# DMERC Dialogue

*DMERC Region D*

CIGNA HealthCare Medicare Administration

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

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## In This Issue



*Cont'd on page 2*

# *From the Medical Director...*

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## Billing Wheelchair Accessories with Miscellaneous HCPCS Code K0108

Data analysis on items coded K0108 revealed many claim denials, frequent requests for additional information, and multiple submissions of claims for payment. Several patterns of billing errors were identified involving large numbers of suppliers across all Region D states. Review of the most common errors may result in more accurate claim filing.

The local medical review policy (LMRP) entitled Wheelchair Options and Accessories (*DMERC Region D Supplier Manual*, Ch. 9, pgs. 1-6) details the coverage and payment criteria which must be met for any accessory to be considered for coverage. Those requirements are:

1) The patient has a wheelchair that meets Medicare coverage criteria; and

2) The patient's condition is such that without the use of a wheelchair, he would be bed or chair confined (an individual may qualify for a wheelchair and still be considered bed confined); and

3) The options/accessories are necessary for the patient to perform one or more of the following activities:

   (a) function in the home;
   (b) perform instrumental activities of daily living.

An option/accessory that is beneficial primarily in allowing the patient to perform leisure or recreational activities is noncovered.

Wheelchair options/accessories that are individually coded have defined criteria for coverage. Miscellaneous options, accessories, or replacement parts for wheelchairs that do not have a specific HCPCS code

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



## Acronyms/Abbreviations

| | |
|---|---|
| ADMC | Advance Determination of Medicare Coverage |
| AHI | Apnea-Hypopnea Index |
| ANSI | American National Standard Institute |
| CB | Consolidated Billing |
| CIM | Coverage Issues Manual |
| CMN | Certificate of Medical Necessity |
| CMS | Centers for Medicare & Medicaid Services |
| DMEPOS | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies |
| DMERC | Durable Medical Equipment Regional Carrier |
| DOS | Date of Service |
| HCPCS | Healthcare Common Procedure Coding System |
| HICN | Health Insurance Claim Number |
| HIPAA | Health Insurance Portability and Accountability Act |
| ICD-9 | International Classification of Diseases, 9th Revision |
| LMRP | Local Medical Review Policy |
| NCD | National Coverage Decision |
| NSC | National Supplier Clearinghouse |
| NSF | National Standard Format |
| OIG | Office of the Inspector General |
| SNF | Skilled Nursing Facility |

are to be coded K0108. K0108 items do not have specific coverage criteria. Documentation must indicate that the item meets all the criteria above, as well as outline the specific medically necessary purpose for which this piece of equipment is intended.

If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108. When billing more than one line item with code K0108, suppliers must ensure that the additional information can be matched to the appropriate line item on the claim. It is also helpful to reference the line item to the submitted charge. If code K0108 is billed for nonstandard seat dimensions, the submitted charge should represent the incremental additional charge not included in other submitted codes.

A claim for code K0108 must include a narrative description of the item, the brand name, model name/number of the item, and a statement defining the medical necessity of the item for the particular patient. If it is a customized option/accessory, the statement must clearly describe what was customized. If a formal wheelchair evaluation was performed, it would be helpful to include this information. Other information that is helpful in assisting the medical review staff to determine coverage includes:

- information on the patient's diagnosis
- the patient's abilities and limitations as they relate to the equipment (e.g., degree of independence or dependence, frequency and nature of the activities the patient performs, etc.)
- duration of the condition
- expected prognosis
- past experience using similar equipment
- any other information that would enable a claim approver to understand the purpose or function of a K0108 item

Most importantly, it is necessary for suppliers to submit **all** the required information for K0108 items at the same time. Claims received with partial information will be paid or denied based on submitted records. That data is then filed and not available for review with subsequent claims. If a claim is resubmitted with additional information, copies of any previously supplied documents should be included as well. Complete documentation will allow a speedy and accurate determination.

# MEDICAL POLICY

## Compression Bandage Systems

A revision of the Surgical Dressings policy in the accompanying *DMERC Region D Supplier Manual* update includes coverage for multi-layer compression bandage systems when they are used in the treatment of venous stasis ulcers. The revised policy is effective for claims with dates of service on or after April 1, 2002. When a multi-layer compression bandage system is provided, each component is billed using a specific code for the component if available; the multi-layer kit may not be billed as a single unit under the miscellaneous code A4649. Code A4460 is used for traditional elastic bandages as well as for other short-stretch and long-stretch compression bandages and for self-adherent cohesive compression bandages. The unit of service for code A4460 is one roll, regardless of the length or width. Codes A6263 for elastic roll gauze and/or code A6264 for nonelastic roll gauze are used when appropriate. The unit of service for these codes is one linear yard. Zinc oxide paste impregnated roll gauze bandages (e.g., Unna Boot and multiple other brand names) are billed using code A6266. The unit of service of this code is one linear yard. Components of multi-layer compression bandage systems that do not have a specific code (e.g., cotton or synthetic padding roll) are billed with the miscellaneous surgical supply code A4649.

Gradient compression stockings are also eligible for coverage under the Surgical Dressings benefit when they are used as part of a multi-layer compression system for the treatment of venous stasis ulcers. In these situations, code A4649 must be used. Codes L8100-L8239 will continue to be used for compression stockings that are provided to patients who do not have a venous stasis ulcer at the time they are dispensed. These codes will continue to be denied as noncovered.

Claims for code A4649 must include the brand name and manufacturer of the item that is provided and a brief description of the item to explain why it doesn't fall under a specific HCPCS code.

Code A4465 (non-elastic binder for extremity) remains noncovered in all situations.

It is important to note that compression bandage systems and gradient compression stockings are only eligible for coverage under the Surgical Dressings benefit when they are used in the treatment of a venous stasis ulcer. The X1-X9 modifier (as appropriate for the number of ulcers) must be added to the code if this coverage criterion is met. When these items are used for the treatment of venous insufficiency, lymphedema, or edema of other causes in the absence of an ulcer or surgical wound, they are denied as statutorily noncovered.

## Continuous Positive Airway Pressure (CPAP) CIM Revision

*Coverage Issues Manual* (CIM), Section 60-17, Continuous Positive Airway Pressure (CPAP), is revised to expand Medicare coverage for CPAP in the use of obstructive sleep apnea (OSA) and to require Medicare contractors to develop a method for monitoring compliance for CPAP devices.

This revision to the CIM is a National Coverage Decision (NCD). NCDs are binding on all Medicare Carriers, Intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans. Under 42 CFR 422.256 (b), an NCD that expands coverage is also binding on a Medicare +Choice Organization. In addition, an administrative law judge may not review an NCD. (See §1869 (f)(1)(A)(I) of the Social Security Act.)

This policy revision is effective for services provided on or after April 1, 2002. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy. Also, refer to the revised Continuous Positive Airway Pressure System LMRP included in the accompanying supplier manual update.

## Continuous Positive Airway Pressure (CPAP) LMRP Revision

The accompanying *DMERC Region D Supplier Manual* update contains a revision of the Continuous Positive Airway Pressure (CPAP) device local medical review policy (LMRP). The revised policy updates the Coverage and Payment rules to reflect the National Coverage Decision (NCD) allowing use of an apnea-hypopnea index (AHI) for the diagnosis of obstructive sleep apnea. In addition, the revised policy provides instructions for continued coverage of the device beyond the first three months, clarifies that accessories used with CPAP are separately reimbursable, and provides coverage for heated humidifiers used with a CPAP device.

A major change in the revised policy is the elimination of the CPAP Certificate of Medical Necessity (CMN).

In lieu of a CMN, the supplier must use a KX modifier to indicate that the Coverage and Payment Rules have been met. KX modifier use applies to both the E0601 and accessories. Suppliers should note that the LMRP revision is effective for dates of service on or after July 1, 2002. However, the change in the national policy (*Coverage Issues Manual,* § 60-17) to cover CPAP based on the AHI is effective for dates of service on or after April 1, 2002. Therefore, the following instructions must be followed by suppliers submitting claims for code E0601 and related accessories:

DOS prior to 4/1/02

Form HCFA-1500 and CPAP CMN - LMRP and CIM, § 60-17, in effect for these dates of service apply.

DOS on or after 4/1/02 but prior to 7/1/02

Form HCFA-1500 with E0601 and accessories - No modifier; no CMN; no LMRP; revised CIM, § 60-17, in effect.

DOS on or after 7/1/02

Form HCFA-1500 with E0601 and accessories - No CMN; KX modifier on E0601 and accessories if revised LMRP policy requirements are met; revised CIM, § 60-17, in effect.

There is no LMRP in effect for dates of service between April 2002 and July 2002; however, claims for CPAP and accessories are still bound by the requirements in the revised national policy (CIM, § 60-17). National policy requires that initial claims for CPAP devices must be supported by documentation in the medical record indicating that the patient meets Medicare's stated coverage criteria. This information must be available to the DMERC upon request.

## Pneumatic Compression Devices CIM Revision

*Coverage Issues Manual* (CIM), Section 60-16, Pneumatic Compression Devices, is revised to divide the policy into two separate parts based on indications and establishes coverage criteria for the two different indications.

This revision to the CIM is a National Coverage Decision (NCD). NCDs are binding on all Medicare Carriers, Intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not review an NCD. (See §1869(f)(1)A)(I) of the Social Security Act.)

This policy revision is effective for services provided on or after January 14, 2002. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy. Also, refer to the revised Pneumatic Compression Devices (Used for Lymphedema) local medical review policy included in the accompanying supplier manual update.

## Respiratory Assist Devices – Continued Coverage

In the Respiratory Assist Devices local medical review policy, Coverage and Payment Rules section, Medicare Beneficiary Statement subsection, the last sentence will be revised by deleting the phrase "that the beneficiary has seen the treating physician within the month of statement completion and at least 61 days after initiating use of the machine." Though there continues to be a requirement for a separate physician statement completed no sooner than 61 days after initiation of the device which documents compliant use of the RAD, there is no requirement that there be an office visit and no requirement that the physician statement and beneficiary statement be completed in the same month.

The Documentation section of the policy specifies that on the fourth month's claim (and any month thereafter) the ZX modifier (KX after July 1, 2002) may not be added unless criteria for the physician's statement and beneficiary statement have been met. As an example, if use of a RAD is begun on 7/1 and if a qualifying physician statement is not obtained until 10/15 and a qualifying beneficiary statement is not obtained until 11/20, then if the claims for 10/1 and 11/1 (i.e., the fourth and fifth month's claims) are not submitted until on or after 11/20 (i.e., after both statements have been obtained), the ZX modifier may be added to the appropriate claim lines. However, if the 10/1 and 11/1 claims are submitted before 11/20, the ZX modifier may not be added. (The revised Respiratory Assist Devices LMRP is included in the accompanying supplier manual update.)

## Supplier Manual Policy Revisions

In the accompanying *DMERC Region D Supplier Manual* update, the following policies have been revised. A brief summary of the changes in each policy is described; however, suppliers are advised to review each policy for complete details.

**Ankle-Foot/Knee-Ankle-Foot Orthosis**
(Effective for DOS on or after April 1, 2002)

- New HCPCS Codes descriptors adding "prefabricated"
- New descriptor for code L4396
- Deleted splint codes now under local carrier jurisdiction - L2102, L2104, L2122, L2124
- Per July 2000 newsletter article, definition of custom-fabricated added
- Added RT and LT modifiers
- Added new GY modifier

**Commodes**
(Effective for DOS on or after July 1, 2002)

- New HCPCS E code replacing K code for extra wide, heavy-duty commodes
- New HCPCS code for commode with seat lift mechanism and coverage criteria allowing for its reimbursement
- A new KX modifier to be used with a commode with seat lift mechanism if coverage and payment rules have been fulfilled

**Continuous Positive Airway Pressure System**
(Effective for DOS on or after July 1, 2002)

- Updates Coverage and Payment Rules to reflect National Coverage Decision to cover CPAP based on apnea-hypopnea index
- Eliminate CMN
- KX modifier used to indicate coverage criteria met
- Revised verbiage of HCPCS code K0184
- Allow coverage of either heated or non-heated humidifier with a covered CPAP device

**Enteral Nutrition**
(Effective for DOS on or after April 1, 2002)

- Code B4086 replaces codes B4084 and B4085
- ZY modifier deleted from policy; enteral nutrients not administered through feeding tube now coded A9270
- Expected range of calories/kg/day eliminated

**External Infusion Pumps**
(Effective for DOS on or after July 1, 2002)

- C-peptide level minimum raised to ≤ 110% of lower limit of normal of laboratory's measurement method
- HCPCS code K0548 added for insulin lispro
- Expanded allowable dosage range for dopamine (≤ 5 mcg/kg/min)
- Replaced ZX with KX modifier

**Home Blood Glucose Monitors**
(Effective for DOS on or after July 1, 2002)

- New HCPCS codes E0620, E2100, E2101 and A4257
- Definition of E0620 (skin piercing device for collection of capillary blood, laser, each) added to definition section
- Deletion of E0609 and crosswalk to E2100, E2101
- Coverage and Payment rules addition for E2101
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Replaced ZX with KX modifier
- Changed timeframe for new prescription from every 6 months to every 12 months
- Application of Least Costly Alternative authority to E0620 and A4257

**Home Dialysis Supplies and Equipment**
(Effective for DOS on or after July 1, 2002)

- All HCPCS codes for "kits" have been eliminated and replaced by new codes for individual supply items
- Addition of a KX modifier to be used only when the supplier has a written agreement with the backup dialysis facility and all other coverage and payment rules have been fulfilled
- Re-emphasis on using the EM modifier for emergency supplies only once in the lifetime of a beneficiary

**Hospital Beds and Accessories**
(Effective for DOS on or after April 1, 2002)

- HCPCS code E0316 added to policy
- Deletes requirement to list ICD-9 diagnosis codes for bed cradles (E0280)

**Immunosuppressive Drugs**
(Effective for DOS on or after April 1, 2002)

- Added new HCPCS code J7511
- Added code J7511 to Coverage and Payment Rules

**Lower Limb Prostheses**
(Effective for DOS on or after April 1, 2002)

- Included HCPCS code changes that have been made since the policy was last published – L5301-L5341, L5671, L5704-L5707, L5847, L5968, L5975, L5979, L5988-L5990, L8420, L8430, L8470, L8480

- Added statements concerning provision of prostheses to patients prior to discharge from a hospital or SNF which have been previously published in Region D newsletters
- Revised section on replacement of prostheses
- Added coding guidelines on suspension locking mechanisms
- Clarified documentation needed to support the use of a K modifier on a claim

**Nebulizers**
(Effective for DOS on or after April 1, 2002)

- Expansion of coverage for large volume nebulizers with saline or water for use with tracheobronchial stents (519.1)
- Expansion of indications for use of pentamidine with added ICD-9 codes
- Expansion of indications for use of mucolytics with added ICD-9 codes
- New HCPCS E codes replace K codes
- New HCPCS codes for inhaled corticosteroids
- Revision of HCPCS code for albuterol to include levalbuterol and its proper billing unit

**Pneumatic Compression Devices (Used For Lymphedema)**
(Effective for DOS on or after January 14, 2002)

- Based on a CMS National Coverage Decision, the distinction between lymphedema and chronic venous insufficiency and the respective coverage and payment rules for use of these devices for either condition is further clarified.

**Respiratory Assist Devices**
(Effective for DOS on or after July 1, 2002)

- New criteria for obstructive sleep apnea, involving an apnea-hypopnea index
- Liberalization of documentation requirements for the beneficiary and physician compliance statements (see article entitled “Respiratory Assist Devices-Continued Coverage” in this newsletter)
- Liberalization extending coverage and separate payment for heated humidifiers (K0531) when prescribed for use with a covered RAD without backup rate (K0532)
- RAD with backup rate used with invasive interface (K0534) added to explain when to bill this code
- Replaced ZX with KX modifier

**Spinal Orthoses: TLSO and LSO**
(Effective for DOS on or after July 1, 2002)

- Included HCPCS code changes that have been made since the policy was last published – L0315, L0317, L0321, L0331, L0391, L0515, L0561, L0986
- Eliminated codes K0112 and K0113
- Added or revised definitions for several terms used in HCPCS code descriptors
- Added statements concerning coverage of orthoses relating to inpatient hospital or SNF stays which have been previously published in newsletters
- Added noncoverage statement of L0984 which was previously published in a newsletter

**Suction Pumps**
(Effective for DOS on or after April 1, 2002)

- New HCPCS code for gastrointestinal suction pumps as distinguished from tracheal suction pumps
- New HCPCS A codes replacing K codes for canisters and tubing
- Definitional distinction between tracheal and oral suction catheters
- Allowance of an additional ICD-9 diagnosis code for coverage of tracheal suction equipment and supplies

**Surgical Dressings**
(Effective for DOS on or after April 1, 2002)

- Included HCPCS code changes that have been made since the policy was last published – A6010-A6024, A6196-A6202, A6222-A6224, A6231-A6233
- Current code for tape, A6265, made invalid for DMERC and two new codes for tape, K0572 and K0573, established
- Substituted GY modifier for ZY modifier
- Added coverage and coding guidelines for compression bandage systems used for the treatment of venous stasis ulcers
- Added statement about coverage of compression dressings
- Revised coverage statements concerning secondary dressings to allow for multi-layer compression bandage systems
- Revised statements regarding kits to clarify coverage of medically necessary components of kits
- Impregnated roll gauze dressings designed for the treatment of venous stasis ulcers (e.g., Unna Boot) are coded using A6266
- Removed specific mention of Nurse Practitioners, Physician Assistants, and other non-physician practitioners in statements about documentation requirements. This is to be consistent with wording in other policies. The general statements

about the acceptance of orders from non-physician practitioners which are found in the supplier manual continue to apply to this policy.

**Therapeutic Shoes for Diabetics**
(Effective for DOS on or after July 1, 2002)

- Crosswalk HCPCS code A5502 to A5509, A5510 and A5511
- Non-coverage statement for A5510
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Added RT and LT modifiers
- Replaced ZX with KX modifier
- Clarified that code A5507 can be used for repairs to diabetic shoes
- Clarified that the certifying physician may not be a podiatrist

**Urological Supplies**
(Effective for DOS on or after July 1, 2002)

- Adds to policy HCPCS codes A4319, A4324, A4325, A4331-A4333, A4348, A4360, K0572, K0573
- Deleted from policy HCPCS codes A4329, A4359, A4554, A5149, A6265, K0280, K0281, K0407-K0409, K0411
- Adds use of GY modifier for non-covered conditions
- Replaced ZX with KX modifier

# *COVERAGE AND BILLING*

## Advance Determination of Medicare Coverage (ADMC) - Claim Submission Instructions

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

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

- Wheelchair Base: Manufacturer, Model Name or Number, Suggested Retail Price
- Miscellaneous Accessories (HCPCS code K0108): Manufacturer, Part Number, Description and Suggested Retail Price

This information must be provided at the time of claim submission, even if it was provided as part of the ADMC documentation for medical necessity determination. If this information is not provided at the time of claim submission, the item(s) lacking the information will be denied.

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

## Billing for Glucose Test Strips and Supplies

Based on a recent OIG report entitled "Blood Glucose Test Strips: Inappropriate Medicare Payments and Marketing to Medicare Beneficiaries," CMS is requiring suppliers of test strips to bill using appropriate "start" and "end" dates on their claim forms. For the remainder of this article, the "start" and "end" dates will be referred to as "From" and "To" dates to correspond with item 24A of the HCFA-1500 claim form.

Beginning with date of service April 1, 2002, suppliers must span the dates of service on every claim for glucose test strips and supplies. Dates of service must be spanned for the following covered supplies: blood glucose test reagent strips (A4253), platforms (A4255), glucose control solutions (A4256), and lancets (A4259). If the dates of service are not spanned, the claim line will be denied with ANSI reason code 16 and new remark code N64.

ANSI reason code 16 – Claim/service lacks information which is needed for adjudication.

***New*** Remark code N64 - The 'From' and 'To' dates must be different.

The "From" date is the date the item is provided directly to the beneficiary or the shipping date where a delivery/shipping service is used. The "To" date should be the last day in which the supplies are to be used. For example, the physician's order is for the beneficiary to test 3 times per day. A box of 100 strips is dispensed. A box of 100 strips will accommodate 33 days of testing for this beneficiary. If the date of delivery is 04/15/2002, the "From" date would be 04/15/2002 and the "To" date 5/17/2002.

In addition to these requirements, beneficiary-filed claims for glucose test strips and supplies for dates of service on or after April 1, 2002 will be denied. The beneficiary will receive a message on their Medicare Summary Notice that states "Your provider must complete and submit your claim."

## Diabetic Shoe Insert – A5510 – Noncovered

An article in the Winter 2002 (January) Region D *DMERC Dialogue* announced the establishment of three new codes for diabetic inserts – A5509, A5510, and A5511 – which were effective for dates of service on or after January 1, 2002 and replaced code A5502. The Centers for Medicare & Medicaid Services (CMS) has determined that inserts that are not heat-molded to the patient's foot at the time of dispensing do not meet the requirements of the statutory benefit for coverage of therapeutic shoes and inserts for diabetics. Therefore, code A5510 (for diabetics only, direct formed, compression molded to foot without external heat source, multiple density insert(s), prefabricated, per shoe) will be denied as noncovered effective for dates of service on or after January 1, 2002.

## DMEPOS Billing Procedures

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

Frequency of Claims

In consideration of efficient and effective use of Medicare program resources and administrative requirements, where there are cases of known continuous periods of service, DMEPOS suppliers should submit their claims in sequence and should not submit their DMEPOS claims more or less frequently than monthly and for one months' worth of DMEPOS. By limiting the billing to a 30-day cycle, the Centers for Medicare & Medicaid Services (CMS) is saving extensive operational expenditures, and at the same time simplifying the review process. These services will include all items processed by the DMERCs. If a DMERC policy allows suppliers to bill for more than one month's worth of DMEPOS at a time (e.g., diabetic test strips), that policy overrides this requirement.

Be alert to situations where the rental period or treatment plan is completed or discontinued because the beneficiary dies or moves.

Suppliers Should Submit Their Claims in Sequence

For items or services furnished over an extended period (e.g., capped rental equipment), submit claims in sequence for each beneficiary. When there is a break in service (e.g., interruption of capped rental as the result of an extensive inpatient stay), continue sequential billing when the services resume.

Automatic Mailing/Delivery of DMEPOS

Suppliers/manufacturers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. A supplier may not initiate a refill of an order. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. This is consistent with information provided in Chapter 3 of the *DMERC Region D Supplier Manual*, which states: "The description of the item (on an order) may be completed by someone other than the physician (most commonly the supplier). However, the physician must review the order and sign and date it to indicate agreement." Again the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

*(Medicare Carriers Manual, Section 3010)*

## Home Blood Glucose Monitors and Hypoglycemia

According to the national policy and local medical review policy (LMRP) for home blood glucose monitors (*Coverage Issues Manual,* § 60-11, and the *DMERC Region D Supplier Manual*, Ch. 9, pgs. 1-4, respectively), to be eligible for coverage of a blood glucose monitor (E0607, E2100, or E2101) and diabetic testing supplies, the beneficiary must have diabetes mellitus (ICD-9 codes 250.00-250.93). While hypoglycemia (low blood sugar) can be a complication associated with the treatment of diabetes, hypoglycemia may also be associated with other medical conditions unrelated to diabetes mellitus. Therefore, if the beneficiary's primary diagnosis is hypoglycemia or they have hypoglycemia due to other medical conditions and do not have diabetes, then ICD-9 codes 251.0-251.9 should be used. Home blood glucose monitors and testing supplies for patients with hypoglycemia as a primary diagnosis, or hypoglycemia due to other conditions in the absence of a diabetes diagnosis, will be denied as not medically necessary.

## New Benefit Category Determinations

The Centers for Medicare & Medicaid Services (CMS) has issued a determination that clitoral therapy devices do not fall within one of Medicare's statutorily defined benefit categories. Also, a similar determination was rendered for wigs. As a result of the benefit category determinations, these items are noncovered.

## New Billing Requirement on Dialysis Claims

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. Effective with dates of service on or after July 1, 2002, suppliers must use the KX modifier on the line level for all Method II home dialysis claims. The KX modifier indicates that the supplier has this documentation on file. The supplier must provide the documentation to the DMERC upon request.

Dialysis claims received for dates of service on or after July 1, 2002, without the KX modifier will be rejected back to the supplier. The supplier may correct and resubmit the claim with the appropriate modifier once the supporting documentation is on file.

**Note:** The KX modifier replaces the ZX modifier effective July 1, 2002.

## New Permanent Modifier - KX

Effective for dates of service on or after July 1, 2002, a new Level II national modifier has been created:

**KX - Specific Required Documentation on File**

The KX modifier will replace the local modifier ZX currently used in local medical review policies (LMRPs). The new modifier is required when a LMRP directs the use of a modifier to indicate "specific required documentation on file." The following LMRPs are affected by this change:

Epoetin
External Infusion Pumps
Home Blood Glucose Monitors
Negative Pressure Wound Therapy
Orthopedic Footwear
Osteogenesis Stimulators
Pressure Reducing Support Surfaces - Group 1
Pressure Reducing Support Surfaces - Group 2
Refractive Lenses
Respiratory Assist Devices
Speech Generating Devices
Urological Supplies
Walkers
Therapeutic Shoes for Diabetics

The following LMRPs have been revised and now require use of the KX modifier to indicate "specific required documentation on file:"

Commodes
Continuous Positive Airway Pressure System
Home Dialysis Supplies and Equipment
External Infusion Pumps

Under the standard grace period, modifier ZX will continue to be accepted on claims with dates of service on or after July 1, 2002 that are received by September 30, 2002. Claim lines with modifier ZX with dates of service on or after July 1, 2002 that are received on or after October 1, 2002 will be rejected or denied as invalid coding.

## Notification to Carriers and Providers of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Coding Information on CMS Web site

As of January 1, 2002, coding information for SNF CB may be found on the CMS Web site at www.hcfa.gov/medlearn/refsnf.htm under the topic "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers." This information may be used by carriers and providers to determine by procedure code whether services rendered to beneficiaries in Part A covered SNF stays or non-Part A covered SNF stays (Part A benefits exhausted), are included or excluded from CB. The carrier will reimburse services that are excluded from CB. Services that are included in CB, must be billed to the SNF for payment. These files are for services rendered in calendar year 2002. Carriers and providers will be notified of any subsequent coding changes.

Four code files will be found on the Web site:

• Codes for physician professional services (other than the interpretation of diagnostic tests) that when rendered to beneficiaries in a Part A covered stay are not included in CB and must be submitted to the carrier or DMERC for payment.

• Codes for the physician interpretation of diagnostic tests that when rendered to beneficiaries in a Part A covered stay and submitted with a 26-professional component modifier are not included in CB. These services must be submitted to the carrier for payment.

• Codes for ambulance services that will always be included in CB when submitted with an NN modifier and must not be submitted to the carrier for payment. These services must be submitted to the SNF for payment. There are additional situations in which ambulance services are consolidated. Refer to Program Memorandum AB-01-159 to identify these situations.

• Codes for physical, occupational, and speech therapy services that, when rendered to a beneficiary in a non-Part A covered stay, (i.e., Part A benefits exhausted), are included in CB and may not be submitted to the carrier for payment. They must be submitted to the SNF for payment.

## Rib Belts and Abdominal Binders Now Covered

The Centers for Medicare & Medicaid Services (CMS) has issued a determination that elastic rib belts (A4572, L0210, L0220) and abdominal binders (A4462) may be covered as braces when they are used in the following fashion:

1) The brace serves a medical purpose and it is only associated with treating an illness, injury, or malformed body member;

2) It provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace;

3) It is not a device used to supply compression therapy (for example, to reduce the size, volume, or swelling of a body member or to help circulation);

4) It is not a device used for convenience or appearance; and

5) It is not a device used for cosmetic purposes.

Coverage will apply to claims for dates of service on or after August 1, 2001.

# *HCPCS UPDATES*

## Home Blood Glucose Monitors and Supplies – New Codes

(The following article was inadvertently omitted from the Winter 2002 (January) Region D *DMERC Dialogue*. We apologize for any inconvenience the omission may have caused.)

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for laser skin lancing devices.

A4257 - Replacement lens shield cartridge for use with laser skin piercing device, each

E0620 - Skin piercing device for collection of capillary blood, laser, each

Laser skin lancing devices use laser technology to pierce the skin in order to obtain capillary blood for use in home blood glucose monitors. Suppliers are reminded that the establishment of a unique code for a

particular product does not necessarily indicate coverage.

Also effective for dates of service on or after January 1, 2002, code E0609 (blood glucose monitor with special features, e.g., voice synthesizers, automatic timers, etc.) is discontinued and crosswalked to the following codes:

E2100 - Blood glucose monitor with integrated voice synthesizer

E2101 - Blood glucose monitor with integrated lancing/blood sample collection

Home blood glucose monitors previously meeting the description of code E0609 must be coded E2100 or E2101, whichever is applicable. The coverage and payment rules associated with code E0609 will also apply to codes E2100 and E2101. Under the standard grace period, code E0609 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with code E0609 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected or denied as invalid coding. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Home Blood Glucose Monitors included in the accompanying supplier manual update.

## New Ostomy Codes As of April 1, 2002

Several ostomy codes have been made invalid for submission to the DMERC, while many new codes become effective with dates of service (DOS) on or after April 1, 2002. As explained below, some of these new codes represent add-on features which may be billed separately.

Codes invalid for submission to the DMERC for DOS on or after 4/1/02

A4368 - Ostomy filter, any type, each
A4370 - Ostomy skin barrier, paste, per oz.
A4374 - Ostomy skin barrier, with flange (solid, flexible, or accordion, extended wear, with built-in convexity, any size, each
A4386 - Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, any size, each
A5061 - Pouch, drainable; with barrier attached (1 piece)
A5123 - Skin barrier; with flange (solid, flexible or accordion), any size, each
A6265 - Tape, all types, per 18 square inches

New Codes

K0561 - Ostomy skin barrier, non-pectin based, paste, per ounce
K0562 - Ostomy skin barrier, pectin-based, paste, per ounce
K0563 - Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built in convexity, 4 x 4 inches or smaller, each
K0564 - Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
K0565 - Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
K0566 - Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
K0567 - Ostomy pouch, drainable, with karaya based barrier attached, without built-in convexity, 1 piece, each
K0568 - Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity, (1 piece), each
K0569 - Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), each
K0570 - Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
K0571 - Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each
K0572 - Tape, non-waterproof, per 18 square inches
K0573 - Tape, waterproof, per 18 square inches
K0574 - Addition to ostomy pouch, filter, integral or added separately to pouch, each
K0575 - Addition to ostomy pouch, rustle-free material, per pouch
K0576 - Addition to ostomy pouch, friction and irritant-reducing, absorbent, interface layer (comfort panel), per pouch
K0577 - Addition to ostomy pouch, odor barrier, incorporated into pouch laminate, per pouch

K0578 - Addition to ostomy pouch, faucet-type tap with valve for draining urinary pouch, each
K0579 - Addition to ostomy pouch, absorbent material (sheet/pad/crystal packet) to thicken liquid stomal output, for use in pouch, each
K0580 - Addition to ostomy pouch, flange locking mechanism, each

Definitions of New Codes: The following are revisions or additions to definitions found in the LMRP for Ostomy Supplies in the *DMERC Region D Supplier Manual*, referring to the new codes.

Barriers

A solid barrier (wafer) is an interface between the patient's skin and the pouching system, has measurable thickness and has an adhesive property. Barriers may be integrated into a "1 piece" pouch, they may be manufactured with a flange and be part of a "2 piece" pouch system (skin barrier with flange, e.g., K0570), or they may be used independently (e.g., A4362), usually with a pouch that does not have its own integral skin barrier. When barriers are used as part of a "1 piece" drainable pouch, they may be either pectin-based (e.g., K0568) or karaya-based (e.g., K0567). An extended wear barrier (e.g., K0565) is a pectin-based barrier with special additives which achieve a stronger adhesive seal, resist breakdown by urine or bowel effluent, permit longer wear times between changes, and normal wear times for those who cannot achieve them with standard barriers. There are distinct codes for extended wear compared to standard wear barriers.

A barrier with built in convexity (e.g., K0563) is one in which an outward curve is usually achieved with plastic embedded in the barrier, allowing better protrusion of the stoma and adherence to the skin. There are distinct codes for barriers with built-in convexity compared to flat barriers.

Ostomy skin barriers greater than 4x4 inches (K0564, K0566, K0571) refer to the size of the skin barriers themselves, and not to the area of any surrounding tape.

Pouches

A "high output" pouch (K0569) has a capacity of greater than or equal to 0.75 liters, an anti-reflux valve, a large bore solid spout with cap or plug and is part of a 2 piece system.

Add-On Features to Pouches

Filters (K0574) allow venting of gas trapped in the ostomy pouch. They may also include materials such as charcoal to deodorize the vented gas. Filters may be incorporated in the pouch, inserted into a venting ring on the pouch, or attached to the pouch exterior.

Rustle-free material (K0575) reduces the crackling noise produced by pouch materials.

Friction and irritant-reducing, absorbent interface layer (comfort panel) (K0576) is a soft material layer on the body side of the pouch that reduces skin irritation, sticking and sweating that would otherwise result from direct contact of the pouch with the skin.

An odor barrier (K0577) is a film layer (e.g., polyvinyl dichloride) incorporated into the pouch, which serves to retain odor within the pouch. It is separate from any odor absorbing material contained in a pouch filter (K0574).

A faucet-type tap (K0578) with a valve for draining urinary pouches (A4391, A4392, A4393, A5071, A5072, A5073) is distinguished from plugs, caps, fold up or clip type drainage closures.

Absorbent material (K0579) may come as sheets, pads or crystals, that is added to the ostomy pouch.

Code K0580 describes a lever type flange locking mechanism. It differs from simple push on pouch securing mechanisms. The mechanism may be incorporated either in the pouch flange or skin barrier flange.

Pastes

A paste is used as a protective layer and sealant beneath ostomy appliances, and is applied directly on the skin. It may be primarily pectin based (K0562), or non-pectin based, e.g., karaya (K0561).

Additional Allowances for Certain Codes

When supplied with a covered ostomy pouch, codes K0574 - K0580 are paid separately and in addition to the ostomy pouch codes for which these K codes represent add-on features. They should be billed on separate claim lines, in addition to the pouch code, when they represent additional features of that pouch.

For codes K0575, K0576, K0577, K0578, K0580, only one unit of each code per pouch may be billed.

Usual Maximum Quantities of New Codes: Only those new codes that are direct analogues of eliminated codes, for which maximum quantities had been listed

in the table in the Ostomy Supplies LMRP, are listed below:

K0567 and K0568 replace A5061; the usual maximum allowable quantity remains 20 units per month.

K0570 and K0571 replace A5123; the usual maximum allowable quantity remains 20 units per month.

K0572 and K0573 replace A6265; the usual maximum allowable quantity remains 40 units per month.

K0561 and K0562 replace A4370; the usual maximum allowable quantity remains 4 units per month.

An order from the treating physician must specify the quantity of ostomy supplies required by a beneficiary, and if greater than the usual maximum quantity of supplies per month stated in the LMRP are needed, this should be specified on the order and the reasons for the increased need documented in the patient's medical record. The add-on codes (K0574-K0580) do not need to be specifically listed on the physician's order.

Under the standard grace period, the invalid HCPCS codes will continue to be accepted on claims for dates of service on or after April 1, 2002, that are received by June 30, 2002. However, use of the invalid codes for dates of service on or after April 1, 2002, received on claims on or after July 1, 2002, will be denied as incorrect coding.

Fee schedule amounts for the above new ostomy codes are not available at this time. The fees will not be available until the July 2002 update to the fee schedule. Until then, the reimbursement will be based on the gap-filled methodology.

## Tape – Code Changes

Two new codes have been established for tape.

K0572 - Tape, non-waterproof, per 18 square inches
K0573 - Tape, waterproof, per 18 square inches

These codes are effective for dates of service on or after April 1, 2002. The current code for tape, A6265 (tape, all types, per 18 square inches), has been made invalid for claim submission to the DMERC for dates of service on or after April 1, 2002. Under the standard grace period, code A6265 will continue to be accepted on claims with dates of service on or after April 1, 2002 that are received by June 30, 2002. Claim lines with code A6265 with dates of service on or after April 1, 2002 that are received on or after July 1, 2002 will be rejected as invalid coding. Code A6265 will continue to be valid for claims with dates of service on or before March 31, 2002, regardless of the date that the claim is received.

This code change applies to use of the tape code in all situations including the following policies: Facial Prostheses, Ostomy Supplies, Surgical Dressings, and Urological Supplies.

# *APPEALS*

## New Appeals Procedures

On September 27, 2001, CMS released the new 12000-12999 Sections of the *Medicare Carriers Manual*, which concern the appeals process. These new sections replace the prior sections and the implementation date was November 15, 2001. Changes were made to the appeals process, which could have an impact on suppliers seeking appeals on their claims, e.g., the proper party criteria, the appointment of a representative, the reopening procedure, etc. The new sections are available online at http://www.hcfa.gov/pubforms/htmltoc.htm (select Publication #14, Carrier Manual, Part III, Chapter XII).

## Parties to An Appeal

An appeal request must be submitted by someone who is considered a party to the appeal. The appeal will be dismissed if the person requesting is not a proper party. Any of the following are considered proper parties to an appeal:

- A beneficiary;
- A participating supplier;
- A non-participating supplier taking assignment for a specific item or service;
- A non-participating supplier of DME potentially responsible for making a refund to the beneficiary under Section 1834(a)(18) of the Act;
- A supplier of medical equipment and supplies not taking assignment and is responsible for making a refund to the beneficiary under Section 1834(j)(4) of the Act;
- A Medicaid State agency or party authorized to act on behalf of the State; or
- Any individual whose rights may be affected by the claim being reviewed.

Appointment of Representative

A beneficiary or supplier can appoint any individual to

act as their representative in requesting an appeal. A representative may be appointed at any time in the appeals process. The appointment of representative is valid for one year from either 1) the date signed by the beneficiary or supplier making the appointment, or 2) the date the appointment is accepted by the representative, whichever is later. A copy of the completed appointment must be submitted with each appeal request.

The appointment can be made by completing an appointment of representative form (Form CMS-1696-U4). However, an appointment of representative form is not necessary. A written statement containing all the required elements is also acceptable as a valid appointment of representative. The required elements for a written statement are:

- Name, address, phone number of the beneficiary or supplier;
- Health Insurance Claim Number if the party is the beneficiary;
- Medicare Supplier Number if the party is the supplier;
- Name, address, phone number of the individual being appointed as representative;
- A statement that the party (beneficiary or supplier) is authorizing the representative to act on their behalf for the claims at issue and a statement authorizing disclosure of individually identifiable information to the representative;
- Signature of the party (beneficiary or supplier) making the appointment and the date signed;
- Signature of the individual being appointed as representative, accompanied by a statement that they accept the appointment and the date signed;
- Prohibition Against Charging a Fee for Representation: A supplier that furnished services to a beneficiary may represent them on their claim or appeal involving those services. However, the supplier may not charge the beneficiary a fee for representation. Further, the supplier being appointed as representative must acknowledge that they will not charge the beneficiary a fee for such representation. The supplier does this by including a statement to this effect on the form or written statement, and then signs and dates it.

Attorney Representation

If the person representing the party is an attorney, they are not required to sign the representative form or written statement. In order to release individually identifiable beneficiary information to an attorney, the beneficiary must sign and complete an appointment naming the attorney or complete a release of information.

Power of Attorney

A power of attorney is a valid appointment if it contains all of the required elements of an appointment and it authorizes the designated person to conduct the beneficiary's affairs. This can include authorization to conduct personal and financial matters. It can also be a general authorization or may include very specific authorization to pursue benefits under the Medicare program or government entitlement programs. A power of attorney that authorizes the designated person to make health care or medical care decisions alone is not a valid appointment.

Written Requests for Review Filed on Behalf of the Beneficiary

A written request for review may be submitted by someone other than the beneficiary or an appointed representative on behalf of a beneficiary. An appointment of representative form is not needed if the request for review clearly shows the beneficiary knew of or approved the submission of the request for review (e.g., the request is submitted with the beneficiary's EOMB/MSN or with a written authorization from the beneficiary.) People who often act on behalf of a beneficiary in filing a review request include: the spouse, parent, daughter or son, sister or brother, or neighbor/friend.

Beneficiary advocacy groups, suppliers, doctors, and Members of Congress may also submit a request for review on behalf of a beneficiary. These requests will be accepted if the request for review clearly shows the beneficiary knew of or approved the submission. In absence of the beneficiary's clear knowledge or approval, an appointment of representative form or written statement is required.

Deceased Beneficiary

If the beneficiary is deceased, the appeal request may be filed by the legal representative of the estate. If there is no legal representative, it may also be filed by any person who has assumed responsibility for settling the decedent's estate. In this situation, we must have proof that the person has assumed responsibility for settling the estate. This proof may be a copy of the will or probate court document.

Release of Beneficiary Information to Representative

We can not release a beneficiary's information without their explicit written authorization. In accordance with the Privacy Act, the beneficiary must (1) complete and sign an appointment of representative form naming an individual as their representative, or (2) complete and

sign an authorization form explicitly allowing the release of their claim information to the representative.

*(Medicare Carriers Manual, Section 12004)*

# *ELECTRONIC DATA INTERCHANGE (EDI)*

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

## Changes in Reporting Weight on CMNs

In today's National Standard Format (NSF 3.01) environment, the subscriber's (patient's) weight on Certificates of Medical Necessity (CMNs) is reported in pounds. With the migration to ANSI, this will be changing. When transmitting this information electronically, the weight must be reported in grams until further notice. CIGNA Medicare is encouraging all suppliers to check with their software vendors to determine how their software will report weight information. If your software will not calculate the weight from pounds to grams, then it is your responsibility to convert the weight as provided on the original CMN to grams when transmitting electronically. If you have questions, please contact the EDI Department.

Conversion Factor: 1 pound = 454 grams

## Electronic Transmission of Arterial Oxygen Saturation and/or Arterial Blood Gas(ABG) Values

CIGNA Medicare has been receiving incorrect oxygen saturation/ABG values on electronic oxygen CMNs (DMERC 484.2). For example, if the oxygen saturation level is 88 and your software transmits 088, the system will interpret it as 08 making the oxygen saturation level incorrect. Effective immediately, if these values are entered incorrectly, related claims are denied as invalid CMN information. If your claim is denied for invalid CMN information, the claim and the required CMN may only be resubmitted on paper.

Please check with your software vendor to determine how you should be entering this information in your software.

Following is information about fields that require oxygen saturation and ABG values.

| **Record Type: GX0** | |
|---|---|
| **Field Name/ Description** | **Field Number** |
| ARTERIAL BLOOD GAS (Question 1a) The Arterial Blood Gas test results taken on or before the certification date (furnish results of recent hospital tests.) Cobol pic = 9(2)v9 (implied decimal). | 22.0 |
| OXYGEN SATURATION (Question 1b) The Oxygen Saturation test results taken on or before the certification date (furnish results of recent hospital tests.) Cobol pic = 9(2)v9 (implied decimal). | 23.0 |
| ARTERIAL BLOOD GAS ON 4 LPM (Question 7a) Arterial Blood Gas test results when taken on 4 LPM. Cobol pic = 9(2)v9 (implied decimal). | 17.0 |
| OXYGEN SATURATION ON 4 LPM (Question 7b) The oxygen saturation test results taken on 4 LPM with the patient in a chronic stable state. Cobol pic = 9(2)v9 (implied decimal). | 18.0 |

## Transmitting Decimals Within the 837 ANSI Transaction

Currently the NSF format implies decimals on all numeric fields including percentages and dollar amounts. By implying decimals, the software and user assumes the decimal is placed two positions from the right. For example, when "2500" is submitted for a dollar amount we assume it is "$25.00".

When users migrate to the ANSI X12N 837 version 4010 format they will need to send decimals where appropriate. As in the example above, when "2500" is submitted as a dollar amount we will assume it is "$2500.00".

To send $25.00 in the ANSI format, either manually insert the decimal or follow your software instructions for inserting decimals. If you are unsure how your software handles decimals, please contact your software vendor.

## Your New Stratus ID Numbers for ANSI

Once you have contacted the EDI Department to migrate to the ANSI X12N 837 version 4010 format you will be assigned a **new** Stratus ID, also known as MB number. This MB number will be sent to you along with your testing instructions and new *Region D DMERC EDI Manual*.

Upon assigning you a new MB number, your old number will be deactivated in ten (10) days. During this time you may still transmit files using your old MB number, however, your Electronic Receipt Listing (ERL) and/or Electronic Remittance Notice (ERN) files will be sent to your new MB number. To download your ERL and ERN files you must logon to Stratus with your new MB number.

If you have any questions, please call the EDI Department at 866.224.3094, option 4.

# *HIPAA*

## Introducing The HIPAA Web site Section

We are pleased to announce the newest section to the CIGNA Medicare Web site. Just point your browser to www.cignamedicare.com/hipaa for the latest on general HIPAA information as well as more specific information such as the DMERC ANSI testing instructions, and links to other HIPAA-related sites.

## Updated Implementation Dates for HIPAA

CIGNA Medicare has received instructions from the Centers for Medicare & Medicaid Services (CMS) that update timeframes associated with the implementation of HIPAA transactions. Of particular note is the final implementation date, which moves from October 16, 2002 to October 16, 2003.* This delay is a result of the Administrative Simplification Compliance Act (H.R. 3323), which requires, among other things, that a waiver process be followed to obtain the one-year delay. It is important to note that the delay is not global. There are specific steps the submitter must take to receive approval to delay. Please review H.R. 3323 for more information about the delay and the waiver.

In addition to the final implementation date, the following HIPAA implementation dates have been updated. Please make note of these changes and notify your staff of the revised dates.

**Health Care Claim (X12N 837)**

Submitter testing will open by April 16, 2002. Testing instructions for the Region D DMERC may be found at *www.cignamedicare.com/hipaa*. All requested testing must be completed by October 16, 2003.*

**Electronic Remittance Notice (X12N 835)**

ANSI 835 testing will be available to submitters that request testing by May 16, 2002. All requested submitter testing must be completed by October 16, 2003.*

**Claim Status Inquiry (X12N 276/277)**

Submitter testing is not required on this transaction, however, it may be requested. CIGNA Medicare will be ready to accept tests for this transaction by July 16, 2002.

**Beneficiary Eligibility (X12N 270/271), Claim Attachment (X12N 278) and NCPDP**

CMS has not provided instructions on the implementation date for the ANSI 270/271 transaction, ANSI 278 transaction or the NCPDP format. However, each of these will be implemented by the final implementation date of October 16, 2003.*

**Free Billing Software**

Currently, Region D DMERC offers DMERC Medicare Automated Claims System (DMACS), a free billing software product for Region D electronic billers. DMACS is programmed for the current NSF 3.01 format. CMS has instructed CIGNA Medicare to issue a HIPAA-compliant Medicare free billing software product for providers who wish to use such a program to comply with HIPAA. The new HIPAA-compliant software will be available for distribution by December 3, 2002. Please note that CMS' announcement regarding the elimination of the free billing software remains effective for FY 2004 (October 2003).

**New EDI Submitters**

Suppliers who are planning to begin billing electronically to Region D DMERC should begin with the HIPAA format (ANSI X12N v.4010), rather than test and transmit production claims in the NSF 3.01 format. If a new submitter is unable to begin transmitting with the HIPAA format, Region D DMERC will accept new EDI submitters using the NSF 3.01 format up until October 1, 2002. After October 1, 2002, new EDI submitters must begin using the HIPAA format, ANSI X12N v. 4010.

Currently, Region D DMERC is preparing to implement these transactions before or by the dates listed above. EDI submitters should be updating their billing systems with the applicable HIPAA transactions to avoid last

minute testing concerns. For the most up-to-date information regarding Region D DMERC's HIPAA implementation, please visit www.cignamedicare.com/hipaa.

***Only if waiver is on file. Otherwise, October 16, 2002 will still remain as the final implementation date. Instructions on the waiver process will be published as more information becomes available.**

# *MEDICARE SECONDARY PAYER (MSP)*

## Medicare Secondary Payer on Capped Rental Items

A supplier must offer the beneficiary a purchase option on capped rental items in the 10th month of continuous rental. When Medicare is the secondary payer we will make secondary payments for these ten months if all guidelines are met and we could have made a primary payment. A copy of the primary payer's explanation of benefits must be attached to each Medicare claim.

If the beneficiary chooses to purchase the item in the 10th month and Medicare is secondary, we will make secondary rental payments for up to 13 continuous months. The claim must always be filed with the primary insurance first and then submitted to Medicare with a copy of the primary payer's explanation of benefits.

The primary insurance does not have to honor the purchase option if it is not consistent with their policy requirements. However, a claim must be submitted to the primary insurance first.

Medicare as secondary payer cannot, under any circumstances, pay more than it would have paid as a primary payer. If the primary insurance pays for the lump sum purchase of a capped rental item (except electric wheelchair), Medicare cannot make a secondary payment. Medicare would not make a primary payment; therefore, could not make a secondary payment for the lump sum purchase of a capped rental item.

Electric wheelchairs are the only exception to capped rental guidelines. Medicare as primary payer could pay for purchase or rental. When Medicare is secondary payer, the primary insurance must be filed first and Medicare would process the claim secondary.

Medicare may not pay secondary benefits when the primary payer pays the supplier's charges in full, or when the supplier is either obligated to accept, or voluntarily accepts, the primary payer's payment as payment in full.

## Medicare Secondary Payer (MSP) Overpayment Refunds

When refunding overpayments made on MSP claims, in order to avoid a delay in the processing of the refund, please remember to include the following information:

1. The beneficiary's health insurance claim number (HICN);
2. An explanation of benefits (EOB) from the third party payer;
3. The type of primary insurance involved (i.e., EGHP, liability, workers' compensation,no fault);
4. The Medicare Remittance Notice or Medicare Summary Notice for the date(s) of service in question; and
5. A check in the amount of the original Medicare payment.

The claim will then be adjusted according to the MSP guidelines and any additional benefits due will be issued at that time.

All refunds should be made payable to CGLIC - Medicare and sent to:

CIGNA Federal Insurance Benefits - DMERC
PO Box 10927
Newark, NJ 07193-0927

# *MISCELLANEOUS*

## CIGNA Medicare Selected for Wheelchair Demonstration Project

The Centers for Medicare and Medicaid Services (CMS) has selected CIGNA Healthcare - Medicare Administration as the contractor to process claims for the Consumer Directed Durable Medical Equipment (CD-DME) Wheelchair Demonstration project. CMS anticipates that the project will begin sometime in Spring of 2002 and run for approximately 3 years.

CMS and CIGNA Medicare will partner with four Centers for Independent Living (CILs) whose staff will educate beneficiaries to be savvy purchasers of wheel-

chairs (either manual or power). The CILs are located in Tulsa, OK; Portland, ME; Pittsburgh, PA; and Worcester, MA. A beneficiary, with the assistance of CIL staff members, will collect and submit medical records, product information about the wheelchair and accessories selected and other documentation to CIGNA Medicare to determine if they qualify for a wheelchair. If approved, the beneficiary will receive a "voucher" indicating a dollar amount that they may spend to purchase a wheelchair and accessories. In addition, the claim will be assigned an approval number that the beneficiary will furnish to the DMEPOS supplier submitting the wheelchair claim. The beneficiary then selects a wheelchair supplier and "negotiates" a best price. Suppliers should note that beneficiaries will be purchasing the wheelchair and accessories selected, even though the model chosen may normally be a capped rental item.

DMEPOS suppliers selected by a beneficiary participating in the CD-DME project must submit the wheelchair claim, model and accessory information, and certificate of medical necessity (CMN) in hard copy. An approval number, given to the beneficiary at the time CIGNA Medicare authorizes their claim, should be listed in Block 19 of the HCFA-1500 form. In addition, claims submitted for beneficiaries participating in the CD-DME project must be sent to CIGNA Medicare, not your local DMERC. The address for claim submission is:

CIGNA Healthcare - Medicare Administration
Attn: CD-DME Project
P.O. Box 22059
Nashville, TN 37202

This information may also be accessed on the CIGNA Medicare web site at www.cignamedicare.com/dmerc.

## Coming soon to a computer near you… Medicare Learning On-Demand

Medicare Learning On-Demand offers learning at your convenience by offering two **new** Medicare learning formats, *Webinars* and *NetCourses*. Through the use of a computer and/or telephone, *Webinars* will allow attendees to join a live presentation given by Medicare representatives. These presentations will be interactive, allowing participants and presenters to communicate with one another during the presentation. Each session will be approximately 60 minutes in length and will be offered multiple times. For users without Internet access, the courses may also be accessed via telephone. The second new learning format, *NetCourses*, are pre-developed mini courses available on the Internet. *NetCourses* enable users to learn at their own pace and on their own schedule.

More information regarding these new Medicare learning formats may be found on the CIGNA Medicare Web site, www.cignamedicare.com. We will announce new courses through CIGNA Medicare's Electronic Mailing List. To sign-up to receive notifications via e-mail, visit our home page and click on "Join Now."

## Correction To Article Published In HME News

In the December 2001 issue of *Home Medical Equipment News*, an article in the Reimbursement section entitled "Medicare Capped Rental" states: "Can patients change their mind regarding their Medicare capped rental choice?" The author responded that Region D allows patients to change their minds after a decision has been reached on the rent/purchase option letter. This response is not correct. Consistent with Medicare regulations, Region D **does not** allow beneficiaries to change their minds once a decision has been made on the rent/purchase option letter. Medicare rules concerning capped rental items are published in the *Medicare Carriers Manual* (MCM), Section 5102. Following is an excerpt from the MCM:

*". . . suppliers must give beneficiaries the option of converting their rental equipment to purchased equipment during their 10th continuous rental month. . ."*

*". . . Beneficiaries have one month from the date the supplier makes the offer to accept this option. . ."*

Capped rental rules are also published in the *DMERC Region D Supplier Manual*, Chapter 5, pages 2-5.

## Deceased Physicians' UPINs on DMERC Claims

Effective April 1, 2002, the Common Working File (CWF) will reject DMERC claims using deceased physicians' Unique Physician Identification Numbers (UPINs) whose dates of service exceed the physician's date of death. Assigned claims will be denied based on medical necessity if submitted with invalid or deceased ordering or referring physician's UPINs or claims whose dates of service exceed the physician's date of death. Unassigned claims will be developed. Maintenance, service, and repair codes will be ex-

cluded from this editing.

The UPIN deceased physician list will be matched against the American Medical Association's deceased physician database and the Social Security Administration's Death File. Physicians who have died in the past 15 months will not be part of the deceased physician list.

The following new messages will be printed on the supplier's Medicare Remittance Notice (MRN) for claims denied due to deceased UPIN:

Reason code 52 - The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Remark code M33 - Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid.

Claims denied based on a deceased UPIN will require a new order and/or Certificate of Medical Necessity (CMN) from the current treating physician.

## 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). Three revisions have been published since the Winter 2002 publication of the Region D *DMERC Dialogue.*

- Transmittal 16, released November 28, 2001, revises Benefit Integrity sections of the PIM in Chapters 1 through 4, 7 and Exhibits.
- Transmittal 17, released December 12, 2001, revises Chapter 3, sections 4 through 6 and Exhibit 14.4, which address prepayment and postpayment review procedures. The implementation: April 1, 2002.
- Transmittal 18, released January 17, 2002, revises Chapter 6 to manualize Program Memorandum (PM) A-00-08, Change Request 1064, dated March 2000. This PM addressed Skilled Nursing Facility medical review instructions.

This manual is available on the Internet, HTML format. To access the PIM, go to http://www.hcfa.gov/pubforms/83_pim/pim83toc.htm. CMS does not publish hard copies of this manual.

## Reporting Address and Other Changes to the National Supplier Clearinghouse (NSC)

Suppliers must notify the National Supplier Clearinghouse (NSC) of **any changes** that occur after the initial application is filed, including changes to their street, "Mail to," and "Pay to" addresses. Changes must be submitted on the CMS-855S Application Form which can be obtained by contacting a NSC representative toll-free at 866.238.9652 or downloaded from www.palmettogba.com. The form must be mailed to:

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

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

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

## Suggested Intake Form

A new Suggested Intake Form is included in this newsletter (Appendix A-1). It is intended only as a tool to assist suppliers in obtaining information, at the time of patient intake, regarding same/similar equipment, Medicare eligibility, or other information the supplier may need for their particular type of business. Suppliers may use this form or model a similar form to fit their needs. This form is not required for claim submission and does not replace obtaining an Advance Beneficiary Notice (ABN) when there is reason to believe the item(s) may be denied as not medically necessary. Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, for information about same or similar equipment and ABNs, and the Limitation of Liability section in Chapter 6 for more information.

# *Notes*

# Suggested Intake Form

| | | |
|---|---|---|
| Order taken by: | Date: | |
| Referral Person Calling in Order: | Telephone: | |
| **BENEFICIARY INFORMATION** | | |
| Name: | Date of Birth: | |
| Street Address: | Gender: ❑ Male ❑ Female | |
| City, State, Zip: | Weight: | Height: |
| Telephone: | Medicare Number: | |
| **Name of Legally Responsible Representative:** | | |
| Relationship to beneficiary: | | |
| Street Address: | | |
| City, State, Zip: | Telephone: | |
| **ORDERING PHYSICIAN INFORMATION** | | |
| Name: | UPIN #: | |
| Street Address: | | |
| City, State, Zip: | Telephone: | |
| Specialty: | | |
| **QUESTIONS FOR THE BENEFICIARY** | | |
| Has the beneficiary ever received the same or similar supplies/equipment? | ❑ Yes | ❑ No |
| If yes, list equipment/supplies: | | |
| Who was it purchased or rented from? | | |
| Date purchased or if rented, how many months? | Date of past setup: | Date equipment was returned: |
| Was item returned to original supplier? | ❑ Yes | ❑ No |
| Why was the item returned? | | |
| Is the item being replaced? | ❑ Yes | ❑ No |
| Is there a new medical necessity? | ❑ Yes | ❑ No |
| Describe condition for previous need: | | |
| Describe new/changed condition: | | |
| Is the beneficiary enrolled in a Medicare HMO/managed care program? | ❑ Yes | ❑ No |
| Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)? | ❑ Yes | ❑ No |
| **QUESTIONS FOR THE SUPPLIER** | | |
| **If providing repairs on equipment obtain the following information for the item being repaired:** | | |
| Manufacturer: | Model Name or Number: | Serial Number: / Purchase Date: |
| Reason or nature of repairs: | | |
| Do you have medical necessity to file for repairs? | ❑ Yes | ❑ No |
| Does beneficiary meet criteria for item being repaired? ❑ Yes ❑ No | Where will the item be used? | |
| Did I photocopy the Medicare card and/or other insurance cards? | ❑ Yes | ❑ No |
| Do I have a dispensing order and/or a detailed written order? | ❑ Yes | ❑ No |
| Will I need a Certificate of Medical Necessity (CMN)? | ❑ Yes | ❑ No |
| Do I have supporting documentation on file to meet medical necessity? | ❑ Yes | ❑ No |
| Should I obtain an Advance Beneficiary Notice (ABN)? | ❑ Yes | ❑ No |
| What is the primary diagnosis? | List any other diagnoses if applicable: | |
| Is Medicare the beneficiary's ❑ primary or ❑ secondary insurer? | | |
| Is the beneficiary or beneficiary's spouse employed? | ❑ Yes | ❑ No |
| Is the current condition related to employment, auto or other accident? | ❑ Yes | ❑ No |
| Is the beneficiary nearing Medicare eligibility? ❑ Yes ❑ No | If yes, give eligibility date: | |
| Do I need to obtain a one-time authorization form? | ❑ Yes | ❑ No |
| Did the beneficiary sign and date this intake form? | ❑ Yes | ❑ No |
| Beneficiary Signature: | Date Signed: | |

This is just a **suggested** intake form and suppliers can model one to fit their particular type of business. For example if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advance Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the DMERC Region D Supplier Manual, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.

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# *DMERC Region D Publication Order Form*

**Name:** _____

**Company Name:** _____

**Address:** _____

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

**Phone:** _____ **Fax:** _____

**Email:** _____

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

## Subscription (12 months) $50.00/year per publication

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

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

## DMERC Individual Requests

**Region D *DMERC Dialogue** $10.00 Each Issue**

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

*Includes (if applicable) the supplier manual update.

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

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

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

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

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

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

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

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

If you have not billed CIGNA Medicare within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary copy of the Region D *DMERC Dialogue* and supplier manual update.

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

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# *Customer Service Available*

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

***Supplier Help Line***: 877.320.0390 ***Beneficiary Help Line***: 800.899.7095

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

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

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

***Supplier Application Packages and Changes of Address***—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC).

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

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

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

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

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

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

*Welcome Spring!*

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

CIGNA Medicare
DMERC Region D
PO Box 690
Nashville TN 37202
877.320.0390



***Region D DMERC Serves. . .***

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

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