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

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"From the Medical Director……"

by Robert D. Hoover, Jr., M.D.

Region D Announces New Associate Medical Director

CIGNA HealthCare Medicare Administration (CIGNA Medicare) is pleased to announce the addition of Dr. Doran Edwards as the Associate Medical Director for the Durable Medical Equipment Regional Carrier. As the DMERC system moves out of its infancy and into the next phase of growth, CIGNA Medicare and the Health Care Financing Administration (HCFA) felt it was time to add more resources to meet the growing demands placed on the Medical Director.

Dr. Edwards is a Tennessee native and completed his undergraduate degree in pharmacy from the University of Tennessee College of Pharmacy. Working through medical school as a pharmacist, he obtained his M.D. degree from the University of Tennessee College of Medicine and continued on to complete a residency in general surgery. Prior to joining CIGNA Medicare, Dr. Edwards was the Medical Director for a private corporation providing medical services to correctional institutions.

In addition to his 20 years of practice experience as a general surgeon, Dr. Edwards' background as a pharmacist and member of several committees involving home care and nutritional therapy brings to Region D DMERC and our supplier community an expanded knowledge base that complements my internal medicine background. Dr. Edwards will be working closely with the medical review staff on provider reviews, physician, supplier and beneficiary education, and law enforcement support.

Oxygen Policy Revised

A revision of the Oxygen and Oxygen Equipment policy is included in the accompanying *Region D Supplier Manual* update. This revision incorporates changes previously published in the *DMERC Dialogue*. Suppliers should be aware that this is the first revision of the Oxygen policy since 1993 and numerous changes will be found in all sections of the policy. Therefore, we encourage you to read the entire policy carefully. Also, note that the Documentation Section has been reorganized for easier determination of when initial, revised, and recertification Certificates of Medical Necessity (CMNs) are needed.

Two coding changes should be noted and are effective for claims with dates of service on or after July 1, 2000. Codes E1405 and E1406 (oxygen and water vapor enriching system) are invalid for claim submission to the DMERC. The DMERCs have determined that the devices for which these codes were established are no longer in production. Oxygen concentrators which are

capable of delivering 85% or greater oxygen concentration at the prescribed flow rate and are used with a humidifier are correctly billed using code E1390. (There is no separate billing or payment for a humidifier used in conjunction with rented oxygen equipment.) If a manufacturer or supplier has an oxygen concentrator that they thought should be coded as E1405 or E1406, they should contact the SADMERC for a coding determination.

Code ZZ010 (transtracheal oxygen catheter for patient-owned equipment) is invalid for claim submission to the DMERC. As noted in the policy, accessories are separately payable only when they are used with a patient-owned system that was purchased prior to June 1, 1989. Accessories used with a patient-owned system that was purchased on or after June 1, 1989 are noncovered.

Spinal Orthoses

The following information is provided as guidance in coding claims for body jacket type, molded to patient model, spinal orthoses (HCPCS codes L0390-L0420, L0550, L0560).

Codes L0390-L0420, L0550, and L0560 may **only** be used for body jacket type orthoses. As defined in the medical policy on spinal orthoses, a body jacket type orthosis is characterized by a **rigid plastic shell** that encircles the trunk and provides a high degree of immobility. If a spinal orthosis is made of firm foam or other nonrigid material (other than cloth or elastic material), it must be coded as L1499. (There are specific L codes for cloth corsets and elastic spinal orthoses.) Questions concerning the coding of specific items should be directed to the SADMERC.

Codes L0390-L0420, L0550, and L0560 may **only** be used for custom fabricated items that are molded to a patient model (MTPM). As defined in the Spinal Orthoses policy, 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 sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item." An MTPM orthosis is "a particular type of custom fabricated orthosis in which an impression of the specific body part is made (usually by means of a plaster cast) and this impression is then used to make a positive model (usually of plaster) of the body part. The orthosis is then molded on this positive model." In some instances the impression of the body part is taken by means of a machine which scans the body part digitally recording information. This information is used to direct the carving of a positive model of the body part. For codes L0390-L0420, L0550, and L0560, the orthotist's records must document if a mold, cast, or digitized image was taken and the date of the visit. If only measurements were used to provide the orthosis, then an MTPM code must **not** be used. If a prefabricated **body jacket type** TLSO or LSO is provided, codes L0430, L0440, or L0565 may be appropriate. (As defined in the Spinal Orthoses policy, a prefabricated orthosis is one which is manufactured without a specific patient in mind. It may be trimmed, bent, molded (with or without heat) or otherwise modified for use by a specific patient. Any orthoses that does not meet the definition of a custom fabricated orthoses is considered prefabricated.) For items without a specific code, code L1499 must be used.

If a claim is submitted with code L1499, it must include at least the following information: the manufacturer and model name/number of the item (if applicable) or if not, a detailed description of the item which was provided, including major materials used, etc. (The picture in the AOPA Illustrated Guide is not sufficient.) The information should be attached to a hard copy claim or entered into the HA0 record on an electronic claim.

If a custom fabricated orthosis is ordered by the physician, this must be clearly indicated on the written order which has been signed and dated by the treating physician. If the DMERC requests to see the order for a custom fabricated orthosis and the order is not sufficiently specific, the claim may be denied or may be paid comparable to a prefabricated orthosis.

As a final note, certain types of spinal orthoses are fabricated for use shortly following major spine surgery. While it is certainly appropriate and common practice for these orthoses to be fabricated prior to the hospital admission, if the orthosis is needed after surgery and is applied during the patient's inpatient hospital stay, reimbursement is included in the Diagnosis Related Group (DRG) payment. Orthotists should obtain reimbursement from the hospital for the brace and must **not** submit a claim to the DMERC. Refusal of the hospital to provide medically necessary items (including orthoses) for inpatients may be reported to the fraud department of the local Medicare Fiscal Intermediary (FI) for the hospital.

DMERC Region D Supplier Manual Reorganization

Beginning with this edition of the Region D *Supplier Manual* update, you will notice a change in the format that reflects the first step in a reorganization of the *DMERC Region D Supplier Manual.* This reorganization is the result of several cost and quality analyses done in an effort

to improve the methods used to present information to the DMEPOS supplier community.

With this update, you will notice that there are no "shaded" blocks that indicate changes in revised policies. Although indicating policy revision changes with shading or colored ink is helpful in quickly determining what changed in a policy, it is very labor-intensive to setup and can be confusing once a policy has "aged" and the revision is no longer current. We will continue to describe the notable points associated with a policy revision in the *Region D DMERC Dialogue* article that accompanies the *Supplier Manual* updates. Look for the "new and improved" Region D *Supplier Manual* in early 2001.

Oral Anticancer Drugs

The Spring 2000 issue of the Region D *DMERC Dialogue* announced expanded coverage under the Oral Anticancer Drug regional medical review policy to include two additional drugs – busulfan (Myleran®) and temozolomide (Temodar®). Suppliers were instructed to temporarily use the miscellaneous HCPCS code J8999 to submit claims for these drugs. Effective for claims received on or after July 1, 2000, suppliers can submit claims for these drugs using the appropriate NDC numbers. (Refer to the Spring 2000 *DMERC Dialogue* for a listing of the NDC numbers and the effective date of coverage for each drug). If code J8999 is used for these drugs on claims received after October 1, 2000, the claim will be processed as a return/reject and the supplier should resubmit using the NDC number.

Two additional NDC numbers have been added for methotrexate products:

Methotrexate, 2.5 mg, oral	00378-0014-50
Methotrexate, 2.5 mg, oral	51285-0509-02

These numbers are valid for claims received on or after July 1, 2000.

As new NDC numbers for covered drugs are established, the DMERC will announce in its bulletin when those numbers can be accepted by our claim processing system. Until such time as a new NDC number can be accepted, suppliers must submit claims using code J8999 (Prescription drug, oral, chemotherapeutic, not otherwise specified). Claims using this code must include the name of the drug, the NDC number, and the number of tablets/capsules dispensed in the HA0 record of an electronic claim or attached to a hard copy claim. Claims using code J8999 for drugs with NDC numbers that are valid for submission to the DMERC will be processed as a return/reject.

Oral Antiemetic Drugs

Effective for dates of service on or after October 1, 2000, claims for drugs which are addressed by the DMERC policy on Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) and which are dispensed by a physician must be submitted to the DMERC. Claims from physicians for these drugs with dates of service prior to October 1, 2000 must continue to be submitted to the local carrier, regardless of the date of claim submission. Physicians must obtain a supplier number from the National Supplier Clearinghouse before they can submit claims to the DMERC. Refer to the DMERC policy for information on coverage and payment rules, coding guidelines, and documentation requirements.

Surgical Dressings – Composite Dressings

The 1999 HCPCS Update established codes A6200-A6202 for composite dressings **without** an adhesive border. (These codes are in addition to existing codes for composite dressings **with** an adhesive border, A6203-A6205.) As a result of this, the definition of composite dressings in the Surgical Dressings policy is modified to remove the requirement for an adhesive border for all composite dressings. The revised definition is:

> Composite dressings are products combining physically distinct components into a single dressing that provides multiple functions. These functions **must** include, but are not limited to: (a) a bacterial barrier, (b) an absorptive layer other than an alginate, foam, hydrocolloid, or hydrogel, and (c) either a semi-adherent or nonadherent property over the wound site.

Enteral Nutrition in Nursing Facilities

The revision to the Enteral Nutrition policy published in the *Region D DMERC Supplier Manual* Spring 2000 update concerning claim jurisdiction for enteral nutrition provided to beneficiaries in nursing facilities was incorrect. The incorrect statement is on page 29 of Chapter IX. For patients who are **not** in a Medicare Part A covered stay, the instruction should read: "In this situation, the enteral nutrition must be billed to the DMERC." The nursing facility does **not** have the option of submitting the claim to the fiscal intermediary. For patients who **are** in a Medicare Part A covered stay, the policy is correct in saying that those claims must be billed by the skilled nursing facility to the intermediary.

Surgical Dressings – Hydrogel

Three new codes have been established for surgical dressings:

K0535 Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, without adhesive border, each dressing
K0536 Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
K0537 Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., without adhesive border, each dressing

These new K codes are effective for claims with dates of service on or after July 1, 2000. Currently the products that will be billed using these new K codes are coded using the hydrogel wound cover codes A6242-A6244; the A codes should continue to be used for claims with dates of service prior to July 1, 2000.

In the medical policy on Surgical Dressings, the definition of impregnated gauze dressings is modified as follows:

> Impregnated gauze dressings are woven or non-woven materials in which substances such as *hydrogel,* iodinated agents, petrolatum, zinc compounds, crystalline sodium chloride, chlorhexadine gluconate (CHG), bismuth tribromophenate (BTP), water, aqueous saline, or other agents have been incorporated into the dressing material by the manufacturer.

Codes A6228-A6230 will continue to be used for gauze dressings impregnated with water or normal saline. Codes A6222-A6224 will continue to be used for gauze dressings impregnated with substances **other than** water, normal saline, or hydrogel.

Refer to the medical policy on Surgical Dressings for information on coverage and payment rules, coding guidelines, and documentation requirements. General coverage criteria for hydrogel dressings apply to these new codes. An amorphous hydrogel wound filler (A6248) or a hydrogel wound cover (A6242-A6247) used in the same wound at the same time as hydrogel-impregnated gauze dressings will be denied as not medically necessary. An appropriate wound cover (i.e., one which is appropriate for a wound with minimal or no exudate), other than a hydrogel wound cover, would be allowed in addition to impregnated hydrogel gauze.

Fee Schedules For New Surgical Dressing Codes

The fees for the hydrogel-impregnated gauze dressings listed below are effective July 1, 2000.

Code	State	2000 Fee
K0535	AK	4.80
	AZ	4.80
	CA	4.80
	HI	4.80
	IA	4.80
	ID	4.80
	KS	4.80
	MO	4.80
	MT	4.80
	ND	4.80
	NE	4.80
	NV	4.80
	OR	4.80
	SD	4.80
	UT	4.80
	WA	4.80
	WY	4.80

Code	State	2000 Fee
K0536	AK	7.05
	AZ	7.05
	CA	7.05
	HI	7.05
	IA	7.05
	ID	7.05
	KS	7.05
	MO	7.05
	MT	7.05
	ND	7.05
	NE	7.05
	NV	7.05
	OR	7.05
	SD	7.05
	UT	7.05
	WA	7.05
	WY	7.05

Code	State	2000 Fee
K0537	AK	19.69
	AZ	19.69
	CA	19.69
	HI	19.69
	IA	19.69
	ID	19.69
	KS	19.69
	MO	19.69
	MT	19.69
	ND	19.69
	NE	19.69
	NV	19.69
	OR	19.69
	SD	19.69
	UT	19.69
	WA	19.69
	WY	19.69

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Facial Prostheses Fee Schedule

Listed below are the year 2000 fee schedules for the facial prostheses codes. When a replacement prosthesis is fabricated starting with a new impression/moulage, use the KM modifier. When a replacement prosthesis is fabricated using a previous master model, use the KN modifier. When a replacement involves a new impression/moulage (KM) rather than use of a previous master model (KN), the reason for the new impression/moulage must be clearly documented in the supplier's records and be available to the DMERC on request. Please refer to your *Region D Supplier Manual*, Chapter IX, page 131, for the Facial Prostheses Policy.

	K0440	K0441	K0442	K0443	K0444	K0445	K0446	K0447	K0449
AK	1662.29	2003.53	2251.15	2521.27	2791.40	1753.26	1800.91	922.97	17.92
AZ	1551.10	1869.70	2100.77	2352.87	2604.96	1637.26	1680.62	861.31	19.78
CA	1551.10	1869.70	2100.77	2352.87	2604.96	1637.26	1680.62	861.31	19.78
HI	1591.41	1918.22	2155.31	2413.95	2672.59	1682.61	1724.26	883.68	17.92
IA	1385.73	1670.28	1876.72	2101.93	2327.13	1468.53	1501.38	769.46	15.54
ID	1480.44	1784.52	2005.09	2245.71	2486.31	1560.75	1604.07	822.09	18.64
KS	1385.73	1670.28	1876.72	2101.93	2327.13	1468.53	1501.38	769.46	15.54
MO	1385.73	1670.28	1876.72	2101.93	2327.13	1468.53	1501.38	769.46	15.54
MT	1378.25	1661.31	1866.63	2090.62	2314.61	1468.53	1493.31	765.31	20.25
ND	1378.25	1661.31	1866.63	2090.62	2314.61	1468.53	1493.31	765.31	20.25
NE	1385.73	1670.28	1876.72	2101.93	2327.13	1468.53	1501.38	769.46	15.54
NV	1551.10	1869.70	2100.77	2352.87	2604.96	1637.26	1680.62	861.31	19.78
OR	1480.44	1784.52	2005.09	2245.71	2486.31	1560.75	1604.07	822.09	18.64
SD	1378.25	1661.31	1866.63	2090.62	2314.61	1468.53	1493.31	765.31	20.25
UT	1378.25	1661.31	1866.63	2090.62	2314.61	1468.53	1493.31	765.31	20.25
WA	1480.44	1784.52	2005.09	2245.71	2486.31	1560.75	1604.07	822.09	18.64
WY	1378.25	1661.31	1866.63	2090.62	2314.61	1468.53	1493.31	765.31	20.25
	K0440KM	K0441KM	K0442KM	K0443KM	K0444KM	K0445KM	K0446KM	K0447KM	
AK	1579.20	1903.35	2138.57	2395.23	2651.84	1665.60	1710.87	876.81	
AZ	1473.55	1776.23	1995.73	2235.21	2474.70	1555.41	1596.59	818.23	
CA	1473.55	1776.23	1995.73	2235.21	2474.70	1555.41	1596.59	818.23	
HI	1511.83	1822.31	2047.54	2293.28	2538.95	1598.49	1638.06	839.50	
IA	1316.45	1586.77	1782.87	1996.82	2210.77	1395.10	1426.30	730.98	
ID	1406.43	1695.31	1904.84	2133.42	2361.99	1482.72	1523.88	781.00	
KS	1316.45	1586.77	1782.87	1996.82	2210.77	1395.10	1426.30	730.98	
MO	1316.45	1586.77	1782.87	1996.82	2210.77	1395.10	1426.30	730.98	
MT	1309.33	1578.23	1773.30	1986.10	2198.89	1395.10	1418.64	727.05	
ND	1309.33	1578.23	1773.30	1986.10	2198.89	1395.10	1418.64	727.05	
NE	1316.45	1586.77	1782.87	1996.82	2210.77	1395.10	1426.30	730.98	
NV	1473.55	1776.23	1995.73	2235.21	2474.70	1555.41	1596.59	818.23	
OR	1406.43	1695.31	1904.84	2133.42	2361.99	1482.72	1523.88	781.00	
SD	1309.33	1578.23	1773.30	1986.10	2198.89	1395.10	1418.64	727.05	
UT	1309.33	1578.23	1773.30	1986.10	2198.89	1395.10	1418.64	727.05	
WA	1406.43	1695.31	1904.84	2133.42	2361.99	1482.72	1523.88	781.00	
WY	1309.33	1578.23	1773.30	1986.10	2198.89	1395.10	1418.64	727.05	
	K0440KN	K0441KN	K0442KN	K0443KN	K0444KN	K0445KN	K0446KN	K0447KN	
AK	664.93	801.42	900.46	1008.52	1116.56	701.30	720.35	369.18	
AZ	620.42	747.87	840.31	941.14	1041.98	654.91	672.25	344.52	
CA	620.42	747.87	840.31	941.14	1041.98	654.91	672.25	344.52	
HI	636.58	767.29	862.13	965.59	1069.03	673.04	689.70	353.47	
IA	554.29	668.09	750.69	840.76	930.86	587.42	600.57	307.79	
ID	592.17	713.81	802.03	898.29	994.53	624.30	641.62	328.82	
KS	554.29	668.09	750.69	840.76	930.86	587.42	600.57	307.79	
MO	554.29	668.09	750.69	840.76	930.86	587.42	600.57	307.79	
MT	551.28	664.52	746.65	836.26	925.86	587.42	597.32	306.12	
ND	551.28	664.52	746.65	836.26	925.86	587.42	597.32	306.12	
NE	554.29	668.09	750.69	840.76	930.86	587.42	600.57	307.79	
NV	620.42	747.87	840.31	941.14	1041.98	654.91	672.25	344.52	
OR	592.17	713.81	802.03	898.29	994.53	624.30	641.62	328.82	
SD	551.28	664.52	746.65	836.26	925.86	587.42	597.32	306.12	
UT	551.28	664.52	746.65	836.26	925.86	587.42	597.32	306.12	
WA	592.17	713.81	802.03	898.29	994.53	624.30	641.62	328.82	
WY	551.28	664.52	746.65	836.26	925.86	587.42	597.32	306.12	

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Year 2000 Fee Revisions for L2405, L2415, L2425, and L2430

It was brought to our attention that the fee for code L2430 was established using the wholesale and not the retail price list. In examining this code we decided to review the other sequence of "Addition to knee joint" codes. The base fees for codes L2405, L2415, and L2425 were initially gap-filled by the previous local carriers. The result of this review increased base fees for code L2405 and L2430. The current fees for codes L2415 and L2425 were found to actually reflect the cost of a pair of joints instead of per each joint, as described by the codes listed below. Therefore, the base fees for these two codes will decrease.

CIGNA Medicare Region D will revise the year 2000 fees for all four codes for claims with dates of service January 1, 2000 and after that are processed on or after July 1, 2000. The revised fees for these codes were developed using available price lists.

L2405 Addition to knee joint, drop lock, each joint
L2415 Addition to knee joint, cam lock (Swiss, French, bail types) each joint.
L2425 Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint.
L2430 Addition to knee joint, ratchet lock for active and progressive knee extension, each joint

The chart below reflects the revised base fees including the final fees to be implemented July 1, 2000.

Code	State	Current Base Fee	Revised Base Fee	Revised 2000 Fee	Code	State	Current Base Fee	Revised Base Fee	Revised 2000 Fee
L2405	AK	37.25	54.94	64.69	L2415	AK	117.28	76.55	90.13
	AZ	25.76	54.94	64.69		AZ	91.53	76.55	90.13
	CA	36.88	54.94	64.69		CA	116.12	76.55	90.13
	HI	39.83	54.94	64.69		HI	125.41	76.55	90.13
	IA	23.00	54.94	65.95		IA	93.00	76.55	91.90
	ID	32.03	54.94	64.69		ID	94.26	76.55	90.13
	KS	27.69	54.94	65.95		KS	138.47	76.55	91.90
	MO	27.69	57.26	65.95		MO	138.47	79.78	91.90
	MT	39.33	54.94	67.01		MT	98.07	76.55	93.38
	ND	6.61	54.94	67.01		ND	108.82	76.55	93.38
	NE	27.69	54.94	65.95		NE	138.47	76.55	91.90
	NV	25.76	54.94	64.69		NV	91.53	76.55	90.13
	OR	30.89	54.94	64.69		OR	91.53	76.55	90.13
	SD	6.61	54.94	67.01		SD	108.82	76.55	93.38
	UT	41.55	58.10	67.01		UT	208.04	80.95	93.38
	WA	34.69	54.94	64.69		WA	94.26	76.55	90.13
	WY	8.63	54.94	67.01		WY	88.42	76.55	93.38

Code	State	Current Base Fee	Revised Base Fee	Revised 2000 Fee	Code	State	Current Base Fee	Revised Base Fee	Revised 2000 Fee
L2425	AK	168.95	90.33	106.37	L2430	AK	62.56	86.30	106.37
	AZ	114.91	90.33	106.37		AZ	61.94	86.30	106.37
	CA	167.28	90.33	106.37		CA	61.94	86.30	106.37
	HI	180.66	90.33	106.37		HI	66.90	86.30	106.37
	IA	116.84	90.33	108.44		IA	61.94	86.30	108.44
	ID	138.44	90.33	106.37		ID	61.94	86.30	106.37
	KS	116.84	90.33	108.44		KS	61.94	86.30	108.44
	MO	102.03	94.15	108.44		MO	64.56	89.95	108.44
	MT	76.91	90.33	110.18		MT	61.94	86.30	110.18
	ND	198.32	90.33	110.18		ND	61.94	86.30	110.18
	NE	116.84	90.33	108.44		NE	61.94	86.30	108.44
	NV	134.93	90.33	106.37		NV	61.94	86.30	106.37
	OR	86.45	90.33	106.37		OR	61.94	86.30	106.37
	SD	198.32	90.33	110.18		SD	61.94	86.30	110.18
	UT	202.71	95.52	110.18		UT	65.50	91.26	110.18
	WA	79.10	90.33	106.37		WA	61.94	86.30	106.37
	WY	198.32	90.33	110.18		WY	61.94	86.30	110.18

If you have any questions regarding these changes, please send them to:

CIGNA Medicare Region D
Medicare Reimbursement
PO Box 690
Nashville, Tennessee 37202

Note: Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

Levalbuterol (Xopenex®)

Levalbuterol is the R-isomer of standard racemic albuterol, used as a beta-adrenergic bronchodilator administered through nebulizers. According to available literature, this form of albuterol has no clinically significant advantage over standard albuterol. Therefore, when billing for levalbuterol, use HCPCS codes J7618 or J7619, and payment will be based upon these codes' billing units - per 1 mg.

Submitting Additional Documentation with the Review Request

The DMERC Review Department makes every effort to provide a thorough analysis of every request we receive. It is important that we have ALL of the facts available concerning the issues involved. Trained medical professionals evaluate medical information submitted and their opinions are taken into consideration as a part of the final review decision. If you have submitted additional information along with your original claim please note this on your review request. All medical documentation must be signed and dated by a health care professional. If the beneficiary has signed an Advance Beneficiary Notice, please submit a copy along with your review request.

The following are examples of additional documentation that we recommend be sent with the review request:

Surgical Dressings

- A **dated** wound evaluation that gives the stage, drainage and size of the wound. It should be dated within 30 days of the date of service in question.
- If you are billing an NOC code, we need a detailed description of the item such as the product name and product number.
- A detailed written order from the patient's physician.

Urologicals

- Nurses notes and patients daily care records. If the patient requires additional quantities of catheters the reason for the need must be documented.
- Documentation from the patient's doctor providing information about the patient's medical condition including episodes of pyuria, fevers and/or urinary tract infections.

Wheelchairs, Attachments and Accessories

- The Certificate of Medical Necessity
- The Physical or Occupational Therapist's notes
- Medical records which explain the need for the wheelchair and each individual accessory.
- Manufacturer's name and product number, invoice/ suggested retail price
- Description of the patient's routine activities outside the home
- For code K0005 - Describe features needed compared to the K0004 or K0003 wheelchair.

Prosthetics and Replacement Sockets

- A new order signed by the doctor
- Measurements of residual limb changes
- Medical documentation that explains the need for socket replacements or new prosthetic. This information should include any weight changes, level of activity, length of time since amputation, number of sock plies used.

Orthotics

- Treatment plan from the doctor and supplier
- Documentation about the patient's condition which explains the need for new or replacement orthotics.

Lymphedema Pumps

- The Certificate of Medical Necessity
- Additional documentation that describes the location of the lesion(s), any other treatments tried or the reasons other treatments could not be tried.

Multiple Ventilators

- Medical records to show the spontaneous breathing time for the patient and to demonstrate the medical need for more than one ventilator.

Tracheal Suction Catheters

- Documentation describing the patient's condition and that of the tracheostomy site.
- The medical reasons for any increase in catheter usage.

Enteral Formula (Category IV and V Nutrients)

- Lab results
- Test results
- Documentation that demonstrates the patient's condition on the Category I nutrient as opposed to the Category IV or V nutrient over a period of time.

Parenteral Formula

- Discharge Summaries
- Operative reports
- Fecal/Fat tests
- Evidence of failed tube trails and significant malnurishment

Air Fluidized Beds

- The Certificate of Medical Necessity
- Current wound evaluation
- Additional documentation that outlines patient's condition, description of other treatments tried, the level of bed confinement and the possibility of institutionalization in the absence of the bed.

Support Surfaces

- The Certificate of Medical Necessity
- A statement from the ordering physician

Infusion Pumps for Dobutamine, Milrinone and Dopamine

- Hospital Discharge Summary
- Inotropic data form (Supplier Manual IX-41.2)
- Cardiac Catheterization report

Power Operated Vehicles

- The Certificate of Medical Necessity
- A copy of the physician's evaluation performed that resulted in the POV prescription

Same or Similar Equipment Denials

- The Certificate of Medical Necessity
- Physician's order
- Signed pick up and delivery tickets
- A detailed outline of events (who provided what and when)

Break In Service Denials

- A description of the patient's prior medical condition which necessitated the previous item;
- A statement explaining when and why the medical necessity for the previous item ended; and
- A statement explaining the patient's new or changed medical condition and when the new need began.

Telephone Review Reminders

Telephone reviews are available for providers, beneficiaries, and their representatives. Our Automated Response Unit (ARU) provides an option for telephone reviews as part of the menu. This option should be used only for telephone review requests. It should not be used for general inquiries.

- The person taking the telephone review request can accept a maximum of one review per call.
- Telephone reviews are not appropriate for complex issues. If you have a complex case with unusual circumstances, it is more appropriate to request the review in writing. That way you can be sure that the reviewer gets all of the information that may affect the outcome of your case.
- Telephone reviews will not be accepted if there are more than 4 pages of additional information to be faxed.
- Telephone reviews must be requested within 5 months of the initial determination. This is a safeguard should an appellant call in and the issues cannot be resolved over the telephone. The appellant will still have one month to request a written review. Please remember that ALL reviews must be requested within 6 months of the date of the initial determination.

We will need the following information in order to take your telephone review. Please have it ready when you call.

- Your name
- Your telephone number
- Your supplier number
- The name of the beneficiary
- The beneficiary Health Insurance Claim Number (HICN)
- The date of service
- The type of equipment or supplies
- The reason for the review request (why you disagree with the original decision)

During the call you will be given a confirmation number. Please use this number for all future contacts concerning this review request.

New Review/Adjustment Request Form

We are providing a new form to be used for review and adjustment requests. Please provide as much information as possible. This form is NOT to be used for Hearing requests. (Form is on page 11.)

Forgotten ZX Modifiers

Claims denied due to the lack of a ZX modifier are frequently seen in appeals accompanied only by a statement that the supplier forgot to add the ZX modifier. If the appropriate documentation substantiating the beneficiary met criteria is not submitted, the Review Department will no longer add the ZX modifier to claims with this or other similar statements. Effective immediately, reviews for claims without a ZX modifier that are submitted without the appropriate documentation will be developed for the documentation that the ZX represents, based on the relevant policy.

Certificates of Medical Necessity (CMN) – Highlighting

It is permissible for a supplier to highlight questions and appropriate related fields on the CMN that the physician must complete (Section B and Section D). For copy readability, the DMERC recommends the supplier use a yellow highlighter.

The CMN fields can be highlighted before sending to the physician, but the supplier may not highlight the **answers** that would qualify the beneficiary for Medicare coverage.

Certificate of Medical Necessity Initial Date

Medicare Certificates of Medical Necessity (CMN) are forms approved by the Office of Management and Budget (OMB) and are required by the Health Care Financing Administration (HCFA). Instructions for completion of the CMN are provided on the back of the form.
The instructions on the back of the CMN for "Certification Type/Date" state: "If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL."

The date of initial need is the date determined by the physician that the patient needs the item. The date of initial need may or may not be the same as the date the item is delivered to the patient. Also, the date of initial need may or may not be the same as the date the physician signs section D of the CMN.

If the initial date of need on a CMN for any item is different than the delivery date, an explanation may be entered in the HA0 record when billing electronically, or included with a hardcopy claim.

Nebulizer Drugs with Missing or Incorrect Modifiers and Dispensing Fees

Claims for nebulizer drugs billed with missing or incorrect modifiers are returned as incomplete/invalid procedure code(s) and must be resubmitted with the correct modifiers. Because the related nebulizer drug dispensing fee(s) (E0590 or Q0132) must be billed on the same claim as the nebulizer drug(s), if the claim line for the drug is rejected due to missing or incorrect modifier, the claim line for the dispensing fee will also reject with the same message. The charge for E0590 should then be resubmitted on the same claim as the resubmitted drug code(s).

Be aware that if dispensing fee Q0132 is submitted with a date of service after December 31, 1999, or E0590 is submitted for a date of service before January 1, 2000, in either situation those claims will also be returned for incomplete/invalid procedure code. Therefore, you may have a situation where the nebulizer drug code modifier is missing or incorrect and the dispensing fee code is erroneous due to the date of service. Both the dispensing fee code and the nebulizer drug code modifier must be correct or the claim for the dispensing fee will be returned for incomplete/invalid procedure code.

Overpayment Refund Checks

The following is a correction to page 15 of the Fall 1999 *DMERC Dialogue*:

All overpayment refund checks for Durable Medical Equipment Regional Carrier (DMERC) Region D should be mailed to:

CIGNA FEDERAL INSURANCE BENEFITS - DMERC
P.O. Box 10927
Newark, NJ 07193-0927

Correction to the Winter 1999 *DMERC Dialogue*

In the Winter 1999 *DMERC Dialouge* article titled "Region D DMERC Fall 1999 Seminars - Questions and Answers," it was indicated that adjustments could be phoned into Customer Service. This is incorrect. Adjustment requests must be mailed to P. O. Box 690, Nashville, TN 37202. We regret any confusion this may have caused.

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
615.251.8182

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

MEDICARE REVIEW/ADJUSTMENT REQUEST FORM

Mail To: CIGNA HealthCare Medicare Administration
DMERC Region D
P. O. Box 22995
Nashville, TN 37202

DATE_____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: DME Oxygen Supplies Orthotics Prosthetics ESRD PEN IV Therapy
Other _____

CLAIM INFORMATION ☐ Assigned ☐ Non-Assigned

Service Date	HCPCS	Charge	Claim Control #	Denial Reason/ANSI Code

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

Please see the Spring 2000 *DMERC Dialogue* for additional documentation requirements.

_____ HCFA 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation

Other _____

CONTACT INFORMATION

PROVIDER: (Contact Name – Please Print)	BENEFICIARY: (Contact Name – Please Print)
Phone # Area Code ( )	Phone # Area Code ( )

DMERC Region D Publication Order Form

Name:_____

Company Name:_____

Street:_____

City:_____State:_____Zip:_____

Phone:_____

Fax:_____

Email:_____

Note: Government agencies, state associations, HCFA, CIGNA employees, and other insurance companies do not need to submit payment.

Subscription (12 months) $50.00/yr. per publication

DMERC Dialogue _____ Includes (if applicable) Supplier Manual updates

Subtotal:_____

DMERC Individual Requests

DMERC Dialogue* $10.00 Each Issue

	Quantity	Yr.		Quantity	Yr.
Spring	_____		Summer	_____	
Fall	_____		Winter	_____	

*Includes (if applicable) the Supplier Manual updates

DMERC Supplier Manual_____ $50.00/Manual_____

DMERC Fee Schedule_____ $10.00/Schedule_____

Subtotal:_____

Your Total Order

Subscription Subtotal _____

DMERC Individual Requests Subtotal _____

Total Amount Due:_____

Send completed order form and payment (check or money order) to:
Connecticut General Life Insurance Company, P.O. Box 360295, Pittsburgh, PA 15251-0295

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: 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

...a service of
CIGNA HealthCare Medicare Administration
PO Box 690
Nashville TN 37202
615.251.8182

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

DMERC Dialogue – Summer 2000
Included in This Issue:

CIGNA HealthCare Medicare Administration

DMERC–Region D
PO Box 690
Nashville TN 37202