DME Medicare News

DMERC Region A Service Office v P. O. Box 6800 v Wilkes-Barre, PA 18773-6800

No. 17 METRAHEALTH March, 1995

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

METRAHEALTH

Region A DMERC
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DMERC Names New Medical Director

Paul J. Hughes, M.D. has been named Medical Director of MetraHealth's Durable Medical Equipment Regional Carrier (DMERC) in Nanticoke, PA. He will be joining the staff in March on a part-time basis and will be the full-time Medical Director as of May 15, 1995.

Dr. Hughes brings to the position a wide range of experience. In addition to his eleven years in medical practice, he has also been involved in the insurance business as an Associate Medical Director with Blue Cross of Northeastern Pennsylvania for two years. He has experience in medical education, quality assurance/improvement and an extensive background in computers.

According to Dr. Hughes, "I am looking forward to beginning my work as Medical Director at the DMERC. I believe that, from my years in practice and other experiences, I have an appreciation of the health care industry as a whole, from the physician to the DME supplier. I think of the health care industry holistically, and I believe this perspective will help when writing and developing Medicare guidelines as Medical Director."

As DMERC Medical Director, Dr. Hughes will be responsible for assuring that medical guidelines are written clearly and concisely and assisting with educating the medical community of the guidelines and documentation requirements for approval of claims. Interacting with medical societies, peer groups, suppliers, and medical directors at other carriers to share information concerning medical policy will be another major area of responsibility.

Dr. Hughes is a member of the American Medical Association, the American Academy of Family Physicians, and the American College of Physicians Executives. He is also involved in many state and local associations, such as the Pennsylvania Academy of Family Physicians, the Pennsylvania Medical Society, as well as several local committees and associations.

Please join us in congratulating Dr. Hughes and welcoming him to the MetraHealth family.

Medical Policy

SUBJECT: Orthopedic Footwear

HCPCS Codes

L3000 Foot, insert, removable, molded to patient model, "UCB" type, Berkeley shell, each

L3001 Foot, insert, removable, molded to patient model, Spenco, each

L3002 Foot, insert, removable, molded to patient model, plastazote or equal, each

L3003 Foot, insert, removable, molded to patient model, silicone gel, each

L3010 Foot, insert, removable, molded to patient model, longitudinal arch support, each

L3020 Foot, insert, removable, molded to patient model, longitudinal /metatarsal support, each

L3030 Foot, insert, removable, formed to patient foot, each

L3040 Foot, arch support, removable, premolded, longitudinal, each

L3050 Foot, arch support, removable, premolded, metatarsal, each

L3060 Foot, arch support, removable, premolded longitudinal/metatarsal, each

L3070 Foot, arch support, non-removable, attached to shoe, longitudinal, each

L3080 Foot, arch support, non-removable attached to shoe, metatarsal, each

L3090 Foot, arch support, non-removable, attached to shoe longitudinal/metatarsal, each

L3100 Hallus-Valgus night dynamic splint

L3140 Foot, rotation positioning device, including shoe(s)

L3150 Foot, rotation positioning device, without shoe(s)

L3160 Foot, adjustable shoe styled positioning device

L3170 Foot, plastic heel stabilizer

L3201 Orthopedic shoe, oxford with supinator or printer, infant

L3202 Orthopedic shoe, oxford with supinator or pronator, child

L3203 Orthopedic shoe, oxford with supinator or pronator, junior

L3204 Orthopedic shoe, hightop with supinator or pronator, infant

L3206 Orthopedic shoe, hightop with supinator or pronator, child

L3207 Orthopedic shoe, hightop with supinator or pronator, junior

L3208 Surgical boot, each, infant

L3209 Surgical boot, each, child

L3211 Surgical boot, each, junior

L3212 Benesch boot, pair, infant

L3213 Benesch boot, pair, child

L3214 Benesch boot, pair, junior

L3215 Orthopedic footwear, ladies shoes, oxford

L3216 Orthopedic footwear, ladies shoes, depth inlay

L3217 Orthopedic footwear, ladies shoes, high top, depth inlay

L3218 Orthopedic footwear, ladies surgical boot, each

L3219 Orthopedic footwear, men's shoes, oxford

L3221 Orthopedic footwear, men's shoes, depth inlay

L3222 Orthopedic footwear, men's shoes, hightop, depth inlay

L3223 Orthopedic footwear, men's surgical boot, each

L3224 Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)

L3225 Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)

L3230 Orthopedic footwear, custom shoes, depth inlay

L3250 Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each

L3251 Foot, shoe molded to patient model, silicone shoe, each

L3252 Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each

L3253 Foot, molded shoe plaztazote (or similar) custom fitted, each

L3254 Non-standard size or width

L3255 Non-standard size or length

L3257 Orthopedic footwear, additional charge for split size

L3260 Ambulatory surgical boot, each

L3265 Plastazote sandal, each

L3300 Lift, elevation, heel, tapered to metatarsus, per inch

L3310 Lift, elevation, heel and sole, neoprene, per inch

L3320 Lift, elevation, heel and sole, cork, per inch

L3330 Lift, elevation, metal extension (skates)

L3332 Lift, elevation, inside shoe, tapered, up to one-half inch

L3334 Lift, elevation, heel, per inch

L3340 Heel wedge, SACH

L3350 Heel wedge

L3360 Sole wedge, outside sole

L3370 Sole wedge, between sole

L3380 Clubfoot wedge

L3390 Outflare wedge

L3400 Metatarsal bar wedge, rocker

L3410 Metatarsal bar wedge, between sole

L3420 Full sole and heel wedge, between sole

L3430 Heel, counter, plastic reinforced

L3440 Heel, counter, leather reinforced

L3450 Heel, SACH cushion type

L3455 Heel, new leather, standard

L3460 Heel, new rubber, standard

L3465 Heel, Thomas with wedge

L3470 Heel, Thomas extended to ball

L3480 Heel, pad and depression for spur

L3485 Heel, pad, removable for spur

L3500 Miscellaneous shoe addition, insole, leather

L3510 Miscellaneous shoe addition, insole, rubber

L3520 Miscellaneous shoe addition, insole, felt covered with leather

L3530 Miscellaneous shoe addition, sole, half

L3540 Miscellaneous shoe addition, sole full

L3550 Miscellaneous shoe addition, toe tap, standard

L3560 Miscellaneous shoe addition, toe tap, horseshoe

L3570 Miscellaneous shoe addition, special extension to instep (leather with eyelets)

K3580 Miscellaneous shoe addition, convert instep to velcro closure

L3590 Miscellaneous shoe addition, convert firm shoe counter to soft counter

3595 Miscellaneous shoe addition, March bar

L3600 Transfer of an orthosis from one shoe to another, caliper plate, existing

L3610 Transfer of an orthosis from one shoe to another, caliper plate new

L3620 Transfer of an orthosis from one shoe to another, solid stirrup, existing

L3630 Transfer of an orthosis from one shoe to another, solid stirrup new

L3640 Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both sides

L3649 Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers

BENEFIT CATEGORY: Braces (Orthotics), Prosthetic Device

REFERENCE: Coverage Issues Manual 70-3

COVERAGE AND PAYMENT RULES:

Shoes, inserts, and modifications are covered in limited circumstances. They are covered in selected patients with diabetes for the prevention or treatment of diabetic foot ulcers. However, different codes (A5500-A5507) are used for footwear provided under this benefit. See the medical policy on Therapeutic Shoes for Diabetics for details.

Shoes are also covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980-L2030, L2050

L2060, L2080, or L2090. Oxford shoes (L3215, L3219, L3224, L3225 - see "Coding Guidelines") are covered in these situations. Other shoes, e.g. high top, depth inlay or custom for nondiabetic, etc. (L3216, L3217, L3221, L3222, L3230, L3251-L3253, L3649 - see "Coding Guidelines"), are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600-L3640) involving shoes on a covered brace are also covered. Inserts and other shoes modifications (L3000-L3170, L3300-L3450, L3465-L3520, L3550-L3595) are covered if they are on a shoe that is an integral part of a brace and if they are medically necessary for the proper functioning of the brace. Shoes and related modifications, inserts, heel/sole replacements or shoe transfers billed without a ZX modifier will be denied as non-covered. (See "Documentation" section for definition of ZX modifier).

According to a national policy determination, a shoe and related modifications, inserts, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe which is not attached to the brace and items related to that shoe should not be billed with a ZX modifier and will be denied as non-covered.

Shoes which are billed separately (i.e. not as part of a brace) will be denied as non-covered even if they are later incorporated into a brace. A ZX modifier may not be used in this situation.

Prosthetic shoes (L3250) are covered if they are an integral part of a prosthesis for patients with a partial foot (ICD-9 diagnosis codes 895.0-896.3, 755.31, 755.39). Shoes are denied as non-covered when they are put on over a partial foot or other lower extremity prosthesis L5010-5600).

With the exception of the situations described above, orthopedic footwear billed using codes L3000-L3649 will be denied as non-covered.

Coding Guidelines

For dates of service prior to 1/1/95. Shoes that are an integral part of a brace are billed using codes L3215-L3217, L3219-L3222, L3230, L3251-L3253 with a ZX modifier (see "Documentation" section). Shoes that are not an integral part of a brace are billed using these codes without a ZX modifier. For codes L3215-L3217, L3219-L3222, and L3230 one unit of service is on one pair of shoes; for codes L3251-L3253, one unit of service is each shoe.

For dates of service on or after 1/1/95. Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225 with a ZX modifier. For these codes, one unit of service is each shoe. Oxford shoes that are not part of a leg brace are billed with codes L3215 or L3219 without a ZX modifier. Other shoes (e.g. high top, depth inlay or custom shoes for nondiabetic, etc.) that are an integral part of a brace are billed using code L3649 with a ZX modifier. Other shoes that are not an integral part of a brace are billed using codes L3216, L3217, L3221, L3222, L3230, L3251-L3253 without a ZX modifier.

Depth-inlay or custom molded shoes for diabetics (A5500-A5501) and related inserts and modifications (A5502-A5507) are billed using these A codes whether the shoe is an integral part of a brace or not. (See policy on "Therapeutic Shoes for Diabetics" for coverage, documentation, and additional coding guidelines).

The right (RT) and left (LT) modifiers should be used with footwear codes. When bilateral items are provided on the same date of service, bill both on the same claim line using the LTRT modifier and 2 units of service.

Documentation

An order for the shoe and related modifications and inserts must be signed and dated by the ordering physician and kept on file by the supplier. The physician must see to it that the patient's medical record contains information which supports the medical necessity of the item ordered. An order is not required for a heel or sole replacement or transfer of a shoe to a brace.

When billing for a shoe that is an integral part of a leg brace or for related modifications, inserts, heel/sole replacements or shoe transfer, a ZX modifier should be added to the code. If the shoe or related item is not an integral part of a leg brace, the ZX modifier may not be used. (The ZX modifier indicates that "The specified coverage criteria in the medical policy are met and documentation is available in the supplier's records").

When billing for prosthetic shoes, a diagnosis code defining the medical condition must be entered on the claim.

When code L3649 with a ZX modifier is billed, the claim must include a narrative description of the item provided as well as a brief statement of the medical necessity for the item. This could be attached to a hard copy claim or entered in the HA0 record of an electronic claim.

Effective Date: Coverage criteria and coding changes are effective for claims with dates of service on or after 1/1/95. The ZX modifier must be used, if appropriate, for all claims received by the DMERC on or after 3/1/95.

Immunosuppressive Drugs

Coverage for immunosuppressive drugs, initially established by OBRA 1986, has until recently been limited to one year after a covered organ transplant. OBRA 1993 authorized a phased-in extension of the benefit from 12 months to 36 months. Due to the provisions of the law and subsequent technical amendments, over the next few years the length of coverage for a particular beneficiary will be determined by the month of discharge following a Medicare covered transplant. The accompanying table associates the month of discharge from a covered organ transplant with the total number of months of coverage. For example, if the patient were discharged on January 1, 1994, coverage would be for 18 months and would end on June 30, 1995; if the patient were discharged on October 15, 1994, coverage would be for 27 months and would end on January 14, 1997.

Coverage for beneficiaries whose dates of discharge from the hospital following a covered transplant was on or before July 31, 1993 is limited to one year. Effective January 3, 1995, claims processing systems have been changed to accommodate the law and technical amendments to process claims for covered transplants with hospital discharge dates of August 1, 1993 and thereafter.

For beneficiaries who are eligible for the extended coverage, claims which have been submitted and were denied may be resubmitted, or if a claim was not filed, an original bill for a previously unbilled month (1994 or 1995) may be submitted. The dates of service must not extend beyond the authorized period of extended coverage, and the total months of coverage defined by the law and technical amendments may not be exceeded.

Phased-in Benefit Periods for Immunosuppressive Drug Therapy

Total Discharge Month:	Months of Coverage:	Discharge Month:	Total Months of Coverage:
08/93	13	08/94	25
09/93	14	09/94	26
10/93	15	10/94	27
11/93	16	11/94	28
12/93	17	12/94	29
01/94	18	01/95	30
02/94	19	02/95	31
03/94	20	03/95	32
04/94	21	04/95	33
05/94	22	05/95	34
06/94	23	06/95	35
07/94	24	07/95	36

Change in Billing for Pessaries

HCFA has advised that A4560 is the correct code assigned for all types of pessaries, including silicone pessaries. Do not use A4649 (surgical supply, miscellaneous) to bill for silicone pessaries. In the future, the DMERCs will give further consideration to the need to distinguish a separate code for silicone pessaries.

The above is a retraction to the Silicone Pessaries article published in the December edition of *DME Medicare News* (page 4).

Lymphedema Pumps

Effective for claims received by the DMERC on or after May 1, 1995:

All claims reporting the rental or purchase of a lymphedema pump must provide the model number and manufacturer's name.

For paper CMNs, the information must be attached. For electronic claims, the information must be entered into the HA0 record. If the manufacturer's name and model number are not included, the item will be denied.

Therapeutic Shoes

As of March 1, 1995, CMN 04.01 is no longer required for Therapeutic Shoes. A statement of certifying physician for Therapeutic Shoes should be used and kept on file. Please use modifier ZX to indicate that coverage criteria has been met.

Faxed Documentation

As an initial order for an item, it is acceptable to have an order faxed to your area of operation. The supplier must obtain an original medical document signed and dated by the physician prescribing the equipment within a reasonable time frame. There should also exist a signed agreement by the physician to the supplier that a hand stamp will not be used. All original documents signed and dated by the prescribing physician must be maintained by the supplier as CMNs, orders, and additional medical documentation.

Microfilm is not an acceptable method for post-payment audit. Should an audit be performed by The MetraHealth DMERC, "fax" documents are not acceptable.

UPS Delivery Log

Please be advised that a UPS delivery **log** or a copy of a log, is an acceptable form of proof of delivery for a DMEPOS item. The **log** or copy must be maintained in the beneficiary's file as would any other documentation.

Electronic Media Claims

Important EMC Numbers

Bulletin Board

Non-Participating Suppliers	717-735-9515
Participating Suppliers	800-842-5713

EMC Help Desk

717-735-9517	717-735-9527
717-735-9518	717-735-9258
717-735-9519	717-735-9530

EMC Billing Reminders

Below are helpful tips which should be followed when submitting claims electronically. These tips will help your claims move through the system faster and help eliminate payment errors.

1. Capped Rental Items should have the same "From" and "To" dates and the Units of Service equal to 1.

2. A CMN should not be sent with every claim. CMN's should only be sent when they are Initial, Revisions, or Recertification.

3. When billing electronically, the units of service must be a whole number. If you are provided with a fractional unit of service, it should be rounded up to the next whole number.

4. Dates of service cannot span years. These must be broken down so each year and its corresponding services are on a separate line.

5. When submitting Parenteral and Enteral Nutrition claims, the nutrients must be billed with the actual From and To dates and the exact number of services. If billing for one tube (B4081, B4082, B4083, B4084, K0147), use the same From and To date not the date span.

6. If using modifiers, make sure they are correct modifiers. Please refer to the Region A *Supplier Manual*.

7. The release of information indicator should be answered with a "Y" if you have a signed HCFA-1500 form on file.

8. The entire correct NSC number must be on the electronic claim. This is entered in the FA0 record field 23.

Top Reasons for Front-End Rejects

1. Incorrect or missing source of payment indicator (DA0 field 5) - This is required on all insurance records for each electronic claim. This is a one-position alpha character. This information can be found in the National Standard Format Matrix and the Region A "Accelerate manual."

2. Missing duration on the oxygen CMN (GX0 field 16)- This is required on the oxygen CMN. It is a 2 position numeric field and the acceptable values equal 01-24.

3. Missing or incorrect date of last medical exam (GU0 field 18) - This is required on CMN's 01.01 - 10.01.

4. Missing or invalid doctor's UPIN (FB1 field 9) - This is a required field for all claims being submitted to the DMERC. Each line item on a claim must have the doctor's UPIN.

5. Invalid or missing Health Insurance Claim (HIC) number (DA0 field 18) - This field must be properly constructed. Use the correct amount of numeric characters and alpha characters for each number. There should not be any spaces in the HIC number.

6. Invalid or missing initial date on the CMN record (GU0 field 19) - This is a required field on the CMN record and must be completed.

7. Invalid or missing revision / recertification date on the CMN record (GU0 field 20) - This field must be completed when submitting a CMN and must indicate that it is a revision or recertification.

8. Missing exercise routine on the Oxygen CMN (GX1 field 06) - This field must be completed if the type of oxygen system is portable.

Electronic Eligibility Inquiry

The Electronic Eligibility Inquiry Capability System will soon be available. It will be offered to participating physicians and suppliers, and their authorized billing agents, who bill Medicare electronically using the National Standard Format (NSF). This system will help us provide better customer service to those physicians and suppliers who participate in the Medicare program.

Participating providers and their authorized billing agents will be able to request eligibility information by using an asynchronous telecommunications connection, along with a predefined HCFA format. Access will be provided on a toll basis: i.e., the EMC submitter will incur all wire charges and access will be available April 1, 1995. The information to be made available includes:

- ❑ Entitlement Date
- ❑ Termination Date
- ❑ Deductible Met (yes or no) for current and prior year
- ❑ HMO Data
- ❑ HMO Name
- ❑ HMO Zip Code
- ❑ HMO Code (cost or risk)
- ❑ Entitlement Date
- ❑ Termination Date
- ❑ MSP Data (yes or no)

Access to this information will require, at a minimum, the beneficiary's health insurance claim number (HICN), surname, first initial, and gender. Please note, users of Accelerate (Medicare's free software) will not have access to this feature through the software at this time.

If you would like programming requirements or have any questions, please contact one of our EMC marketing representatives at 717-735-9519, 9530.

Electronic File Acknowledgments

Suppliers who submit electronically to Region A via the Bulletin Board system can now receive their file acknowledgments electronically. These file acknowledgments are located on the Bulletin Board under menu pick "J." Electronic file acknowledgments for files which are received between 1:00 A.M. - 1:00 P.M. each day will be available the following day at 7 A.M. Electronic file acknowledgments for files which are received between 1:00 P.M. - 1:00 A.M. each day will be available the following day at 1:00 P.M.

Example:

- ❑ Electronic claim file received Monday before 1:00 P.M.
- ❑ Electronic acknowledgment is available on the Bulletin Board at 7:00 A.M. on Tuesday.
- ❑ Electronic claim file received Monday after 1:00 P.M.
- ❑ Electronic acknowledgment is available on the Bulletin Board at 1:00 P.M. on Tuesday.

Electronic acknowledgments will remain on the Bulletin Board for 10 working days. Please retrieve the files promptly. New files will not overlay uncollected acknowledgments from previous days.

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Paper Acknowledgment Stopped - Action

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Presently, electronic submitters who submit via the Bulletin Board receive their acknowledgments electronically and by paper. Paper acknowledgments will not be sent to these electronic submitters as of April 1, 1995.

Electronic acknowledgments can be viewed and printed in a report format by using the free Genacks program supplied by MetraHealth or by using a program created by your vendor. Tape and diskette submitters will continue to receive paper acknowledgments only.

Please contact the EMC Unit at 717-735-9530, 9519, 9527 if you have questions regarding these acknowledgment.

Advantages of Electronic Billing

- ❑ 13-Day vs. 27-day Payment Floor. This begins on the date of receipt of the claim(s). Submitting claims electronically can be done 7 days a week, including holidays. The paper claim payment floor is 27 days. The 27 days begin after the mailroom receives the claim.
- ❑ Increased Cash Flow.
- ❑ Reduced Cost. Handling time and postage of paper claim submission is eliminated.
- ❑ Reduced Errors. Data is received precisely as input by your office, eliminating the chance of processing error.
- ❑ Electronic CMN's. CMN's can be transmitted electronically.
- ❑ ERNs and EFTs. Electronic Remittance Notices and Electronic Funds Transfers are available for faster posting.
- ❑ On-Line Claims Status / Weekly Status Report. Pending claim status for assigned claims can be reviewed daily or weekly.
- ❑ Electronic File Acknowledgments.
- ❑ Electronic Eligibility. Electronic Eligibility will be available April 1, 1995 for participating physicians and suppliers.

How to Get Started With Electronic Billing

Interested in a cost effective and accurate method of submitting DMEPOS claims? Electronic billing can supply the solution. The Region A DMERC offers a free software program called "Accelerate" which uses a claim entry screen that resembles the HCFA -1500 form. The EMC Team will assist with software installation and provide the support needed to run this program. By following the steps listed on the next page, the EMC Team can start today to help you with electronic billing, even with a vendor or billing service.

Please check all that apply:

❑ I am interested and would like the FREE software package.

❑ I would like more information regarding EMC submission mailed to me.

❑ I have a computer system which is supported by ______________________________ (indicate name of vendor/billing service). Please have an EMC Representative call me.

Office Name ______________________________

Street ______________________________

City ____________________ State _____ Zip ____________________

Contact Person ______________________________

Telephone ( ) ____________________ ____________________

Volume of Medicare DMEPOS claims per month ______________________________

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How to Bill Electronically

If You Are Using Accelerate:

1. Contact the EMC Team by phone, mail, or FAX.
2. A signature agreement will be mailed to you.
3. Upon receipt of the signature agreement, the EMC Department will issue a submitter number and send the “Accelerate” free software to you.
4. Our EMC Team will then help you to install and transmit your DMEPOS claims.

If You Are Using a Vendor/Billing Service:

1. Contact the EMC Team by phone, mail, or FAX.
2. A signature agreement will be mailed to you.
3. Upon return of the signature agreement, the EMC Department will issue a submitter number. Contact your vendor/billing service to arrange for testing . Once these tests are passed, you are ready to transmit DMEPOS claims.
4. Our EMC Team will assist you in setting up to transmit your claims through a vendor/billing service.

EMC is available to both participating and non-participating suppliers. Assigned and non-assigned claims are accepted. Complete the form above for more information, and mail or fax to:

DME Region A
Attn: EMC Department
P.O. Box 6800
Wilkes-Barre, PA 18773
FAX: 717-735-9510

If you have specific questions, please call 717-735-9532 or 717-735-9528.

Electronic Reconsideration

Faxed Electronic Reconsideration (EREs) are an advantage for electronic submitters. Paper claims cannot be submitted by fax for reconsideration / reviews.

Effective February 20, 1995, faxed reviews for paper claims will no longer be accepted. Suppliers will be called and informed that their claim is not being accepted for Electronic Reconsideration and should be sent via mail. Paper claims, which are being submitted for review, should be sent to the following address:

MetraHealth
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attention: Review Department

Suppliers who are submitting reconsideration for electronic claims should remember that each fax transmission is limited to six pages.

New Free Software Print Package

The Region A EMC Unit is providing a free software print package to all EMC submitters. This package will display the electronic file acknowledgment into a readable report.

If you wish to use this software, it is located under menu pick "G", Support Systems Files. You will find three files which need to be downloaded to your system. They are genacks.exe, genacks.txt and ttbrowse.com.

Those submitters who are using a vendor software should contact your vendor regarding the use of this program.

Please contact the EMC Unit at 717-735-9517, -9519, -9528 if you have questions regarding this program.

NSF Programming

Region A is tightening its front-end edits in accordance with the National Standard Format (NSF) matrix for versions 1.03 and 1.04. Those vendors and in-house programmers who are in compliance with the NSF should not experience any problems with claims submissions.

If a field is required it must be completed according to the specifications listed in the NSF. If a field is conditional, optional, or not used, and information is being supplied to the DMERC in these fields, they must also be completed according to the specifications in the NSF.

If fields are not completed according to the specifications listed in the NSF, then the claims, and possibly the entire file, will reject. Please refer to your error code booklet with regard to possible reasons for claim rejection.

Pricing

Revised 1994 Surgical Dressing Fee Schedules

The following is the Revised 1994 Surgical Fee Schedule for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New York, New Jersey, Pennsylvania, and Delaware:

HCPCS	Fee	HCPCS	Fee
A4460	$0.89	K0237	$6.95
K0154	$12.63	K0238	$20.03
K0196	$6.46	K0240	$10.76
K0197	$14.45	K0241	$2.25
K0199	$4.64	K0242	$5.34
K0203	$3.68	K0243	$10.83
K0204	$3.10	K0244	$34.52
K0207	$6.45	K0245	$6.38
K0209	$6.59	K0246	$8.71
K0210	$17.50	K0247	$20.90
K0211	$25.81	K0248	$14.27
K0212	$8.53	K0249	$0.76
K0214	$9.04	K0251	$1.76
K0216	$0.07	K0252	$0.48
K0217	$0.38	K0253	$0.79
K0219	$0.84	K0254	$1.07
K0220	$2.26	K0255	$2.66
K0222	$1.86	K0257	$1.35
K0223	$2.12	K0258	$3.78
K0224	$3.17	K0259	$9.61
K0229	$3.17	K0262	$0.97
K0234	$5.75	K0263	$0.25
K0235	$14.79	K0264	$0.43
K0236	$23.94		

Refer to the June edition of *DME Medicare News* for descriptions of these HCPCS codes.

Vision

When billing for lenses, the correct number of services must be indicated:

1 pair = 2 number of services

When billing a discount on vision claims, the discount for each line item needs to be deducted from the amount billed on each line.

Downcoding

Numerous claims are being submitted whereby the original code submitted was downcoded and suppliers are, in turn, using this code when billing for the item. This should not be done. The original code submitted must be used on all subsequent claims. If the decision to downcode the item is reversed as a result of a requested review, the original code must still be submitted; however, the original code will not be downcoded after the reversed decision.

Use of the RP Modifier

When billing the region A DMERC for Orthotic or Prosthetic equipment, the RP Modifier does not have to be used to indicate replacement of an item. In this instance, this modifier is informational only and does not have to be reported. Suppliers should only use the RP Modifier to indicate a repair of an Orthotic or Prosthetic item. In addition, suppliers should always use the appropriate informational modifier(s) of LT and/or RT. When a claim for a bilateral patient is billed, use one line to indicate the HCPCS code being billed with unit of service 2 (two), and indicate LTRT.

Blood Glucose Monitors

The 1995 fees for blood glucose monitors (code E0607) are being limited to a special payment after February 16, 1995. Any claim with a date of service prior to February 16, 1995, will be priced by the fee schedule. Claims with dates of service after February 16, 1995, have a payment limit as follows:

Purchase (New): $60.18

Purchase (Used): $45.13

Rental: $6.02 per month

This does not apply to home glucose monitors with special features (E0609).

Deleted Codes/Modifiers

Claims for services rendered in the current year, which contain deleted codes/modifiers, can be processed with these deleted codes/modifiers for a three-month period after each HCPCS update. The grace period applies to claims received prior to April 1, 1995 and containing dates of service January 1, 1995 through March 31, 1995.

States	E0670	E0750
CT	119.29	6969.84
ME	119.32	6969.84
MA	119.29	6969.84
NH	118.05	6969.84
RI	119.32	6969.84
VT	119.27	6969.84
NY	119.32	6880.42
NJ	119.32	6880.42
PA	119.32	6390.98
DE	119.32	6390.98

Code J1350 is given individual consideration.

The following table contains the old "Q" codes, paired with the new "A" codes:

Codes		Fees	
Old	**New**	**1994**	**1995**
Q0117	A5500	$58.00	$59.00
Q0118	A5501	$174.00	$178.00
Q0119	A5502	$29.50	$30.00
Q0120	A5503	$29.50	$30.00
Q0121	A5504	$29.50	$30.00
Q0122	A5505	$29.50	$30.00
Q0123	A5506	$29.50	$30.00
Q0133	A5507	$29.50	$30.00

Cochlear Implant

There has been some confusion regarding the jurisdiction of claims for the repair and replacement of the external portion of the Cochlear Implant.

Clarification

Until more specific codes for the Cochlear components can be developed, assigned jurisdiction and implemented by the local carriers, claims for Cochlear component parts, replacement and repair are to be submitted to and processed by the Region A DMERC using HCPCS code L7510.

Procedure Code E1350

As of February 10, 1995, code E1350 is based upon one-half hour of service. If a supplier submitted claims between February 10, 1995 and March 30, 1995 for E1350 based on one hour, this will internally be changed by our processors. To allow for proper reimbursement, please submit claims for E1350 on a half-hour basis.

Examples:
1-1/2 hours of service = 3 numbers of service
1 hour of service = 2 numbers of service

Oral Anti-Cancer Drug Code Listing
January 1995 Quarterly Update

System Code	NDC Code		Code Descriptor	January Nat'l Update
WW010	Bristol/Meyer	00015-0504-01	Cyclophosphamide Tabs, 25 mg	$1.50
WW011	Bristol/Meyer	00015-0503-01	Cyclophosphamide Tabs, 50 mg	$3.00
WW013		00015-0503-02	Cyclophosphamide Tabs, 50 mg	$3.00
WW030	Bristol/Meyer	00015-3091-45	Etoposide, Vepesid, Caps, 50 mg	$33.73
WW055	Algen	00405-4643-36	Methotrexate Tabs, 2.5 mg	$2.88
WW056		00405-4643-01	Methotrexate Tabs, 2.5 mg	$2.88
WW050	Rugby	00536-3998-01	Methotrexate Tabs, 2.5 mg	$2.88
WW051		00536-3998-36	Methotrexate Tabs, 2.5 mg	$2.88
WW052	Lederle	00005-4507-23	Methotrexate Tabs, 2.5 mg	$2.88
WW053	Barr	00555-0572-35	Methotrexate Tabs, 2.5 mg	$2.88
WW054		00555-0572-02	Methotrexate Tabs, 2.5 mg	$2.88
WW055	Geneva	00781-1076-36	Methotrexate Tabs, 2.5 mg	$2.88
WW056		00781-1076-01	Methotrexate Tabs, 2.5 mg	$2.88
WW057	Goldline	00182-1539-01	Methotrexate Tabs, 2.5 mg	$2.88
WW058	Harper	51432-0522-03	Methotrexate Tabs, 2.5 mg	$2.88
WW067	Major	00904-1749-73	Methotrexate Tabs, 2.5 mg	$2.88
WW059		00904-1749-60	Methotrexate Tabs, 2.5 mg	$2.88
WW060	Mylan	00378-0014-01	Methotrexate Tabs, 2.5 mg	$2.88
WW061	Professional Pharmaceutical	58469-3998-30	Methotrexate Tabs, 2.5 mg	$2.88
WW062	Qualitest	00603-4499-21	Methotrexate Tabs, 2.5 mg	$2.88
WW063	Schein	00364-2499-01	Methotrexate Tabs, 2.5 mg	$2.88
WW064	UDL	51079-0670-05	Methotrexate Tabs, 2.5 mg	$2.88
WW068	Roxane	00054-4550-25	Methotrexate Tabs, 2.5 mg	$2.88
WW069		00054-8550-03	Methotrexate Tabs, 2.5 mg	$2.88
WW070		00054-8550-05	Methotrexate Tabs, 2.5 mg	$2.88
WW071		00054-8550-06	Methotrexate Tabs, 2.5 mg	$2.88
WW072		00054-8550-07	Methotrexate Tabs, 2.5 mg	$2.88
WW073		00054-8550-10	Methotrexate Tabs, 2.5 mg	$2.88
WW080	Burroughs-Welcome	00081-0045-35	Mephalan Alkeran Tabs, 2 mg	$1.49

Fees for New 1995 HCPCS Codes

The following are the fees for the new 1995 HCPCS Codes. Unless otherwise indicated, the fees are shown for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New York, New Jersey, Pennsylvania, and Delaware:

Inexpensive or Routinely Purchased

HCPCS	New	Used	Rental	
E0671	$374.16	$280.61	$37.42	Segmental gradient pressure pneumatic appliance, full leg
E0672	$290.73	$218.06	$29.08	Segmental gradient pressure pneumatic appliance, full arm
E0673	$241.57	$181.19	$24.16	Segmental gradient pressure pneumatic appliance, half leg

Inexpensive or Routinely Purchased (Purchase New Only)

K0267	$5.92	Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each

Capped Rental

K0193 *	$112.01	Continuous positive airway pressure, with humidifier
K0194 *	$190.71	Intermittent assist device with continuous positive airway pressure, with humidifier
K0284 *	$15.08 (CT, ME, MA, NH, VT, NJ)	External infusion pump, mechanical, reusable, for extended drug infusion
K0284	$13.24 (RI)	External infusion pump, mechanical, reusable, for extended drug infusion
K0284	$14.70 (NY)	External infusion pump, mechanical, reusable, for extended drug infusion
K0284	$14.52 (PA)	External infusion pump, mechanical, reusable, for extended drug infusion
K0284	$14.80 (DE)	External infusion pump, mechanical, reusable, for extended drug infusion

Surgical Dressings

K0265	$0.12	Tape, all types, per 18 square inches
K0266	$1.73	Gauze, impregnated, other than water or normal saline, any width, per linear yard

Ostomy

K0277 *	$3.96	Skin barrier; solid 4 x 4 or equivalent, with built-in convexity, each
K0278 *	$5.78	Skin barrier; with flange (solid, flexible or accordion), with built-in convexity, any size, each
K0279 *	$7.93	Skin barrier; with flange (solid, flexible or accordion), with built-in convexity, extended wear, any size, each
K0280 *	$2.87	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each
K0281 *	$0.12	Lubricant, individual sterile packet, for insertion of urinary catheter, each

Prosthetics and Orthotics

HCPCS	CT, ME, MA, NH, RI, VT	NY, NJ	PA, DE
L2860	$262.46	$254.86	$249.85
L3160	$0.00 (ICC)	$0.00 (ICC)	$0.00 (ICC)
L3890	$262.46	$254.86	$249.85

* See Invalid K Codes on page 16 of this newsletter.

Parenteral and Enteral Nutrition

Submission of PEN Claims

When submitting Parenteral and Enteral claims, suppliers must indicate on the claim when a beneficiary has changed suppliers. The new supplier NSC Number and the date of the change must also be indicated. This includes both paper and EMC claims. For EMC claims, this documentation should be provided in the HA0 record / documentation text field or in question 15 on the DMERC 10.01 form.

PEN Denial Issues

Please be advised, there are several PEN issues which are causing denials that could be avoided if the recommendations below are followed:

1. Relative to initial claim submission, if the start date of the pump is different from that of the nutrient, this information must be documented on a new CMN or indicated in question #15 on the CMN. If the documentation is not provided as described above, the dates will be adjudicated as both initiating on the same date. Also, if a break in service occurs, it must be documented as to the length of time and the correct date span.
2. For nutrients less than 20 cal / kg / day or greater than 35 cal / kg / day additional medical necessity documentation of why greater than 35 cal / kg / day or why less than 20 cal / kg / day should not be considered supplemental for this beneficiary should be submitted with the initial claim to avoid denial.
3. Claims denied with action code 353, "Medicare can not pay for this service until we receive a new, revised, or renewal prescription," and action code 307, "Medicare does not pay for equipment that is the same or similar to equipment already being used," should be resubmitted and not sent to review. (Also, a claim must accompany the request with the supporting documentation and not the EOMB).
4. Nutrients and supplies require a from and to date (correct date span). If a single date is on the claim form ("FROM" date only), the system will only pay one day's worth of units.

PEN Poles

When billing for a PEN pole (E0776), the starting date the pole was used must be indicated.

Crossover

Blue Cross/Blue Shield of Missouri

Blue Cross / Blue Shield of Missouri recently became a complementary insurer. The OCNA number for BC / BS of Missouri, 63108B001, is no longer needed when submitting claims for beneficiaries with secondary insurance provided by this entity. Please make this correction to the OCNA listing beginning on page 4-21 of your *Supplier Manual.*

Exhibit A, on the following page, identifies the status of other complementary entities in production. Exhibit B, also on the following page, identifies the crossover status of the Blue Cross / Blue Shield organizations.

Exhibit A

Complementary in Production *(Updated 2/6/95)*

	Par	Non-Par	Assigned	Non-Assigned
Aetna	X	X	X	X
Mutual of Omaha	X	X	X	X
BCBS Rhode Island	X	X	X	X
AARP/Prudential	X	X	X	X
American General	X	X	X	X
APWU	X	X	X	X
BCBS Alabama	X	X	X	X
BCBS Delaware	X	X	X	X
United American	X	X	X	X
The Hartford (ITT)	X	X	X	X
BCBS Michigan	X	X	X	X
NALC	X	X	X	X
BCBS Pennsylvania	X	X	X	X
BCBS Western New York	X	X	X	X
Olympic Health	X	X	X	X
American Republic	X	X	X	X
BCBS Connecticut (CHC)*	X	X	X	X
Empire BCBS	X	X	X	X
BCBS Missouri	X	X	X	X

* Constitution Health Care (CHC) is the only part of BCBS Connecticut that is complementary. The OCNA # for CHC is 06473C0001. The OCNA # for all other BCBS Connecticut entities is 06473B0001.

Exhibit B

Status of BCBS *(Updated 2/6/95)*

	Medigap	Complimentary	Par	Non-Par	Assigned	Non-Assigned
BCBS Michigan		X(E)	X	X	X	X
Empire BCBS		X(E)	X	X	X	X
BCBS Rhode Island		X(E)	X	X	X	X
BCBS Alabama		X(E)	X	X	X	X
BCBS Delaware		X(E)	X	X	X	X
BCBS Maine	X(E)		X		X	
BCBS Massachusetts**	X(P)		X		X	
BCBS National Capital**	X(P)		X		X	
BCBS New Hampshire**	X(P)		X		X	
BCBS Utica (Watertown)**	X(P)		X		X	
BCBS Connecticut (CHC)		X(E)	X	X	X	X
BCBS Vermont	X(P)		X		X	
BCBS Illinois	X(P)		X		X	
BCBS New York	X(P)		X		X	
BCBS New Jersey	X(P)		X		X	
BCBS Pennsylvania		X(E)	X	X	X	X
BCBS Western New York		X(E)	X	X	X	X
BCBS Missouri		X(E)	X	X	X	X
BCBS Connecticut	X(P)		X		X	

Key: P = Paper E = Electronic Output

** Please note that the December edition of *DME Medicare News* listed these entities as both participating and non-participating. That information was incorrect. These entities are Medigap, Participating/Assigned as shown above.

Review

DMERC Action Codes For Resubmission

When suppliers receive a denial on a submitted charge which they believe should have been allowed, there are two ways to seek payment:

1. Resubmit the claim and any pertinent documentation.

2. Request a review of the claim

If the item was denied based on medical necessity, the claim would need to be reviewed in order for payment to be considered. If the item was denied due to lack of medical necessity information on or with the claim, the claim should be resubmitted with the needed documentation. A resubmitted claim is treated as a "new" claim and will be processed according to the appropriate payment floor. The DMERCs have up to 45 days to complete a review. Therefore, it is in the best interest of the supplier to resubmit a claim, when appropriate, rather than request a review.

The following partial list of action codes is provided to assist suppliers in determining whether to resubmit a claim or request a review.

330 Medicare does not pay because our records show that you do not have Part B coverage under the Medicare number shown on this notice. If you do not agree, contact your Social Security office.

331 Medicare does not pay because the date of service is after date of death.

353 Medicare cannot pay for this service until a new, revised, or renewal prescription is received.

347 Medicare records show that either the name or Medicare number shown on this claim is incorrect. If the information shown is wrong, please contact your provider to make sure that the provider's records are correct and that a new claim will be filed. If you think the information is correct, please contact your Social Security office.

573 Medicare cannot pay for this service because the dates of service on the claim show the service being billed before it was provided.

574 Medicare does not pay for this in the place or facility where you received it.

Second Requests

If suppliers have reviews over 45 days and have not received a response, they should send the review in again with SECOND REQUEST indicated on the review. EMC submitters may take advantage of faxing reviews since there is only a two-day backlog of these types of reviews. Faxed reviews should be limited to five pages so our fax machine is not tied up for long periods. Reviews longer than five pages should be mailed to the Review Department.

The time limit for suppliers to request a review is six months after date of initial determination. The timely filing requirement will not be compromised if a supplier requests a SECOND REQUEST on a ***previously*** submitted review after the six-month time limit.

Medical Review Department vs. Accounting/MSP Department

Explanations of Medicare benefits with action code denials, such as those listed below, must be sent directly to the attention of the DMERC's Accounting / MSP Unit.

350 Medicare cannot pay for this service because we need an identification number for the provider who billed or performed this service. Please submit a new complete claim to us with all the required information. The assignment agreement remains in effect and will apply to a new claim.

742 Medicare does not pay for these services because they may be covered under the Black Lung Program.

880 Our records show that you are a member of an employer sponsored group health plan., During the 18-month coordination period, your employer group health plan must pay for these end-stage renal disease (ESRD) services first. After the claim has been processed by that plan, and if the bill has not been paid in full, resubmit this claim along with your bills and a copy of the notice you receive from the other insurance company.

881 Medicare cannot pay for items or services which can be paid for under an automobile medical insurance policy or plan or under any other no-fault insurance. After the claim has been processed by that plan, and if the bill is not paid in full, resubmit this claim along with your bills and a copy of the notice you receive from the other insurance company.

Notification of overpayment or overpayment information with your company check attached, should be directed to the Accounting / MSP Unit.

Miscellaneous

Tape, Repair of Prosthesis - Deletion of Existing Codes

The following codes are effective for dates of service on or after January 1, 1995. The previous codes, A4454 and L7500, will be invalid for claims received by the DMERC on or after June 1, 1995.

K0265 Tape, all types, per 18 square inches

K0285 Repair of prosthetic device, labor component, per 15 minutes

Invalid K Codes

Below is a listing of K codes that are considered to be invalid for claim submission to the DMERC at this time. These codes will be valid when new medical policies are published. All other codes in this range are valid.

K0109	Custom wheelchair accessory
K0140-K0146	Nebulizer Drugs
K0148-K0152	Surgical Dressing (invalid for dates of service on or after March 30, 1994)
K0153	Composite dressing
K0155-K0161	Support surfaces
K0193-K0194	CPAP with humidifier
K0269-K0270	Nebulizer equipment
K0271-K0276	Ostomy supplies
K0277-K0278	Prosthetics and Orthotics
K0279	Ostomy supplies
K0280-K0281	Prosthetics and Orthotics
K0284	External infusion pump, mechanical, reusable, for extended drug infusion
K0286-K0335	Nebulizer drugs

Newsletter Correction

The DMERC medical policy on Therapeutic Shoes for Diabetics, published in the December 1994 edition of *DME Medicare News*, contained an error (see page 16). The statement, "On hard copy claims, this statement should be on a separate sheet attached to the claim. On electronic claims, it would be put in the HA0 record," should be deleted.

The statement is contradictory to what is stated in the paragraph above it and should have been removed prior to publication.

Please Note: No statement is required to be submitted with the claims.

Using Valid UPINs

The Region A DMERC did a random 3 month sampling on UPINs and discovered that several facilities had an abundant number of claims submitted with the UPIN OTH000.

The OTH000 UPIN should only be used in the following situations:

- ❑ The service billed is a service that requires referring / ordering information
- ❑ The ordering or referring physician has not been assigned a UPIN and the ordering and performing physician are one in the same
- ❑ The ordering and performing physician has not been assigned a UPIN and does not qualify for any other surrogate UPIN

If the UPIN is not furnished, the supplier must contact the physician for this information.

Refer to page 4-13 of the Region A Supplier Manual for more information on UPINs.

Supplier Manual Revisions

The following statement is to be added to the Documentation section of the Therapeutic Shoe policy and the Epoetin policy published in the December edition of *DME Medicare News*:

Descriptor for the ZX modifier: "Specific requirements found in the documentation section of the medical policy have been met and evidence of this is available in the supplier's records."

These new medical policies, along with others, will be included in an upcoming *Supplier Manual* revision.

Organizational Changes

The Region A DMERC announces the appointments of the following:

- ***Diane Belles*** - Manager, Medical Review, Hearings and Utilization
- ***Joe Koslick*** - Manager, Beneficiary and Provider Services
- ***Jodi Harward*** - Claim Entry Day Manager

A complete listing of the DMERC Management can be found in the Supplier Manual Pre-Release that begins on the following page.

Split Payments

Per Part III of the *Medicare Carriers Manual* (MCM) Section 3040.3, a physician or supplier must show charges collected (deductible and / or coinsurance) from a beneficiary before submitting an assigned claim on the HCFA-1500 form. Per Section 2010.2 of the MCM Part IV, physicians and suppliers are to enter "the total amount the patient paid on the covered charges" in item 29 (amount paid) of the HCFA-1500 form. The aforementioned Part III MCM reference directs that Medicare carriers refund to the beneficiary, to the extent feasible, any over collection of deductible and coinsurance.

Some physicians and suppliers are incorrectly completing item 29 of the HCFA-1500 form by including in this block all moneys which a beneficiary pays on account, instead of showing only the total amount paid on the covered charges. When this occurs, Medicare carriers split the bill and refund the overpayment to the beneficiary.

1.1 DME Region A Service Office

DME Region A Service Office
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Supplier Help Line
(717) 735-9445

Beneficiary Toll-Free Line
(800) 842-2052

Connie Parry
District Manager

Steven Crittenden
Office Manager

Dwayne Thomas
Manager, Claim Entry, Night

Jodi Harward
Manager, Claim Entry, Day

Beth Chabala
Manager, Electronic Media Claims

Paul Hughes, M.D.
Medical Director

Terrance Southward
Manager, Mail and Control

Joe Koslick
Manager, Telephone Services

Diane Belles
Manager, Medical Review / Utilization Review

Victoria Bacso
Manager, Professional Relations

Karen Furman
Manager, Quality Assurance / Pricing / Resolutions

Joanne Nerbecki
Manager, Correspondence

1.2 Ombudsmen

Ombudsmen have been assigned to specific regions and are your personal contacts for any questions concerning the transition policies, procedures and training.

Doris Spencer
New England
(CT, MA, ME, NH, RI, VT)
Meriden, CT
(203) 639-3150 *or*
(717) 735-9415

Amy Capece
(Area to be determined)
(717) 735-9409

Dan Fedor
New York, Pennsylvania, New Jersey, Delaware
Nanticoke, PA
(717) 735-9414

1.3 DMERC Regional Offices

Region A — Connecticut, Delaware, Maine, Massachusetts, New Hampshire New Jersey, New York, Pennsylvania, Rhode Island, Vermont

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

Region B — District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia, West Virginia, Wisconsin

AdminaStar Federal, Inc.
P.O. Box 7078
Indianapolis, IN 46207-7078

Region C — Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands

Palmetto Government Benefits
Administrators
Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141

Palmetto Government Benefits Administrators (Palmetto GBA) is now the operational name for Blue Cross and Blue Shield of South Carolina in the administration of the Medicare Regional DMEPOS contract for Region C.

Region D — Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

CIGNA
Medicare Region D DMERC
P.O. Box 690
Nashville, TN 37202

1.4 National Supplier Clearinghouse (NSC)

NSC

National Supplier Clearinghouse
P.O. Box 100142
Columbia, S.C. 29202-3142
803-754-3951

DME REGION A

SUPPLIER MANUAL

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