: through the FFS Medicare contractor and the Managed Care Payment systems in the monthly capitation rate for the beneficiary. When the electronic data systems recognize that a beneficiary has enrolled in a M+CO, the M+CO receives capitation payments for the beneficiary, retroactive to the effective date of enrollment. During the period of time between the effective date of enrollment and when the CMS electronic data system updates, physicians, providers, and suppliers may not be aware of the beneficiary's enrollment in the M+CO and bill the Medicare FFS system for services and items provided to that beneficiary.

Effective October 1, 2003, CMS contractors will initiate overpayment recovery procedures to retract original Part A and Part B payments and generate adjustments to update or cancel claims connected to erroneous approvals for payment of FFS claims during periods of Managed Care enrollment.

If you have questions about this article, please contact DMERC Region D.

## 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). Seven revisions have been published since the publication deadline of the Summer 2003 Region D *DMERC Dialogue*.

- Transmittal 40, released May 16, 2003, revises Chapter 1, adding Section 5, which manualizes LPET program activities, staffing, methods, strategy, Quality Improvement, reporting, and deliverable requirements. The effective/implementation date is May 16, 2003.

- Transmittal 41, released May 23, 2003, revises Chapter 10 to clarify the enrollment process for new Medicare providers/suppliers. The instruction will aid in the prevention of fraudulent or excluded providers from entering the Medicare program. The effective/implementation date is May 23, 2003.

• Transmittal 42, released June 20, 2003, revises Chapter 6. The instructions included within this chapter contain medical review (MR) guidelines for intermediaries. Many of these instructions are outdated and are being deleted to allow intermediaries to develop their own MR guidelines. In addition to being outdated, this chapter also contains lists of coverage criteria for therapy services that are being deleted. These lists include the number of therapy visits that may be covered for a specific duration for a specific diagnosis. These instructions represent coverage policies and should not be in the PIM. For medical review purposes, the PIM provides instructions to the contractors on the medical review process and the evidence each contractor should use in determining whether a service is reasonable and necessary. This chapter also contains instructions for the completion of CMS form 485 that are being deleted. This form is not required and for the most part the information can be found on the OASIS or other parts of the medical record. The form is optional and the regulation requires only that certain elements be included in the medical record. CMS anticipates in the near future deleting the remaining instructions found in this chapter. The effective/implementation date is July 1, 2003.

• Transmittal 43, released June 20, 2003, revises Chapter 9. The documentation that supports the Plan of Care must be in the medical record. Therefore, CMS will no longer mandate the use of the Plan of Treatment for Outpatient Rehabilitation (HCFA Form 700) or the Updated Plan of Progress for Outpatient Rehabilitation (HCFA Form 701) in Exhibit 24. CMS is deleting the forms, all *Program Integrity Manual* Chapter 9 references to the forms, and table of contents references to the forms. Instead, providers may use any written format, including a form resembling the HCFA Forms 700/701, to convey the required information. The effective/implementation date is July 1, 2003.

• Transmittal 44, released July 25, 2003, revises Chapter 13 and the Exhibits section. It requires contractors to undertake certain activities to move all LMRPs from www.LMRP.net to the new Medicare coverage database on www.cms.hhs.gov. It also includes the LMRP requirements of transmittal AB-02-098. The effective/implementation date is October 1, 2003.

• Transmittal 45, released July 25, 2003, revises the Chapter 7, Section 7 requirement that FMR activity reports and bulletins should be sent to CMS central office. FMR reports should only be sent to regional offices. The effective date for this revision is May 1, 2003 and the implementation date is August 8, 2003.

• Transmittal 46, released July 25, 2003, revises Chapter 3, section 5.1.1, Prepayment Edits to delete "in the early stages" in the instructions to contractors not to install edits that result in the automatic denial of services based solely on the diagnosis of progressively debilitating disease where treatment may be reasonable and necessary. Examples are added. Contractors are instructed to evaluate automated edits annually and all routine and complex edits quarterly. The effective/implementation date is August 1, 2003.

• Transmittal 47, released July 25, 2003, includes the following changes:

1) Revises Chapter 2, section 2, Data Analysis, to change PRO to QIO, and HCFA to CMS; it also deletes a redundant bullet.
2) Revises Chapter 3, section 5.4, CMS Mandated Edits, to describe how contractors should handle claims suspended for manual coverage and coding review by CMS mandated edit. It also adds HHA demand claims to the list of CMS mandated edits for intermediaries.
3) Revises Exhibit 1, Definitions, to include a definition of demand bill or demand claim. The effective/implementation date is August 8, 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.

## Payment Denial For Medicare Services Furnished To Alien Beneficiaries Who Are Not Lawfully Present In The United States

**Background:**

This Program Memorandum (PM) provides claims processing procedures for all Medicare contractors that process claims containing Medicare services submitted for alien beneficiaries.

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal public benefits including Medicare. The term "qualified alien" is defined to include six groups of aliens as follows:

(1) Aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act (Act);
(2) Aliens who are granted asylum under section 208 of the Act;
(3) Refugees admitted into the United States under

section 207 of the Act;
(4) Aliens who are paroled into the United States under section 212(d)(5) of the Act for a period of at least 1 year;
(5) Aliens whose deportation is being withheld under section 243(h) of the Act; or
(6) Aliens who are granted conditional entry pursuant to section 203(a)(7) of the Act as in effect prior to April 1, 1980.

Two groups of qualified aliens were added to the statute after the original enactment of the restriction in the 1996 Welfare Reform statute. These groups are certain Cuban and Haitian entrants to the United States and certain "battered aliens."

Under the terms of the PRWORA, non-qualified aliens could not receive Medicare benefits.

Section 5561 of the Balanced Budget Act of 1997 (BBA) amended section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for non-qualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions.

Under the provisions of the final rule, payment may be made for services furnished to an alien who is lawfully present in the United States (and, provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

**Policy:**

Medicare can make no payments for Medicare services furnished to an alien beneficiary who is not lawfully present in the United States. An auxiliary file will be established based on information from the enrollment database from the Social Security Administration in order to appropriately edit the claims specifically associated with alien beneficiary. These claims will be denied with the following messages:

Medicare Remittance Notice (MRN):

ANSI reason code 30 - "Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements."

Medicare Summary Notice (MSN):

Message 5.7, "Medicare payment may not be made for the item or service because, on the date of service, you were not lawfully present in the United States."

Message 5.7 "Medicare no puede pagar por este articulo o servicio porque, en la fecha en que lo recibió, usted no estaba legalmente en los Estados Unidos."

**Appeals**

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that the beneficiary was lawfully present in the United States on the date of service.

## Privacy Act Of 1974 And HIPAA Privacy Rules

A revision to "The Privacy Act of 1974" section in Chapter 1 of the *DMERC Region D Supplier Manual* is included in the October 2003 supplier manual update. The update is available on the DMERC publications CD-ROM and on our Web site at http://www.cignamedicare.com/dmerc/dmsm/index.html. The privacy information has been updated to incorporate HIPAA Privacy rules.

## Keys To Successful Claims Filing

**Verify whether an initial Certificate of Medical Necessity should be submitted with the claim.**

Chapter 4 and Chapter 16 of the *DMERC Region D Supplier Manual* lists the items that require a CMN. Also, refer to individual local medical review policies (LMRPs) for CMN requirements and the CMN chart on page 7 of this issue.

**Verify that all your orders contain all the required elements.**

Required elements for an order to dispense, as well as the elements required on a written order to submit the claim are listed in the "Orders" section of Chapter 3 of the *DMERC Region D Supplier Manual*.

**Depending on what method of delivery you use, verify that your proof of delivery documentation contains all the required information.**

There are three methods of delivery. In the *DMERC Region D Supplier Manual*, Chapter 3, each method is listed and what documentation is required depending on which method the supplier uses.

**Verify the amount listed in Field 29 of the CMS-1500 Form.**

Field 29 should only show the amount the patient paid on the covered service only.

# Update To The American National Standard Institute (ANSI) Codes

New Remittance Advice Remark Codes

N157 Transportation to and from this destination is not covered.
N158 Transportation in a vehicle other than an ambulance is not covered.
N159 Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N160 The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.
N161 This drug/service/supply is covered only when the associated service is covered.
N162 This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.
N163 Medical record does not support code billed per the code definition.
N164 Transportation to/from this destination is not covered.
N165 Transportation in a vehicle other than an ambulance is not covered.
N166 Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N167 Charges exceed the post-transplant coverage limit.
N168 The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.
N169 This drug/service/supply is covered only when the associated service is covered.
N170 A new/revised/renewed certificate of medical necessity is needed.
N171 Payment for repair or replacement is not covered or has exceeded the purchase price.
N172 The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
N173 No qualifying hospital stay dates were provided for this episode of care.
N174 This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group “PR”.
N175 Missing/incomplete/invalid Review Organization Approval.
N176 Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
N177 We did not send this claim to beneficiary’s other insurer. They have indicated no additional payment can be made.
N178 Missing/invalid/incomplete pre-operative photos or visual field results.
N179 Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
N180 This item or service does not meet the criteria for the category under which it was billed.
N181 Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.
N182 This claim/service must be billed according to the schedule for this plan.
N183 This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
N184 Rebill technical and professional components separately.
N185 Do not resubmit this claim/service.
N186 Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
N187 You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N188 The approved level of care does not match the procedure code submitted.
N189 This service has been paid as a one-time exception to the plan’s benefit restrictions.
N190 Missing/incomplete/invalid contract indicator.
N191 The provider must update insurance information directly with payer.
N192 Patient is a Medicaid/Qualified Medicare Beneficiary.
N193 Specific federal/state/local program may cover this service through another payer.
N194 Technical component not paid if provider does not own the equipment used.
N195 The technical component must be billed separately.

N196 Patient eligible to apply for other coverage which may be primary.
N197 The subscriber must update insurance information directly with payer.
N198 Rendering provider must be affiliated with the pay-to provider.
N199 Additional payment approved based on payer-initiated review/audit.
N200 The professional component must be billed separately.
N201 A mental health facility is responsible for payment of outside providers who furnish these services/ supplies to residents.

Revised Remittance Advice Remark Codes

M19 Missing/incomplete/invalid oxygen certification/re-certification.
M20 Missing/incomplete/invalid HCPCS.
M21 Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22 Missing/incomplete/invalid number of miles traveled.
M23 Invoice needed for the cost of the material or contrast agent.
M24 Missing/incomplete/invalid number of doses per vial.
M29 Missing/incomplete/invalid operative report.
M30 Missing/incomplete/invalid pathology report.
M31 Missing/incomplete/invalid radiology report.
M33 Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34 Claim lacks the CLIA certification number.
M35 Missing/incomplete/invalid pre-operative photos or visual field results.
M44 Missing/incomplete/invalid condition code.
M45 Missing/incomplete/invalid occurrence codes or dates.
M46 Missing/incomplete/invalid occurrence span code or dates.
M47 Missing/incomplete/invalid internal or document control number.
M49 Missing/incomplete/invalid value code(s) or amount(s).
M50 Missing/incomplete/invalid revenue code(s).
M51 Missing/incomplete/invalid procedure code(s) and/or rates.
M52 Missing/incomplete/invalid “from” date(s) of service.
M53 Missing/incomplete/invalid days or units of service.
M54 Missing/incomplete/invalid total charges.
M56 Missing/incomplete/invalid payer identifier.
M57 Missing/incomplete/invalid provider identifier.
M58 Missing/incomplete/invalid claim information. Resubmit claim after corrections.
M59 Missing/incomplete/invalid “to” date(s) of service.
M62 Missing/incomplete/invalid treatment authorization code.
M64 Missing/incomplete/invalid other diagnosis.
M67 Missing/incomplete/invalid other procedure code(s) and/or date(s).
M68 Missing/incomplete/invalid attending or referring physician identification.
M76 Missing/incomplete/invalid diagnosis or condition.
M77 Missing/incomplete/invalid place of service.
M78 Missing/incomplete/invalid HCPCS modifier.
M79 Missing/incomplete/invalid charge.
M81 Patient’s diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M99 Missing/incomplete/invalid Universal Product Number/Serial Number.
M108 Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
M110 Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
M119 Missing/incomplete/invalid National Drug Code (NDC).
M120 Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
M122 Missing/incomplete/invalid level of subluxation.
M123 Missing/incomplete/invalid name, strength, or dosage of the drug furnished.

M124 Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
M125 Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
M126 Missing/incomplete/invalid individual lab codes included in the test.
M127 Missing/incomplete/invalid patient medical record for this service.
M128 Missing/incomplete/invalid date of the patient's last physician visit.
M129 Missing/incomplete/invalid indicator of X-ray availability for review.
M130 Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131 Missing/incomplete/invalid physician financial relationship form.
M132 Missing/incomplete/invalid pacemaker registration form.
M135 Missing/incomplete/invalid plan of treatment.
M136 Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.
M141 Missing/incomplete/invalid physician certified plan of care.
M142 Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.
MA06 Missing/incomplete/invalid beginning and/or ending date(s).
MA27 Missing/incomplete/invalid entitlement number or name shown on the claim.
MA29 Missing/incomplete/invalid provider name, city, state, or zip code.
MA30 Missing/incomplete/invalid type of bill.
MA31 Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32 Missing/incomplete/invalid number of covered days during the billing period.
MA33 Missing/incomplete/invalid noncovered days during the billing period.
MA34 Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35 Missing/incomplete/invalid number of lifetime reserve days.
MA36 Missing/incomplete/invalid patient name.
MA37 Missing/incomplete/invalid patient's address.
MA38 Missing/incomplete/invalid birth date.
MA39 Missing/incomplete/invalid gender.
MA40 Missing/incomplete/invalid admission date.
MA41 Missing/incomplete/invalid admission type.
MA42 Missing/incomplete/invalid admission source.
MA43 Missing/incomplete/invalid patient status.
MA48 Missing/incomplete/invalid name or address of responsible party or primary payer.
MA49 Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52 Missing/incomplete/invalid date.
MA58 Missing/incomplete/invalid release of information indicator.
MA60 Missing/incomplete/invalid patient relationship to insured.
MA61 Missing/incomplete/invalid social security number or health insurance claim number.
MA63 Missing/incomplete/invalid principal diagnosis.
MA65 Missing/incomplete/invalid admitting diagnosis.
MA66 Missing/incomplete/invalid principal procedure code or date.
MA69 Missing/incomplete/invalid remarks.
MA70 Missing/incomplete/invalid provider representative signature.
MA71 Missing/incomplete/invalid provider representative signature date.
MA75 Missing/incomplete/invalid patient or authorized representative signature.
MA76 Missing/incomplete/invalid provider identifier for HHA or hospice when physician is performing care plan oversight services.
MA81 Missing/incomplete/invalid provider/supplier signature.
MA82 Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.

MA86 Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87 Missing/incomplete/invalid insured's name for the primary payer.
MA88 Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.
MA89 Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90 Missing/incomplete/invalid employment status code for the primary insured.
MA92 Missing/incomplete/invalid primary insurance information.
MA95 De-activate and refer to M51.
MA97 Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.
MA99 Missing/incomplete/invalid Medigap information.
MA100 Missing/incomplete/invalid date of current illness, injury or pregnancy.
MA102 Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
MA104 Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
MA105 Missing/incomplete/invalid provider number for this place of service.
MA110 Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111 Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
MA112 Missing/incomplete/invalid group practice information.
MA114 Missing/incomplete/invalid information on where the services were furnished.
MA115 Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA120 Missing/incomplete/invalid CLIA certification number.
MA121 Missing/incomplete/invalid date the X-Ray was performed.
MA122 Missing/incomplete/invalid initial date actual treatment occurred.
MA128 Missing/incomplete/invalid six-digit FDA approved, identification number.
MA129 This provider was not certified for this procedure on this date of service.
N1 You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N3 Missing/incomplete/invalid consent form.
N4 Missing/incomplete/invalid prior insurance carrier EOB.
N6 Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
N24 Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N26 Missing/incomplete/invalid itemized bill.
N27 Missing/incomplete/invalid treatment number.
N29 Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.
N31 Missing/incomplete/invalid prescribing/referring/attending provider license number.
N37 Missing/incomplete/invalid tooth number/letter.
N38 Missing/incomplete/invalid place of service.
N40 Missing/incomplete/invalid X-Ray.
N50 Missing/incomplete/invalid discharge information.
N53 Missing/incomplete/invalid point of pick-up address.
N56 Procedure code billed is not correct/valid for the services billed or the date of service billed.
N57 Missing/incomplete/invalid prescribing/dispensed date.
N58 Missing/incomplete/invalid patient liability amount.
N65 Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N66 Missing/incomplete/invalid documentation.
N70 Home health consolidated billing and payment applies.
N71 Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claim.
N73 A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

N75 Missing/incomplete/invalid tooth surface information.
N76 Missing/incomplete/invalid number of riders.
N77 Missing/incomplete/invalid designated provider number.
N80 Missing/incomplete/invalid prenatal screening information.
N95 This provider type/provider specialty may not bill this service.
N103 Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
N108 Missing/incomplete/invalid upgrade information.

Retired Remittance Advice Remark Codes

M72 Did not enter full 8-digit date (MM/DD/CCYY).
MA05 Incorrect admission date patient status or type of bill entry on claim.
MA98 Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
N41 Authorization request denied.
N44 Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.

## *Frequently Asked Questions*

1. What are the DMERC requirements for an over-night home oximetry study?

   **ANSWER:** This is the position of the DMERCs on the use of over-night home oximetry to qualify patient for Medicare coverage of oxygen (and other items addressed by DMERC local medical review policies where sleep oximetry results are required). At this time, the following conditions would be an acceptable manner of obtaining over-night oximetry in order to meet the coverage criteria in the DMERC oxygen policy where test results are required:

   - At a minimum the oximetry test be preset, self-sealed, non-adjustable by the patient, and provide a printout that documents an adequate number of sampling hours, percent of oxygen saturation and an aggregate of the results;
   - The provider of the test is not the Durable Medical Equipment (DME) supplier of the item or service for which the test's results are required (e.g., oxygen or respiratory assist device), or anyone financially associated with or related to the DME supplier;
   - The provider is a registered and qualified biller of the local Medicare Part B carrier that would reimburse for this test;
   - The provider of the test bills the local Medicare Part B carrier for each test, confirms with the local carrier's policy on the standard of conducting the test, is subject to prepayment and postpayment scrutiny that the policy's coverage criteria have been met, and is deemed reimbursable for the performance of the test;
   - There is no secondary inducement or "kick-back" relationship between the treating physician ordering the item or service for which the test's results are required (or the test itself) or the DME supplier – and the provider of the test that would be in violation of Medicare's regulations or other Federal or state statute.

2. What date does the supplier list as a re-certification date when a Group I oxygen patient who has been ordered oxygen for lifetime misses their re-evaluation at 12 months?

   **ANSWER:** For Group I patients whose length of oxygen need is lifetime, the date of the re-evaluation must be used as the re-certification date. If coverage criteria are met at that time, coverage continues with no break in payment. Claims must be held until the re-evaluation is completed.

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

   **ANSWER:** For Group I patients whose length of need is less than lifetime, the date the testing is actually performed must be used as the re-certification date. If coverage criteria are met at that time, coverage will continue with no break in payment. Claims must be held until the testing is completed.

4. What date does the supplier list as a re-certification date when a Group II oxygen patient is not retested prior to the re-certification?

   **ANSWER:** For Group II patients, a new initial Certificate of Medical Necessity (CMN) is required, regardless of the initial length of oxygen need. The new initial date would be the date that the testing is performed. Coverage would resume once the new testing has occurred.

5. If I have a patient that came from another company and the first company did not perform the re-certification in time, what type of Certificate of Medical Necessity (CMN) should I get?

   **ANSWER:** For Group I patients whose length of need is less than lifetime, you should have new testing performed and submit a re-certification CMN with an initial date that reflects the date the oxygen was initially ordered and a re-certification date that reflects the date that the new testing was performed. For Group I patients whose length of need is lifetime, the patient should be seen and re-evaluated by the treating physician and the re-certification date should be the date of the re-evaluation.

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

6. Are there situations where a beneficiary can simultaneously qualify for a wheelchair and a seat lift mechanism (SLM)?

   **ANSWER:** No, coverage criteria for a SLM conflict with coverage criteria for a wheelchair; thus, a beneficiary cannot qualify for both items simultaneously. Specifically, in order to qualify for a SLM, the beneficiary must, once standing, be able to ambulate. Conversely, coverage criteria for a wheelchair requires that the beneficiary be functionally non-ambulatory (unable to walk) within the home.

7. What should the supplier do if they discover they are providing a wheelchair to a beneficiary who recently received a seat lift mechanism (SLM)?

   **ANSWER:** It is always a good idea to question the beneficiary about any equipment he/she previously rented or purchased. If you discover that the beneficiary has a Medicare covered SLM, it is recommended that you obtain thorough documentation from the beneficiary's physician to support that the beneficiary now meets coverage criteria for the wheelchair ordered. This documentation should include information in the medical records that the beneficiary's medical condition changed between the time he/she received the SLM and the time the wheelchair was ordered. This additional documentation does not have to be submitted with the claim but must be available to the DMERC upon request.

8. We have a patient that was tested in a physician's office for home oxygen use. The resting arterial oxygen saturation on room air was 95% and the exercise arterial oxygen saturation dropped to 84%. Because there was no oxygen available for use in this physician's office, the only recovery saturation documented was 91% on room air. Based on these results, would this patient qualify for home oxygen?

   **ANSWER:** No, the Medicare *Coverage Issues Manual* §60-4 states that, if the hypoxemia only occurs during exercise, home oxygen will be covered, "if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air." There can be no evidence that the use of oxygen improves hypoxemia unless the patient is actually placed on oxygen and retested. If the testing condition for home oxygen coverage is "during exercise," three arterial oxygen saturation values should be taken and recorded. The first arterial oxygen saturation should be taken while the patient is at rest and breathing room air. The second arterial oxygen saturation must be taken while the patient is exercising and breathing room air. The third arterial oxygen saturation ***must*** be taken while the beneficiary is still exercising and has been placed on oxygen. Only the second value is actually entered on the CMN but all three results must be in the supplier's files and available to the DMERC upon request.

9. We are providing home oxygen to a beneficiary who is confined to a bed. This beneficiary needs portable oxygen for doctor's appointments. Is portable oxygen covered in this situation?

   **ANSWER:** No, the coverage criterion for a portable oxygen tank is that the beneficiary be mobile within the home. This means that the beneficiary must either be able to walk or move around the home in a wheelchair. Portable oxygen is not covered if the beneficiary only needs the portable unit for use outside the home.

10. What coverage stipulations apply when the value listed on the Certificate of Medical Necessity (CMN) was obtained while the beneficiary was hospitalized?

    **ANSWER:** In this situation, the qualifying value cannot be taken more than 2 days prior to discharge **and** must be the value on room air closest to discharge. For example, the beneficiary ***does not*** qualify for home oxygen therapy if the arterial oxygen saturation on room air of 87% is recorded the day before discharge but on the day of discharge the medical records document the arterial oxygen saturation on room air as 90%.

# 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:** |
|---|---|---|

**Email:**

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

## Subscription (4 quarterly publications) $40.00

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

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

## Individual Publication Requests

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

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

***Subtotal*** **$_____**

**CD-ROM ($10.00 each)**

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

***Subtotal*** **$_____**

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

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

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

***Subtotal*** **$_____**

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

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

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

***Total Amount Due*** **$_____**

## Payment Information

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

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

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

*(Rev. 10/2003)*

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# MEDICARE REVIEW REQUEST FORM

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

**DATE** _____

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

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

## CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

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

## SUPPORTING DOCUMENTATION

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

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

## CONTACT INFORMATION

| PROVIDER: (Contact Name and Signature) | BENEFICIARY: (Contact Name - Please Print) |
|---|---|
| Phone #<br>Area Code ( ) | Phone #<br>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.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired LMRPs. Paper copies of LMRPs are available upon request by writing to: CIGNA Medicare, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

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

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

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

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

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

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

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

*Fall - Nature's Art*

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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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.