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
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"From the Medical Director..."

Progressive Corrective Action

In August of this year, the Health Care Financing Administration issued final instructions to Medicare carriers for implementing a plan called progressive corrective action (PCA). The basic principles underlying PCA are:

- Data analysis should guide all decisions
- Corrective actions should be appropriate to the level and type of provider error
- Education is a key component of all actions

Data analysis is the first step in PCA. Data available to the carrier may include information from such sources as governmental and non-governmental reports, internal claim analysis, reports from the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), and supplier, physician and beneficiary complaints. If data analysis shows a potential problem exists, "probe reviews" are conducted. Probe review involves a request for supplier and medical records that the medical review department will use to evaluate the validity and extent of the potential problems identified in the data analysis step.

Once the probe review has been conducted, the supplier's error rate is calculated based on the dollar amounts paid in error by the Medicare carrier and the dollar amount of services reviewed. The supplier's error rate, combined with any aggravating or mitigating factors, will guide the carrier in determining the appropriate level of corrective action. Aggravating factors might include past history of abusive billing practices or a high percentage of particular types of errors. Mitigating factors might include actions such as a compliance plan or a mandatory training program for employees. Corrective actions may include options such as simple education on billing errors, prepayment review of a percentage of claims, sampling of claims with overpayment projection, consent settlements and payment suspension.

Suppliers targeted by PCA, also called "providers-at-risk," are tracked throughout the process with respect to compliance with the educational efforts of the carrier and other corrective action efforts. Follow-up information is provided at frequent intervals and the results of the follow-up are communicated to the provider-at-risk. The overall goal is to ensure proper billing practices so that claims will be submitted and paid correctly. Achievement of this goal will also result in removal of suppliers from medical review as soon as possible.

For details on PCA, refer to Program Memorandum AB-00-72 on the HCFA website at www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.

2001 Fee Schedule

Due to pending legislation, the 2001 fee schedule has not been finalized. Therefore, the hard copy of the 2001 fee schedule will not be available until a later date. You will be able to access the 2001 fees via the CIGNA Medicare website at www.cignamedicare.com, or through the Health Care Financing Administration at www.hcfa.gov.

External Infusion Pumps – Policy Revision

A revision of the External Infusion Pump policy is being published with the accompanying update to the *DMERC Region D Supplier Manual*. The revision incorporates allowance for the use of either invasive hemodynamic monitoring or thoracic electrical bioimpedance, also known as impedance cardiography, in order to qualify a patient for Medicare coverage of inotropic drugs in the treatment of congestive heart failure.

Although the effective date of the revised policy is January 1, 2001, the results for this alternative form of cardiac monitoring will be considered with claims for dates of service on or after July 1, 1999.

Lightweight Wheelchairs – K0003 and K0004

Suppliers are reminded of the coverage and payment rules for lightweight wheelchairs (K0003) and high strength lightweight wheelchairs (K0004). (*DMERC Region D Supplier Manual*, Regional Medical Review Policies, "Manual Wheelchair Base")

A K0003 is covered when a patient:

a) cannot self-propel in a standard wheelchair using arms and/or legs, and
b) the patient can and does self-propel in a lightweight wheelchair.

A K0004 is covered when, in addition to qualifying for a K0003, the patient either:

a) engages in frequent activities that cannot be performed in a standard or lightweight wheelchair, or
b) the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair AND spends at least two hours a day in the wheelchair.

Additionally, a high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

When billing for any type of lightweight wheelchair please ensure that the wheelchair provided to the beneficiary and billed to Medicare is the same base wheelchair that is documented on the physician's order and the Certificate of Medical Necessity (CMN). For example, if the physician's order and the CMN state "lightweight wheelchair," the supplier must provide the K0003. It is the supplier's responsibility to ensure the physician is educated on the differences between the two chairs. Under no circumstances should a wheelchair be upcoded or downcoded by the supplier, for example, by providing a K0004 when a K0003 is ordered on the CMN, or billing for a K0004 when a lightweight wheelchair was ordered by the physician.

"Good Denials" from Medicare

The staff at CIGNA Medicare often hear "I need a 'good' denial from Medicare" to get a claim paid by a secondary insurer. Unfortunately, for dual eligible beneficiaries, CIGNA Medicare has little latitude when assigning a denial code to a claim. CIGNA Medicare cannot:

- Change American National Standards Institute (ANSI) messages. The language in these messages is determined by insurance industry and governmental agencies and cannot be modified by CIGNA Medicare staff.
- Assign a medical necessity denial to a claim that has technical or "critical" errors. Claims first edit for beneficiary demographic information, eligibility information, Unique Physician Identification Number (UPIN), or supplier number.
- Adjudicate claims based on a secondary insurer's guidelines. If Medicare insurance is primary, claims must first be decided based on Medicare guidelines, not those of the secondary insurer.
- Assign a medical necessity denial in place of a coverage denial (or vice versa).

For more information on Medicare as the primary and secondary insurer, please consult the *DMERC Region D Supplier Manual*.

External Cardiac Defibrillators

A new code has been established for automated external cardiac defibrillators.

E0617 External defibrillator with integrated electrocardiogram analysis

This code is effective for dates of service on or after January 1, 2001. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.

Correction to 2000 Fee Schedule

The following Surgical Dressing codes were published in the Summer 2000 DMERC Dialogue with the incorrect fee schedule amount. The new fees were entered into our system November 15, 2000. Claims processed or adjusted on or after November 15, 2000 will be processed using these new fees. The corrected fee schedule amounts are listed below.

K0535 - All states $4.46
K0536 - All states $6.57
K0537 - All states $18.30

Rollabout Chairs (E1031)

A rollabout chair (E1031) is covered as described in national HCFA policy (*Coverage Issues Manual*, Section 60-9):

It is covered if it "...has been prescribed by the patient's physician in lieu of a wheelchair. Coverage is limited to those roll-about chairs having casters of at least 5 inches in diameter and specifically designed to meet the needs of ill, injured, or otherwise impaired individuals.

"Coverage is denied for the wide range of chairs with smaller casters as are found in general use in homes, offices, and institutions for many purposes not related to the care or treatment of ill or injured persons. This type is not primarily medical in nature."

Rollabout chairs may be called by other names such as "transport" or mobile geriatric chairs ("geri-chairs"). However, regardless of any name used for a rollabout chair, the instructions given above present the only distinctions relevant to Medicare coverage.

In addition to other factors, a manual wheelchair coded as K0001-K0009 must not only have wheels larger than 5 inches, but the wheels must also be designed and positioned on the chair such that a patient would be able to readily reach and use them to propel himself in the chair. Chairs designed only to be pushed by the caregiver must not be coded as a wheelchair.

Because rollabout chairs are not wheelchairs, wheelchair accessory codes billed as attachments to rollabout chairs are denied as having no related equipment.

A supplier wanting to know which code to use to describe a particular product should contact the Statistical Analysis DME Regional Carrier (SADMERC) – Palmetto Government Benefits Administrators.

Speech Generating Devices - New Codes

In a recent national coverage determination, the Health Care Financing Administration (HCFA) announced that "communicators" (*Coverage Issues Manual,* Section 60-9) would be eligible for coverage for dates of service on or after January 1, 2001. Coverage is provided under the durable medical equipment benefit category.

In accordance with HCFA's coverage decision, seven temporary "K" codes have been established. These new codes are effective for dates of service on or after January 1, 2001.

K0541 Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
K0542 Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes recording time
K0543 Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
K0544 Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
K0545 Speech generating software program, for personal computer or personal digital assistant
K0546 Accessory for speech generating device, mounting system
K0547 Accessory for speech generating device, not otherwise classified

In addition, effective for dates of service on or after January 1, 2001, HCPCS code E1900 (synthesized speech augmentative communication device with dynamic display) will no longer be valid for submission to the DMERCs.

Note that the establishment of a new code does not necessarily indicate coverage of an item. Until formal publication of the change in the *Coverage Issues Manual* or development of a regional medical review policy, claims for speech generating devices will be adjudicated based on individual consideration for dates of service on or after January 1, 2001.

Support Surfaces – Group 3 - Policy Revision

A revision of the Pressure Reducing Support Surfaces - Group 3 medical policy is included in the accompanying *DMERC Region D Supplier Manual* updates. The DMERC policy incorporates recent revisions made to the national policy in *Coverage Issues Manual*, Section 60-19.

Therapeutic Shoes for Diabetics – Statement of Certifying Physician Revised

The suggested form suppliers of therapeutic shoes for diabetics are to have completed and signed prior to submitting a claim to the DMERC has been revised. The revision clarifies for the certifying physician that all the statements on the form (not just those relating to foot deformity) should be circled, only if they apply.

The person signing this form must be a certifying physician. The certifying physician must be an M.D. or D.O. A podiatrist (D.P.M.) may not sign this form.

The prescribing physician, who issues the order for the shoes, may be an M.D., D.O., or D.P.M.

Suppliers are also reminded that merely receiving a signed statement from the certifying physician does not necessarily allow them to add a ZX modifier to the HCPCS code on the claim for the shoes. The statements that are circled on the form must indicate the coverage criteria of the DMERC medical policy on Therapeutic Shoes for Diabetics have been fulfilled in order to properly apply the ZX modifier to the HCPCS code.

Tracheostoma Valves and Heat and Moisture Exchangers

Several new codes have been established to bill for tracheostoma valves and for tracheostoma heat and moisture exchangers. These codes are effective for dates of service on or after January 1, 2001.

A tracheostoma valve (A7501) is a device that is used by some laryngectomy patients who have had a tracheoesophageal puncture procedure and have a "voice prosthesis" in their tracheoesophageal puncture site. It consists of a plastic body which contains a thin silicone diaphragm. The valve body fits into a plastic housing which is held in place over the tracheostoma by an adhesive disc made of tape or foam. The diaphragm of the tracheostoma valve closes during speaking to allow air to flow from the trachea through the voice prosthesis and into the esophagus to produce speech. Without a tracheostoma valve, the patient with a tracheoesophageal voice prosthesis would have to occlude the opening of the tracheostoma with their finger in order to be able to speak.

A tracheostoma valve (A7501) is to be distinguished from a tracheostomy speaking valve (L8501). A tracheostomy speaking valve (L8501) is a device which is attached to a tracheostomy tube. During speaking, the diaphragm in this device closes to keep air from flowing out through the tracheostomy tube, and instead directs air to flow normally through the larynx. In contrast, the tracheostoma valve described by code A7501 is used over a tracheostoma in a patient who has had their larynx removed and has a tracheoesophageal voice prosthesis, but who does not have a tracheostomy tube.

A tracheostoma heat and moisture exchanger is a system that is used by some patients with a tracheostoma to add warmth and water vapor to the air when they take in a breath. It consists of a plastic cassette/holder which contains a filter made of foam, paper, or other material. The holder fits into a plastic housing which is held in place over the tracheostoma by an adhesive disc. A heat and moisture exchanger may be used by itself or in addition to a tracheostoma valve (A7501).

Below is a list of the new codes and the brand names and manufacturers of some of the products that would be billed using each code. Questions concerning the coding of other products should be directed to the SADMERC.

A7501 Tracheostoma valve, including diaphragm, each

Products: Blom-Singer Adjustable Tracheostoma Valve (InHealth Technologies), Bivona Tracheostoma Valve (Bivona), Bivona Tracheostoma Valve II (Bivona)

A7502 Replacement diaphragm/ faceplate for tracheostoma valve, each

Product: Blom-Singer Replacement Diaphragm/ Faceplate (InHealth Technologies)

A7503 Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each

Products: Blom-Singer HumidiFilter Holder (InHealth Technologies), Blom-Singer HumidiFilter ATSV Cap (InHealth Technologies), TrachiNaze Occlusion Cap (Kapitex Healthcare)

A7504 Filter, for use in a tracheostoma heat and moisture exchange system, each

Product: Blom-Singer Foam Filters (InHealth Technologies), TrachiNaze Filters (Kapitex Healthcare)

A7505 Housing, reusable, without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each

Products: Blom-Singer Tracheostoma Valve Housing (InHealth Technologies), Bivona Housing (Bivona)

A7506 Adhesive disc, for use in a heat and moisture exchange system and/or with a tracheostoma valve, any type, each

Products: Blom-Singer Adhesive Disc (InHealth Technologies), Bivona Adhesive Disc (Bivona)

A7507 Filter holder and integrated filter, without adhesive, for use in a tracheostoma heat and moisture exchange system, each

Product: Provox HME cassette (Atos Medical)

A7508 Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each

Products: Provox Adhesive (Atos Medical), Blom-Singer True Seal Adhesive Housings (InHealth Technologies), Blom-Singer Tracheostoma Baseplate (InHealth Technologies), TrachiNaze Baseplate (Kapitex Healthcare)

A7509 Filter holder and integrated filter, housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each

Products: Provox StomVent (Atos Medical), StomVent II (Atos Medical)

Limb Orthoses – Code Narrative Changes

In the 2001 HCPCS Update, the narratives for many base codes for limb orthoses (L1600 - L4398) have been revised to more clearly indicate whether the code describes a prefabricated or a custom fabricated orthosis.

A prefabricated orthosis is one which is manufactured in quantity without a specific patient in mind. It is preformed with a shape that generally conforms to the body part. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). A preformed orthosis is considered prefabricated even if it requires the attachment of straps and/or the addition of a lining and/or other finishing work. Multiple measurements may be taken of the body part to determine which stock size of a prefabricated (preformed) orthosis will provide the best fit. An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom fabricated orthosis is considered prefabricated.

A custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of flat sheets, bars, etc. It involves substantial work such as vacuum forming, cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than just trimming, bending, or making other modifications to a substantially prefabricated item.

Prior to this revision, many of the codes for custom fabricated limb orthoses contained the term "molded-to-patient-model." Molded-to-patient-model describes the way that thermoplastic limb orthoses are custom fabricated. An impression of the specific body part is made (by means of a plaster or fiberglass cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then custom fabricated and molded on this positive model. In the revised narratives for limb orthoses, the term "molded-to-patient model" has been deleted and the term "custom fabricated" has been substituted.

If suppliers or manufacturers have a question about the correct code to use for their product, they should contact the SADMERC for a written coding determination.

A list of the limb orthosis codes affected by these changes can be found in the 2001 HCPCS Update article in this publication.

Ventilator Code Change – E0450 - Reminder

As of January 1, 2000, the descriptor for the code E0450 was changed as follows: Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube). Therefore, code E0450 must not be used to bill for a ventilator used with a non-invasive interface.

Similarly, code K0534 describes a positive pressure respiratory assist device having bi-level pressure capacity, with backup rate, used with an invasive interface. Code K0534 should only be billed if it is being used with an invasive interface (e.g., tracheostomy tube).

Positive pressure respiratory assist devices used to deliver respiratory assistance via a non-invasive interface must be coded with K0532 (bi-level pressure device without a backup rate), or K0533 (bi-level pressure device with a backup rate).

Code E0460, a negative pressure ventilator, should not be used to bill for a positive pressure ventilator used to administer respiratory assistance via a nasal and/or oral mask interface.

Refer to the Respiratory Assist Devices regional medical review policy in the *DMERC Region D Supplier Manual* for coverage criteria, coding guidelines and documentation requirements concerning these codes.

Oxygen Enriching Systems - Payment Information

Codes E1405 and E1406 describe oxygen and water vapor enriching systems with or without heated delivery respectively. Due to their design, these devices require substantially higher oxygen flow rates in order to deliver

the same concentration of oxygen as that achieved by standard oxygen delivery systems (for example, concentrators or liquid/gaseous systems). Since codes E1405 and E1406 require the higher flow rate but do not provide a benefit to the beneficiary in terms of the inspired concentration of oxygen, payment will not be made at the 150% of the Medicare fee schedule for these devices. The modifiers QF and QG, which are appended to claim lines to indicate oxygen flow rates greater than 4 liters/minute, must not be used with codes E1405 and E1406.

Ostomy Supplies

The regional medical review policy on Ostomy Supplies contains guidelines on the usual maximum amount of supplies allowed. Some of these guidelines are being revised to increase the usual maximum amount (see table).

Usual Maximum Quantity of Supplies

Code	#/month	#/6 months
A4357	1	
A4361		3
A4362	20	
A4364	4	
A4367	1	
A4397	4	
A4398		2
A4399		2
A4402	4	
A4404	10	
A4455		16
A5051	60	
A5052	60	
A5053	60	
A5054	60	
A5055	31	
A5061	20	
A5062	20	
A5063	20	
A5071	20	
A5072	20	
A5073	20	
A5081	31	
A5082	1	
A5093	10	
A5102		2
A5119		3
A5121	20	
A5122	20	
A5123	20	
A5126	10	
A5131	1	
A6216	60	
A6265	40	

The current policy restrictions on the medical necessity of closed pouches (A5051-A5054, A4387) are rescinded.

Suppliers are reminded that there should be documentation in the patient's medical record supporting the type and amount of supplies ordered. This is particularly important when the patient's needs are greater than the "usual maximum quantity" for the type of supplies they use.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals. This information does not have to be routinely sent to the DMERC but must be made available to the DMERC upon request.

The Ostomy Supplies policy will be revised to include this information.

These changes are effective for claims with dates of service on or after October 1, 2000.

Billing Electronically Cuts Disbursement Time in Half!

Recent analysis shows that more than 80 percent of our claims are transmitted electronically. Why are so many people choosing to bill electronically?

One of the biggest reasons is that when billing electronically the disbursement time is cut in half. The payment floor for paper claims is 26 days, which means that if you have a clean claim, you will be eligible for payment on the 27th day. Whereas, with electronic claims, the payment floor is only 13 days, therefore clean claims will be eligible for payment on the 14th day.

If you would like more information on billing electronically, please contact the EDI department at 208.333.2141, option 1.

Coverage of Breast Prostheses for Partial Mastectomy or Lumpectomy

Breast prostheses for patients who have undergone a partial mastectomy or lumpectomy are covered under the existing Regional Medical Review Policy (RMRP) entitled "External Breast Prostheses." When billing for partial breast prostheses under the circumstances described above, use the current HCPCS codes. The same coverage and payment rules, coding guidelines, and documentation requirements apply to these patients as currently outlined in the RMRP.

Pessaries - New Codes

Effective for dates of service (DOS) on or after January 1, 2001, coding changes are established for pessaries. HCPCS code A4560 will be deleted and replaced by two separate codes as follows:

Code	Description	Change	Effective
A4560	Pessary	Deleted	DOS January 1, 2001 for claims received April 1, 2001 and after
A4561	Pessary, rubber, any type	Added	DOS January 1, 2001 and after
A4562	Pessary, non rubber, any type	Added	DOS January 1, 2001 and after

Rubber and non-rubber pessaries provided to beneficiaries on or after January 1, 2001, should be billed with the new codes. Claims for A4560 received on or after April 1, 2001, for DOS on or after January 1, 2001, will be rejected as an invalid code. Pessaries are covered by the DMERCs when ordered by the treating physician.

If physicians wish to directly bill the DMERC for these pessaries, they are reminded that they must apply for a supplier number from the National Supplier Clearinghouse (NSC). They may be contacted at P.O. Box 100142, Columbia, SC 29202-3142; by toll-free telephone number (866) 238-9652; or online at the following website: www.palmettogba.com.

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 drugs. 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 drugs. 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. Physicians are considered to have been "deemed" the right to dispense prescription drugs, and therefore do not require a pharmacy license.

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 on the date of service. 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").

These messages are used for denied services:

Medicare Summary Notice (MSN): "Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay."

Medicare Remittance Notice (MRN): "This service/procedure is denied/reduced when performed/billed by this type of provider, in this type of facility, or by a provider of this specialty." (ANSI code B6, group code CO--the provider may not bill the beneficiary.)

Additionally, remark code M143 will appear on remittance notices: "We have no record that you are licensed to dispense drugs by the State in which you are located."

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 another medical necessity reason (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.

Comprehensive Error Rate Testing (CERT)

In order to improve the processing and medical decision making involved with payment of Medicare claims, HCFA began a new program effective August 2000. This program is called Comprehensive Error Rate Testing (CERT) and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (DynCorp of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. DynCorp's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. HCFA will use the

DynCorp findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. The first will be the durable medical equipment carriers (DMERCs). On a monthly basis, DynCorp will request a small sample of claims– approximately 200–from each DMERC, as the claims are entered into their system. DynCorp will follow the claims until they're adjudicated, and then compare the DMERC's final claims decision with its own. Instances of incorrect processing (e.g., due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement, in appropriate ways. Consequently, it is HCFA's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How else are suppliers impacted by CERT?

Suppliers of the sampled claims will be asked during the course of the DynCorp review, to provide additional information (e.g., medical records, certificates of medical necessity, etc.) for DynCorp staff to verify services billed were delivered, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information and the name of a contact person.

General questions regarding the CERT initiative may be directed to Laura Castelli, DynCorp Project Director for the CERT Program, at 804.264.1778. Otherwise, suppliers will be contacted ONLY if their claim(s) is selected and additional information is required by DynCorp.

The Hype About HIPAA

If you haven't heard of HIPAA, you have a lot of catching up to do!

In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all nonstandard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

The Transaction Final Rule is the first of the Administrative Simplification requirements to be published in the *Federal Register*. It was published on August 17, 2000, and requires providers to use the applicable standards for electronic transactions such as: submitting claims; receiving remittance advice statements; querying patient eligibility; checking claim status; requesting prior authorization where required for certain items of durable medical equipment; or requesting payment for the limited number of drugs covered by Medicare. These standards will be fully implemented October 16, 2002, (October 16, 2003, for small health plans). When fully implemented, Medicare contractors and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards.

Health care providers and suppliers who conduct business electronically are urged to begin considering what steps they may need to take to upgrade their software to conform to the new standards. This can be done either independently or through commercial vendors. Health providers can also consider arranging for the services of a commercial clearinghouse or billing service knowledgeable about the new requirements to translate data on their behalf.

A copy of the Transaction and Code Set Final Rule, as well as more information on the full range of Administrative Simplification requirements (including identifiers, security and privacy of health information proposed rules) can be obtained from the following website: http://aspe.hhs.gov/admnsimp/.

Look for further important HIPAA information in upcoming issues of this publication.

Clinical Trials

On June 7, 2000, the President of the United States issued an executive memorandum directing the Health Care Financing Administration (HCFA) to "explicitly authorize [Medicare] payment for routine patient care costs…and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, this National Coverage Decision (NCD) serves to define the routine costs of clinical trials and identify the clinical trials for which payment for such routine costs should be made for eligible services furnished on or after September 19, 2000.

HCFA has developed a National Coverage Determination (NCD) which can be accessed and downloaded from the HCFA web page at www.hcfa.gov/quality/8d.htm. This NCD states that Medicare covers: 1) the routine costs of qualifying clinical trials as well as, 2) reasonable and necessary items and services used to diagnose and treat

complications arising from participation in all clinical trials. This instruction addresses routine costs of qualifying clinical trials including complications resulting from qualifying clinical trials. All other Medicare rules apply.

Clinical Trial Services That Qualify for Coverage

Clinical trial services covered by Medicare must meet both the following requirements:

1. **Qualifying Trial.** In order to be covered, the service must be part of a trial that meets ***all*** of the following criteria in order to be considered a qualifying trial:

   a) **Evaluates a Medicare Benefit.** The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).

   b) **Has a Therapeutic Intent.** The trial must have a therapeutic intent (i.e., is not designed exclusively to test toxicity or disease pathophysiology).

   c) **Enrolls Diagnosed Beneficiaries.** Trials of ***therapeutic interventions*** must enroll patients with diagnosed disease rather than healthy volunteers. Trials of ***diagnostic interventions*** may enroll healthy patients in order to have a proper control group.

   d) **Has Desirable Characteristics.** The desirable characteristics are listed in the NCD.

   - Deemed Trials. Some trials are considered automatically deemed as having desirable characteristics. They include:

     Effective September 19, 2000

     - Trials funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), HCFA, Department of Defense (DOD), and Department of Veterans Affairs (VA);
     - Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, HCFA, DOD and VA;
     - Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drugs Administration (FDA); and
     - Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) are deemed until the qualifying criteria are developed and the certification process is in place. At time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status.

       Until the Medicare clinical trials registry is established, the sponsors of both IND trials and IND-exempt trials must identify themselves by e-mail to clinicaltrials@hcfa.gov for administration, payment and program integrity purposes.

   - Self-Certified Trials. In the future, a multi-agency Federal panel (see NCD for further details) will develop qualifying criteria that will indicate a strong probability that a trial exhibits the desirable characteristics as stated in the NCD. No trials are covered based upon self-certification at this time.

2. Routine Costs. Routine costs of a clinical trial include all items and services that are provided in either the experimental or the control arms of a trial except those listed below as not covered. Services provided to Medicare beneficiaries in both the experimental group and the control group are eligible for coverage provided that all other criteria in this instruction are met.

   Routine costs do NOT include (and are therefore are not covered):

   - The investigational item or service, itself;
   - Items and services:
   - For which there is no Medicare benefit category; or
     - Which are statutorily excluded; or
     - That fall under a national noncoverage policy;
   - Items and services furnished solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
   - Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
   - Items and services provided solely to determine trial eligibility.

Routine costs DO include (and are therefore covered):

- Items or services that are typically provided absent a clinical trial (e.g., medically necessary conventional care);
- Items and services required for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent);
- Items and services required for the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.

This national coverage policy is based upon the authority found in §1862(a)(1)(E) of the Social Security Act (Act). It is binding on all Medicare carriers, intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, Health Care Prepayment Plans, and Medicare+Choice organizations (§1852 (a)(1)(A) of the Act)."

Effective for dates of service on or after September 19, 2000, when submitting claims for services or items that meet the requirements as outlined in the final National Coverage Decision you must identify these services with the "QV" procedure code modifier. "QV" - "Item or service provided as routine care in an approved clinical trial" (The full coverage policy regarding clinical trials may be accessed at www.hcfa.gov/quality/8d.htm.)

The modifier is line item specific and must be used to identify items and services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary's participation in a Medicare covered clinical trial. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the clinical management of the patient are not covered and may not be billed using the QV modifier. Items and services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category also may not be billed using the QV modifier. Finally, items and services customarily provided by the research sponsor free of charge for any enrollee in the trial may not be billed.

In addition to the QV modifier, providers must also report diagnosis code V70.5 (Health Examination of Defined Subpopulations) as a secondary diagnosis for patients participating in Medicare covered clinical trials.

The QV modifier and V70.5 diagnosis code will serve as your attestation that the service meets the Medicare coverage criteria (i.e., was furnished to a beneficiary who is participating in a Medicare qualifying clinical trial and represents routine patient care, including complications associated with qualifying trial participation.)

Submit separate line items for clinical trial services when billing other covered services not directly related to a Medicare qualifying clinical trial on the same claim.

When submitting claims with the QV procedure code modifier and V70.5 diagnosis code, the billing provider must include in the beneficiary's medical record the following information: trial name, sponsor, and sponsor-assigned protocol number. This information should not be submitted with the claim but must be provided if requested for medical review. A copy of the signed informed consent document must also be made readily available if requested for medical review

Payment for these qualifying clinical trial services furnished on or after September 19, 2000, will be made based on the payment methodology applicable for the service that was furnished (e.g., physician fee schedule, lab fee schedule, DME fee schedule, reasonable charge). All applicable deductible and coinsurance rules apply to these services with one exception. Managed care enrollees will not be responsible for the Part A and Part B deductibles for covered clinical trial services billed as fee for service.

If you have a claim for a Medicare qualifying clinical trial service that has been denied for a date of service on or after September 19, 2000, the action you take to get the claim paid will depend on whether the service was initially submitted with the QV modifier and ICD-9 code.

Initial Claim Did Not Include the QV Modifier and ICD-9 Code V70.5.--If clinical trial routine care services on a claim are denied and were not identified as clinical trial services (i.e., the clinical trial modifier and ICD-9 code was not included), resubmit the services on a new claim with the QV modifier and ICD-9 code V70.5 for the care or medical complications arising from a Medicare qualifying clinical trial.

Denied Service Included the QV Modifier and ICD-9 Code.--If a service Medicare covers is billed with the QV modifier and ICD-9 code and initially denied (e.g., for medical necessity or utilization) contact us (877.320.0390) and request an adjustment to the claim. If appropriate, we will adjust and pay the claim.

Payment Of Clinical Trial Services For Managed Care Enrollees.-- Until Medicare capitation rates are adjusted to account for clinical trials, payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans will be made on a fee for service basis by the Medicare contractors that process fee for service claims. Providers will need to submit fee for service bills for Medicare covered clinical trial services furnished to managed care enrollees. The payment amounts will be based on the applicable Medicare fee schedules for such services. In addition, the Part A and Part B deductibles are assumed to be met for covered clinical trial services billed as fee for service for managed care enrollees.

Home Health Prospective Payment System (PPS)

The Balanced Budget Act of 1997 requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services will be made to a single home health agency (HHA) overseeing that plan.

The law states that payment will be made to the primary HHA whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements existed with the primary agency, or "otherwise." Payment for all items is scheduled in the home health PPS episode payment that the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision include:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies; (see following)
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Non-Routine Medical Supplies (DMERCs)

When a beneficiary is in a 60-day episode, these items are included in the PPS episode payment. HHAs must bill for all supplies provided during the 60-day episode including those not related to the Plan of Care because of the consolidated billing requirements. The codes listed below were published in the *Federal Register*.

A4212	A4356	A5053	A6200	A6239	K0280
A4213	A4357	A5054	A6201	A6240	K0281
A4215	A4358	A5055	A6202	A6241	K0407
A4310	A4359	A5061	A6203	A6242	K0408
A4311	A4361	A5062	A6204	A6243	K0409
A4312	A4362	A5063	A6205	A6244	K0410
A4313	A4363	A5071	A6206	A6245	K0411
A4314	A4364	A5072	A6207	A6246	K0419
A4315	A4365	A5073	A6208	A6247	K0420
A4316	A4367	A5081	A6209	A6248	K0421
A4320	A4368	A5082	A6210	A6251	K0422
A4321	A4397	A5093	A6211	A6252	K0423
A4322	A4398	A5102	A6212	A6253	K0424
A4323	A4399	A5105	A6213	A6254	K0425
A4326	A4400	A5112	A6214	A6255	K0426
A4327	A4402	A5113	A6215	A6256	K0427
A4328	A4404	A5114	A6219	A6257	K0428
A4329	A4421	A5119	A6220	A6258	K0429
A4330	A4455	A5121	A6221	A6259	K0430
A4335	A4554	A5122	A6222	A6261	K0431
A4338	A4460	A5123	A6223	A6262	K0432
A4340	A4462	A5126	A6224	A6266	K0433
A4344	A4481	A5131	A6228	A6402	K0434
A4346	A4622	A5149	A6229	A6403	K0435
A4347	A4623	A6020	A6230	A6404	K0436
A4351	A4625	A6154	A6234	A6405	K0437
A4352	A4626	A6196	A6235	A6406	K0438
A4353	A4649	A6197	A6236	K0277	K0439
A4354	A5051	A6198	A6237	K0278	A4355
A5052	A6199	A6238	K0279		

Listed below are codes that were deleted and cross-walked to new codes.

Codes	Deleted As Of	New "A" Code	Valid As Of
A4363	12/31/99	A4369	01/01/00
A4363	12/31/99	A4370	01/01/00
A4363	12/31/99	A4371	01/01/00
K0277	12/31/99	A4372	01/01/00
K0278	12/31/99	A4373	01/01/00
K0279	12/31/99	A4374	01/01/00
K0280	12/31/00	A4331	01/01/01
K0281	12/31/00	A4332	01/01/01
K0407	12/31/00	A4333	01/01/01
K0408	12/31/00	A4334	01/01/01
K0409	12/31/00	A4319	01/01/01
K0410	12/31/00	A4324	01/01/01
K0411	12/31/00	A4325	01/01/01
K0419	12/31/99	A4375	01/01/00
K0420	12/31/99	A4376	01/01/00
K0421	12/31/99	A4377	01/01/00
K0422	12/31/99	A4378	01/01/00
K0423	12/31/99	A4379	01/01/00
K0424	12/31/99	A4380	01/01/00
K0425	12/31/99	A4381	01/01/00
K0426	12/31/99	A4382	01/01/00
K0427	12/31/99	A4383	01/01/00
K0428	12/31/99	A4384	01/01/00
K0428	12/31/99	A4385	01/01/00
K0429	12/31/99	A4386	01/01/00
K0430	12/31/99	A4387	01/01/00
K0431	12/31/99	A4388	01/01/00
K0432	12/31/99	A4389	01/01/00
K0433	12/31/99	A4390	01/01/00
K0434	12/31/99	A4391	01/01/00
K0435	12/31/99	A4392	01/01/00
K0436	12/31/99	A4393	01/01/00
K0437	12/31/99	A4394	01/01/00
K0438	12/31/99	A4395	01/01/00
K0439	12/31/99	A4396	01/01/00

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.

New Toll-Free Numbers

The Health Care Financing Administration is pleased to announce the installation of the following new supplier toll-free numbers:

DMERC Region A	HealthNow NY, Inc.	866.419.9458
DMERC Region B	AdminaStar Federal	877.299.7900
DMERC Region C	Palmetto Government Benefits Administrators	866.238.9650
DMERC Region D	CIGNA Medicare	877.320.0390
National Supplier Clearinghouse (NSC)	Customer Service Center	866.238.9652
Statistical Analysis DMERC	HCPCS Help Line	877.735.1326

This transition to toll-free lines reflects Medicare's increased focus on customer service for suppliers.

Medicare HMO Beneficiaries Transferring to Fee-For-Service Medicare

In some areas of the country, Medicare beneficiaries have the option of enrolling in a Medicare health maintenance organization (HMO). The benefit to the enrollee is that Medicare HMOs may offer more services or have more lenient coverage policies than traditional fee-for-service (FFS) Medicare. In addition, beneficiaries have the option of moving into and out of the HMO and fee-for-service programs. The movement of beneficiaries, whether voluntarily or involuntarily (i.e., disenrollment of the HMO or Managed Care plan from participation in the Medicare program), has implications for coverage under FFS Medicare rules.

A beneficiary who was previously enrolled in a Medicare HMO/Managed Care program, returning to traditional FFS Medicare, is subject to the same benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare. When a beneficiary returns to FFS Medicare it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a manual wheelchair through an HMO/Managed Care plan must under traditional FFS Medicare obtain a CMN and meet FFS Medicare criteria for a wheelchair before a new capped rental period would begin.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. Enrollment in an HMO for 60 or more days would be considered an end to medical necessity.

Suppliers should maintain open communication with beneficiaries and determine, prior to delivery of an item or continued rental, whether there has been a change in enrollment from a Medicare HMO to FFS Medicare.

Delivery of Orthoses or Other DMEPOS Items and Hospitalization

This serves to remind suppliers that if a patient requires a DMEPOS item during hospitalization, the supplier may provide it for use during the patient's hospital stay under the following conditions:

1. If a DMEPOS item such as an orthosis is to be used initially in the hospital, the item should not be delivered to the patient before hospital admission. Items delivered to the home setting before the patient has need of them are denied by the DMERC as not medically necessary. However, this requirement does not prohibit the supplier or fitter from evaluating, fabricating, and/or fitting an orthosis before hospitalization or surgery.

2. If an item is dispensed to the patient and initially used in the hospital, for example following elective surgery, reimbursement for the item is included in Medicare's payment to the hospital. The supplier must not bill the DMERC but must seek reimbursement from the hospital. Under these circumstances claims billed to the DMERC will be denied as incorrect jurisdiction.

On the other hand if an item is intended for initial use after hospitalization and the item is delivered to a hospitalized patient for the sole purpose of fitting or training up to two days before discharge to the home setting, the item should be billed to the DMERC with the discharge date as the date of service.

(See the article, "Delivery of DMEPOS Items Prior to Hospital Admission" in the Spring 1999 *DMERC Dialogue*.)

Deleted and Crosswalk Codes

The following codes will be deleted effective for dates of service on or after January 1, 2001. Deleted codes received on or after April 1, 2001, with a date of service on or after January 1, 2001, will be denied with ANSI codes M51 or B18 (Claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission. Please re-submit with the correct procedure code). Refer to the Coding Chapter of the *DMERC Region D Supplier Manual* for the complete list of crosswalk codes.

Deleted Codes	Replacement Codes
A4560	A4561
A4560	A4562
A5149 (Ostomy)	A4421
A5149 (Urological)	A4335
A6020	A6021-A6024
E1375	E0570
K0182	A7018
K0269	E0572
K0270	E0574
K0280	A4331
K0281	A4332
K0283	A7019
K0407	A4333
K0408	A4334
K0409	A4319
K0410	A4324
K0411	A4325
K0440	L8040
K0441	L8041
K0442	L8042
K0443	L8043
K0444	L8044
K0445	L8045
K0446	L8046
K0447	L8047
K0448	L8048
K0449	L8049
K0450	A4364
K0451	A4365
K0456	E0298
K0457	E0168
K0458	E0148
K0459	E0149
K0501	E0571
K0529	A7020
K0535	A6231
K0536	A6232
K0537	A6233
ZZ010	A4608

New Codes for 2001

The following new codes are effective for dates of service on or after January 1, 2001. If you bill these codes for dates of service before January 1, 2001, they will be denied as invalid codes.

A4348 Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)

A4396 Ostomy belt with peristomal hernia support

A4464 Joint supportive device/garment, elastic or equal, each

A4561 Pessary, rubber, any type

A4562 Pessary, non-rubber, any type

A6021 Collagen dressing, pad size, 16 sq. inches or less, each

A6022 Collagen dressing, pad size more than 16 sq. inches, but less than or equal to 48 sq. inch, each

A6023 Collagen dressing, pad size more than 48 sq. inches, each

A6024 Collagen dressing wound filler, per 6 inches

A7501 Tracheostoma valve, including diaphragm, each

A7502 Replacement diaphragm/faceplate for tracheostoma valve, each

A7503 Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each

A7504 Filter for use in a tracheostoma heat and moisture exchange system, each

A7505 Housing, reusable, without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each

A7506 Adhesive disc, for use in a heat and moisture exchange system and/or with a tracheostoma valve, any type, each

A7507 Filler holder and integrated filter, without adhesive, for use in a tracheostoma heat and moisture exchange system, each

A7508 Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each

A7509 Filter holder and integrated filter, housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each

E0617 External defibrillator with integrated electrocardiogram analysis

E0765 FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting

E0830 Ambulatory traction device, all types, each

E1035 Multi-positional patient transfer system, with integrated seat, operated by caregiver

K0541 Speech generating device (SGD), digitized, using pre-recorded messages, less than or equal to 8 minutes recording time

K0542 Speech generating device (SGD), digitized, using pre-recorded message, greater than 8 minutes recording time

K0543 Speech generating device (SGD), synthesized speech, requiring message formulation by spelling and access by physical contact with the device

K0544 Speech generating device (SGD), synthesized speech, permitting multiple methods of message formulation and multiple methods of device access

K0545 Speech generating software program, for personal computer or personal digital assistant

K0546	Accessory for speech generating device, mounting system
K0547	Accessory for speech generating device, not otherwise classified
J0282	Injection, amiodarone hydrochloride, 30 mg
J1452	Injection, fomivirsen sodium, intraocular, 1.65 mg
J1563	Injection, immune globulin, intravenous, 1 g
J2270	Injection, quinupristin/dalfopristin, 500 mg
J2795	Injection, ropivacaine hydrochloride, 1 mg
J2915	Injection, sodium ferric gluconate complex in sucrose injection, 62.5 mg
J2993	Injection, reteplase, 18.8 mg
J2997	Injection, altheplase recombinant, 1 mg
J3485	Injection, zidovudine, 10 mg
J7525	Tacrolimus, parenteral, 5 mg
J7520	Sirolimus, oral, 1 mg
L3760	Elbow orthosis, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments, any type
L3923	Hand finger orthosis, without joint(s), prefabricated, includes fitting/adjustments, any type

Verbiage Changes for 2001

Listed below are codes for which verbiage will change effective January 1, 2001. The words that have been added or changed are in italics:

A6222	Gauze, impregnated with other than water, normal saline, *or hydrogel,* pad size 16 sq. in. or less, without adhesive border, each dressing
A6223	Gauze, impregnated with other than water, normal saline, *or hydrogel,* pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6224	Gauze, impregnated with other than water, normal saline, *or hydrogel,* pad size more than 48 sq. in., without adhesive border, each dressing
B4150	Enteral formulae; category I; semi-synthetic intact protein/protein isolates *administered through an enteral feeding tube*, 100 calories = 1 unit
B4151	Enteral formulae; category I; natural intact protein/protein isolates *administered through an enteral feeding tube,* 100 calories = 1 unit
B4152	Enteral formulae; category II; intact protein/ protein isolates (calorically dense), administered *through an enteral feeding tube,* 100 calories = 1 unit
B4153	Enteral formulae; category III; hydrolized protein/amino acids, *administered through an enteral feeding tube,* 100 calories = 1 unit
B4154	Enteral formulae; category IV; defined formula for special metabolic need, *administered through an enteral feeding tube,* 100 calories = 1 unit
B4155	Enteral formulae; category V; modular components, *administered through an enteral feeding tube,* 100 calories = 1 unit
B4156	Enteral formulae; category VI; standardized nutrients, *administered through an enteral feeding tube* 100 calories = 1 unit
E0424	Stationary compressed gaseous oxygen system, rental; includes *container,* contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing
E0431	Portable Gaseous oxygen system, rental; *includes portable container,* regulator, flowmeter, humidifier, cannula or mask, and tubing
E0439	Stationary liquid oxygen system, rental; *includes container*, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing *(deleted 1 unit = 10 lbs.)*
E0441	Oxygen contents, gaseous (for use with owned gaseous stationary system or when both a stationary and portable gaseous system are owned) *(deleted 1 unit* – 50 cubic feet)
E0442	Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned) *(deleted 1 unit = 10 lbs.)*
E0443	Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used) *(deleted 1 unit = 5 cubic feet)*
E0444	Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used) *(deleted 1 unit = 1 lbs.)*
E0575	Nebulizer, ultrasonic, *large volume*
E1800	Dynamic adjustable elbow extension/flexion device, *or equal*
E1805	Dynamic adjustable wrist extension/flexion device, *or equal*
E1810	Dynamic adjustable knee extension/flexion device, *or equal*
E1815	Dynamic adjustable ankle extension/flexion device, *or equal*
E1825	Dynamic adjustable finger extension/flexion device, *or equal*
E1830	Dynamic adjustable toe extension/flexion device, *or equal*
J0895	Injection, deferoxamine mesylate, 500 mg *(deleted per 5 cc)*
J3010	Injection, fentanyl citrate, *0.1 mg (deleted up to 2 ml)*
J7618	Albuterol, *all formulations including separated isomers*, inhalation solution administered through DME, concentrated form, per 1 mg
J7619	Albuterol, *all formulations including separated isomers,* inhalation solution administered through DME, unit dose form, per 1 mg
L3807	Wrist hand finger orthosis, *without joint(s), prefabricated, includes fitting and* adjustment, any type
L4392	*Replacement,* soft interface material, static AFO

L5674 Addition to lower extremity, below knee, *suspension sleeve,* any material, each
L5675 Addition to lower extremity, below knee, *suspension sleeve,* heavy duty, any material, each

Custom-fabricated is added to the descriptions of the following codes:

L1630, L1640, L1680, L1685, L1700, L1710, L1720, L1730, L1755, L1834, L1840, L1844, L1846, L1855, L1858, L1860, L1870, L1880, L1900, L1904, L1920, L1940, L1945, L1950, L1960, L1970, L1980, L1990, L2000, L2010, L2020, L2030, L2036, L2037, L2038, L2039, L2040, L2050, L2060, L2070, L2080, L2090, L2102, L2104, L2106, L2108, L2122, L2124, L2126, L2128, L3720, L3730, L3740, L3800, L3805, L3900, L3901, L3902, L3904, L3906, L3907, L3963, L3985, L3986.

Prefabricated, includes fitting and adjustment is added to the descriptions of the following codes:

L1600, L1610, L1620, L1650, L1660, L1686, L1690, L1750, L1800, L1810, L1815, L1820, L1825, L1830, L1832, L1843, L1845, L1847, L1850, L1885, L1902, L1906, L1910, L1930, L2035, L2112, L2114, L2116, L2132, L2134, L2136, L3650, L3660, L3670, L3675, L3700, L3710, L3808, L3910, L3912, L3914, L3916, L3918, L3920, L3922, L3924, L3926, L3928, L3930, L3932, L3934, L3936, L3938, L3940, L3942, L3944, L3946, L3948, L3950, L3952, L3954, L3960, L3962, L3964, L3965, L3966, L3968, L3969, L3980, L3982, L3984, L4350, L4360, L4370, L4380, L4396, L4398.

L0430 Classification List

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is in the process of creating a classification list for products that would be classified as L0430 (TLSO, anterior-posterior-lateral control, with interface material, custom fitted). The SADMERC has been directed by the Health Care Financing Administration (HCFA) to develop this classification list. Upon completion and publication of this list, only the products included on the list may be billed using the code L0430. If a manufacturer or supplier thinks that another product meets the definition of this code, they should contact the SADMERC for a coding determination. Suppliers of L0430 may wish to contact their manufacturing source to determine if the manufacturer has provided the required information to the SADMERC.

Nutrients Administered Orally

Code descriptions for enteral nutrients have been revised to specify that the codes represent only nutrients that are given through an enteral feeding tube. As a result, nutrients dispensed to the patient for **oral administration** must no longer be billed to the DMERC using codes B4150-B4156.

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine. Beneficiaries who are able to take nutrients by mouth (orally) do not qualify for the prosthetic benefit, and the nutrients as well as any related supplies are noncovered. In this situation claim submission is not required. However, if the beneficiary is not in a covered Part A stay and asks the supplier to submit a claim, code A9270 must be used to bill the DMERC for nutrients provided for oral administration.

New Supplier Standards

The final ruling on the new twenty-one Supplier Standards has been approved by the Office of Management and Budget (OMB) and has been published in the *Federal Register*. These new standards, which establish additional standards for an entity to qualify as a Medicare supplier for purposes of submitting claims and receiving payment for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), will be effective starting December 11, 2000. Suppliers must be in compliance with all twenty-one standards by that date.

The *Federal Register* document pertaining to the new Supplier Standards can be accessed from the National Supplier Clearinghouse (NSC) website at www.palmetto.gba.com.

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 will be initiated from, and researched at the COB Contractor. This will no longer be a function of your local Medicare fiscal intermediary (FI) 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 will provide customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

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 for Claims Payment

FIs 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 FI or 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 FI 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 will be the sole authority in ensuring 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 and/or spousal 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.

Contacting the COB Contractor

Effective January 1, 2001, please refer all MSP inquiries; including, the reporting of potential MSP situations, changes in a beneficiary's insurance coverage, changes in employment, and general MSP questions/concerns to the COB Contractor. Continue to call your local FI and/or carrier regarding claims-related 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 AM to 8 PM, 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.

Clip and Save for Physician Education

"Pearls" for Ordering Oxygen

A surprising number of oxygen claims have recently been submitted with "PRN" on the physician order. While physicians are accustomed to including this "as needed" descriptor for certain items and services, Medicare guidelines specifically prohibit payment for oxygen used and ordered only on a PRN basis.

Oxygen therapy is a major expenditure under Part B Medicare totaling over $1.5 billion annually. And that's just the equipment. Not included in this total are the cost of physician evaluations, laboratory tests and respiratory therapy services. To insure their patients have ready access to and payment for necessary oxygen requirements, physicians are reminded to:

- Review any test results with a critical eye and determine if and when the patient requires the oxygen supplementation.
- Write orders that detail oxygen use for a specific activity or time period and not PRN.
- Consider the length of need for oxygen very carefully when prescribing for Medicare beneficiaries.
- Be careful when relying on outside agencies to express a patient's oxygen needs accurately.
- Be aware of the potential conflicts of interest inherent in a DME supplier of oxygen performing qualifying oximetry or arterial blood gas testing. Medicare regulations prohibit DME suppliers from performing the qualifying test.

Diligent attention to details when ordering oxygen therapy will help prevent delays in patients receiving the Medicare benefits they need and deserve.

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Associate Medical Director
DMERC Region D

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.

D

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 HealthCare Medicare Administration
DMERC Region D
Attn: EFT Enrollment
PO Box 690
Nashville TN 37202
877.320.0390

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 Web site 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 208.333.2141, or send us e-mail at www.cignamedicare.com/customer_service.

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

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

DMERC Dialogue

CIGNA HealthCare
Medicare Administration

HCFA
Health Care Financing Administration

...a service of
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Nashville TN 37202

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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.

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Included in This Issue

CIGNA HealthCare Medicare Administration

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PO Box 690
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