Region D

DMERC DIALOGUE

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

CIGNA HealthCare Medicare Administration
Connecticut General Life Insurance Company
Part B & DME Contracted Carrier for
HCFA
Health Care Financing Administration

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"From the Medical Director…"

Medicare Goes "BIPA'ing" Along

First there was the BBA, then HIPAA, then the BBRA and now BIPA. The Benefits Improvement and Protection Act (BIPA) was passed by Congress and President Clinton on December 21, 2000, and has many provisions that affect the durable medical equipment, orthotic and prosthetic community. In this edition of the *DMERC Dialogue* and *DMERC Region D Supplier Manual* update, you will find several articles and policy revisions that reflect changes mandated by BIPA and that have already been operationalized (or will be shortly) by the Health Care Financing Administration and the Medicare contractors. Other provisions have yet to be communicated to us by HCFA; therefore, "stay tuned" and we will provide further information in the *DMERC Dialogue* and CIGNA Medicare website (www.cignamedicare.com) as it becomes available.

Below is a brief summary of the sections of the Act that may affect you in the coming months and years.

Section 112. Preservation of Coverage of Drugs and Biologicals Under Part B of the Medicare Program

Clarifies policy with regard to coverage of drugs, provided incident to physicians' services, which cannot be self-administered. The provision specifies that such drugs are covered when they are not usually self-administered by the patient.

Section 113. Elimination of Time Limitation on Medicare Benefits for Immunosuppressive Drugs

Eliminates the current time limitations on the coverage of immunosuppressive drugs for beneficiaries who have received a covered organ transplant. The provision applies to drugs furnished, on or after December 21, 2000.

Section 114. Imposition of Billing Limits on Drugs

Specifies that payment for drugs under Part B must be made on the basis of assignment.

Section 115. Waiver of 24-Month Waiting Period for Medicare Coverage of Individuals Disabled with Amyotrophic Lateral Sclerosis (ALS)

Waives the 24-month waiting period (otherwise required for an individual to establish Medicare eligibility on the basis of a disability) for persons medically determined to have amyotrophic lateral sclerosis (ALS). The provision is effective July 1, 2001.

Section 313. Application of SNF Consolidated Billing Requirement Limited to Part A Covered Stays

Effective January 1, 2001, the provision limits the current law consolidated billing requirement to services and items furnished to SNF residents in a Medicare Part A covered stay and to therapy services furnished in Part A and Part B covered stays. The Inspector General of HHS is required to monitor Part B payments to SNFs on behalf of residents who are not in a Part A covered stay.

Section 425. Full Update for Durable Medical Equipment

Modifies updates to payments for durable medical equipment. For 2001, the payments for covered DME would be increased by the full increase in the consumer price index for urban consumers (CPI-U) during the 12-month period ending June 2000. In general, in 2002 and thereafter, the annual update would equal the full increase in the CPI-U for the 12 months ending the previous June. The provision specifies that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for DME are the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 3.28%.

Section 426. Full Update for Orthotics and Prosthetics

Modifies updates to payments for orthotics and prosthetics. In 2000, the rates would increase by one percent. In 2001, the increase would be equal to the percentage increase in the CPI-U during the 12-month period ending with June 2000. For 2002, payments would be increased by one percent over the prior year's amounts. The provision specifies that for the period January 1, 2001, through June 30, 2001, the applicable amounts paid for these items would be the amounts in effect before enactment of this provision. The amounts in effect for the period July 1, 2001, through December 31, 2001, would be the amounts established under this section increased by a transitional allowance of 2.6%.

Section 427. Establishment of Special Payment Provisions and Requirements for Prosthetics and Certain Custom Fabricated Orthotic Items

Certain prosthetics or custom fabricated orthotics would be considered for coverage by Medicare if furnished by a qualified practitioner and fabricated by a qualified practitioner or qualified supplier. The Secretary is required to establish a list of such items in consultation with experts. Within one year of enactment, the Secretary is required to promulgate regulations to provide these items, using negotiated rulemaking procedures.

Not later than 6 months from enactment, the Comptroller General is required to submit to Congress a report on the Secretary's compliance with the Administrative Procedures Act with regard to HCFA Ruling 96-1; certain impacts of that ruling; the potential for fraud and abuse in provision of prosthetics and orthotics under special payment rules and for custom fabricated items; and the effect on Medicare and Medicaid payments if that ruling were overturned.

Section 428. Replacement of Prosthetic Devices and Parts

Authorizes Medicare coverage for replacement of artificial limbs, or replacement parts for such devices, if ordered by a physician for specified reasons. Effective for items furnished on or after enactment, coverage applies to prosthetic items 3 or more years old, and supersedes any 5-year age rules for such items under current law.

Section 429. Revised Part B Payment for Drugs and Biologicals and Related Services

Requires the Comptroller General to study and submit a report to Congress and the Secretary on the reimbursement for drugs and biologicals and for related services under Medicare; the report must include specific recommendations for revised payment methodologies. The Secretary would revise the current payment methodologies for covered drugs and biologicals and related services based on these recommendations; however, total payments under the revised methodologies could not exceed the aggregate payments the Secretary estimates would have been made under the current law. The provision establishes a moratorium on reductions in payment rates, in effect on January 1, 2001, until the Secretary reviews the GAO report.

Section 521. Revisions to Medicare Appeals Process

Modifies the Medicare appeals process. Generally, initial determinations by the Secretary would be concluded no later than 45-days from the date the Secretary received a claim for benefits. Any individual dissatisfied with the initial determination would be entitled to a redetermination by the carrier or fiscal intermediary who made the initial determination. Such redetermination would be required to be completed within 30 days of a beneficiary's request. Beneficiaries could appeal the outcome of a redetermination by seeking a reconsideration. Generally, a request for a reconsideration must be initiated no later than 180 days after the date the individual receives the notice of an adverse redetermination. In addition, if contested amounts are greater than $100, an individual would be able to appeal an adverse reconsideration decision by requesting a hearing by the Secretary (first for a hearing by an administrative law judge, then in certain circumstances, for a hearing before the Department Appeals Board). If the dispute is not satisfactorily resolved through this

administrative process, and if contested amounts are greater than $1,000, the individual would be able to request judicial review of the Secretary's final decision. Aggregation of claims to meet these thresholds would be permitted.

An expedited determination would be available for a beneficiary who received notice: 1) that a provider plans to terminate services and a physician certifies that failure to continue the provisions of the services is likely to place the beneficiary's health at risk; or 2) that the provider plans to discharge the beneficiary.

The Secretary would enter into 3-year contracts with at least 12 qualified independent contractors (QICs) to conduct reconsiderations. A QIC would promptly notify beneficiaries and Medicare claims processing contractors of its determinations. A beneficiary could appeal the decision of a QIC to an ALJ. In cases where the ALJ decision is not rendered within the 90-day deadline, the appealing party would be able to request a DAB hearing.

Section 522. Revisions to Medicare Coverage Process

Clarifies when and under what circumstances Medicare coverage policy could be challenged. An aggrieved party could file a complaint concerning a national coverage decision. Such complaint would be reviewed by the Department Appeals Board (DAB) of HHS. The provision also permits an aggrieved party to file a complaint concerning a local coverage determination. In this case, the determination would be reviewed by an administrative law judge. If unsatisfied, complainants could subsequently seek review of such a local policy by the DAB. In both cases, a DAB decision would constitute final HHS action, and would be subject to judicial review. The Secretary is required to implement DAB decisions and ALJ decisions (in the case of a local coverage policy) within 30 days. The provision also permits an affected party to submit a request to the Secretary to issue a national coverage or noncoverage determination if one has not been issued. The Secretary has 90 days to respond. HHS is required to prepare an annual report on national coverage determinations.

Section 531. Reimbursement Improvements for New Clinical Laboratory Tests and Durable Medical Equipment

Specifies that the national limitation amount for a new clinical laboratory test would equal 100% of the national median for such test. The Secretary is required to establish procedures that permit public consultation for coding and payment determinations for new clinical diagnostic laboratory tests and new durable medical equipment. The Secretary is required to report to Congress on specific procedures used to adjust payments for advanced technologies; the report must include recommendations for legislative changes needed to assure fair and appropriate payments.

Section 532. Retention of HCPCS Level III Codes.

Extends the time for the use of local codes (known as HCPCS level III codes) through December 31, 2003; the Secretary is required to make the codes available to the public.

Section 961. National Institute of Biomedical Imaging and Bioengineering

Establishes a National Institute of Biomedical Imaging and Bioengineering within the National Institutes of Health.

(The entire text of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 may be accessed at www.thomas.gov and searching for Public Law 106-554 or H.R. 4577.)

Medicare *Program Integrity Manual*

The Medicare *Program Integrity Manual* (PIM) is the new HCFA manual that replaces instructions in various other HCFA contractor and provider manuals. It consolidates program integrity (medical review and fraud and abuse) instructions from HCFA's *Medicare Carriers Manual* (MCM), the *Medicare Intermediary Manual* (MIM), and the provider manuals into a single electronic manual.

The Initial Issuance of the PIM was released by HCFA on May 30, 2000. It consists of nine chapters which contain the program integrity language formerly located in MCM (§§7500 and 14000), MIM (§3900), and provider manuals. In addition, one chapter contains Program Memoranda. Since this manual incorporates program instructions for all users, the wording of the instructions may be altered from wording found in previous manuals. However, the *instructions* contained in the PIM Initial Issuance were not changed. The latest version of the PIM was released on January 31, 2001.

HCFA has not published hard copies of this new manual. It is available on the Internet, HTML format. To access the PIM manual, go to http://www.hcfa.gov/pubforms/83_pim/pimtoc.htm. Watch for information about revisions to the *PIM* in future publications of *DMERC Dialogue* and on our website at www.cignamedicare.com/DMERC.

Physician Assistant Rules Concerning Orders And Certificates of Medical Necessity

In the latest revision of the *Program Integrity Manual* (PIM), HCFA added the provision that physician assistants may write and sign detailed written orders for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). In addition, physician assistants may complete Section B and sign Section D of a Certificate of Medical Necessity (CMN). This change is effective for dates of service (DOS) on or after July 1, 2001.

In order to complete CMNs and sign orders, physician assistants must meet *all* of the following requirements:

- They meet the definition of physician assistant found in 1861(aa)(5)(A) of the Act and §2156(A) of the *Medicare Carriers Manual*; and,
- They are treating the beneficiary for the condition for which the item is needed; and,
- They are practicing under the supervision of a Doctor of Medicine (MD) or Doctor of Osteopathy (DO); and,
- They have their own UPIN; and,
- They are permitted to do all of the above by law in the state in which the services are rendered.

Certificates Of Medical Necessity (CMNs) – New Instructions For Corrections

In the Summer 1999 *DMERC Dialogue* (page 14), information was provided on how to correctly identify changes on a CMN once the physician had signed Section D. In that article, instructions for corrections indicated that the physician should draw a line through the erroneous information, sign in full and provide the date of the change.

Effective for dates of service on or after November 22, 2000, physicians may indicate changes to information on the CMN by drawing a line through the erroneous information, *initialing* the change and providing the date of the change. Suppliers also have the option of having the physician complete a new CMN.

State License Required to Dispense All Medicare-Covered Drugs

Medicare's licensure requirement for suppliers and physicians who bill for Medicare-covered drugs has been expanded. Effective for dates of service on or after December 11, 2000, suppliers and physicians who desire to bill the DMERC for *any* Medicare-covered drug (prescription or non-prescription) must have a state license to dispense the drug. Previously, the licensure requirement applied only to Medicare-covered prescription drugs used in conjunction with durable medical equipment or prosthetic devices. This included drugs addressed in the regional medical review policies (RMRPs) for External Infusion Pumps, Parenteral Nutrition, and Nebulizers. The new requirement expands the list to include drugs addressed in the RMRPs for Immunosuppressive Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), and Oral Anticancer Drugs (including the oral antiemetics covered under that policy). There is no pharmacy licensure requirement for oxygen, enteral nutrients or erythropoetin.

When Medicare-covered prescription or non-prescription drugs are dispensed by an entity not qualified as described above, the drugs are considered not reasonable and necessary because HCFA cannot be assured of the drug's safety and effectiveness. Similarly, equipment used to administer drugs dispensed by a non-licensed entity is also considered to be not reasonable and necessary because of the related safety and effectiveness concerns. Therefore, claims for drugs submitted by entities not licensed to dispense drugs and claims for related equipment will be denied for lack of medical necessity.

Mandatory Assignment for All Medicare-covered Drugs

Under Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000), payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.

For claims with dates of service on or after February 1, 2001, suppliers must accept assignment on all claims for Medicare-covered drugs and biologicals.

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Oxygen – Beneficiaries Switching from HMOs to Fee-for-Service

The DMERC regional medical review policy (RMRP) entitled Oxygen and Oxygen Equipment states that, for initial certifications, the blood gas study reported on the CMN must be obtained within 30 days prior to the initial date on the CMN. A special exception is being made for beneficiaries who transfer from a Medicare HMO to traditional Medicare fee-for-service in January 2001. An initial CMN must be submitted to the DMERC. However, for these beneficiaries, the blood gas study reported on the initial CMN does not have to be obtained within 30 days prior to the initial date, but must be the most recent study obtained while the patient was in the HMO under the testing guidelines specified in the DMERC RMRP.

Non-Implantable Pelvic Floor Electrical Stimulation (PFES) – National Coverage Determination

Effective for dates of service on or after April 1, 2001, the *Coverage Issues Manual* (CIM) is being revised to permit coverage for non-implantable pelvic floor electrical stimulators. Reference to non-implantable pelvic floor electrical stimulators has been moved from CIM §65-9 (incontinence control devices) to CIM §60-24 (Non-Implantable Pelvic Floor Electrical Stimulator).

Section 60-24, Non-Implantable Pelvic Floor Electrical Stimulator, permits coverage for non-implantable pelvic floor electrical stimulators for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Suppliers submitting claims to the DMERC for PFES should use HCPCS code E0740 (Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer). This code is in the Inexpensive or Routinely Purchased (IRP) reimbursement category. Suppliers are reminded that there must be documentation in the patient's medical record that the coverage criteria outlined in the national policy have been met. This documentation does not have to be routinely sent with the claim but must be available to the DMERC upon request.

Speech Generating Devices (SGD) – New Policy

The DMERC regional medical review policy (RMRP) entitled Speech Generating Devices is published in the accompanying *DMERC Region D Supplier Manual* update and posted on the CIGNA Medicare website at www.cignamedicare.com/dmerc. In addition, the website posting also includes a "Response to Comments" document that summarizes the comments received from clinical organizations, suppliers, manufacturers, and beneficiary organizations during the 60-day public comment period that ended on December 19, 2000. The DMERC's medical directors' response to each comment is also detailed in this document. The SGD RMRP reflects changes adopted by the DMERCs in response to comments and is effective for dates of service on or after July 1, 2001.

As noted in the Winter 2000 *DMERC Dialogue* (page 3), the development of this policy reflects a change in HCFA's national coverage of "communicators" and HCFA's issuance of *Coverage Issues Manual* 60-23 which was effective for dates of service on or after January 1, 2001. Therefore, claims submitted for these devices between January 1, 2001, and June 30, 2001, will be adjudicated based on individual consideration.

Immunosuppressive Drugs Following Transplant – Coverage Change

Effective for immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for this Medicare benefit. This policy applies to all Medicare beneficiaries who meet all of the other program requirements for coverage under this benefit. Beneficiaries who satisfy all eligibility requirements for immunosuppressive drug coverage but for whom coverage expired prior to December 21, 2000, due to time limitations imposed by Medicare statute may have immunosuppressive drug coverage reinstated on or after December 21, 2000. However, there is no provision for coverage between the time of previous benefit expiration and the resumption of the benefit on or after December 21, 2000. Therefore, claims for dates of service after expiration of benefits but prior to December 21, 2000, will be denied as noncovered.

A new DMERC Information Form (DIF) for Immunosuppressive Drugs is not required for beneficiaries who had previously received coverage for immunosuppressive drugs and are now resuming coverage

under this benefit extension *unless* there has been a change in the drug regimen since the initial DIF was filed. If there has been a change in the drug regimen, a new *initial* DMERC Information Form (DIF) for Immunosuppressive Drugs must be completed when claim submission resumes for these beneficiaries.

In the accompanying *DMERC Region D Supplier Manual* update, the regional medical review policy on Immunosuppressive Drugs has been updated to reflect this change in coverage time limits.

Immunosuppressive Drugs Following Intestinal Transplantation – Coverage and DMERC Information Form (DIF)

Effective April 1, 2001, Medicare covers intestinal transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Coverage of immunosuppressive drugs is being extended to include patients who meet *all* of the following criteria:

- The patient receives a Medicare-covered intestinal transplant on or after April 1, 2001; and,
- The patient was enrolled in Medicare Part A at the time of the transplant and is enrolled in Medicare Part B at the time that the drugs are dispensed; and,
- The drugs are medically necessary to prevent or treat rejection of the organ transplant in the particular patient; and,
- The drugs are furnished on or after discharge from the hospital following the intestinal transplant.

Suppliers billing for immunosuppressive drug(s) related to an intestinal transplant must, for question #5 on the DIF, answer "7" (Reserved For Future Use) if this correctly identifies the patient's situation. Enter the statement "Intestinal Transplant" in the blank space on the DIF next to Item 7 in question #5. If the claim is filed electronically, enter "intestinal transplant" in the narrative (HA0) record.

Refer to the Immunosuppressive Drugs policy in the *DMERC Region D Supplier Manual* for more information on Coverage and Payment Rules, Coding Guidelines, and Documentation requirements.

Oral Antiemetic Drug Policy – Revised

The DMERC regional medical review policy (RMRP) entitled Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) is published in the accompanying *DMERC Region D Supplier Manual* update. The revision language reflects a change in jurisdiction for claim submission by physicians who are also DMEPOS suppliers. In addition, the policy incorporates instructions from the HCFA regarding entities qualified to dispense and bill for Medicare-covered drugs. (See accompanying article in this *DMERC Dialogue* entitled "State License Required to Dispense All Medicare-Covered Drugs.") The revised policy is effective for dates of service on or after April 1, 2001.

Osteogenesis Stimulators – Policy Revision

A revision of the Osteogenesis Stimulators regional medical review policy (RMRP) is included in the accompanying *DMERC Region D Supplier Manual*. The major changes are:

1. Ultrasonic osteogenesis stimulators (E0760) are covered under conditions specified in the recent revision to Medicare *Coverage Issues Manual*, Section 35-48.
2. Use a ZX modifier if coverage criteria for an **ultrasonic** osteogenesis stimulator are met. (The ZX modifier is not for use with electrical osteogenesis stimulators E0747 and E0748.)
3. The Certificate of Medical Necessity (CMN) will not be used for ultrasonic osteogenesis stimulators, but will continue to be used for electrical osteogenesis stimulators.
4. Relevant ICD-9 diagnosis codes are required on claims for **all** osteogenesis stimulators, electrical and ultrasonic. For patients with nonunion of a fracture, in addition to the generic code for nonunion (733.82) the policy also requires the ICD-9 diagnosis code specifying the fracture site.

Coverage for ultrasonic osteogenesis stimulators became effective for claims with dates of service on or after January 1, 2001. The revised documentation requirements for all osteogenesis stimulators are effective for claims with dates of service on or after July 1, 2001.

The ultrasonic osteogenesis stimulator is in the Inexpensive or Routinely Purchased (IRP) payment category.

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Insulin Lispro - New Code

Effective for claims with dates of service on or after April 1, 2001, a new HCPCS code has been established for insulin lispro.

K0548 Injection, insulin lispro, up to 50 units

For dates of service prior to April 1, 2001, all forms of insulin, including insulin lispro, should be coded as J1820 (Injection, insulin, up to 100 units). However, for dates of service on or after April 1, 2001, forms of insulin other than lispro must continue to be coded as J1820 while lispro should be coded K0548.

Insulin is covered by Medicare *only* when administered through an insulin pump, and in accordance with the Coverage and Payment Rules outlined in the "External Infusion Pumps" policy in the *DMERC Region D Supplier Manual.*

Consolidated Billing (CB) for Skilled Nursing Facility (SNF) Residents

Section 4432(b) of the Balanced Budget Act (BBA) requires Consolidated Billing for the SNF. The CB 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.

For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs will no longer be able to unbundle services to an outside provider of services or supplies that can then submit a separate bill directly to the Medicare carrier. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, Power of Attorney, or any other direct payment arrangement. (See 42 CFR 424.73) As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare carrier, for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF's bill to the Fiscal Intermediary (FI).

Per 4432 (b)(4) of the BBA, when physicians provide services to a beneficiary residing in a SNF, the physician must include the Medicare facility provider number of the SNF (OSCAR number) on the claim form or electronic record. This number is not currently required for claims billed to the DMERC.

It is the supplier's responsibility to check with the facility to see if their patient is a resident in a covered Part A stay. If so, all services must be sent to Medicare by the SNF. Services billed to the DMERC for a beneficiary in a covered Part A stay may be denied.

DMEPOS items for beneficiaries in a covered Part B stay may be billed to the DMERC until further notice.

This requirement only applies to Medicare fee-for-service beneficiaries residing in a participating SNF. Services to risk-based HMO enrollees are not included in consolidated billing.

DMERC Services Excluded From Consolidated Billing in a SNF

Erythropoietin (EPO) Services.—These services are not included in the SNF Part A PPS rate and are excluded from CB. EPO services are identified by the following HCPCS codes:

- Q9920 - Injection of EPO, per l,000 units, at patient HCT of 20 or less;
- Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 2l through 39; or
- Q9940 - Injection of EPO, per l,000 units, at patient HCT of 40 or above.

Dialysis.—Home dialysis equipment, home dialysis support services, institutional dialysis services and supplies are excluded from CB and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment. Claims for services for dialysis patients must have one of the following ICD-9-CM diagnosis codes:

403.01	403.11	403.91
404.02	404.12	404.92
584.5	584.6	584.7
584.8	584.9	585
586	788.5	958.5

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Customized Prosthetic Devices

L5050	L5060	L5100	L5105	L5150	L5160	L5200
L5210	L5220	L5230	L5250	L5270	L5280	L5300
L5310	L5320	L5330	L5340	L5500	L5505	L5510
L5520	L5530	L5535	L5540	L5560	L5570	L5580
L5585	L5590	L5595	L5600	L5610	L5611	L5613
L5614	L5616	L5617	L5618	L5620	L5622	L5624
L5626	L5628	L5629	L5630	L5631	L5632	L5634
L5636	L5637	L5638	L5639	L5640	L5642	L5643
L5644	L5645	L5646	L5647	L5648	L5649	L5650
L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666
L5667	L5668	L5669	L5670	L5672	L5674	L5675
L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697
L5698	L5699	L5700	L5701	L5702	L5704	L5705
L5706	L5707	L5710	L5711	L5712	L5714	L5716
L5718	L5722	L5724	L5726	L5728	L5780	L5785
L5790	L5795	L5810	L5811	L5812	L5814	L5816
L5818	L5822	L5824	L5826	L5828	L5830	L5840
L5845	L5846	L5850	L5855	L5910	L5920	L5925
L5930	L5940	L5950	L5960	L5962	L5964	L5966
L5968	L5970	L5972	L5974	L5975	L5976	L5978
L5979	L5980	L5981	L5982	L5984	L5985	L5986
L5988	L6050	L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570
L6580	L6582	L6584	L6586	L6588	L6590	L6600
L6605	L6610	L6615	L6616	L6620	L6623	L6625
L6628	L6629	L6630	L6632	L6635	L6637	L6640
L6641	L6642	L6645	L6650	L6655	L6660	L6665
L6670	L6672	L6675	L6676	L6680	L6682	L6684
L6686	L6687	L6688	L6689	L6690	L6691	L6692
L6693	L6700	L6705	L6710	L6715	L6720	L6725
L6730	L6735	L6740	L6745	L6750	L6755	L6765
L6770	L6775	L6780	L6790	L6795	L6800	L6805
L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875	L6880
L6920	L6925	L6930	L6935	L6940	L6945	L6950
L6955	L6960	L6965	L6970	L6975	L7010	L7015
L7020	L7025	L7030	L7035	L7040	L7045	L7170
L7180	L7185	L7186	L7190	L7191	L7260	L7261
L7266	L7272	L7274	L7362	L7364	L7366	

The Health Care Financing Administration (HCFA) has a website, www.hcfa.gov/medlearn, to provide suppliers with information regarding the Skilled Nursing Facility Prospective Payment System and Consolidated Billing. They will notify providers of relevant training materials, articles and other relevant information, as it becomes available.

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Elements of an Appeal Request

Contents of a Written Request for Reconsideration or Review

For Part B appeals, the Medicare regulation at 42 CFR 405.807 states that a party who is dissatisfied with an **initial determination** may request that the carrier review **such determination**. A request for review may be filed on Form HCFA-1964 (Request for Review of Part B Medicare Claim) or the Medicare Review Request Form (see page 21) but is not limited to this method. A signed written statement expressing disagreement with the initial determination also constitutes a request for an appeal but must contain **all** of the following information:

- Beneficiary name;
- Medicare health insurance claim number (HICN);
- Name and address of provider/supplier of item/ service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and
- Which item(s), if any, and/or service(s) are at issue in the appeal.

Note: Unprocessable claims have **no appeal rights**. Any claim that is returned as missing required data (unprocessable) **cannot** be corrected through the review process.

Development of Requests for Provider/ Supplier-Initiated Appeals

Providers/suppliers, Medicaid state agencies, or the party authorized to act on behalf of the Medicaid state agency are responsible for submitting documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies. This documentation may be supplied with the appeal request or at the request of the carrier. Failure to submit requested documentation in a timely manner may result in processing delays.

If additional documentation is needed to process an appeal, the carrier will request that the submitter of the appeal (i.e., the provider/supplier) obtain and submit it within the prescribed time period following notification of an initial determination.

Providers or suppliers may request a review by telephone, if the appeal request is not complex, by contacting Customer Service at 877.320.0390. If an appeal from a provider or supplier is **complex** or **if significant documentation is needed** to adjudicate the appeal request, then a written review must be filed within the timely filing period.

Who Can Submit Appeal Requests

Medicaid state agencies and parties authorized to act on behalf of Medicaid state agencies may submit an appeal request on behalf of beneficiaries entitled to Medicare and eligible for Medicaid.

Additionally, the following parties may continue to submit an appeal request:

- Providers, as defined in 42 CFR 400.202, with appeal rights as specified in regulation at 42 CFR405.710(b).
- Suppliers (including physicians, as defined in 42 CFR 400.202) with appeal rights as specified in regulations at 405.801(b), accepting assignment on the claim at issue, and suppliers with refund requirements under §1842(l)(1), 1834(a)(18), or 1834(j)(4) of the Act.

Beneficiaries and their authorized representatives (a copy of a complete Appointment of Representative form must be submitted along with the request).

Unprocessable Claims Have No Appeal Rights

In 1996, the Health Care Financing Administration (HCFA) had carriers implement the initiative to "return as unprocessable" claims that were missing basic information. These claims do enter our system and are assigned claim control numbers. However, these claims are **not processed** as they lack specific information needed for claim adjudication.

Unprocessable claims have **no appeal rights**. Any claim that is returned as missing required data (unprocessable) **cannot** be corrected through the review process. Please do not use the Medicare Review Request Form to make corrections. Suppliers must make the necessary corrections and **submit the claims as a new claim**.

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

Follow-up or Duplicate Review Requests

If a supplier disagrees with a denial or reduced payment on a claim, a review of the claim should be requested. The Health Care Financing Administration (HCFA) requires reviews to be completed within 45 days of carrier receipt. Please allow 8 weeks from the time you mail your request before sending a follow-up request. This will allow ample time for the carrier to receive, review, and respond via letter or corrected Medicare Remittance Notice.

Managing Medicare Appeals Workloads in FY 2001

In an effort to manage incoming appeals in FY 2001 with the given resources, HCFA has provided guidance relative to processing appeals. Incoming appeal requests submitted without necessary supporting documentation will be given secondary priority to appeal requests submitted with appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.

New And Revised Supplier Manual

Soon you will be receiving a new and revised *DMERC Region D Supplier Manual*. The accompanying supplier manual updates have been formatted to fit the new manual. If you receive the updates before the new supplier manual, be sure to insert them into the manual when you receive it.

In an effort to provide the most accurate information to our suppliers, we have revised outdated information and incorporated new information. Some chapters have been totally rewritten. We have also incorporated information previously published in the *DMERC Dialogue.* Some of the changes to the supplier manual include:

- Citations for regulations (not all inclusive) have been added where applicable.
- New chapter added for crossover claims.
- Chapter 9, Regional Medical Review Policies (RMRPs):
  - New Introduction with "Citations for DMEPOS Benefit Categories" chart.
  - Acronym page numbering system incorporated for each RMRP.
- Added initially published dates and revision history at the end of each RMRP in Chapter 9 and at the end of each Coverage Issue in Chapter 10 (revision dates reflect DMERC Region D published dates).
- Chapter 16, Coding:
  - Acronym page numbering system incorporated for the jurisdiction chart, crosswalk tables, HCPCS codes, oral anticancer drugs, and the modifiers chart.
  - HCPCS codes have been placed in a chart format that includes the code, description, benefit category, and states which codes require a Certificate of Medical Necessity (CMN) or DMERC Information Form.
  - The product classification list has been removed.

The new supplier manual is being mailed to all Medicare DMEPOS suppliers that have a valid billing number issued by the National Supplier Clearinghouse (NSC). The manual is being sent to the current mailing address on file with the NSC. If you do not receive a new supplier manual by May 31st, please contact us at 877.320.0390.

Website Savvy

The *DMERC Dialogue* and *DMERC Region D Supplier Manual* serve as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines. The *DMERC Dialogue* and updates to the *DMERC Region D Supplier Manual* are published quarterly.

Special notices concerning changes in regulations issued between publication releases are posted on the CIGNA Medicare website at www.cignamedicare.com/dmerc. The information is posted at Durable Medical Equipment under "What's New." Visit the website frequently to ensure you have the most current information available.

CIGNA Medicare's Policy on Tokens of Appreciation

Occasionally, customers send gifts of recognition to our employees. While your gift is appreciated, it is the policy of CIGNA Medicare to prohibit employees from accepting gifts, gratuities, favors, or other tokens of appreciation from providers, suppliers, government employees, or others. If you are inclined to recognize exceptional service from one of our employees, a letter of appreciation is appropriate.

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Newsletters issued after March 1999 are available at no-cost from our website atwww.cignamedicare.com.

Quarterly Update to 2001 Fee Schedule

The fees listed below were established for the 2001 fee schedule, 2nd quarter updates, for the following states: Alaska, Arizona, California, Hawaii, Iowa, Idaho, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming.

E0617RR	$290.88
E0740NU	$500.23
E0740RR	$50.02
E0740UE	$375.19
E0760NU	$2,785.93
E0760RR	$278.59
E0760UE	$2,089.45
E0765NU	$80.48
E0765RR	$8.06
E0765UE	$60.38

Home Health Prospective Payment System (PPS) – Non-Routine Medical Supplies (DMERCs)

Below are the corrections to the article that was published in the Winter 2000 *DMERC Dialogue,* page 11. Deleted code K0428 was listed twice, which caused the original article's new "A" codes to crosswalk incorrectly.

Codes	Deleted as of	New "A" Codes	Valid as of
K0428	12/31/99	A4384	1/1/2000
K0429	12/31/99	A4385	1/1/2000
K0430	12/31/99	A4386	1/1/2000
K0431	12/31/99	A4387	1/1/2000
K0432	12/31/99	A4388	1/1/2000
K0433	12/31/99	A4389	1/1/2000
K0434	12/31/99	A4390	1/1/2000
K0435	12/31/99	A4391	1/1/2000
K0436	12/31/99	A4392	1/1/2000
K0437	12/31/99	A4393	1/1/2000
K0438	12/31/99	A4394	1/1/2000
K0439	12/31/99	A4395	1/1/2000

New Code	Effective Date
A4396	1/1/2001

EDI News to Note …

EDI Edge is Moving to the Web

In today's age, it is important to remain up to date with technology and the communication media it offers. To allow for better access for electronic billers, the *EDI Edge*, the quarterly newsletter published by the EDI department, will now be available exclusively on the Web. Issues as far back as 1998 may be accessed at www.cignamedicare.com.

Coming Soon … EDI Section in the DMERC Dialogue

As of December 2000, more than 80 percent of our claims were transmitted electronically. From observing this high percentage, the EDI department realizes the importance of utilizing every available source to communicate with its customers. Beginning with the Summer 2001 issue, the EDI department will begin using the *DMERC Dialogue* as an information source. For the convenience of its customers, there will be a separate section dedicated to the EDI department, including such information as *EDI Edge* excerpts, updates, and other important news for electronic billers.

Keep watching for other developments coming soon from the EDI department.

Elimination of HCFA Free Billing Software

Since the late 1980s, the Health Care Financing Administration (HCFA) has required CIGNA Medicare to offer free electronic billing software to our providers upon request. These generally simple pieces of software allowed our providers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format, the UB-92, or the X12N 837 format. CIGNA Medicare was required to offer this software in order to increase electronic claim submissions. The software gave our providers an opportunity to try electronic billing at low cost, with the expectation that providers would experience the benefits and procure or develop more sophisticated practice management or billing software that would do additional functions. Additionally, use of this software reduced processing costs to the Medicare program as providers switch from paper to electronic claims.

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With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare specific electronic formats. The same format will be used by providers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for providers, and should encourage more providers to use electronic transactions. These changes have prompted HCFA to assess whether or not to continue offering the free billing software in the post-HIPAA environment. HCFA will require CIGNA Medicare to begin phasing out the free billing software requirement effective FY 2004, approximately one year after HIPAA standards are implemented. This will give our providers enough time to find substitute software that can work with all payers. You will be notified when the transition period will begin to phase out the free billing software.

Dive Deeper Into Medicare with Our Spring Seminars

If you are looking to deepen your Medicare knowledge you should attend our upcoming spring seminars entitled "Dive Deeper Into Medicare." We will be presenting Respiratory for a full day, followed by two half-day sessions, Updates Unlimited and Wheelchairs. To sign up, please fill out the registration form located at the back of this publication. Soon you'll be the sharpest fish in the sea!

Fall 2000 Seminar Questions and Answers

Public Relations

1. *Q: If a patient is no longer eligible for Part B do they receive a new card to indicate the change?*

   A: Yes, Social Security will send a new card to the patient, which will reflect the new eligibility status.

2. *Q: Why will Medicare crossover assigned & non-assigned claims for Medicaid but not for Medigap?*

   A: Section 4081 of the Omnibus Budget Reconciliation Act of 1987 carries a provision that is intended to speed payment of Medicare supplemental insurance benefits to **participating** suppliers by automatic transfer of claims information to Medigap insurers. This provision does not apply to nonparticipating suppliers.

3. *Q: How often does a one-time authorization need to be signed?*

   A: On assigned claims it is required when a new service or a new piece of equipment is ordered. For non-assigned rentals a one-time authorization is required with each DME rental claim.

4. *Q: Is the monthly Part B premium fee waived for Part B hardship?*

   A: The beneficiary would need to contact the Social Security Administration at 800.772.1213 for information regarding waiver of the Medicare premium.

5. *Q: What is a valid attempt to collect co-payment in a hardship situation?*

   A: You must attempt to collect the co-payment each time a claim is submitted. The attempt may be a letter, phone call, or any other communication method. Each attempt must be documented in the beneficiaries record.

6. *Q: Do I have to verify financial hardship every month or every claim?*

   A: Financial hardship must be verified with each claim submitted to DMERC.

7. *Q: Is the deductible applied to non-covered charges also?*

   A: The beneficiary is responsible for paying the first $100 each year of the charges approved by Medicare.

8. *Q: Is field 30 left blank on every claim?*

   A: For paper claims, it is acceptable to leave field 30 blank. For electronic claims see the EDI section below.

9. *Q: If a patient moves, how do we do Maintenance and Servicing?*

   A: The supplier providing the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15 month period. The supplier can choose to make arrangements to provide maintenance and servicing with another supplier in the beneficiary's new area.

10. *Q: If a beneficiary did not return the rent/purchase option letter, can we send the beneficiary a letter indicating that they are responsible for the maintenance and service fee?*

A: In the event that the rent/purchase option letter is not returned within the required 30 days, the supplier must append a BU modifier to indicate the beneficiary's indecision. The item continues to rent and therefore, the supplier is responsible for providing maintenance and servicing payable twice per year. On assigned claims for maintenance and servicing, the supplier can bill the beneficiary for any unmet deductible amount and the 20 percent coinsurance amount. On non-assigned claims the beneficiary is responsible for the balance between the Medicare allowed amount and the supplier's charge.

11. *Q: During the initial intake a beneficiary is overweight and receives a heavy-duty wheelchair. The beneficiary loses weight and now needs another chair. Does this allow for a new capped rental period?*

    A: Since the beneficiary lost weight, this would be a change in medical need from the heavy-duty wheelchair. Medicare would consider starting a new capped rental period.

12. *Q: A beneficiary wants to purchase a used power wheelchair in the first month. What will Medicare pay?*

    A: The allowable for used equipment is 75 percent of the new equipment fee schedule. For example: The fee schedule for a K0011NU in the state of Idaho is $5067.20 and the used fee schedule is $3800.40.

13. *Q: A beneficiary is using a bi-level pressure device and needs the re-evaluation between the 61st and 90th day, but cannot get the evaluation because the doctor will be on vacation until after the 90th day. What type of documentation will I need to submit the claim?*

    A: If the supplier cannot obtain the evaluation until after the 90th day, they may choose to hold the claim until the required documentation is received. It is important to remember that when using the ZX modifier, this indicates that the beneficiary meets criteria and that all required documentation is on file.

14. *Q: A beneficiary's primary insurance purchased oxygen equipment prior to coming to Medicare. Now that the beneficiary is Medicare eligible what types of oxygen equipment will Medicare cover?*

    A: Medicare does not pay for accessories for oxygen systems that were purchased on or after June 1, 1989, regardless of whether the patient was or was not a Medicare beneficiary at the time of the purchase. For example, if the patient was not Medicare eligible in 1997 and they or their previous insurance company purchased an oxygen system, we would NOT pay for accessories after the patient becomes Medicare eligible.

    Medicare will pay for oxygen contents for patient owned equipment, provided that Medicare criteria is met, but not repairs or any other supplies or accessories.

    If patient-owned equipment needs to be replaced, Medicare would consider coverage on a monthly rental basis only.

    Please refer to the oxygen chart in the June/July 1994 *DMERC Dialogue* for specific cases. Additional information concerning oxygen contents was published in the January 1995 *DMERC Dialogue*.

15. *Q: What can the supplier fill out on a detailed written order?*

    A: Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. The supplier must keep in mind that the documentation in the physician's records must validate what is contained in the detailed written order.

16. *Q: What is the difference between a dispensing order and a detailed written order? When is a detailed written order required?*

    A: A detailed written order is required before submitting the claim to the DMERC. It is **in addition to** the dispensing order. The dispensing order is required before dispensing the item to the beneficiary. It can be written, faxed, or verbal and requires the following elements:
    - Description of the item
    - Name of the beneficiary
    - Name of the physician
    - Date of the order

    The dispensing order does not require as much information as the detailed written order.

    If the dispensing order contains all the details required in a detailed written order, it may serve as both the dispensing order and the detailed written order.

17. *Q: A beneficiary has a wheelchair purchased by Medicare, do we need a new order for each repair?*

    A: A new physician's order **is not required** before replacing lost, stolen or irreparably damaged items when in the judgement of the carrier, the item as originally ordered, considering the age of the item, still fulfills the patient's medical needs. The carrier may, however, require proof of loss or damage through documentation such as a police report, picture or corroborating statement.

A new physician's order **is required** when the item is being replaced because the item is irreparably worn or the patient's condition has changed. The supplier's records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in the supplier's files and be made available to the DMERC upon request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in claim(s) denial.

18. *Q: If a resident doctor issued a dispensing order, but when trying to get the signature of the doctor the supplier finds out that the doctor has moved. Can the overseeing doctor sign the CMN?*

    A: In this case, assuming the overseeing physician is the attending physician for the Medicare beneficiary, he/she can sign the CMN or detailed written order without obtaining a new dispensing order.

19. *Q: Is the amount in controversy for the appeals process the total charge or total allowable?*

    A: The amount in question is 80 percent of the difference between the amount billed and the amount previously allowed. To meet the limit you may combine claims that have been reviewed and denied within the past six months.

EDI

20. Q: Does the system process claims on a weekend if suppliers transmit on a weekend?

    A: Medicare claims are processed on business days, excluding weekends and holidays. If a claim is received any time after Friday, 5:00 p.m. Eastern Time, it will be considered as received by CIGNA Medicare on the next business day.
    [Reference: *EDI Edge*, 1st Quarter 2000, page 1]

21. *Q: Do you leave a space in the name if it is hyphenated on EDI claims?*

    A: Yes, use a space in place of a hyphen.

22. *Q: Is Field 30 left blank on every claim?*

    A: For EMC claims, Field 30 (balance due) on the HCFA 1500 form is a required field and must be completed.
    [Reference: The NSF matrix may be accessed at www.hcfa.gov/medicare/edi/edi3.htm#CLAIM. Please click on NSF V3.1 and review the DA1 record, Field 24.0 for the balance due.]

23. *Q: Billing electronically, how do we complete Field 31?*

    A: Field 31(provider signature) on the HCFA 1500 form is completed by indicating either "Y" for signature of provider is on file, or "N" for signature of provider is not on file. According to the NSF, the definition of provider signature is: "the signature of the provider of service(s) reported on this claim which acknowledges the performance of the service(s) and authorizes payment is on file in the provider's office."

    Reference: The NSF matrix may be accessed at www.hcfa.gov/medicare/edi/edi3.htm#CLAIM. Please click on NSF V3.1 and review the EA0 record, Field 37 for the provider signature indicator.

2001 DMEPOS Fee Schedule

Due to possible changes in legislation, the 2001 DMEPOS Fee Schedule will not be printed at this time. The fees are available on the CIGNA Medicare website at www.cignamedicare.com (select Durable Medical Equipment) or through the Health Care Financing Administration at www.hcfa.gov.

Suppliers who do not have access to the internet may request a copy of the 2001 DMEPOS Fee Schedule by writing to: CIGNA Medicare, Attn: DMERC Publications, P. O. Box 690, Nashville, TN 37202.

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

From the DAC . . .

HCFA, CIGNA Medicare, and the DAC are working together in partnership.

In the *DMERC Dialogue* of Spring 2000, the then-Chair of the DMERC Advisory Committee (DAC) for CIGNA Medicare Region D DMERC, Chuck Gunther, closed an article with the following:

"…The DAC would like to thank CIGNA Medicare for allowing us to publish this information…"

If you refer to this particular article you will learn that the DAC is a group open to any Home Medical Equipment supplier that provides DME services to Medicare beneficiaries within the 17 states in the Region D DMERC area. Suppliers are not required to be affiliated with any state or national association. Several national associations participate as well with the DAC. The objective of the DAC is to interact together with HCFA and CIGNA Medicare to work, address, and channel efforts to solve issues that are pertinent to the delivery of DME services to Medicare beneficiaries in their homes.

Throughout the year 2000, this relationship has been strengthened and has evolved to levels of suppliers' participation never seen before. The following is the current organizational structure of the DAC:

Executive Committee

Chair	Carlos Reyes, Lincare Inc., Washington	509.467.0362
Vice-Chair	Laura McIlvaine, Shield Healthcare, California	661.294.4291
Past Chair	Chuck Gunther, Clinical Support Services, Inc., California	760.731.2000
Secretary	Troy Paz, Maag Medical, Idaho	208.233.2063
Treasurer	Wade Hendrickson, Med Equip, Iowa	800.572.5482

State Representatives & A Teams Members (See Chart)

Administrative Office

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DAC Operations Region D
One Capital Mall, Suite 320
Sacramento, CA 95814-3228

Phone: 916.444.3568
Fax: 916.444.7462
E-mail: gpeterson@rjaa.com

Jim Underhill representing Region X HCFA Office, Dr. Robert Hoover, Medical Director, leading several CIGNA Medicare representatives, and members of the DAC meet four times a year. The A Teams are constantly meeting via conference calls with CIGNA Medicare representatives on a needed basis.

Many issues have been addressed and resolved through these meetings, and we continue to work together to come to a resolution in others. It is impressive and motivating to see how many people care to come together to give their time and efforts to accomplish a noble and important purpose – ***the delivery of DME services to Medicare beneficiaries in their homes to meet their medical needs***.

It is only fitting to close this article saying:

The DAC would like to thank HCFA and CIGNA Medicare for allowing us to work together in the pursuit of the best possible delivery of DME services to Medicare beneficiaries in their homes, in an environment of mutual fiscal responsibility.

J. Carlos Reyes
Chair, DAC Region D

REGION D - DMERC ADVISORY COMMITTEE (DAC)

STATE REPRESENTATIVES or CHAMPIONS

ALASKA
Kimberlie Rogers-Bowers 724.873.7804

ARIZONA
Maureen Hanna 480. 837.3229

CALIFORNIA/CAMPS
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Laura McIlvaine (See Executive Committee)

HAWAII — HAHC (See Alaska)

IDAHO/BIG SKY
Troy Paz - Executive Committee

IOWA/MAMES
Wade Hendrickson - Executive Committee

KANSAS/MAMES
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HME
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EDUCATION/COMMUNICATION
Maureen Hanna 480.837.3229

EDI/EMC
Len Mandaro 714.427.4829

NATIONAL ASSOCIATIONS

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Ruth Ann Kaiser 703.838.6109

NAIT (National Alliance for Infusion Therapy)
Alan K. Parver, Esq. 202.624.7225

AAH (American Association for Homecare)
Asela Cuervo, Esq. 703.836.6263

NASL (National Assn. for the Support of Long Term Care)
Barbara Morehouse
703.549.8500

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Gloria Peterson 916.443.2115

HAHC (Hawaii Association of Home Care)
Rose Ann Poyzer 808.735.2970

MAMES (Midwest Assn. of Medical Equip. Suppliers Iowa / Kansas/Missouri/Nebraska/North Dakota/South Dakota)
Rose Schafhauser 651.351.5395

BIG SKY – Idaho/Montana

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Jennifer Jones 503.253.9385

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Questions and Answers From the DMERC Advisory Committee (DAC) Meeting on January 8, 2001

1. What do CIGNA Medicare and/or HCFA define as the "official" version of the supplier manual?

   a. Is it the printed version or the version contained on the CIGNA Medicare website?
   b. Is this cited in law and/or regulation?
   c. If so, where?

   Answer:
   a. It is the printed version.
   b. This is a direction from HCFA.
   c. N/A.

2. Are providers required to be compliant will all 21 new supplier standards by 12/11/00?

   a. Many suppliers are not aware of the new standards due to the fact that it has not been published in DMERC bulletins.

   Answer: Yes.

   a. This is a National Supplier Clearinghouse (NSC) issue and needs to be addressed to the NSC. CIGNA Medicare did publish an article about the new supplier standards in the Winter 2000 *DMERC Dialogue*. The *DMERC Dialogue*s may be accessed through our website at www.cignamedicare.com.

3. The Waiver of Liability provision for "unassigned" claims (published by CIGNA Medicare in July 1997) appears to have been implemented within Region D.

   a. What is the status of this provision?
   b. Did CIGNA implement?
   c. If so, when?
   d. If not, will the 7/97 information be revised in an upcoming DMERC bulletin?

   Answer:
   a. While there are provisions in the *Medicare Carriers Manual (MCM)* for non-assigned liability and they have been implemented on the Part B side for several years, Region D DMERC has never been issued final implementation instructions from HCFA.
   b. See above. In addition, CIGNA Medicare educates through seminars that Advanced Beneficiary Notices do not apply to non-assigned claims at this time.
   c. N/A.
   d. CIGNA Medicare does not have plans to publish another article at this time. However, CIGNA Medicare will notify suppliers when we receive implementation instructions from HCFA.

4. At a Region D meeting on October 17, 2000, an ombudsman stated that all oxygen patients must be re-tested to get a re-certification, even if the initial CMN was for lifetime. Please advise.

   Answer:

   According to the *DMERC Region D Supplier Manual*, Chapter IX, page 67, a new test would not be required at recertification time if the doctor had ordered the equipment initially for lifetime. However, new testing is required if there is a major change in the patient's medical condition. In addition, the most recent test must be reported at the time of recertification. This may or may not be the same test result used to initially certify the patient for oxygen.

5. Patient A receives Rx for 1 x day testing on January 1. Three month supply provided on Jan 1 on initial setup. On February 1, same patient brings in revised Rx for 3 x day testing with justification and log to substantiate increase. Patient has gone from 3-month supply non-insulin (100 test strips) to 3-month supply insulin dependent (300 test strips). Does the supplier recalculate the test strips as a new order beginning February 1? During the first month 30 test strips would be used, leaving 70 beginning February 1st. The remaining 70 will last less than 1 month. So, can 200 test strips be dispensed on February 1 to complete the 3-month supply that began January 1?

   Answer:
   Since a change in medical necessity has occurred, the guidelines for insulin treated beneficiaries would apply. Make sure to change the modifier from KS to ZX.

6. Has CIGNA Medicare reviewed the possibility of making video's and/or cassette tape available of educational seminars?

   Answer:
   CIGNA Medicare developed a training video a few years ago. Due to the constant changing of Medicare rules and regulations, the video was outdated the month after it was produced.

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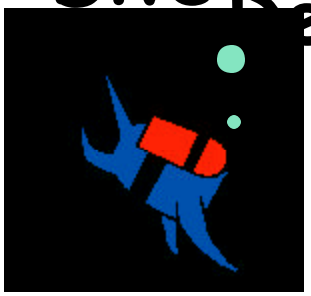
Dive Deeper Into Medicare



CIGNA HealthCare Medicare Administration is a Part B & DME Contracted Carrier for HCFA

CIGNA Medicare Region D DMERC* is presenting three specialty seminars for DMEPOS** suppliers. Deepen your knowledge of Medicare by attending one or **all** of the spring seminars. Soon you'll be the sharpest fish in the sea. **Space is limited, so mail in your registration right away!**

Day One — Respiratory

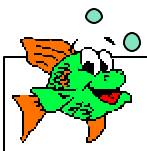
Topics include:

- Oxygen
- Nebulizers
- Ventilators
- Respiratory Assist Device
- Continuous Positive Airway Pressure

Registration: 8:00 am - 8:30 am
Seminar: **8:30 am - 4:00 pm**

$50*/person registration fee*

(Lunch On Your Own)



Day Two —

Updates Unlimited

Topics include:

- Health Insurance Portability and Accountability Act (HIPAA)
- Utilizing the Internet
- Prospective Payment System – Skilled Nursing Facility/Consolidated Billing
- Policy Updates
- Audit Procedures

Registration: 8:00 - 8:30 am
Seminar: **8:30 - 11:30 am**

$20*/person registration fee*

Wheelchairs

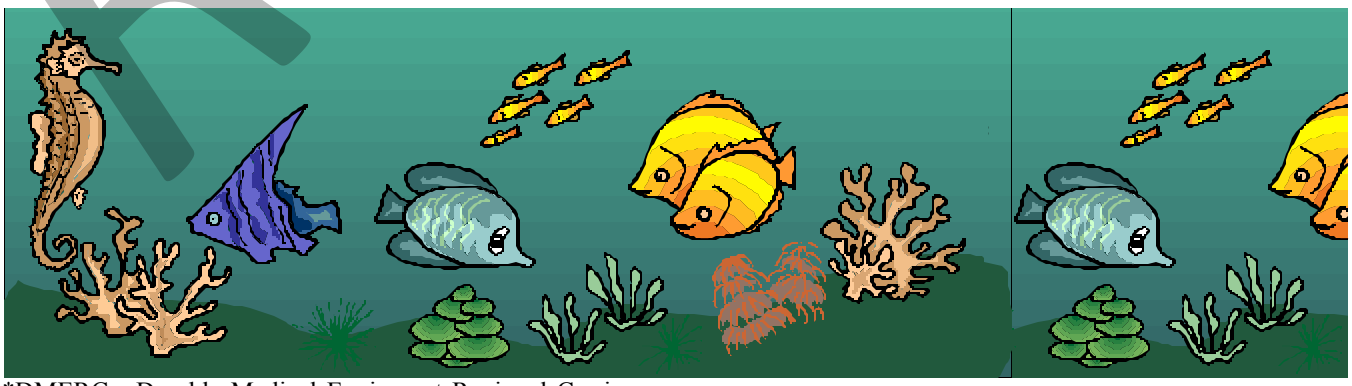
Topics include:

- Coverage criteria
- Claim submission
- Capped Rental
- Documentation
- Repair
- Maintenance & Servicing

Registration: 12:30 - 1:00 pm
Seminar: **1:00 - 4:00 pm**

$25*/person registration fee*

(Lunch On Your Own)



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

Spring 2001 Seminar Schedule

April 3 - 4
Boise, ID
MK Plaza
720 Park Blvd
Boise, ID 83712
208.333.2140

April 17 - 18
Seattle, WA
The Westin Seattle
1900 Fifth Avenue
Seattle, WA 98101
206.728.1000

April 24 - 25
Phoenix, AZ
DoubleTree
Paradise Valley Resort
5401 N Scottsdale Rd
Scottsdale, AZ 85250
480.947.5400

May 1 - 2
Omaha, NE
DoubleTree
Downtown
1616 Dodge St
Omaha, NE 68102
402.346.7600

May 8 - 9
Anaheim, CA
Hyatt Regency Alicante
100 Plaza Alicante
Garden Grove, CA 92803
714.750.1234

May 15 - 16
Fresno, CA
Holiday Inn
Fresno Airport
5090 E Clinton
Fresno, CA 93727
559.252.3611

May 22 - 23
St. Louis, MO
Radisson Hotel
St. Louis Airport
11228 Lone Eagle Dr
Bridgeton, MO 63044
314.291.6700

Registration forms must be received at least two weeks prior to seminar date to secure space and materials for each attendee. We cannot guarantee these items for walk-ins. Refunds will only be issued up to two weeks prior to seminar date.

Please contact the meeting facility for specific information regarding directions and parking.

If you have any other questions or if you would like to confirm registration, please call the Public Relations Department at 208.333.2140.

Seminar Registration

Company:	
Supplier Number:	*Submitter ID:*
Address:	
City:	*State:* *Zip:*
Phone Number: ( )	
Fax: ( )	*E-mail:*
Are you billing electronically?	❑ Yes ❑ No
Seminar Site (City):	
Which seminar(s) would you like to attend?	❑ **Respiratory** (Day 1, 8:30am - 4:00pm) **$50** ❑ **Updates Unlimited** (Day 2, 8:30am - 11:30am) **$20** ❑ **Wheelchairs** (Day 2, 1:00pm - 4:00pm) **$25**
Attendee Name:	

Send completed registration form and check (*payable to CIGNA*) to:

CIGNA HealthCare
Medicare Administration
Attention: DMERC
Spring Seminars
PO Box 360295
Pittsburgh, PA 15251-0295

Confirmation notices will <u>not</u> be sent.

Sorry, we cannot accept credit cards.

Please send in one registration form for each attendee.

DD

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 Central Time, Monday through Friday.

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

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

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

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

DMERC Hearings
CIGNA HealthCare Medicare Administration
PO Box 22263
Nashville TN 37202

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

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 208.333.2141, or send us e-mail at www.cignamedicare.com/customer_service.

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

Overpayments and Refunds—When refunding a check, make it payable to CGLIC—Medicare and send it to:
CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

DMERC Dialogue

CIGNA HealthCare Medicare Administration

HCFA Health Care Financing Administration

...a service of
CIGNA HealthCare Medicare Administration
PO Box 690
Nashville TN 37202

877.320.0390

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

DMERC Dialogue - Spring 2001

Included in This Issue

CIGNA HealthCare Medicare Administration

DMERC–Region D
PO Box 690
Nashville TN 37202