Region
DMERC DIALOGUE

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

CIGNA HealthCare
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"*From the Region D DMERC Advisory Committee (DAC).....*"

The Region D DAC is the primary communications vehicle between the home medical equipment industry and CIGNA HealthCare Medicare Administration (CIGNA Medicare), the Region D DMERC. The DAC was formed to provide the 17 states in the Region D DMERC area and other national associations an opportunity to liaison directly with the DMERC staff. The DAC represents all providers whether or not they belong to state or national associations. The DAC's purpose is to address key issues from throughout the region and to consolidate these issues into a format that allows for productive proactive efforts to solve these issues.

The DAC is managed by an Executive Committee, which is elected on an annual basis. The purpose of the Executive Committee is to direct the activities of the DAC to achieve the DAC's goals. The current Executive Committee is listed below:

Chairman	Chuck Gunther, Clinical Support Services Inc., California
Vice-Chairman	Carlos Reyes, Lincare, Washington
Past Chairman	Dave Hosman, American Home Patient, Missouri
Secretary	Laura McIlvaine, Shield Healthcare, California
Treasurer	Que Christensen, Interwest Home Medical, Utah

The DAC, which includes representatives from all 17 states and 7 national associations, meets with CIGNA Medicare (once in Nashville and Boise, where their offices are located, and at both Medtrade West and East meetings). Schedules for these meetings vary from year to year.

An integral part of the DAC is the "A" Teams, which represent specialty subcommittees of the DAC. The "A" Teams are made up of providers who practice in the specialty area and have significant knowledge of Medicare policies and billing practices. Below is a list of the current DAC "A" Teams:

- Respiratory (O2)
- DME
- I.V. (PEN)
- Medical Supplies and Wound Care
- Rehab
- Orthotics and Prosthetics
- EDI/EMC

The DAC is taking nominations for representation on the "A" Teams. Providers can nominate themselves for a potential "A" Team position. The DAC Executive Committee, in conjunction with the "A" Team chairperson, will ultimately determine "A" Team membership. The "A" Teams will meet twice yearly at the Medtrade East and West shows with the DAC and will have frequent conference calls to review system problems and solutions. If there are "A" Team nominations, or if a provider has questions or problems related to DMERC billing, the DAC may be reached at the following DAC operations address:

Region D DAC Operations
One Capital Mall, Suite 320
Sacramento, CA 95814-3228
Phone:916-444-3568
Fax: 916-444-7462
E-Mail:gpeterson@rjaa.com

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

Chuck Gunther
Region D DAC Chairperson

Quarterly Fee Schedule Update

Effective for dates of service on or after April 1, 2000, codes E0784 (External ambulatory infusion pump, insulin) and A4232 (Syringe with needle for external insulin pump, sterile, 3cc) are billable to the DMERC. See the article in this bulletin entitled "External Infusion Pump Policy Update." The E0784 is in the capped rental category and the A4232 is a supply. The fees are listed below:

HCPCS	MOD	STATE	FEE
A4232		AK	2.49
A4232		AZ	2.49
A4232		CA	2.49
A4232		HI	2.49
A4232		IA	2.49
A4232		ID	2.49
A4232		KS	2.49
A4232		MO	2.53
A4232		MT	2.49
A4232		ND	2.49
A4232		NE	2.49
A4232		NV	2.49
A4232		OR	2.49
A4232		SD	2.49
A4232		UT	2.53
A4232		WA	2.49
A4232		WY	2.49
E0784	RR	AK	398.22
E0784	RR	AZ	398.22
E0784	RR	CA	398.22
E0784	RR	HI	398.22
E0784	RR	IA	398.22
E0784	RR	ID	398.22
E0784	RR	KS	398.22
E0784	RR	MO	398.29
E0784	RR	MT	398.22
E0784	RR	ND	398.22
E0784	RR	NE	398.22
E0784	RR	NV	398.22
E0784	RR	OR	398.22
E0784	RR	SD	398.22
E0784	RR	UT	398.29
E0784	RR	WA	398.22
E0784	RR	WY	398.22

Medicare Secondary Payer (MSP) Tips

- If the primary insurer denies a service on a Medicare secondary claim, the reason for denial should be provided in order for Medicare to consider primary payment.
- In order to avoid misdirected payments, suppliers should not enter the primary payment amount in Block 29 of the HCFA-1500 form.

Understanding Your Medicare Remittance Notice (MRN)

The Offset Details indicates if the claim was offset (OF) or adjusted (AJ). Other details can be found in the Glossary listed below the Offset Details on the MRN. If the claim is offset, a number will be listed in the Financial Control Number (FCN) column. This number is used to match the MRN to the corresponding overpayment letter previously received. The FCN is located in lower right hand corner of the overpayment letter.

The amount field details the dollars offset or adjusted depending on the indicator in the Offset Details column. If the claim is offset, the amount is the difference between the Total Provider Paid column and the Amount of Check column minus any adjustments involved.

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DMERCs — Pre-Discharge Delivery of DMEPOS for Fitting and Training

This article clarifies HCFA policy and billing procedures regarding the circumstances under which durable medical equipment, prosthetics, and orthotics — but not supplies — may be delivered to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home.

Conditions That Must Be Met:

In some cases it would be appropriate for a supplier to deliver a medically necessary item of durable medical equipment (DME), a prosthetic, or an orthotic — but not supplies — to a beneficiary who is an inpatient in a facility (that does not qualify as the beneficiary's home). HCFA will presume that the pre-discharge delivery of a DME, prosthetic, or orthotic (hereafter "item") is appropriate if the following conditions are met:

1. The item is medically necessary for use by the beneficiary in the beneficiary's home.

2. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.

3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for such item or training the beneficiary in the use of such item and the item is for subsequent use in the patient's home.

4. The supplier delivers the item to the beneficiary no earlier than two days before the day the beneficiary is discharged from the facility.

5. The supplier ensures that the item is taken home by the beneficiary or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.

6. The item furnished by the supplier is not for the purpose of eliminating the responsibility of the facility to provide an item that is medically necessary for use or treatment of the beneficiary while the beneficiary is in a facility. Such items are included in the DRG and PPS rates.

7. The supplier does not claim payment for the item for any day prior to the date of discharge.

8. The supplier does not claim payment for any additional costs that may be incurred by the supplier in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.

9. The beneficiary's discharge must be to a qualified place of service, i.e., home, custodial facility, etc., but not to another facility (inpatient, skilled nursing, etc.) that does not qualify as the beneficiary's home.

Date of Service for Claims Processing:

The general rule is the date of service is the date of delivery. However, the rule for pre-discharge delivery of items is that the date of service is the date of discharge. The following three scenarios illuminate both this latter rule (when the date of service is the date of discharge) and exceptions thereto.

1. If the supplier leaves the item with the beneficiary at the facility two days prior to the date of discharge, and if the supplier, as a practical matter, need do nothing further to effect delivery of the item to the beneficiary's home (because the beneficiary or a caregiver takes it home), then the date of discharge is deemed to be the date of delivery of the item and such date shall be the date of service for the purpose of claim submission. (This is not an exception to the general DMEPOS rule that the date of service must be the date of delivery. Rather, it recognizes the supplier's responsibility — per condition #5, above — to ensure that the item is actually delivered to the beneficiary's home on the date of discharge.) No billing can be made for days prior to the date of discharge.

2. If the supplier fits the item to the beneficiary or trains the beneficiary in its use while the beneficiary is in the facility, but thereafter removes the item and subsequently delivers the item to the beneficiary's home, then the date of service shall be the date of actual delivery of the item, provided such date is not earlier than the date of discharge.

3. If the supplier leaves the item at the facility and the item is not taken home by the beneficiary, or sent or taken to the beneficiary's home by a third party, or otherwise (re)delivered to the beneficiary's home by the supplier on or before the date of discharge, then the date of service

may not be earlier than the actual date of delivery of the item, i.e., the actual date the item arrives, by whatever means, at the beneficiary's home.

Facility Responsibilities During the Transition Period:

1. A facility remains responsible for furnishing medically necessary items to a beneficiary for the full duration of the beneficiary's stay. Such items are covered by the DRG and PPS rates.

2. A facility may not delay furnishing a medically necessary item for the use or treatment of a beneficiary while the beneficiary is in the facility nor may a facility prematurely remove a medically necessary item from the beneficiary's use or treatment on the basis that a supplier has delivered a similar or identical item to the beneficiary for purpose of fitting or training.

3. A facility may not, through the stratagem of relying upon a supplier to furnish such items, improperly shift to Medicare Part B its costs for furnishing medically necessary items to a beneficiary who is a resident in the facility.

Nevertheless, beginning two days before the beneficiary's discharge, a facility may take reasonable actions to permit a supplier to fit or train the beneficiary with the medically necessary item that is for subsequent use in the beneficiary's home. These actions may include the substitution of the supplier-furnished item, in whole or in part, for the facility-furnished item during the beneficiary's last two inpatient days provided such substitution is both reasonable and necessary for fitting or training and the item is intended for subsequent use at the beneficiary's home.

4. For P&O items, the above restrictions apply to residents in a covered Part A stay. For DME, the above restrictions apply in a covered Part A or a Part B stay.

Physician's Assistants (PAs)

The Summer 1998 *DMERC Dialogue* article entitled "Certificates of Medical Necessity (CMNs) and Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)" provided guidelines for NPs and CNSs ordering durable medical equipment, prosthetics, orthotics, and supplies and signing CMNs. As a result of this publication, CIGNA HealthCare Medicare Administration has received numerous calls asking if physician's assistants (PAs) are also permitted to sign Section D of the CMN. According to the Health Care Financing Administration, PAs were not included in this revision to the statute as a result of the Balanced Budget Act of 1997. Therefore, PAs remain prohibited from signing Section D of the CMN (See *Region D Supplier Manual,* Chapter VIII- 3*)*.

Nebulizer Drugs – Documentation

According to the Region D regional medical review policy for Nebulizers, amounts of nebulizer drugs exceeding the usual suggested dosing guidelines outlined in the policy must be accompanied by additional documentation to justify medical necessity. Claims for extra nebulizer drugs are often denied because the additional documentation is vague or contains stock phrases such as "patient requires this medication due to severe COPD and emphysema."

When a policy allows for an "exception" to the usual guidelines with additional documentation, this additional documentation should be patient-specific and provide detailed information about why the standard therapy is inadequate or failed. When billing for nebulizer drugs in amounts more than the guidelines outlined in the Nebulizers policy, we recommend this additional documentation include:

- A copy of the prescription that is signed and dated by the treating physician describing the name of the drug, strength and frequency of use.
- Medical records documenting:

1. The failure of therapy at the doses outlined in the policy guidelines.

2. Signs, symptoms, and severity of the beneficiary's lung condition (e.g. pulmonary function tests [PFTs]).

3. Alternative therapies and/or medications tried and the results.

The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records or records from other health care professionals. Providing this additional detailed documentation will assist the Region D Medical Review staff in processing your claim(s) for these drugs. Please refer to the Nebulizers policy in the *Region D Supplier Manual* IX-139 for further details on coverage, coding and documentation requirements.

Diabetic Supplies and Correct Units of Service

An examination of claims for diabetic supplies shows common billing errors on the number of services for lancets and strips. This article addresses billing errors we see frequently.

1) Suppliers providing the same number of strips as lancets are billing the same units of service for both, even though codes A4253 and A4259 represent different numbers of items.

Resolution. One unit of service for code A4253 represents 50 test strips for a blood glucose monitor, while one unit of service for code A4259 represents 100 lancets. Use caution when entering the numbers of services on these claims. For example, if 200 strips and 200 lancets are provided, the supplier should bill A4253 with 4 units of service, and A4259 with 2 units of service.

Item Provided	Code	Correct Units of Services
200 strips	A4253	4
200 lancets	A4259	2

2) The number of days the strips are for (e.g., 30) or the number of individual strips supplied (e.g., 50) is entered in Item 24G of the HCFA-1500 claim form.

Resolution. The correct number of units as defined above must be entered into Item 24G of the claim form. This field should not be used to enter a number of days or the number of individual strips.

3) Some units of service are billed with added zeroes. For example, "020" is entered in Item 24G for 2 units of service. We read this as "20" units of service instead of "2."

Resolution. To bill the correct units of service, enter and submit the actual number of units; do not add zero.

Wheelchairs and K0004 Claim Documentation

According to the Regional Medical Review Policy on the Manual Wheelchair Base, a high strength, lightweight wheelchair (K0004) is covered when a patient meets the criteria in (1) and/or (2):

1) The patient self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair.

2) The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least 2 hours per day in the wheelchair.

For a beneficiary that does not meet criteria number one but does meet criteria number two for a wheelchair coded K0004, coverage is considered for claims accompanied by documentation in additional to the Certificate of Medical Necessity (CMN). We recommend such documentation include:

A) the wheelchair dimension(s) that necessitated the K0004 wheelchair that was provided, and

B) an explanation of the reasons the patient needs the particular wheelchair dimension(s) that necessitate the use of the K0004 wheelchair.
The explanation in B should:

- be derived from a patient-specific wheelchair evaluation,
- include relevant patient measurements, and
- provide detailed information on how the patient's individual functional needs affect the wheelchair dimension(s) that necessitate use of the K0004.

Patient measurements provided may include, but would not necessarily be limited to, the patient's hip-to-hip width, a measurement of the patient's most posterior point to the bend of knee, and/or height from seating surface to top of shoulder. The description of how the patient's functional needs affect the wheelchair dimensions may include, but would not necessarily be limited to, whether the patient self-propels, how the patient self-propels, and/or the degree of truncal support the patient requires and why. The documentation should relate the patient measurement and function to the wheelchair dimension(s).

The documentation provided will be used to determine whether the beneficiary meets the criteria for the K0004 wheelchair. If criteria for a K0004 are not met but criteria for a K0003 are met, payment will be based on the least costly medically appropriate alternative, K0003. If the criteria for a K0003 are not met, but are met for a standard wheelchair, payment will be made for the least costly medically appropriate alternative, K0001.

Oral Anticancer Drugs – Busulfan and Temozolomide

Coverage of oral anticancer drugs has been expanded to include two additional drugs.

Coverage of oral busulfan (Myleran®) is effective for dates of service on or after August 1, 1999. The NDC code for oral busulfan is:

00173-0713-25 Busulfan, 2 mg, oral

Coverage for oral temozolomide (Temodar®) is effective for dates of service on or after November 1, 1999. The NDC codes for temozolomide are:

00085-1248-01 Temozolomide, 5 mg, oral
00085-1248-02 Temozolomide, 5 mg, oral
00085-1244-01 Temozolomide, 20 mg, oral
00085-1244-02 Temozolomide, 20 mg, oral
00085-1259-01 Temozolomide, 100 mg, oral
00085-1259-02 Temozolomide, 100 mg, oral
00085-1252-01 Temozolomide, 250 mg, oral
00085-1252-02 Temozolomide, 250 mg, oral

Until the DMERC publishes notification that the NDC codes may be used, claims for these two drugs must be submitted using code J8999 (Prescription drug, oral, chemotherapeutic, not otherwise specified). Include the name of the drug, the NDC code, and the number dispensed in the HA0 record of an electronic claim or attached to a hard copy claim.

Refer to the DMERC regional medical review policy on Oral Anticancer Drugs for additional information on coverage, coding, and documentation.

External Infusion Pump Policy Update

In the accompanying *Region D Supplier Manual* update is a revision of the External Infusion Pump regional medical review policy (RMRP). This policy revision incorporates new HCPCS codes that became effective January 1, 2000. In addition, the coverage criteria for liposomal amphotericin B were corrected to consider coverage in patients with impaired *renal* function rather than impaired *hepatic* function.

The RMRP also includes new coverage criteria for external insulin infusion pumps (HCPCS code E0784) as a result of a revised national coverage determination for §60-14 of the Coverage Issues Manual. As outlined in the RMRP, external insulin infusion pumps and supplies are covered for type 1 diabetics (only) who meet Medicare coverage criteria. An ICD-9-CM code specific to the fifth digit (e.g. 250.11), describing the condition which necessitates the insulin pump, must be included on all claims for insulin pumps, insulin and/or supplies. Submission of a claim lacking a covered ICD-9-CM diagnosis code will result in a denial for medical necessity. Alternatively, failure to provide an ICD-9-CM diagnosis code on the claim will result in rejection of the claim for missing information.

Supplies for the insulin pump should be billed using codes A4221 and A4232. Insulin for use in the pump is billed using code J1820. Codes A4230 (infusion set for external insulin pump, non-needle cannula type) and A4231 (infusion set for external insulin pump, needle type) are not valid for claim submission to the DMERC because they are included in code A4221.

This policy revision is effective for dates of service on or after April 1, 2000. Please refer to the External Infusion pump regional medical review policy in the *Region D Supplier Manual* for further details on the coverage and payment rules, coding guidelines, and documentation requirements.

Immunosuppressive Drug Policy Update

In the accompanying *Region D Supplier Manual* update is a revision of the Immunosuppressive Drug regional medical review policy. This policy revision incorporates new HCPCS codes which are effective April 1, 2000. It also includes the details of the immunosuppressive drug benefit extension (see table below) found in the Balanced Budget Refinement Act of 1999. The benefit extension is effective for dates of service on or after January 1, 2000, and affects beneficiaries whose benefit would otherwise be expiring in the year 2000-2004.

Discharge Date After Covered Transplant Surgery	Drug Benefit Period
July 1, 1995-Dec. 31, 1996	Limited to 36 months from date of discharge.
Jan. 1, 1997-Dec. 31, 1997	Extended to 44 months from date of discharge.
On or after Jan. 1, 1998	At least 36 months from date of discharge, with an additional number of months to be determined.

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For patients discharged on or after January 1, 1998, the exact length of coverage will be determined at a later date by the Health Care Financing Administration (HCFA) in accordance with statutory guidelines. The new limits of coverage will be published by the DMERC when announced by HCFA.

Maintenance and Servicing Messages

Maintenance and Servicing for capped rental items is only covered after 15 rental months have been paid. Effective with claims processed on or after April 17, 2000, the following messages will be used in order to avoid any misunderstanding that may cause maintenance and servicing claims to be billed in error. Suppliers should use these messages to determine why the claim was denied and what they can do to correct it.

ANSI Message	Reason for Denial	Possible Resolutions
B17 - Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Rental claim is billed and at least 15 months have elapsed since the initial date of the capped rental period but 15 rentals have not been paid. No explanation is provided with the claim.	· Have 15 rental months been billed, *or* · Has there been a break in service, *or* · Was there a delay in delivery? Re-submit the claim with the relevant documentation.
M6 - You must furnish and service this item for as long as the patient continues to use it. We can pay for maintenance and/or servicing for every 6 months period after the 15th paid rental month or the end of the warranty period. 35- Benefit maximum has been reached.	Rental claim is billed and 15 months have been paid. Additional rental months are not allowed.	15 rental months have been paid. Maintenance can be billed beginning 180 days (6 months) from the end of the last rental month, if the beneficiary is still using the item and meets the medical criteria for it.
M6 - *see message above*. 46 - This service is not covered.	Maintenance and servicing claim is billed and there has not been 180 days (6 months) since the end of the last rental month or from the last paid maintenance.	Maintenance has been billed too soon. It must be 180 days (6 months) from the end of the last rental paid or from the last maintenance paid.
M6 - *see message above* 30 - Benefits are not available for these services until the patient has met the required waiting or residency period.	Maintenance and servicing claim is billed and 15 rental months have not been paid.	Maintenance is not covered if 15 rental months have not been paid. Evaluate the record to determine which months are missing and why. Refile the missing months if possible, otherwise follow the normal appeal process with a full explanation as to why 15 months have not been submitted and/or paid.

The supplier is responsible for tracking the rental months billed and rental months paid. Any information such as delay in delivery or break in service that would affect the capped rental period should be sent with the claim, otherwise you may experience unnecessary denials. This information should be attached to a hard copy claim or entered in the HA0 record of an electronic claim.

Sirolimus (Rapamune®) - New Immunosuppressive Drug Coverage

Effective for dates of service on or after September 15, 1999, sirolimus (Rapamune®) is eligible for Medicare reimbursement under the immunosuppressive drug benefit. Until a unique code is granted, this drug should be coded using HCPCS code J7599 (Immunosuppressive drug, not otherwise classified). When using this code, the name of the drug, dosage strength, number dispensed, and administration instructions must be included on the claim. All of the requirements for eligibility and length of the benefit apply as outlined in the Immunosuppressive Drugs regional medical review policy.

Osteogenesis Stimulators

A revision of the Osteogenesis Stimulators policy is included in the accompanying *Region D Supplier Manual* update. The major change in the policy is a revision of the definition of nonunion of a long bone fracture which is one of the conditions for which a nonspinal electrical osteogenesis stimulator (E0747) is covered. This is the result of a change in the national policy in the Medicare Coverage Issues Manual, §35-48. The revised policy is effective for claims with dates of service on or after April 1, 2000. The policy also clarifies the bones that are considered long bones.

Until such time as the wording of question 6a on the Osteogenesis Stimulators Certificate of Medical Necessity (CMN) (04.03C) can be revised to more clearly describe the new definition of a fracture nonunion, with each CMN that is sent to a physician the supplier must attach the following statement: "For purposes of answering question #6a on the attached Certificate of Medical Necessity (CMN), a fracture nonunion is considered to exist only when a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days and each including multiple views of the fracture site, have been interpreted by a physician in writing as showing that there has been no evidence of fracture healing between the two sets of radiographs. If this definition of nonunion is not met, question 6a must be answered No."

Urological Supplies Policy Revision

In the Winter 1999 *Region D Supplier Manual* update, verbiage was inadvertently omitted from the Urological Supplies regional medical review policy (RMRP) revision. The italicized verbiage below was present in previous versions of the policy but was absent in the latest revision published. Coverage and Payment Rules for indwelling catheters (IX-37), indications #3 and #4 for non-routine changes should read:

3. Catheter is obstructed by encrustation, mucous plug, *or blood clot*

4. History of recurrent obstruction or *urinary tract* infection for which it has been established that an acute event is prevented by a scheduled change at intervals of less than one per month

We are republishing this information with the corrected verbiage with this update of the *Region D Supplier Manual.*

The RMRP also reflects updates to the Coding Guidelines (IX - 37.5) which clarify the previously published payment policy for HCPCS code A5200 (Percutaneous catheter/tube anchoring device, adhesive skin attachment). (See Winter 1998 *DMERC Dialogue*, page 12.)

Milrinone (Primacor®)

Milrinone (J2260) is an intravenous inotropic drug used in an infusion pump. The full code narrative is: Injection, milrinone lactate, per 5 ml. The code descriptor was originally established when the drug was supplied in vials with 5 mg of milrinone in 5 ml of solution. When suppliers submit claims for code J2260, they must report 1 unit of service for each 5 mg of milrinone provided, regardless of the volume of solution in which it is dispensed. This is a clarification.

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Prescription Drugs and Related Equipment Billed by Suppliers Not Licensed to Dispense Prescription Drugs

Medicare does not cover a drug(s) used as a supply with DME or a prosthetic device if the drug is provided by an entity that is not licensed to dispense the drug. HCFA cannot be assured of the safety and effectiveness of the drug(s) unless it is dispensed by an entity that has a State license that qualifies it to dispense the drug. In addition, when DME or a prosthetic device is used to administer a drug(s) that has not been dispensed by a properly licensed entity, the equipment is also denied because of the related safety and efficacy concerns.

The DMERC denies claims for prescription drugs and related equipment, when the National Supplier Clearinghouse's (NSC's) files show the supplier is or was not licensed to dispense the drugs. Retroactive to December 1, l996, the DMERC recoups overpayments from these non-licensed suppliers for drugs and associated equipment. Such denials are based on §l862 (a)(1)(A) of the Social Security Act ("reasonable and necessary"). If the drugs can be denied on the basis of coverage (e.g., not covered when administered via a disposable pump; self-administered drugs) or medical necessity (e.g., not necessary to administer through an infusion pump; not necessary for particular medical condition), these situations take precedence over denials based on a non-licensed pharmacy.

Questions and Answers Regarding Refractive Lens Billing

The following questions and answers have been compiled from questions asked at our seminars and questions asked to our Customer Service Center.

Q1) What date of service do we use on our claims? The day the beneficiary ordered the item(s) or the day the beneficiary received the item(s)?

A1) The date of service is either the actual date the patient received the item or the shipping date if the item is shipped. (*Region D Suppler Manual*, Chapters VI - 2 and VII - 5 and 6)

Q2) What place of service do we use on our claims? Since the beneficiary received the item in our office should we use place of service "11" for office?

A2) The place of service should be shown as the place where the item, equipment or supply would be used. The supplier should not bill using place of service "11." (*Region D Supplier Manual*, Chapter IV - 9 and 10)

Q3) If the order only lists the strength of the correction, is this enough to have in our file for a written order?

A3) No, this does not meet the requirements of a dispensing order and a detailed written order. Please refer to the *Supplier Manual* VII - 1 for what needs to be on a dispensing order before dispensing the item and pages 2 and 3 information regarding detailed written orders. The dispensing order and the detailed written order must follow all the requirements as any other DMEPOS billed to Medicare. A prescription with only the strength of the correction is not enough when the physician wants the patient to have frames and any additional add-ons. The description of each item(s) must be stated on the dispensing order and the detailed written order.

Q4) What additional information do we need to have in our files?

A4) Please refer to the *Region D Supplier Manual* in Chapter IX pages 42-46 and Chapter VII regarding beneficiary authorization, proof of delivery, and supporting medical necessity documentation.

Q5) Does Medicare pay both lenses after each cataract surgery or just the lens for the one surgery performed?

A5) Medicare will cover one **pair** of eyeglasses or contact **lenses (both lenses)** after each cataract surgery with insertion of an intraocular lens. However, if a beneficiary has a cataract extraction with intraocular lens (IOL) insertion in one eye, subsequently has a cataract extraction with IOL insertion in the other eye, and does not receive corrective lenses between the two surgical procedures, Medicare covers only one pair of eye glasses or contact lenses provided after the second surgery. In addition, if a beneficiary has a pair of eyeglasses, has a cataract extraction with IOL insertion, and receives only new lenses but not new frames after the surgery, the benefit would not cover new frames supplied at a later date unless provided with lenses following a subsequent cataract extraction in the other eye. (*Region D Supplier Manual*, Chapter IX - 45)

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Q6) Which UPIN number do we need on the claim? The UPIN number for the doctor who performed the surgery or the doctor who prescribed the corrective lenses?

A6) The UPIN of the doctor who ordered the corrective lenses. (*Region D Supplier Manual*, Chapter IX - 46 and IV - 6 and 7)

Q7) Does Medicare ever cover glasses if a patient does not have an IOL?

A7) Yes, Medicare will cover refractive lenses when they are medically necessary to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of congenital absence or surgical removal without IOL implant. (*Region D Supplier Manual*, Chapter IX - 45)

Q8) Do you need to have a RT for right and/or LT for left on the HCPCS code?

A8) Yes, the appropriate modifiers must be used with the procedure code(s) on the claim. When lenses are provided bilaterally and the same code is used for both lenses, bill both on the same claim line using the LTRT modifier and 2 units of service. (*Region D Supplier Manual*, Chapter IX - 46)

Q9) What is the proper use of the ZX modifier in this policy?

A9) If tints, anti-reflective coating, U-V lenses, or oversized lenses are specifically ordered by the treating physician and are not only a patient preference item, the ZX modifier should be added to the code. The ZX modifier is only to be used when this requirement is met and documentation to support the medical necessity of the lens feature is available to the DMERC on request. If documentation does not support the medical need, then a supplier should obtain an advance beneficiary notice (ABN) on assigned claims. If a properly executed ABN has been obtained, the supplier must append the GA modifier to the HCPCS Code for waiver to apply. (*Region D Supplier Manual*, Chapter IX - 45 and 46 and III - 3 and 4, January 1996 *DMERC Dialogue*, page 6)

Oxygen Testing and Documentation in the Medical Records

Region D DMERC periodically conducts audits on claims submitted by various suppliers of home oxygen and related equipment for which medical records from the referring physician may be requested. Audit findings show that many oxygen Certificates of Medical Necessity include only an oxygen saturation taken by pulse oximetry, while the medical records also contain results of one or more arterial blood gas studies (ABGs). The Coverage Issues Manual (CIM) 60-4 states, "When the arterial blood gas and oximetry studies are both used to document the need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source of documenting medical need." In addition the most recent test taken on or before the certification date must be entered on the CMN.

In this situation, if documentation in the medical record contains the result of an ABG performed on the same day as the oximetry saturation recorded on the CMN and they are the most recent tests taken on or before the certification date on the CMN, the ABG will be used to determine oxygen coverage for that certification. If the ABG does not substantiate the need for oxygen the claim(s) will be denied as not reasonable and necessary. If the tests are not performed on the same day, the most recent test will be used in the determination for oxygen coverage.

Oxygen CMN – Revision

The Office of Management and Budget (OMB) has mandated a revision of the Oxygen Certificate of Medical Necessity, HCFA Form 484. The changes on the back of the form are as follows: a change in the estimate of the time needed to collect the information, a HCFA address change, and substitution of the term "treating physician" for "ordering physician." There are no changes to the front of the CMN except that the date of the form (found in the lower left corner) has been changed from 5/97 to 11/99. There are no changes to the National Standard Format (NSF) for this CMN. This revised CMN is still designated DMERC Form 484.2. The revised DMERC 484.2 (11/99) may be used for oxygen claims received on or after April 1, 2000 and is required for all oxygen CMNs received on or after October 1, 2000. The current Form 484.2 (5/97) may continue to be used for claims received on or before September 30, 2000; however, it will be invalid for all oxygen CMNs received on or after October 1, 2000.

A revision of the form is published in Chapter VIII of the accompanying Region D *Supplier Manual* update. The revised form is also available on the Region D DMERC web site, www.cignamedicare.com.

Authorization for Electronic Funds Transfer

Supplier Name _____ Supplier ID Number _____

City _____ State _____

I hereby authorize Connecticut General Life Insurance Company, hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my checking account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name _____ Branch _____

City _____ State _____ ZIP _____

Routing Number _____ Account Number _____

Please Check One:
- ☐ Enrollment
- ☐ Change
- ☐ Cancellation

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination or change in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination (at least 10 days notice).

Name _____ Title _____
(Please Print)

Signed _____ Date _____

Please include a voided check or deposit slip with this agreement for verification of your account number. Return this agreement to:

CIGNA DMERC
Att: EFT Enrollment
PO Box 690
Nashville TN 37202
615.251.8182

DMERC Region D Publication Order Form

Name:_____

Company Name:_____

Street:_____

City:_____State:_____Zip:_____

Phone:_____

Fax:_____

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Notes

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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: 615.251.8182 **Beneficiary Help Line**: 800.899.7095

Written Inquiries—Forward to:
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
803.754.3951

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 208.333.2141, or send us e-mail at dmercedi@cigna.com.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 803.736.6809.

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

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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.

Included in This Issue:

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Medicare Administration

DMERC–Region D
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Nashville TN 37202