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 01-3

Fall 2001 (October)

Fall Seminars – Just Around the Corner

Another round of seminars has taken place and, once again, they were a great success. With over 1,200 attendees, the Spring 2001 two-day seminars proved to be very informative and educational to those who attended. On behalf of the entire staff, we thank all the Spring 2001 seminar attendees for their participation and for their suggestions for future seminars.

Currently we are preparing for the Fall 2001 "Taking the Mystery Out of Medicare" seminar and are anticipating another successful round. The seminar format will once again focus on specialty topics. If you struggle with trying to figure out what documentation or which Certificate of Medical Necessity (CMN) needs to be submitted for a particular item, this seminar may be just what you are looking for. Representatives from the Public Relations Department are planning to present information on documentation, CMNs, CMN and electronic media claims (EMC) rejections, and legislative and policy updates. Additionally, representatives from the Electronic Data Interchange (EDI) Department will present the latest on the Health Insurance Portability and Accountability Act (HIPAA). In addition, they will present a brief session to acquaint suppliers with the newly developed EDI Web section of the CIGNA Medicare Web site, as well as the new EDI forms.

We encourage everyone to attend these educational seminars as they provide a great opportunity to gain more knowledge about Medicare and offer a chance to visit with CIGNA Medicare staff. For your convenience, the Fall 2001 Seminar Schedule has been added to the CIGNA Medicare Web site. You may register online at www.cignamedicare.com (select Workshops).

As an added service to our suppliers, we have invited DMERC software vendors to market their products and services at six (6) different sites. This will give seminar attendees the opportunity to visit the vendors' booths and obtain information on vendors' products and services. If you are considering billing electronically, looking for a business that provides billing software, or if you would like to find out what other software options are available, we urge you to attend a seminar at one of the following sites.

DMERC software vendors will be exhibiting at the following seminars.

September 18:	Salt Lake City, Utah
October 2:	Omaha, Nebraska
November 6:	Portland, Oregon
November 13:	Torrance, California
November 15:	Anaheim, California
December 11:	Scottsdale, Arizona

Voice Amplifiers Covered by Medicare

The Health Care Financing Administration (HCFA) has determined that voice amplifiers used for beneficiaries with impaired function of their larynx (which is still present) are eligible for coverage by Medicare. This decision is retroactive, and therefore applies to any dates of service on which these items were/are provided.

When billing for these items use HCPCS code L8499 (unlisted procedure for miscellaneous prosthetic services); include the name, model number and manufacturer of the device as well as documentation explaining the medical necessity for the item.

Because a voice amplifier is not the same as a voice prosthesis, do not use the HCPCS codes that describe an artificial larynx (L8500), or tracheostomy speaking valve (L8501).

Hospital Beds Policy Revised

A revision with consolidation of the DMERC policies for all types of hospital beds and their accessories is published in the Fall 2001 *DMERC Region D Supplier Manual* update. The revisions involve coding guidelines and the newer codes for heavy duty and extra heavy duty beds.

The Summer 2001 Region D *DMERC Dialogue* contains the article "Status of Codes for Heavy Duty Hospital Beds" that summarized the hospital bed codes and a history of their previous or current valid dates for billing to the DMERC. HCPCS code K0459 was misprinted and should read K0549 (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).

Pressure Reducing Support Surfaces - Group 1 Policy Revision

Included in the Fall 2001 *DMERC Region D Supplier Manual* update is a revision to the Pressure Reducing Support Surfaces – Group I regional medical review policy (RMRP). This policy revision incorporates a recent coverage determination by the Health Care Financing Administration (HCFA) that reclassified synthetic sheepskin pads and lambswool sheepskin pads (HCPCS codes E0188 and E0189, respectively) as durable medical equipment and placed them 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.

As noted in the Summer 2001 *DMERC Dialogue* article entitled, "Sheepskin Pads – Group I Pressure Reducing Support Surfaces," 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 Pressure Reducing Support Surfaces - Group 1 RMRP. *Do not simply resubmit the claim*. Claims resubmitted will be denied as duplicates.

Biofeedback for Urinary Incontinence

In a recent national coverage determination published in the Medicare *Coverage Issues Manual*, Section 35-27.1, coverage criteria are defined for biofeedback therapy for the treatment of urinary incontinence. The policy specifies that coverage can be considered when the therapy is rendered by a practitioner in an office or other facility setting. The policy specifically states that home use of biofeedback therapy for urinary incontinence is not covered. Biofeedback devices for home use for the treatment of urinary incontinence will be denied as not medically necessary.

If these devices are provided for home use, they must be billed to the DMERC using code E1399 – durable medical equipment, miscellaneous. The claim should include the manufacturer and brand name/number of the device and information describing the condition for which it is being used. This information should be entered in the HA0 record of an electronic claim or attached to a paper claim.

Physicians and suppliers should refer to information published by their local carriers and intermediaries for details concerning coding and coverage of biofeedback therapy in the office or other facility setting.

Medicare does cover home use of non-implantable pelvic floor electrical stimulators (PFES) for the treatment of urinary incontinence. See the article in the Spring 2001 Region D *DMERC Dialogue* for additional information about PFES devices.

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.

Ostomy Supplies Policy Revised

Included in the Fall 2001 *DMERC Region D Supplier Manual* update is a revision to the Ostomy Supplies policy. Revisions include updates to HCPCS codes since the policy's last publication, definitional changes to help with clarity and inclusion of material from various previously published bulletins.

Speech Generating Devices Policy - Correction

In a recent *DMERC Region D Supplier Manual* update, the regional medical review policy on speech generating devices (SGDs) was published. In the Coding Guidelines section, there is a typographical error. The coding of mounting systems should read, "Mounting systems necessary to place the SGD devices, switches and other access devices within reach of the patient must be coded K0546," and not K0547 as published. Please make a note of this change. The DMERCs will incorporate this correction in the next revision of the SGD policy.

Oximetry Testing

Measurement of oxygen saturation in the capillary blood using an oximeter is an option for documenting medical necessity of home oxygen and respiratory assist devices. Suppliers are reminded that in order to be considered acceptable documentation, this test must be performed by a Medicare-approved provider.

A Medicare-approved provider may be a physician, hospital, nursing facility, home health agency, laboratory, or independent diagnostic testing facility (IDTF) that is enrolled with a local carrier, local intermediary, or regional home health intermediary (RHHI). Entities that just perform the technical component of a test (e.g., providing the oximeter for home sleep studies) which is then purchased by a physician and billed by the physician to the local carrier must also be an enrolled Medicare provider – even though they will not bill Medicare directly.

In addition, in order to be considered acceptable documentation, the test may not be performed by a DMEPOS supplier or anyone financially associated with or related to the supplier.

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). Three revisions have been published since the last publication of the *DMERC Dialogue*.

- Revision 6, released on May 24, 2001, adds Chapter 1, Section 7.4, instructing contractors to maintain the confidentiality of all Medical Review records,
- Revision 7, released May 31, 2001, adds Chapter 10, instructions for physician identification and registration, and
- Revision 8, released July 11, 2001, revises Chapter 1, Sections 2, 2.1 and 2.3 through 2.3.4., addressing clarification of and changes in the Medical Review program.

This manual is available on the Internet, in 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.

Implementation of Mandatory Assignment for Drug Claims – Update

Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) states, in part, "Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis." A recent program memorandum dated June 18, 2001, from the Health Care Financing Administration clarified that mandatory assignment applies only to those drugs "for which payment may be made" - i.e., Medicare-covered drugs. Drugs that would never be paid (e.g., no benefit category, never medically necessary) are not subject to mandatory assignment. This article is a clarification of an article that appeared in the Summer 2001 Region D *DMERC Dialogue*.

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.

Nebulizers – Correct Use of KP and KQ Modifiers

The regional medical review policy on nebulizer equipment and nebulizer drugs details coding guidelines for the proper billing of nebulizer drugs using the KP and KQ modifiers. The modifier KP is used with the first drug of a multiple drug unit dose formulation and KQ is used for the second or subsequent drug of a multiple drug unit dose formulation. According to the policy, when two or more drugs are combined in the same unit dose container, the KP and KQ modifiers should be added to the appropriate drug codes in such a manner that it yields a pricing combination resulting in the lowest cost to the beneficiary.

Data analysis staff at the Region D DMERC have noted that a significant number of suppliers are not utilizing the correct placement of the KP and KQ modifiers. As a result, overpayments are being requested. Suppliers are reminded to confirm that they are correctly billing all drug combinations such that the reimbursement amount yields the lower cost to the beneficiary.

Suppliers are also reminded to carefully calculate the number of units of service when billing for inhalation drugs – especially albuterol. Although the drug is dispensed as albuterol sulfate, the common way of expressing dosage and the unit of service of the code is the number of milligrams of albuterol base. 3 mg of albuterol sulfate = 2.5 mg of albuterol base. Therefore, for example, when billing for 10 unit dose vials of the drug DuoNeb™, each containing 3 mg of albuterol sulfate and 0.5 mg of ipratropium bromide, code the albuterol as J7619KQ, 25 units of service (2.5 mg of albuterol base per vial x 10 vials = 25 mg and 25 mg = 25 units of service) and code the ipratropium as J7644KP, 5 units of service (0.5 mg of ipratropium bromide per vial x 10 vials = 5 mg and 5 mg = 5 units of service).

For additional details on the coverage and payment rules, coding guidelines and documentation requirements, refer to the regional medical review policy on nebulizers and nebulizer drugs in the *DMERC Region D Supplier Manual*.

Billing Reminder

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

Immunosuppressive Drugs Policy – DMERC Information Form (DIF) Completion

Effective for dates of service on or after October 1, 2001, a new DIF will no longer be required when a new drug is added to or replaces an existing drug in a beneficiary's immunosuppressive drug regimen or if an immunosuppressive drug's HCPCS code changes. This applies to beneficiaries who are currently receiving medications covered under the Medicare immunosuppressive drug benefit.

For additional details on the coverage and payment rules, coding guidelines and documentation requirements, refer to the regional medical review policy on immunosuppressive drugs in the *DMERC Region D Supplier Manual*.

Power Operated Vehicles (POVs) - Options and Accessories

The Medicare allowance for a POV includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc. When these items are provided at the time of initial issue, they must not be billed separately. Medically necessary replacement accessories for beneficiary-owned POVs meeting Medicare coverage criteria are separately payable. Effective for claims with dates of service on or after January 1, 2002, a replacement item for a beneficiary-owned POV, including but not limited to replacement batteries, should be billed using the specific wheelchair option or HCPCS accessory HCPCS code if one exists and modifier RP. (Refer to the Wheelchair Options and Accessories regional medical review policy in the *DMERC Region D Supplier Manual* for a list of specific HCPCS codes.) If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified). Do not use code E1399 for miscellaneous replacement POV accessories.

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.

Expanded Coverage of Diabetes Outpatient Self-Management Training

Diabetes Outpatient Self-Management Training is now a covered Medicare service for a wider variety of Medicare providers/suppliers. Local carriers, not DMERCs, have claims processing jurisdiction for these services. To qualify for payment under this benefit, the supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must first be enrolled in the Medicare program and currently eligible to receive reimbursement for Medicare covered services. All suppliers must meet the American Diabetes Association's (the successor to the National Diabetes Advisory Board) National Standards for Diabetes Self-Management Education Programs that were published in Diabetes Care, Volume 23, Number 5.

If you are a DMEPOS supplier that wants to receive Medicare reimbursement for diabetes education and meet the above qualification, you should contact the local Medicare carrier who services your area. See http://www.hcfa.gov/Medicare/incardir.htm to determine the local carrier for your area. The carrier will require you to submit a completed Form HCFA-855, along with your ADA recognition certificate. After it has been determined that you meet the quality standards, you will be sent your billing number. Once you have received your billing (PIN) number, you can begin receiving reimbursement for this service. All providers and suppliers including DMEPOS suppliers are eligible to receive retroactive payment for this service back to the later of February 27, 2001, or the date of recognition by the ADA. Specific coverage and payment criteria apply. DMEPOS suppliers should become familiar with the details of this covered Medicare service by reviewing HCFA-Pub. 60B, Transmittal B-01-40 on the HCFA Web site at www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.

Revised Diagnosis Reporting Requirements for Routine Care Clinical Trial Services

Effective for services furnished on or after January 1, 2002, billers will use procedure code modifier "QV" to identify and report routine care for Medicare qualifying clinical trial services. The reporting of diagnosis code V70.5 as a secondary diagnosis on Form HCFA-1500 or the electronic claim equivalent will no longer be required for dates of service on or after January 1, 2002. For dates of service on or after January 1, 2002, the QV modifier constitutes the biller's attestation that a service, supply or equipment meets the Medicare qualifying coverage criteria for clinical trial services processed by carriers and DMERCs.

EXCEPTION: Routine care clinical trial services furnished on or after January 1, 2002, to healthy, control group volunteers participating in Medicare qualifying diagnostic clinical trials are to be coded and billed in the following manner:

- The "QV" procedure code modifier is reported at the line item level.
- Diagnosis code V70.7 (Examination of participant in clinical trial) is reported as the primary diagnosis for applicable line items on the Form HCFA-1500 or electronic claim equivalent.

If diagnosis code V70.7 is reported as a secondary rather than the primary diagnosis the service/item will not be considered as having been furnished to a healthy, control group, diagnostic trial volunteer.

COB Contractor Fact Sheet for Providers

The Health Care Financing Administration (HCFA) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. HCFA awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the COB contractor. This is no longer the function of your local Medicare intermediary or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

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.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses first before Medicare. The table below describes a few of these methods and programs.

Method/Program	**Description**
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.
IRS/SSA/HCFA Data Match	Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
Voluntary MSP Data Match Agreements	Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between HCFA and employers or various insurers.

Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions regarding Medicare claim or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local intermediary or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in HCFA's Database

The COB Contractor is the sole authority to ensure the accuracy and integrity of the MSP information contained in HCFA's database (i.e., Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. HCFA also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

Termination and Deletion of MSP Auxiliary Records in HCFA's Database

Intermediaries and carriers will continue to terminate records on the CWF where the provider has received information that MSP no longer applies (e.g. succession of employment, exhaustion of benefits). Termination requests should continue to be directed to your local intermediary or carrier. MSP records on the CWF that you identify as invalid should be reported to the COB Contractor for investigation and deletion.

Contacting the COB Contractor

Effective January 1, 2001, refer all MSP inquiries; including, the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/ concerns to the COB contractor. Continue to call your local intermediary and/or carrier regarding claims-related and recovery questions. The COB Contractor's Customer Call Center toll free number is 1.800.999.1118 or TDD/ TYY 1.800.318.8782. Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, eastern standard time, except holidays. Clip and post this section in a handy place for access by your office and billing staff.

HIPAA EDI Transaction Testing

EDI Submitter Testing

HCFA requires EDI submitters to pass certain levels of testing on the ANSI X12N 4010 837 Health Care Claim prior to moving into production. A minimum of three levels of testing (levels 1, 2 and 4) on version 4010 of the ANSI X12N 837 Health Care Claim are required unless the software being used has been approved by CIGNA Medicare for use with ANSI 4010 claims.

HCFA has adopted the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-workgroup's recommendations on the levels of testing that need to occur to ensure HCFA is in line with the health care industry's testing recommendations. For a complete list of all testing levels, see the testing white paper at www.wedi.org. The levels of testing that CIGNA Medicare will conduct include:

- **Level 1 - Transmission/Transaction Integrity**

The CIGNA Medicare translator must test for high-level accuracy of the transmission and transactions and validate the syntax compliance at the ANSI X12N 4010 standard level.

- **Level 2 - Data Integrity**

This testing is related to implementation guide (IG) requirements and editing for implementation guide specific requirements, such as, required segments and data elements, relational edits (for example, numeric data in numeric-defined elements), and valid code values, such as qualifiers specific to a particular IG.

- **Level 4 - Situational Testing**

The testing of specific inter segment situations described in the HIPAA implementation guides, such that: If A occurs then B must be populated. This is considered to include validation of situational fields given values or situations present elsewhere in the file. Examples would be claims containing CMN's or Oxygen Certifications.

Health care providers and suppliers are strongly encouraged to contact their software vendor, billing agent, clearinghouse or other third party entities to determine their overall HIPAA preparedness and testing requirements. If you are using a billing agent, clearinghouse, or vendor supplied software to generate a claims transaction and that billing agent, clearinghouse, or software package has passed testing requirements, you may be able to send production claims using the same program/software to generate the transaction. Though we will allow this to occur, we strongly encourage suppliers to go through our testing process. The supplier is ultimately responsible for filing their claims and we encourage them to test their specific data situations prior to submitting production claims.

CIGNA Medicare will begin to test EDI claim submitters on the ANSI X12N 4010 837 Health Care Claim after September 30, 2001. All testing must be completed by October 16, 2002. We encourage you to begin testing as early as possible. If you delay testing until after June 30, 2002, CIGNA Medicare can not guarantee testing will be completed by October 1, 2002.

If a health care supplier, billing agent, software vendor or clearinghouse submits transactions directly to several contractors, they are still required to perform, at a minimum, compatibility testing with each contractor on each standard system with whom they exchange electronic transactions. This will ensure communication protocols and volume considerations unique to each contractor are tested.

As of October 1, 2001, CIGNA Medicare encourages all EDI submitters to begin using the ANSI X12N 837 version 4010 for inbound EDI claim transactions. All new EDI submitters not using a current, CIGNA Medicare approved billing agent, clearinghouse, or software vendor, who request to begin sending inbound EDI claim transactions, must use version 4010 of the inbound ANSI X12N 837 Health Care Claim transaction. New EDI submitters using a current Medicare approved billing

agent, clearinghouse, or software, may use the current version supported by these entities until they are able to provide ANSI X12N 837 version 4010 agents. This solution is temporary in nature and all claim transactions must be submitted in the ANSI X12N 837 version 4010 beginning October 16, 2002.

CIGNA Medicare will continue to allow new EDI submitters who wish to use the current non-HIPAA version of DMACS, to submit claims until April 2002. After April 2002, CIGNA Medicare will only provide the HIPAA, ANSI X12N 4010 837 transaction software by request. Current DMACS users will be allowed to continue using the non-HIPAA version until October 1, 2002, at which time only HIPAA standard transactions will be accepted by CIGNA Medicare.

EDI Receiver Testing

By January 2, 2002, CIGNA Medicare will begin to test remittance advice (ERN) receivers who have requested testing. Remittance advice receivers must either request testing for receipt of the ANSI X12N 4010 835 remittance advice prior to October 2002 or be confident that they have completed system changes as required to accept production ANSI X12N 4010 835 transactions by October 16, 2002. Any trading partner that prefers to have remittance advice testing conducted prior to transmission of production data must test as soon as possible to assure testing will be completed before October 2002.

New EDI receivers who wish to receive current versions of Medicare remittance advice may do so, however, this is temporary, and all remittance advice will be required to be in the ANSI X12N 835 version 4010 beginning October 16, 2002.

Third-Party Certification Systems and Services

Third-party HIPAA certification systems provide test data and testing services for compliance of the HIPAA transactions. While CIGNA Medicare strongly encourages EDI submitters, and trading partners to test with a certification system, we are not mandating such a requirement.

Additional Information and Testing Instructions for CIGNA Medicare

CIGNA Medicare will continue to provide information regarding testing and other HIPAA migration information through our publications, our website (www.cignamedicare.com), and our educational seminars. To request instructions to begin the testing process or for additional information regarding the testing process, please contact the EDI department at 866.244.3094 after September 28, 2001.

Questions and Answers - Region D DMERC Spring 2001 Dive Deeper Into Medicare Seminar

Respiratory

1. Please define oxygen testing conditions “at rest” and “during exercise.”

Answer:

Dorland's Medical Dictionary describes sleep as the “behavioral state marked by characteristic immobile posture and diminished but readily reversible sensitivity to external stimuli.” “At rest” refers to the testing of a patient while awake but not during or immediately following exercise or exertion. A minimum of 20 minutes should be allowed for a patient to return to the “at rest” state following exercise or exertion before oxygen testing is performed.

Qualification during exercise indicates that the patient needs oxygen therapy during exertion. Exertion might be the result from a prescribed exercise program; however, it may also result from performance of various activities of daily living within the home. The oxygen may be provided by either a stationary system and/or a portable supply. The portable supply will be covered only if the patient meets the policy criteria for portable oxygen systems. *DMERC Dialogue, Winter 1998, page 3*

2. Can a nurse practitioner qualify a patient for oxygen?

Answer:

A nurse practitioner or clinical nurse specialist may complete and sign Section B of the CMN if they are treating the beneficiary for the condition for which the item is needed, and they are practicing independently of a physician, and they bill Medicare for other covered services using their own provider number, and they are permitted to do all of the above in the state in which the services are rendered. *Region D DMERC Supplier Manual, Chapter 4, page 1*

3. What happens when an oxygen portable system is added before recertification of a stationary system? Must we recertify the stationary, and then do another recertification on the portable?

Answer:

Regarding oxygen recertification, the initial CMN certifies the need for oxygen therapy. Changes in oxygen equipment neither alter the existing recertification schedule nor do they require separate recertifications.

4. Can apneas be of a different type?

Answer:

National policy limits coverage for continuous positive airway pressure (CPAP) systems to patients with a diagnosis of obstructive sleep apnea with documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during six to seven hours of recorded sleep. In other words, coverage for CPAP is limited to patients with a diagnosis of obstructive sleep apnea and documented episodes of apnea. Only apnea should be reported on question 12 on the DMERC CMN 03.02. Hypopneas are not recognized by national policy as qualifying criteria for CPAP coverage and should not be reported in question 12 of DMERC CMN 03.02. *DMERC Dialogue, Winter 1998, page 4*

5. For Respiratory Assist Devices, if the supplier does not receive the beneficiaries and/or physician's statement(s) within the time allotted, what are their options?

Answer:

If the statements are not obtained until after the 90th day, claims may be held until documentation is received and reviewed for continued medical need and then submitted with the ZX modifier, if requirements are met. If the statements have not been completed and submitted by the 90th day, another other option would be to submit the claims without the ZX modifier. If the statements are obtained at a later date and within review timeliness, the supplier could request a review of the claims.

6. When a supplier bills for a ventilator used while in a wheelchair and another ventilator used while in a bed – would you bill the same code on the same claim or would it deny same or similar?

Answer:

Please refer to *DMERC Dialogue,* December 1997, page 8 regarding backup equipment that is not covered by Medicare versus examples of multiple items that may be covered by Medicare. In the scenario above, you would need to submit the claim with the same HCPCS code on the same claim on two separate lines. An explanation describing the medical necessity for the second piece of equipment must accompany the claim.

7. Does saline fall under the state license to dispense requirement when used with a Nebulizer?

Answer:

Saline used as a diluent for a nebulizer drug must be dispensed by a licensed pharmacy.

Wheelchair

1. Does a supplier have to transfer title of a capped rental item after the 13th paid month by Medicare if the beneficiary refuses to pay their 20% copay and deductible and refuses to sign an indigent form?

Answer:

Questions and answers concerning capped rental issues were published in an article entitled "Questions & Answers" in the Region D *DMERC Dialogue*, April 1995, page 20, as follows:

Q1) After 15 continuous rental months have been paid where the beneficiary elected to rent the DME or after 13 months continuous rental months have been paid where the beneficiary elected the purchase option, may suppliers charge beneficiaries additional amounts?

A1) Suppliers may not charge beneficiaries or any other entity for equipment after 15 continuous rental months have been paid where the beneficiary elected to rent the DME or after 13 continuous rental months have been paid where the beneficiary elected the purchase option. Suppliers may charge for outstanding coinsurance amounts for maintenance and servicing of the equipment. Note that the supplier may not charge in excess of the maintenance and servicing fee established by the carrier for the semi-annual maintenance fee for rented equipment.

Q2) May suppliers bill beneficiaries for purchase of equipment after the beneficiary has elected the purchase option during the 10th rental month?

A2) Once the 10th rental payment is made, suppliers must offer the beneficiary the purchase option. If the purchase option is accepted, the supplier must transfer title to the item to the beneficiary after an additional three months of rental payments have been paid. As such, suppliers may not bill the beneficiary for purchase of the equipment but must continue to bill on a rental basis for an additional three months.

Q3) May suppliers cease billing and recover the DME?

A3) Suppliers may cease billing and recover the DME at any time before 10 continuous rental months have been billed. Once the 10th rental month has been billed, the supplier may not pick up the equipment until the beneficiary has responded to the rent/ purchase option letter and elected rental or until 30 days have passed since the offer was made. If either of these occurs, the supplier may then pick up the equipment at any time but before the 15th rental month is billed. The supplier may not pick up the equipment if the beneficiary elects the purchase option or if the 15th rental month is billed.

Q4) What happens if a supplier recovers the DME anyway?

A4) The supplier may be subject to the sanctions provision; contact the Inspector General.

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.)

Dial Toll-Free

In an effort to provide convenience to our customers, we are pleased to announce that there is now a toll- free line available for all your EDI support issues. Effective May 8, 2001, the new number is 866.224.3094. The toll-free line has three (3) options available to route you to the appropriate department. Select option 1 for technical support or option 2 for customer service. Both options will route you to the EDI Support Specialists. If you select option 3, you will be routed to the Public Relations department. The previous number, 208.333.2141, will no longer connect you to the EDI department.

CSC Helpdesk

In addition to the EDI department's new toll-free number, the Customer Support Center's Electronic Commerce Helpdesk may now be reached toll-free at 800.810.3388. Dial this number for all calls regarding any Stratus password or inactive user id support.

Other DMERCs

Two other DMERCs have also adopted a toll-free line for their EDI departments. For your convenience, below are the other region's new EDI departments' toll-free phone numbers.

Region B: 800.470.9630
Region C: 866.749.4301

Please be sure to inform your staff and update your materials to reflect these phone number changes.

Trouble Dialing Us?

If you have been unable to reach our office by dialing 866.224.3094, please make certain the telephone system you are dialing from is programmed to recognize 866 as a toll-free prefix. Please request from your telecommunications person that 866 be added as a toll-free prefix in your telephone system.

Definitions to Assist You in the Migration to ANSI

With change come new terms and definitions. We have identified some new terms that will be used as we transition from the current National Standard Format (NSF) to the ANSI X12N formats. We encourage everyone to become familiar with these terms so that they may be able to better understand the new format. Though this is not an all-inclusive list of new terms, they do represent the most common items identified. For more information on these terms, please refer to the Implementation Guides, available at www.wpc-edi.com.

ANSI (American National Standards Institute) - The national standards organization that coordinates voluntary standards in the United States. Does not develop standards, but approves a standard when the sanctioned development organizations prove substantial agreement from those affected by the proposed standard.

Billing Provider - The entity transmitting electronic claims. This will be the provider of medical services who is requesting adjudication of the claim.

Code Set - A group of codes with pre-defined meanings. A code set may be controlled by ANSI X12N or by an independent industry group. Only values from a named code set may be used in specific data elements.

Element - The smallest named unit of information in the ANSI X12N standards. An element is almost always defined as variable length with specified minimum and maximum requirements. Elements do not repeat within a segment. They may be optional or mandatory.

Functional Acknowledgment (997) - An EDI message sent in response to the receipt of an electronic transaction used to notify the sender that the information was received. It acknowledges receipt only and does not imply agreement with acceptance of the content of the transaction.

Implementation Guide - Set of standards developed by the ANSI X12N sub-committee to specify format and data requirements to be used for the electronic transactions named in the HIPAA Transactions and Code Sets Final Rule. These guides are available to download, free of charge, at www.wpc-edi.com.

Loop - The largest named unit of information in a transaction set. A loop contains logically related segments in a defined sequence in order to group related information together. Loops may repeat up to a specified number of times. They may be optional or mandatory based on the usage of the first segment of that loop.

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.

the physician who provided the order to the subscriber or completed the DMERC CMN.

Patient - The individual for who a health insurance claim is being submitted, if different from the subscriber. For Medicare claim purposes this will not apply because the patient (beneficiary) will always be the subscriber.

Payer - The entity from which payment is being requested.

Pay-to Provider- The entity receiving payment for the claims in this transaction. This provider information would only be used if the pay-to provider is different from the billing provider. This information is not used for DMERC claim processing because the billing provider represents the company who provided the services for this claim.

Qualifier - A code from an approved code list used to define the data contained in the element following the qualifier.

Segment - An intermediate unit of information in a transaction set. A segment contains logically related data elements in a defined sequence which can be used in one or more business transactions. It consists of a segment identifier (which is not a data element), one or more data elements delimited by a data element separator, and a segment terminator. The data segment is always defined as variable length, with the exception of the very first segment within the transaction. Segments may repeat up to a specified number of times. They may be optional or mandatory within the transaction set.

Subscriber - The individual for who the Medicare claim is being submitted. This individual is also referred to as the Medicare beneficiary. For Medicare claim purposes, the beneficiary is always the subscriber.

Taxonomy Code - A code that identifies the provider's specialty, a segment of the population that a health care provider chooses to service, a specific medical service, a specialization in treating a specific disease, or any other descriptive characteristic about the providers practice relating to the services rendered.

Trading Partner- Any entity conducting electronic transactions with another entity.

Transaction Set - The culmination of data that represents the information exchange between trading partners for a specified business process.

Intentionally Left Blank

CIGNA HealthCare
Medicare Administration

Taking the Mystery out of Medicare

CIGNA Medicare Region D DMERC* will present one-day specialty seminars for DMEPOS** suppliers. Magnify your knowledge of Medicare by attending a seminar near you! You are sure to uncover many helpful clues. **Space is limited, so mail your registration today!**

Clues to...

Documentation
Certificates of Medical Necessity (CMNs)
CMN & Electronic Data Interchange (EDI) Rejections
Health Insurance Portability and Accountability Act (HIPAA)
Updates and Other Breaking Information

Seminar Schedule

Registration:	8:00 - 8:30 a.m.
Seminar Part I:	8:30 - 11:30 a.m.
Lunch (on your own):	11:30 a.m. - 1:00 p.m.
Seminar Part II:	1:00 - 4:00 p.m.

Registration

- All attendees must be pre-registered and registrations must be paid in advance. Due to limited space, registration is on a first-come, first-served basis. In the event that you are unable to attend, refund requests must be received at least two weeks in advance of seminar.

- Please complete the form on the reverse side of this page and send with a **check or money order for $50** per attendee, payable to the recipient below. Credit cards and cash are not accepted.

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

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

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.

Fall/Winter 2001 Seminar Schedule

AUG

28th - Boise, ID
MK Plaza
720 Park Blvd
Boise, ID 83712
866.224.3094
Seating Limit 30

SEP

11th - Casper, WY
Holiday Inn
300 West F Street
Casper, WY 82601
307.235.2531
Seating Limited to 40

13th - Billings, MT
Ponderosa Inn
2511 First Ave North
Billings, MT 59101
406.259.5511
Seating Limited to 50

18th - Salt Lake City, UT
Sheraton City Centre
500 South 150 West
Salt Lake City, UT 84101
801.401.2000
Seating Limited to 100

20th - Anchorage, AK
Westmark Hotel
720 West 5th Ave
Anchorage, AK 99508
907.276.7676
Seating Limited to 30

OCT

2nd - Omaha, NE
Doubletree Downtown
1616 Dodge Street
Omaha, NE 68102
402.346.7500
Seating Limited to 125

4th - Des Moines, IA
The Hotel Savery
401 Locust
Des Moines, IA 50309
515.244.2151
Seating Limited to 125

9th - Sioux Falls, SD
Radisson Encore Hotel
1300 Empire Place
Sioux Falls, SD 57106
605.361.6684
Seating Limited to 70

11th - Fargo, ND
Best Western
DoubleWood
3333 13th Ave South
Fargo, ND 58103
701.235.3333
Seating Limited to 70

16th - Wichita, KS
Wichita Marriott
9100 Corporate Hills Dr
Wichita, KS 67207
316.651.0333
Seating Limited to 90

18th - Kansas City, MO
Holiday Inn South
5701 Longview Road
Kansas City, MO 64137
816.765.4100
Seating Limited to 160

Please call seminar meeting facility for specific information regarding directions, parking, and other accommodations.

NOV

6th - Portland, OR
Doubletree
Columbia River
1401 N Hayden Island Dr
Portland, OR 97217
503.283.2111
Seating Limited to 100

8th - Edmonds, WA
Edmonds Harbor Square
Harbor Room
120 West Dayton
Edmonds, WA 98020
425.775.9363
Seating Limited to 100

13th - Torrance, CA
Torrance Marriott
3635 Fashion Way
Torrance, CA 90503
800.228.9290
Seating Limited to 175

15th - Anaheim, CA
Hyatt Regency
Orange County
11999 Harbor Blvd
Garden Grove, CA 92640
714.750.1234
Seating Limited to 200

29th - Las Vegas, NV
Fitzgeralds Holiday Inn
301 Freemont Street
Las Vegas, NV 89101
702.388.2400
Seating Limited to 50

DEC

4th - San Francisco, CA
Doubletree, SF Airport
835 Airport Blvd
San Francisco, CA 94010
650.344.5500
Seating Limited to 100

11th - Scottsdale, AZ
Hilton Scottsdale Resort
6333 N. Scottsdale Road
Scottsdale, AZ 85250
480.948.7750
Seating Limited to 125

12th - Honolulu, HI
Ala Moana Hotel
410 Atkinson Dr
Honolulu, HI 96814
808.955.4811
Seating Limited to 100

13th - San Diego, CA
Holiday Inn on the Bay
1355 North Harbor Dr
San Diego, CA 92101
619.232.3861
Seating Limited to 100

Questions? **Call the Public Relations department at 866.224.3094, choose option 3.**
Please notify our department if you have any special accessibility needs.

Registration Form – FALL 2001

(Please submit one registration form per attendee)

Attendee Name _____ (First) _____ (Last)

Company Name _____

Seminar Location

Supplier Number (10 dig UNSC #)

Address _____

City, State, Zip _____

Phone (____)_____ Fax (____)_____

E-mail

Amount enclosed _____

Check #_____

Submitter ID #_____

Have you attended a Region D DMERC seminar in the past?

- ☐ Yes
- ☐ No

DD

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.

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

...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 - Fall 2001

Included in This Issue

CIGNA HealthCare Medicare Administration

DMERC–Region D
PO Box 690
Nashville TN 37202