DME Medicare News

DME Region A Service Office ❖ Suite 339, 320 S. Pennsylvania Blvd ❖ Wilkes-Barre, PA 18701-2215

No. 3 The Travelers December, 1993

Season's Greetings

At the time of your state's transfer (page 3), send all Medicare DMEPOS claims to:

The Travelers Insurance Company
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Contents

NSC Number a Must!

Claims submitted to Medicare without a National Supplier Clearinghouse (NSC) supplier number will be returned. All suppliers and physicians who dispense Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS) ***must*** have a supplier number issued by the National Supplier Clearinghouse. DMEPOS includes the following items:

- ❑ Oxygen
- ❑ Durable Medical Equipment, such as walkers, wheelchairs, and hospital beds
- ❑ Prosthetics and Orthotics, such as artificial limbs, braces, and splints
- ❑ Supplies, such as surgical dressings and ostomy supplies for patients to use at home
- ❑ Optical Lenses (after cataract surgery)
- ❑ Home Dialysis Equipment and Supplies
- ❑ Immunosuppressive Drugs
- ❑ Parenteral and Enteral Nutrition Supplies
- ❑ Chemotherapeutic Drugs Used in Home Infusion Pumps

If you have *not* received a National Supplier Clearinghouse (NSC) supplier number, or if you have *not* received an application, you *must* immediately contact the NSC at (800) 851-3682. Once you have received your supplier number, we will immediately send you a Region A DMEPOS *Supplier Manual* and contact you regarding electronic claim submission. Physicians/suppliers who do not have a NSC supplier number may *not* bill DMEPOS items to Medicare, and will no longer receive editions of *DME Medicare News*.

Season's Greetings from the Region A DMERC Professional Relations Unit

Professional Relations Manager

We are very pleased to introduce Victoria (Vikki) Bacso (pronounced Basho), our Professional Relations Manager. Vikki is a registered nurse (BS - Duquesne) with a wide range of experience in nursing, health care management and professional relations. Vikki will oversee all of our professional relations activities including outreach, ombudsmen, seminars, newsletters, Supplier Manual and congressional relations. You will be hearing from Vikki in upcoming newsletters. Vikki will attend as many outreach seminars and meetings as possible and is excited about meeting our suppliers and beneficiaries.

Educational Seminar Video

We had planned on releasing a video of our educational seminars. Some of the critical pieces of information and policies have changed, some a little, some a lot. We are concerned that a video containing outdated and now incorrect information would be very misleading and confusing. We will not, therefore, be releasing the video. If you have a group meeting and would like a DMERC presentation, please call our ombudsmen.

The Region A DME Medicare News is published by The Travelers Government Operations DMERC Professional Relations Unit for DMEPOS suppliers in Region A. For further information on this publication, please contact:

TheTravelers

Region A DMERC
Professional Relations - Outreach
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

Joanne Policare, Editor (717) 820-5895

Congressional Inquiries

As part of the Professional Relations Unit, The Travelers Durable Medical Equipment Regional Carrier has established a Congressional Services Unit.

Currently, the staff of this unit has two primary objectives:

- To introduce The Travelers DMERC to the 10-state Congressional delegations, and
- To inform the various Congressional staffs about the changes taking place in Medicare.

As a result, the Congressional staffs will be better informed when presented with DMEPOS questions or concerns by their constituents. On-site visits are being held throughout the region to personally visit as many congressional offices as possible.

For further information, or if our attendance at a meeting is desired, please call our Congressional Liaison, Louise Stuart, at (717) 820-5830.

Ombudsmen

Vince Temples	NY	(717) 820-5711
Martin Szmal	De, NJ, Pa	(717) 820-5846
Doris Spencer	New England	(203) 639-3150

Nurse Consultant

Diane Belles, RN	(717) 820-5730

Region A DMERC Key Contacts

DME Region A Service Office	(717) 820-5700
Service Representatives	(800) 842-2563
National Supplier Clearinghouse	(800) 851-3682
Electronic Media Claims	(717) 820-5840
FAX, for EMC only	(717) 820-5850
FAX, for all other	(717) 820-5750

Transition Schedule Changes

The transfer of claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) to Durable Medical Equipment Regional Carriers has been revised. The schedule appears below.

PEN claims will be transferred on a state-by-state basis. When a state is scheduled to transfer to the DMERC, any supplier located in that state will submit all PEN claims to the appropriate DMERC.

When a state is scheduled to transfer to the DMERC, suppliers located in that state must submit all Medicare Part B DMEPOS claims for all Railroad Retirement Board Medicare beneficiaries to the appropriate DMERC.

Transition Examples

The following examples cover a variety of situations from the DMERC's, the local carrier's, and the supplier's perspectives:

1. The supplier is located in New Hampshire, and the beneficiary resides in New Hampshire: Beginning December 1, 1993, the supplier is to submit DMEPOS claims, previously sent to Massachusetts Blue Shield, to the Region A DMERC.

2. The supplier is located in Vermont, and the beneficiary resides in Florida: Beginning December 1, 1993, the supplier is to submit DMEPOS claims, previously sent to Massachusetts Blue Shield, to the Region C DMERC.

3. The supplier is located in New Jersey, and the beneficiary resides in New Hampshire: Beginning January 1, 1994, the supplier is to submit DMEPOS claims, previously sent to Pennsylvania Blue Shield, to the Region A DMERC.

Note: Maine, New Hampshire and Vermont transition on December 1, 1993; Florida transitions on March 1, 1994; New Jersey transitions on January 1, 1994.

REVISED DMERC STATE-BY-STATE TRANSFER SCHEDULE

Date	Region A	Region B	Region C	Region D
11/01/93	Connecticut Rhode Island	Indiana	South Carolina	Idaho Montana Washington
12/01/93	Maine New Hampshire Vermont	Minnesota Ohio West Virginia	Kentucky Mississippi New Mexico North Carolina Oklahoma Tennessee	Iowa Kansas Missouri Nebraska North Dakota South Dakota Utah
01/01/94	Delaware New Jersey	Maryland Illinois Wisconsin District of Columbia*	Alabama Arkansas Colorado Georgia Louisiana	Alaska Oregon Wyoming
02/01/94	Pennsylvania	Michigan Virginia	Puerto Rico Texas Virgin Islands	American Samoa Arizona California Guam Hawaii Marianna Islands Nevada
03/01/94	Massachusetts New York		Florida	

*** Includes the following Virginia areas: City of Alexandria, Arlington County, and Fairfax County**

Electronic Media Claims

Accelerate Update

Recently, The Travelers provided FREE "Accelerate" software to both the EMC and paper submitters located in Connecticut, Delaware, Maine, New Hampshire, New Jersey, Rhode Island, and Vermont. This software is designed to make submission of Medicare claims easy and fast. By sending an electronic file directly to the DMERC, costly paper handling is eliminated and postage expenses are reduced. The EMC Support Team is available for those suppliers / providers who require assistance with installation or any questions regarding electronic billing.

Accelerate is being mailed to all suppliers / providers who have returned the EMC questionnaire to the Region A DMERC. This questionnaire provides important information concerning your hardware specifications. The software will be mailed approximately one month before the date of the state's transition.

Electronic billing is available for both participating and non-participating suppliers / providers and for both assigned and non-assigned claims. Please call the EMC Unit for more information at (717) 820-5884.

Rejected Files

Our system had required the rejection of an entire file of EMC claims, if even only one claim contained an error. We have modified our system to accept the entire file and suspend any individual claim containing an error. If necessary, the claim processor will contact the supplier to obtain correct or missing information.

An acknowledgment letter is mailed to the submitter and reflects the date the file was received, the number of claims in the file, and the total submitted charges.

Help Desk Hotline

From January 4th, 1994 through June 30, 1994, a special EMC Help Desk Hotline is available to provide assistance to anyone having difficulty loading our EMC software, transmitting files, records rejection, or requesting reports. The EMC Help Desk Hotline is (800) 842-1305.

Free Software Workshops

Staff from our EMC Unit will hold workshops to demonstrate our free "Accelerate" software package and to give suppliers hands-on experience. Computers will be available for installation demonstrations and for the actual entry of "live" claims. All suppliers are invited to attend whether or not they are currently submitting electronically.

Workshops will be at 8 a.m., 10 a.m., 12 p.m., 2 p.m., and 4 p.m. To attend, please call (717) 820-5841 to make a reservation and obtain directions. Reservations are required.

January 11, 1994

The first workshop will be at the offices of the Pennsylvania Association of Medical Suppliers (PAMS).

PAMS
1st Floor East
1919 N. Front St.
Harrisburg, PA 17102

January 13, 1994

The second workshop will be at the offices of the Region A DMERC.

The Travelers Insurance Company
320 S. Pennsylvania Blvd.
Wilkes-Barre, PA 18702

ESRD Claims

For all suppliers submitting claims, please be sure to include the following information on all claims:

- ❑ Method of dialysis
- ❑ Type of dialysis (HEMO, CAPD, CCPD, or PERI)

Electronic submitters should include this information in the documentation field (HA0 record).

Weekly Status Report

An electronic status report is available upon request. This report itemizes the claims in the system that are pending at the end of the weekly period and those claims that were adjudicated during the week. A status code is provided on pending claims showing the general cause for pending the claim. The report covers only assigned claims and does not reflect amounts of deductibles, coinsurances or payments. Information on these items is available on the Electronic Remittance Notice.

The weekly status report is available only as an ASCII file on our Bulletin Board. To request this report, please call the EMC Service Desk at (800) 842-1305.

Timing the Transmission

All electronically submitted claims are processed through our system at night.

- ❑ Claim transmissions received prior to 1:00 p.m. are processed the same night.
- ❑ Claim transmissions received after 1:00 p.m. are processed the next night.
- ❑ Acknowledgment letters are mailed the morning after the transmission is processed.

For example:

Transmission A, received Monday, 11:00 a.m.
Transmission B, received Monday, 3:00 p.m.
Transmission C, received Tuesday, 8:00 a.m.

Transmission A is processed Monday night.
Transmission A acknowledgment letter is mailed Tuesday.

Transmission B is processed Tuesday night.
Transmission B acknowledgment letter is mailed Wednesday.

Transmission C is processed Tuesday night.
Transmission C acknowledgment letter is mailed Wednesday.

Additional Documentation

The HA0 record of the National Standard Format contains a documentation text field (pos 40-320) which can be used to provide additional documentation on electronic claims. In situations requiring paper documentation to support a claim being submitted electronically:

- ❑ State within the document text field:
  - Additional documentation was sent
  - Sent via FAX or mail
  - Date sent
- ❑ Make sure the paper documentation clearly identifies the supplier (NSC number), the beneficiary (HIC number), and the billing dates.
- ❑ FAX or mail the documentation to the EMC Unit.
- ❑ FAX to **(717) 820-5850** on the same day the claim is transmitted.

Mail, 3 - 5 days before the claim is submitted, to:

The Travelers Insurance Company
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Attn: EMC Unit

Please put a red line, dot, or sticker in the lower left corner of the envelope.

Vendor/Billing Service Update

Currently, several vendors and billing services are testing with the Region A DMERC. A list of Certified Software Vendors, Billing Services and Clearinghouses is on the next page. Once vendors and billing services have developed a billing package, they must contact the EMC Unit to request the test packages. There is a test package for each CMN plus one additional test package with no CMNs. Vendors and billing services must indicate which test packages are needed based on the types of claims the supplier will be submitting. A test date is then scheduled with the EMC Unit. Test results will be reviewed, and notification of results provided within 3 working days.

Suppliers who use vendor software must also go through testing and need to request the test packages from the EMC Unit. These are the same test packages used to test the vendors software. Please call the EMC Unit for further information regarding testing or The Travelers free Accelerate software package at (717) 820-5884.

Certified Software Vendors, Billing Services and Clearinghouses

Following is a list of certified software vendors, billing services and clearinghouses who have demonstrated their ability to submit DMEPOS claims and certifications electronically to any of the DMERC's, as of November 12, 1993. Each of these companies was certified using the DMERC Standard Test Packages. This is a composite list provided by all four DMERC's, and shows the DMERC region certifying the format.

Conditional certification will be extended until January 31, 1994 for companies whose systems have not been successfully tested for other payer (MSP, Medigap, Medicaid) capabilities. The types of untested other payer capabilities for which the entity *has not* been certified are indicated in the "Type" column. Refer to the codes at the top of the right-hand column on this page. Claims involving the noted numeric type of other payer information should be submitted on paper until the system changes are completed. Companies that are not fully certified by that date will be decertified and their customers will be notified. Please contact the certifying DMERC for updated lists of certified companies.

REGION A: The Travelers Insurance Company

EMC Technical Support
320 S. Pennsylvania Blvd., Ste 339
Wilkes-Barre, PA 18701-2215
Phone: (717) 820-5841

REGION B: AdminaStar Electronic Services

Marketing Department
6802 Hillsdale Court
Indianapolis, IN 46250
Phone (800) 952-2068

REGION C: Palmetto Government Benefits Administrators

DMERC EDI
PO Box 100145
Columbia, SC 29202-3145
Phone (803) 788-9751

REGION D: CIGNA Medicare

EMC Marketing Assistants
PO Box 49
Boise, ID 8370
Phone (208) 342-4440

DMERC Certified Software Vendors
(as of 11/12/93)

Type:
- B - Billing Service
- C - Clearinghouse
- V - Software Vendor
- 1 - Not certified for MSP
- 2 - Not certified for Other Payer
- 3 - Fully certified only for claims that do not require CMNs

Note: If no number is shown, the entity is fully certified for all claims.

Company	Certifying Region	Type
Companion Technologies I-20 E @ Alpine Rd. Columbia SC 29216 Frank Harris 803-736-5980	A	C
Comp U Aims 5661 E Shelby Dr. Memphis TN 38141 Phoebe Freeman 901-369-8027	A	V
Computer Applications Unlimited 6360 Flank Dr., Ste 100 Harrisburg PA 17112 Scott Straining 717-541-0651	A	V
Computers Unlimited 2407 Montana Ave. Billings MT 59101 Cindy Allen 406-255-9500	A	V
CTI 14500 Avion Pkwy. Chantilly VA 22021 Steve Torris 703-803-2776	A	V
Curtis Software 520 S. Main Street, Ste 2521 Akron OH 44311 Dave Schroyer 800-648-2377 216-648-2377, Ext 211	C	V

Company	Certifying Region	Type
DataHouse One Perimeter Park South Ste 100 South Birmingham AL 35243-2343 Jim Collins 205-972-9292	C	V
Del Crane Medical, Inc. 520 South Main Street Lebanon OH 45140 513/831-2544 Dave Gidley	B	V,1
Dezine Associates 758 State Hwy. 18, Suite 110 Suite 206 Plano TX 75074 Ray Asmar or Jeff Bloom 800/447-7370	A	V,1
Dynamic Energy Systems 710 East Park Blvd Suite 206 Plano TX 75074 Sandra Myers 214/423-5171	C	V
Elcomp 681 Anderson Dr. Pittsburgh PA 15220 Barbra MacMast 412/937-900	B	V,1
MCS, Inc./Mestamed 400 Penn Center Blvd. Pittsburgh PA 15220 Jim Liska 412/823-7440	C	V
Medicare Claims Management 9002 N. Meridia Indianapolis IN 46260 Donna Ferguson 317/573-4244	B	B
Medical Data Management 37800 Mound Rd. Sterling Heights MI 48310 Norma Burell 313/268-8440	B	B,2
Medical Data Systems 1267 W. Bagley Berea OH 44017 Greg Kirsch 800/343-5854	B,V	B
Medical Solutions 1 Sugar Creek Surgarland TX 77478 Bill Moore 800/264-4674	B	V,1
Prism 1700 N. Lebanon Street Lebanon IN 46052 Mary Walker 800/223-3828	A	V
QS1 P.O. Box 6052 Spartanburg SC 29304 Mary Winters 803/578-9455	A	V
Sandata, Inc. 48 Harbor Park Port Washington NY 11050 Pat Matthews 516/484-0700	B	V
TeleClaims, Inc. 820 Shades Creek Pkwy. Suite 1000 Birmingham AL 35209 Johnnie Farley 203/879-3022	C	C,3
Tropical Software 6860 Gulfport Blvd. Suite 270 St. Petersburg FL 33730 Ted Wade 813/367-8061	A	V

Miscellaneous Notes

Grandfathering

The Common Working File (CWF) contains the "master" records for each beneficiary. A "skeleton" record of the most recent Certificate of Medical Necessity information from the local carriers is held by the CWF.

Capped Rental Items

If the CWF skeleton record shows a certification period for 12 or more months, the DMERC will extend the length of medical necessity by 3 months, and assume the 15-month certification for the capped rental items. A recertification CMN will not be requested.

If the CWF skeleton record shows a certification period of less than 12 months, the DMERC will send a development letter to the physician when the certification period has expired, asking if the patient is still at home (Medicare's definition in MCM § 2100.3), if the patient is still using the equipment, and the estimated period the equipment will continue to be used. The DMERC will make a determination of continued payment based on the physician's response.

Frequently Serviced Items

If the CWF skeleton record shows a lifetime certification period, the DMERC will pay indefinitely, or until medical necessity ends. A recertification will not be needed.

If the CWF skeleton record shows a certification period of less than lifetime, the DMERC will send a development letter to the physician, as described above.

Incorrect CWF Information

If the supplier feels the CWF information is incomplete or inaccurate, the supplier should call a Region A Service Representative at (717) 842-2563.

UPIN Manuals

Suppliers who have never received a Uniform Physician Identification Number (UPIN) manual may request one through their respective Medicare Part B carrier(s). Send a written request on letterhead that includes the requesting organization's name and address. Please indicate on the mailing envelope that this is a "UPIN Directory" request. Send the request to your local area Medicare Part B carrier. The addresses of the Part B carriers within DMERC Region A are:

Blue Shield of Western New York
Upstate Medicare Division
7 - 9 Court St.
Binghamton, NY 13901

Empire of New York
2651 Strang Blvd.
Yorktown Hgts., NY 10598

GHI (Group Health Inc.
88 West End Ave.
New York, NY 10023

The Travelers Insurance Co.
538 Preston Ave.
Meriden, CT 06454

Pennsylvania Blue Shield
1800 Centre St.
Camp Hill, PA 17809

BC/BS of Rhode Island
44 Westminister St.
Providence, RI 02903-3279

BC/BS of Massachusetts
75 William Terry Dr.
Hingham, MA 02044

Dialysis Solutions

The medical policy (see the DMERC Region A *Supplier Manual*, Chapter 13 page 13-51, under the heading "Coding Guidelines") entitled "Home Dialysis Supplies and Equipment" states that "Dialysis solutions (A4700, A4705) should not be included in the supply kit, but should be separately billed."

Since this policy has been made public, the DMERC medical staff has become aware that this position has given rise to many issues and concerns. A meeting was held with several suppliers of this service. Discussion revealed the difficulty suppliers would have submitting bills under this policy. The DMERC medical staff had difficulty developing a suitable alternative policy.

The participants in the discussions agreed that the billing for dialysis kits (A4820, A4900, A4901, A4905) would continue to be billed and paid as they have been by the South Carolina carrier at least until March 1994. The dialysates will continue to be included in the dialysis kits. The DMERC medical staff will continue to work on a policy that will fill the needs of both the DMERC and the suppliers.

Continous Cycling Peritoneal Dialysis (CCPD) was discussed at the same meeting. The DMERC medical staff has decided that usual activities of daily living (i.e., school, work) would be included in the determination of medical necessity for this modality. CCPD would be covered when necessary in order to perform these other activities.

Supplier Manual Revisions

Supplier Manual Revision 001 has been mailed to all suppliers. If you have not received your manual revision by the end of December, please call our Service Representatives at (800) 842-2563.

Revisions to the Region A DMERC *Supplier Manual* are included in this newsletter and have been perforated for easy removal and insertion into the *Supplier Manual.*

These revisions are for OCNA Numbers and Pricing Information. See instructions on page 11 for inserting the OCNA Number changes and on page 21 for the Pricing Information changes.

Reviews

The local area carrier handles reviews and hearings on claims processed by the local area carrier. The Region A DMERC handles reviews and hearings on claims processed by the Region A DMERC. The Region A DMERC cannot review or hold a hearing for any claim which was processed / denied by another carrier. All requests for reviews that are incorrectly submitted to the DMERC will be returned to the submitter.

Interest Rates

Overpayments

If the supplier fails to refund an overpayment in a timely manner after receiving notice from the DMERC, interest charges will be applied.

The interest rate for Medicare overpayments on or after October 14, 1993 is 13.5%.

Delayed Payments

If the DMERC does not process and pay the claim timely, interest charges will be applied and added to the amount owed by Medicare.

The interest ceiling is now 30 days. Interest is payable beginning on the 31st day after the date of receipt for clean electronic and paper claims that are not yet paid.

Coding Assistance

The SADMERC HCPCS Help Line provides assistance in determining the appropriate HCPCS code to use for a particular DMEPOS product. The Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto Government Benefits Administrators in South Carolina - can be reached at (803) 736-6809, from 9 a.m. to 12 p.m. and 1 p.m. to 4 p.m. Eastern time. Written inquiries can be sent to:

Laura Godfrey, HCPCS Manager
Medicare SADMERC
P.O. Box 100143
Columbia, SC 29202-3141

CROSSOVER Table

Other Carrier Name and Address (OCNA) Numbers

Supplier Manual Update: Remove Supplier Manual pages 4-21 through 4-42 and insert newsletter pages 11 - 20.

Other insurance coverage, outside of Medicare, is identified by the supplier or provider through discussion with the beneficiary. The coverage falls into one of two basic categories: group or individual.

Group Coverage

Group coverage (referred to as Supplemental coverage) is usually provided through employers or unions. The beneficiary should have an insurance card indicating a company or union name and a group policy number. If group coverage is present and the Medicare carrier:

- ❑ *contracts* with the insurer, claim information will be forwarded automatically, and electronically, from the Medicare carrier to the insurer. This arrangement is referred to as "complimentary" and is available to Medigap, Medicaid and Supplemental insurers, and may provide for crossover of claim types other than assigned claims from participating providers.
- ❑ *does not contract* with the insurer, the beneficiary must submit the claim information to the insurer.

Note: Do not enter any information in *Block 9d* of the HCFA 1500 form. Medicare will not recognize this information.

Periodically, the Medicare carrier will publish a list of group plans (i.e., supplemental insurers) with which the Medicare carrier has contracted. (See page 10 of this newsletter.)

Individual Coverage

Individual coverage may be of two types: Medigap and Medicaid. If individual coverage is present:

- ❑ for Medigap, the claim must be an assigned claim and must be from a participating provider
- ❑ the OCNA number must be in *Block 9d* of the HCFA 1500 form, in all instances, to ensure the claim will cross.
- ❑ the claim information will be forwarded automatically or, on paper, to the insuring entity.

Interfaces

The Medicare carrier interfaces with three types of insurers:

- ❑ Medigap (individual coverage provided by an insurer)
- ❑ Medicaid (individual coverage provided by the state)
- ❑ Supplemental (group coverage provided by an insurer)

Various contractual arrangements, as well as billing and crossover methods exist between the three types of insurers and the Medicare carrier. The chart on the bottom of the page identifies how claims may be handled for each type of insurer.

Medicare Has a Contractual Relationshhip With Insurer	Crossover Applies to These Insurer Types	Method of Identifying Eligible Beneficiary to Medicare Carrier	Crossover Method Used by Medicare Carrier
Yes	Medigap Medicaid Supplemental	Electronic Eligibility File From Insurer	Electronic (1)
No	Medigap Medicaid	OCNA Number on HCFA 1500	Paper or Electronic (1)

(1) Medicare carrier produces an electronic file of claim information which is sent to the insurer.

OCNA List

Pricing Information for 1994

Supplier Manual Update: Insert newsletter pages 21 - 26 after Supplier Manual page 5-75.

Level II Coding Grace Period

Certain Level II HCPCS codes (A-V) are being phased out for claim submission to the DMERC. In the Coding Guidelines section of individual medical policies, these codes are described as being not valid for claim submission to the DMERC. The deleted Level II DMEPOS (old) codes, and their replacement Level II "K" (new) codes", are listed on pages 6-7.1 and 6-7.2 of the Region A DMERC *Supplier Manual.*

A grace period has been established for billing the old codes. The DMERC will accept these codes on claims received on or before December 31, 1993, with reimbursement based on existing pricing levels. On or after January 1, 1994, deleted DMEPOS codes will be denied as invalid, regardless of date of service (with the exception of deleted capped rental codes, please refer to Deleted Capped Rental Codes article found on this page).

Even though there is a grace period for acceptance of deleted DMEPOS Level II codes, avoidance of these codes and use of valid DMERC codes will facilitate claim adjudication.

Level III (Local Carrier) DMEPOS Codes

Level III local carrier DMEPOS codes will be accepted when billed prior to January 1, 1994, but will be automatically crosswalked to a corresponding code (see Crosswalk Listing on pages 6-7.3 - 6.7.5 of the Region A DMERC *Supplier Manual)* and subjected to the DMERC medical policy. Therefore, if the cross-walked code is not covered by the DMEPOS policy, a denial will occur. Local carrier Level III DMEPOS codes billed to the DMERC on or after January 1, 1994 will be automatically denied as invalid, regardless of medical policy.

Deleted Capped Rental Codes

The rule for capped rental codes is as follows:

"WHATEVER PROCEDURE CODE IS USED TO INITIALLY BILL FOR CAPPED RENTAL ITEMS MUST BE USED WHEN BILLING FOR THE DURATION OF THE CAPPED RENTAL PERIOD, INCLUDING CHARGES FOR MAINTENANCE AND SERVICE."

Bearing in mind the above rule, suppliers must continue to bill using any "deleted" Level II capped rental code, "non-deleted" Level II capped rental code, or new "K" capped rental code for capped rental agreements that begin before January 1, 1994. For capped rental agreements that begin on or after January 1, 1994, suppliers must bill using either the new "K" codes, or existing Level II capped rental codes that have not been deleted.

Fee Schedule Payment Changes

The 1994 update factor for Durable Medical Equipment is 3 percent; for Prosthetics and Orthotics it is zero percent for 1994 and 1995. Payment for Transcutaneous Electrical Nerve Stimulators (TENS) is being further reduced by an additional 30 percent.

Reasonable Charge Payment Changes

For supplier services and/or items paid on a reasonable charge basis (e.g., for ESRD supplies), the Inflation Indexed Charge (IIC) screen is increased by 3 percent. Please note that there is no increase for PEN codes in 1994.

New HCPCS DMEPOS Codes for 1994

A4465	NON-ELASTIC BINDER FOR EXTREMITY
E0669	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0670	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
J3535	DRUG ADMINISTERED THROUGH A METERED DOSE INHALER
J7051	STERILE SALINE OR WATER, UP TO 5 CC
J9010	DOXORUBICIN HCL, 50 MG
J9062	CISPLATIN, 50 MG
J9080	CYCLOPHOSPHAMIDE, 200 MG
J9090	CYCLOPHOSPHAMIDE, 500 MG
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM
J9110	CYTARABINE, 500 MG
J9140	DACARBAZINE, 200 MG
J9182	ETOPOSIDE, 100 MG.
J9185	FLUDARABINE PHOSPHATE, 50 MG
J9250	METHOTREXATE SODIUM, 5 MG
J9265	PACLITAXEL, 30 MG
J9268	PENTOSTATIN, PER 10 MG
J9290	MITOMYCIN, 20 MG
J9291	MITOMYCIN, 40 MG
J9375	VINCRISTINE SULFATE, 2 MG
J9380	VINCRISTINE SULFATE, 5 MG
L0984	PROTECTIVE BODY SOCK, EACH
L2275	ADDITION TO LOWER EXTREMITY, VARUS/VULGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED
L2397	ADDITION TO LOWER EXTREMITY ORTHOSIS, SUSPENSION SLEEVE
L5614	ADDITION TO LOWER EXTREMITY, ABOVE KNEE-KNEE DISARTICULATION, 4-BAR LINKAGE, WITH PNEUMATIC SWING PHASE CONTROL
L5667	ADDITION TO LOWER EXTREMITY, BELOW KNEE, SOCKET INSERT, SUCTION SUSPENSION, WITH LOCKING MECHANISM
L5669	ADDITION TO LOWER EXTREMITY, BELOW KNEE, SOCKET INSERT, SUCTION SUSPENSION WITHOUT LOCKING MECHANISM
L5700	REPLACEMENT, SOCKET, BELOW KNEE, MOLDED TO PATIENT MODEL
L5701	REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCLUDING ATTACHMENT PLATE, MOLDED TO PATIENT MODEL
L5702	REPLACEMENT, SOCKET, HIP DISARTICULATION, INCLUDING HIP JOINT, MOLDED TO PATIENT MODEL
L5704	REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, BELOW KNEE
L5705	REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, ABOVE KNEE
L5706	REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, KNEE DISARTICULATION

New HCPCS DMEPOS Codes for 1994

L5707	REPLACEMENT, CUSTOM SHAPED PROTECTIVE COVER, HIP DISARTICULATION
L5840	ADDITION, ENDOSKELETAL KNEE/SHIN SYSTEM, MULTIAXIAL, PNEUMATIC SWING PHASE CONTROL
L5855	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, MECHANICAL HIP EXTENSION ASSIST
L5925	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, KNEE DISARTICULATION OR HIP DISARTICULATION, MANUAL
L5962	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, FLEXIBLE PROCTECTIVE OUTER SURFACE COVERING SYSTEM
L5964	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM
L5966	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, FLEXIBLE PROTECTIVE OUTER SURFACE COVERING SYSTEM
L5979	ALL LOWER EXTREMITY PROSTHESES, MULTIAXIAL ANKLE/FOOT, DYNAMIC RESPONSE
L5981	ALL LOWER EXTREMITY PROSTHESES, FLEX-WALK SYSTEM OR EQUAL
L8485	STUMP SOCK, SINGLE PLY, FITTING, UPPER LIMB, EACH
L8490	ADDITION TO PROSTHETIC SHEATH/SOCK, AIR SEAL SUCTION RETENTION SYSTEM
Q0117	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI-DENSITY INSERT(S), PER SHOE.
Q0118	FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF SHOE MOLDED FROM CAST(S) OF PATIENT'S FOOT (CUSTOM MOLDED SHOE), PER SHOE.
Q0119	FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT(S), PER SHOE.
Q0120	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH ROLLER OR RIGID ROCKER BOTTOM, PER SHOE.
Q0121	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH WEDGE(S), PER SHOE.
Q0122	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH METATARSAL BAR, PER SHOE.
Q0123	FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH OFF-SET HEEL(S), PER SHOE.

HCPCS DMEPOS Code Deleted for 1994

J9240	MEDROXYPROGESTERONE ACETATE, 100 MG

HCPCS Drug Codes and Allowable Charges

Listed are the HCPCS codes for nebulizer drugs, chemotherapy drugs, and immunosuppressive drugs. Also listed are the DMERC allowables per unit. These prices have been calculated using the median Redbook price.

IMMUNOSUPRESSIVE DRUGS

J2920	METHYLPREDNISOLONE SODIUM SUCCINATE, $2.00 PER 40 MG
J2930	METHYLPREDNISOLONE SODIUM SUCCINATE, $5.31 PER 125 MG
K0119	AZATHIOPRINE, $1.09 PER 50 MG
K0120	AZATHIOPRINE, $60.99 PER 100 MG
K0121	CYCLOSPORINE, $1.17 PER 25 MG
K0122	CYCLOSPORINE, $20.80 PER 250 MG
K0123	LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, $209.79 PER 5 ML
K0124	MONOCLONAL ANTIBODIES, $535.00 PER 5 ML
K0125	PREDNISONE, $.03 PER 5 MG TAB
K0166	METHYLPREDNISOLONE, $.41 PER 4 MG
K0167	PREDNISONE, $.03 PER 5 MG TAB
J0895	DESFERAL, $8.64 PER 500 MG
J1170	DILAUDID, $1.07 PER 4 MG
J1640	HEPARIN, NOT COVERED
J1820	INSULIN, NOT COVERED
J2175	MEPERIDINE, $1.00 PER 100 MG
J2270	MORPHINE SULFATE, $.93 PER 25 MG
J2275	MORPHINE SULFATE, PRESERVATIVE FREE, $17.54 PER 10 MG
J3010	FENTANYL CITRATE, $2.34 UP TO 2 ML
J3370	VANCOMYCIN HCL, $18.51 UP TO 500 MG
J7799	ACYCLOVIR, $46.97 PER 500 MG VIAL
J7799	AMPHOTEROCIN B, $7.50 PER GRAM
J7799	FOSCARNET SODIUM, $73.28 PER 250 ML
J7799	GANCICLOVIR, $34.80 PER 500 MG
J9000	DOXORUBICIN HCL, $45.08 PER 10 MG
J9040	BLEOMYCIN SULFATE, $256.19 PER 15 UNITS
J9100	CYTARABINE, $6.00 PER 100 MG
J9190	FLUOROURACIL, $1.54 PER 500 MG
J9360	VINBLASTINE SULFATE, $2.13 PER 1 MG
J9370	VINCRISTINE SULFATE, $31.75 PER 1 MG
XX009	DOBUTAMINE, $50.77 PER 250 MG

NEBULIZER DRUGS

J7610	ACETYLCYSTEINE, 10% - $1.23 PER ML
J7615	ACETYLCYSTEINE, 20% - $1.48 PER ML
J7620	ALBUTEROL SULFATE, 0.083% - $.43 PER ML
J7625	ALBUTEROL SULFATE, 0.5% - $.68 PER ML
J7630	CROMOLYN SODIUM, PER 20 MG- $.76 PER 20 MG
J7640	EPINEPHRINE, 2.25% PER ML - $.60 PER ML
J7650	ISOETHARINE HYDROCHLORINE, 0.1% PER ML - $.16 PER ML
J7651	ISOETHARINE HYDROCHLORIDE, 0.125% PER ML - $.14 PER ML

HCPCS Drug Codes and Allowable Charges

J7652 ISOETHARINE HYDROCHLORIDE, 0167% PER ML - $.19 PER ML
J7653 ISOETHARINE HYDROCHLORIDE, .2% PER ML - $.23 PER ML
J7654 ISOETHARINE HYDROCHLORIDE, 0.25% PER ML - $.39 PER ML
J7655 ISOETHARINE HYDROCHLORIDE, 1% PER ML - $.46 PER ML
J7660 ISOPROTERENOL HYDROCHLORIDE, 0.5% PER ML - $2.22 PER ML
J7665 ISOPROTERENOL HYDROCHLORIDE, 1.0% PER ML - $2.09 PER ML
J7670 METAPROTERENOL SULFATE, 0.4% PER ML - $.44 PER ML
J7672 METAPROTERENOL SULFATE, 0.6% PER ML - $.44 PER ML
J7675 METAPROTERENOL SULFATE, 5.0% PER ML - $.97 PER ML
J2545 NEBUPENT, $85.00 PER 300 MG
XX001 SALINE SOLUTION,
.45%, 3 ML - $.03 PER ML
.9%, 3 ML - $.03 PER ML
.9%, 5 ML - $.02 PER ML

CHEMOTHERAPY DRUGS

J9020 ASPARAGINASE, $56.36 PER 10 ML VIAL
J9045 CARBOPLATIN, $75.00 PER 50 MG
J9050 CARMUSTINE, $76.46 PER 100 MG
J9060 CISPLATIN, $31.59 PER 10 MG
J9070 CYCLOPHOSPHAMIDE, POW - $58.92 PER 100 MG
J9093 CYCLOPHOSPHAMIDE, LYOPHILIZED, $74.40 PER 100 MG
J9100 CYTARABINE, $5.08 PER 100 MG
J9120 DACTINOMYCIN, $10.54 PER 0.5 MG
J9130 DACARBAZINE, $13.17 PER 100 MG
J9150 DAUNORUBICIN HCL, $71.10 PER 10 MG
J9165 DIETHYLSTILBESTEROL DIPHOSPHATE, $11.98 PER 250 MG
J9181 ETOPSIDE, $13.65 PER 10 MG
J9208 IFOSFOMIDE, $344.40 PER 1 GM W/MESNA
J9209 MESNA, $344.40 W/ABOVE CHEMOTHERAPY
J9211 IDARUBINICIN HCL, $226.00 PER 5 MG
J9230 MECHLORETHAMINE HCL, $38.97 PER 10 MG
J9260 METHOTREXATE SODIUM, $6.88 PER 50 MG
J9270 PLICAMYCIN, $72.44 PER 2.5 MG
J9280 MITOMYCIN HCL, $418.74 PER 20 MG
J9293 MITOXANTRONE HCL, $574.70 PER 20 MG
J9300 STREPTOZOCIN, $54.25 PER 1 GM

New DMERC National Level III HCPCS Codes

The SADMERC has developed new National Level III HCPCS Codes for enteral products. These nutrients were previously billed under the codes B4154 and B4155. These new codes are effective immediately. Also listed are the 1993 and 1994 prevailings.

		1993 & 1994 Prevailings
XX030	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, ACCUPEP	$ 1.99
XX031	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, AMINAID	1.60
XX032	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, ENTERA OPD	1.73
XX033	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, GLUCERNA	1.09
XX034	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, HEPATIC AID	5.16
XX035	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, IMPACT	3.95
XX036	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, IMPACT WITH FIBER	4.05
XX037	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, IMMUNAID	2.46
XX038	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, LIPTSORB	1.33
XX039	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NEPRO	.79
XX040	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NEW REPLETE	1.05
XX041	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NEW REPLETE WITH FIBER	1.12
XX042	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NUTRIHEP	4.64
XX043	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NUTRIVENT	.77
XX044	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PEPTAMEN	3.26
XX045	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PERATIVE	1.21
XX046	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PREGESTIMIL	* ICC
XX047	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PRATAIN XL	1.14
XX048	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PROVIDE	1.37
XX049	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PULMOCARE	.63
XX050	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, REABILAN HN	2.58
XX051	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, SUPLENA	.52
XX052	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, STRESSTEIN	2.34
XX053	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, TRAUMACAL	.69
XX054	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, TRAUMAID HBC	2.20
XX055	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, TRAVASORB HEPATIC	4.24
XX056	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, TRAVASORB MCT	1.10
XX057	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, TRAVASORB RENAL	1.81
XX058	CATEGORY IV ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, VIVONEX TPN	1.99
XX059	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, CASEC	2.72
XX060	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, CONTROLYTB	.41
XX061	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, ELEMENTRA	10.00
XX062	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, FIBRAD	.43
XX063	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, LIPOMUL	.52
XX064	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, MCT OIL	1.26
XX065	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, MICROLIPD	.51
XX066	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, MODUCAL	.43
XX067	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, NUTRISOURCE	*ICC
XX068	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, POLYCOSE	.45
XX069	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PROMOD	.86
XX070	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PROMIX	2.46
XX071	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, PROPAC	1.55
XX072	CATEGORY V ENTERAL PRODUCT, 100 CALORIES = 1 UNIT, SUMACAL	.27

* ICC = Individual Consideration Code

Fraud and Abuse

The following article appeared in a recent Region B Supplier Newsletter. We liked the article so much we asked for permission to reprint it in its entirety in our newsletter. So, here it is, with thanks to AdminiStar Federal, the Region B DMERC.

The DMERC Fraud and Abuse Unit is responsible for investigating complaints of alleged fraud and abuse, misrepresentation, over utilization of services and other issues received from beneficiaries, physicians, suppliers, the Health Care Financing Administration, Office of Inspector General, and internal and external sources.

In compliance with Section 1842(1)(C) of the Social Security Act, the DMERC Fraud Unit is to "make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part." The unit's responsibility also includes assuring that services were actually furnished as billed, were medically necessary and that providers complied with all applicable Medicare law, regulation and guidelines in furnishing and billing for the items or services.

Documentation Requests and Requirements (Billing Audits)

The DMERC Fraud Unit will be conducting audits of the billing practices of suppliers. If the supplier receives a letter requesting additional claim documentation, they are required to forward to the DMERC Fraud Unit all pertinent information which will support the services as billed to the Medicare program.

This may include, but is not limited to:

- ❑ Certificate of Medical Necessity (CMN)
- ❑ Order (prescription)
- ❑ Delivery and pick-up slips
- ❑ Billing records
- ❑ Description of equipment provided

If the above information is not sent to the DMERC Fraud Unit as requested, the service and or equipment will be considered as not documented and a refund will be requested. Additionally, the DMERC Fraud Unit staff may, during the audit, contact the prescribing physician and the beneficiary to verify the services were actually provided and that medical necessity requirements are met.

Postpayment Audits

When a postpayment audit is performed involving durable medical equipment, the following is expected to be in the beneficiary's record and available for review:

- ❑ A signed and dated delivery slip
- ❑ A signed and dated pickup slip when equipment has been returned
- ❑ A complete description of equipment supplied including the appropriate serial numbers
- ❑ A signed authorization for Medicare payment

Further we recommend that suppliers:

- ❑ Document all contacts with the patient or representative and maintain a contact report in the file.
- ❑ Identify all rented equipment with the DME supplier name and phone number.
- ❑ Give explicit instructions on how and when to return the equipment and advise the patient and representative the supplier is to be contacted if the patient expires, moves and/or is admitted to a nursing home or hospital, or the equipment is no longer needed.
- ❑ Retain and have available Medicare beneficiary records for seven (7) years.

Claim Audits, Prior Authorization and Prescription Requirements

The DMERC Fraud Unit is also required to review the Certificate of Medical Necessity (CMNs), prior authorization requests and prescriptions to assure that the guidelines regarding physician completion of the CMN are being adhered to, that the services and/or equipment are medically necessary and, that the service and or equipment billed to Medicare was received by the beneficiary.

The purpose of this audit is to:

- ❑ Detect whether a supplier completed any part of the medical necessity justification before or after the physician completed the form.

- ❑ Determine if the recipient of the equipment or supplies was charged and paid deductibles and coinsurance
- ❑ Determine whether the physician initiated the request for the item(s) or whether the recipient was approached by the supplier.
- ❑ Determine if the diagnosis and other statements on the CMNs and prior authorization requests are consistent with the medical records.
- ❑ Determine whether the equipment/supplies billed were actually received by the beneficiaries and if the items received were as billed, e.g. the items were new or used.

Suppliers may:

- ❑ Complete only the administrative portion of the form or other comparable documentation for DME items only (beneficiary's name, address, Medicare number, supplier's identifying information and the physician's name, address, and phone number).
- ❑ Enclose a cover letter to the physician verifying the physician's original order(s) or description of the patient's need and a complete narrative description of the specific equipment contemplated.
- ❑ Physicians may not charge suppliers for completing DME certifications and recertification forms. (Suppliers asked to pay fees to physicians for completing Medicare required medical necessity certification forms should be advised that the Office of the Inspector General (OIG) considers the soliciting of such fees as a potential felony. Allegations of physicians charging suppliers for completing CMNs should be reported to the DMERC Fraud Unit for investigation).

Based upon the findings of the audit, the appropriate action will be followed which can consist of: provider education, refund request, prepayment flag, re-audit, and/or referral to the OIG for criminal or administrative sanctions.

Authority to Exclude Practitioners, Providers and Suppliers of Services

Under the Medicare and Medicaid Patient and Program Protection Act (MMPPA) of 1987, Public Law 100 93, the Secretary of the Department of Health and Human Services has the authority to exclude health care providers, individuals and businesses from receiving payment for services that would otherwise be payable under Medicare, Medicaid, the Maternal and Child Health Block Grant Program and the Block Grants to states for social services programs.

The Office of Inspector General (OIG) also has the authority, by Section 11 28(b)(6) of the Social Security Act, to exclude practitioners and other perons who have engaged in certain forms of program abuse. Payment is not made for items or services furnished by an excluded practitioner or other person. Where Medicare payment is precluded as a result of exclusion, payment also is not made under state health care programs.

Exclusions under Section 1128(b)(6) are imposed following a determination that a provider has:

- ❑ submitted, or caused to be submitted, bills or requests for payment under Medicare or a state health care program containing charges for items or services furnished substantially in excess of its usual charges; or,
- ❑ furnished or caused to be furnished, items or services to patients substantially in excess of the needs of such patients or of a quality that does not meet professionally recognized standards of health care.

The DMERC Fraud and Abuse Unit reviews and evaluates cases to determine if they warrant exclusion action. Examples of abuse cases suitable for exclusion include, but are not limited to providers who:

- ❑ because of repeated instances of overutilization must have their bills reviewed continually;
- ❑ furnish or cause to be furnished items or services substantially in excess of the patient's needs or are of a quality that does not meet professionally recognized standards of health care;
- ❑ are the subject of prepayment review for an extended period of time (no longer than six months) and who have not corrected their pattem of practice after educational warning letters.

Medical Policy Development

Prepared by Paul D. Metzger, M.D.
Consultant to the Medical Director

Since publication of the DMERC Region A Medical Policies, The Travelers has spent the last several months in an intensive outreach effort, holding educational seminars for suppliers and physicians throughout the northeastern United States. As with any new program of this scope, experience reveals the need for clarification and emphasis in some areas, as well as changes and new decisions. The Region A DMERC staff wishes to express our gratitude to the supplier community, the national supplier organizations, and the physician community, for their cooperation and efforts to facilitate the DMERC transition, providing many useful suggestions and valuable feedback.

CMNs

Follow these guidelines in completing CMNs:

- ❑ For wheelchairs, hospital beds and lymphedema pumps, the supplier is also to attach a narrative of the HCPCS codes for the items being ordered, to the CMN sent to the physician for completion.
- ❑ Suppliers may complete both Sections A & B of CMNs for Prosthetics, Orthotics, and Supplies.
- ❑ Only the physician or someone in the physician's employ may complete Section B for items of Durable Medical Equipment. (Completion instructions are in the title of Section B and on the back of the CMN.)
- ❑ A grace period permits supplier completion of the CMN until April 1, 1994 for CMNs 02.01, 03.01, 04.01, 09.01, and 01.01 (for hospital beds only).
- ❑ Once CMNs are completed, signed and returned from the physician, the supplier will keep the original on file for future review by the DMERC.
- ❑ If submitting paper claims to Medicare, send a paper copy of the CMN.
- ❑ If submitting an electronic claim, accurately transcribe the CMN's information into the electronic media and retain the original CMN on file for possible future review by the DMERC.
- ❑ If only an order is required (where CMNs are not), do not submit the order with the claim, unless specifically instructed to do so in a policy. The supplier should keep the order on file.

CMN Section B

The date the referring physician last examined the patient should be the last date the patient was seen prior to ordering the item of DMEPOS - not literally the last date patient was seen. For oxygen, parenteral and enteral nutrition, and Air-Fluidized Beds (E0194), the physician should have seen the patient within 30 days prior to ordering the item. In all other cases, the DMERC will consider 90 days to be a reasonable period of time. If the physician has not seen the patient within this period of time prior to ordering, note the identity of the person who is monitoring the patient for the relevant problem on the CMN (paper/EMC), or on other paper.

The ICD-9 Diagnosis Code is needed on the CMN to properly adjudicate the claim. The DMERC has granted a grace period up to April 1, 1994, during which time narrative codes will be accepted. After April 1, 1994, claims with CMNs not containing a proper ICD-9 Diagnosis Code will be denied. Since only a physician may make a medical diagnosis, the physician must supply the ICD-9 Diagnosis Code.

Orders

Where CMNs are not required, orders are required for items of DMEPOS, their repair and replacement. The reason for orders for repairs is to ascertain, through the physician, that the item of DMEPOS is still medically necessary. The supplier may complete the entire order, based on verbal or telephone instructions from the physician, with the physician subsequently signing and dating the order. This encourages the necessary dialogue between these two members of the health care team, assuring the appropriate level of DMEPOS equipment for the patient. Except for the following items, orders may be obtained retroactively (within 30 days of delivery or repair) and by verbal or telephone confirmation with the physician. Suppliers must have written orders from the physician, on hand before delivery of the following items: Seat Lift Mechanisms; Power Operated Vehicles; Transcutaneous Electrical Nerve Stimulators; and several pressure-reducing support surface items for decubitus care (refer to the *Supplier Manual* for these codes (page 12-23).

Physician Signature

Orders and CMNs should have a physician's written signature and not a hand-stamp signature. Suppliers using *Fax'd orders or CMNs*, must have a signed agreement with the physician indicating that the physician is not submitting stamped signatures to the supplier, and that either the physician or the supplier will retain the originals on file for seven years. The physician signature date, both on orders and CMNs, should be within a reasonable period of time after delivery of the CMN to the physician's office for completion and/or signature. The specific items to be included on the order are still being developed.

Prior Authorization

Prior Authorization allows the patient, supplier and physician to know, before purchase of an item and submission of a claim for payment, whether Medicare will pay for it, and how much the payment is estimated to be. This opportunity is presently available only for the purchase of Transcutaneous Electrical Nerve Stimulators (TENS), Power Operated Vehicles - (scooters, not motorized wheelchairs), and Seat Lift Mechanisms. In order to prior authorize any of these items, the supplier must send in a completed DMERC CMN (number 06.01 or 07.01) before submitting the claim for the item.

Prior Authorization is available only for purchases. However, TENS equipment must first be rented for one to two months as a trial period before the decision to purchase the item may be made. First, a CMN must be completed for each of the one or two rental months. Then, a CMN may be completed for prior authorization.

Regarding question 14 on the DMERC CMN 07.01, for Power Operated Vehicles, "Does the patient's condition preclude a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?" If the physician answers "N" (No) to this and then proceeds to give documentation as to why the patient cannot get to see one of these specialists, this question combination of answers is, of course, self-contradictory. Although this statement may seem obvious to the reader, we have already received several such responses, and felt it worth mentioning.

Skin Barriers

Liquid, Paste or Powder Skin Barriers (K0137, K0138, K0139) will only be paid for use with ostomies. Although listed in the beginning of the "Incontinence Appliances and Care Supplies" policy, they will not be covered when used for care of the incontinent patient. Claims received with these codes and not accompanied by an ICD-9 Diagnosis Code for an ostomy, will be denied.

Enteral Nutrition

The coverage of enteral nutrition for Alzheimer's and other patients with loss of cognitive function, whose *initial* defect does *not* involve the swallowing function of the GI tract, has received much discussion. Because such patients may eventually deteriorate to a point where they do lose the organic ability to swallow, the DMERC has expanded coverage of enteral nutrition to those patients lacking a gag reflex for whatever reason, consistent with the DMERC philosophy of focusing on functional levels as well as diagnoses. The gag reflex may be tested and documented either by the attending or consulting physician or a speech pathologist using swallowing function studies. The *Supplier Manual* will be revised.

Oxygen

Only one recertification is needed after the initial order for oxygen. If a patient has Group II arterial blood gases/oximetry results, or Group I, with the physician specifying recertification in 3 months, then that 3-month recertification will be for the lifetime of the patient. If the initial tests place the patient in Group I and the physician does not estimate need as any sooner, the 12-month recertification will be the second one needed and will be for the lifetime of the patient. Therefore, there will be only one recertification required in either case, unless otherwise indicated by the ordering physician. It is important to remember that revised CMN's are required whenever there is a change in the liter flow of oxygen, or a change of the patient's attending physician. The DMERC may also request further CMN's at it's discretion, in developing individual claims.

Ostomy Supplies

The provision of ostomy supplies should be limited to a one-month supply for a patient in a nursing facility and a three-month supply for a patient at home. *Medicare will only pay for one-month's supply* ***prospectively****, regardless of the patient's residence.* The supplier may bill each month for a 1-month's prospective supply or may bill retroactively for more than one month with some or all of the charges being for supplies previously furnished (for example, submit a bill on 11/29/93 for a 3-month supply covering the period 10/1/93 - 12/31/93).

Immunosuppressive Drugs

Be sure to use "J" codes when submitting grandfathered immunosuppressive drug claims to the DMERC.

Certificates of Medical Necessity

The Processing of Medicare claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) is changing. New Certificates of Medical Necessity (CMNs) are now required for many items. An order is required for all DMEPOS items that do not require a CMN. The following list identifies the types of equipment that are associated with each of the Certificates of Medical Necessity being used for **DMEPOS Medicare claims:**

CMN No:	DMEPOS Item:
01	Hospital Beds Support Surfaces
02	Motorized Wheelchair Base Manual Wheelchair Base Wheelchair Options
03	CPAP Suction Pumps
04	Ankle/Foot Orthosis Lymphedema Pumps Osteogenesis Stimulator Therapeutic Shoes
05	Surgical Dressing Urological Supplies
06	Transcutaneous Electrical Nerve Stimulator (TENS)
07	Seat Lift Mechanisms Power Operated Vehicles
08	Immunosuppressive Drugs
09	Infusion Pumps Home Glucose Monitor
10	Enteral Nutrition Parenteral Nutrition
Form 484	Home Oxygen Therapy

A complete set of CMN's is included in this newsletter and can be easily removed to be used as originals for duplicating/photocopying.

Suppliers who have registered to participate under the new Medicare rules have received detailed manuals containing medical policies, Certificates of Medical Necessity, and billing instructions. Medical policies and Certificates of Medical Necessity are available in an electronic WordPerfect or ASCII format, *free of charge*, from the Region A DMERC. To obtain the file, call our Bulletin Board at (800) 842-5713 through any communication package/modem attached to your personal computer. Follow the instructions that will appear on your personal computer screen. If you need help downloading the file, call our HELP desk at (717) 820-5840.

Physician Completion of CMN

The Certificate of Medical Necessity forms have been designed with questions having "YES/NO" answers to facilitate completion by the physician. In addition, much of the information on the form may be entered by the supplier of the item(s) being ordered, prior to completion and signing by the physician. The physician must complete Section B on the following CMNs: 01, 02, 03, 04, 06, 07, 09, and HCFA 484-Oxygen. The supplier may complete all other information.

HCFA will defer implementation of the requirement for physician completion of the medical portion of DME CMNs for dates of service prior to April 1, 1994. Physicians still must sign all CMNs. The grace period does not apply for the physician completion of CMNs for the following items:

> Oxygen (484), paraffin bath, TENS, POVs, air fluidized beds, alternating pressure pads and mattresses, seat lift mechanisms, and other items, with HCFA approval, determined by the DMERC to be subject to fraud or abuse.

Questions regarding the completion of the Certificates of Medical Necessity may be directed to our Service Representatives at (800) 842-2563.

CMN Samples

Questions and Answers

Breast Prosthesis

1. **When will a breast prosthesis be denied? How many bras are allowed each year?**

   The policy does not identify a specific quantity. These items are paid based on medical necessity.

2. **Is the ICD-9 code required for breast prosthesis on the physician's order? Do silicone/soft form prostheses have to be listed and on which side?**

   An ICD9 code is not required. Yes, RT and LT modifiers should be used to identify the right and / or left side, respectfully.

Claims Processing

1. **How can we affect a policy change, what can we do?**

   You may write to the DMERC at any time to express your concerns and opinions.

2. **What codes are going to be used when in the 10th month a patient decides to purchase?**

   The correct modifiers to use in this instance are: RR, BP, KJ:

RR	Rental
BP	Beneficiary elected purchase option.
KJ	Rental 4th through 15th months.

3. **If a patient lives in Florida but is temporarily staying with a relative in Connecticut, do we need a Florida provider number to bill if equipment is bought in Connecticut?**

   Only the National Supplier Clearinghouse number of the actual supplier is required to bill the DMERCs.

4. **Does a physician treating a Florida resident in Connecticut have to obtain a Florida provider # in order for us to bill using them as a referring provider?**

   No, a Connecticut physician does not need a Florida provider number. Under the DME regionalization, supplier numbers are national and are recognized by all four DME Regional Carriers.

5. **Will the action code currently being used for A9270 be acceptable in the future?**

   Action code 577 which states "Medicare does not pay for these services or supplies" will be used for A9270.

6. **If a patient is terminal, and he/she isn't expected to survive 30 days, will the claim be denied?**

   Claim decision is based on medical need, not whether the patient is or is not terminal.

7. **Are two modifiers to be used when billing a capped rental item?**

   At least two and up to four modifiers may be used.

8. **Are HCPCS Code lists for batteries and bearings per pair/kit or each?**

   HCPCS codes for batteries and bearings are each.

9. **How do you go about billing for assigned, transparent dressings?**

   Transparent dressings should be billed with HCPCS code A4190 with the appropriate modifier and check Block 27 as "yes" for the assignment of benefits.

10. **How are ostomy supplies (such as drainable bags or pouches that come in boxes of 5) to be billed being that these items price higher than the more common ostomy supplies?**

    All ostomy bags and pouches are billed by the actual number of individual bags or pouches supplied to the patients.

11. **Referring to block 29, what is required here (20% paid prior or just MSP prior payments)?**

    Block 29 should contain the total amount that the patient paid on the submitted charge.

12. **Will we be provided with national HCFA codes?**

    Chapter 5 of the *Supplier Manual* contains the DME HCPCS codes.

13. **How can a supplier get reimbursement for a capped-rental item that has been rented for a couple of months from another provider?**

    The first item rented must be returned and another order needs to be received by the new supplier and a new piece of equipment rented. The DMERC needs to be notified of the return of the original item rented.

14. Which modifier should be used in place of "ZD", which is no longer listed.

The ZD modifier has not been replaced.

15. What is the sequence number?

The sequence number is part of the control number assigned to each claim as it enters the DMERC's claim adjudication process. The control number is made up of the Julian date followed by a 5 digit control number starting at 00001 daily stamped on claims as they come in. For example, the first claim received on January 1, 1994, will have the control number 400100001.

16. Is a "To Date" required? If so, can this date be before the actual billing date?

The "To Date" can be either before or after the billing date. The "From Date" needs to be before the billing date.

17. Is a modifier to be used when sending in claims from a physician's office for supplies given to patients to be used at home?

No, there is no DMERC modifier for this situation. The DMERC will utilize the "Place of Service" code on the claim.

18. When a claim is denied due to lack of a completed CMN, does it get treated like an original when resubmitted?

Yes and it should be accompanied by the fully completed CMN.

19. If a beneficiary is institutionalized in a custodial care facility or a nursing facility, which place of service code should be used?

Custodial care facility is place of service 33, and a nursing facility is place of service 32.

20. If a beneficiary resides in SNF, what place of service code should be used?

If a beneficiary resides in a SNF use place of service 31.

21. If the beneficiary is in Custodial Care Facility and this is considered to be in his/her home, is DME covered under Medicare Part B?

Custodial care facilities are considered the patient's home. DMEPOS items would be covered by the DMERC based on medical necessity.

22. What is the procedure regarding request for payment when notification is sent more than 3 times and there is no response?

If the beneficiary was sent 3 letters requesting payment, the suppliers duty to collect the co-pay is satisfied. The supplier does not have to bill again as far as Medicare is concerned.

23. Should railroad Medicare claims be sent to the Augusta address?

Medicare claims for DMEPOS items should be sent to the correct regional DMERC depending on the beneficiary's residence and the transition schedule.

24. Is there a cap to maintenance fees? Is the 22nd month of rental significant?

No, there is not a cap to billing for maintenance fees. Continue to use the HCPCS code for the equipment throughout the maintenance period.

25. Why won't Medicare pay for bathroom grab bars?

These are not considered "primarily" medical in nature.

26. Will Region A have the capability to receive faxed claims?

At the present time, the Region A DMERC is not accepting faxed claims. However, review is underway to determine if the DMERC will be accepting faxed claims in the future. We will keep you advised of the DMERC's status of accepting faxed claims.

27. Are the brand names/model of lymphedema pumps necessary when billing?

Yes. Brand names and models help identify the correct HCPCS code. A description of the lymphedema pump is required to be written in on the CMN or attached as a separate paper.

28. If a service must be rebilled after transition, will it be billed to the DMERC? If not what guidance can be given for determination of which carrier to bill?

If requesting a review, contact the local area carrier who adjudicated the claim. It should be rebilled to the local area carrier if requesting a review. If resubmitting as a new claim it can be billed to the DMERC.

29. Will overnight Polysomnograms be covered under Medicare? What are the guidelines, if any?

Polysomnograms are handled by the local carrier.

30. How can information in the common working file be challenged, verified and changed?

This can only be done in a review process.

31. Please clarify the rules on waiver of liability.

The basic purpose of Section 1879 of the Social Security Act (Waiver of Liability) is to protect beneficiaries from liability in denial cases under certain conditions when services they received are found to be excluded from coverage as not reasonable and necessary.

Where items or services are denied because they are determined to be not reasonable and necessary, the Medicare program makes payment when neither the beneficiary nor the physician or supplier knew, and could not reasonably be expected to have known, that the items or services were excluded.

When the beneficiary did not have such knowledge, but the *physician or supplier knew*, or could have been expected to know of the exclusion of the items or services, the liability for the charges rests with the beneficiary, i.e., he or she is responsible for making payment to the physician or supplier.

When the *beneficiary knew* or could have been expected to know that the items or services were excluded, the liability for the charges rests with the beneficiary, i.e., he or she is responsible for making payment to the physician or supplier.

For more information refer to Chapter 12 in the *Supplier Manual*.

32. If a patient is in a hospital that does not carry his/her needed supplies, can he/she bill Medicare?

All supplies used by a beneficiary in a covered inpatient stay are billed to Part A.

33. How long do records have to be maintained?

When a CMN or an order is required for coverage, the supplier must maintain the written order on file for seven years, even if submitted electronically to the DMERC.

34. What complaints are to be logged and how in depth should records be?

Records need to contain the information specified in the documentation section of each policy.

35. Does a participating supplier have to accept assignment?

A participating supplier must always accept assignment.

36. Explain non-participating providers giving the beneficiaries letters for non-medical necessity.

The limitation of liability letter is not necessary for non-assigned claims, but could be helpful to the supplier. For assigned claims, a limitation of liability letter is necessary when the supplier has reason to expect Medicare will deny part or all of the services.

37. For a PEN supplier servicing SNF residents, is a waiver necessary for each month's service if medical necessity is questionable?

Yes, a waiver is necessary for each month's service when the medical necessity is questionable.

38. Have the policies for elastic stockings and undergarments changed?

These items will remain non-covered as stated in 60-9 of the *Coverage Issue Manual.*

39. What is the impact on the DME rental policy for the place of service?

DME rental is covered in homes (place of service code = 12) and custodial care facilities (place of service code = 33).

40. Will a copy of the explanation of benefits be available to non-participating suppliers?

An explanation of benefits is *not* available to the non-participating physician / supplier.

41. How is Pulmo-Aid/Compressor Percussor classified?

HCPCS code E0570 is classified as requiring frequent and substantial service.

42. Are you going to supply a list of "Primaries" that negates the supplier complying with the law as far as filing HCFA forms?

A list of Insurance Company plans, HMO's, PPO's, etc. which are primary payors, making Medicare secondary, is not available.

43. If a patient purchases an item on a nonassigned basis, when does the patient submit the claim?

The Medicare Program requires the providers to submit the claims.

44. What is the rationale for basing payment on where the beneficiary lives rather than where the item is purchased?

One of the program requirements and goals to be accomplished by DME regionalization was the rule published in the Federal Register to change claim payment jurisdiction from the current "point-of-sale" to "beneficiary residence."

45. When we have an extenuating circumstance or review claim and "Medical Staff" has to review, will these be the same problems as with the existing carrier, because the so called "Medical Staff" is not qualified?

No, the DMERC medical staff is fully qualified and will use specialty consultants when needed.

46. Why won't local carriers let the supplier know if a Medicare recipient has reached his yearly deductible?

This is covered under the Privacy Act. We cannot release information on beneficiaries.

47. Please clarify which claims go where.

Intermediaries cover Part A Medicare. All DMEPOS items used in the home and not incident to a physician's service are billable to the DMERC. All other items are billed to the local Part B area carrier. A more detailed matrix is being developed for release in the near future.

48. Is it true that New York state receives 50% Federal funding but other states receive 70-80%?

This is a Medicaid question and not known by Medicare DMERC.

49. How does a supplier determine if Medicare has paid for a particular item, for example a walker or cane?

This cannot be determined in advance except by asking the beneficiary, due to the Privacy Act.

50. Are there any special regulations going to be applied to physicians' relatives and if so, when will they be modified?

There are no regulations at this time unless the physician has a vested interest in the business.

51. Will these regulations be applied even to those companies which the physicians have no vested interest or in corporations of which the physicians are not officers?

No, if the physician has no vested interest there are no regulations.

52. Can you provide updated HCPCS codes, CPT codes and fee schedule references?

HCPCS codes are in Chapter 5 of the *Supplier Manual*. Fee schedule references are in Chapter 6.

53. Can you supply OCNA information?

OCNA (Other Carrier Name and Address) information is contained in Revision 001 of our *Supplier Manual*.

54. If the beneficiary lives 6 months in one state and 6 months in another state, where should their DMEPOS claims be submitted?

Their DMEPOS claims should be submitted to the DMERC who services the state in which the beneficiary's primary residence is located. Primary residence is where the beneficiary resides for 6 months plus one day or longer each year. It is the beneficiary's responsibility to inform the supplier of their primary residence so the supplier may bill the proper DMERC.

55. Why are all services with a MS following the procedure code denied with a D01 code?

This question should be referred to the local carrier.

56. What is the DMERC procedure if the patient moves to another state? Is it the patient's responsibility to notify Medicare and identify to which office the claim should be reported?

The beneficiary is responsible for contacting the Social Security office for a change of address. The provider is then responsible for submitting the beneficiary's claims to the proper DMERC based on the address on the claim.

57. Will extra documentation guarantee coverage or should we not accept assignment and get the reimbursement up front?

Coverage is not guaranteed by submitting additional documentation. Acceptance of assignment of benefits is the decision of the supplier.

58. Will billing be handled by Travelers or by our local area Part B carriers?

Claims for DMEPOS items will be processed by the DMERC. All other services should be billed to the local area Part B carrier.

59. Will a field representative visit all providers?

Ombudsmen, and service representatives, are available to answer questions. Ombudsmen will be conducting and attending various meetings throughout the region. With over 26,000 projected suppliers, a visit to each is not feasible.

60. Are the beneficiaries being notified of the changes and if so, are they being supplied with an 800#?

Beneficiaries are being informed by newsletters and releases through a number of agencies. Beneficiaries can contact the Region A DMERC at (800) 842-2052.

61. Will suppliers receive an updated UPIN listing?

UPIN lists can be requested from your local carrier.

62. How can names be added to the DME M/C mailing list?

Suppliers are added when their NSC number is issued. Other entities may contact the DMERC at (800) 842-2563.

63. Can a provider bill a patient for the difference in the rental months and not accept assignment on a capped rental item?

Yes. If the supplier has *not* accepted assignment, the difference can be billed

64. Should supplies given to patients *during* the course of treatment in the physician's office be billed to the DMERC?

These are incident to a physicians service and are billable to the local Part B carrier, unless sold to the patient for use at home.

65. Is there a fee for private consultation regarding part B billing?

There is not a fee for private consultation. The supplier may call the DMERC service representatives at (800) 842-2563.

66. How are impairments requiring a supply indicated when a diagnosis is not sufficient?

Additional medical documentation should accompany the claim.

67. Where should future questions be sent?

Future questions can be sent to the DMERC at:

The Travelers Insurance Company
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18701-6800

or faxed to (717) 820-5750

68. Where does a UPIN number originate?

The local carrier develops the UPIN.

69. Are "K" codes *required* as of 12/31/93 for non-capped rentals such as oxygen?

There are no new "K" codes for oxygen. There are new "K" codes for wheelchairs, wheelchair accessories and options, surgical dressings and TENS supplies to name a few. A complete list is in the *Supplier Manual.*

70. Is some type of "Press Kit" available for use to release to doctors and social workers/planners, to uniformly introduce them to your system and CMN procedures?

DMERC has a *Supplier Manual* that includes the new CMNs. Each hospital Discharge Planning or Social Service Office has received a *Supplier Manual.* The DMERC is speaking at many Discharge Planning Organization meetings. The *DME Medicare News*, No. 3, contains a full set of CMN's and instructions.

CMN

1. Am I to understand that, for any DME item which requires a CMN, a written prescription must be in hand before the item can be delivered? If the CMN then follows, where do verbal and telephone orders from the physician fit in?

A written order, which may be in the format of a CMN, is required on all items. Below are the codes which require a written order *prior* to delivery:

A4640	E0176	E0177	E0178	E0179	E0180	E0181
E0182	E0184	E0185	E0186	E0187	E0188	E0189
E0192	E0193	E0194	E0196	E0197	E0198	E0199
E0277	E0627	E0628	E0629	E0720	E0730	E0731
E1230						

The supplier can take a verbal or telephone order, in any format, which must then be written, signed by the physician and made part of the supplier's records.

2. Can the provider write in the UPIN if the CMN is returned without the UPIN?

Yes, the supplier may write in the UPIN.

3. What kind of instructions are being provided to physicians on completing the new CMNs?

We are currently in the process of informing physicians through our informational seminars as well as through carriers and medical associations.

4. Will CMNs for glucose monitor prescriptions for ostomy supplies be sufficient or will a new CMN or prescription be required?

If a prescription is on file for a grandfathered item, a new prescription / order will not be required.

5. Clarify which items require a CMN, which an order?

Items requiring a CMN are listed at the top of each CMN. An order is required for all other DMEPOS items.

A CMN serves as an order except for a hospital bed, a wheelchair or a lymphedema pump which require that a description of the item ordered be written in on the CMN or on an attachment.

6. Can the supplier call the physician for answers to the CMN questions to fill in or must the CMN be returned to the physician?

Certain CMN's must be returned for the physician to complete Section B. Each CMN specifies if this does or does not apply. All CMN's must be signed by the physician.

7. What is the meaning of the asterisk after some of the HCPCS codes?

This was a printing error, please ignore the asterisks.

8. Section B (ICD9 codes) of the Enteral Nutrition CMN has room for only 4 diagnosis. In the case of severely ill patients with more than four diagnosis, where do the additional codes go?

List the primary diagnosis codes that are necessary for this item. If you feel that you need to submit more than 4, please attach additional documentation.

9. The CMN addresses AFO and KAFO. Is there a need for CMNs on spinal braces such as L0400, knee braces such as L1832, prosthetics such as artificial extremities, L5300, and all accompanying additions?

CMNs are not required on items that are *not* listed in any Regional Medical policies.

10. How should the term "indefinite" be interpreted on a physician's order or a CMN?

The term "indefinite" should be interpreted as lifetime on a physician's order or a CMN.

11. Are letters of medical necessity becoming obsolete?

The DMERC has developed 10 new Certificates of Medical Necessity which should be used in place of the letters of medical necessity.

12. Is the CMN the *only* item that has to be filled out by the physician?

Where CMNs are required, an order is not additionally required. However, because only HCPCS codes are listed on the CMNs, the supplier will be attaching a narrative description of the ordered items for wheelchairs, hospital beds, and lymphedema pumps, when the CMN for these items is sent to the physician for completion.

Where CMNs are not required, an order for items of DMEPOS, their repair and replacement must be completed by a physician and kept on file by the supplier. To facilitate order completion with less paperwork, we will allow the supplier to fill out the order, based on the physician's telephone order. This order is then to be sent to the physician for his / her review, signature and signature.

13. Are all CMNs for equipment good for 99 months?

The length of need on CMNs is determined by the physician based on the beneficiary's medical necessity for the item ordered. If the length of need is lifetime, enter 99 on the CMN.

14. Are CMNs required to be returned to us fully completed within 30 days of verbal order?

The period of time a CMN must be returned should be a reasonable time frame.

15. Some enteral formulas are not listed - does this mean they are not covered?

There are new national Level III "XX" codes for enteral formulas which will be published soon.

16. Do CMNs apply to orthopedic practices supplying to patients?

If a CMN is required for an item, the appropriate CMN must be submitted with the claim in order to receive payment.

17. Which place of service should be used for therapeutic shoes for diabetic patients, office or home? What are the CMN requirements for these items?

Question 16 on CMN #04.01 must be answered. The place of service is office.

18. Are physicians required to have CMN's in their office?

No.

19. What is considered a non-CMN billable item?

Please see Chapter 11 of the *Supplier Manual* for the ten (10) DMERC CMNs. Those items requiring a CMN are listed on each CMN.

20. Have the policies for filling out CMN's for casting and splinting supplies changed?

A CMN is not required for these items.

21. How do you suggest having the surgeon/physician sign the CMN form as well as taking the time to read and acknowledge the form?

The supplier's are urged to help educate the physicians on the new requirements and forms. All local Medical Societies have received the *Supplier Manual*.

Crossover

1. Is there a listing available of providers who have crossed over?

A list will be published in an upcoming newsletter of those entities with which we are contracting for crossover. All Medigap claims will be crossed.

EMC

1. Can suppliers access the Bulletin Board without submitting claims electronically?

The Bulletin Board is a privilege for electronic submitters only. Electronic submitters can access the Bulletin Board at any time without having to submit claims.

2. Will remittance tapes include payment data for both paper and EMC submissions?

Yes, data for both paper and EMC claims will be on the electronic remittance notices.

3. Are electronic remittance notices accepted by most insurance/Medicaid carriers for processing co-insurance and deductible claims?

With increasing emphasis being placed on Electronic Data Interchange (EDI) more and more entities will be handling all types of electronic transactions.

4. Are there going to be special seminars for using The Travelers EMC system?

EMC training is available at all scheduled seminars. Help is available from EMC personnel by calling (717) 820-5840.

5. How will EMC software distinguish what is billed to local carriers and what goes to DMERC? Do we need the old software *plus* the new software?

EMC software will not distinguish between DMEPOS and non-DMEPOS items. The submitter should use the Region A DMERC software to submit any DMEPOS claims to the DMERC.

6. Can patient databases be backed-up to transfer to program updates?

Suppliers using our Accelerate software will be able to retain databases into new versions.

7. When, after EMC transmission, can a claim be checked?

The status of a claim can be obtained after 2 to 3 days.

8. When will the Accelerate program be ready?

The Accelerate program is available upon request. The software will be sent to all current EMC submitters and to all who have requested it at least one month before the state is scheduled for transition.

9. Are the fields established for EMC transmission and required responses?

Yes, this is determined by the National Standard Format.

10. How does the The Travelers' package differ from that of Blue Cross and Blue Shield Medicare?

The main difference is that the Accelerate program can transmit CMNs electronically.

11. When submitting claims electronically, does the CMN data reported require the HCPCS or product description? If so, how should it be abbreviated being that the field only holds 20 characters?

The HCPCS code is transferred from the claim entry screen to the CMN screen automatically. The narrative field holds 240 characters.

12. Is it necessary to submit claims electronically when only a few are being sent in monthly?

It is never "necessary" to bill electronically, the supplier chooses how to bill. However, it is an advantage to the supplier to bill electronically because of the 14 versus 27 day payment floor. The FREE Accelerate software is an excellent way to submit claims.

13. When a company has multiple branches, is it better to submit electronically as a whole or branch by branch?

Companies may follow their usual billing practices. Electronic billing can be done as a whole or branch-by-branch.

14. Are the nine-digit zip codes a requirement for electronic billing?

A nine-digit zip code is preferred for all billing, paper or electronic, but the 5-digit zip code is required.

15. Will submitting electronically become mandatory any time in the near future?

Whether or not it will become mandatory is not known at this time.

Fraud And Abuse

1. Will Medicare fraud reports be followed up more thoroughly now and will stricter penalties apply?

Proper procedures will continue. Penalties are not set by the DMERC.

2. When a purchased item is returned because of lack of need or death, can a supplier accept this and resell or re-rent it?

Yes, Medicare does not get involved in ownership.

Glucose Monitor

1. Please identify what codes would be used for 1) home blood glucose monitoring, 2) nebulizers, 3) fees related to these services and codes for training of how to use Home Blood Glucose Monitors and nebulizers?

Home glucose monitors are billed using codes E0607 and E0609. Nebulizers are billed using codes E0570, E0575, E0580 and E0585. The fees for these items are listed in the supplier manual by state. Training for the use of this equipment is not covered. When billing for this service use A9270.

2. What restrictions if any apply to who is eligible to receive payment for use of a Home Blood Glucose Monitor by Medicare, must patient be insulin using?

The patient must be diabetic and currently using insulin injections.

3. Why are participating providers required to bill for items which we *know* will not be reimbursed, such a blood glucose testing agents for noninsulin dependent diabetics?

A supplier may know that the item is non covered but the beneficiary believes that the service may be covered or desires a formal Medicare determination. The supplier may file a claim for that service. The supplier may write a note on the claim stating their belief that the service or item is non covered and that it is being submitted at the beneficiary's insistence. The Medicare denial may be necessary for the beneficiary to file for secondary insurance coverage.

4. Can you bill for one box of 200 lancets per month?

If billing for more than a 1 month's supply, indicate on the HCFA 1500 the number of months. If more than 100 per month is needed, submit medical documentation explaining the medical necessity.

5. Will a diagnosis of Insulin Dependent Diabetes Mellitus (IDDM) be sufficient for a glucose monitor?

Yes.

6. **Where does "injectable" have to be included on the submitted claim?**

   A completed CMN 09.01 needs to be submitted. The term "injectable" does not have to be submitted.

7. **We currently use A4772 (reagent strips per 50 box) through our current carrier. This code is not listed on HCPCS coding. The code shown in manual is A4253. Is this the code we now use?**

   Yes, A4253 is the code for Glucose Monitor strips. The A4772 code is for strips used without a glucose monitor and is non-covered.

Grandfathering

1. **On capped rental items which are grandfathered with the old HCPCS codes, will the six month maintenance codes remain the old codes or switch to new ones?**

   Maintenance and servicing fees should be billed with the old codes.

2. **Will grandfathered items that were covered in the past, but which no longer are, still be covered?**

   Yes, grandfathered items that were covered in the past will be covered.

3. **Can you still get a product if you are grandfathering out of state?**

   Yes, if coverage by another local area Part B carrier can be proved.

HCPCS Codes

1. **Where can I find a list of the new codes with a description, not just the referral to the old code?**

   This information is contained in the *Supplier Manual*, Chapter 5.5.

2. **Why aren't *all* HCFA codes paid by Medicare?**

   There are many HCPCS codes that are for items that are not covered by Medicare. These codes are not used exclusively by Medicare.

3. **It was stated that all procedure codes presently being billed to PBS will be looked at by The Travelers. Will they then recognized unclassified codes presently being used?**

   Local carrier codes have been crosswalked to an existing Level II or a new Level III HCPCS DMERC code.

4. **If a code is not listed in the manual, does that mean my local carrier will still accept that particular code?**

   No. There are codes not in our *Supplier Manual* that are still DMERC billable codes. Watch for updates in our newsletter.

5. **I would like to understand why "K" codes have been presented/invented that are not covered items?**

   New K codes more clearly define an item. These items were previously billed with a NOC code and needed a description.

6. **We were told E0188 Sheepskin is not a covered item, yet there is a code and a listed price? Why?**

   E0188 sheepskin pad is a non-covered item as defined by Medicare. It can be billed in order to get a denial needed to bill a secondary insurance.

Hospital Beds

1. **Will coverage be invalid for an electric bed if the patient is terminal?**

   The need for the electric feature of a hospital bed is not affected by whether or not the patient is terminally ill.

2. **Will the physician have to show additional medical justification for the variable height feature on hospital beds?**

   No, the questions on the CMN are all that is required.

3. **What is the policy for a patient that has had an electric bed for a while, will the new policy carry over after February 1st?**

   If the previous local area Part B carrier covered the bed, that coverage will be grandfathered.

Incontinence Supplies

1. **When do you anticipate policy development for other supplies, e.g., urological, and how do you anticipate paying for these until the policy is developed? Are policies being developed for orthotics, such as wrist (WHFO), knee, and elbows ?**

   Policies are being developed on an ongoing basis for all DMEPOS items including orthotics. Payment will be made based on medical necessity submitted with the claim.

2. Are urethral catheters and insertion kits covered for permanently incontinent patients, and if so, how many?

Yes. Please refer to the regional medical policy on incontinence supplies, Chapter 13 of the *Supplier Manual.* Two foley catheters per month are covered without additional medical necessity documentation.

3. When a foley catheter is used because the patient has urinary retention, and the catheter is not covered, may we bill the beneficiary? Is a liability waiver needed?

If this foley was inserted in the physician's office or clinic it would be considered incident to the physician's services and should be billed to local are Part B carrier. If billed to the DMERC and permanent urinary incontinence is *not* the diagnosis, the claim will be denied as not medically necessary and would require a waiver of liability.

4. Is it possible to bill for more urological/ostomy supplies than allowed when necessary?

If medically necessary, more supplies may be covered if supported by additional medical documentation submitted with the claim.

IV Pumps

1. Is IVAB (Intravenous Antibiotic) covered by Medicare Part B?

The antibiotics listed in the IV pump policy in Chapter 13 of the *Supplier Manual* are covered when medically necessary

2. Please explain how to submit a claim for IV infusion pump with drugs?

Drugs and pumps are billable to the DMERC when the patient is receiving them at home. Refer to the medical policy in Chapter 13 and page 10-6 of the *Supplier Manual.*

3. Will there be any special consideration given to chemotherapy drugs not named in the policy, and if so, what will be required for coverage?

Yes, new drugs will be considered when FDA approval and medical need for administration through an IV Pump is established.

4. Will there be any consideration given for coverage of pain management for other than "intractable cancer pain"?

At this time the DMERC is held by the requirements in the Coverage Issues Manual (CIM) which states this is the only reason we can cover pain management.

5. How will the new system affect infusion pumps? Are there new codes?

A DMERC CMN, 09.01 is needed for billing an infusion pump. The new codes K0110 & K0111 are for supplies to be used with an infusion pump.

6. Are infusion pump suppliers required to provide HCFA DME standards and warranties?

Warranty information is required on CMN 09.01 if the pump is purchased.

7. What are the reimbursements for infusion pump rentals?

The fee schedule for infusion pump rentals is in the *Supplier Manual.* Please see Chapter 6.

K Codes

1. If Medicare is the secondary payor, will other insurers accept the new "K" codes?

DMERC can not say what other insurers will accept.

2. What are the allowable charges for K0100 and K0111?

The allowable charges for K0110 and K0111 are listed below.

K0110		K0111	
CT	19.83	CT	52.00
DE	18.81	DE	49.33
MA	19.75	MA	51.80
ME	20.13	ME	52.77
NH	18.81	NH	49.33
NJ	18.81	NJ	49.33
NY	18.81	NY	49.33
PA	18.81	PA	49.33
RI	18.81	RI	49.33
VT	19.56	VT	51.30

National Supplier Clearinghouse

1. What are the procedures just for physicians to submit claims?

In order for a physician to bill to the DMERC they must obtain an NSC number. The physician will then receive a *Supplier Manual*, which contains all billing instructions and may call the Region A DMERC at 1-800-842-2563. However, only DMEPOS items are billable to the DMERC, non-DMEPOS items must be submitted to the local carrier.

2. Where does the NSC number go on the HCFA-1500 Form?

Enter the NSC number in Block 33 of the HCFA-1500 Form. This block also shows the UPIN number.

3. Will local carriers begin using the NSC number for claims they must still process once change over to DMERC begins?

Suppliers should continue to use their old provider numbers for any claims that they will bill to the local carriers.

Nebulizer

1. How will the volume for Bronchodilator Medications be billed, milligrams (MG) or milliliters (ML)?

At this time, the J codes must continue to be used. The dosage should be shown as milliliters (ML).

2. Please identify what is considered "medically necessary", complete with indicators and acceptable diagnosis, for nebulizer/bronchodilator.

This policy is currently being developed. At this time, no CMN is required.

3. What will be the policy for pulmo-aid breathing machines and inhalation drugs?

The nebulizer policy is being developed. Continue to use the old "J" HCPCS codes for nebulizer inhalation medications.

Orders

1. Does the written order need to be attached to the claim?

No. The order should be on file with the referring physician and the supplier. Do not submit the order with the claim.

2. If you fill orders through a visiting nurse's association, is it necessary to have written orders for supplies on file at the pharmacy or is it sufficient to have orders at the VNA's office or MD's office?

The orders for supplies from a visiting nurse association must be on file where the supplies were obtained.

3. What are the requirements when the provider and the supplier are the same?

A provider, who is also the supplier, does not need an order on file. The patient's medical record should provide the justification.

4. Is listing the diagnosis, prognosis, reason and duration still necessary on a prescription for orthopedic items?

Yes.

5. How is the PRN done?

PRN, whenever necessary, on an order is *not* sufficient. The DMERC needs a number per day, week or month. If an EMC claim, the PRN needs to be defined. This can be added in the HA0 section.

6. If a physician calls in an order, does it still have to be signed by him?

Yes, a signed order is always necessary. A CMN is an order.

7. We receive most orders by phone (verbally) from physicians and discharge planners. Are we going to be required to obtain written Rx as well as verbal orders?

Yes. A verbal order must always be followed-up with a written, signed order. A CMN is an order.

8. How do I know if a Medicare beneficiary who has given me an order for a walker for example - has not just received a walker from another supplier? My present carrier will not give any specific information on this; thus my claim will be denied.

There is no way you can know this except by asking the beneficiary. If you are unsure for some reason you could elect to file nonassigned.

Orthotics and Prosthetics

1. **Should a physician's office send a claim for a cockup wrist splint, sling, sling and strip, knee immobilizer, wooden shoe, etc, to the DMERC or continue to send to the local area Part B carrier?**

   If these items are incident to a physician's service, then the local area Part B carrier should be billed. They should only be billed to the DMERC if they are not incident to a physician's service.

2. **Are orthotics for shoulder contracture/elbows covered?**

   Payment for these claims is based on medical necessity.

3. **Is there any allowance for an orthotic patient (L1960) who cannot be accommodated with anything other than extra depth custom molded shoes due to severe arthritis or deformity?**

   L1960 is an AFO that fits inside a shoe. The shoe is not an integral part of the brace and therefore the shoe is not covered.

4. **Which CMN should be used for neck or back traction or soft goods?**

   Currently a CMN is not required for neck or back traction on soft goods.

5. **Do items such as velcro splints, cervical collars, lumbar braces, knee immobilizers, knee braces and ankle air splints have to be sent to a DMERC carrier?**

   Yes, claims for orthotics must be billed to the DMERC.

6. **Are policies being developed for orthotics, such as wrist (WHFO), knee and elbows?**

   New regional medical policies are being developed on an ongoing basis. DMERCs started by developing policy on the 100 most frequently submitted HCPCS codes.

7. **What orthotic and prosthetic supplies are billable from a Skilled Nursing Facility?**

   All orthotics and prosthetics are billed to the DMERC, even if the patient is in Skilled Nursing Facility.

Ostomy

1. **Is there a CMN for ostomy products?**

   A CMN is not required for ostomy supplies. Submit the HCFA-1500 Form. An order should be on file.

2. **Who needs to request increased amounts of ostomy supplies, the supplier or the physician?**

   The physician can request increased amounts of ostomy supplies.

3. **Is a doctor's order needed on non-assigned ostomy supplies and other supplies that do not require a CMN? If so, what should be done about patients visiting the area for a short period of time?**

   Yes, an order should be on file for all claims for ostomy supplies submitted to the DMERC. The out-of-town beneficiary would also need an order for a different supplier to bill Medicare.

4. **Is it possible to bill for more urological/ostomy supplies than allowed when necessary?**

   Yes. Documentation needs to be submitted substantiating the medical necessity.

Oxygen

1. **Why is portable oxygen content not reimbursable by Medicare? How can Medicare help with the issue of Medicare not paying for oxygen used when the patient *leaves the home*? Can Medicare notify the beneficiaries of this policy?**

   Portable oxygen content is covered if the patient is mobile within the home. Please refer to the medical policy on oxygen in Chapter 13 of our *Supplier Manual*. The beneficiary will be notified of the coverage determination through a message on the Explanation of Medicare Benefits.

2. **Can another department of the same hospital provide pulse oximetry to qualify patients for oxygen?**

   Hospitals are exempt from the rule that states a DME supplier is not considered a qualified provider nor supplier of laboratory services for purposes of the oxygen policy guidelines.

3. **Can a state licensed respiratory therapist, not working for the company, perform a pulse oximetry (POX) for (re)certification? Can another home care company? A doctor's office? A visiting nurse?**

   Any qualified person may perform the oximetry test as long as they are not an employee of the supplier.

4. **For oxygen claims, does the date of the ABG's have to be before or on the set up date?**

   The date the ABGs are done may be from 30 days before up to the date the oxygen is ordered.

5. **On the 1993 DME fee schedules regarding oxygen contents, what are the codes SE, OC, PC and PE?**

   SE Stationary equipment
   PC Portable contents
   OC Oxygen contents
   PE Portable equipment

6. **Will *every* new oxygen customer have to be recertified at three months?**

   A 3-month recertification is needed if the PO2 on the initial certification was 56mm HG or greater, or the oxygen saturation was 89% or greater. If the original certification proved levels to be below these amounts then a recertification is due in 12 months.

7. **Must an ABG be done on "room air"?**

   If possible blood gas should be done on room air, if done when patient is on oxygen, document why, and the amount of oxygen, body position during testing and similar information.

8. **When patients become Medicare primary, how will contents for oxygen be paid? (Commercial insurance companies are now paying for the purchase of oxygen equipment; sale of equipment was post 1989)**

   If the patient owns their own oxygen equipment, contents will be paid if the patient meets the oxygen policy criteria.

9. **If a patient needs oxygen prescribed by a physician requiring 4 LPM, how can I receive reimbursement from Medicare? What specific information is needed?**

   The DMERC needs a statement of medical necessity for greater than 2 L / min. The reimbursement for 1-4 L / min is the same.

10. **What specific criteria are needed to receive reimbursement for portable rentals? What if the doctor ordered oxygen (stationary system for a patient) and then three to four months down the road orders a portable system, will we receive payment for the portable? Does the portable have to be ordered on the original CMN?**

    Portable oxygen can be added when the patient is mobile within the home and the physician orders portable oxygen.

PEN

1. **Will there be any flexibility to broadening the current definition of nutritional dependency?**

   Claims for calories outside the policy parameters of 20 to 35 calories will be adjudicated according to the documentation of medical necessity.

2. **Does a PEN patient who goes into the hospital for 2 months, and is still receiving therapy while admitted, need a recertification?**

   A patient who has been receiving PEN in a hospital needs a new CMN filed with the first claim submitted to the DMERC after discharge from the hospital.

3. **For enteral CMN's, how do we accommodate for a number of HCPCS codes?**

   Rarely would more than 4 HCPCS codes be needed and 4 could easily fit on the CMN. If the supplier wants to show more than 4, use an additional sheet of paper. This does not mean we are asking for more documentation. The 4 primary HCPCS codes should be sufficient.

POV

1. **Are "lift alls" for the car going to be allowed for a patient with a POV?**

   "Lift alls" to get a POV into a car are not covered.

Pricing

1. **How can I get the pricing for all states?**

   A written request must be submitted to the DMERC. This information is also available in the *Supplier Manual.*

2. **Will reimbursement rates be the same as in 1993?**

   Fee schedules are normally updated annually.

3. **Will there be any difference in reimbursement for patients receiving DME supplies in the physician's office vs. a "regular" supplier?**

   If incident to a physicians services the reimbursement follows PPR rules and is billed to the local area Part B carrier not to the DMERC.

4. **Will the orthotics and prosthetics fees for 1994 be affected by the regionalization plan? If so, in which states?**

   No, fees for orthotics and prosthetics will continue to be calculated the same way.

5. **What fee schedule should be used for procedure codes not listed on the fee schedule?**

   If a code is not on the fee schedule, it will most likely be reimbursed using the reasonable charge method (i.e., customaries, prevailings, etc.). Page 6-4 of the *Supplier Manual* lists those codes. There are items which are also reimbursed on Individual Claim Consideration (ICC), in which case there will be no fee schedule amount.

6. **How can I receive a fee schedule for orthotics "L" codes?**

   The *Supplier Manual* provides fee schedule information.

Prior Authorization

1. **Will Medicare consider prior authorization for custom seating systems, for example those in excess of a set amount?**

   No. Prior authorization can only be obtained on seat lift mechanisms, power operated vehicles (POV) or transcutaneous electric nerve stimulators (TENS).

2. **Does a prior authorization guarantee payment?**

   Prior authorization does not guarantee payment. Prior authorization allows a pre-determined decision on the claim.

3. **When an item is prior approved, you have 30 days to deliver. What if the order takes more than 30 days to be delivered?**

   The timeframe for the delivery of an item which has been prior approved has been expanded to 60 days.

4. **Does prior authorization apply to non-assigned claims? Home dialysis?**

   Prior authorization applies to both assigned and non-assigned claims but only for TENS, seat lift mechanisms, and POV. Home dialysis does not need and cannot receive prior authorization.

Recertification

1. **How will the DMERC's handle "Life/Lifetime" in terms of when a recertification is required?**

   Recertification for "Life/Lifetime" is required on oxygen claims after the initial CMN expires. PEN suppliers must submit a new CMN for the active period of medical necessity with the first claim that is submitted to the DMERC. These CMN's do not require the suppliers to obtain signatures from physicians.

Refractive Lenses

1. **When a person develops a secondary membrane after cataract surgery and subsequent laser surgery results in a change in the prescription, will this change in prescription be covered as being related to the original surgery?**

   If the cataract surgery includes the IOL implant, Medicare coverage is limited to one pair of eyeglasses per eye; a change in prescription would not be covered in this case. However, if there was no implant, a change in prescription could be covered.

2. **If optical progressive lenses are non covered, is the patient liable for the charge?**

   Even in assigned claims the patient who wants progressive lenses or deluxe frames may be charged the difference in price without the need for a waiver of liability statement.

3. **Will an optometrist have to send a CMN for eyeglasses other than the prescription, and if so, is a photocopy of the prescription sufficient?**

   A CMN is not required for eyeglasses. An order must be kept on file.

4. **How should photochronic lenses be billed if only their U.V. properties are medically necessary?**

   Photochronic lenses should be billed using HCPCS code V2755.

5. If a person resides in one state, but orders glasses in another, which state will the frame allowance go by?

The allowance for DME items is based on the state where the patient resides.

6. Are tints for lenses covered if for a medical reason?

Tinted lenses are covered if they are medically necessary.

7. Will the code V43.1 be sufficient to stand alone on a HCFA-1500 Form or is 366.52?

ICD9 code V43.1 will be sufficient on the HCFA-1500 Form.

8. Regarding refractive lenses, are orders needed if rendering physician is also the ordering physician?

If the ordering physician is also the supplier, an additional order is not necessary. The physician's medical record would show medical necessity.

9. Regarding lenses, post-cataract surgery, is a CMN form used or a Medicare form?

There is no CMN for refractive lenses. An order on file is sufficient. Use HCFA-1500 Form to bill Medicare.

10. Regarding "15 month" CMN on file for equipment that is capped, will you ever require a renewal/revised CMN to be sent with maintenance and service claims?

A revised CMN is *not* required for every 6-month maintenance and service charge for a 15-month capped rental item.

11. Which CMN forms should be used by providers of aphakic lenses and glasses?

A CMN is not required for refractive lenses; an order on file by the supplier is all that is required.

12. If progressive lenses are ordered and they are not covered now, do we code them as bifocals or trifocals?

Code the progressive lens charge on a second line with K0162 using the additional price difference for the progressive lens from standard bifocal or trifocal lens charge shown on the first line with the difference in price between the progressive lens and the standard lens.

13. If a prescription changes for healing or removal of stitches, will lenses still be paid for?

If pseudophakic only, one pair of lenses is payable. If aphakic lens, changes are payable when medically necessary.

14. What is the time frame for a second pair of aphakic glasses?

When medically necessary due to change of prescription or due to breakage.

15. Is it required to separate dispensing fee from the material fee for glasses and contact lenses?

The dispensing fee must be separated and sent to local area Part B carrier.

16. Is it possible to group together charges for lenses and note this as one code?

For proper payment, separate charges.

17. If a physician participates and the patient has received the two pair of spectacle lenses and frames after cataract surgery w/IOL's and Medicare has processed and paid, is it required for the supplier to bill Medicare for the third, fourth etc. pair of frames and lenses the patient purchases?

This is not a Medicare requirement. The beneficiary may ask the supplier to submit subsequent claims for denial for secondary insurance purposes.

18. Will a submitted claim for one pair of reading glasses and one pair of far vision glasses be denied for aphakic and pseudophakic patients?

Medicare can allow only one pair of glasses for pseudophakic patients unless another cataract surgery is performed.

Repairs

1. How can a physician competently sign orders to repair equipment? Does he really know if it needs repair(s)?

The order for the repair can be sent by the supplier to the physician for review and signature. The supplier knows the need for repair. The physician is certifying to the continued medical need for the item.

2. Why is a order needed for every repair for wheelchair-bound patients? Isn't a lifetime (99) necessity sufficient?

An order is needed for a repair to ensure that the physician certifies to the continued medical necessity for the item being repaired.

3. Will repairs and supplies for orthotics and prosthetics be grandfathered to the new carrier?

As long as they are still medically necessary.

Review

1. **Can multiple claims be sent for more than one patient, or are individual review requests sent for each claim control number?**

   Multiple claims can be sent for more than one patient but each line item must request the review for that item.

2. **Will a review form for previously denied claims be provided and where will this need to be mailed?**

   Claims denied by the previous local area Part B carrier must be submitted to that local area Part B carrier for the review and hearing. Only the carrier that adjudicated the claim can conduct a review and hearing.

3. **Does The Travelers provide a special form to request a review for denial/reduction of payment?**

   No special form is required. The EOMB or a letter requesting a review will be accepted.

Nursing Facilities

1. **Can you bill DMEPOS to nursing home patients?**

   A nursing facility does not meet the definition of the beneficiary's home if it is primarily engaged in providing health related care and services on a regular basis. This is generally indicated in the place of service 31.

2. **Can LTCs bill the DMERC for items?**

   Long-Term care facilities should bill the DMERC for PEN, Orthotics and Prosthetics.

3. **In instances where the patient is a resident of an SNF is the date the patient was last seen still required or is the statement "patient in SNF" sufficient?**

   The statement "patient in SNF" is sufficient when billing for services to a resident of a SNF.

4. **If a beneficiary is institutionalized in a custodial care facility or a nursing facility, which place of service code should be used?**

   Custodial care facility is place of service 33, and a nursing facility is place of service 32.

5. **If a beneficiary resides in SNF, what place of service code should be used?**

   If a beneficiary resides in a SNF use place of service 31.

Suction Pump

1. **Suction catheters, suction kits and sterile water being provided to a tracheostomy patient in an SNF would these be covered under Part B?**

   If a patient is in a SNF environment, these items should be billed to the Part A intermediary.

2. **What are the restrictions on the amount of suction catheters that can be supplied in a given time frame?**

   Three (3) oropharyngeal suction catheters per week.

   Three (3) tracheal suction catheters per day.

3. **What are the correct codes for completing a CMN for a vacu-pump?**

   There is no CMN for Vacu-pump.

Therapeutic Shoes

1. **Which UPIN number should be used for diabetic patients, the ordering physician's UPIN or the medical doctor's UPIN?**

   The medical doctor that is treating the patient's diabetes must be the one to order the therapeutic shoes. This doctor's UPIN number should be used.

2. **Will Medicare pay for shoes for diabetics and arthritics?**

   Medicare will pay for therapeutic shoes for diabetics who meet the medical necessity requirements. Shoes for any other condition are covered only for diabetics and only if an integral part of a brace for arthritis.

Tracheostomy

1. **What specific documentation would be required if we needed to provide more than 1 tracheostomy kit per day? (example please)**

   The medical necessity reason as to why the patient needs more than one kit per day needs to accompany the claim.

2. **Which procedure code should be used for replacement of tracheostomy tubes and how many are allowed per month?**

   Use code A4623 for replacement of the tracheostomy tubes. There is not a specific number of tracheostomy tubes per month that are covered. Payment will be based on medical necessity.

Walkers

1. What are the requirements for a folding walker for coverage?

The requirements for a folding walker are the same as a standard walker. Refer to Chapter 13, page 13-4 of the supplier manual.

2. What are the procedures to undertake for a prescription stating "1 walker - use as directed"?

The supplier would provide a standard walker.

3. Are there contraindicated products? For example: walker and wheelchair, cane and walker, walker and commode? If so, please provide specifics.

Medicare does not cover "like" equipment unless medically necessary such as in a rehab situation and the patient is progressing from a wheelchair to a walker.

Wheelchairs

1. How can we collect for 6 month maintenance fees for wheelchairs? We have problems with our current Part B carrier. Please clarify how MS fees are to be billed?

Providers need to bill the DMERC for this fee *once* every 6 months by using the HCPCS code with an MS modifier. No problems are anticipated in processing these claims.

2. Please explain how wheelchair rental/purchase will be handled, new way versus old. For example, a wheelchair with removable arms and elevating leg rest would have been billed with one code; now will have three codes, one for the base, one for the arm and one for the leg.

The rental / purchase of wheelchair will continue to be reimbursed as they are currently. They will remain a capped rental item for up to 15 months. The maintenance and service fee will be paid every 6 months. Modifiers are required for all codes. The new "K" modifiers MUST be on the codes. Use modifier KH for the first month rental or purchase, KI for the second and third month rental, and KJ for month four to fifteen.

Since the wheelchairs are modular and the base code also includes the standard arm, seat, and leg rests, the option and accessories can be billed separately. The rests are added to the chair due to the medical necessity of each patient. These features are not standard to each chair and should be billed separately. The options / accessories codes can be billed as the patient's condition dictates.

3. Are the footrests considered accessories with elevating legrests?

A footrest is not separately billable with an elevating legrest.

4. What happens to footrests when the beneficiary gives them back to the supplier after receiving elevating legrests?

The supplier can use the footrests again on another wheelchair.

5. Can wheelchair attachments/components be changed prior to 3 months?

If wheelchair accessories are added in the first 3 months after purchase or rental, payment is reduced to what would have been paid if these accessories had been placed on the wheelchair at the time of the original issue.

6. Do we need to put all codes on wheelchairs for each additional option, such as standard lightweight wheelchairs with elevating legs and detachable arms. Would this require three different codes?

Yes, all codes needed for this particular wheelchair are required.

7. What is considered customized (codes K0008 and K0013)?

The definition of customized that the DMERC's use is from the July 30, 1993, Final Rule Implementation of the Federal Register. The quote is as follows: "A custom manual wheelchair base is one which has been uniquely constructed or substantially modified for a specific beneficiary and is so different from another item used for the same purpose, that the two items cannot be grouped together for pricing purposes."

- ❑ The feature needed cannot be available in an already manufactured base.
- ❑ Using modular components does not meet the requirement for customized as modular components can be similarly priced.
- ❑ Using customized components or features does not cause the base to be considered customized.
- ❑ Therefore, the frame must be customized for the wheelchair base to be considered customized.

8. What documentation is required?

The DMERC CMN 02.01 with the appropriate questions on the CMN answered with a Y, N, or D which was completed by the physician or someone in his employee. For K0008 (customized manual) and for K0013 (customized motor) we must also have documentation that must include the brand name and model name/number of the base, and a statement justifying the medical necessity for the particular patient including why another base was not acceptable. If it is a customized base the statement must clearly describe what was customized. This information is vital in order to properly price the wheelchair.

If individual consideration is to be applied, the documentation might include information on the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment (e.g. degree of independence/ dependence, frequency, and nature of the activities the patient performs outside the home), the duration of the condition, the expected prognosis, and past experience using similar equipment.

9. When are codes K0009 (other manual) and K0014 (other motorized) used?

These codes would be used when a wheelchair base is not described by codes K0001 - K0007 or K0010 - K0012. (Example: a 22" base, is not a "custom" wheelchair but as a HCPCS code has not been assigned to this yet it would be appropriate to use K0009.) Some wheelchairs are modified to meet a patient's needs or requirements. As it was not feasible or practical to have codes for each kind of "unusual" wheelchair, codes K0009 and K0014 are intended to be used to identify these wheelchairs. A narrative description of the wheelchair is required for billing purposes.

10. How will the DMERC calculate the reimbursement amount for a K0008 or K0009?

The regular gap-filling techniques used to establish fees for codes for which there is no fee for will also be applied in the calculation of the allowables for these two codes.

11. How will K0009 be reimbursed?

This code will be reimbursed as a capped rental item.

12. How will a supplier bill and be paid for a wheelchair with options?

The wheelchair base code will be reimbursed based on the appropriate fee schedule. The options/accessories fall into the category of inexpensive or routinely purchased items and therefore can be rented up to the purchase price or be purchased outright.

13. What code should be used for options/accessories for which there is no code? Should E1399 be used?

E1399 should *not* be used in this instance. The code K0108 should be used to bill options/accessories for which there is no HCPCS code. When replacing parts with no HCPCS code, K0108RP and a narrative description of the item should be used when billing for these items.

14. When is the modifier KA used?

The KA modifier is to be used when an option/accessory has been added *3 months* after the initial rental/purchase of the wheelchair due to a change in the patient's condition. Please see Attachment I of the RMRP on wheelchair options/accessories. If there is an "X" by the code under the title *KA* it will be reimbursed separately as an add-on.

15. When is the modifier "RP" used and will it be reimbursed?

The modifier "RP" is to be used when replacing a previously used part or accessory of the same type. Please see Attachment I of the RMRP on wheelchair options/accessories. If there is an "X" by the code under the title *RP* it will be reimbursed as a replacement.

16. Will an option/accessory that is added on at the time of initial rental/purchase of the base be separately reimbursed?

Please see Attachment I of the RMRP on wheelchair options/accessories. If there is an "X" by the code under the title *Initial Issue*, it will be separately reimbursed. Please see Attachment II of the RMRP. If the base wheelchair code is in Column I and the option/accessory is in Column II it will not be reimbursed separately and will be included in the fee for the wheelchair.

17. Why were the "K" codes established?

These codes were made at the suggestion of the industry and HCFA. The DMERC Medical Directors made very few changes from what the industry had requested. The wheelchair codes reflect/represent the features and options which are incorporated into the design of the wheelchair frame itself. The accessory codes were made to define equipment that serves an additional functional need, that are added to the wheelchair. These accessories do not require changes in the design of the wheelchair itself.

18. Can customized wheelchairs receive prior authorization?

Prior authorization applies only to TENS, POV and seat lift mechanism

19. Do non-assigned suppliers have to offer the beneficiary the option to purchase the wheelchair in the 10th month?

Yes. The beneficiary MUST be offered the option of purchasing the equipment in the 10th month regardless of assignment.

20. How does a supplier bill for repairs? How should loaned equipment be billed?

E1350 should be used when billing for repairs on wheelchairs. Include a breakdown of the charges included in this code (e.g., labor, cleaning, etc.). The code E1350 does not require the use of a modifier.

Use the appropriate code with the "RR" modifier when billing for loaned equipment (e.g., E1130RR); listing it separately. Be aware that we will group the allowable for the loaned equipment in with the allowable for the E1350 for system purposes.

When billing for replacement parts, use the HCPCS code for the part that is being replaced with an "RP" modifier (e.g., K0015RP). If the item being replaced does not have a HCPCS code, use code K0108RP and a narrative description of the item on the claim form.

Happy Holidays and a Joyous New Year from the Region A DMERC