Fall

DMERC Dialogue

DMERC Region D

October 2002

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

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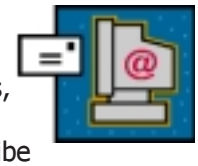

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From the Medical Director...

Robert Hoover, Jr., MD, MPH

Local Medical Review Policy (LMRP) Reconsideration Process

The LMRP Reconsideration Process is a mechanism by which interested parties can request a revision of an LMRP. In order to be considered a valid request, the following requirements must be met:

- Requestor must be qualified
- Subject must be appropriate
- Information submitted must be adequate
- Process for submission must be followed

Any request for LMRP reconsideration that, in the judgment of the DMERC, does not meet these requirements is invalid.

Requestor

The DMERC will consider all LMRP reconsideration requests from:

- Beneficiaries residing in our jurisdiction; or
- Suppliers doing business in our jurisdiction.

We may consider LMRP reconsideration requests from any other interested party doing business in our jurisdiction.

Subject

The LMRP Reconsideration Process is available only for final LMRPs. The whole LMRP or any part of the LMRP may be reconsidered. Requests are not accepted for other documents including:

- National Coverage Decisions (NCDs) – for example, *Coverage Issues Manual*;
- Coverage provisions in interpretive manuals – for example, *Medicare Carriers Manual*;
- Draft LMRPs;
- Retired LMRPs;
- Individual claim determinations;
- Bulletins, articles, training materials; and
- Any instance in which no LMRP exists, i.e., requests for development of an LMRP.

In This Issue *(Cont'd)*

Local Medical Review Policy (LMRP) Reconsideration Process (cont'd)

If modification of the LMRP would conflict with an NCD, the request is not valid. Refer to the NCD reconsideration process at http://www.cms.hhs.gov/coverage/8a1.asp.

Information to be Submitted

The request must identify the language that the requestor wants added to or deleted from an LMRP. Requests must include a justification supported by new evidence, which may materially affect the LMRP's content or basis. When articles or textbooks are cited, copies of the published documents must be included.

The level of evidence required for LMRP reconsideration is the same as that required for new/revised LMRP development. As described in the Medicare *Program Integrity Manual*, LMRPs are to be based on the strongest evidence available. In order of preference, LMRPs are based on:

- Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies;
- General acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:

  a. Scientific data or research studies published in peer-reviewed medical journals; or
  b. Consensus of expert medical opinion (i.e., recognized authorities in the field); or
  c. Medical opinion from medical associations or other healthcare experts.

Acceptance by individual healthcare providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with financial interest in the outcome, are not sufficient evidence of general acceptance by the medical community. The broad range of available evidence will be considered and its quality will be evaluated before a conclusion is reached.

Submission Process

In order to be valid, the request for LMRP reconsideration must be in writing and must include the name and mailing address of the requestor. Inclusion of a telephone number and/or e-mail address is optional. If the requestor is neither a beneficiary nor a supplier, the requestor must identify the nature of their business and who they are representing (if applicable).

Requests may be submitted by mail or fax to:

MAIL: Robert D. Hoover, Jr., MD, MPH
CIGNA Medicare
2 Vantage Way
Nashville, TN 37228

FAX: 615.782.4680

Because of Privacy Act regulations, CIGNA Medicare cannot accept requests for LMRP reconsiderations via electronic mail.

DMERC Response

Within 30 days after the request is received, the DMERC will determine whether the request is valid or invalid and will notify the requestor of that determination. If the request is invalid, we will explain why it was invalid.

If the request is valid, within 90 days after the request is received, the DMERC will make a reconsideration decision and will notify the requestor of the decision with its rationale. Decision options include: no revision, revision to a less restrictive policy, revision to a more restrictive policy, or retiring the policy.

Any revision to the policy will then be published in a future update to the *DMERC Region D Supplier Manual*.

MEDICAL POLICY

CPAP Documentation And KX Modifier Usage

Recently, the local medical review policy on CPAP devices was published and included documentation requirements for the use of the KX modifier. Questions have arisen regarding the use of the KX modifier for beneficiaries with CPAP therapy initiated prior to the July 1, 2002 effective date of the policy.

The policy stipulates that in order to use the KX modifier for the fourth month's claim and any month thereafter, evidence of continued use of the device must be obtained from either the beneficiary or the treating physician. Therefore, regardless of the start date of CPAP therapy, in order to bill Medicare and use the KX modifier, suppliers must ascertain that the beneficiary is continuing to use the CPAP device. The requirement to verify a beneficiary's continued use of capped rental equipment prior to billing the DMERC is not new or unique to the CPAP policy, but rather applies to all items in the capped rental payment category. This documentation does not have to be submitted with the claim but must be retained in the supplier's files and be made available to the DMERC upon request.

DMERC Coverage Of Treprostinil (Remodulin®)

In May 2002, the Food and Drug Administration (FDA) approved treprostinil for the treatment of pulmonary artery hypertension. Treprostinil is administered via subcutaneous injection using a type of infusion pump similar to the pump used for subcutaneous insulin infusion.

Coverage of this therapy, effective for dates of service on or after May 21, 2002, will be considered under the DMERC local medical review policy (LMRP) for external infusion pumps. Beneficiaries with pulmonary artery hypertension must meet the same coverage criteria as for the administration of parenteral epoprostenol:

A. The pulmonary hypertension is *not* secondary to pulmonary venous hypertension (e.g., left sided atrial or ventricular disease, left sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.); and

B. The patient has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, diet drugs, congenital left to right shunts, etc. If these conditions are present, the following criteria must be met:

1. The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; and
2. The mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion; and
3. The patient has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and
4. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.

These coverage instructions will be incorporated into a future revision of the External Infusion Pumps Local Medical Review Policy.

Region D DMERC Supplier Notification Of Local Medical Review Policy (LMRP) Effective Date

The 45-day notice period for LMRPs typically begins when published via the Region D *DMERC Dialogue* and the *DMERC Region D Supplier Manual* update. Recently, the Centers for Medicare & Medicaid Services instructed contractors to discontinue printing and distributing publications until after September 30, 2002. Therefore, effective immediately, the notice period for all LMRPs will begin on the date the LMRP is posted on the CIGNA Medicare Durable Medical Equipment Web site.

To receive automatic notification via e-mail of the posting of LMRPs, publications and other important Medicare announcements, subscribe to the CIGNA Medicare electronic mailing list at www.cignamedicare.com/mailer/subscribe.asp.

Repairs Policy – Retired

The current DMERC local medical review policy on Repairs is being retired effective for dates of service on or after October 1, 2002. A revised policy containing updated information will be published in a future *DMERC Region D Supplier Manual* update.

Respiratory Assist Devices – Disease Classification

In the local medical review policy (LMRP) on Respiratory Assist Devices, the covered conditions are divided into four categories. The first category is Restrictive Thoracic Disorders. This category includes patients with either neuromuscular disorders (e.g., ALS) or severe chest wall deformities. It does not include patients with various interstitial lung diseases that often lead to pulmonary fibrosis and are sometimes referred to as restrictive lung diseases. RADs are not part of the treatment for these conditions. Similarly, obesity is not included in the Restrictive Thoracic Disorders category. Patients with severe obesity may qualify under other categories such as the Obstructive or Central Sleep Apnea categories if a polysomnogram and other tests, as detailed in the LMRP, indicate this is the appropriate diagnosis.

Suppliers should refer to the LMRP on Respiratory Assist Devices for further details concerning coverage, coding and documentation requirements for these devices.

Supplier Manual Policy Revisions

Revisions of the following policies are included in the Fall 2002 *DMERC Region D Supplier Manual* update available at http://www.cignamedicare.com/dmerc/dmsm/TOC.html. A brief summary of the major changes in each policy is provided. Suppliers are advised to review each policy for complete details.

Oral Anticancer Drugs
(Effective for dates of service on or after October 1, 2002)

- Updates list of National Drug Codes.
- Adds codes A9270 and J8999 and instructions for their use.

Home Blood Glucose Monitors
(Effective for dates of service on or after October 1, 2002)

- Revises definitions of order renewal and order refill.
- Clarifies that coverage of E2101 for beneficiaries with manual dexterity impairments is not dependent on visual impairment.
- Emphasizes that suppliers have an obligation to monitor a beneficiary's utilization of supplies and dispense supplies accordingly.
- States specific elements required for orders.
- Clarifies the DMERC position on the use of data collection forms.
- Removes bundling table.

COVERAGE AND BILLING

Estimated Length Of Need: Correct Entries On Certificates Of Medical Necessity (CMNs)

Suppliers are reminded that physicians should be instructed to follow CMN completion instructions (located on the reverse side of the CMN form) when entering estimated length of need (ELN) on recertifying and revised CMNs. The revised length of need must represent the total number of months needed from the initial date forward. In other words, the estimated length of need must indicate a cumulative number of months that the physician expects the patient will have required the use of the ordered item.

Some physicians may insist on reevaluating their patients for continuation of a Medicare covered service (e.g., oxygen therapy) outside of the DMERC's required recertification schedule. Remember that a Recertification CMN is a CMN that is due when required by the DMERC (e.g., the 12 month recertification for group 1 oxygen patients). However a Revised CMN is one that becomes necessary because the physician changes certain orders or wishes to extend the length of need for continued certification of items initially ordered for less than lifetime.

The following examples may help clarify this requirement:

1. A patient begins oxygen therapy as a group 1 patient. He is not required to have a recertification for 12 months. However, the physician enters 6 months in the ELN field of the Initial CMN. The patient will therefore need a Revised CMN in 6 months for continued Medicare coverage, if the physician deems that oxygen therapy is still medically necessary. At that time, if the physician wishes to update the initial estimated length of need to reflect that the patient requires oxygen for another year, he must put an "18," in the ELN field (6 + 12 months from date initially needed). Note that the Recertification CMN would still be necessary twelve months from the initial date as required by the DMERC.

2. A physician requires oxygen patients to be reevaluated for continued certification on a yearly basis. On

the Initial CMN, he would enter a "12," as the ELN. After the first year he must enter a "24" on the Recertification CMNs ELN in order to extend the length of need another year. Subsequent Revised CMNs should continue with the cumulative length of need from the initial date such as "36," "48," etc.

3. The physician certifies the patient for lifetime need. He enters a "99" in the ELN of the initial certification and/or the DMERC required recertification. A recertified CMN will still be required according to Local Medical Review Policy.

Suppliers may wish to show this bulletin to physicians to convince them of this requirement, since physicians might otherwise be reluctant to enter the number "48," for example, when he actually wishes to reevaluate the patient for continued certification in another 12 months.

Suppliers are reminded that if a physician requires a Revised certification in addition to the DMERC scheduled recertifications, it is necessary for the patient to have a repeat blood gas determination within 30 days prior to the date when the physician has ordered the revised certification.

ICD-9-CM Coding Update

Beginning October 1, 2002, providers may begin using the 2003 ICD-9-CM codes. There will be a grace period from October 1, 2002 through December 31, 2002 for deleted ICD-9 diagnosis codes. For claims received on or after January 1, 2003, the latest version of the ICD-9 codes **must** be used by providers.

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

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

- Medicode - 800.999.4600
- CMS's website - www.cms.gov
- American Medical Association (AMA) - 800.621.8335 or www.ama-assn.org

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

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

ICD-9 Codes Will Be Date Of Service Driven

Effective January 1, 2003, the annual ICD-9 updates will be date of service specific. Providers and billing staff must bill claims using the diagnosis codes that are in effect at the time the service is rendered. As required by CMS, the DMERCs will edit for the validity of diagnosis codes based on the date of service. A 90-day grace period will apply to both old and new codes for dates of service October 1 through December 31 of each year.

Incorrectly Coded DMEPOS Items To Be Denied

CMS requires contractors' Medical Review staff to deny payment on claims whenever there is evidence that a service was not billed in compliance with national and local coding requirements (Medicare *Program Integrity Manual*, Chapter 3, section 4.2). Effective immediately, claims submitted with valid HCPCS codes and/or modifiers that do not correctly represent the DMEPOS items billed may be denied. The Medicare Remittance Advice message for this denial is ANSI Reason Code B18, "Payment denied because this procedure code/modifier was invalid on the date of service or claim submission." This is the same message that is used when an invalid HCPCS code and/or modifier is submitted. To further clarify the reason for denial, a second message, ANSI Remark Code N56, "Procedure code billed is not correct for the service billed," is also included.

Suppliers whose claims are denied because an incorrect HCPCS code and/or modifier is used for the item provided are encouraged to resubmit the claim with the correct HCPCS code and/or modifier. Claims that are resubmitted with the same code/modifier as previously submitted will be denied as duplicate claims.

Suppliers should refer to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Web site at www.palmettogba.com/ (select Other Partners then SADMERC) or contact the SADMERC for guidance on the correct coding for DMEPOS items.

Jurisdiction Change For Disposable Hyperbaric Oxygen Chambers

Effective for dates of service on or after January 1, 2003, the jurisdiction for submitting claims for HCPCS code A4575 (topical hyperbaric oxygen chamber, disposable) will change from local carriers to the Durable Medical Equipment Regional Carriers (DMERCs).

In accordance with instructions in the *Coverage Issues Manual* § 35-10 (D), claims for topical hyperbaric oxygen will continue to be denied as not medically necessary.

Jurisdiction For Implanted Devices, Accessories And Supplies

Providers are reminded that claims for the following items must be billed to the local carriers, not to the DMERC.

- Implanted durable medical equipment
- Implanted prosthetic devices
- Replacement parts (external or internal)
- Accessories and supplies for the implanted durable medical equipment or prosthesis

Claims submitted to the DMERC will be returned as unprocessable for incorrect jurisdiction.

Medicare Beneficiaries In State Or Local Custody Under A Penal Authority

I. GENERAL INFORMATION

A. Background:

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

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

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

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

B. Policy:

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

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

ANSI Reason code: CO 96 - Non covered charges.

New Remark code: N103 - Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished

to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

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

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

C. Implementation:

Carrier/DMERC Claims Processing Procedures - Carriers must deny claims for items and services rendered to beneficiaries when rejected by CWF. Provide appeal rights as specified above.

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

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

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

New Medicare Medical Review Guidelines For Claims For Diabetic Testing Supplies

Program Memorandum (PM) B-02-037 establishes the following guidelines for DMERCs to use when processing claims for diabetic testing supplies.

I. General Requirements:

A. For purposes of this PM, an order refill is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid. An order refill does not have to be approved by the ordering physician as it is assumed that the ordering physician has approved that quantity of product.

B. For purposes of this PM, an order renewal is the act of obtaining an order for an additional period of time beyond that previously ordered by the physician.

II. Physician Requirements:

A. Claims for diabetic testing supplies must be supported by a valid order. The order may be in the form of a written, faxed, or electronic order and must state to the supplier:

1. The item(s) to be dispensed;
2. The quantity of item(s) to be dispensed;
3. The frequency of testing ("as needed" is not acceptable);
4. Whether the patient has insulin-treated or non-insulin-treated diabetes;
5. A physician signature;
6. A signature date; and,
7. A start date of the order – only required if the start date is different than the signature date.

B. For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Orders are valid for up to 12 months if the physician does not indicate an earlier expiration date.

C. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

D. We expect that physician records will reflect the care provided to the patient including, but not limited to evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide addi-

tional information to suppliers unless specifically requested of the supplier by the DMERC.

III. Supplier Requirements:

A. If a DMERC requests a supplier to justify quantity billed, the supplier must provide all documentation listed in section II, A., above and any other information requested by the DMERC. At the beneficiary's request, suppliers may refill orders without consulting the treating physician; so long as the order remains valid and allows for refills. Under no circumstances may suppliers automatically dispense supplies on a predetermined basis; even if the beneficiary has "authorized" this in advance.

B. Upon expiration of the order, the supplier may contact the physician to renew the order. However, the request for renewal may only be made with the beneficiary's continued monthly use of the supply and only with the beneficiary's request for refill or renewal.

C. A supplier may not dispense more than a 3-month supply of diabetic testing supplies at a time. Suppliers should not dispense a quantity of supplies exceeding a beneficiary's expected utilization (e.g., testing once a day would require approximately 100 strips in a 3-month period).

D. Suppliers share responsibility for providing care that is reasonable and necessary. To this end, suppliers should only provide supplies in quantities needed and at appropriate times. Suppliers should also stay attuned to atypical utilization patterns on behalf of their clients and verify with ordering physicians that the atypical utilization is, in fact, warranted.

E. In response to DMERC requests, suppliers may need to collect specific information from physicians in order to corroborate the care provided. While we do not prohibit suppliers from creating data collection forms in order to gather this information, the DMERCs will not rely on these forms to prove the medical necessity of services provided. The DMERCs should expect physician notes, prescriptions, and medical charts to corroborate the care provided. Suppliers should assure that they do not attribute any self-generated forms or data collection requests to the Medicare Program, CMS, or the DMERCs.

IV. DMERC Requirements:

DMERCs retain the authority to review claims and other documentation in order to verify that the care provided was reasonable and necessary.

Time Limit For Filing Claims

Claims for services provided between October 1, 2000 and September 30, 2001 must be received at the carrier by December 31, 2002. Claims that are not submitted within these time limits will be denied. The timely filing period may be extended by submitting a written Statement of Intent (SOI) to claim Medicare benefits. Refer to the *DMERC Region D Supplier Manual* (Chapter 6, pages 16-18) for information about the SOI.

Updates To Procedures Subject To Home Health Consolidated Billing

The following changes apply to claims processed for Home Health Consolidated Billing on or after October 5, 2002 with 2002 dates of service. These non-routine medical supply codes are included in the payment made to the Home Health agency.

The update reflects a new set of "K" codes for ostomy supplies that were published in Program Memorandum AB-02-001. The following new "K" codes replace codes currently on the Home Health (HH) consolidated billing code list. Note that two new codes may replace the same deleted code.

New Codes and Descriptions	Deleted Codes and Descriptions
K0561 - Non-pectin based ostomy paste	A4370 - Skin barrier paste per oz
K0562 - Pectin based ostomy paste	
K0563 - Ext wear ost skn barr <4sq"	A4374 - Skin barrier extended wear
K0564 - Ext wear ost skn barr >4sq"	
K0565 - Ost skn barr w flng <4sq"	A4386 - Ost skn barrier w flng ex wr
K0566 - Ost skn barr w flng >4sq"	
K0567 - 1 pc drainable ost pouch	A5061 – Pouch drainable w barrier at
K0568 - 1 pc cnvx drainabl ost pouch	
K0570 - Ostomy skn barr w flng <4sq"	A5123 – Skin barrier with flange
K0571 - Ostomy skn barr w flng >4sq"	

The following new "K" codes are added to the HH consolidated billing code list, without a replacement.

New Codes and Descriptions
K0569 - 2 pc drainable ost pouch
K0574 - Ostomy pouch filter
K0575 - Ost pouch rustle free mat
K0576 - Ostomy pouch comfort panel
K0577 - Ostomy pouch odor barrier
K0578 - Urinary pouch faucet/drain
K0579 - Ost pouch absorbent material
K0580 - Ost pouch locking flange

The Centers for Medicare & Medicaid Services has determined that the following codes, which were published in Program Memorandum AB-02-001, are **not** subject to HH consolidated billing.

Codes and Descriptions
K0572 - Non-waterproof tape
K0573 - Waterproof tape

Following is the complete list of non-routine supply codes for 2002 dates of service.

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	A4371	A4372
A4373	A4375	A4376	A4377	A4378	A4379
A4380	A4381	A4382	A4383	A4384	A4385
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	A5062	A5063	A5071	A5072	A5073
A5081	A5082	A5093	A5102	A5105	A5112
A5113	A5114	A5119	A5121	A5122	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	K0561	K0562	K0563
K0564	K0565	K0566	K0567	K0568	K0569
K0570	K0571	K0574	K0575	K0576	K0577
K0578	K0579	K0580			

FEE SCHEDULE

Correction To The 2002 Fee Schedule (Ostomy Codes)

The following Ostomy codes fees will be corrected in our system on October 1, 2002. Claims processed or adjusted on or after this date will be processed using these new fees. The corrected fee schedule amounts are listed below:

States	K0563	K0564	K0567	K0570
AK	8.66	9.76	2.04	4.88
AZ	8.66	9.76	2.04	4.88
CA	8.66	9.76	2.04	4.88
HI	8.66	9.76	2.04	4.88
IA	8.66	9.76	2.04	4.88
ID	8.66	9.76	2.04	4.88
KS	8.66	9.76	2.04	4.88
MO	8.66	9.76	2.04	4.88
MT	8.66	9.76	2.04	4.88
ND	8.66	9.76	2.04	4.88
NE	8.66	9.76	2.04	4.88
NV	8.66	9.76	2.04	4.88
OR	8.66	9.76	2.04	4.88
SD	8.66	9.76	2.04	4.88
UT	8.66	9.76	2.04	4.88
WA	8.66	9.76	2.04	4.88
WY	8.66	9.76	2.04	4.88

APPEALS

BIPA Changes For Appeals

Reduction of the Amount in Controversy Required to Request a Part B ALJ Hearing

Section 1869 of the Social Security Act (the Act), as amended by § 521 of the Benefits Improvement and Protection Act (BIPA), reduces the Amount in Controversy (AIC) for Part B Administrative Law Judge (ALJ) hearings. Beneficiaries, physicians, and suppliers wishing to file appeals must satisfy the AIC requirement in order to obtain a Part B ALJ hearing. Like the AIC requirement for Part A ALJ hearings, the AIC requirement for Part B ALJ requests will be $100, for **initial determinations** made on or after October 1, 2002.

New Time Limit for Filing a Request for Appeal

Section 1869 of the Social Security Act (the Act), as

amended by § 521 of BIPA, also substantially revises the Medicare claim appeals process. Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all **initial determinations**.

Effective October 1, 2002, the time limit for filing a Part B review request will be 120 days from the date of the **initial determination**. **Initial determinations** made prior to October 1, 2002 will continue to have six months from the date of **initial determination** to request a review.

Changes to Remittance Advice Remark Codes

The following Remittance Advice Remark Codes will be updated with the new time frames for requesting a review. The changes are printed in bold.

M25 - Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim **either within 6 months of the date of this notice, if this notice is dated September 30, 2002 or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002 or later.** If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 - Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or

- If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later.** However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

Please contact this office if you have any questions about this notice.

MA01 - If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review,

you must write to us **within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later**, unless you have a good reason for being late.

ELECTRONIC DATA INTERCHANGE (EDI)

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

ANSI 837 Narrative Fields

The ANSI X12N 837 v.4010 format allows for a narrative field at the claim level and one at the line level. Each narrative field (NTE segment) will be 80 characters long. We recommend placing the narrative information that applies to all of the lines on the claim in the claim NTE segment and put line specific information in each line NTE segment.

For example, when you are billing a Not Otherwise Classified (NOC) code you will want to indicate general information at the claim level narrative (NTE) and be very specific at the line level (NTE). If the specific information on the NOC code is placed at the claim level, we may not be able to identify which line item it is referring to and your claim will reject.

When entering the narrative information, please be as specific as possible and include only information required by the policy. A list of wheelchair abbreviations is available in the Jan–Mar (98-1) issue of the EDI Edge. This issue may be found on our Web site at www.cignamedicare.com/dmerc/edge.

ANSI Testing Has Started

As of June 10, 2002, Region D DMERC is currently accepting test files for the ANSI 835 Electronic Remittance Notice (ERN) transaction. Once you begin testing you will receive the National Standard Format (NSF) ERNs and the ANSI 835 ERNs simultaneously until you request the NSF ERNs to be turned off. Effective October 16, 2003, the NSF ERNs will be automatically turned off. In addition to the ANSI 835 transaction, the Region D DMERC has been accepting test files for the ANSI 837 (health care claim) transaction since April 15, 2002.

We encourage you to test early to ensure you have time to complete the migration process. October 16, 2002 remains as the final implementation date unless a compliance plan has been requested and completed from the U.S. Department of Health and Human Services (DHHS). In this case, mandatory migration to the new transactions is required no later than October 16, 2003. For instructions on how to complete the model compliance plan, refer to CMS' Web site at www.cms.hhs.gov/hipaa.

If your are ready to start testing either ANSI 835 or the 837 transaction, please call the EDI Department at 866.224.3094, option 4. If you would like more information regarding the testing process, please visit www.cignamedicare.com/hipaa.

Are You Looking For An ANSI-Ready Software Vendor?

We are proud to announce our new ANSI 837 Approved Vendors List. This list contains software vendors whose billing software has been approved to transmit ANSI X12N 837 v.4010 (health care claim) transaction to the Region D DMERC. The most recent list is available electronically at www.cignamedicare.com/hipaa (select Transactions and Code Sets). The list will be updated monthly and will be announced via the electronic mailing list. If you haven't done so already, you may join the mailing list through CIGNA Medicare's home page at www.cignamedicare.com, (select Join E-Mail List).

Important Reminder: Changes In Reporting Weight On Certificates Of Medical Necessity (CMNs)

An article entitled "Changes in Reporting Weight on CMNs" was published in the Winter 2002 edition of the *EDI Edge* and the Spring 2002 edition of the Region D *DMERC Dialogue*. This article was written to provide instructions for suppliers and vendors migrating to the ANSI X12N v. 4010 format. The patient's weight reflected on the CMN must be transmitted in grams when transmitting ANSI X12N 837 v.4010 claims. This is different than in today's NSF environment that requires the weight to be transmitted in pounds.

NUCC Announces Health Care Provider Taxonomy Code Set Version 2.1 Available Electronically For Use With HIPAA Transactions

(The National Uniform Claim Committee (NUCC) released the following on May 10, 2002.)

The National Uniform Claim Committee (NUCC) and Washington Publishing Company (WPC) announced

today the official release of the updated Health Care Provider Taxonomy Code Set (Version 2.1) and the establishment of a Web-based system for accessing and requesting codes for the Health Care Provider Taxonomy Code Set.

The Provider Taxonomy Code Set is an external non-medical data code set designed for use in an electronic environment, specifically within the American National Standards Institute Accredited Standards Committee Insurance Subcommittee (ANSI ASC X12N) health care transactions. This includes the transactions mandated under HIPAA.

In the absence of an all-encompassing Provider Classification System, both X12N and the National Provider System Workgroup from the Centers for Medicare and Medicaid Services (CMS) commenced work on identifying and coding an external provider table that would be able to codify provider type and provider area of specialization for all medical related providers. CMS' intent was to provide a single coding structure to support work on the National Provider System, while X12N needed a single common table for trading partner use. The two projects worked independently to some extent until April 1996 when the lists were coordinated and a single taxonomy was proposed. A workgroup was charged with resolving differences in the two proposed taxonomies. Their work resulted in a single taxonomy code set that both CMS and members of X12N found meaningful, easy to use, and functional for electronic transactions.

In 2001, ANSI ASC X12N asked the NUCC to become the official maintainer of the Health Care Provider Taxonomy Code Set. Since then, the NUCC began working on updating the code set and developing a user-friendly mechanism to submit change requests. The NUCC has a formal operating protocol, and its membership includes representation from key provider and payer organizations as well as state and federal agencies, standard development organizations and the National Uniform Billing Committee (NUBC). The NUCC has also been working with the National Medicaid EDI HIPAA (NMEH) Work Group. Representatives from NMEH regularly participate in the NUCC's Provider Taxonomy meetings.

The NUCC developed procedures for processing all new and outstanding taxonomy change requests that had accumulated since 1998 and has worked diligently at updating the taxonomy list and definitions of the codes. The new Web site and updated Health Care Provider Taxonomy Code Set (Version 2.1) can be accessed on the Web or downloaded free-of-charge at www.wpc-edi.com/codes. In addition, an electronic representation of the list in an X12 format is available on a paid subscription basis.

The NUCC also developed guidelines for change requests, which are posted on the Web site. A web-based system for submitting those requests to the NUCC has been developed. Code requests are reviewed by the NUCC on a regular basis and all changes to the code set will be published biannually in January and July with effective dates of April and October, respectively. For more information regarding the Health Care Provider Taxonomy Code Set go to: www.wpc-edi.com/codes.

Testing Update For Claim Status Inquiry

The Claim Status Inquiry/Response (ANSI X12N 276/277 v.4010) transaction will open for testing by August 30, 2002. Testing is not required; however, if you would like to test with the Region D DMERC, please contact the EDI Department after testing has opened. For the latest testing dates, please see our Web site at www.cignamedicare.com/hipaa.

MISCELLANEOUS

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 Summer 2002 Region D *DMERC Dialogue.*

- Transmittal 27, released July 2, 2002, revises Chapter 13, Section 4.C to include language regarding Medicare contractors' review of local medical review policies (LMRPs). It is effective October 1, 2002.

- Transmittal 28, released July 10, 2002, revises Chapter 13 by adding Section 11. It instructs contractors to establish a new process of Local Medical Review Policy (LMRP) reconsideration. It standardizes the process contractors have used informally to revise LMRP. This transmittal addresses requests received by the contractor that do NOT refer to §1869(f) of the Social Security Act (the Act). CMS Ruling No. 01-01 states that "If a complaint under §1869(f) of the Act is filed with a carrier, fiscal intermediary or PSC requesting a review of a national or local coverage deter-

mination under §1869(f) of the Act, the carrier, fiscal intermediary, or PSC must within 10 business days, forward a complaint concerning an LCD to SSA's Office of Hearings and Appeals…" This PIM change does NOT address requests for review under §1869(f). The effective date and implementation date of this revision is October 1, 2002.

- Transmittal 29, released July 24, 2002, revises Chapter 10 to clarify the enrollment process for new Medicare providers/suppliers. The instructions will aid the prevention of fraudulent or excluded providers from entering the Medicare program. The effective/implementation date is July 26, 2002.

This manual is available on the Internet, HTML format. To access the PIM, go to http://www.cms.hhs.gov/manuals/108_pim/pim83toc.asp. CMS does not publish hard copies of this manual.

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

New ANSI Reason And Remark Codes For Duplicate Denials

A notice of initial determination provides appropriate appeals information for processed claims. An initial determination is the first adjudication (decision) made following a request for Medicare payment for an item or supply. Claims that are denied as a duplicate of a previously processed claim do not have appeal rights. The appeal rights are afforded to the initial determination for that service or item.

Effective for claims processed January 1, 2003, claims denied as a duplicate of a previously processed claim will receive the following codes:

ANSI Reason Code: CO 18 - Duplicate claim/service.

New Remark Code: N111 - This service was included in a claim that was billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Supplier Guide To The Automated Telephone System

CIGNA Medicare is pleased to offer you a quick and easy way to get information about your claims for durable medical equipment, prosthetics, orthotics and supplies.

When you call CIGNA Medicare, toll-free **1.877.320.0390**, our automated telephone system, called the Interactive Voice Response (IVR) system, will answer the phone. *There is no limit to the number of claims you can check in the IVR!* Select Option 1 and the IVR can tell you if your claim was received, paid, denied or applied to deductible. The IVR can also tell you the paid amount and the check date for assigned claims.

To get claim status, you must enter your supplier number, the beneficiary's HICN (Health Insurance Claim Number) and the date of service. The IVR will instruct you as follows:

To enter a supplier number: Enter the 10-digit number followed by the pound **(#)** key.

To enter a beneficiary's Medicare number:

- If the Medicare number begins with a letter, press **1**. Enter the letter(s) at the beginning of the Medicare number, then enter the numbers.

If the letter is A, press 1	If the letter is CD, press 5
If the letter is MA, press 2	If the letter is WD, press 6
If the letter is WA, press 3	If the letter is WCD, press 7
If the letter is WCA, press 4	All others press 0 for a customer service representative

- If the Medicare number begins with a number, press **2**. Enter the numbers, then enter the letter(s).

If the letter is A, press 1	If the letter is M, press 5
If the letter is B, press 2	If the letter is T, press 6
If the letter is C, press 3	If the letter is W, press 7
If the letter is D, press 4	All others press 0 for a customer service representative
If the letter is followed by a number, press the number. If not, press the pound (#) key.	

To enter the date of service: Use MM/DD/YY format (e.g., 07/01/02).

The IVR also offers other options for information that you may find helpful. To speak with a customer service representative, press 0. Customer service representatives are available Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time). The IVR is available outside normal business hours as long as the mainframe system is functional.

Frequently Asked Questions

1. What amount should be listed in Field 29 of the CMS 1500 form on a non-assigned claim?

   ANSWER: On an assigned claim, if the beneficiary wants to pay their unmet deductible and/or coinsurance up front, they can do that at the time of service and the supplier would list the amount paid in Field 29. On non-assigned claims, the supplier would list the total amount the beneficiary paid up front on covered services.

2. For the Signature on File (SOF), who is considered an authorized representative?

   ANSWER: A legal guardian, representative payee, relative or friend may sign the Signature on File (SOF), giving his/her name, address, relationship to the beneficiary and why the beneficiary cannot sign for themselves. (*DMERC Region D Supplier Manual, Chapter 6, page 12)*

3. If the beneficiary receives an upgraded wheelchair and the wheelchair requires repairs at a later date, will the Certificate of Medical Necessity (CMN) on file for the wheelchair ordered be sufficient to determine coverage for the repairs?

   ANSWER: Medicare will maintain information in our files regarding what the physician ordered and what the beneficiary upgraded to. The CMN sent to Medicare must list the ordered item, not the upgraded item.

4. A wheelchair is rented for 6 months at which time the patient's condition improved such that they no longer meet criteria for coverage and only use the wheelchair for activities outside the home. How is this billed?

   ANSWER: A revised Certificate of Medical Necessity (CMN) should be submitted indicating the wheelchair is not being used within the home.

5. How does a supplier document that the old equipment has been picked up when they are unable to obtain a pickup ticket from either the beneficiary or the previous supplier?

   ANSWER: Suppliers may obtain a written statement from the beneficiary attesting to the retrieval of the old equipment by the previous provider. It is anticipated that these situations would be infrequent; therefore, individual consideration will be given.

6. If we know the item will not be covered by Medicare, but the patient insists that we submit a claim anyway, does this require an Advance Beneficiary Notice (ABN)?

   ANSWER: For items that have no benefit or that are statutorily excluded such as bathtub rails, no ABN would be needed. Because the item is statutorily excluded from the Medicare program, the physician/supplier can bill the beneficiary at the time of service.

   Ordinarily, a physician or supplier does not bill the Medicare program for noncovered services. However, if the beneficiary (or his/her representative) believes that a service may be covered or desires a formal Medicare determination, the physician or supplier must file a claim for that service to effectuate the beneficiary's right to a determination. Suppliers should note on the claim their belief that the service is noncovered and that it is being submitted at the beneficiary's insistence. *(Medicare Carriers Manual, Section 3043)*

7. Can an Advance Beneficiary Notice (ABN) be obtained after the equipment is delivered to the beneficiary?

   ANSWER: An ABN may not be obtained after the delivery of the item(s).

   "The beneficiary must be given the reasons for the possible denial in advance of the date of service or delivery

Frequently Asked Questions (cont'd)

upon which the medical determination for approval of the claim will be based. In the case of an ongoing rental, if the ABN is signed after the initial months claim date, a proper ABN would apply to the following months of rental." *(Region D DMERC Dialogue, Fall 1999, page 9)*

8. What ostomy codes products may be coded K0564?

ANSWER: The description for K0546 is "Ostomy skin barrier with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4X4 inches, each". Currently, only the following products have been identified as meeting the code description:

Manufacturer	Product Number	Product Name
Convatec	125286	Sur-Fit Natura Durahesive Wafer w/Convex-It, w/1 1/2" stoma, 5" x 5"
Convatec	125287	Sur-Fit Natura Durahesive Wafer w/Convex-It, w/1 5/8" stoma, 5" x 5"
Convatec	125288	Sur-Fit Natura Durahesive Wafer w/Convex-It, w/1 3/4" stoma, 5" x 5"
Convatec	125289	Sur-Fit Natura Durahesive Wafer w/Convex-It, w/2" stoma, 5" x 5"
Hollister	15804	New Image Cut-to-Fit Flexend Convex Barrier: 2 3/4" flange, Barrier opening up to 2"

Please refer specific coding questions on products to the Statistical Analysis DMERC (SADMERC).

9 What type of patient qualifies under Medicare for a heavy duty walker with multiple braking system and variable wheel resistance (E0147), and what documentation is required to be submitted with the claim?

ANSWER: The E0147 walker is covered for patients who meet coverage criteria for a standard walker, but who are unable to use a standard walker due to the restricted use of one hand caused by a severe neurological disorder or other medical condition. The claim must include the manufacturer's name, the model name/number, and documentation from the treating physician giving a description of the functional limitations which prevent the patient from using another type of wheeled walker and the diagnosis causing this limitation. *(DMERC Region D Supplier Manual, Chapter 9, WALK, page 2)*

10. What is the supplier's obligation for verifying that a patient is still using a Continuous Positive Airway Pressure (CPAP) device E0601 or the Respiratory Assist Devices (RAD) K0532 and K0533?

ANSWER: If there is discontinuation of usage of a CPAP device (E0601) or the RAD devices (K0532 and K0533) at any time, the supplier is expected to ascertain this, and stop billing for the equipment and related accessories and supplies. *(DMERC Region D Supplier Manual Chapter 9, CPAP, page 2; Chapter 9, RAD, page 2)*

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DMERC Region D Publication Order Form

Name: _____

Company Name: _____

Address: _____

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

Phone: _____ **Fax:** _____

Email: _____

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

Subscription (12 months) $50.00/year per publication

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

Subtotal **$**_____

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Region D *DMERC Dialogue $10.00 Each Issue**

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Summer	_____	_____	**Winter**	_____	_____

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

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

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

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

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MEDICARE REVIEW REQUEST FORM

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

DATE _____

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

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

CLAIM INFORMATION

☐ Assigned ☐ Non-Assigned

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

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

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

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

CONTACT INFORMATION

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

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Customer Service Available

Telephone Inquiries—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

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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.

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