DMERC Region D

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SPECIAL NOTICE

DMERC Quarterly Publications

Enclosed is the Summer 2001 Region D *DMERC Dialogue.* The quarterly update to the *DMERC Region D Supplier Manual,* usually mailed with the *DMERC Dialogue,* is not included. The Summer 2001 *DMERC Region D Supplier Manual* updates are accessible at the CIGNA Medicare Web site, http://www.cignamedicare.com/dmerc/dmsm/index.html.

Previous issues of the Region D *DMERC Dialogue* and supplier manual updates are available on our Web site, www.cignamedicare.com. Just select the Durable Medical Equipment icon.

For the latest in DMERC news, check the **What's New** section.

Electronic Data Interchange

The *EDI Edge,* an informational newsletter designed for our Region D electronic billers, is available exclusively at http://www.cignamedicare.com/edi/. You can access issues as far back as 1998. Look for features from the *EDI Edge* to be included in the *DMERC Dialogue* in our new section ***"From The Edge."***

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

Region

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

DMERC Region D
General Release 01-2

Summer 2001 (July)

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"From the Medical Director…"

Prior Authorization Eliminated for POVs, TENS, and Seat Lifts

Effective September 1, 2001, prior authorization will no longer be available for power operated vehicles (POVs), seat lift mechanisms, and transcutaneous electrical nerve stimulators (TENS). Prior authorization requests for these items received on or after that date will be returned to the requestor.

Advance Determination of Medicare Coverage for Wheelchairs

Advance Determination of Medicare Coverage (ADMC) is a process by which the DMERC will provide the supplier and beneficiary with a coverage decision prior to delivery of an item. Effective October 1, 2001, an ADMC will be available as an option **only** for the following wheelchair base HCPCS codes and related options and accessories:

K0005
K0009
K0011 - **only** when a power tilt and/or power recline seating system or non-joystick control device (e.g., head control, sip and puff, switch control) is ordered
K0014 - **only** when a power tilt and/or power recline seating system or non-joystick control device (e.g., head control, sip and puff, switch control) is ordered

Note that only a limited subset of K0011 and K0014 wheelchairs (as described above) are eligible for ADMC. When a particular wheelchair base is eligible for ADMC, **all** wheelchair options and accessories ordered by the physician for that patient along with the base HCPCS code will be eligible for ADMC.

ADMC requests may either be mailed to the DMERC at CIGNA Medicare, PO Box 1460, Nashville, TN 37202 or sent by fax to 615.782.4645. ADMC requests cannot be submitted electronically.

ADMC requests must be accompanied by a copy of the appropriate Certificate(s) of Medical Necessity (CMN) - HCFA Form 844 for manual wheelchairs or HCFA Form 843 for power wheelchairs, plus HCFA Form 854 if more space is needed in section C to list options and accessories. Completion of the CMN should follow all the standard rules; refer to Chapter 4, Certificates of Medical Necessity, in the *DMERC Region D Supplier Manual*. The manufacturer and model name of the wheelchair base must be listed in Section C. For items billed with HCPCS code K0108 (miscellaneous wheelchair accessory), the narrative in Section C of the CMN must clearly identify the item. (HCPCS code E1399 is not used for wheelchair options or accessories.)

ADMC requests must also be accompanied by information which documents the medical condition of the patient that necessitates the use of the wheelchair, options, and accessories that are ordered. Special attention should be given to any item billed with HCPCS code K0108. Examples (not all-inclusive) of the types of information which will assist the DMERC in making a determination are: the patient's

medical records with dated entries; identification of person(s) performing evaluations; date of onset of the condition; strength of the extremities and function of the extremities (including tone, ROM limitations, etc.); the distance that the patient can walk (a) independently and (b) with the assistance of a cane, crutch, or walker; how the patient transfers from bed/chair to a wheelchair; cognitive abilities; visual impairments; current activity level; whether the patient is expected to be fully independent in the use of the wheelchair. Objective measurements should be reported whenever possible.

If the patient currently has a wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

Upon receipt of an ADMC request, the DMERC will make a determination within 30 calendar days. The DMERC will provide the supplier and beneficiary with its determination, either affirmative or negative, in writing. If it is a negative determination, the letter will indicate why the request was denied - e.g., not medically necessary, insufficient information submitted to determine coverage, statutorily noncovered.

If a wheelchair base receives a negative determination, all accessories will also receive a negative determination. If a wheelchair base receives an affirmative determination, each accessory will receive an individual determination. If a wheelchair base receives an affirmative determination, the supplier may not submit a separate ADMC request for additional accessories.

A negative ADMC may not be appealed because it does not meet the regulatory definition of an initial determination since no request for payment is being made. However, if the ADMC request for the wheelchair base is denied and if the supplier obtains additional medical documentation, an ADMC request may be resubmitted. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may **not** be resubmitted for those accessories. ADMC requests may only be resubmitted once during the 6 month period following a negative determination.

An affirmative determination only relates to whether the item is reasonable and necessary based on the information submitted. An affirmative determination does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it provide assurance that any other Medicare requirements (e.g., place of service, Medicare Secondary Payer) have been met. Only upon submission of a complete claim can the DMERC make a full and complete determination. An affirmative determination does not extend to the price that Medicare will pay for the item.

An affirmative ADMC is only valid for items delivered within 6 months following the date of the determination. If the wheelchair is not delivered within that time, the supplier has the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item).

If the item is provided within 6 months following an affirmative determination and if the claim is for all the same items which were listed on the ADMC request, the CMN does not need to be submitted with the claim. If any of the items on the ADMC request were described by HCPCS code K0108 and if those items were provided, the supplier must ensure that the narrative description used on the claim matches the narrative description used on the ADMC determination letter. If options or accessories are provided that were not listed on the ADMC request, a revised CMN must be submitted with the claim and the supplier should also submit whatever information is appropriate to document the medical necessity for the new item(s).

If a supplier provides a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted. If new information is provided with the claim, coverage will be considered. If the claim is denied, it may be appealed through the usual process.

Finally, the DMERC may review selected claims on a pre-payment or post-payment basis and may deny a claim or request an overpayment if it determines that an affirmative determination was made based on incorrect information.

Medicare *Program Integrity Manual* Revised

The Medicare *Program Integrity Manual* (PIM) contains the medical review and fraud and abuse instructions from the Health Care Financing Administration (HCFA). The latest version of the PIM, Revision 5, was released by HCFA on February 26, 2001. It revises Section 7 of Chapter 5, which addresses Advance Determination of Medicare Coverage (ADMC) of Customized DME. This manual is available on the Internet, HTML format. To access the PIM, go to *http://www.hcfa.gov/pubforms/83_pim/pim83toc.htm*. HCFA does not publish hard copies of this manual.

Clinical Trials CIM Revision Added

Coverage Issues Manual, Section 30-1, Routine Costs of Clinical Trials, created a new section to implement new policy to cover routine costs in clinical trials. This policy is in accordance with the June 7, 2000, executive memorandum from the President of the United States to

provide coverage of routine patient care costs in clinical trials.

This national coverage policy is based on the authority found in §1862(a)(1)(E) of the Social Security Act (the Act). It is binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, and Medicare+Choice organizations (§1852(a)(1)(A) of the Act). In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862(a)(1) of the Act. 42 C.F.R. §405.860.

See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy. The policy is effective for services rendered on or after September 19, 2000.

Blood Gas Testing for Oxygen Qualification by Home Health Agencies

Recently, suppliers of home oxygen have asked about home health nurses performing the blood gas test to qualify Medicare beneficiaries for home oxygen. Based on the requirements found in the *Coverage Issues Manual (CIM)* and the *Medicare Carriers Manual (MCM),* a home health agency (HHA) or HHA employee may not be a qualified provider of this service for the purpose of coverage for home oxygen therapy.

Coverage Issues Manual (CIM) §60-4 states the Medicare coverage criteria for home oxygen and related equipment. Laboratory evidence for oxygen qualification requires measurement of arterial oxygen saturation by arterial blood gases or pulse oximetry. The requirements for qualification to perform this test are found in *CIM* 60-4, Section C which states:

> ....is also acceptable when ordered and evaluated by the attending physician and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services.

Therefore, the *CIM* provides for two sources of a qualifying blood gas test – either performed by a qualified provider or supplier of laboratory services or performed under the supervision of attending physician.

The *Medicare Carriers Manual* (MCM) §15048 defines the obligations of physicians who bill Medicare for services rendered by non-physicians under their supervision. 42 CFR § 410.32 defines the levels of physician supervision. For payment by Medicare, individuals supervised by a physician must be in the employ of the physician and ". . . the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician." Supervision includes direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform the tests, and the qualification of non-physician personnel who use the equipment.

The *MCM* §2070.1 details the requirements for independent laboratory services. An independent laboratory is one that is independent of either an attending or consulting physician's office. Alternatively, laboratories operated by or under the supervision of a hospital also qualify. Unless the HHA qualifies as an independent laboratory as outlined in *MCM* §2070.1, the agency (and its employees) would not meet the *CIM* requirement as a provider of blood gas testing for the purposes of Medicare oxygen coverage.

Osteogenic Stimulation CIM Revision

Coverage Issues Manual (CIM), Section 35-48, Osteogenic Stimulation, has been revised to permit coverage for ultrasonic osteogenic stimulators when there are two sets of radiographs documenting nonunion of a fracture, and the patient has failed at least one surgical intervention for the treatment of the fracture.

This revision to the CIM is a national coverage decision made under §1862(a)(1) of the Social Security Act (the Act). National coverage determinations (NCDs) are binding on all Medicare carriers, fiscal intermediaries, Peer Review Organizations, and other contractors. Under 42 CFR 422.256(b) an NCD that expands coverage is also binding on a Medicare+Choice Organization. In addition, an administrative law judge may not disregard, set aside, or otherwise review a national coverage decision issued under §1862(a)(1) of the Act, (see 42 CFR 405.732 and 405.860).

This policy revision is effective for services provided on or after January 1, 2001. See Chapter 10 of the *DMERC Region D Supplier Manual* for the complete text of this national policy. Also, refer to the Osteogenesis Stimulators regional medical review policy in Chapter 9 for additional coverage details.

Sheepskin Pads - Group 1 Pressure Reducing Support Surfaces

In a recent coverage determination by the Health Care Financing Administration (Transmittal AB-01-53), synthetic sheepskin pads and lambswool sheepskin pads (HCPCS codes E0188 and E0189, respectively) were re-classified as durable medical equipment and placed in the inexpensive or routinely purchased payment category. Effective for dates of service on or after January 1, 2001, codes E0188 and E0189 will be given coverage consideration by the DMERC. The regional medical review policy (RMRP) on Group 1 Pressure Reducing Support Surfaces will be updated in a future publication of the *DMERC Region D Supplier Manual* updates to reflect this coverage change.

Suppliers should note that the HCFA instructions included a directive to the DMERC not to process previously denied claims unless requested by the supplier. Therefore, suppliers with claims for codes E0188 and E0189 with dates of service on or after January 1, 2001, that have previously been denied should request **adjustments** for those claims. Claims submitted for adjustment must comply with the requirements outlined in the Group 1 Pressure Reducing Support Surfaces RMRP. *Do not simply resubmit the claim*. Claims resubmitted will be denied as duplicates.

Oxygen CMN Length of Need

DMERCs use the physician's stated Estimated Length of Need indicated in Section B of the Initial, Revised or Recertification Certificate of Medical Necessity (CMN) in determining the period of covered oxygen services. For beneficiaries for whom oxygen coverage criteria are met, the covered period for oxygen equipment begins with the Initial Date and extends to the end of the length of need or until the scheduled Recertification date (if applicable), whichever occurs first. For example, a beneficiary meeting Group II oxygen coverage criteria may have an Initial Date of July 25 and a length of need of 4 months. The covered period of oxygen therapy would extend from July 25 up to October 25 (3 months) because the 3-month Recertification is due before the end of the length of need.

The Length of Need may have to be changed (e.g., extended) when the scheduled Recertification CMN is completed or when completing a Revised CMN. Physicians should be reminded that the number of months listed on the CMN must be the total number of months counted from the Initial Date listed in Section A of the CMN.

The Initial Date should be either the specific date that the physician gives as the start date of the medical necessity or, if the physician does not give a specific start date, the Initial Date would be the date that the verbal order is received or the written order is signed (not necessarily the date of delivery).

Please refer to the *DMERC Region D Supplier Manual* for additional information about oxygen policy and CMN requirements.

Protective Body Socks

HCPCS code L0984 (protective body sock) describes a garment made of cloth or similar material that is worn under a spinal orthosis. There is no Medicare benefit category for products coded L0984. Therefore, effective for dates of service on or after October 1, 2001, claims for HCPCS code L0984 will be denied as non-covered.

AC/DC Power Adapters and Backup Batteries

Claims for power adapters and batteries used as alternative power sources for equipment capable of AC power operation are not covered by Medicare and will be denied as not medically necessary. Beneficiaries who need uninterrupted electric service to operate medically necessary equipment are encouraged to contact the power company servicing their area for information.

Mandatory Assignment for All Drugs and Biologicals Billed to Medicare

Effective for claims with dates of service on or after February 1, 2001, under §114 of the Benefits Improvement and Protection Act (BIPA), suppliers must accept assignment on **all** claims for drugs and biologicals they bill to the DMERCs. A supplier may not render a charge or bill to anyone for these drugs and biologicals for any amount other than the Medicare Part B deductible and coinsurance. Mandatory assignment does not apply to HCPCS code E0590, the dispensing fee for nebulizer drugs.

If a supplier submits an unassigned claim for a drug or biological with a date of service on or after February 1, 2001, the DMERC will process the claim as though the supplier accepted assignment. If the patient already paid for the billed services, enter the amount paid for covered services, coinsurance and deductible in block 29 of the HCFA 1500 claim form.

The DMERC will reimburse the beneficiary any amount they paid over the patient responsibility amount shown on the Medicare Remittance Notice (MRN). The supplier must issue the beneficiary a refund within 30 days of the date of the MRN for the difference between the beneficiary's payment to the supplier and the total of the amount shown as the patient responsibility and as paid to the beneficiary on the MRN.

This is a clarification of an article that appeared in the Spring Region D *DMERC Dialogue*, "Mandatory Assignment for All Medicare-Covered Drugs." The previous article stated the assignment requirement applied only to Medicare-covered drugs; however, it applies to all drugs billed to Medicare.

Replacement of Durable Medical Equipment

Medicare covers replacement of durable medical equipment (DME) that the beneficiary owns or is purchasing when:

– the item is lost or irreparably damaged; or,
– the item is worn beyond repair; or,
– the patient's medical condition changes such that the current equipment no longer meets the patient's medical need(s).

Claims involving replacement equipment necessitated because of wear or a change in the patient's condition must be supported by a current physician's order.

Occasionally, an accessory required for the effective use of a DME item is irreparably worn and the replacement part needed is no longer available and cannot be substituted with another manufacturer's part. In those circumstances, the DME item itself must be replaced. For example, a transcutaneous electrical nerve stimulator (TENS) unit's lead wires are no longer manufactured and cannot be substituted with another brand. Therefore, the TENS unit itself is effectively nonfunctional and must be replaced. In these situations, the supplier must obtain and submit with the claim a current detailed written physician's order with an explanation of why the item must be replaced. For items that require a Certificate of Medical Necessity (CMN), a current CMN may serve as the detailed written order if the narrative description in Section C is sufficiently detailed.

Tracheoesophageal Voice Prostheses

Tracheoesophageal voice prostheses are devices that are used by laryngectomy patients who have had a tracheoesophageal puncture procedure to enable them to speak. There are two types of devices: one type is removed and reinserted by the patient on a daily basis and the other "indwelling" type is inserted by the physician on a periodic basis. Both types of devices should currently be billed using code L8499 (unlisted procedure for miscellaneous prosthetic services). The claim must be accompanied by information that clearly describes whether the item is a patient-inserted or physician-inserted device, including the manufacturer and model name/number of the device. This information may be entered in the HA0 record of an electronic claim or attached to a hard copy claim. Questions concerning the coding of specific products should be directed to the SADMERC (877.735.1326).

Casts and Splints – Codes A4570, L2102, L2104, L2122, L2124

The following HCPCS codes will become invalid for Medicare. Claims for these HCPCS codes with dates of service on or after October 1, 2001, will be rejected:

A4570 Splint
L2102 Ankle foot orthosis, tibial fracture cast orthosis, plaster type casting material
L2104 Ankle foot orthosis, tibial fracture cast orthosis, synthetic type casting material
L2122 Knee ankle foot orthosis, femoral fracture cast orthosis, plaster type casting material
L2124 Knee ankle foot orthosis, femoral fracture cast orthosis, synthetic type casting material

Effective for dates of services on or after October 1, 2001, claims for casts and splint materials will be the jurisdiction of the local carriers and intermediaries. A new series of HCPCS codes, Q4001-Q4051, has been established to describe cast and splint supplies. Physicians and suppliers should refer to information published by their local carriers and intermediaries for details concerning coding and coverage of these items.

Status of Codes for Heavy Duty Hospital Beds

Below is a table with the effective dates of service (DOS) for new and deleted codes affecting the hospital beds policies:

Codes	Description	Effective DOS	Invalid DOS
K0456	Hospital bed, heavy duty, extra wide, with any type side rails with mattress	July 1 , 1998	January 1, 2001
E0298	Hospital bed, heavy duty, extra wide, with any type side rails with mattress	January 1, 2001	July 1, 2001
K0459	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	July 1, 2001	N/A
K0550	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	July 1, 2001	N/A

For dates of service prior to July 1, 2001, E1399 is used to bill for an extra heavy duty bed (now billed using K0550 on or after July 1, 2001). For dates of service on or after July 1, 2001, E1399 may still be used to bill for beds not described by any of the above codes, for example, if a heavy duty or extra heavy duty bed is provided without a mattress (as when used with a support surface for treatment of pressure ulcers). The regional medical review policies (RMRP) on hospital beds will be updated in a future publication of the *DMERC Region D Supplier Manual* updates to reflect this coverage change.

Residual Limb Support System – New "K" Code

Effective for dates of service on or after July 1, 2001, a new "K" code has been established for residual limb support systems (stump support systems).

K0551 - Residual limb support system, solid base with adjustable drop hooks, mounts to wheelchair frame, each

The new code describes residual limb supports that have adjustable drop hooks, a solid base that mounts on a wheelchair frame, and an adjustable bracket that attaches to the base with a contoured pad to support the stump of a below knee amputee. Previously, these items were billed using code K0048 (elevating legrest, complete assembly). For dates of service prior to July 1, 2001, suppliers should continue to bill stump support systems using code K0048. However, if the item is provided on or after July 1, 2001, code K0551 should be used if the item provided meets the description accompanying the code.

Suppliers should be aware that not all stump support systems meet the description of this new code. For example, if billing for a plastic or covered board, which is placed under the weight of the buttocks and is non-adjustable, this device should be billed as HCPCS code K0108. Similarly, if the stump support system does not have adjustable drop hooks, it should be coded with HCPCS code K0108.

Suppliers with questions concerning the proper coding of a specific stump support system should contact the Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto GBA (877.735.1326).

Wheelchairs – K0008, K0013 – Code Deletion

Codes K0008 (custom manual wheelchair base) and K0013 (custom motorized wheelchair base) will be discontinued and rejected as invalid codes for dates of service on or after October 1, 2001.

These codes are being deleted because they do not reflect the way that wheelchairs with individualized features should be billed. In order to meet the needs of a particular beneficiary, various options or accessories are typically selected. In some situations, the frame of the wheelchair base is modified in order to accommodate the beneficiary. In all these situations, the wheelchair is correctly billed by selecting the appropriate code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. If there isn't a specific code for a wheelchair option, accessory, or modification, code K0108 (wheelchair component or accessory, not otherwise specified) is used.

A Product Classification List including many wheelchair bases can be found on the Palmetto Government Benefits Administrators' Web site at www.palmettogba.com; select Other Medicare Partners then SADMERC. Questions concerning the coding of wheelchair bases or wheelchair accessories not on this list should be directed to the SADMERC at 877.735.1326. For items not on the Product Classification List, suppliers should use their knowledge of the product and information in the medical policy to determine the appropriate code until a determination is published in a future Product Classification List or they receive from the SADMERC a written response to a coding inquiry.

2001 Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Effective July 1, 2001, the Medicare DMEPOS Fee Schedule allowances will increase for services furnished on or after July 1, 2001. The table below reflects the percentage increase applied to the January 1, 2001, fee schedule update and the percentages applicable to services provided July 1, 2001, through December 31, 2001. Included are increases that will be applied January 1, 2002. The July 1 updated fee schedule will be available through the HCFA homepage by June 1, 2001 and on CIGNA Medicare's Web site (www.cignamedicare.com) by July 1, 2001.

These changes are based on the Benefits Improvement and Protection Act (BIPA) of 2000, the Balanced Budget Reform Act (BBRA) of 1999 and the Balanced Budget Act (BBA) of 1997.

Category	January 1, 2001	July 1, 2001	January 1, 2002
DME (other than oxygen)	0.3*	3.7 + 3.28*	0.6*
Oxygen and Oxygen Equipment	0.3*	see below*	0.6*
Prosthetics & Orthotics	1.0*	3.7 + 2.6*	1.0
Ostomy/Tracheostomy/Urologicals	0.0	3.7 + 3.28*	0.0
Surgical Dressings	0.0	3.7 + 3.28*	0.0
Therapeutic Shoes	0.3*	3.7 + 3.28*	0.6*
Parenteral & Enteral Nutrition	0.0	n/a	0.0
Reasonable Charge (other than ambulance)	3.7	n/a	CPI-U

* Temporary increase not to be carried over into future periods, except in the case of oxygen and oxygen equipment, where the 0.3 percent increase applies to items furnished on or after January 1, 2001, and before January 1, 2002.

Third Quarter 2001 DMEPOS Fee Schedule Update

The following fees have been added to the 2001 3rd quarter fee schedule. K0549, K0550, and K0551 are new codes effective July 1, 2001. These fees will be effective for date of service July 1, 2001.

	K0549RR	K0550RR	K0551NU	K0551RR	K0551UE
AK	353.65	787.28	392.83	39.28	294.63
AZ	288.79	787.28	392.83	39.28	294.63
CA	296.42	787.28	392.83	39.28	294.63
HI	292.83	787.28	392.83	39.28	294.63
IA	310.53	787.28	392.83	39.28	294.63
ID	310.53	787.28	392.83	39.28	294.63
KS	310.53	787.28	392.83	39.28	294.63
MO	310.53	787.28	392.83	39.28	294.63
MT	280.57	787.28	392.83	39.28	294.63
ND	280.19	787.28	392.83	39.28	294.63
NE	310.53	787.28	392.83	39.28	294.63
NV	295.76	787.28	392.83	39.28	294.63
OR	310.53	787.28	392.83	39.28	294.63
SD	305.14	787.28	392.83	39.28	294.63
UT	310.53	787.28	392.83	39.28	294.63
WA	310.53	787.28	392.83	39.28	294.63
WY	304.20	787.28	392.83	39.28	294.63

The fees for code A6021 are corrections and codes E0188 and E0189 are additions to the January - June 2001 fee schedule.

	A6021	E0188NU	E0188RR	E0188UE	E0189NU	E0189RR	E0189UE
AK	20.05	44.57	4.46	33.43	96.70	9.66	72.53
AZ	20.05	25.29	2.97	18.99	49.71	5.39	37.29
CA	20.05	25.29	2.96	18.99	49.71	5.39	37.29
HI	20.05	29.61	2.96	22.20	103.43	10.34	77.57
IA	20.05	24.00	2.52	18.01	42.25	4.58	31.70
ID	20.05	22.95	2.52	17.22	49.71	5.39	37.29
KS	20.05	25.29	2.97	16.14	42.25	4.58	31.70
MO	20.05	25.29	2.97	18.99	49.11	4.90	36.85
MT	20.05	25.29	2.97	18.99	48.92	4.90	36.68
ND	20.05	21.50	2.52	16.14	42.25	4.58	31.70
NE	20.05	21.50	2.52	16.14	42.25	4.58	31.70
NV	20.05	25.29	2.97	18.99	49.71	5.39	37.29
OR	20.05	25.29	2.94	18.99	42.25	4.58	31.70
SD	20.05	21.50	2.52	16.14	42.25	4.58	31.70
UT	20.05	24.36	2.52	18.27	42.25	4.58	31.70
WA	20.05	25.29	2.94	18.99	42.25	4.58	31.70
WY	20.05	23.84	2.52	17.87	47.99	4.80	36.01

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.

Codes E1340, L4205 and L7520 have been added to the national/regional fee schedule. The January – June 2001 fees and the July 2001 updated fees are listed below.

	January – June 2001			July 2001		
	E1340	L4205	L7520	E1340	L4205	L7520
AK	16.54	19.35	22.74	17.66	20.39	23.95
AZ	10.57	19.50	24.04	11.29	20.53	25.32
CA	10.57	19.50	24.04	11.29	20.53	25.32
HI	10.88	19.35	22.74	11.62	20.39	23.95
IA	8.98	14.62	19.72	9.60	15.40	20.77
ID	8.98	16.68	23.66	9.60	17.57	24.93
KS	8.98	14.62	19.72	9.60	15.40	20.77
MO	8.98	14.62	19.72	9.60	15.40	20.77
MT	8.98	14.62	23.39	9.60	15.40	24.64
ND	10.57	14.62	23.39	11.29	15.40	24.64
NE	8.98	14.62	19.72	9.60	15.40	20.77
NV	10.57	19.50	24.04	11.29	20.53	25.32
OR	8.98	16.68	23.66	9.60	17.57	24.93
SD	9.81	14.62	23.39	10.47	15.40	24.64
UT	8.98	14.62	23.39	9.60	15.40	24.64
WA	10.57	16.68	23.66	11.29	17.57	24.93
WY	10.57	14.62	23.39	11.29	15.40	24.64

Additional HCPCS Codes Subject to Home Health Consolidated Billing

The Health Care Financing Administration (HCFA) previously released a listing of procedures that were subject to home health consolidated billing effective October 1, 2000. Based upon revisions to the procedure codes, we are issuing a new list of procedures that, when billed during a home health episode are subject to denial because payment is provided to the Home Health Agency creating the episode.

There are now 194 non-routine supply codes that replace the previous list of 178. Newly added codes are in bold.

A4212 A4310 A4311 A4312 A4313 A4314 A4315 A4316 A4319 A4320 A4321 A4322 A4323 A4324 A4325 A4326 A4327 A4328 A4329 A4330 A4331 A4332 A4333 A4334 A4335 A4338 A4340 A4344 A4346 A4347 **A4348** A4351 A4352 A4353 A4354 A4355 A4356 A4357 A4358 A4359 A4361 A4362 A4364 A4365 A4367 A4368 A4369 A4370 A4371 A4372 A4373 A4374 A4375 A4376 A4377 A4378 A4379 A4380 A4381 A4382 A4383 A4384 A4385 A4386 A4387 A4388 A4389 A4390 A4391 A4392 A4393 A4394 A4395 **A4396** A4397 A4398 A4399 A4400 A4402 A4404 A4421 A4455 A4460 A4462 A4481 A4622 A4623 A4625 A4626 A4649 A5051 A5052 A5053 A5054 A5055 A5061 A5062 A5063 A5071 A5072 A5073 A5081 A5082 A5093 A5102 A5105 A5112 A5113 A5114 A5119 A5121 A5122 A5123 A5126 A5131 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

This new list of procedures is effective for claims with dates of service January 1, 2001, through December 31, 2001, that are submitted to the carrier or intermediary July 1, 2001, and later. Codes deleted from the list are A4213 and A4215.

Yearly updates to this list of procedures will be issued in conjunction with the release of the yearly HCPCS update.

These codes should be billed through the Home Health Agency to the Regional Home Health Intermediary if provided to a Medicare beneficiary during a home health episode.

Revision of Existing Home Health Prospective Payment System (HHPPS) Consolidated Billing Edits

In October 2000, edits were installed in the Common Working File (CWF) to enforce the consolidated billing of home health services for dates of services falling within an open HHPPS episode of care. Currently, claims for specific non-routine medical supplies will reject from CWF if the date of service is within the 60-day home health episode period posted to CWF or within the earliest and latest billing activity shown on the CWF record Effective October 1, 2001, CWF will alter these edits to take the following actions. If a 60-day home health episode is posted at CWF, but there has been no billing activity, the claim will be paid conditionally. The following message will appear on the remittance notice:

> This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Once the home health billing activity is posted at CWF, the conditional payment may be recouped if the dates of service are within the home health claim dates. If the home health billing activity is posted at CWF at the time the DMERC claim if filed, CWF will reject the claim for denial. Suppliers will need to contact the home health agency for reimbursement of these services.

ICD-9-CM Coding Update

Beginning October 1, 2001, providers may begin using the 2002 ICD-9-CM codes. There will be a grace period from October 1, 2001, through December 31, 2001. For claims received on or after January 1, 2002, 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
- HCFA's Web site - www.hcfa.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).

Policies Reprinted

Several regional medical review policies are being reprinted and are included in the Summer 2001 supplier manual updates. These policies have been reprinted due to minor corrections pertaining to typographical errors, punctuation, underlining, etc. that were present in the new supplier manuals distributed this spring. There have not been any substantive changes or revisions made to these policies.

Correction to BIPA Article

In the article entitled "Medicare Goes BIPA'ing Along" published in the Spring 2001 *DMERC Dialogue*, the Web site address in the reference at the end of the article should be corrected to thomas.loc.gov.

Get Your Information Fast: CIGNA Medicare E-mail Notification COMING SOON!

CIGNA Medicare will soon offer Region D DMERC suppliers the opportunity to subscribe to a new electronic mailing list designed to improve customer service. When you subscribe you'll receive timely e-mail notifications with hyperlinks to important news and information on the CIGNA Medicare Web site, including:

- New publications
- New systems updates
- New draft regional medical review policies
- New workshops and educational opportunities

Check www.cignamedicare.com frequently for the latest information.

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

From *The Edge*

(The following articles were derived from the DMERC Region D Summer 2001 *EDI Edge*. The entire publication can be accessed at www.cignamedicare.com/dmerc/edge/index.html.)

Toll-free Line for EDI and Public Relations

We are pleased to announce that we now have a toll-free number for the Electronic Data Interchange (EDI) and Public Relations departments. **The toll-free number is 866.224.3094.** Effective May 1, 2001, when calling the previous EDI and Public Relations numbers, the caller will be informed of the new number and instructed to disconnect and dial toll-free. Please be sure to inform other staff members and update your materials to reflect this change.

Electronic Oxygen CMN Completion – UPDATE

CIGNA Medicare's claim processing system will accept electronic Oxygen Certificates of Medical Necessity (CMNs) without a response to questions 8, 9, and 10, which only apply to Group II oxygen patients. Remember that **electronic CMNs must reflect the exact information indicated on the signed, original CMN**. Suppliers may not submit responses which the ordering physician has not indicated on the hard copy. When transmitting electronically, it is not appropriate for the supplier to enter "D" for "does not apply" when the physician leaves the answer to a question blank. This update supercedes other articles CIGNA Medicare published in the *DMERC Dialogue*, Summer 1998, page 9 and the *EDI Edge*, fourth quarter 1998, page 3.

Front-End Reject Code – 732-OTA Amt Invld

On January 8, 2001, CIGNA Medicare activated the *732 edit, OTA Amt Invld*, in order to allow Medicare Secondary Payer (MSP) claims data to be entered at the line level. This edit checks for a positive, unsigned, numeric value to be present in field 48 of the FA0 record in the National Standard Format (NSF) version 3.01. If there is no data to submit, this field must be zero filled.

Although the edit checking this field is new, **the requirement to zero fill this field is not**. A number of electronic billers' claims were rejected when this edit was first activated on January 8, 2001, with the edit of 732 - *FA0-48, OTA Amt Invld*. Since then, CIGNA Medicare has developed a temporary solution to allow claims to bypass this edit and allow those claims into our processing system as well as give software vendors enough time to update their billing software. **Based on discussions with HCFA, we will continue with our temporary solution and will notify you of any changes in future newsletters.**

Please note: The software vendors listed on our *Certified* and *Select Certified Vendor* lists have been notified of this situation. If you have any questions regarding your software's ability to complete this field correctly, please contact your software vendor.

HIPAA and the Migration to ANSI

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a very large and complicated law designed to standardize the health care industry. One part of that law which will impact our electronic submitters is Administrative Simplification, and more specifically, Transactions and Code Sets.

The Transactions and Code Sets Final Rule was published August 17, 2000. This wave of HIPAA mandates will impact the health care industry over the next few years. It is important to note that *this rule does not require suppliers to submit claims or receive remittance advices electronically. It also does not require suppliers to submit electronic queries and receive electronic responses for claim status and eligibility.* It does make it easier and more efficient to use electronic transactions by adopting and requiring the use of standardized, electronic transmission of administrative and financial data throughout the entire health care industry, not just Medicare.

The standard format for transactions that has been adopted by HIPAA is the American National Standards Institute (ANSI) format. The current format accepted by all four DMERCs is the National Standard Format (NSF) version 3.01. These two formats are very different. The ANSI format compresses the data whereas the NSF requires that the data be entered in specific positions with a certain number of spaces allotted for each entry of information. With compression of data in the ANSI format, the time to transmit your claim files may be reduced as may the amount of space needed to store this data. An example of both formats is shown below.

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.

The first example is the NSF and it shows the first required record in the NSF which contains information specific to the entity transmitting the file to Medicare. The second example shows the ANSI equivalent of the same information.

Example of NSF:

```
AA0D08600000          ASY   000003MEDICARE CLAIM SUBMITTER          123 S MAIN STREET
ANYWHERE          US11111       JOHN DOE                  000000000020010308      05655
C0030100301PROD                 1    00
```

Example of ANSI:

```
NM1*41*2*MEDICARE CLAIM SUBMITTER*****46*D08600000~PER*IC*JOHNDOE*TE*1234567891~
NM1*40*2*CIGNA MEDICARE*****46*05655~
```

This information is being provided to give you an understanding of the changes that will need to take place within your software to generate this new format. This format is created by the software and should require minimal effort on your part. As an example, in order to create a valid claim file, the software will have to be modified to capture data requirements that aren't needed in today's NSF environment. If you are unsure of your software's progress, contact your software vendor. For suppliers using the DMACS32 program, DMERC's EDI department is working on creating the update to the software and will be sending out information, as it becomes available. If you require further assistance, please contact the EDI department at 866.224.3094 (toll-free).

HIPAA Update

The Secretary of the Department of Health and Human Services designated the ANSI X12N 837 version 4010 transaction, under HIPAA, as the standard format for electronic health care claim transactions. On or about October 16, 2002, CIGNA Medicare will switch exclusively to the ANSI X12N 837 for all electronic health care claim transactions. This includes both inbound transactions from providers and outbound transactions for Coordination of Benefits (COB) and crossovers. At that time, we will no longer accept any version of the National Standard Format. All electronic billers must comply with the requirements of the X12N 837 version 4010. If an electronic biller contracts with a clearinghouse to translate their claim data into the X12N 837 format, then they must furnish that clearinghouse all data required by X12N 837 version 4010. Anyone that elects to use a clearinghouse for translation services is liable for the associated costs.

Testing – Start Early!

To ensure the accuracy of production claims, there are certain testing requirements that must be met before submitting a claim in the X12N 837 version 4010 transaction. Electronic billers or their software vendor, clearinghouse, or billing service will be required to test their billing software with CIGNA Medicare, expected to begin October 2001. Due to the large number of providers/suppliers, agents, billing services, clearinghouses, and trading partners to be tested and the number of standard transactions that are to be implemented, it will not be feasible to test each entity during the last quarter of the transition process. We cannot guarantee testing by the end of September 2002 for any entities that delay testing late in the transition period. Medicare will not charge for this testing. We strongly encourage everyone to test as early in the transition period as possible.

Does Testing Apply To You?

Electronic billers who use a software vendor, clearinghouse, or billing service to generate transactions, will not be required to test if their software vendor, clearinghouse, or billing service meets both of the following conditions:

1. They have passed our testing requirements.
2. They are using the same program to generate the transaction for all of their clients.

Though not required, we encourage those using vendor software to test for data validation. During the testing process, CIGNA Medicare will assist in identifying and resolving Medicare-specific formatting and data requirement issues before any actual production claims are transmitted.

More Information to Come

We will continue to provide more information regarding HIPAA transactions and specifics about the testing process, as they become available. Check future issues of this publication as well as our Web site, www.cignamedicare.com, to obtain the most up-to-date information. For complete information about the X12N 837 version 4010, the implementation guide may be downloaded free of charge from www.wpc-edi.com/HIPAA.

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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 866.224.3094, or send us e-mail at www.cignamedicare.com/customer_service.

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

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

DMERC Dialogue

CIGNA HealthCare Medicare Administration

HCFA Health Care Financing Administration

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

DMERC Dialogue - Summer 2001

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