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S P E C I A L N O T I C E

DMERC Quarterly Publications

Enclosed is the Summer 2002 Region D *DMERC Dialogue.* The quarterly update to the *DMERC Region D Supplier Manual* is usually mailed with the *DMERC Dialogue*; however, the supplier manual updates will not be mailed and will only be available on the CIGNA Medicare Web site. The Summer 2002 *DMERC Region D Supplier Manual* updates can be accessed and downloaded from the CIGNA Medicare Web site at www.cignamedicare.com/dmerc/dmsm/index.html. The Fall 2002 *DMERC Dialogue* and Fall 2002 *DMERC Region D Supplier Manual* updates will also not be mailed. They will be available approximately September 16 for access and download on the CIGNA Medicare Web site.

Visit ***What's New*** on the Web at www.cignamedicare.com/dmerc/ for information concerning changes in regulations issued between publication releases. You may also elect to receive notification of additions to the Web site and other late-breaking news by subscribing to the CIGNA Medicare electronic mailing list (List Server) at www.cignamedicare.com/mailer/subscribe.asp.

DMERC Dialogue

DMERC Region D

CIGNA HealthCare Medicare Administration

CMS CENTERS for MEDICARE & MEDICAID SERVICES

General Release 02-2

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

Summer 2002 (July)

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From the Medical Director...

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Documentation Requirements For Power Operated Vehicles (POVs) - Region D Change

In 1997, a *DMERC Dialogue* article was published instructing suppliers that additional documentation must be submitted with all POV claims (*DMERC Dialogue,* July 1997, page 1). Effective for claims received on or after May 1, 2002, those instructions are rescinded and CIGNA Medicare will no longer require additional documentation to be submitted with every POV claim.

Suppliers are reminded that a POV is covered when all of the following criteria are met:

1) The patient's condition is such that without the use of a wheelchair the patient would not be able to move around in their residence; and

2) The patient is unable to operate a manual wheelchair; and

3) The patient is capable of safely operating the controls for the POV; and

4) The patient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV; and

5) It is ordered by a physician who is one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. Exceptions: When such a specialist is not reasonably accessible (e.g., more than one day's round trip from the beneficiary's home or the patient's condition precludes such travel), an order from the beneficiary's physician may be acceptable.

A POV will be denied as not medically necessary when it is needed only for use outside the home. A POV that is beneficial primarily in allowing the patient to perform leisure or recreational activities will be denied as not medically necessary.

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Reminders. . .

- Suppliers must accept assignment for all claims for Medicare covered drugs. (Effective for dates of service on or after February 1, 2001.) - *§114, Benefits Improvement and Protection Act (BIPA)*

- Suppliers are required to submit claims and span dates of service on all claims, assigned or nonassigned, for diabetic supplies. (Effective beginning with dates of service April 1, 2002.) - *CMS Program Memorandum, Transmittal B-01-74.*

Effective for claims received on or after May 1, 2002, CIGNA Medicare will focus additional documentation requests, based on data analysis, on those claims where information indicates that coverage criteria for a POV may not have been met. Suppliers receiving additional documentation development letters should respond by forwarding the information requested in the letter. Suppliers are responsible for providing additional documentation requested by the DMERC, even if the claim is billed unassigned. If the additional documentation requested is not provided, the claim will be denied as not medically necessary.

MEDICAL POLICY

Continuous Positive Airway Pressure (CPAP) System Policy

A revision is being made in the CPAP policy that was published in the April 2002 *DMERC Region D Supplier Manual* update. In the Coverage and Payment Rules section under Initial Coverage, the fifth paragraph is revised to say:

"For the purpose of this policy, polysomnographic studies must not be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

The effective date of the policy remains the same – i.e., dates of service on or after July 1, 2002.

Home Blood Glucose Monitor Supply Claims And Spanned Dates

As stated in the Spring 2002 *DMERC Dialogue*, effective for dates of service April 1, 2002 and after, supplies for blood glucose monitors must be billed using "From" and "To" dates, or spanned dates. The following addresses issues that have arisen since implementation.

Test strips/lancets: When a supplier provides 100 glucose monitor test strips (A4253) or lancets (A4259) for a beneficiary who tests once a day, or 300 to a beneficiary who tests three times a day, the supplier may bill this as a 3 month supply rather than billing as a 100 day supply. For example, if the test strips/lancets are provided on April 15, 2002, claim dates will be spanned from April 15, 2002 through July 14, 2002.

Calibration solution: To span dates for calibration solution (A4256), the supplier may use the date of ser-

vice and the shelf life of the solution to determine the "To" date. For example, if calibration solution with an opened shelf life of 6 months was provided on June 21, 2002, the "From" date would be June 21 and the "To" date would be December 20, 2002.

Excess quantities: The DMERC frequently finds that the number of supplies billed on one or more claims exceeds the number of items we would generally expect the beneficiary to need over the period of time indicated by the claim(s). To be assured of prompt, appropriate payment, suppliers must provide an explanation of the beneficiary's need for additional quantities.

Refills: A beneficiary or the beneficiary's caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance.

When the beneficiary has requested a refill, the DMERC recognizes that suppliers may need to deliver or ship supplies a couple of days before the beneficiary actually needs them. We recognize that this will cause some claims to have overlapping dates of service and will be taken into consideration when processing claims with spanned dates. Suppliers should not refuse to provide supplies merely on the basis that the beneficiary's stock is not completely exhausted.

Home Blood Glucose Monitors – Policy Revision

Effective for dates of service on or after January 1, 2002, the paragraph and table in the Coding Guidelines section of the Home Blood Glucose Monitors local medical review policy (LMRP) dealing with bundling of accessories and supplies (Column I and Column II) is being deleted. This policy change will be reflected in a revision of the LMRP to be published at a later date.

Several suppliers and manufacturers have contacted the DMERCs to obtain clarification of the instructions contained in that article. Specifically, suppliers want guidance on how to bill for supplies that are not included with the starter kits at the time of initial monitor issue.

Answer: A supplier may bill for testing accessories such as test strips and other supplies that they themselves package together with the monitor and ship to the beneficiary. However, items that are received by the supplier free of charge (such as those items included in "starter kits") must not be billed to Medicare or charged to the beneficiary.

Suppliers may bill for medically necessary supplies and accessories provided at the time of initial issue as long as they incurred a cost in purchasing them. For example: A beneficiary purchases a new blood glucose monitor that includes a small number of test strips and lancing devices. However, there are only enough strips and lancets to perform about a week of testing so the beneficiary also purchases a box of 50 test strips, 100 lancets and two vials of control solution. In this example, the supplier may bill Medicare for the monitor, the box of 50 test strips, 100 lancets and the two vials of control solution. The supplier must not bill for the small number of test strips and lancing devices that were obtained free of charge from the manufacturer in exchange for buying the manufacturer's monitor.

Refer to the local medical review policy on Home Blood Glucose Monitors in the *DMERC Region D Supplier Manual* for additional information regarding coverage and payment rules and coding guidelines for these items.

Intrapulmonary Percussive Ventilation (IPV) System – New Policy

In the Summer 2002 *DMERC Region D Supplier Manual* update, a new local medical review policy (LMRP) on Intrapulmonary Percussive Ventilation (IPV) Systems is being published. The policy was developed in conjunction with the establishment of a HCPCS code for this item, E0481 (Intrapulmonary percussive ventilation system and related accessories).

The new LMRP reflects Medicare's National Coverage Determination in the *Coverage Issues Manual* §60-21 that this device is not covered. The effective date of the new policy is for claims with dates of service on or after July 1, 2002.

Non-Contact Normothermic Wound Therapy (NNWT) - Coverage Issues Manual Update

The *Coverage Issues Manual* has been updated with a new section, §60-25, to reflect a noncoverage decision on Non-Contact Normothermic Wound Therapy (NNWT). The Centers for Medicare & Medicaid Services' (CMS) National Coverage Determination (NCD) states there is insufficient scientific or clinical evidence

to consider this device as reasonable and necessary within the meaning of §1862(a)(1)(A) of the Social Security Act. Therefore, effective for dates of service on or after July 1, 2002, NNWT will be denied as not medically necessary. Individual consideration will be applied to claims with dates of service (DOS) on or before June 30, 2002.

NNWT is a device reported to promote wound healing by warming a wound to a predetermined temperature. New codes were issued for NNWT effective for dates of service on or after January 1, 2002:

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

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

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

NCDs are binding on all Medicare Carriers, Intermediaries, Peer Review Organizations, Administrative Law Judges, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on a Medicare +Choice Organization.

Respiratory Assist Devices - Policy Republication

In the Spring 2002 *DMERC Region D Supplier Manual* update, the local medical review policy (LMRP) on Respiratory Assist Devices was republished. This revision of the policy contained an error in the Documentation section; therefore, it is being corrected and the Documentation section pages republished in the Summer 2002 supplier manual update. The effective date of the revised policy remains July 1, 2002.

The corrected policy states: "Where permitted, the KX [modifier] must be added to codes K0532, K0533, and codes for accessories used with K0532."

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

Supplier Manual Policy Revisions

Revisions of the following policies are included in the Summer 2002 *DMERC Region D Supplier Manual* update. The revisions include all changes to HCPCS codes and modifiers and any other information that has been included in bulletins since the policy was last published. A brief summary of the major changes in each policy is described. Suppliers are advised to review each policy for complete details.

Commodes
(Effective for date of service (DOS) on or after July 1, 2002)

- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

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

- Revised language regarding who is a qualified provider of polysomnographic studies.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

Epoetin
(Effective for DOS on or after October 1, 2002)

- Updated the target hematocrit range to 33 – 36% (this is already in effect).
- Added a requirement to use ICD-9 code V45.1 if the patient is on Method II home hemodialysis.
- Replaced the ZX modifier with KX. Even though the effective date of the policy revision is October 1, 2002, the KX modifier should be used in place of the ZX modifier (as described in the current policy) beginning with DOS on or after July 1, 2002.
- Effective for dates of service on or after October 1, 2002, required that KX modifier be used on every claim for EPO if policy criteria are met.
- Eliminated use of the EJ modifier with subsequent EPO claims.

Facial Prostheses
(Effective for DOS on or after July 1, 2002)

- Added codes A4364, A4365, K0572, K0573, L8040-L8049.
- Deleted codes K0440-K0449, K0265, K0450, K0451.
- Added LT and RT modifiers.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

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

- Incorporated information from Fall 2001 bulletin article about when a new DMERC Information Form (DIF) is not required.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

Negative Pressure Wound Therapy Pumps
(Effective for DOS on or after July 1, 2002)

- Staging of pressure ulcers revised under Definition section.
- Coverage and Payment Rules section E deleted which is no longer applicable at this time.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.
- Replaced ZX modifier with KX modifier.

Orthopedic Footwear
(Effective for DOS on or after July 1, 2002)

- Replaced the ZX modifier with KX.
- Updated the codes for therapeutic shoes for diabetics.
- Added SADMERC reference with paragraph referring to SADMERC Web site under Coding Guidelines.

Osteogenesis Stimulators
(Effective for DOS on or after July 1, 2002)

- Replaced ZX modifier with KX modifier.
- Added SADMERC reference with paragraph referring to SADMERC Web site under Coding Guidelines.

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

- Added codes K0561-K0580.
- HCPCS codes A4368, A4370, A4374, A4386, A5061, A5123, A6265 become invalid for DMERC submission.
- Definitions expanded to include new code features.
- Specific diagnoses for certain products removed from policy.
- Billing instructions included in coverage and payment rules when using K0561-K0580.
- Usual Maximum Quantity of Supplies table updated and crosswalked to appropriate new codes.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

Pressure Reducing Support Surfaces-Group 1
(Effective for DOS on or after July 1, 2002)

- Changed ZX modifier to KX.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

Pressure Reducing Support Surfaces-Group 2
(Effective for DOS on or after July 1, 2002)

- Staging of pressure ulcers revised under Definition section.
- Changed ZX modifier to KX, including all references in policy.
- Replaced SADMERC reference with paragraph referring to SADMERC Web site.

Refractive Lenses
(Effective for DOS on or after July 1, 2002)

- Replaced ZX modifier with KX modifier.
- Added definition of progressive lenses (V2781).
- Removed requirement for UV lenses (V2755) to be justified by additional documentation.
- Defined when the RT and LT modifiers must be used.
- Allowed either a narrative diagnosis or ICD-9 diagnosis on the physician order.

Speech Generating Devices
(Effective for DOS on or after July 1, 2002)

- Replaced the ZX modifier with KX modifier.
- Corrected typographical error in Coding Guidelines instructing the use of code K0547 for mounting hardware instead of K0546.

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

- Replaced the ZX modifier with KX.
- Instructed suppliers to check the SADMERC Web site to identify products that are correctly coded as E0147 and revised the documentation requirements for this code.

COVERAGE AND BILLING

Abdominal Binders (A4462) vs. Abdominal Supports (L0900-L0960)

In the Spring 2002 *DMERC Dialogue* (page 10), notice was given of coverage for rib belts and "abdominal binders." The incorrect code (A4462) was listed for the

items being referenced. A4462 (Abdominal dressing holder/binder, each) refers to binders that hold surgical dressings on an abdominal wound. These should be distinguished from abdominal supports that are covered under the brace benefit and are coded with HCPCS codes in the L0900-L0960 series.

Beneficiaries Previously Enrolled In Managed Care Who Return To Traditional Fee-For-Service

When a beneficiary who was previously enrolled in a Medicare HMO/managed care program returns to traditional fee-for-service (FFS), he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. When a beneficiary returns to FFS, it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may only continue to receive these items and services if they are entitled to them under Medicare FFS coverage criteria and documentation requirements.

A partial exception to this rule involves home oxygen claims, effective July 1, 2002. If a beneficiary was started on oxygen while under a Medicare HMO, when the beneficiary returns to FFS, the supplier must obtain an initial CMN and submit it to the DMERC at the time that FFS coverage begins. However, the beneficiary does not have to obtain the required blood gas study within 30 days prior to the initial date on the CMN. The test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or managed care plan no longer participates in the Medicare +Choice program.

Billing Of DMEPOS With Chiropractors As Referring Physician

Suppliers are reminded of a longstanding Medicare regulation that items and services ordered by chiropractors are statutorily excluded from Medicare coverage. The *Medicare Carriers Manual* §2251 states that Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation. No other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is covered.

Based on data analysis, Region D has identified numerous claims with a referring chiropractor UPIN (Unique Physician Identification Number). In accordance with the findings of this widespread billing problem, Region D will edit for claims for DMEPOS items with chiropractors listed as the referring UPIN received on or after September 1, 2002, and deny them as statutorily noncovered (Social Security Act §1861(r)(5)). Previously paid claims for DMEPOS items ordered by chiropractors may be selected for postpayment review and denied similarly. Suppliers are urged to voluntarily refund Medicare for payment received for items ordered by chiropractors (see *DMERC Region D Supplier Manual*, Chapter 12, and the article on page 15 of this *DMERC Dialogue* for voluntary refund instructions.)

Billing Of Home Dialysis Supplies Codes For Non-Dialysis Beneficiaries

Certain supplies codes are to be used only to bill for supplies used for home dialysis. These codes must not be used to bill for supplies used by beneficiaries who are not receiving home dialysis. The following codes have been identified as being billed incorrectly:

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

A4927 - Gloves, non-sterile, for dialysis, per 100

Blood pressure equipment used for non-dialysis beneficiaries must be coded E1399 (Durable medical equipment, miscellaneous). Disposable gloves used for non-dialysis beneficiaries must be coded A9270 (Noncovered item or service).

Effectively immediately, when dialysis supplies codes are billed for non-dialysis beneficiaries, assigned claims will be rejected and unassigned claims will be denied for incorrect coding. Suppliers should refer to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Web site or contact the SADMERC for guidance on the correct coding for these items.

Billing Reminder

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

CMS 1500 Claim Form

The Health Care Financing Administration (HCFA) has changed its name to Centers for Medicare & Medicaid Services (CMS). As a result, the Agency forms will also be changed to reflect the new name. As stock of each form is depleted, new forms will be printed replacing all HCFA references with CMS.

As part of the preliminary phase, the HCFA-1500 (12-90) form has been changed to the CMS-1500 (12-90) form. Both the HCFA and CMS versions are acceptable for claim submission until further notice. You may obtain an electronic copy of the CMS-1500 (12-90) form, as well as access other forms issued by CMS, at www.cms.hhs.gov/forms.

Correct Use Of RT And LT Modifiers

Certain local medical review policies (LMRPs) require the use of RT (right side) and LT (left side) modifiers. Correct use of these modifiers is important to assure that suppliers are paid correctly. Generally, when an item is provided for one side and a like item is not provided for the other side on the same date, the appropriate modifier, LT or RT, should be used. When the same item (code) is provided for both sides on the same date, the combined modifiers, LTRT, must be used on the same line of the claim form with two units of service. Individual exceptions to this coding guideline (e.g., Therapeutic Shoes for Diabetics) may be noted in the Coding Guidelines sections of individual LMRPs.

Suppliers are reminded that when an LMRP specifies the use of these modifiers, they must be used or the claim line(s) will be rejected if the claim is assigned or denied for incorrect coding if the claim is unassigned. Assigned claims must be corrected and resubmitted. Unassigned claims may also be corrected and resubmitted. The following LMRPs currently require the use of the LT/RT modifier:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- External Breast Prosthesis
- Facial Prostheses
- Lower Limb Prostheses
- Orthopedic Footwear
- Refractive Lenses
- Therapeutic Shoes for Diabetics
- Wheelchair Options/Accessories

Past payment for incorrectly billed codes is not an assurance that future claims will be paid when not coded correctly. Edits for correct coding of breast prostheses were implemented with the April 1, 2002 effective date of the revised LMRP. Additional claim edits for other LMRPs will be implemented for claims received on or after September 1, 2002. In the meantime, if you bill for any of these items, you should take steps to assure that your billing software and/or billers are prepared to handle this requirement.

See also the April 1998 Region D *DMERC Dialogue*, page 6, article entitled "RT/LT Modifiers Requirement."

Home Dialysis Emergency Supplies

Medicare beneficiaries who chose Method II home dialysis treatment may receive a one month reserve of the supplies used with dialysis. The reserve supplies are covered in addition to the regular monthly supplies provided. When billing for the reserve supplies, add modifier EM to the HCPCS code for the item provided. This modifier may not be used on dialysis equipment. This is a one-time benefit for covered dialysis patients. Emergency dialysis supplies must be billed on one claim to avoid unnecessary denials.

Medicare Carriers Manual (MCM) Revision To Section 2010.2 And Section 3005

MCM, Section 2010.2

Effective for claims received on or after October 1, 2002, the word "same" is not acceptable for item 32 of the HCFA-1500 claim form. For item 32, enter the name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.

Claims received on or after October 1, 2002, that do not meet the above requirement will be denied with ANSI code 16 and remark MA114.

MCM, Section 3005

- The name of this section has been changed from

Incomplete or Invalid Claims to Unprocessable Claims.
- The terms "reject" and "return/reject" were replaced with "return."
- A sentence was added indicating this section applies to assigned claims.
- All references to HCFA-1500 have been changed to CMS-1500 to reflect the change of the agency's acronym.
- Item 32 was revised to correspond with the revision of section 2010.2.

Medicare Carriers Manual (MCM) Rules For Maintenance And Servicing Claims

"DMEPOS suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six months have passed from the end of the final paid rental month. (See §5102.1.E.4.) Furthermore, DMEPOS suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself." - MCM 3010.D

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

New National Drug Code (NDC) Numbers For Methotrexate

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

Methotrexate, 5 mg, oral (NDC #00555-0927-01)
Methotrexate, 7.5 mg, oral (NDC #00555-0928-01)
Methotrexate, 10 mg, oral (NDC #00555-0929-01)
Methotrexate, 15 mg, oral (NDC #00555-0945-01)

These numbers are valid for claims received on or after April 30, 2002.

Submission Of Additional Information For Code K0010

In the Winter 1998 *DMERC Dialogue*, an article was published instructing suppliers billing code K0010 (Standard-weight frame motorized/power wheelchair) to provide the manufacturer's name, model number, and pricing information. Effective July 1, 2002, this information is no longer required.

HCPCS UPDATES

Use Of KX Modifier With Code L0430

In the Winter 2000 *DMERC Dialogue*, an article was published announcing that the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) was developing a product classification list for code L0430 (TLSO, anterior-posterior-lateral control [body jacket], with interface material, custom fitted). Manufacturers were instructed to contact the SADMERC for a coding determination if they believed their product(s) meet the definition of code L0430. To date, the following products have been reviewed by the SADMERC and coded L0430:

Johnson's Orthopedic Design T.L.S.O.

Camp Healthcare TLSO Jacket (Model 8262S and 8262F)

Only those products appearing on the SADMERC product classification list may be coded L0430. Effective for dates of service on or after October 1, 2002, suppliers billing code L0430 must include a KX modifier if the specific product being delivered to the beneficiary appears on the SADMERC product classification list for code L0430. Claim lines for code L0430 billed without a KX modifier will be rejected if the claim is assigned or denied for incorrect coding if the claim is unassigned. Assigned claims must be corrected and resubmitted. Unassigned claims may also be corrected and resubmitted.

Suppliers wanting to know which products have been coded L0430 by the SADMERC should consult the SADMERC Web site at http://www.palmettogba.com (Link to: Other Partners/SADMERC) or call the SADMERC Helpline at 877.735.1326.

FEE SCHEDULE

Correction To The 2002 Fee Schedule

The following TLSO (Thoracic-lumbar-sacral-orthoses) code fees were updated in our system on May 8, 2002. The new fees apply to claims processed or adjusted on or after that date.

TLSO Code Fees

States	L0321	L0331	L0391
AK	425.31	494.27	620.05
AZ	425.31	494.27	620.05
CA	425.31	494.27	620.05
HI	425.31	494.27	620.05
IA	433.62	503.92	632.19
ID	425.31	494.27	620.05
KS	433.62	503.92	632.19
MO	433.62	503.92	632.19
MT	440.52	511.95	642.24
ND	440.52	511.95	642.24
NE	433.62	503.92	632.19
NV	425.31	494.27	620.05
OR	425.31	494.27	620.05
SD	440.52	511.95	642.24
UT	440.52	511.95	642.24
WA	425.31	494.27	620.05
WY	440.52	511.95	642.24

Third Quarter 2002 Fee Schedule Update

New Ostomv Codes (effective 4/1/02)	Fee Schedule
K0561	3.36
K0562	5.68
K0563	8.91
K0564	*IC
K0565	6.15
K0566	8.94
K0567	2.57
K0568	3.74
K0569	5.44
K0570	4.89
K0571	5.93
K0572	.09
K0573	.36
K0574	.46
K0575	.28
K0576	.28
K0577	.28
K0578	.53
K0579	.12
K0580	.35

*Individual consideration.

ELECTRONIC DATA INTERCHANGE (EDI)

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

Changes To Claim Status Inquiry

Effective April 1, 2002, some of the screens in the Claim Status Inquiry (CSI) product will be changing. These changes are necessary in order to make the current online CSI product compliant with the requirements set forth by the Transactions and Code Sets Final Rule (a rule that comes from the Health Insurance Portability and Accountability Act, or HIPAA). These changes ensure that the information suppliers view in the online CSI product is consistent with the information received when using the new HIPAA-required 276/277 batch claim status inquiry transaction.

These changes include adding information to the screens such as:

- Beneficiary's date of birth
- Beneficiary's sex
- Pay type – EFT, check or non-payment
- 277 category code and verbiage *
- 277 claim status code and verbiage *
- Line item control number

*A complete list of the category and status codes can be viewed on the WPC Web site at www.wpc-edi.com.

One important change in the online CSI product's Provider Pending Inquiry System (EMCI) is that the use of the word "**all**" in the HICN field will no longer be valid. This feature was removed because there is not an equivalent search value in the 276/277 batch CSI transaction.

The EDI Department has updated the Claim Status Inquiry manual to reflect the changes to this system and they will be mailed to all CSI users by April 1, 2002. In addition, the manual may be found at www.cignamedicare.com/edi under the Products & Services page. If you have any questions regarding these changes, or would like more information regarding either of the Claim Status Inquiry products (online or 276/277 batch), please contact the EDI Department.

NSC Update

Recently, the National Supplier Clearinghouse (NSC) revised their form (CMS-855S) for Medicare supplier re-enrollment and new enrollment. During this time, there was a paragraph added to section 9 that stated, "A copy of all **EDI** agreements between the clearinghouse(s) and the DMERC(s) **must** be submitted with this application." This was inserted into the application in error. Below is an excerpt from the *NSC News* 2002 Winter newsletter which explains this error:

> "The NSC does not process EDI agreements and so it is not necessary to submit them with the application form when you re-enroll. **Please do not contact your DMERC for a copy of your contract to submit with your application form.**"

To read the article from the NSC in its entirety please visit their Web site at http://www.PalmettoGBA.com, then access Providers, National Supplier Clearinghouse, Newsletters, 2002 Winter NSC Newsletter (First Quarter), View Attachments and 2002 Winter.pdf. The article is located on page 2.

If you have any questions regarding this form or any other issue associated with your supplier re-enrollment, please contact the NSC at 866.238.9652.

Purchase Additional/Replacment EDI Materials

In an effort to better serve your needs, the EDI Department gives submitters the opportunity to purchase additional/replacement EDI materials such as manuals, diskettes, and CDs. Effective July 1, 2002, we have a new price schedule for purchasing replacement items. The latest order form is located in the back of this newsletter for your convenience.

Question 9 On A Manual Wheelchair Certificate Of Medical Necessity (CMN) For Electronic Submission

Physicians should pay close attention to the left column which identifies the item being addressed in Section B of the Manual Wheelchair CMN 02.03B. This column explains which questions need to be answered according to the item(s) ordered by the physician. If the patient is receiving only a K0001 manual wheelchair and no other options and/or accessories, only question 1 must be answered. However, if a physician answers question 8, then question 9 must also be answered. When transmitting electronically, it would be appropriate for the supplier to enter "D" for "does not apply" in question 9, if the physician answered question 8 and left question 9 blank. These instructions only apply to question 9 of the manual wheelchair CMN.

Update: Revised Vendor List Published

The 2002 Certified and Select Certified Vendor Lists, developed in conjunction with Regions A, C and D DMERCs, have been revised. Please go to www.cignamedicare/edi to download the most current version.

Utilizing The X12N 837 (Version 4010) When Submitting Medicare Secondary Payer (MSP) Claims

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physician and suppliers request a one year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the OTAF (Obligated to Accept as Payment in Full) amount. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When you migrate to the X12N 4010 837, you must use the line level contract information (CN1) segment to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available.

The chart below identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

For questions on OTAF, allowed, and approved amounts, please contact Customer Service at 877.320.0390. For questions on completing the fields in your software, please contact your software vendor.

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None
Line Primary Payer Allowed Amount	2-475-AMT02 AMT01= B6	FB0-06	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2-475-AMT02 AMT01=CT	FA0-48	2400 CN102 CN101 = 09	None

HIPAA

HIPAA Quick Reference

The Centers for Medicare & Medicaid Services (CMS) has published many Program Memoranda regarding the Health Insurance Portability and Accountability Act (HIPAA). For your reference, below is a list of these Program Memoranda, as well as a short description of each. These are available on the CMS Web site at http://www.hcfa.gov/medicare/edi/hipaadoc.htm.

Program Memorandum	Description
PM B-00-49	Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Transaction Standards
PM B-00-68	X12N Professional Flat File
PM B-01-06	HIPAA Health Care Claim and Coordination of Benefits (COB)
PM B-01-32	HIPAA Health Care Claim and Coordination of Benefits
PM B-01-35	X12N 835 (Payment/Remittance Advice) Transaction Standard Format
PM B-01-71	X12N 837 Professional Health Care Claim Companion Document
PM B-01-76	Issuance of Standard Paper Remittance (SPR) Advice Notice and SPR X12 835V4010 Crosswalk
PM AB-01-29	Free Electronic Billing Software
PM AB-01-96	HIPAA EDI Testing and Reporting Requirements (07/12/01)
PM AB-01-106	X12 276/277c.xls - Inquiry/Response Combined Flat File
PM AB-01-106	X12 276/277s.xls - Inquiry/Response Separate Flat File
PM AB-01-124	HIPAA Budget Requests for EDI Testing and Reporting
PM AB-01-132	Further Guidance Concerning Implementation of the HIPAA Transactions
PM AB-01-169	Transaction Certification and Testing

HIPAA Model Compliance Extension Plan And Instructions Now Available

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transactions and code sets. October 16, 2002 is the deadline for covered entities such as health plans, clearinghouses and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002 the opportunity to extend their compliance deadline by 1 year – to October 16, 2003. This extension opportunity is applicable to all HIPAA covered entities other than small health plans (those with less than $5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a compliance plan by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it are available on the Centers for Medicare & Medicaid Services (CMS) Web site, www.cms.hhs.gov/hipaa. You can submit this on-line model plan electronically through the Web site or print and mail it. You can submit your own paper version of the plan as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and where you are in implementing and testing including whether or not you plan to use a vendor). The CMS strongly encourages electronic filing but if you must file on paper, you should send your form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If you file electronically through the Web site, you will receive an electronic confirmation number acknowledging and granting your extension. If you file a paper version, you won't receive a confirmation, but if your paper plan consists of the required equivalent information, you may consider your extension granted.

The instructions give more details on how to complete the form; explanation of who should file for an extension; data you need to include; and where to get more information on definitions, frequently asked questions, etc.

For more information, submit questions to askhipaa@cms.hhs.gov.

Providers Using Medicare Supplied Billing Software - Medicare contractors will continue to provide electronic billing software for providers to use to submit their Medicare claims. The HIPAA compliant version of this software may not be available until December 2002. As this is after the initial compliance deadline of October 16, 2002, any providers that plan to use the current version of this software after October 15, 2002 must submit a Compliance Extension Plan as described above.

MISCELLANEOUS

Changes To The Standard Paper Remittance (SPR) Advice Notice

Effective July 1, 2002, the format of the Standard Paper Remittance (SPR), also known as the Medicare Remittance Notice (MRN), will change to correspond with the X12 835 changes for HIPAA. Some fields will be re-named, and some fields will be deleted and incorporated into other fields. The changes are described below:

- "Amount Paid To Beneficiary" and "MSP Amount" fields will be reported as Reason Code Adjustments rather than in separate fields. "Amount Paid To Beneficiary" will be reason code 100 and "MSP Amount" will be reason code 23.
- There will be a new claim level field for the informational reporting of late filing reductions.
- There will be space to provide the submitted HCPCS/NDC code and the paid HCPCS/NDC code at each service line.
- The "Total Offset" field will be renamed as "Provider Adj."
- The "Total Paid to Beneficiary" and "Total Other Adjustments" will be deleted at the provider level.
- The following fields will be deleted and reported as part of the "RC-Amt": Total Prev Pd, Total Pd to Bene, Total Primary.
- The following fields will be deleted and reported as part of the "Prov Adj Amt": Total Int, Total Offset, Total Other Adjs.

- "Prov Adj Amt" will be a new total field and will show the sum of the details in the "Provider Adj" section.

- An "ACNT" field will contain the patient account (control) number submitted on the claim.

- Only one crossover carrier will be reported on the SPR, even if the claim was passed on to more than one crossover partner.

- The SPR will report the HCPCS code under which the claim was paid. If the paid HCPCS code is different than the submitted HCPCS code, both will be reported.

Please be aware of these changes and look for them on SPRs printed on or after July 1, 2002.

CMN Effectiveness Study Underway

The Centers for Medicare & Medicaid Services (CMS) has implemented a study to evaluate the effectiveness of Certificates of Medical Necessity (CMNs) as a medical review screening tool. CMS selected Tricenturion, LLC, a Program Safeguard Contractor (PSC), to conduct this study.

Tricenturion will select a sample of CMN related claims and perform an independent review of the medical record associated with these claims to corroborate the responses provided on the CMN. The study will compare the information contained in the medical records with the information included on the CMN. This will serve as the basis for measuring the accuracy of the CMN.

You may have already received an information request as part of this study. As with any study, participation is voluntary. However, the results of this study will impact the future use of the CMN. By participating in this study, you are contributing to the future direction of Medicare. CMS strongly encourages your cooperation in this study. Please provide the requested information as soon as possible to ensure timely completion of this study.

If you have any questions on this project, contact Joyce Graham, Tricenturion, LLC, at 803.264.7513.

Expand Your Knowledge with Medicare Learning On-Demand

Medicare Learning On-Demand offers two convenient methods of training for Region D DMERC Suppliers.

Webinars

Webinars, officially launched this April, have been well received by participants. Webinars are web-based presentations that integrate both the Internet and telephone, allowing interaction between the participant and presenter. Currently, the Webinars offered are "Completing the CMS-1500 Form" and "Advance Beneficiary Notice (ABN) and Upgrades." Additional training sessions will be offered in the near future.

On-site Seminars

CIGNA Medicare will be conducting on-site seminars beginning August 2002. Topics include ANSI Reason Codes, Proper Use of Modifiers, Medicare Updates,and The Appeals Process. Software vendors will be hosting booths at 8 of the 26 seminar locations. Seminar dates, locations, and registration information will be posted on the CIGNA Medicare Web site.

To obtain additional information or register for Webinars and On-site Seminars, visit the Medicare Learning On-Demand Web site section at: www.cignamedicare.com/wrkshp/dm.

Medicare Program Integrity Manual Revised

The Medicare *Program Integrity Manual* (PIM) contains the medical review (MR) and benefit integrity (BI) instructions from the Centers for Medicare & Medicaid Services (CMS). The following revisions have been published since the publication of the Spring 2002 Region D *DMERC Dialogue.*

- Transmittal 19, released February 8, 2002, with the same effective date, revises Benefit Integrity Unit security requirements in Chapter 1, Section 3.2.6.

- Transmittal 20, released February 21, 2002, with the same effective date, revises Part A Intermediary instructions for reviewing ambulance claims in Chapter 6, Section 12.

- Transmittal 21, released February 28, 2002, revises the types of inpatient hospital claims for which contractors are responsible for performing MR functions in Chapter 1, Section 1.2. The effective date is April 1, 2002.

- Transmittal 22, released March 5, 2002, with the same effective date, adds Chapter 11 - Fiscal Administration. In previous years, *Medicare Carriers Manual* (MCM), Part 1, 4213 contained requirements regarding how carriers were to allocate MR costs, savings and workload in CAFM and CROWD. Parallel requirements for Fiscal Intermediaries (FIs) were located in *Medicare Intermediary Manual* (MIM), Part 1, 1213. Most of the MR language in the MCM and MIM was eliminated in the summer of 2001 and replaced with generic language that directs contractors to the PIM. This transmittal adds those previous requirements to Chapter 11 of the PIM and updates them to reflect the workload, costs and savings allocation requirements formerly listed in the MR Budget and Performance Requirements (BPR). The implementation date is April 1, 2002.

- Transmittal 23, released March 18, 2002, revises Part A Intermediary instructions in Chapter 6, Section 3, Medical Review of Home Health Services. The implementation date is May 2, 2002.

- Transmittal 24, released April 5, 2002, removes the local medical review policy (LMRP) and related sections from Chapter 1 and moves them into a new chapter— Chapter 13, eliminates a perceived conflict with the Paperwork Reduction Act, and clarifies the situations where the LMRP Comment and Notice process must be followed and where it is not required. The implementation date is October 1, 2002.

- Transmittal 25, released April 25, 2002, is revised to exclude all medical review functions for inpatient Diagnostic Related Group (DRG) claims. The implementation date is July 1, 2002.

- Transmittal 26, released April 27, 2002, without an implementation date, deletes section 1.7 of Chapter 6, Quality Issues in SNF and Referral to Other Agencies. This section was inadvertently not deleted when replacing existing language with guidelines to support SNF PPS medical review. Contractors should follow guidelines in PIM Chapter 3, section 10, "Referral of Cases to Other Entities for Action" when referrals are needed as a result of SHF PPS medical review. If payment was solely based on the instructions contained in this section, contractors are to reopen the claim(s) and adjudicate payment without regard to section 1.7.

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.

PIM revisions are also posted at www.cignamedicare.com. Visit the site frequently for revisions posted between publications.

New Source of Provider/Supplier Information Available on CMS Web Site

The Centers for Medicare & Medicaid Services (CMS) released the first issue of *The CMS Quarterly Provider Update* on April 22, 2002. Future issues will be released the first business day of each subsequent calendar quarter. These quarterly updates will include all changes to Medicare instructions that affect providers/suppliers, or may be of interest to them. They will provide a single source for national Medicare provider/supplier information and give providers/suppliers advance notice on upcoming instructions and regulations.

The first release is a Web-based document and is available at http://www.cms.hhs.gov/providerupdate. For ease of use by individual providers/suppliers, regulations and instructions are collated and sorted based on the interests of the user.

Each update will include the full text of instructions to be implemented 90 or more days after its release. For example, instructions included in the April update will have an implementation date of July 1, 2002 or later. The listings of regulations will be presented into two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS' goal is to make it easier for providers/suppliers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the update and ensure they are responsive to provider/supplier needs, a feedback form will be included with each issue. CMS encourages anyone accessing the update to use the

feedback form to forward comments on its utility, organization and format.

Provider/Supplier Electronic Enrollment Forms

Five electronic Medicare Provider/Supplier Enrollment forms can now be accessed on the CMS Web site at www.hcfa.gov/medicare/enrollment/forms/. These forms include the CMS 855A, CMS 855B, CMS 855I, CMS 855R and CMS 855S. A comprehensive user guide, providing detailed instructions on how to download these applications, is also available on the Web site. Providers/suppliers can complete a form on their computer, save it as a file, and print the completed form for final signature and submission. Providers/suppliers cannot submit these forms electronically at this time.

DMERC suppliers should contact the National Supplier Clearinghouse (NSC) at 866.238.9652 for questions regarding enrollment form CMS 855S.

Reporting Address And Other Changes To The National Supplier Clearinghouse (NSC) – Corrected Effective Date

The effective date in the article entitled "Reporting Address and Other Changes to the National Supplier Clearinghouse (NSC)," published in the Spring 2002 *DMERC Dialogue*, has been revised from April 1, 2002 to October 1, 2002. Effective October 1, 2002, the DMERC will use "return service requested" envelopes for all hardcopy Medicare Remittance Notices (MRNs) in addition to using them for hardcopy checks.

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

Requests From Collection Agencies On Behalf Of Suppliers

Region D DMERC has been receiving requests from collection agencies on behalf of suppliers requesting payment or explanation for denied claims. These requests will not prompt us to make payment for a denied claim. Also, they do not meet the requirements for appeal requests or claim reopenings.

When the supplier accepts assignment of a claim, they are notified of the claim determination via the Medicare Remittance Notice (MRN). Special attention should be made to the claim remarks and ANSI codes. These codes explain the basis for payment, reason(s) for denial, and other pertinent claim information. We recommend you keep all MRNs in your files for future reference.

If you have not received payment for a claim it may be because the claim was submitted incorrectly, the claim was missing necessary documentation or information, the item is not covered, or the claim was not received.

Claim status inquiries should be conducted through our Interactive Voice Response (IVR) system, toll-free 877.320.0390. However, if the IVR is unavailable for use, a customer service representative will be glad to assist supplier inquiries. Customer service representatives are available Monday - Friday from 8:00 a.m. - 6:00 p.m. (CST).

Services Incorrectly Denied

There is a possibility that a small number of claims for services provided in a facility setting may have been incorrectly denied between April 1, 2002 and April 15, 2002, due to system changes at the Common Working File. The denial messages applied were ANSI code 109 and Remark code N73 ("Claim is not covered by this payer/contractor. You must send the claim to the correct payer/contractor."). If the service was provided to a patient in a skilled nursing facility (SNF) during a Part A covered stay, the denial is correct. However, if you feel you received a denial in error, the claim may be resubmitted. Customer Service Representatives will be unable to determine which claims may have been incorrectly denied. If a claim is resubmitted and denies again with the same message, it was initially denied correctly against a Part A covered SNF stay.

The Public Relations Department

The Public Relations Department, located in Boise, Idaho, is responsible for education and training. Public Relations Ombudsmen are available to assist suppliers with technical or billing problems that cannot be resolved through normal channels. Contact the Public Relations Department at 1.866.224.3094, option # 3, if you have questions regarding:

- Seminar registration
- Education and Training
- CMN rejections on electronically transmitted claims (**These are different from front-end rejections on electronically transmitted claims.**)

Please remember to first contact Customer Service at 1.877.320.0390 regarding all other issues.

Voluntary Refund Form

It is the supplier's responsibility to refund overpayments. When submitting voluntary refund checks to the Region D Durable Medical Equipment Regional Carrier (DMERC), the Voluntary Overpayment Refund form must be completed and returned to ensure proper recording and receipt of the check. This will allow for the timely processing of your refund. A copy of the form is provided in this newsletter and is also available in Chapter 12 (page 5) of the *DMERC Region D Supplier Manual*.

Refund checks should be made payable to Connecticut General Life Insurance Company (CGLIC) and included with the completed Overpayment Refund form and mailed to:

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

FROM THE DAC

Medicare Region D DAC

The Medicare Region D DMERC Advisory Committee (DAC) is a nonprofit volunteer provider organization. The primary function of the DAC is to serve as a communications vehicle between the home medical equipment (HME) industry and CIGNA HealthCare Medicare Administration (CIGNA Medicare), the Region D DMERC. The DAC was formed to provide the 17 states in the Region D DMERC area and other national associations an opportunity to liaison directly with the DMERC staff.

The DAC is comprised of providers throughout the Region D area to represent the provider community's concerns to CIGNA. All providers are represented and welcomed to participate whether or not they belong to state or national associations. Its purpose is to address key issues from throughout the region, and to consolidate these issues into a format that allows for a productive and proactive means of reaching a solution.

The DAC meets with CIGNA Medicare quarterly. Issues addressed at the meetings are developed through the work of the DAC's A-Teams, which represent specialty subcommittees of the DAC. The A-Teams are made up of providers who practice in the specialty area of the A-Team and have significant knowledge of Medicare policies and billing practices.

Current DAC A-Teams include: Respiratory, DME, I.V., Medical Supplies and Wound Care, Rehab, Orthotics and Prosthetics, and EDI/EMC.

A-Team members are nominated. The DAC Executive Committee, in conjunction with the A-Team Leader, reviews each nominee to determine acceptance of his or her nomination. To nominate yourself or another individual you can contact the DAC central office at:

Region D DMERC Advisory Committee
One Capitol Mall, Suite 320
Sacramento, CA 95814
(916) 444-3568

E-Mail: gpeterson@rjaa.com
Web site: www.dacd.org

Acronyms

CIM	Coverage Issues Manual
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMERC	Durable Medical Equipment Regional Carrier
HCPCS	Healthcare Common Procedure Coding System
HICN	Health Insurance Claim Number
ICD-9	Internal Classification of Diseases, 9th Revision
LMRP	Local Medical Review Policy
MCM	Medicare Carriers Manual
NCD	National Coverage Determination
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier

Frequently Asked Questions

1. What date does the supplier list as a re-certification date when an oxygen patient misses their re-evaluation at 12 months (for lifetime) or within 30 days prior to re-certification (for less than lifetime)?

   ANSWER: For Group I patients, the date of the re-evaluation must be used as the re-certification date. If coverage criteria are met at that time, coverage continues with no break in payment. Claims must be held until the re-evaluation is completed. For Group II patients, a new initial Certificate of Medical Necessity (CMN) is required. *(DMERC Region D Supplier Manual, Chapter 9, OXY, page 5)*

2. If an oxygen patient transfers services from Provider A to Provider B and the DMERC has Provider A's initial and re-certification CMN on file and Provider B obtains a new initial and submits the patient's claim, Provider B will be paid based on the re-certification CMN the DMERC has on file. Given that Provider B's CMN qualifies, would this be acceptable in an audit situation?

   ANSWER: If there is a new supplier, that supplier must be able to provide the DMERC with an original CMN on request. (An original CMN is a CMN which has a physician's original signature on it. It is not necessarily an initial CMN or the first CMN for the patient.) If the supplier obtains a new CMN, it is considered a **Revised CMN**. In this situation, if the oxygen order is the same, the CMN does not have to be submitted with the claim. *(DMERC Region D Supplier Manual, Chapter 9, OXY, "Revised CMN is required," page 5)*

3. If an oxygen patient transfers from Provider A (with no break in service) to Provider B, is it acceptable for Provider B to obtain new test results and a new initial CMN and have it entered into Medicare's system. If not, why? Provider B would then follow up to obtain a re-certification based on their initial CMN.

   ANSWER: The therapy follows the beneficiary, therefore, if CIGNA already has an initial CMN and/or a re-certification for a period of time, the second supplier only needs to get a revised CMN. The revised CMN must use the most recent test result. *(DMERC Region D Supplier Manual, Chapter 9, OXY, page 5)*

4. Under the Advance Beneficiary Notice (ABN) Upgrade provision, do I need to bill two lines on every claim submitted, or just the first month's claim?

   ANSWER: If you are billing for a beneficiary choice upgrade item, two lines, with the appropriate modifier must be billed on each claim. If you are billing for a free upgrade only one line should be billed. *(Region D DMERC Dialogue, Winter 2002, page 19)*

5. When a supplier is billing for supplies or services in a Skilled Nursing Facility (SNF), why does it matter what type of Medicare "stay" the beneficiary is under?

   ANSWER: Section 4432(b) of the Balanced Budget Act (BBA) requires Consolidated Billing for a Skilled Nursing Facility (SNF). The Consolidated Billing requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services. It is the supplier's responsibility to check with the facility to see if their patient's SNF stay is covered by Medicare Part A. If so, all services, with the exceptions listed in the Spring 2001 *Region D DMERC Dialogue* (pages 7 & 8) must be sent to Medicare by the SNF. DMEPOS items for beneficiaries whose SNF stay is not covered by Part A must be billed to the DMERC. *(Region D DMERC Dialogue, Spring 2001, page 7 & 8)*

6. The revised Continuous Positive Airway Pressure System (CPAP) policy was released on April 1, 2002. Will CIGNA's system require that new patients (who are set up from April 1, 2002 to July 1, 2002) have a Certificate of Medical Necessity (CMN) on file, or are they prepared to pay claims based on the prescription?

Frequently Asked Questions (cont'd)

ANSWER: For dates of service beginning April 1, 2002, the coverage criteria in the revised *Coverage Issues Manual* (CIM) §60-17, the national coverage determination for CPAP, apply. The following policies and documentation requirements apply to CPAP claims as indicated by date of service.

Date of Service (DOS)	CIM §60-17	LMRP	CPAP CMN	KX Modifier
DOS before 4/1/02	Former	Former	Yes	No
DOS 4/1 - 6/30/02	Revised	None	No	No
DOS 7/1/02 & after	Revised	Revised	No	Yes*

*To be used only if specified requirements in the documentation section of the local medical review policy (LMRP) have been met.

(*Region D DMERC Dialogue, Spring 2002, pages 3 & 4)*

7. The new CPAP policy states that for continued coverage beyond the first three months of therapy (no sooner than the 61st day after initiating therapy) the supplier ascertain the continued use of the CPAP from either the beneficiary or the treating physician. Can this be documented with a phone call?

   ANSWER: As a general rule, suppliers should ascertain information in a manner that is verifiable. Typically, this is through written documentation; however, telephone calls are not prohibited.

8. In some instances, private insurers or beneficiaries have purchased devices falling under Medicare's frequent and substantially serviced payment category prior to Medicare eligibility. In this case, will Medicare reimburse for replacement accessories used for the customer-owned frequently serviced equipment, such as the respiratory assist device, code K0533? What documentation will the supplier need for billing and reimbursement purposes?

   ANSWER: Based on the Social Security Act §1834(a), Medicare does not pay for accessories or supplies used with frequently serviced equipment, including the respiratory assist device (RAD), code K0533, if the equipment was purchased on or after January 1, 1989. A different date applies to oxygen; Medicare does not pay for accessories or supplies used with oxygen equipment purchased on or after June 1, 1989. However, Medicare will pay for the rental of an additional piece of frequently serviced equipment, and allowance for accessories and supplies would be included in the monthly allowance for the equipment. (*DMERC Region D Supplier Manual, Chapter 5, page 1)*

9. Does the DMERC acknowledge receipt of Advance Determination of Medicare Coverage (ADMC) requests and how many days does the DMERC have to make a determination on an ADMC request?

   ANSWER: The DMERC acknowledges receipt of the ADMC request in the response or determination letter. Upon receipt of an ADMC request, the DMERC will make a determination within 30 calendar days and provide the supplier and beneficiary a detailed written response. Duplicate requests should not be submitted during the initial 30-day request period. *(DMERC Region D Supplier Manual, Chapter 9, pages 2 & 3)*

10. Why is there now a GZ modifier?

    ANSWER: The new modifier GZ was established for dates of service on or after January 1, 2002, 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 or 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 or necessary and an Advance Beneficiary Notice **is** on file.)

    (Region D DMERC Dialogue, Winter 2002, page 20)

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Replacement Manual/ Diskette Application

Customer Information

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

Order/ Replacement Items

Please indicate which of the following manuals or diskette you would like to replace or order an additional copy for your office. The cost is indicated by each item.

❑	Region D DMERC EDI Manual	$20.00
❑	DMACS Users Manual	$ 5.00
❑	DMACS CD	$ 5.00
❑	Passport for Windows Diskette – used for CSI only	$ 5.00
❑	Beneficiary Eligibility Manual	$ 5.00
❑	Claims Status Inquiry (CSI) Manual	$ 6.00

Form Submission

All applications are processed within 10 to 21 business days from the date the application is received. Please note that applications with 100 or more supplier numbers will require an additional 10 business days for processing.

Please return this application with your check made payable to **CIGNA** and mail to the following address:

Connecticut General Life Insurance Company
PO Box 360295
Pittsburgh, PA 15251-0295

Please Note – Incomplete Applications May Be Returned

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VOLUNTARY OVERPAYMENT REFUND

TO BE COMPLETED BY MEDICARE CONTRACTOR

Date:_____
Contractor Deposit Control #:_____ Date of Deposit:_____
Contractor Contact Name:_____ Phone #:_____
Contractor Address:_____
Contractor Fax:_____

TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER

Provider/Physician/Supplier Name:_____
Address: _____

Provider/Physician/Supplier #:_____ Check Number #:_____
Contact Person:_____ Phone #:_____
Amount of Check $:_____ Check Date:_____

REFUND INFORMATION

For each claim, provide the following:
Patient Name:_____ HIC #:_____
Medicare Claim Number:_____ Date of Service:_____
Claim Amount Originally Paid by Medicare: $_____Claim Amount Refunded: $_____

Reason for Refund: (please check one per claim or adjustment)

☐ Corrected Date of Service ☐ Patient Enrolled in an HMO ☐ Duplicate
☐ Incorrect HIC Number ☐ Corrected CPT Code(s) ☐ Incorrect Assignment
☐ Not Our Patient(s) ☐ Modifier Added/Removed ☐ Billed in Error
☐ Services Not Rendered ☐ Insufficient Documentation ☐ Medical Necessity

MSP and Other Payor Involvement: (check which applies)

☐ Group Health Plan Insurance ☐ No Fault Insurance
☐ Veterans Administration ☐ Workers Comp. (Including Black Lung)
☐ Other (Please Specify) ☐ Liability Insurance

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment.

For Institutional Facilities Only:
Cost Report Year(s):_____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? Yes ☐ No ☐

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DMERC Region D Publication Order Form

Name: _____

Company Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

Email: _____

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

Subscription (12 months) $50.00/year per publication

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

Subtotal **$**_____

DMERC Individual Requests

Region D *DMERC Dialogue $10.00 Each Issue**

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

*Includes (if applicable) the supplier manual update.

Subtotal **$**_____

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

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

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

Subtotal **$**_____

Total Amount Due **$**_____

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

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

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

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

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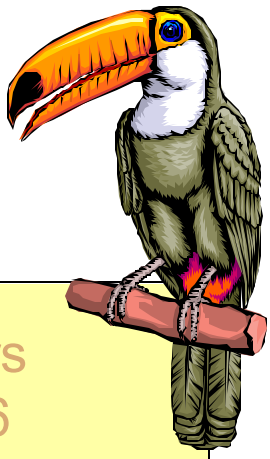
...Coming To A City Near You

Join CIGNA Medicare Region D DMERC* as we present one-day specialty seminars for DMEPOS** suppliers.

Be the first to know...

Watch for information regarding seminar dates, locations, and registration to be posted on *www.cignamedicare.com*.

Join our electronic mailing list and you will be notified when seminar information is updated on line!



Seminar Topics

ANSI Reason Codes
Proper Use of Modifiers
Medicare Updates
The Appeals Process

Software Vendors will be at 8 of 26 Seminar Sites

All attendees must be pre-registered with a **$25.00 registration fee** to be paid in advance and submitted with the registration form. All seminar information, including on-line registration, will be available at www.cignamedicare.com.

**DMERC - Durable Medical Equipment Regional Carrier*
***DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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MEDICARE REVIEW REQUEST FORM

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

DATE _____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

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

CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

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

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

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

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

CONTACT INFORMATION

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

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Customer Service Available

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

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

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

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

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

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

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

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

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

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

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

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

Celebrate the 4th!

DMERC Dialogue *...a service of*

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

Region D DMERC Serves. . .

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

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