Region
DMERC DIALOGUE

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

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From the Region D DMERC Medical Director…..

Region D Medical Review's Experience with Power Mobility – Lessons Learned

Last year around this time I described the principle of progressive corrective action (*DMERC Dialogue*, Winter 2000) and the emphasis the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the DMERCs placed on education of the supplier community. Feedback from the carrier to the supplier is an essential step in helping to correct billing and coding errors and explain the Medicare guidelines for coverage and payment of services. The information in this article is compiled from the Region D Medical Review experience with power wheelchair reviews over the past two years and details, in order of frequency cited, the top 10 educational issues addressed in our summary findings to suppliers.

1. Failure of the documentation to support medical necessity. Records submitted to the carrier did not indicate that the beneficiary was nonambulatory within the home. Either the records did not contain an assessment that adequately defined the beneficiary's functional level in objective, measurable terms or they indicated that the beneficiary could ambulate within the home.
2. The delivery slip did not contain the supplier's address and/or phone number. This becomes an educational issue when the only information left with the beneficiary after delivery of the wheelchair is the delivery ticket. Without a supplier's address or phone number, it may be difficult for the beneficiary to contact the supplier of the wheelchair should problems arise with the product(s) provided.
3. The delivery slip did not list all accessories. While this is not an absolute requirement of CMS or the DMERCs, delivery slips are a common method of documenting "proof of delivery." Maintaining in the supplier's files and providing to the beneficiary a detailed list of what was delivered and when it was delivered is a sound business practice. Moreover, it allows the DMERC to confirm that the items billed to Medicare were actually provided to the beneficiary.
4. Section C of the Certificate of Medical Necessity (CMN) contained a list of pre-printed accessories, not all of which were provided to the beneficiary. Section C of the CMN should contain only those items ordered by the treating physician. Pre-printing a "laundry list" of accessories, some of which will not be provided, fails to accurately advise the physician of what was ordered and is being provided. Section C should be individualized for each beneficiary, reflect accurately what was ordered by the treating physician and list the cost and Medicare fee schedule for each item.

5. Ordering physician failed to provide medical records. While I recognize that it is sometimes difficult to obtain medical records in support of medical necessity from providers, it is the supplier's responsibility to ensure that medical necessity criteria are met since it is the supplier who is billing Medicare. I will continue to be an advocate for suppliers to the physician community in reminding them of their statutory obligation to provide medical records when requested by the carrier.
6. Medical records failed to document upper extremity weakness such that a manual wheelchair could not be used. The coverage criteria for a power wheelchair stipulate that the beneficiary's medical condition precludes the use of a manual wheelchair. Suppliers should help educate the physician community about Medicare coverage criteria and the appropriate documentation of a beneficiary's medical condition.
7. The supplier did not respond to the carrier's request for records. Section 1833(e) of the Social Security Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person…." In other words, when the carrier requests records from the supplier to determine if a service is reasonable or necessary, the supplier must supply those records or risk denial of the claim(s).
8. Section A of the CMN did not include a complete list of all codes billed that require a CMN. Suppliers are reminded that Section A of the CMN should be completed accurately and list all codes billed that require a CMN.
9. Lack of documentation in the supplier's files of a signed statement authorizing the release of a beneficiary's medical information. The Privacy Act requires that suppliers obtain a signed authorization from the beneficiary or the beneficiary's authorized representative prior to releasing medical information.
10. Lack of documentation in the supplier's files of a signed "One-Time Authorization" form. Suppliers must have this documented in their files signed by either the beneficiary or the beneficiary's authorized representative indicating that the supplier is authorized to bill Medicare on behalf of the beneficiary. Note that for assigned claims, the one-time authorization is sufficient; however, on unassigned claims for durable medical equipment provided on a rental basis, a new authorization must be obtained prior to each month's billing.

(Special thanks to Carol Bradley, RN for tracking and compiling this information.)

A New Name, A Clearer Focus

Effective July 1, 2001, the Health Care Financing Administration (HCFA) is now the Centers for Medicare & Medicaid Services (CMS). The Department of Health and Human Services Secretary, Tommy G. Thompson, made the announcement on June 14, 2001. Secretary Thompson claims that the change is more than just a new name – it's an increased emphasis on responsiveness to beneficiaries and providers, and quality improvement. *"We're making quality service the number one priority in this agency,"* Thompson said. Furthermore, Thompson stated, *"These sweeping reforms will strengthen our programs and enable our dedicated employees to better serve Medicare and Medicaid beneficiaries, as well as health care providers. We're going to encourage innovation, better educate consumers about their options, and be more responsive to the health care needs of Americans.*"

Three new business centers are being established as a part of the transition, including the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

CMS has launched a national media campaign to educate seniors and other Medicare beneficiaries about their options, allowing them to make better decisions. Beginning October 1, 2001, the Medicare toll-free number, 1-800-MEDICAR (1.800.633.4227), will be enhanced to provide service to beneficiaries 24 hours a day, seven days a week.

Secretary Thompson stated: "*More changes are on the way*," and "*we're going to keep fine-tuning this department so Americans are receiving the highest quality health care possible.*"

Medicare Program Integrity Manual Revised

The Medicare *Program Integrity Manual* (PIM) contains the medical review and fraud and abuse instructions from the Health Care Financing Administration (HCFA) [now the Centers for Medicare & Medicaid Services (CMS)]. Seven revisions have been published since the Fall 2001 publication of the Region D *DMERC Dialogue*.

- Revision 9, released on July 2001, revises or adds Chapter 1, §§ 2.3.5 - 2.3.9, and Exhibits 6 and 6.1. These sections address contractor requirements for local medical review policy (LMRP) comment and notice processes, and LMRP format. There is no effective date.

- Revision 10, released September 17, 2001, revises Chapter 1, § 2.7.6 by clarifying the timeframe for Contractor Advisory Committees (CAC). Effective date: October 17, 2001.
- Revision 11, released September 18, 2001, revises or adds Chapter 5, §§ 1.1.4, 3.3 and 3.3.1. These sections provide instructions on how DMERCs handle electronic Certificates of Medical Necessity (CMNs), describe CMNs and how DMERCs use them as evidence of medical necessity, and clarify that DMERCs should accept faxed, copied, and electronic orders and CMNs on review of DMEPOS claims as being accurate unless indications of potential fraud exist. §§1.1.4.1 - 1.1.4.3 are added to change section numbers to be more consistent throughout the manual. §1.1.4.2 requires that for changes made to any section of the CMN after the physician has completed Section B and signed Section D, the physician must line through, initial and date the correction; or the supplier may choose to have the physician complete a new CMN. Effective date: September 24, 2001.
- Revision 12, released on September 20, 2001, adds Chapter 12 - FI, Carrier, DMERC and RHHI Interaction and Coordination with Program Safeguard Contractors (PSCs). This chapter provides background information regarding the workflow interaction between the PSCs and FIs, Carriers, DMERCs and RHHIs, and manualizes Program Memorandum AB-01-08. There is no effective date.
- Revision 13, released and effective on September 26, 2001, adds Chapter 3, §2.2, which allows contractors flexibility in applying review requirements to providers who are impacted by natural and man-made disasters and whose medical record documentation may be impaired, destroyed, or affected by delays in the U.S. mail delivery system.
- Revision 14, released on September 26, 2001, revises Chapter 1, §2.3.7 and Exhibit 6 and 6.1 by changing the contractor LMRP submission contact, revises the LMRP format chart, and clarifies requirements for submitting LMRPs for multiple contractor corporations. Effective date: October 1, 2001.
- Revision 15, released on October 29, 2001, revises Chapter 6, §15 to clarify the circumstances under which intermediaries should issue "technical denials" and when they should issue (1862(a)(1)(A) denials, remove language that could have been construed as a National Coverage Decision or coverage provision in an interpretive manual, and move some examples from the benefit category list to the reasonable and necessary list. Effective date: August 2, 2001.

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.

Regional Medical Review Policies (RMRPs) Have a New Name

The Centers for Medicare and Medicaid Services (CMS), formerly HCFA, has instructed the Durable Medical Equipment Regional Carriers (DMERCs) to change the name of their policies. Local Medical Review Policies (LMRPs), formerly RMRPs, will now be used when referring to policies published by the DMERCs.

Insulin Pumps – Revised Criteria

Effective for dates of service on or after January 1, 2002, the criteria for coverage of an insulin infusion pump and related supplies and insulin have been revised. An external insulin infusion pump and related items will be covered for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus (ICD-9-CM codes 250.00-250.93) which has been documented by a fasting serum C-peptide level that is less than or equal to (≤) 110 percent of the lower limit of normal of the laboratory's measurement method. For example, if the normal range for C-peptide in a laboratory is 0.9-4 ng/ml, a C-peptide level of 0.99 or less (i.e., 0.9 x 1.1) would qualify for coverage under the new criteria.

For patients who have obtained an external insulin infusion pump that was not eligible for reimbursement by Medicare prior to January 1, 2002, insulin and supplies used with the pump are covered for dates of service on or after January 1, 2002, provided the patient has a fasting C-peptide such that the test result is less than or equal to (≤) 110 percent of the lower limit of normal of the laboratory's measurement method.

If an insulin pump which did not meet previous coverage criteria but does meet the new criteria was provided on a rental basis prior to January 1, 2002, **and is still being rented on January 1, 2002**, rental coverage would begin in January 2002. In this situation, the KH rental modifier should be used depending on when the rental actually began. If an insulin pump which did not meet previous coverage criteria but does meet the new criteria was provided on a **purchase** basis prior to January 1, 2002, no payment for that pump is possible and rental claims must not be submitted. However, coverage for the insulin and supplies would be available after January 1, 2002, as described in the previous paragraph.

For all claims for external insulin infusion pumps, insulin and/or supplies with dates of service on or after January 1, 2002, if the results of the patient's C-peptide level meet

the requirements outlined above, a ZX modifier should be added to the HCPCS code. The C-peptide level does not need to be submitted on claims with dates of service on or after January 1, 2002.

Refer to the medical policy on External Infusion Pumps in the *DMERC Region D Supplier Manual* for additional information regarding coverage and payment rules and coding guidelines for these items.

Infusion Pumps CIM Revision

Coverage Issues Manual (CIM), Section 60-14, Infusion Pumps, revises the C-peptide requirement to be less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method. This change expands the value of the laboratory test to be considered in determining the coverage of the insulin infusion pump for all diabetic patients. (Type II diabetics are no longer excluded.)

This section of the CIM is a national coverage decision made under §1862(a)(1) of the Social Security Act (the Act). National Coverage Decisions (NCDs) are binding on all Medicare carriers, intermediaries, Peer Review Organizations, and other contractors. Under 42 CFR 422.56(b) an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862(s)(1) of the Act. (42 CFR 405.732, 405.860)

This policy revision is effective for services provided on or after January 1, 2002. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy. Also, refer to the External Infusion Pump DMERC local medical review policy in Chapter 9 for additional coverage details.

Manual and Power Wheelchairs, POVs – Policy Revisions

Revisions of the local medical review policies on Manual Wheelchair Bases, Motorized/Power Wheelchair Bases, and Power Operated Vehicles (POVs) are included in the accompanying *DMERC Region D Supplier Manual* update. The revisions include changes in codes, coverage and payment rules, coding guidelines, and documentation requirements, including Advance Determination of Medicare Coverage (ADMC), which have occurred since the policies were last published.

Walkers – Policy Revision

A revision of the local medical review policy on Walkers is included in the accompanying *DMERC Region D Supplier Manual* update. The revision incorporates the new codes for heavy duty walkers which were established in January 2001.

Spinal Orthoses – HCPCS Coding Changes

Effective for dates of service on or after January 1, 2002, several new codes are established for prefabricated spinal orthoses and one existing code (L0515) is being revised. The new/revised codes are:

L0321 Thoracic-lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0331 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0391 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral-rotary control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0515 Lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0561 Lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0986 Addition to spinal orthosis, rigid or semi-rigid abdominal panel, prefabricated

Also effective for dates of service on or after January 1, 2002, codes L0315 (TLSO, flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel) and L0317 (TLSO, flexible dorso-lumbar surgical support, hyperextension, elastic type, with rigid posterior panel) will be invalid for claim submission to the DMERC. Code L0321 should be used instead. In accordance with the standard grace period, codes L0315 and L0317 will be accepted for claims with dates of service on or after January 1, 2002, that are received by March 31, 2002. However, claims for codes L0315 and L0317 received on or after April 1, 2002, will be rejected or denied as invalid coding.

To be coded as a TLSO the rigid or semi-rigid posterior panel of the orthosis must extend to the area of the scapular spines. The rigid or semi-rigid posterior panel of an LSO typically extends to the inferior border of the scapula. The lower end of the posterior panel of an LSO or TLSO is at the level of the sacrococcygeal junction. Anteriorly, the TLSO and LSO extend from the pubic symphysis to just below the xiphoid process.

In the codes listed above, anterior-posterior control is achieved by a rigid or semi-rigid posterior panel. Lateral control is achieved by a rigid or semi-rigid panel in the mid-axillary lines that is either an integral part of a posterior panel or a separate panel. Rotary control is achieved by a rigid or semi-rigid panel in the upper chest area that is attached by a rigid connection to a posterior, lateral, or abdominal panel.

Code L0986 would be used in addition to any of the other codes listed if the prefabricated orthosis had a rigid or semi-rigid abdominal panel.

As defined in the Spinal Orthoses: TLSO and LSO local medical review policy, codes L0320-L0340 and codes L0520-L0540 may only be used for custom fabricated spinal orthoses. Refer to the Spinal Orthoses: TLSO and LSO local medical review policy for definitions of prefabricated and custom fabricated orthoses.

Codes L0300 and L0310 (Thoracic-lumbar-sacral orthosis, flexible), L0500 and L0510 (Lumbar-sacral orthosis, flexible), and L0600 and L0610 (Sacroiliac flexible support) are used for spinal orthoses that do not have rigid or semi-rigid panels. Sacroiliac orthoses encompass the pelvis and extend from the pubic symphysis to the waist anteriorly. Flexible spinal orthoses may be made of cloth, elastic, or other stretchable material. They may have vertical stays made of flexible metal or other material. Codes L0300, L0500, and L0600 are for prefabricated orthoses; codes L0310, L0510 and L0610 are for custom fabricated orthoses.

Useful Lifetime for External Breast Prosthesis

Effective for dates of service on or after April 1, 2002, the Centers for Medicare and Medicaid Services (CMS) has determined that a period shorter than five (5) years more accurately reflects the useful lifetime expectancy for external breast prostheses.

The useful lifetime expectancy for silicone breast prostheses is two (2) years. For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six (6) months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as noncovered.

An external breast prosthesis of the same type can be replaced at any time if it is lost or is irreparably damaged (this does not include ordinary wear and tear). An external breast prosthesis of a different type can be covered at any time if there is a change in the patient's medical condition necessitating a different type of item.

The Medicare program will pay for only one breast prosthesis per side at any one time. More than one external breast prosthesis per side at any one time will be denied as not medically necessary.

Suppliers must use the RT and LT modifiers to delineate the side or sides being billed.

TENS Policy Revised

A revised Transcutaneous Electrical Nerve Stimulators (TENS) policy is included in the accompanying *DMERC Region D Supplier Manual* update. The revisions include changes in coverage and payment rules, coding guidelines, and documentation requirements, as well as elimination of availability for prior authorization for this item.

Home Prothrombin Time (INR) Monitors – Coverage Change

In a September 18, 2001, National Coverage Decision Memorandum, the Centers for Medicare and Medicaid Services (CMS) stated that home prothrombin time (INR) monitors used to manage anticoagulation are only eligible for coverage under the diagnostic services benefit. That is to say that individual tests performed by the patient or caregiver using the device can be considered for coverage. However, these tests must be billed by a laboratory to the local carrier or local intermediary. There is no coverage for the monitor or related supplies under the durable medical equipment benefit or any other benefit administered by the DMERC. If claims for these items are received by the DMERC, they will be denied as incorrect billing jurisdiction. Claims denied for this reason are not eligible for appeal through the DMERC.

Prostheses and Orthoses Related to a Hospital Stay

Hospitals are required to provide whatever equipment or other items are needed by a patient during a Part A covered inpatient hospitalization. Hospitals may provide the item either directly or under arrangement with a supplier. This includes items which are provided **prior** to

hospital admission but whose medical necessity begins during the hospital stay. One example is a custom fabricated spinal orthosis that is needed following spinal surgery. Even if this item is fabricated prior to hospital admission and is given to the patient to take to the hospital, the hospital **must** be the one to reimburse the orthotist for the item. In this situation, the orthotist is not permitted to submit a claim to the DMERC for that item.

Similarly, if an item is medically necessary during an inpatient stay, it must be provided and paid for by the hospital either directly or under arrangement – even if the patient will continue to use the item at home. A supplier may deliver an item to an inpatient during the two days prior to discharge to home and bill the DMERC for the item **only if it is not** medically necessary for the patient to use the item in the hospital. For example, if a patient needs a brace following discharge, the orthotist may come to the hospital, do any fitting or custom fabrication that is needed, and leave the brace with the patient to take home. Alternatively, a supplier may bring an item that will be needed at home to the hospital to show the patient how to use it and then leave the item with the patient to take home. If the patient does not wear or use the item in the hospital, the supplier may submit a claim to the DMERC for the item. However, **if the patient wears or uses the item in the hospital – indicating that the item was a medically necessary part of treatment or rehabilitation during the hospital stay – then reimbursement is included in the hospital's payment for the inpatient admission**, even if the patient will continue to use the item following discharge. When the patient wears or uses the item in the hospital, the hospital must pay the supplier for the item; the supplier may **not** submit a claim to the DMERC for the item.

Orders and Certificates of Medical Necessity (CMNs) – Fax and Electronic

Effective for dates of service on or after September 24, 2001, the DMERCs will accept orders and Certificates of Medical Necessity (CMNs) that have been faxed or transmitted electronically between a supplier and physician. Prior to that date, suppliers were required to be able to provide to the DMERC on request a hard copy of the order or CMN with the physician's original signature and a handwritten signature date entered by the physician. Except for not requiring a document with the original signature and date, a fax or electronic order or CMN must meet all the requirements specified in the *DMERC Region D Supplier Manual.*

For a fax transmission, the supplier may send the order or CMN with the information that they are allowed to complete to the physician. For CMNs that are faxed to a physician, the supplier must fax the back side of the CMN as well as the front side. If the supplier is faxing multiple CMNs to the physician at the same time, only one back side needs to be faxed. For orders, the physician makes any additions or corrections that are needed to the order information, adds diagnoses and other medical necessity information as needed, signs and dates the order, and faxes it to the supplier. For CMNs, the physician reviews, completes, and corrects Section A as needed, completes Section B, reviews Section C, signs and dates Section D, and faxes the form to the supplier. When a physician faxes a completed CMN to the supplier, the back side of the CMN does not need to be faxed. The supplier is required to be able to provide on request a legible copy of the document that they received from the physician.

For an electronic transmission, the requirements described for fax transmission also applies. Electronic CMNs must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/definitions as printed on the back of the hard copy form. Electronic orders and CMNs must allow the physician to add to or correct information that was entered by the supplier prior to sending it to the physician or that was entered by the physician prior to signing and dating the form. There must be a record of the original information entered and a history of what was changed, by whom, and the date of the change. Electronic orders and CMNs must have an electronic physician signature and a date that is entered by the physician. Each electronic CMN that is sent to a physician by a supplier must include the back page of the CMN. When a physician sends a completed CMN electronically to the supplier, the back page must be attached. The supplier is required to be able to provide on request a legible copy of the document that they received from the physician.

The supplier must have the original or a photocopy, fax, or electronic order and/or CMN in their records before they submit a claim to Medicare. Items provided without a written physician order will be denied as not medically necessary.

Refer to the *DMERC Region D Supplier Manual* for more information on orders and CMNs.

Home Blood Glucose Supplies

Manufacturers of home blood glucose monitors often sell monitoring "kits" which include the home blood glucose monitor and small quantities of starter supplies (e.g., test strips, lancet device with lancets, etc.). Both the monitor and starter supplies are included in the manufacturer's price for these kits. If these monitoring "kits" are provided to Medicare beneficiaries, the starter supplies are considered part of the service of furnishing the monitor. They are not separately payable and should not be billed separately.

Additionally, many manufacturers provide free monitors or free supplies of test strips in return for purchasing their brand of monitor and test strips. This practice is potentially a violation of the Medicare and Medicaid anti-kickback statute. This statute makes it illegal to offer or pay anything of value to induce a person to order any item or service for which payment may be made under the Medicare or Medicaid program. If a supplier receives test strips or monitors free from the manufacturer and provides those items to a Medicare beneficiary, then only those items the supplier paid for can be billed to Medicare and the beneficiary. There cannot be a charge for the item that was provided free of charge by the manufacturer.

A supplier may bill for test strips and other supplies that they themselves package together with the monitor and ship to the beneficiary. However, if any of the items shipped were received by the supplier free of charge they may not be billed.

New Modifier for Rental Items

Effective for dates of service on or after April 1, 2002, a new modifier has been established to indicate billing of durable medical equipment for a partial month of service.

KR Rental Item - billing for partial month

The KR modifier is for use by suppliers who wish to exercise the option of billing Medicare for a partial month(s) of rental on DME. Although suppliers are entitled to bill and receive a full month's reimbursement for rented DME provided to qualifying beneficiaries, suppliers now have the option of billing for a partial month of service and receiving reimbursement on a prorated basis by using the KR modifier.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the HCFA-1500 claim form for each partial month of billing. The modifier "RR," indicating rental, and any other applicable modifiers must also be appended to the claim line for the partial month rental item(s).

Pessary Codes – Change in Jurisdiction

Effective for dates of service on or after January 1, 2002, jurisdiction for processing claims for pessary codes will change from the Durable Medical Equipment Regional Carriers (DMERCs) to the local carriers:

A4561 - Pessary, rubber, any type
A4562 - Pessary, non rubber, any type

Suppliers and physicians should contact the local carrier in their area for instructions on how to submit claims for these items.

Suction Catheters – Oropharyngeal vs. Tracheoesophageal

Claims data analysis in Region D indicates that some suppliers are incorrectly coding suction catheters. HCPCS code A4624 describes a tracheal suction catheter (Illustration A). These are long, flexible catheters typically contained in a sterile package. Suppliers should distinguish code A4624 from an oropharyngeal suction catheter (HCPCS code A4628), commonly referred to as a Yankauer suction tube (Illustration B). These are short, rigid, plastic suction instruments of durable construction. For additional information on the coverage and payment rules, coding and documentation guidelines, suppliers should consult the local medical review policy on Suction Pumps in the *DMERC Region D Supplier Manual*.

Illustration A *Illustration B*

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

Infusion Pump Supplies - Correct Coding and Billing

According to the local medical review policy (LMRP) on External Infusion Pumps, supplies used with an external **insulin** infusion pump (E0784) are billed using HCPCS codes A4221 and A4232. Supplies used with all other types of external infusion pumps (E0779-E0782, E0791, K0455) are billed using codes A4221 and A4222.

Data analysis of claims in Region D indicates that suppliers are receiving a significant percentage of denials for codes A4221 and A4222. In order to bill these codes, supplies must be used with a DME-type pump (i.e,. E0779-E0782, E0784, E0791, or K0455). There is no Medicare benefit for infusion supplies used without a DME-type pump (e.g., gravity infusion or disposable pump); they must be coded A9270. Failure to correctly code these items may result in an incorrect denial type.

When billing supplies (A4221, A4222, and A4232) used with patient-owned DME-type pumps, the supplier should indicate such by noting with the initial claim billed "Patient-owned infusion pump," the date of purchase, manufacturer, make and model of the pump and a

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completed infusion pump CMN or comparable medical necessity information, in the HA0 record of an electronic claim or as an attachment to a hard copy claim.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

For more details on the coverage and payment rules, coding and documentation guidelines, please refer to the LMRP on External Infusion Pumps in the *DMERC Region D Supplier Manual*.

Tracheo-esophageal Voice Prostheses - New HCPCS Codes

Effective for claims with dates of service on or after January 1, 2002, two new codes have been established for tracheo-esophageal voice prostheses:

L8507 Tracheo-esophageal voice prosthesis, patient inserted, any type, each

L8509 Tracheo-esophageal voice prosthesis, inserted by licensed health care provider, any type, each

Claims for these items with dates of service prior to January 1, 2002, must continue to be submitted with the miscellaneous code L8499. The new codes are in the prosthetic devices payment category.

These codes describe small tubes that are placed in a surgically created opening between the trachea and esophagus in selected patients who have had a laryngectomy. The tubes have a one-way valve that allows the flow of air from the trachea, through the tube, and into the esophagus, enabling the patient to speak.

Code L8509 describes a device that is designed to be removed and replaced only by a physician or other health care provider. An example (not all-inclusive) of a product described by this code is the Blom-Singer Indwelling Low Pressure Voice Prosthesis (InHealth Technologies).

Code L8507 describes a device that is designed to be removed and replaced by the patient for cleaning. Even if this type of device is inserted by a physician, code L8507 must be used. Examples (not all-inclusive) of products described by this code are: Blom-Singer Duckbill Voice Prosthesis (InHealth Technologies), Blom-Singer Low Pressure Voice Prosthesis (InHealth Technologies), Ultra Low Resistance Voice Prosthesis (Bivona), Duckbill Voice Prosthesis (Bivona).

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

Nebulizers Policy – New and Revised HCPCS Codes for Drugs

New Codes:

Effective for claims with dates of service on or after January 1, 2002, new HCPCS codes have been established:

J7622 Beclomethasone, inhalation solution administered through DME, unit dose form, per milligram

J7624 Betamethasone, inhalation solution administered through DME, unit dose form, per milligram

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

J7641 Flunisolide, inhalation solution administered through DME, unit dose, per milligram

These medications have been billed using HCPCS code J7699. For dates of service on or after January 1, 2002, they should be billed using the new codes. Under the standard grace period, HCPCS code J7699 (used to bill for the steroid drugs) will continue to be accepted on claims with dates of service on or after January 1, 2002, that are received by March 31, 2002. HCPCS code J7699 should not be used to describe these drugs for claims received on or after April 1, 2002.

Revised Codes:

Effective for claims with dates of service on or after January 1, 2002, the HCPCS codes for concentrated and unit dose albuterol have been revised:

J7618 Albuterol, all formulations, including separated isomers, inhalation solution administered through DME, concentrated form, per 1 mg. (albuterol) or per 0.5 mg (levalbuterol)

J7619 Albuterol, all formulations, including separated isomers, inhalation solution administered through DME, unit dose, per 1 mg. (albuterol) or per 0.5 mg (levalbuterol)

These code revisions were made to accommodate billing for levalbuterol (Xopenex®), a separated isomer of albuterol. Note the change in billing units for both J7618/ J7619 and levalbuterol before and after the January 1, 2002, effective date.

DOS prior to January 1, 2002
1 mg. levalbuterol = 1 unit J7619

DOS on or after January 1, 2002
1 mg. levalbuterol = 2 units J7619

The billing for the standard formulation of albuterol is not affected by this change in code J7618/J7619.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these supply items.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Nebulizers in the *DMERC Region D Supplier Manual*.

Heating Pad – New HCPCS Code

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for an infrared heating pad.

E0221 Infrared heating pad system

Code E0221 is in the inexpensive or routinely purchased payment category. This code includes both the power source and the infrared therapy pads. Manufacturers or suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on whether a particular device meets the definition of this code. Suppliers are reminded that the establishment of a unique code for a particular product does **not** necessarily indicate coverage.

Gastric Suction Pump – New HCPCS Code

Effective for claims with dates of service on or after January 1, 2002, a new HCPCS code has been established for gastric suction pumps.

E2000 Gastric suction pump, home model, portable or stationary, electric

Prior to the establishment of this new code, the gastric suction pump was billed using HCPCS code E1399 (Durable medical equipment, miscellaneous). This pump is used to suction gastrointestinal secretions.

Under the standard grace period, HCPCS code E1399 will continue to be accepted on claims for gastric suction pumps with dates of service on or after January 1, 2002, that are received by March 31, 2002. HCPCS code E1399 should not be used to describe this item for claims received on or after April 1, 2002.

Note that the code for tracheal suction pumps (E0600) has not changed. Items meeting the description of a tracheal suction pump must continue to be billed using HCPCS code E0600.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

Gastrostomy Tubes – New HCPCS Code

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for use with gastrostomy and jejunostomy tubes.

B4086 Gastrostomy/jejunostomy tube, any material, any type, standard or low profile, each

This code is effective for claims with dates of service on or after January 1, 2002, and replaces codes B4084 and B4085. Under the standard grace period, codes B4084 and B4085 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 codes B4084 and B4085 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.

Joint Contracture Devices – New and Revised HCPCS Codes

Several new codes have been established for devices used in the management of joint contractures:

E1801 Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs

E1806 Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs

E1811 Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs

E1816 Bi-directional static progressive stretch ankle device with range of motion adjustment, includes cuffs

E1818 Bi-directional static progressive stretch forearm pronation/supination device with range of motion adjustment, includes cuffs

E1821 Replacement soft interface material/cuffs for bi-directional static progressive stretch device

These codes are effective for dates of service on or after January 1, 2002. Claims for these items for dates of service prior to January 1, 2002, will continue to be billed using code E1800 (elbow), E1805 (wrist), E1810 (knee), E1815 (ankle), E1399 (forearm pronation/ supination), and/or E1820 (soft interface). The new codes are considered durable medical equipment and are in the capped rental payment category (except for code E1821 which is in the inexpensive or routinely purchased category). The rental allowance for codes E1801, E1806, E1811, E1816, and E1818 **includes** cuffs and any other interface material that is needed. Code E1821 would be payable **only** in situations in which a medically necessary device is owned by the patient. Examples of products billed using these codes are the JAS devices by Joint Active Systems. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items. Suppliers are reminded that the establishment of a unique code for a particular product does **not** necessarily indicate coverage or full payment.

Changes have also been made in the related series of codes describing dynamic adjustable extension/flexion devices – E1800, E1805, E1810, E1815, E1825, and E1830. Effective for dates of service on or after January 1, 2002, the phrase "or equal" has been removed from the code narrative and the phrase "includes soft materials" has been added to each code. In addition, a new code has been added effective for dates of service on or after January 1, 2002:

E1840 Dynamic adjustable shoulder flexion/abduction/ rotation device, includes soft interface material

Beginning with dates of service on or after January 1, 2002, the rental allowance for all these codes **includes** the soft interface material. Code E1820 (replacement soft interface material, dynamic adjustable extension/flexion device) is payable **only** in situations in which a medically necessary device is owned by the patient. Examples (not all-inclusive) of products billed using these codes are joint contracture devices manufactured by Dynasplint Systems, Ultraflex, and Empi. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

Lower Limb Prosthetics (Suspension Socket Locking Mechanisms) – HCPCS Code Changes

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for suspension socket locking mechanisms.

L5671 Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert

Also effective for dates of service on or after January 1, 2002, code L5669 (addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism) is discontinued. Items previously coded L5669 should be coded L5660, L5662, L5663, or L5664, whichever is applicable. Under the standard grace period, code L5669 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 L5669 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.

Code L5667 (addition to lower extremity, below knee/ above knee, socket insert, suction suspension with locking mechanism) is also discontinued effective for dates of service on or after January 1, 2002. Items previously coded L5667 should be coded with the combination of L5671 and the HCPCS code describing the applicable suspension socket insert. Under the standard grace period, code L5667 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 L5667 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 Lower Limb Prostheses in the *DMERC Region D Supplier Manual*.

Lower Limb Prostheses (Endoskeletal Systems) – HCPCS Code Changes

Effective for dates of service on or after January 1, 2002, new base codes have been established for lower limb endoskeletal prostheses **without** a soft cover and finishing:

L5301 Below knee, molded socket, shin, SACH foot, endoskeletal system

L5311 Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system

L5321 Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee

L5331 Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot

L5341 Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot

Codes L5300, L5310, L5320, L5330, and L5340, which describe lower limb endoskeletal prostheses **including** a soft cover and finishing, are discontinued effective for dates of service on or after January 1, 2002. Under the standard grace period, these codes 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 these codes 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.

Codes L5704, L5705, L5706, and L5707, which describe custom shaped protective covers, are revised effective for dates of service on or after January 1, 2002, by **deleting** the phrase that restricted their use to replacement only. These codes may now be used for a cover that is provided at the time of initial issue, for a cover that is provided after the delivery of the prosthesis, or when a replacement cover is provided.

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 Lower Limb Prostheses in the *DMERC Region D Supplier Manual.*

Multiple Density Shoe Inserts – New HCPCS Codes

Effective for dates of service on or after January 1, 2002, HCPCS code A5502 (For diabetics only, multiple density insert(s), per shoe) is discontinued and the following HCPCS codes are established for multi-density inserts covered under the therapeutic shoes for diabetics benefit category:

A5509 For diabetics only, direct formed, molded to foot with external heat source (i.e., heat gun) multiple density insert(s), prefabricated, per shoe

A5510 For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s), prefabricated, per shoe

A5511 For diabetics only, custom-molded from model of patient's foot, multiple density insert(s), custom-fabricated, per shoe

Under the standard grace period, code A5502 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 A5502 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 Therapeutic Shoes for Diabetics in the *DMERC Region D Supplier Manual*.

Home Dialysis Supplies and Equipment – New HCPCS Codes

Effective for dates of service on or after January 1, 2002, new HCPCS codes have been established describing individual items used to perform dialysis. Many of these new HCPCS codes will replace HCPCS codes that described "kits" in order to allow billing for individual supply items dispensed to the beneficiary. In addition, several dialysis HCPCS codes are being deleted.

New Codes:

The following HCPCS codes for dialysis supplies and equipment will be effective for claims with dates of service on or after January 1, 2002:

A4651	Calibrated microcapillary tube, each
A4652	Microcapillary tube sealant
A4656	Needle, any size, for dialysis, each
A4657	Syringe, with or without needle, for dialysis, each
A4660	Sphygmomanometer/blood pressure apparatus with cuff and stethoscope for Dialysis
A4663	Blood pressure cuff only, for dialysis
A4670	Automatic blood pressure monitor, for dialysis
A4680	Activated carbon filter for hemodialysis, each
A4690	Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each
A4706	Bicarbonate concentrate, solution, for hemodialysis, per gallon
A4707	Bicarbonate concentrate, powder, for hemodialysis, per packet
A4708	Acetate concentrate, solution, for hemodialysis, per gallon
A4709	Acid concentrate, solution, for hemodialysis, per gallon
A4712	Water, sterile, for injection, for dialysis, per 10 ml
A4714	Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon
A4719	Y set tubing for peritoneal dialysis
A4720	Dialysate solution, any concentration of dextrose, fluid volume greater than 249cc, but less than or equal to 999cc, for peritoneal dialysis
A4721	Dialysate solution, any concentration of dextrose, fluid volume greater than 999cc but less than or equal to 1999cc, for peritoneal dialysis
A4722	Dialysate solution, any concentration of dextrose, fluid volume greater than 1999cc but less than or equal to 2999cc, for peritoneal dialysis
A4723	Dialysate solution, any concentration of dextrose, fluid volume greater than 2999cc but less than or equal to 3999cc, for peritoneal dialysis
A4724	Dialysate solution, any concentration of dextrose, fluid volume greater than 3999cc but less than or equal to 4999cc, for peritoneal dialysis
A4725	Dialysate solution, any concentration of dextrose, fluid volume greater than 4999cc but less than or equal to 5999cc, for peritoneal dialysis
A4726	Dialysate solution, any concentration of dextrose, fluid volume greater than 5999cc, for peritoneal dialysis
A4730	Fistula cannulation set for hemodialysis, each
A4736	Topical anesthetic, for dialysis, per gram
A4737	Injectable anesthetic, for dialysis, per 10 ml
A4740	Shunt accessory, for hemodialysis, any type, each
A4750	Blood tubing, arterial or venous, for hemodialysis, each
A4755	Blood tubing, arterial and venous combined, for hemodialysis, each
A4760	Dialysate solution test kit, for peritoneal dialysis, any type, each
A4765	Dialysate concentrate, powder, additive for peritoneal dialysis, per packet
A4766	Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml
A4770	Blood collection tube, vacuum, for dialysis, per 50
A4771	Serum clotting time tube, for dialysis, per 50
A4772	Blood glucose test strips, for dialysis, per 50
A4773	Occult blood test strips, for dialysis, per 50
A4774	Ammonia test strips, for dialysis, per 50
A4801	Heparin, any type for hemodialysis, per 1,000 units
A4802	Protamine sulfate, for hemodialysis, per 50 mg
A4860	Disposable catheter tips for peritoneal dialysis, per 10
A4870	Plumbing and/or electrical work for home hemodialysis equipment
A4890	Contracts, repair and maintenance, for hemodialysis equipment
A4911	Drain bag/bottle, for dialysis, each
A4913	Miscellaneous dialysis supplies, not otherwise specified

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A4918	Venous pressure clamps, for hemodialysis, each
A4927	Gloves, non-sterile, for dialysis, per 100
A4928	Surgical mask, for dialysis, per 20
A4929	Tourniquet, for dialysis, each
E1500	Centrifuge, for dialysis
E1510	Kidney, dialysate delivery system kidney machine, pump recirculating, air removal system, flowrate meter, power off, heater and temperature control with alarm, IV poles, pressure gauge, concentrate container
E1520	Heparin infusion pump for hemodialysis
E1530	Air bubble detector for hemodialysis, each, replacement
E1540	Pressure alarm for hemodialysis, each, replacement
E1550	Bath conductivity meter for hemodialysis, each
E1560	Blood leak detector for hemodialysis, each, replacement
E1575	Transducer protectors/fluid barriers, for hemodialysis, any size, per 10
E1580	Unipuncture control system for hemodialysis
E1600	Delivery and/or installation charges for hemodialysis equipment
E1610	Reverse osmosis water purification system, for hemodialysis
E1615	Deionizer water purification system, for hemodialysis
E1620	Blood pump for hemodialysis, replacement
E1625	Water softening system, for hemodialysis
E1632	Wearable artificial kidney, each
E1636	Sorbent cartridges, for hemodialysis, per 10
E1637	Hemostats, for dialysis, each
E1638	Heating pad, for peritoneal dialysis, any size, each
E1639	Scale, for dialysis, each
E1699	Dialysis equipment, not otherwise specified

Deleted Codes:

The following HCPCS codes for dialysis supplies and equipment will be deleted for claims with dates of service on or after January 1, 2002:

A4650	Centrifuge (includes microcapillary tubes and sealease)
A4655	Needles and syringes for dialysis
A4700	Standard dialysate solution, each
A4705	Bicarbonate dialysate solution, each
A4735	Local/topical anesthetic for dialysis only
A4780	Sterilizing agent for dialysis equipment, per gallon
A4790	Cleansing agent for equipment for dialysis only
A4800	Heparin for dialysis and antidote, any strength, porcine or beef, up 1,000 units, 10-30 ml (for parenteral use, see code B4216)
A4820	Hemodialysis kit supply
A4850	Hemostats with rubber tips for dialysis
A4880	Storage tank utilized in connection with water purification system, replacement tank for dialysis
A4900	Continuous ambulatory peritoneal dialysis (CAPD) supply kit
A4901	Continuous cycling peritoneal dialysis (CCPD) supply kit
A4905	Intermittent peritoneal dialysis (IPD) supply kit
A4910	Nonmedical supplies for dialysis (i.e., scale, scissors, stop-watch, etc.)
A4912	Gomco drain bottle
A4914	Preparation kit
A4919	Dialyzer holder, each
A4920	Harvard pressure clamp, each
A4921	Measuring cylinder, any size, each
E1640	Replacement components for hemodialysis and/or peritoneal dialysis machines that are owned or being purchased by the patient

Under the standard grace period, deleted HCPCS codes will continue to be accepted on claims with dates of service on or after January 1, 2002, that are received by March 31, 2002. However, deleted HCPCS codes received on claims 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 supply items.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Home Dialysis Supplies and Equipment in the *DMERC Region D Supplier Manual*.

Non-Contact Wound Warming System – New HCPCS Codes

Effective for dates of service on or after January 1, 2002, new HCPCS codes have been established for a non-contact wound warming system.

E0231	Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover.

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E0232 Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover.

A6000 Non-contact wound warming cover for use with the non-contact wound warming device and warming card.

Code E0231 is in the capped rental payment category. Codes E0232 and A6000 are in the durable medical equipment supplies payment category. Suppliers are reminded that the establishment of a unique code for a particular product does **not** necessarily indicate coverage or full payment.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these devices.

Deleted and Crosswalk HCPCS Codes

The following codes will be deleted effective for dates of service on or after January 1, 2002. A 3-month grace period applies to discontinued HCPCS codes. We will accept claims for deleted codes with dates of service on or after January 1, 2002, with dates of receipt on or before March 31, 2002. Deleted codes received on or after April 1, 2002, with a date of service on or after January 1, 2002, will be denied with ANSI codes M51 or B18 (Claim/service denied because this procedure code/ modifier was invalid on the date of service of claim submission. Please resubmit with the correct procedure code). Refer to the *DMERC Region D Supplier Manual*, Chapter 16, HCPCS Coding section for the complete description of these codes.

Deleted Codes With Replacement Codes

Deleted Codes	Replacement (Crosswalk) Codes
A4800	A4801
A4850	E1637
A4912	A4911
A5502	A5509, A5510 or A5511
B4084	B4086
B4085	B4086
E0609	E2100, E2101
L5300	L5301
L5310	L5311
L5320	L5321
L5330	L5331
L5340	L5341
L5669	L5660, L5662, L5663 or L5664
Q0185	J7340

Deleted Codes With No Replacement Codes

A4329	A4650	A4655	A4700	A4705	A4735
A4780	A4790	A4820	A4880	A4900	A4901
A4905	A4910	A4914	A4919	A4920	A4921
A5064	A5074	A5075	A9190	E0753	E1640
E1900	J0340	J0400	J0510	J0590	J0695
J0730	J0810	J1090	J1362	J1690	J1739
J1741	J1930	J1970	J2240	J2330	J2350
J2480	J2512	J2640	J2675	J2860	J2970
J3080	J3270	J3390	J3450	J7315	L5667

New Codes For 2002

The following new codes are effective for dates of services on or after January 1, 2002. If you bill these codes for dates of service prior to January 1, 2002, they will be denied as invalid codes.

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

A4360 Adult incontinence garment (e.g., brief, diaper), each

A4651 Calibrated microcapillary tube, each

A4652 Microcapillary tube sealant

A4656 Needle, any size, for dialysis, each

A4657 Syringe, with or without needle, for dialysis, each

A4706 Bicarbonate concentrate, solution, for hemodialysis, per gallon

A4707 Bicarbonate concentrate, powder, for hemodialysis, per packet

A4708 Acetate concentrate solution, for hemodialysis, per gallon

A4709 Acid concentrate, solution, for hemodialysis, per gallon

A4719 Y set tubing for peritoneal dialysis

A4720 Dialysate solution, any concentration of dextrose, fluid volume greater than 249cc, but less than or equal to 999cc, for peritoneal dialysis

A4721 Dialysate solution, any concentration of dextrose, fluid volume greater than 999cc, but less than or equal to 1999cc, for peritoneal dialysis

A4722 Dialysate solution, any concentration of dextrose, fluid volume greater than 1999cc, but less than or equal to 2999cc, for peritoneal dialysis

A4723 Dialysate solution, any concentration of dextrose, fluid volume greater than 2999cc, but less than or equal to 3999cc, for peritoneal dialysis

A4724	Dialysate solution, any concentration of dextrose, fluid volume greater than 3999cc, but less than or equal to 4999cc, for peritoneal dialysis
A4725	Dialysate solution, any concentration of dextrose, fluid volume greater than 4999cc, but less than or equal to 5999cc, for peritoneal dialysis
A4726	Dialysate solution, any concentration of dextrose, fluid volume greater than 5999cc, for peritoneal dialysis
A4736	Topical anesthetic, for dialysis, per gram
A4737	Injectable anesthetic, for dialysis, per 10 ml
A4766	Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml
A4801	Heparin, any type for hemodialysis, per 1000 units
A4802	Protamine sulfate, for hemodialysis, per 50 mg
A4911	Drain bag/bottle, for dialysis, each
A4928	Surgical mask, for dialysis, per 20
A4929	Tourniquet for dialysis, each
A5509	For diabetics only, direct formed, molded to foot with external heat source (i.e., heat gun) multiple density insert(s), prefabricated, per shoe
A5510	For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe
A5511	For diabetics only, custom-molded from model of patient's foot, multiple density insert(s), custom-fabricated, per shoe
A6000	Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card
A6010	Collagen based wound filler, dry form, per gram of collagen
B4086	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each
E0169	Commode chair with seat lift mechanism
E0221	Infrared heating pad system
E0231	Non-contact wound warming device (temperature control unit, AC adapter a and power cord) for use with warming card and wound cover
E0232	Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover
E0316	Safety enclosure frame/canopy for use with hospital bed, any type
E0481	Intrapulmonary percussive ventilation system and related accessories
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0603	Breast pump, electric (AC and/or DC), any type
E0604	Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC)
E0620	Skin piercing device for collection of capillary blood, laser, each
E1500	Centrifuge, for dialysis
E1637	Hemostats, for dialysis, each
E1638	Heating pad, for peritoneal dialysis, any size, each
E1639	Scale, for dialysis, each
E1801	Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs
E1806	Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs
E1811	Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs
E1816	Bi-directional static progressive stretch ankle device with range of motion adjustment, includes cuffs
E1818	Bi-directional static progressive stretch forearm pronation/supination device with range of motion adjustment, includes cuffs
E1821	Replacement soft interface material/cuffs for bi-directional static progressive stretch device
E1840	Dynamic adjustable shoulder flexion/abduction/ rotation device, includes soft interface material
E1902	Communication board, non-electronic augmentation or alternative communication device
E2000	Gastric suction pump, home model, portable or stationary, electric
E2100	Blood glucose monitor with integrated voice synthesizer
E2101	Blood glucose monitor with integrated lancing/ blood sample
J0587	Botulinum toxin type B, per 100 units
J0692	Injection, cefepime hydrochloride, 500 mg
J0706	Injection, caffeine citrate, 5 mg
J0744	Injection, ciprofloxacin for intravenous infusion, 200 mg
J1056	Injection, medroxyprogesterone acetate/ estradiol cypionate, 5 mg/25 mg
J1270	Injection, doxercalciferol, 1 mcg
J1590	Injection, gatifloxacin, 10 mg

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J1655	Injection, tinzaparin sodium, 1000 IU
J1755	Injection, iron sucrose, 20 mg
J1835	Injection, itroconazole, 50 mg
J2020	Injection, linezolid, 200 mg
J2940	Injection, somatrem, 1 mg
J2941	Injection, somatropin, 1 mg
J3100	Injection, tenecteplase, 50 mg
J3395	Injection, verteporfin, 15 mg
J7193	Factor IX (antihemophilic factor, purified, non-recombinant) per I.U.
J7195	Factor IX (antihemophilic factor, recombinant) per I.U.
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7308	Aminolevulinic acid HCL for topical administration, 20%, single unit dosage form (354 mg)
J7316	Sodium hyaluronate, 5 mg for intra-articular injection
J7340	Dermal and epidermal, tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter
J7511	Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral 25 mg
J7622	Beclomethasone, inhalation solution administered through DME, unit dose form, per milligram
J7624	Betamethasone, inhalation solution administered through DME, unit dose form, per milligram
J7626	Budesonide inhalation solution, administered through DME, unit dose form 0.25 mg
J7641	Flunisolide, inhalation solution, administered through DME, unit dose, per milligram
J9017	Arsenic trioxide, 1 mg
J9300	Gemtuzumab ozogamicin, 5 mg
L0321	TLSO, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0331	TLSO, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0391	TLSO, anterior-posterior-lateral-rotary control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0561	LSO, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated
L0986	Addition to spinal orthosis, rigid or semi-rigid abdominal panel, prefabricated
L1005	Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L2768	Orthotic side bar disconnect device, per bar
L3677	Shoulder orthosis, hard plastic, shoulder stabilizer, pre-fabricated, includes fitting and adjustment
L5301	Below knee, molded socket, shin, sach foot, endoskeletal system
L5311	Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot, endoskeletal system
L5321	Above knee, molded socket, open end, sach foot, endoskeletal system, single axis knee
L5331	Hip disarticulation, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot
L5341	Hemipelvectomy, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot
L5671	Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert
L5847	Addition, endoskeletal knee-shin system, microprocessor control feature, stance phase
L5989	Addition to lower extremity prosthesis, endoskeletal system, pylon with integrated electronic force sensors
L5990	Addition to lower extremity prosthesis, user adjustable heel height
L6881	Automatic grasp feature, addition to upper limb prosthetic terminal device
L6882	Microprocessor control feature, addition to upper limb prosthetic terminal device
L8001	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral
L8002	Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral
L8505	Artificial larynx replacement battery/accessory, any type
L8507	Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509	Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type
L8510	Voice amplifier

Verbiage Changes For 2002

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2002. Refer to the *DMERC Region D Supplier Manual*, Chapter 16, HCPCS Coding section for the new verbiage.

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A4351	A4352	A4358	A4660	A4663	A4670
A4680	A4690	A4712	A4714	A4730	A4740
A4750	A4755	A4760	A4765	A4770	A4771
A4772	A4773	A4774	A4860	A4870	A4890
A4913	A4918	A4927	A6196	A6197	A6198
A6199	E0600	E0602	E1520	E1530	E1540
E1550	E1560	E1575	E1580	E1600	E1610
E1615	E1620	E1625	E1632	E1636	E1699
E1800	E1805	E1810	E1815	E1820	E1825
E1830	J2993	J7504	J7618	J7619	K0184
K0541	L0100	L0110	L0515	L1510	L1930
L1940	L2415	L2755	L4000	L4396	L5704
L5705	L5706	L5707			

Reminder – 2002 Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

As mandated by the Balanced Budget Refinement Act of 1999, the fee schedule for DME will be receiving a temporary increase of 0.6 percent for 2002. In accordance with § 1833(o)(2) of the Social Security Act, this 0.6 percent temporary increase for 2002 also applies to the national limit for therapeutic shoes. Because this 0.6 percent increase applies only to 2002, it is not to be carried over into future years (e.g., 2003, 2004).

As mandated by the Balanced Budget Act of 1997, the fee schedule for surgical dressings, ostomy supplies, tracheostomy supplies, and urologicals are to be frozen for 2002. The fee schedule for prosthetic and orthotic devices (excluding ostomy supplies, tracheostomy supplies and urologicals) will be increased by 1 percent for 2002.

The fee schedule for 2002 will be available on CIGNA Medicare's Web site at www.cignamedicare.com. If you do not have access to the Internet, you can request a copy of the fee schedule using the DMERC Region D Publication Order Form provided at the back of this newsletter.

Pricing Changes to Dynamic and Bi-Directional Devices

Medicare payment for DME capped rental items includes payment for any essential accessories. Effective January 1, 2002, the HCPCS description of codes E1800-E1818, E1825 and E1830 have been modified to include the interface material. The 2002 fee schedule for codes E1800 - E1818, E1825 and E1830 have been updated to include payment for the interface material accessory codes E1820 and E1821. Separate payment for interface material (E1820 and E1821) will only be considered for coverage as a replacement item for beneficiary owned equipment (codes E1800-E1818, E1825 and E1830).

Parenteral and Enteral Nutrition (PEN/ENT) Items and Services are Now Fee Schedule

CMS, as authorized by §4315 of the Balanced Budget Act of 1997, has implemented a fee schedule for parenteral (PEN) and enteral nutrition (ENT) items and services. These items and services were previously paid on a reasonable charge basis. The 2002 fee schedule for PEN/ENT codes will be available through the CMS Web site (www.hcfa.gov/stats/pufiles.htm) or CIGNA Medicare's Web site (www.cignamedicare.com). If you do not have access to the Internet, you can request a copy of the fee schedule using the DMERC Region D Publication Order Form provided at the back of this newsletter.

Elimination of DMEPOS Fee Schedules for Labor Component of Repair Codes

Codes E1340, L4205, L7520, and L8049 have been removed from the national/regional fee schedule. Effective for services furnished on or after January 1, 2002, we will revert back to the payment method (gap filling) in use prior to the establishment of the fee schedules for these codes.

Clinical Trials Routine Care Services – Diagnosis Coding Instructions

Effective for dates of service on or after January 1, 2002, providers must use the procedure code modifier "QV" to identify and report routine care for Medicare qualifying clinical trial services. The use of the "QV" modifier serves as the provider's attestation that a service, supply or equipment meets the Medicare qualifying coverage criteria for clinical trial services. In addition, the reporting of diagnosis code V70.5 as a secondary diagnosis will no longer be required as of this date.

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One exception to this billing requirement is for items or services rendered on or after January 1, 2002, to healthy, control group volunteers as part of a qualifying diagnostic clinical trial. Routine care of healthy, control group, volunteers enrolled in a qualifying diagnostic clinical trial must be coded and billed in the following manner:

1. The "QV" modifier must be reported at the line item level; and
2. Diagnosis code V70.7 (Examination of participant in clinical trial) must be reported as the **primary diagnosis** for applicable line items on the HCFA-1500 form or electronic claim equivalent.

Only claims utilizing the "QV" modifier and the diagnosis code V70.7 as the **primary diagnosis** will be considered as services or items rendered to healthy, control group, diagnostic trial volunteers.

Providers submitting claims for routine items and services furnished to beneficiaries in qualifying clinical trials should include information in the beneficiary's medical record about the clinical trial such as: the trial name, sponsor and sponsor-assigned protocol number. This information should not be routinely submitted with the claim but should be provided upon request for medical review. A copy of routine items and services provided should also be maintained and provided to medical review upon request.

Annual Update of Non-Routine Medical Supply and Therapy Codes for Home Health Consolidated Billing (CB)

The non-routine medical supplies subject to home health consolidated billing for dates of service January 1, 2002, through December 31, 2002, are as follows:

A4212 A4310 A4311 A4312 A4313 A4314 A4315 A4316 A4319 A4320 A4321 A4322 A4323 A4324 A4325 A4326 A4327 A4328 A4330 A4331 A4332 A4333 A4334 A4335 A4338 A4340 A4344 A4346 A4347 A4348 A4351 A4352 A4353 A4354 A4355 A4356 A4357 A4358 A4359 A4361 A4362 A4364 A4365 A4367 A4368 A4369 A4370 A4371 A4372 A4373 A4374 A4375 A4376 A4377 A4378 A4379 A4380 A4381 A4382 A4383 A4384 A4385 A4386 A4387 A4388 A4389 A4390 A4391 A4392 A4393 A4394 A4395 A4396 A4397 A4398 A4399 A4400 A4402 A4404 A4421 A4455 A4460 A4462 A4481 A4622 A4623 A4625 A4626 A4649 A5051 A5052 A5053 A5054 A5055 A5061 A5062 A5063 A5071 A5072 A5073 A5081 A5082 A5093 A5102 A5105 A5112 A5113 A5114 A5119 A5121 A5122 A5123 A5126 A5131 A6010 A6020 A6021 A6022 A6023 A6024 A6154 A6196 A6197 A6198 A6199 A6200 A6201 A6202 A6203 A6204 A6205 A6206 A6207 A6208 A6209 A6210 A6211 A6212 A6213 A6214 A6215 A6219 A6220 A6221 A6222 A6223 A6224 A6228 A6229 A6230 A6231 A6232 A6233 A6234 A6235 A6236 A6237 A6238 A6239 A6240 A6241 A6242 A6243 A6244 A6245 A6246 A6247 A6248 A6251 A6252 A6253 A6254 A6255 A6256 A6257 A6258 A6259 A6261 A6262 A6266 A6402 A6403 A6404 A6405 A6406 A7501 A7502 A7503 A7504 A7505 A7506 A7507 A7508 A7509

New code subject to CB for 2002:

A6010 Collagen based wound filler, dry foam

Discontinued code for 2002, no longer subject to CB:

A4329 External catheter start set

Reimbursement for these codes is included in the home health claim billed by the home health agency to the Regional Home Health Intermediary (RHHI) if the beneficiary has a home health plan of care episode. The DMERC will deny these codes if the date of service is within the home health claim dates. If the home health claim has not been billed, the DMERC will pay these codes conditionally. Once the home health claim is billed, a request will be sent to recover any money paid with dates of service within the RHHI claim dates.

New Procedures to Use the ABN Form for DMEPOS Upgrades

An Advance Beneficiary Notice (ABN) is a written notice you can give to a Medicare beneficiary before you provide a beneficiary an item or service that you expect Medicare will deny for the following reasons:

- lack of medical necessity
- prohibited, unsolicited telephone contacts
- no supplier number
- an item that you submitted for an Advance Determination of Medicare Coverage (ADMC) where the DMERC denied the ADMC request

The purpose of an ABN is to inform the beneficiary that Medicare will probably not pay for a certain item or service on a certain occasion, even if Medicare might pay for the item or service under different circumstances. This allows the beneficiary to make an informed consumer decision on whether or not to receive the items or services, for which he/she may have to pay out of pocket or through other insurance.

DMEPOS suppliers have been using an ABN form (HCFA-R-131) when they expect that Medicare may not pay for an item. The Office of Management and Budget (OMB) recently cleared a new, optional ABN form (CMS-R-131-G) that you can also use for the same purpose. You can get copies of this form online at: http://www.hcfa.gov/medicare/bni/.

For example, you may think that the DMERC will determine that the item is not medically necessary, or that the quantities of an item exceed the quantity that Medicare allows. On the ABN, you must specify the item in sufficient detail, so the beneficiary can understand what Medicare will not pay for and the reason Medicare won't pay for it. You may not simply give ABNs to every Medicare beneficiary you serve, unless there is a specific reason (e.g., you only sell items that Medicare never covers) why you feel Medicare will deny payment. Statements such as "I never know when Medicare will pay" are not acceptable on ABNs.

Upgrades

Medicare will accept ABNs on upgrades. For Medicare purposes, CMS defines an upgrade as an item that is more expensive, deluxe, or containing excess components, quantity, or features than **what the physician ordered**. The upgraded item may be from one HCPCS code to another, or within the same HCPCS code. However, the upgraded item must be within the range of services that are appropriate for the beneficiary's medical condition. For example, the beneficiary can upgrade from a standard manual wheelchair to an ultralightweight wheelchair, but not from a cane to a wheelchair. The choice to upgrade lies with the beneficiary.

CMS is not including items that a physician ordered, but which the supplier believes to be more than what Medicare considers medically necessary. You may still use an ABN in this situation, but must continue to follow the current operating procedures for ABNs that are already in place, and bill them as you have billed them in the past (i.e., bill the item that the physician ordered on one line with the GA modifier).

If a beneficiary signs an ABN, you may collect the difference between the charges for the upgraded item and the charges for the non-upgraded item from the beneficiary.

In some cases, you may choose to provide an upgrade for a beneficiary for free (e.g., to lower costs by maintaining an inventory of only one type of manual wheelchair that can supply all of your manual wheelchair needs). When providing a free upgrade, you do not need to have the beneficiary sign an ABN, because you will not be charging them for anything above their normal deductible and co-payment for the non-upgraded item.

ABNs for upgrades can apply to both assigned and unassigned claims.

Billing Claims for Dates of Service Before April 1, 2002

To provide a free upgrade: Bill for the non-upgraded item. You don't need to use any modifiers, but you need to describe the upgraded item in Line 19 of the HCFA-1500/CMS-1500, or the HA0 record on an electronic claim.

To charge for the difference between the Medicare allowed for a non-upgraded item and an upgrade: Bill for the upgraded item with a GA modifier.

Billing Claims for Dates of Service April 1, 2002 and Later

To provide a free upgrade: Use the correct HCPCS code for the non-upgraded item that the physician ordered. You must only charge for the non-upgraded item. Use a GL modifier with the code. In item 19 of the claim, or as an attachment to the claim, specify the make and model of the upgraded item you actually furnished, and describe why this item is an upgrade (e.g., you provided an ultralight wheelchair when the physician ordered a standard wheelchair).

To charge for the difference between the Medicare allowed for a non-upgraded item and an upgrade: You need to bill two lines on your claim. You must bill the upgraded item that you provided to the beneficiary on the first line, with a GA or GZ modifier. Use the GA modifier if the beneficiary signed the form, and the GZ if you did not get an ABN that the beneficiary signed.

On the next line, bill for the item the physician ordered. Use a GK modifier on this line. If you are upgrading from one item to another within the same HCPCS code, this will be the same code you put on line 1, but with a different charge amount.

You must bill both lines sequentially and on the same claim. You may include more than one upgraded item on a claim, as well as any other items for which you use an ABN. However, for items where you provide an upgrade, you must bill the non-upgraded item on the line immediately following the upgraded item.

You must use the full charge on the claim for both the non-upgraded and the upgraded items. Do not calculate the difference between the non-upgraded item and the upgrade yourself.

Noncovered Items, Not Medically Necessary Items, and Advance Beneficiary Notices – New Modifiers

Noncovered Items

Effective for dates of service on or after January 1, 2002, a new modifier has been established to describe situations in which an item or service with a specific code is noncovered.

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

The GY modifier replaces the current ZY modifier for dates of service on or after January 1, 2002. The ZY modifier should continue to be used for claims with dates of service on or before December 31, 2001, regardless of the date of submission. Under the standard grace period, the ZY modifier 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 the ZY 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.

Also, effective for dates of service on or after January 1, 2002, the GX modifier is no longer valid for services not covered by Medicare.

It is important to distinguish situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit from those situations in which at item is denied because it is not reasonable and necessary (see below). Some examples of statutorily excluded items or situations include, but are not limited to:

- Hearing aids
- Eyeglasses or contact lenses – except those provided following cataract removal or other cause of aphakia
- Durable medical equipment and related accessories and supplies provided to patients in nursing facilities
- Dental items
- Personal comfort items
- Orthopedic shoes or shoe inserts – other than those covered under the therapeutic shoes for diabetics benefit or those that are attached to a covered leg brace
- Replacement of items that have not reached their useful lifetime and were not lost, stolen, or irreparably damaged (not including ordinary wear and tear)

A description of the statutory benefits can be found in the *DMERC Region D Supplier Manual*, Chapter 9 – General Medical Policy Information, page 3. Some examples of items or situations which do not meet the definition of a Medicare benefit include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition
- Enteral nutrients that are administered orally
- Infusion drugs that are not administered through a durable infusion pump
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin
- Irrigation supplies that are used to irrigate the skin or wounds
- Immunosuppressive drugs when they are used for conditions other than following organ transplants
- Most oral drugs
- Oral anticancer drugs when there is no injectable or infusion form of the drug or when used for a condition other than cancer
- Nondurable items (that are not covered under any other benefit category) – e.g., compression stockings and sleeves
- Durable items that are not primarily designed to serve a medical purpose – e.g., exercise equipment

Use of the GY modifier is usually limited to situations in which there is a specific HCPCS code to describe the item or service. If there is no specific HCPCS code to describe the item or service, then code A9270 (Noncovered item or service) is usually used. The GY modifier should generally not be used with a "miscellaneous" or "not otherwise classified" code – e.g., E1399. The GY modifier is not needed with code A9270. Code A9270 must not be used in situations in which an item is expected to be denied as not reasonable and necessary (see below).

An Advance Beneficiary Notice (ABN) is not required for items that are statutorily excluded from coverage or that do not meet the definition of any Medicare benefit category since the DMERC does not make limitation of liability determinations for these types of denials.

Not Medically Necessary Items

Effective for dates of service on or after January 1, 2002, a new modifier, GZ, has been established to describe certain situations in which an item or service is expected to be denied as not medically necessary. The new modifier will complement the existing GA modifier which is used in other situations in which an item or service is expected to be denied as not medically necessary.

GZ Item or service expected to be denied as not reasonable and necessary (Used when an Advance Beneficiary Notice is **not** on file)

GA Waiver of liability statement on file (Used when an item or service is expected to be denied as not reasonable and necessary and an Advance Beneficiary Notice **is** on file)

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It is important to distinguish situations in which an item is denied because it is not reasonable and necessary from those situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit (see above). Some examples of items or situations which are medical necessity denials include, but are not limited to:

- Items which are not ordered by a physician or qualified nurse practitioner, clinical nurse specialist, or physician assistant
- Items which do not meet medical necessity coverage criteria or frequency guidelines specified in national or DMERC local medical review policies (LMRPs)
- Items which are the same as or similar to covered items that the beneficiary is already using
- Items whose safety and effectiveness in the home setting has not been established
- Experimental or investigational items - other than Category B IDE devices and items included under clinical trial coverage

A GZ or GA modifier can be used on either a specific or a miscellaneous HCPCS code. It would never be correct to place both modifiers on the same claim line. If both modifiers are used on the same claim line, it will be rejected or denied as invalid coding.

Replacement of Capped Rental Items

If a capped rental item of equipment has been in continuous use by the patient, on either a rental or purchase basis, for the equipment's useful lifetime or if the item is lost or irreparably damaged, the patient may elect to obtain a new piece of equipment. If the patient elects to obtain a new piece of equipment, payment is made on a rental or purchase basis or a lump-sum purchase basis if a purchase agreement has been entered into. Expenses for replacement required because of loss or irreparable damage will be reimbursed without a physician's order if the equipment as originally ordered still fills the patient's medical need. However, claims involving replacement equipment necessitated because of wear or change in the patient's condition must have a current physician's order.

Claims filed for the lump-sum purchase of the replacement item must be billed using E1399RP with the following documentation:

1. Manufacturer's name for both the original piece of equipment and the replacement equipment

2. Product name for both the original piece of equipment and the replacement equipment

3. Date of purchase for the original piece of equipment

4. A detailed explanation of why the original piece of equipment needs to be replaced

   For example:

   a. When indicating replacement due to irreparable damage, indicate how the item was damaged (fire, flood, etc.)

   b. When indicating replacement due to loss, indicate the nature of the loss (theft, fire, etc.)

   c. When indicating replacement due to useful lifetime and cost of repairs, include an itemized breakdown of the estimated repairs necessary to return the original piece of equipment to working order with an explanation of why you feel this piece of equipment has exceeded it's useful lifetime.

Please include any documentation that may be beneficial in the coverage determination such as police, fire, or accident reports.

Sending and Receiving Confidential Information via the Internet

Maintaining the confidentiality of personal and sensitive information is a critical responsibility for CIGNA Medicare. Beneficiaries and suppliers, including electronic billers, expect us to share and store information in a way that protects privacy and prevents misuse of their information.

As usage of the Internet increases, CIGNA Medicare has witnessed certain confidential beneficiary and supplier information being sent via the Internet. CIGNA Medicare has determined that, without encryption, e-mail is not a secure method to communicate sensitive and personal information.

Suppliers should not include Medicare, Social Security, or National Supplier Clearinghouse (NSC) numbers, personal medical information, or other confidential items regarding the Medicare beneficiary and/or supplier in any e-mail inquiry.

Effective immediately, CIGNA Medicare will delete, or replace with asterisks, all sensitive and personal information prior to sending e-mails via the Internet. This includes information contained in the original incoming e-mail as well as information in CIGNA Medicare's response. For example, physician names,

addresses, social security numbers, Medicare numbers, supplier numbers, Login IDs (Stratus numbers), and submitter numbers are all samples of confidential and personal information.

We will be happy to provide or accept secure information via fax, telephone or voice mail, U.S. mail, or common carrier, given that the CIGNA HealthCare Medicare Administration's confidentiality policy and applicable law permits this disclosure. We are requesting that you inform us of which method you would prefer. We hope that you will recognize our efforts to maintain your confidentiality, and like us, will view this as a positive step to protect your confidential information from unauthorized disclosure.

Recent Improvements to Interactive Voice Response System (IVR)

Enhancements have recently been made to our Interactive Voice Response (IVR) System to improve the quality and quantity of information you may receive. These enhancements include the addition of a new option (option 3) to the main menu, which provides the elements and proper party for a review. Detailed information on a line-by-line basis has also been added to the claim status option, which provides a more detailed overview of your claim including the reason for a denial on a line level. You can check not only multiple Medicare numbers but also multiple supplier numbers without having to hang up and call back. Our IVR has an outstanding check option that allows you to check the date and amount of any outstanding Medicare checks on file for your supplier number(s). To improve the quality and availability of our IVR, a new server has recently been installed.

Remember that there is no limit to the number of claims you can check in the IVR so give it a try! Please let us know if you have any suggestions for improvement (e.g., other information you would like to have available through the IVR). Your comments, suggestions, or questions about using the IVR may be directed to any of our customer service representatives. Copies of the supplier IVR script are available upon request.

Current features of the IVR:

- Claim Status Inquiry – pending, denied, paid and/or applied to deductible
- Line-by-line explanation of the payment/denial
- Appeal rights for denied claims
- Multiple Medicare numbers
- Multiple supplier numbers
- Ordering DMERC publications (*DMERC Region D Supplier Manual*, Region D *DMERC Dialogue*, DMEPOS Fee Schedule)
- Information about appeal rights
- Current deductible information (available to participating suppliers)
- Duplicate payment reports
- Review request by telephone
- New legislation and supplier issues
- Educational seminar information
- Allowable information
- Outstanding check information

Simple claim status inquiries should be conducted through our IVR system. Our customer service representatives are available Monday - Friday from 8:00 AM - 6:00 PM (CST) for more complex inquiries.

Spring 2002 "Medicare 101" Web-based Seminars

Coming soon to a computer near you... CIGNA Medicare Region D DMERC presents, "Medicare 101," an introduction to the basics of Medicare. Instead of traveling to select locations, we will be holding our seminars on the Web. A flyer with registration and seminar information will be sent to your mailbox and be available on our Web site (visit www.cignamedicare.com and click on **Workshops**). Notification will also be provided via CIGNA Medicare's Electronic Mailing List.

DMERC Region D Supplier Manual on the Web

CIGNA Medicare Region D DMERC is pleased to announce the HTML conversion of the *DMERC Region D Supplier Manual* on the Web (www.cignamedicare.com/dmerc/). Previously, the supplier manual was available only in PDF format for viewing and downloading. This conversion allows quicker access to specific information as well as search capability and hyperlinks to other important information and Web sites. If you have questions or comments about the site, please let us know through our Online Help Center.

Time Limit for Filing Claims

Claims for services provided between October 1, 1999, and September 30, 2000, must be received at the carrier by December 31, 2001. 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 accompanying update to the *DMERC Region D Supplier Manual* (Chapter 6, pages 16-18) for information about the SOI.

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From The Edge

Join CIGNA Medicare's Electronic Mailing List

Now you can have EDI information delivered right to your e-mail's Inbox ...

CIGNA Medicare is pleased to announce its new electronic mailing list. This list provides you with timely notice of information and provides easy links to your specified area(s) of interest. Information is delivered directly to your e-mail's Inbox as new information is available.

A membership application is available via CIGNA Medicare's Web site and there is no charge for joining. Simply access the CIGNA Medicare Web site, and follow these steps to become a member:

1. Go to www.cignamedicare.com and click on **"Join Now"** in the red box announcing the application.

2. Enter e-mail address information and select the preferred contract. Indicate special interests from the options provided by selecting one or all of the following: Publications, EDI, Workshops and Education, and Medical Review Policies.

Once you submit your application, you will automatically receive a welcome message to confirm your membership. Additionally, members who select EDI as a specific interest will be included in the distribution of messages about system updates, new EDI information, as well as the announcement of new issues of the *EDI Edge* newsletter once available on the Web site.

We are pleased to offer this customized service as a benefit to our customers. This is an opportunity to improve communication, convenience, and efficiency in your business. ***Join now!***

The Testing Process – 837 Claims Transaction

The following steps outline the testing process for the ANSI X12N 4010 837 Health Care Claim transaction. Please refer to a previous article "HIPAA EDI Transaction Testing" published in the Fall 2001 *DMERC Dialogue*, page 7, for an overview of EDI submitter testing.

1. **Contact CIGNA Medicare when you are ready** to test. Be prepared to provide your Submitter ID (the number beginning A08, B08, C08, or D08), your Stratus mailbox number (the number beginning with MB), the name of your software vendor (including software name and version number), and the date you would like to test. **The phone number to reach the ANSI 4010 transaction support line is 866.224.3094, option 4.**
2. A new Stratus mailbox number will be issued to your company. This number will be mailed to your company along with a new EDI Manual. Once this number is received, you can start sending your test claims.
3. Create **at least 10 test claims** using your ANSI software. We recommend testing as many different business scenarios as you can in order to gauge your software's compatibility with your line of business.
4. Dial into the Stratus Network. Be sure to login in with your new Stratus mailbox number.
5. Before you can upload your ANSI test claims, you must first follow the steps below. These instructions can also be found in Chapter 5 of your EDI Manual.
   a. Select option 1 (Mailbox Access Facility).
   b. Change Stratus Data Type.
      1. Select option 1 (Change Data Type).
      2. Select option 7 (SEND_ANSITEST).
6. Upload your test claims.
   a. Select option 6 (Upload: Put a file in Mailbox) from the Mailbox Access Facility screen.
7. Approximately two hours after you have successfully uploaded your test claims, you will then be able to download a 997 Functional Acknowledgement report. This will indicate if your test file was accepted (passed) or rejected (failed) during Phase I of the testing process. In order to download the 997 Functional Acknowledgement report, you must:
   a. Select option 1 (Change Data Type) from Mailbox Access Facility screen.
   b. Select option 6 (RECEIVE_ACK).
8. Download your 997 Functional Acknowledgement report.
   a. Select option 5 (Download: Get a file from Mailbox)

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9. Review your 997 Functional Acknowledgement report. An example of this report can be found in Chapter 6 of your EDI Manual.
   a. If an **"R"** (Rejected) is present in AK901, this means your Phase I test failed. You will need to correct the errors shown on the 997 and resubmit the test file.
   b. If an **"A"** (Accepted) is present in AK901, this means you have successfully passed Phase I and your test will automatically move into Phase II.

   The results of your Phase II test will be available for you to download within two hours. We recommend downloading these results as they will familiarize you with the Electronic Report Package you will receive once you begin submitting production claims.
10. To download your Phase II results:
    a. Select option 1 (Change Data Type) from the Mailbox Access Facility screen.
    b. Select option 8 (RECEIVE_ ANSITEST).
    c. Select option 5 (Download: Get a file from Mailbox)

Review your Phase II test results. An example of this report can be found in Chapter 6 of your EDI Manual. You will be notified of your Phase II test results by telephone within **3 - 10 business days**. If your Phase II test scored below 90 percent accuracy, an EDI Representative will go over the errors with you. Correct the errors and resubmit your ANSI 4010 test file. If you pass with a score of 90 percent or greater, the EDI Representative will let you know you are ready to begin submitting your ANSI claims into the production region. A letter, indicating a successful Phase II test outcome, will be sent to your company.

If you have any questions regarding the testing procedure, please call the ANSI 4010 transaction support line at 866.224.3094, option 4.

Resolving CMN Rejections

The Certificate of Medical Necessity (CMN) reject report appears at the end of the Electronic Receipt Listing (ERL) and lists claims with rejected CMNs. Rejected CMNs have a four-digit reject code. It is possible a claim will be accepted into our processing system, but the CMN may still be rejected. The rejection codes and explanations may be found in Chapter 15 of your EDI Manual. Please update your manual with the information contained in this article.

Many CMNs are rejected simply because they are not completed properly. Here are some tips to help ensure your CMNs are completed correctly. In addition, these simple guidelines may help prevent ANSI Code B17 claim denials.

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

Tip #2: Review CMNs before transmitting with any claims. CMNs should only be transmitted when needed and not with every claim. Following are some questions to consider before transmitting claims:

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

The following are definitions of the CMN reject error codes, what causes that rejection, and suggestions for resolving the rejection. In order to obtain information regarding CMNs on file and the dates listed, CIGNA Medicare suggests contacting the beneficiary, the ordering physician and/or the previous supplier. A final option is to have the beneficiary utilize the toll-free line (800.899.7095) to inquire about previous services. CIGNA Medicare is unable to release specific information to a supplier until they have filed a claim. Once a claim has been received for the item indicated on the CMN reject report, the supplier may contact the Public Relations department toll-free at 866.224.3094, **option 3**.

If the claim has been denied with ANSI code M3 (Equipment is the same or similar to equipment already being used), CIGNA Medicare is unable to release any information to a supplier. The beneficiary will need to contact the Customer Service department toll-free at 800.899.7095.

The six valid error codes for CMN rejections are as follows:

Error Code 3030
Edit Description INIT DATE DUP
Edit Explanation The initial CMN transmitted electronically has the same initial date as the original CMN on file for this procedure code. This error occurs when a duplicate initial CMN was transmitted. An initial CMN should be transmitted only with the initial claim for that item.

For example, a claim is transmitted for a wheelchair with a date of service of 01/14/01, along with an initial CMN with an initial date of 01/14/01. The following month a claim is transmitted with the date of service 02/14/01,

along with the same CMN previously transmitted with an initial date of 01/14/01. Since CIGNA Medicare already has the first initial CMN with an initial date of 01/14/01, the duplicate CMN would be rejected with an error code of 3030.

Resolution: Suppliers should check their software to make sure that a CMN will be transmitted only when necessary. Remember to only transmit a CMN when necessary and not with every subsequent claim.

Error Code 3031
Edit Description INIT DATE < PREV END DATE
Edit Explanation The initial CMN transmitted electronically has an initial date that is prior to the end date of the original CMN on file for the same procedure code. This error most often occurs when a beneficiary changes suppliers for rental equipment. The initial CMN was already on file from the original supplier and then another initial CMN was transmitted either by the same supplier or subsequent supplier. CMNs are categorized in our system by beneficiary not supplier.

For example, ABC Oxygen transmits an initial oxygen CMN for Jane Doe with an initial date of 06/01/00, for a 12-month length of need. On 09/01/00, Jane Doe changes suppliers and XYZ Oxygen transmits an initial oxygen CMN with an initial date of 09/01/00. The CMN from XYZ Oxygen would be rejected with an error code of 3031 because the initial oxygen CMN from ABC Oxygen is not scheduled to end until 06/01/01.

Resolution: In the example above, the therapy for the oxygen starts with the initial date the beneficiary needed the oxygen. Therefore, even if a beneficiary changes suppliers assuming the medical need has not ended, the initial date of therapy has not changed. The subsequent supplier should have obtained a revised CMN. The revised date would be the date the new supplier took over the services for the beneficiary. If the oxygen order is the same, the CMN does not have to be transmitted with the claim. However, the subsequent supplier would need to furnish the revised CMN upon request from the DMERC.

If a change occurred in the medical condition of the beneficiary that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended, the supplier should obtain a new initial CMN. An explanation is needed to document this change in medical condition stating why a new medical need is being established. This CMN would need to be submitted on paper with the documentation for the break of medical necessity. In this case, the CMN cannot be transmitted electronically.

Error Code 3032
Edit Description CUR REC/REV DATE <= PREV
Edit Explanation The recertification or revised CMN transmitted electronically has a recertification or revised date that is prior to or the same as the recertification or revised date on the CMN on file for this procedure code for this beneficiary. This error most often occurs when duplicate recertification or revised CMNs are transmitted, or when recertification or revised CMNs are transmitted out of order.

For example, The Enteral Company transmits a revised CMN with an 08/01/00, date for procedure code B4150 (enteral formula). The CMN is transmitted electronically and posted to CIGNA Medicare's CMN files. Then, a day or more later, The Enteral Company realizes they have a revised CMN with a date of 07/01/00, for B4150. The Enteral Company transmits the revised CMN for 07/01/00. This CMN rejects with edit 3032 because CIGNA Medicare has already posted the CMN with the revised date of 08/01/00.

Resolution: Make sure CMNs are transmitted in sequence. If you receive this error and the claim was processed and paid incorrectly due to the wrong CMN for that date of service, request a review. If the claim was processed and payment was not made, submit the claim and recertification or revised CMN to Nashville on paper for processing. CMNs cannot be transmitted electronically once the recertification or revised CMN has been transmitted out of sequence.

Error Code 3047
Edit Description RCT/REV INIT DATE INVALID
Edit Explanation The recertification or revised CMN transmitted electronically has an initial date that is not the same as the initial date on the initial CMN currently on file for the same procedure code.

For example, CIGNA Medicare already has an initial CMN for a hospital bed set up with an initial date of 06/01/01, sent in by either Company A or Company B. A revised CMN for 09/01/01, is transmitted by Company B and the initial date is 06/11/01. This would cause a 3047 CMN reject error code since CIGNA Medicare has on file an initial date of 06/01/01.

Resolution: Verify the initial date transmitted with the initial date on the CMN you have in your files. Contact the beneficiary, physician, and/or other supplier and if it still cannot be resolved call the Public Relations department in Boise.

Error Code 3048
Edit Description CANNOT REC/REV DISC
Edit Explanation The recertification or revised CMN transmitted electronically cannot be accepted for this procedure code. The initial CMN on file for this procedure code has been discontinued. Any CMN in a discontinued status cannot be recertified or revised.

For example, if a beneficiary had been renting a K0001 wheelchair and then their medical need changed and now they qualified for a K0011 wheelchair. CIGNA Medicare would set the K0001 CMN to be discontinued.

Resolution: If this happens, contact the beneficiary, physician, and/or other supplier. Check your own files and if it still cannot be resolved, call the Public Relations department in Boise.

Error Code 3052
Edit Description CMN CLSD-NO REV
Edit Explanation The revision CMN that was transmitted electronically cannot be accepted for this procedure code. The CMN on file for this procedure code has been closed. Any CMN in a closed status cannot be revised.

For example, if the item was an inexpensive or routinely purchased piece of durable medical equipment such as a Power Operated Vehicle (POV) and it had reached the purchased price, CIGNA Medicare would close the CMN since the maximum allowed had been paid. Another example would be if a beneficiary chose the purchase option for a capped rental item. In this instance, the equipment would belong to the beneficiary in the 14th month and further payment would not be due.

Resolution: Contact the beneficiary, physician, and/or other supplier. Check your files to see how many months the beneficiary rented the item or if the beneficiary purchased at initial issuance. If still cannot be resolved, all the Public Relations department in Boise.

Claim Status Inquiry and HIPAA

As a part of the implementation of the HIPAA administrative simplification provisions, the 276/277 has been named under part 162 of title 45 of the Code of Federal Regulations as the Electronic Data Interchange (EDI) standard for Health Care Claim Status Request/ Response. Suppliers who wish to utilize the ANSI X12N version 4010 276/277 transaction for their claim status inquiry should contact the EDI department. We will begin accepting requests to migrate and/or test the ANSI X12N version 4010 276/277 transaction April 2002 (tentative). As of October 16, 2002 no other electronic format will be allowed for this transaction.

How it Works

The 276 transaction sent to CIGNA Medicare by a supplier includes information that is necessary for us to identify the specific claim in question. The primary, or unique, identifying elements must be supplied in order to obtain an exact match. However, when the requester does not know the unique elements, the claim can generally be located by supplying several parameters including the provider number, patient identifier, dates of service, and submitted charges from the original claims. CIGNA Medicare will use the 277 Health Care Claim Status Response to transmit the current status within the adjudication process to the entity sending the 276 Health Care Claim Status Request. If the 276 request does not uniquely identify the claim within CIGNA Medicare's processing system, the response may include multiple claims that meet the identification parameters supplied by the requestor.

CSI Testing

Though not required, testing will be available on or about April 1, 2002. During the testing process, CIGNA Medicare will assist in identifying and resolving Medicare-specific formatting and data requirement issues before any actual production requests are transmitted. There is no charge for this testing. Due to the large number of providers/suppliers, agents, billing services, clearinghouses, and trading partners to be tested and the number of standard transactions that are to be implemented, it will not be feasible to test each entity during the last quarter of the transition process. We cannot guarantee testing by the end of September 2002 for any entities that delay testing late in the transition period. We encourage everyone to test as early in the transition period as possible.

Clearinghouses

Suppliers who wish to contract with a clearinghouse to translate the claim status information into the X12N 276 format, must furnish that clearinghouse all data required by X12N 276 version 4010. Anyone that elects to use a clearinghouse for translation services is liable for the associated costs.

CIGNA Medicare's Migration

At this time, CIGNA Medicare is evaluating the current Claim Status Inquiry feature available through the use of AT&T Passport for Windows software. The interactive voice response (IVR) is not impacted by this requirement and will still be available after the October 2002 implementation date of the HIPAA transactions.

We will continue to provide more information regarding HIPAA transactions and specifics about our Claim Status Inquiry program utilizing AT&T Passport of Windows and the AT&T Global Network as it becomes available. Check future issues of this publication as well as our Web site, www.cignamedicare.com, to obtain the most up-to-date information. For complete information about the X12N 276/277 version 4010, the implementation guide may be downloaded free of charge from www.wpc-edi.com/hipaa.

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Newsletters issued after March 1999 are available at no-cost from our website at www.cignamedicare.com.

Clip and Save for Physician Education

Completion of Medicare Certificates of Medical Necessity

Dear Physician:

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

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

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

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

Sincerely,

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

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Newsletters issued after March 1999 are available at no-cost from our website at www.cignamedicare.com.

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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 Central Time, Monday through Friday.

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

Written Inquiries
CIGNA DMERC — Region D
PO Box 690
Nashville TN 37202

Paper Claim Submission — Use PO Box 690 (NOTE: The previously published state-specific PO Boxes have been discontinued. Send all Medicare claim submissions and correspondence to PO Box 690.)

Review/Hearing Submission
DMERC Reviews
CIGNA HealthCare Medicare Administration
PO Box 22995
Nashville TN 37202

DMERC Hearings
CIGNA HealthCare Medicare Administration
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
P. O. Box 100142
Columbia, SC 29202-3142 (Phone: 866.238.9652)

Also, remember that no checks will be issued if the PAY TO 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 and Refunds — When refunding a check, make it payable to CGLIC—Medicare and send it to:
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Newark NJ 07193–0927

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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.

DMERC Dialogue – Winter 2002

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