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
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"From the Medical Director……"

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

Marketing Practices and Diabetic Supplies

The Office of Inspector General (OIG) recently published a report detailing their findings related to the marketing practices of diabetic suppliers (*Blood Glucose Test Strips: Marketing to Medicare Beneficiaries*, June 2000, OEI-03-98-00231). This investigation was prompted by the sharp increase in expenditures for diabetic testing supplies – from approximately $102 million in 1994 to $314 million in 1998. In addition, with the expansion of the benefit to include type 2 diabetics in July of 1998, there is the concern over even greater increases in expenditures in the future.

Medicare beneficiaries who use diabetic testing supplies may be greatly influenced by marketing practices such as rebates, discounts, or coupons. Advertisements in newspapers, radio, television, and targeted population magazines are a popular method of reaching beneficiaries. Often these advertisements include language indicating or implying routine waiver of copayments or deductibles. Such routine waivers are unlawful because of the potential for false claims, violations of anti-kickback statutes, and excessive utilization of services paid for by Medicare. When providers, suppliers, or practitioners forgive financial obligations for reasons other than genuine financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or services from them. Anyone who routinely waives coinsurance or deductibles can be criminally prosecuted for violation of 42 U.S.C. 1320a-7b(b) (Medicare and Medicaid Anti-Kickback statute) and possibly excluded from participating in all federally-funded healthcare programs.

In addition to the advertised inducements to waive copayments and deductibles, other potential violations of the anti-kickback statute include providing "free" home blood glucose monitors, requiring a minimum purchase of testing strips to receive a "free" monitor, coupon offers for monitor trade-in schemes to receive a "free" monitor, and "free" monitors and/or supplies for attendance at special "diabetic care seminars."

Finally, the OIG reported that many beneficiaries receive their test strips automatically even after guidelines were published in July, 1998 prohibiting this practice. The OIG sample survey found that 46 percent of beneficiaries who got their strips in the mail received them automatically without prior authorization. Suppliers of diabetic supplies must not dispense test strips, lancets, or control solutions on a predetermined basis. There must be a specific request for supplies from the beneficiary or their caregivers. (See the regional medical review policy on home blood glucose monitors for further details, located at www.cignamedicare.com/dmerc).

Suppliers or providers who engage in these practices or who engage in misleading advertising to Medicare beneficiaries may be in violation of Medicare and Medicaid anti-kickback laws. Suppliers should seek qualified legal counsel if they have any questions or concerns regarding waivers of deductibles and/or coinsurance or the propriety of marketing or advertising materials.

(For a complete copy of the OIG's report on blood glucose testing supplies and to access a copy of their *Compliance Program Guidance for the Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry*, visit their website at www.hhs.gov/progorg/oig).

Nebulizer Coverage Review

Since publication of the Nebulizer RMRP on April 1, 1997, update information in the *DMERC Dialogue* has concentrated on documentation, coding, and claims submission of the drugs involved with the nebulizers. As a result, focus has shifted from other RMRP issues, resulting in an increase in denials. An overview of some of these issues may assist in correcting difficulties encountered.

Coverage and Payment Rules state that a small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, K0501) is covered when:

a) It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease (ICD-9-CM codes 491.0-505), or
b) It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a patient with cystic fibrosis (ICD-9-CM code 277.00) or
c) It is medically necessary to administer pentamidine to patients with HIV (ICD-9-CM code 042), or
d) It is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions (ICD-9-CM code 786.4).

Use of inhalation drugs, other than those listed above, will be denied.

Incorrect drug or ICD-9-CM codes, combining covered drugs with disease codes other than those listed, using covered drugs and covered disease codes in other than the above combinations, or selection of non-covered inhalation drugs will result in automatic denial as not medically necessary.

RMRP states for criterion (a) to be met, the physician *must* have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI *must be documented in the patient's medical record* and be available to the DMERC on request.

Specific coverage criteria also apply to large volume nebulizers (A7017) and related accessories and supplies. These items are covered *only* when it is medically necessary to deliver humidity to a patient with thick, tenacious secretions, *and* who has a diagnosis of cystic fibrosis (ICD-9-CM code 277.00), bronchiectasis (ICD-9-CM code 494, 494.0, 494.1, or 748.1), or a tracheostomy (ICD-9-CM code V44.0 or V55.0).

Similar coverage and payment specificity relates to an E0565 or K0269 compressor and filtered nebulizer (A7006) for medically necessary administration of pentamidine to patients with HIV (ICD-9-CM code 042). Nebulizer codes, related accessories, and drugs must be linked to the appropriate ICD-9-CM codes. Large volume nebulizers and related items used predominantly for indications other than specified in the policy, will be denied as noncovered.

Small volume ultrasonic nebulizers (K0270) will be reimbursed at the least costly medically appropriate alternative (i.e., pneumatic compressor - E0575) because there is no **proven** medical benefit to nebulizing particles to diameters smaller than achievable with a pneumatic model.

Large volume ultrasonic nebulizers (E0575) offer no proven clinical advantage over pneumatic compressors. However, since code E0575 is in a different payment category than pneumatic compressors, payment for a least costly alternate cannot be made. Therefore, when an E0575 nebulizer is provided, it will be denied as not medically necessary as will any related accessories and supplies.

A battery powered compressor (K0501) is rarely medically necessary. If this compressor is provided without accompanying documentation which justifies its medical necessity, and the coverage criteria for code E0570 are met, payment will be based on the allowance for the least costly medically acceptable alternative, E0570.

Other uses of compressors/generators will be considered individually on a case by case basis, to determine their medical necessity.

(For additional information and definitions of equipment, accessories, and inhalation drugs, refer to the *Region D DMERC Supplier Manual*, Chapter IX, pages IX-135-IX-143.)

Oxygen Enriching Systems (E1405, E1406)

Codes E1405 and E1406 describe oxygen and water vapor enriching systems with or without heated delivery, respectively. The revised oxygen policy and a bulletin article published in the Summer 2000 *DMERC Dialogue* stated these codes were no longer valid for claim submission to the DMERC. That decision is rescinded.

Codes E1405 and E1406 may continue to be submitted – but **only** for products for which a written coding determination dated on or after July 1, 2000, specifying use of these codes has been made by the SADMERC. At the present time, the **only** product that may be billed using code E1405 or E1406 is the Oxygen Enricher manufactured by the Oxygen Enrichment Company (OECO). If a manufacturer or supplier has a different device that they believe qualifies for coding as E1405 or E1406, they should contact the SADMERC for a written coding determination.

Effective for claims received on or after December 1, 2000, all claims for E1405 or E1406 must be accompanied by the manufacturer's name and product name of the item provided. This information should be entered in the HA0 record of an electronic claim or attached to a hard copy claim.

Breathing Circuits – Billing Instructions

Code A4618 describes the breathing circuit used with a volume ventilator (E0450) (see below). A breathing circuit is a series of hoses and connectors that deliver the "breath" generated by the ventilator to the patient. Breathing circuits are not used with oxygen equipment or

nebulizers; therefore, do not bill code A4618 for accessories used with these devices.
While code A4618 describes a breathing circuit for use with a ventilator, it is not separately reimbursable since code E0450 is in the frequent and substantial servicing payment category. Claims for A4618 when billed with an E0450 will be denied as not separately payable.

Respiratory Assist Devices And Payment Of Accessories

In some instances, private insurers or beneficiaries have purchased devices falling under the "Respiratory Assist Device (RAD)" regional medical review policy prior to Medicare eligibility. For those devices that utilize separately payable accessories (i.e., K0532), the supplier must obtain the beneficiary statement and physician statement outlined in the policy. These statements must be kept on file by the supplier but should not be routinely submitted with the claim for the accessories. The DMERC may request copies of these documents at its discretion.

Batteries for Power Wheelchairs and POVs

Effective for dates of service on or after October 1, 2000, the DMERC medical policy on "Wheelchair Options and Accessories" is being revised to allow payment for gel cell and/or Group 24 batteries for power wheelchairs if they are ordered by a physician and are reasonable considering the patient's use of the wheelchair. The paragraph in the Coverage and Payment Rules section of the policy concerning batteries will be revised to say:

> Up to two batteries (K0082-K0087) at any one time are allowed if required for a power wheelchair. A battery is separately payable from the wheelchair base.

Batteries are included in the allowance for a POV and must not be billed separately with the initial issue of a POV. Any type battery will also be covered if it is provided as a **replacement** in a POV, is ordered by a physician, and is reasonable considering the patient's use of the POV. When provided as a replacement in a POV, batteries should be billed using the appropriate code with the RP modifier.

Osteogenesis Stimulators

A revision to the Osteogenesis Stimulators policy is published in the accompanying *Region D DMERC Supplier Manual* update. The description of a fracture nonunion is being clarified by indicating that the required radiographs must show no *clinically significant* healing. An article in the Spring 2000 *DMERC Dialogue* stated until the wording of question 6a on the Osteogenesis Stimulators Certificate of Medical Necessity (CMN) is revised to more clearly describe the new definition of a fracture nonunion, suppliers must attach a specific statement to each CMN that is sent to a physician. That statement is revised to say:

"For purposes of answering question 6a on the attached Certificate of Medical Necessity (CMN), a fracture nonunion is considered to exist **only** when a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days and each including multiple views of the fracture site, have been interpreted by a physician in writing as showing that there has been no *clinically significant* evidence of fracture healing between the two sets of radiographs. If this definition of nonunion is not met, question 6a must be answered No."

Tracheostoma Filters

HCPCS Code A4481 (tracheostoma filter, any type, any size, each) describes a soft foam filter designed to provide air filtration for the tracheal stoma. In the Winter 1998 *DMERC Dialogue*, a "usual maximum" guideline of one A4481 per day was published. Effective for dates of receipt on or after October 1, 2000, this "usual maximum" parameter will be removed.

Suppliers are reminded that there should be documentation in the patient's medical record supporting the number of filters ordered. 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 including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists. This information does not have to be routinely sent to the DMERC but must be made available to the DMERC upon request.

New Policy on Negative Pressure Wound Therapy

A new regional medical review policy titled "Negative Pressure Wound Therapy Pumps" (NPWT) is being published in the accompanying *Region D DMERC Supplier Manual* update. The policy is effective for claims with dates of service on or after October 1, 2000.

Three new K codes have been established for negative pressure wound therapy:

K0538 Negative pressure wound therapy electrical pump, stationary or portable
K0539 Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each
K0540 Canister set for negative pressure wound therapy electrical pump, stationary or portable, each

These new K codes will be effective as of the effective date of the policy. Code K0538 will be listed under the capped rental category and codes K0539 and K0540 will be considered supplies. Refer to your accompanying *Region D DMERC Supplier Manual* update for additional details about coverage.

Epoprostenol (Flolan®) – HCPCS Code J1325

A revision of the "External Infusion Pumps" policy is included in the accompanying *Region D DMERC Supplier Manual* update. The only revision is in the coverage criteria for epoprostenol (Flolan®). Because the revised criteria represent an expansion of the current published criteria, they are effective for claims with dates of service on or after October 1, 2000.

Immunosuppressive Drugs – DMERC Information Form

A revision of the "Immunosuppressive Drugs" policy is included in the accompanying *Region D DMERC Supplier Manual* update. The DMERC Information Form (DIF) is revised by adding additional possible responses to question number five which asks for the organ which was transplanted. The new responses include (6) Whole organ pancreas, simultaneous with or subsequent to a kidney transplant and (9) Other. If response (9) is given, the name of the organ transplanted must be entered in the HA0 record of an electronic claim or attached to a hard copy claim. The Documentation section of the policy is revised by eliminating one paragraph that related only to use of the prior DIF.

There is a 6-month "grace period" for the use of the new DIF. Suppliers may use either the old or new DIF for claims received on or after October 1, 2000; however, use of the new DIF will be required for claims received after April 1, 2001. Refer to the "Immunosuppressive Drugs" policy for additional information on Coverage and Payment Rules, Coding Guidelines, and Documentation.

New NDC Numbers for Methotrexate and Cyclophosphamide

Suppliers are currently instructed to bill oral anticancer drugs to the DMERCs using the appropriate National Drug Code (NDC) number.

Five additional NDC numbers have been added for methotrexate products:

- Methotrexate, 2.5 mg, oral (NDC #00005-4507-04)
- Methotrexate, 2.5 mg, oral (NDC #00005-4507-05)
- Methotrexate, 2.5 mg, oral (NDC #00005-4507-07)
- Methotrexate, 2.5 mg, oral (NDC #00005-4507-09)
- Methotrexate, 2.5 mg, oral (NDC #00005-4507-91)

Two additional NDC numbers have been added for cyclophosphamide products:

- Cyclophosphamide, 25 mg, oral (NDC #00054-4129-25)
- Cyclophosphamide, 50 mg, oral (NDC #00054-4130-25)

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

Perianal Fecal Collection Pouch - Code A4330

HCPCS code A4330 (perianal fecal collection pouch with adhesive, each) describes a collection system for fecal output in patients with medical conditions resulting in fecal incontinence. There is no Medicare benefit category under which payment of this code may be made. Therefore, effective for claims with dates of receipt after October 1, 2000, claims for code A4330 will be denied as noncovered (no statutory benefit).

Whirlpool Baths and Additional Documentation

Medicare coverage policy for standard (non-portable) whirlpool baths (E1310) is limited to those cases where the patient is homebound and it is prescribed for conditions where the whirlpool bath can be expected to provide a substantial therapeutic benefit justifying its cost. Payment for conditions such as bursitis or chronic osteoarthritis would not generally be justified because it would not be expected that a whirlpool bath would be significantly more beneficial than a normal warm bath.

If the patient is not homebound, payment for this item in the patient's home is restricted to the cost of providing the service elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly. Payment is restricted to the cost of the whirlpool bath and does not include remodeling or installation expenses.

Documentation supporting the medical necessity for a standard whirlpool bath should accompany all initial claims. This documentation should include:

1. Information concerning the patient's medical condition; and,

2. Evidence that a whirlpool bath offers significantly more therapeutic benefit than a normal warm bath; and,

3. Verification that the patient is homebound or that payment in the home is the least costly alternative.

Portable whirlpools are not covered. Jacuzzis, hot tubs, spas, and other similar types of non-medical bath equipment are also not covered.

Billing Procedures for DMEPOS items

For efficient and effective use of Medicare operational and program resources, claims should not be submitted more frequently than monthly. In the case of continuous periods of service, claims should be submitted in sequence. Suppliers may not automatically mail or deliver durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

A. Frequency of Claims.—Repetitive DMERC services. In consideration of efficient and effective use of Medicare program resources and administrative requirements, where there are cases of known continuous periods of service, claims should be submitted in sequence and should not be submitted more frequently than monthly. By limiting the billing to a 30-day cycle, we are saving extensive operational expenditures and at the same time simplifying the review process. These services will include all items processed by the DMERCs.

   Items or services which will be provided to a single individual on more than one encounter and within a 30-day period, should be billed no more frequently than monthly (or at the conclusion of treatment).

B. Claims Should be Submitted in Sequence.—For items or services furnished over an extended period (e.g., capped rental equipment or therapies) suppliers should bill their claims in sequence for each beneficiary. When there is a break in service (interruption of capped rental or outpatient therapies as the result of an extensive inpatient stay), sequential billing should continue when the services resume.

C. Automatic Mailing/Delivery of DMEPOS.—Suppliers/manufacturers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has **requested** additional supplies/equipment. The reason is to assure that the DMEPOS are actually needed.

   A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before they are dispensed. A supplier may not initiate a refill of an order. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. This is consistent with the DMERC Supplier Manual which states: "The description of the item (on an order) may be completed by someone other than the physician (most commonly the supplier). However, the physician must review the order and sign and date it to indicate agreement." Again the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

These procedures will benefit suppliers by helping to maximize claims processing accuracy, and to reduce the likelihood of a postpayment claim denial because the DMEPOS were not medically necessary.

Surrogate UPINs

DMERC Region D has received revised HCFA-1500 instructions from the Health Care Financing Administra tion (HCFA). These instructions have not been added to the *Region D DMERC Supplier Manual* due to an error with the format of the UPINs.

This supercedes the information currently in the *Region D DMERC Supplier Manual*. As of January 1999,
surrogate UPIN NPP000 is no longer valid. Although surrogate UPIN INT000 is not listed, it is a valid UPIN and can be used. Below is Section 1009.2 from the *Medicare Carriers Manual* that lists the valid UPINs.

"Surrogate UPINs.—Providers/suppliers that submit claims for items or services are responsible for ensuring that the name and UPIN of the ordering/referring physician are obtained and submitted on Form HCFA-1500. The UPIN directory is the primary source for physician names and UPINs. However, some situations may exist in which physicians are not yet issued UPINs. In these instances, surrogate UPINs are to be used.

Surrogate UPINs, with the exception of RET000, are temporary and are to be used only until UPINs are assigned in accordance with the following conditions:

A. Residents.—Billers are to use the six (6) character surrogate UPIN RES000 for a physician meeting the description of "intern, resident," or "fellow" in MCM, Part 3, Section 2020.8A, if the individual does not have a UPIN. However, if a resident already obtained a UPIN, that number is to be used instead of the resident surrogate. If a physician leaves the hospital for private practice and did not receive a UPIN, the physician may continue to use the surrogate used in the hospital until a UPIN is assigned. In this case, do not grant the physician an extended period (more than 30 days from entry into private practice) to apply for a UPIN. Encourage all physicians not assigned a UPIN to apply.

B. Physician with Military, Department of Veterans Affairs and Public Health Service.—Physician/health care practitioners serving in the military or with the Department of Veterans Affairs or the Public Health Service are not exempt from the requirement to obtain a UPIN, particularly if they expect to provide services to Medicare beneficiaries or refer beneficiaries for other services. Until a UPIN is assigned, they are to use the following surrogate UPINs:

- VAD000 - Physicians serving on active duty in the military of the United States and those employed by the Department of Veterans Affairs.
- PHS000 - Physicians serving in the Public Health Service, including the Indian Health Service.

C. Retired Physicians.—These physicians are not issued UPINs and are to use the surrogate RET000. Retired physicians who are assigned a UPIN must use the assigned UPIN.

D. "Special Use" UPIN.—Situations may evolve that do not fall within the above categories. Therefore, one additional surrogate UPIN, OTH000 is provided. Instruct billers that they are to use OTH000 when:

- The service being billed is a service included in the CWF TOS code 3, 4 or 5;
- The ordering and performing physician (or other person) is not assigned a UPIN and does not qualify for any of the other surrogates listed above; and
- A UPIN is required, but the ordering/referring physician has not been assigned one and does not qualify for one of the other surrogates."

Maintenance and Servicing Update

CIGNA Medicare Region D and the DMERC Advisory Committee (DAC) formed a maintenance and servicing workgroup in October 1999. As a result of this workgroup CIGNA Medicare generated a report listing denied maintenance and servicing (MS) claims. The criteria for this report were:

- A rental month denied because the rental period had expired, and
- At least one maintenance and servicing claim was paid, and
- A subsequent maintenance and servicing claim was denied because 15 rental months had not been paid.

CIGNA Medicare has completed the review of this report and many MS claims have been adjusted for payment.

The following items may cause MS claims to be denied or delayed:

- **MS claims billed before they are due**. MS claims should not be billed before 15 rental months have been paid. The first MS claim is payable 180 days from the end of the 15th rental month (90 days for parenteral pumps). Subsequent MS claims should be billed 180 days from the last paid MS claim (90 days for parenteral pumps).
- **MS claims billed with no evidence of rentals.** You may receive a letter requesting information regarding the rental of the item and evidence of medical necessity. The information should be returned within 30 days or the claim may be denied.
- **Electronic CMNs transmitted with the MS modifier.** Please DO NOT transmit CMNs with the MS modifier appended to the HCPCS code. This may cause an unnecessary denial or delay in claim processing.

If after research, you find an MS claim was denied in error and has not been adjusted for payment, resubmit the claim. The claim must be submitted within the time limits for filing.

ICD-9-CM Coding Update

Beginning October 1, 2000, providers may begin using the 2001 ICD-9-CM codes. There will be a grace period from October 1, 2000 through December 31, 2000. For claims received on or after January 1, 2001, the latest version of the ICD-9 codes **must** be used by providers.

It is important for providers to use the most recent version of the ICD-9 coding book and that they code to the highest level of specificity.

The most recent version may be obtained through the following sources:

- Medicode - 800.999.4600
- HCFA's Web site - www.hcfa.gov
- American Medical Association (AMA) - 800.621.8335 or www.ama-assn.org

ICD-9-CM is composed of codes with three, four, or five digits. Some three-digit codes stand alone. Other three-digit codes are further subdivided by the addition of fourth or fifth digits, which provide greater "specificity." Therefore, code as follows:

- Use three-digit codes *only* if there are no four or five-digit codes within that code category.
- Use four-digit codes *only* if there are no five-digit codes for that category.
- Use five-digit codes when they exist in a code category.
- Sometimes fourth and fifth digits are not available. In these cases, do not add fourth and fifth digits to valid three-digit codes (i.e., do not add zeroes to valid three-digit codes).

Differences in Fee Schedule and Non-Fee Schedule Items

The Statistical Analysis Durable Medical Equipment Regional Carrier's (SADMERC) primary responsibility is to assist suppliers with coding requests for the four Durable Medical Equipment Regional Carriers (DMERCs). SADMERC also provides suppliers with Medicare allowances for codes in the DMEPOS Fee Schedule.

The SADMERC cannot answer pricing questions for codes that are individually considered, priced by reasonable charge, or which have no fee schedule amount established. Examples of non-fee schedule items include:

- Drugs
- Therapeutic Shoes for Diabetics
- Enteral and Parenteral Nutrition
- Miscellaneous Codes (E1399, L2999, L3999, K0108 etc.)

Requestors of pricing for non-fee schedule codes will be referred to their DMERC for pricing information.

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

Information Required For Coding Assistance

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) established a helpline to assist suppliers with coding for durable medical equipment, prosthetics, orthotics and supplies. Suppliers calling SADMERC are asked for their supplier number, name, and phone number for statistical information.

For products that have been reviewed by the SADMERC/ DMERCs, the supplier will be asked to provide the manufacturer's name, and the product name/model number. These products would be from the following categories:

- Enteral Nutrition
- Surgical Dressings
- Wheelchairs
- Wheelchair Cushions
- Wheelchair Seating and Back Systems
- Support Surfaces
- Pneumatic Compressors/Lymphedema Pumps
- Nebulizers
- Heavy Duty Multiple Breaking System Walkers

In order to code ostomy supplies, the complete description must be read from the box the item is packaged in **only**.

Prosthetics and orthotics require a complete description for coding assistance. The description should include, but is not limited to the following:

- Is it an orthotic or a prosthetic?
- Is it for the upper limb, lower limb or spine?
- What is the product made of? (e.g., foam, neoprene, plastic)
- What does the product look like?
- How does the product fit the patient?
- What is the length of the product?
- Does the product have any rigid support? (e.g., plastic, metal)
- Is the item custom made or off-the-shelf?
- How is the the product custom made?

When calling SADMERC for coding assistance, it is helpful to have as much information as possible on the product needing to be coded.

SADMERC Website Training

The SADMERC will be adding a new tutorial to their website. This instruction will provide the user with information about the SADMERC. It will guide suppliers, the DMERCs, and any other HCPCS code users on the functions of the SADMERC. Please visit us at the following address: http://www.pgba.com./palmetto/ main.nsf/allframesets/oth_sadm.html.

Region D DMERC Spring 2000 Seminars - Questions and Answers

1. **Q:** Physician evaluation: If the physician does not evaluate the beneficiary within the time that the DMERCs request the evaluation (90 days prior to recertification), will Medicare request a new initial CMN with new testing or should this be documented in the supplier's files in case of an audit and wait to submit the claim until the evaluation is received?

   A: The supplier need not obtain a new initial CMN, but will have to recertify the equipment on the scheduled recertification date. The recertification would not be valid unless the physician had evaluated the beneficiary within the 90-day time period. In an audit situation, if claims were submitted without the evaluation on file, this would result in an overpayment. If the evaluation was completed, but was late, and claims were filed in the mean time, Medicare would request repayment from the date the recertification was invalid to the date of the evaluation.

2. **Q:** If the physician originally orders any type stationary oxygen system, but not a portable system, and at a later date the physician orders the portable system, does the supplier obtain a new initial CMN, or a revised CMN for the portable system? What date is used for the recertification? Will the beneficiary need to have a new evaluation?

   A: When adding a portable system at a later date, the CMN should be sent to the DMERC as a revised CMN. If the CMN is submitted electronically, the CMN should be transmitted as an initial. The portable system would still need to be recertified at the same time as the original Oxygen CMN. The recertification date is based on the initial date

of the CMN from the stationary oxygen system. The beneficiary would not need new testing. Medicare needs the most recent test performed prior to initiating portable oxygen.

3. **Q:** If the beneficiary switches from Medicare to a Health Maintenance Organization (HMO) and then back to Medicare, does Medicare require new testing? What date of eligibility would be correct?

   A: Medicare will not request new testing as long as the test originally done while under Medicare coverage qualifies the beneficiary for the item under consideration. If the beneficiary qualified for the item under the HMO plan, Medicare would consider this person to be a new beneficiary coming into the Medicare program and would require a new evaluation, testing, and initial CMN. The date of eligibility would be the date of change from HMO to Medicare as primary insurance.

4. **Q:** When will Medicare pay for repairs?

   A: Medicare may pay for repair of covered DME which the beneficiary owns or is purchasing, including equipment that the beneficiary was using before becoming enrolled in Part B. If Medicare paid for the equipment, repairs will be considered on an individual basis.

   If Medicare did not pay for the equipment, we will need to have the following documentation attached to the claim to consider coverage of repairs:

   (1) A statement explaining why Medicare did not pay for the equipment being repaired (e.g., purchased before Part B entitlement, primary insurance paid 100%, etc.);

   (2) A certificate of medical necessity must be provided to determine whether the beneficiary meets Medicare's coverage and payment rules for the equipment being repaired;

   (3) Date of purchase; and

   (4) Type of equipment being repaired, including the brand name of model (e.g. Quickie P300 motorized wheelchair)

5. **Q:** Is a DME supplier considered a qualifying provider for oxygen testing?

   A: No. A physician must perform the qualifying blood gas study or a qualified Medicare Part A provider or qualified laboratory. A supplier is not considered a qualified provider or a qualified laboratory for the purposes of this policy. In addition, the qualifying blood gas study may not be paid for by any supplier. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests.

6. **Q:** Participating suppliers can access beneficiary eligibility electronically. Will this be accessible by non-participating suppliers in the future?

   A: No. This service is for participating suppliers only.

7. **Q:** How do participating suppliers access beneficiary eligibility?

   A: To take advantage of this option, you must have a software program that creates the Beneficiary Eligibility upload (request) file and reads the return (response) file. A software vendor and/or in-house programmer could create the program. The DMERC EDI Department does not supply Beneficiary Eligibility software. However, the development matrix with the file specifications for your software vendor or in-house programmer to use in programming the software can be located on our IBBS. For instructions on how to connect to the IBBS, please refer to the 1st Quarter 2000 *EDI Edge*, page two. Once you have the software program installed, you will need to complete a Beneficiary Eligibility application. Upon receipt, the application will be processed and a Beneficiary Eligibility manual will be forwarded to your office.

Correction to Fall 2000 Seminar Flyer

There is a typographical error in the Fall 2000 seminar schedule printed in the *Summer 2000 EDI Edge*. The seminar in St. Louis, Missouri will be held on November 16, 2000.

Correction to Review Request Form

A corrected Medicare Review Request Form is attached. The Supporting Documentation section is corrected to state: "Please see the Summer 2000 *DMERC Dialogue* for additional documentation requirements."

Authorization for Electronic

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

CIGNA HealthCare
Medicare Administration
is a Part B & DME Contracted Carrier for
HCFA
Health Care Financing Administration

DMEPOS* Supplier Education Seminars

Presented by...

Region D DMERC** *

Medicare Basics: Putting the Puzzle Together

Puzzled?
Come to the seminar for a refresher course on basic Medicare billing.

TOPICS

Appeals Process
Electronic Data Interchange
Payment Categories
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Structure of Medicare
Medicare as a Secondary Payer (MSP)
HCFA 1500 Form
Anti-Fraud

Questions?
(208) 333-2140
Public Relations

Registration: 8:30 a.m.
Seminar: 9:00 a.m. – 12:00 p.m.
1:00 p.m. – 4:00 p.m.
(Lunch on your own)

Space is limited! Send in your registration as soon as possible!

- To register, please complete the form on the reverse side of this page.
- Registration forms must be received at least two weeks in advance in order to secure space and materials for each person. We cannot guarantee these items for walk-ins.
- Please call the meeting facility for specific information regarding directions and parking.

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

Fall/Winter 2000 Seminar Schedule

SEPTEMBER

14th - Boise, ID
MK Plaza
720 Park Boulevard
Boise, ID 83712
(208) 333-2140

OCTOBER

5th - Anchorage, AK
Hilton Anchorage
500 West 3rd Ave.
Anchorage, AK 99501
(907) 272-7411

10th – Cheyenne, WY
Holiday Inn
204 W. Fox Farm Rd.
Cheyenne, WY 82007
(307) 638-4466

10th – Sioux Falls, SD
Holiday Inn
100 W. 8th St.
Sioux Falls, SD 57104
(605) 339-2000

12th – Fargo, ND
Ramada Plaza Suites
1635 42nd Street SW
Fargo, ND 58103
(701) 277-9000

17th – Kansas City, MO
Marriott Downtown
200 W. 12th St.
Kansas City, MO 64105
(816) 421-6800

17th – Reno, NV
Eldorado Hotel
345 N. Virginia St.
Reno, NV 89501
(775) 348-9271

18th – Wichita, KS
Wichita Marriott
9100 Corporate Hills Dr.
Wichita, KS 67207
(316) 651-0333

24th – Des Moines, IA
Four Points Hotel West
11040 Hickman Rd. @ I-80
Des Moines, IA 50325
(515) 278-5575

25th – Omaha, NE
Sheraton DoubleTree Downtown
1616 Dodge St.
Omaha, NE 68102
(402) 346-7600

31st – Seattle, WA
Sheraton Seattle
1400 6th Ave.
Seattle, WA 98101
(206) 621-9000

NOVEMBER

2nd – Portland, OR
DoubleTree Columbia River
1401 N. Hayden Island Dr.
Portland, OR 97217
(503) 283-2111

7th – Sacramento, CA
Holiday Inn
11131 Folsom Blvd.
Rancho Cordova, CA 95670
(916) 638-1111

9th – Fresno, CA
Fresno Holiday Inn Airport
5090 E. Clinton Way
Fresno, CA 93727
(559) 252-3611

14th - Springfield, MO
Holiday Inn University Plaza
333 John Q. Hammons Pkwy.
Springfield, MO 65806
(417) 864-7333

16th – St. Louis, MO
Radisson Hotel
11228 Lone Eagle Dr.
Bridgeton, MO 63044
(314) 291-6700

21st - Salt Lake City, UT
Salt Lake City Marriott
75 S.W. Temple
Salt Lake City, UT 84101
(801) 531-0800

28th – Billings, MT
Homestead Quality Inn
2036 Overland Ave.
Billings, MT 59102
(406) 652-1320

28th – Medford, OR
Reston Hotel
2300 Crater Lake Hwy.
Medford, OR 97504
(541) 779-3141

30TH – Spokane, WA
Cavanaugh's River Inn
700 N. Division
Spokane, WA 99202
(509) 326-5577

DECEMBER

5th – Anaheim, CA
Hyatt Regency Alicante
100 Plaza Alicante
Garden Grove, CA 92640
(714) 750-1234

7th – Torrance, CA
Marriott Hotel
3635 Fashion Way
Torrance, CA 90503
(310) 316-3636

12th – San Diego, CA
Holiday Inn on the Bay
1355 N. Harbor Dr.
San Diego, CA 92101
(619) 232-3861

12th – San Francisco, CA
Crowne Plaza
1221 Chess Dr.
Foster City, CA 94404
(650) 570-5700

14th – Honolulu, HI
Ala Moana Hotel
410 Atkinson Dr.
Honolulu, HI 96814
(808) 955-4811

19th – Phoenix, AZ
DoubleTree La Posada
4949 E. Lincoln Dr.
Scottsdale, AZ 85253
(602) 952-0420

Seminar Site _____

Supplier Number _____

Submitter ID _____

Attendee Name(s) _____

Company _____

Address _____

City, State, Zip _____

Phone Number (include area code) _____

REGISTRATION FALL 2000

Please send registration to:
CIGNA Healthcare Medicare Administration
Attn: Fall Seminars
P.O. Box 49
Boise, ID 83707

Confirmation notices will not be sent.

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

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

...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 - Fall 2000
Included in This Issue

CIGNA HealthCare Medicare Administration

DMERC–Region D
PO Box 690
Nashville TN 37202