DME Medicare News

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

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Contacts

DME Region A Service Office
The MetraHealth Insurance Co. . . . . (717) 735-9400
- FAX . . . . . (717) 735-9402

Beneficiary Toll-Free Number . . . . . (800) 842-2052
Bulletin Board
- Participating Suppliers . . . . . (800) 842-5713
- Non-Participating Suppliers . . . . . (717) 735-9515

EMC FAX. . . . . (717) 735-9510
National Supplier Clearinghouse. . . . . (803) 754-3951
Supplier Help Line Number . . . . . (717) 735-9445

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

Michelle Zawatsky, Editor (717) 735-9412

Season's Greetings From the Region A DMERC

Newsletter Highlights

This edition of "DME Medicare News" contains important information for 1996:

- For easy reference, the 1996 DME Fees Schedules are located at the end of the newsletter. The fee schedules start on page 55.
- The 1996 HCPCS Codes are also included under the Pricing section.
- Information on unprocessable claims can be found under the Claim Entry section. Table 1 identifies the types of incomplete or invalid information which will make claims unprocessable.

Please read this edition of "DME Medicare News" very carefully. The information presented is very important.

Medical Policy

SUBJECT: External Infusion Pumps

HCPCS CODES:

The appearance of a code in this section does not necessarily indicate coverage.

Equipment:

E0781 Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by patient

E0782 Infusion pump, implantable

E0791 Parenteral infusion pump, stationary, single or multi-channel

E0776 IV pole

E1399 Durable medical equipment, miscellaneous

K0284 External infusion pump, mechanical, reusable, for extended drug infusion

Supplies:

A4305 Disposable drug delivery system, flow rate of 50 ml or greater per hour

A4306 Disposable drug delivery system, flow rate of 5 ml or less per hour

A9270 Noncovered item or service

K0110 Supplies for the maintenance of a drug infusion catheter, per week

K0111 Supplies for external drug infusion pump, per cassette or bag

Drugs:

J0895 Injection, deferoxamine mesylate, 500 mg per 5 cc

J1170 Injection, hydromorphone, up to 4 mg

J1250 Injection, dobutamine hydrochloride, per 250 mg

J1455 Injection, foscarnet sodium, per 1000 mg

J1570 Injection, ganciclovir sodium, 500 mg

J2175 Injection, meperidine, per 100 mg

J2260 Injection, milrinone lactate, per 5 ml

J2270 Injection, morphine sulfate, up to 10 mg

J2275 Injection, morphine sulfate (preservative-free sterile solution), per 10 mg

J3010 Injection, fentanyl citrate, up to 2 ml

J3370 Injection, vancomycin HCL, up to 500 mg

J7799 NOC drugs, other than inhalation drugs, administered through DME

J9000 Doxorubicin HCL, 10 mg

J9010 Doxorubicin HCL, 50 mg

J9040 Bleomycin sulfate, 15 units

J9065 Injection, cladribine, per 1 mg

J9100 Cytarabine, 100 mg

J9110 Cytarabine, 500 mg

J9190 Fluorouracil, 500 mg

J9200 Floxuridine, 500 mg

J9360 Vinblastine sulfate, 1 mg

J9370 Vincristine sulfate, 1 mg

J9875 Vincristine sulfate, 2 mg

J9380 Vincristine sulfate, 5 mg

XX009 Dobutamine, 250 mg

BENEFITS CATEGORY: Durable Medical Equipment
REFERENCE: Coverage Issues Manual 60-14
DEFINITIONS:

An ambulatory infusion pump (E0781) is an electrical device which is used to deliver solutions containing parenteral medication under pressure at a regulated flow rate. It is small, portable and designed to be carried by the patient.

A stationary infusion pump (E0791) is an electrical device which serves the same purpose as an ambulatory pump but is larger and typically mounted on a pole.

An infusion controller (E1399) is an electrical device which regulates the flow of parenteral solutions under gravity pressure.

A reusable mechanical infusion pump (K0284) is a non-electric device used to deliver solutions containing parenteral medication under pressure at a constant predetermined flow rate. It is small, portable and designed to be carried by the patient. It must be capable of a single infusion cycle of at least 8 hours.

A disposable drug delivery system (A4305, A4306) is a device used to deliver solutions containing parenteral medication under pressure generated from the elastic properties of the container. It is commonly called an elastomeric infusion pump.

Code K0110 includes dressings for the catheter site and flushing solutions not directly related to drug infusion. The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or subcutaneous port, or an epidural catheter.

Code K0111 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges, and preparation charges.

COVERAGE AND PAYMENT RULES:

An infusion pump is indicated for the administration of parenteral medication in the home setting when both of the following criteria are met:

1. parenteral administration of the medication in the home is reasonable and necessary, and
2. an infusion pump is necessary to safely administer the medication.

An external infusion pump is covered for the following indications:

1. In the subcutaneous administration of deferoxamine for the treatment of chronic iron overload.
2. Chemotherapy for the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable or where the patient refuses surgical excision of the tumor.
3. Morphine when used in the treatment of intractable pain caused by cancer.

Additional uses of an infusion pump are covered for the administration of parenteral medication in the home setting if the patient meets:

a) criteria 1, 2, and 3, or

b) criteria 1, 4, and 5

Criteria:

1) Parenteral administration of the medication in the home is reasonable and necessary.
2) The drug is administered by a prolonged infusion of at least 8 hours because of proven improved clinical efficacy.
3) The therapeutic regimen is proven or generally accepted to have significant advantages over (a) intermittant bolus administration regimens or (b) infusions lasting less than 8 hours.
4) The drug is administered by intermittant infusion (each episode of infusion lasting less than 8 hours) which does not require the patient to return to the physician's office prior to the beginning of each infusion.
5) Systemic toxicity or adverse effects of the drug is unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians Desk Reference, American Medical Association's Drug Evaluations, or the U.S. Pharmacopeia Drug Information

The criteria for additional uses of infusion pumps as described in a) and b) above are met in the following situations:

A. Administration of cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin, vincristine or vinblastine by continuous infusion over at least 8 hours when the regimen is proven or generally accepted to have significant advantages over intermittent administration regimens. This does not apply to primary hepatocellular carcinoma or liver metastases from colorectal carcinoma.

B. Administration of narcotic analgesics (except meperidine) in place of morphine to a patient with intractable pain caused by cancer who has not responded to an adequate oral / transdermal

therapeutic regimen and/or cannot tolerate oral/transdermal narcotic analgesics.

C. Administration of the following antibiotics or antiviral drugs: foscarnet, amphotericin B, vancomycin, acyclovir, and ganciclovir.

D. Administration of parenteral inotropic therapy, using the drugs dobutamine, milrinone and/or dopamine for patients with congestive heart failure and depressed cardiac function if a patient has all of the following conditions:

1) Dyspnea at rest despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g. hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and

2) Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):

a) Dobutamine 2.5 - 10 mcg/kg/min
b) Milrinone 0.375 - 0.750 mcg/kg/min
c) Dopamine 2 mcg/kg/min, and

3) Invasive hemodynamic studies performed within 6 months prior to the initiation of home inotropic therapy show (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b) at least a 20 % increase in CI and/or at least a 20 % decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion, and

4) An improvement in patient well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly, and

5) In the case of continous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in a hospital, or

In the case of intermittant infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and

6) Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and

7) The patient is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy, and

8) The patient's cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the patient's medical record.

External infusion pumps and related drugs and supplies will be denied as not medically necessary when these criteria are not met unless there is documentation justifying medical necessity in the individual case.

When an infusion pump is covered, the medication necessitating the use of the pump and necessary supplies are also covered. When a pump has been purchased by the Medicare program, other insurer, or the patient, or the rental cap has been reached, the medication necessitating the use of the pump, and supplies are covered as long as the coverage criteria for the pump are met.

Disposable drug delivery systems, including elastomeric infusion pumps (A4305, A4306) are noncovered devices because they do not meet the Medicare definition of durable medical equipment. Medication and supplies used with disposable drug delivery systems are also noncovered items.

An external infusion pump and related medication and supplies will be denied as not medically necessary in the home setting in the following situations:

1. Heparin for the treatment of thromboembolic disease and/or pulmonary embolism,

2. Insulin for the treatment of diabetes mellitus.

An infusion controller device (E1399) is not medically necessary.

An IV pole (E0776) is covered only when a stationary infusion pump (E0791) is covered. It is considered not medically necessary if it is billed with an ambulatory infusion pump (E0781).

Supplies for the maintenance of a parenteral drug infusion catheter (K0110) are covered during the period of covered use of an infusion pump. They are also covered for the weeks in between covered infusion pump use, not to exceed 4 weeks per episode.

Supplies used with a external infusion pump, K0111, are covered. Allowance is based on the number of cassettes or bags prepared. For intermittent infusions, no more than one cassette or bag is covered for each dose of medication. For continuous infusion, the concentration of the drug and the size of the cassette or bag should be maximized to result in the fewest cassettes or bags in keeping with good pharmacologic and medical practice. Medications and supplies that are dispensed but not used for completely unforeseen circumstances (e.g., emergency admission to hospital, drug toxicity, etc.) are covered. Suppliers are expected to anticipate changing needs for drugs (e.g. planned hospital admissions, drug level testing with possible dosage change, etc.) in their drug and supply preparation and delivery schedule.

The DMERC does not process claims for implantable infusion pumps or medications and supplies used in conjunction with implantable infusion pumps. Claims for these items must be submitted to the local carrier.

RELATED CLINICAL INFORMATION

The Center for Disease Control and Prevention (CDC) has determined that use of vancomycin may increase the possibility of emergence of vancomycin-resistant staphylocci and enterococci. Since the presence of these organisms has a significant negative public health impact, use of vancomycin should be limited to those situations in which it is clearly necessary. The CDC outlined appropriate and inappropriate uses of vancomycin. Of the appropriate uses listed, use of vancomycin administered through an infusion pump in the home setting would usually be limited to the following:

1. Treatment of serious infections due to beta-lactam resistant gram positive microorganisms
2. Treatment of infections due to gram positive microorganisms in patients with serious allergy to beta-lactam antimicrobials

CODING GUIDELINES:

Supplies (including dressings) used in conjunction with an durable infusion pump (E0781, E0791, K0284) are included in codes K0110 or K0111. Other codes should not be used for the separate billing of these supplies.

Use codes K0110 and K0111 only for supplies related to durable infusion pumps. Charges for supplies for noncovered infusion therapy via disposable pump or without a pump may be billed under code A9270.

Medication used in a durable infusion pump should be coded using the appropriate HCPCS codes. If the medication does not have a distinct code, then use the unclassified drug code J7799. Do not use codes A4610 or J9999.

If there is no distinct HCPCS code for the drug billed, and the drug is not administered via an infusion pump, use code A9270.

Use code J2275 only for morphine sulfate that is labeled "preservative free." Morphine sulfate that is not labeled "preservative free" must be coded J2270.

For disposable drug delivery systems (e.g. elastomeric) with a flow rate of more than 5 ml per hour and less than 50 ml per hour, use code A9270.

DOCUMENTATION:

An order for the item which has been signed and dated by the ordering physician and a certificate of medical necessity (CMN) which has been filled out, signed and dated by the ordering physician must be kept on file by the supplier. The CMN for external infusion pumps is DMERC 09.

The initial claim must include a copy of the CMN if filed hard copy. If the claim is filed electronically, the information on the CMN must be transcribed exactly into the GUO record. (See DMEPOS National Standard Format Matrix for details.) If additional medical necessity information is included, it must be transcribed into the HAO record.

If an inotropic drug is ordered, the initial claim must include a copy of the order (prescription and documentation from the ordering physician) which includes information relating to each of the criteria (D1-D8) defined in the Coverage and Payment Rules section. This must include the before and after inotropic drug infusion values defined in D3. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to collect this information may not be completed by the supplier or by anyone in a financial relationship with the supplier. If coverage criteria stated in the policy are not met, the claim should be accompanied by a copy of a letter from the physician giving details of the patient's history (e.g. dates of past hospitalization for heart failure, prior use of parenteral inotropics and the results, etc.) If invasive hemodynamic studies were not performed, the claim should be accompanied by a letter from the attending physician explaining the rationale for not performing the tests accompanied by any other documentation deemed appropriate to explain this exception.

EFFECTIVE DATE: Claims received by the DMERC on or after April 1, 1996.

This is a revision to a previously published policy.

Home Parenteral Inotropic Therapy: Data Collection Form

Patient's name: _____ HIC #: _____

Information below may not be completed by the supplier nor anyone in a financial relationship with the supplier.

1) Results of invasive hemodynamic monitoring:

	Cardiac index	Wedge Pressure	Date:
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____

Drug _____ Dose _____ mcg / kg / min

2) Cardiac medications (digoxin, diuretics, vasodilators) immediately prior to inotrope infusion (list name, dose, frequency):_____

_____

3) Does this represent maximum tolerated doses of these medications? _____

4)

Breathing status (check one in each column):	Prior to inotrope infusion	At time of discharge
No dyspnea on exertion	_____	_____
Dyspnea on moderate exertion	_____	_____
Dyspnea on mild exertion	_____	_____
Dyspnea at rest	_____	_____

5) Initial home prescription: Drug _____ _____ mcg / kg / min

_____ hrs / day _____ day / week (or every _____ days)

6) If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed?_____

7) If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required? _____

8) Is the patient capable of going to the physician for outpatient evaluation:_____

9) Is routine electrocardiographic monitoring required in the home? _____

The above statements and any additional explanations included separately are true and accurate and there is documentation present in the patient's medical record to support these statements.

Physician Signature: _____ Date: _____

Physician Name Printed / Typed: _____ UPIN #: _____

Physician Specialty: _____

SUBJECT: SURGICAL DRESSINGS

The Surgical Dressings Policy, published in June 1995, has been changed. The following is the updated information for Surgical Dressings.

HCPCS CODES:

The appearance of a code in this section does not necessarily indicate coverage.

A4460 Elastic bandage, per roll (e.g., compression bandage)

A4649 Surgical supplies, miscellaneous

A6020 Collagen based wound dressing, wound cover, each dressing

K0154 Wound pouch, each

K0196 Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing

K0197 Alginate dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., each dressing

K0198 Alginate dressing, wound cover, pad size more than 48 sq. in., each dressing

K0199 Alginate dressing, wound filler, per 6 inches

K0203 Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0204 Composite dressing, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0205 Composite dressing, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0206 Contact layer, 16 sq. in. or less, each dressing

K0207 Contact layer, more than 16 but less than or equal to 48 sq. in., each dressing

K0208 Contact layer, more than 48 sq. in., each dressing

K0209 Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing

K0210 Foam dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0211 Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing

K0212 Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0213 Foam dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0214 Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0215 Foam dressing, wound filler, per gram

K0216 Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing

K0217 Gauze, non-impregnated, non-sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0218 Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing

K0219 Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0220 Gauze, non-impregnated, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0221 Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0222 Gauze, impregnated, other than water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing

K0223 Gauze, impregnated, other than water or normal saline, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0224 Gauze, impregnated, other than water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing

K0228 Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing

K0229 Gauze, impregnated, water or normal saline, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0230 Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing

K0234 Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing

K0235 Hydrocolloid dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0236 Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing

K0237 Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0238 Hydrocolloid dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0239 Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0240 Hydrocolloid dressing, wound filler, paste, per fluid ounce

K0241 Hydrocolloid dressing, wound filler, dry form, per gram

K0242 Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing

K0243 Hydrogel dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0244 Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing

K0245 Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0246 Hydrogel dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0247 Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0248 Hydrogel dressing, wound filler, gel, per fluid ounce

K0249 Hydrogel dressing, wound filler, dry form, per gram

K0250 Skin sealants, protectants, moisturizers, any type, any size

K0251 Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing

K0252 Specialty absorptive dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0253 Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing

K0254 Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing

K0255 Specialty absorptive dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in., with any size adhesive border, each dressing

K0256 Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing

K0257 Transparent film, 16 sq. in. or less, each dressing

K0258 Transparent film, more than 16 but less than or equal to 48 sq. in., each dressing

K0259 Transparent film, more than 48 sq. in., each dressing

K0260 Wound cleansers, any type, any size

K0261 Wound filler, not elsewhere classified, gel/paste, per fluid ounce

K0262 Wound filler, not elsewhere classified, dry form, per gram

K0263 Gauze, elastic, non-sterile, all types. per linear yard

K0264 Gauze, non-elastic, non-sterile, per linear yard

K0265 Tape, all types, per 18 square inches

K0266 Gauze, impregnated, other than water or normal saline, any width, per linear yard

K0402 Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing

K0403 Gauze, non-impregnated, sterile, pad size more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0404 Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing

K0405 Gauze, elastic, sterile, all types, per linear yard

K0406 Gauze, non-elastic, sterile, per linear yard

HCPCS MODIFIERS:

X1 Dressing used as a primary or secondary dressing on one surgical or debrided wound

X2 Dressing used as a primary or secondary dressing on two surgical or debrided wounds

X3 Dressing used as a primary or secondary dressing on three surgical or debrided wounds

X4 Dressing used as a primary or secondary dressing on four surgical or debrided wounds

X5 Dressing used as a primary or secondary dressing on five surgical or debrided wounds

X6 Dressing used as a primary or secondary dressing on six surgical or debrided wounds

X7 Dressing used as a primary or secondary dressing on seven surgical or debrided wounds

X8 Dressing used as a primary or secondary dressing on eight surgical or debrided wounds

X9 Dressing used as a primary or secondary dressing on nine or more surgical or debrided wounds

ZY Potentially non-covered item or service billed for denial or at a beneficiary's request (not to be used for medical necessity denials)

BENEFIT CATEGORY: Surgical Dressings

DEFINITIONS:

Wound fillers are dressing materials which are placed into open wounds to eliminate dead space, absorb exudate,or maintain a moist wound surface.

Wound covers are flat dressing pads. A wound cover with adhesive border is one which has an integrated cover and distinct adhesive border designed to adhere tightly to the skin.

A surgical dressing kit is defined as non-individualized, standardized packaging containing repetitive quantities of dressings not related to the individual medical needs of a beneficiary, or whose contents have not each been prescribed for the care of the specific wounds of that beneficiary, or that contain materials in addition to surgical dressings.

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

Contact layers are thin non-adherent sheets placed directly on an open wound bed to protect the wound tissue from direct contact with other agents or dressings applied to the wound. They are porous to allow wound fluid to pass through for absorption by an overlying dressing.

Impregnated gauze dressings are woven or non-woven materials in which substances such as iodinated agents, petrolatum, zinc compounds, crystalline sodium chloride, chlorhexadine gluconate (CHG), bismuth tribromophenate (BTP), water, aqueous saline, or other agents have been incorporated into the dressing material by the manufacturer. However, when the dressing and the substance with which it is impregnated are listed in combination in the FDA Orange Book (e.g. an antibiotic impregnated dressing which requires a prescription), then the entire item is considered a drug

which is noncovered under the surgical dressing benefit and should not be coded using K0222-K0224.

Specialty absorptive dressings are unitized multilayer dressings which provide (a) either a semi-adherent quality or nonadherent layer, and (b) highly absorptive layers of fibers such as absorbent cellulose, cotton, or rayon. These may or may not have an adhesive border.

A wound pouch is a waterproof collection device with a drainable port that adheres to the skin around a wound.

The staging of pressure ulcers used in this policy is as follows:

Stage I - nonblanchable erythema of intact skin

Stage II - partial thickness skin loss involving epidermis and / or dermis

Stage III - full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia

Stage IV - full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures

COVERAGE AND PAYMENT RULES:

Surgical dressings are covered when either of the following criteria are met:

1) They are medically necessary for the treatment of a wound caused by, or treated by, a surgical procedure; or

2) They are medically necessary when debridement of a wound is medically necessary.

Surgical dressings include both primary dressings (i.e. therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin) or secondary dressings (i.e. materials that serve a therapeutic or protective function and that are needed to secure a primary dressing). Items such as adhesive tape, roll gauze, or elastic bandages are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. In the very rare situation when one of these items might possibly be used as a secondary dressing, it should be coded A4649 and individual consideration will be given to claims submitted with additional documentation demonstrating that the item is medically necessary, serves a therapeutic or protective function, and is needed to secure the primary dressing. If an alternative secondary dressing item (e.g., adhesive tape) is effective in securing the primary dressing, the aforementioned items would not be covered.

The surgical procedure or debridement must be performed by a physician or other health care professional to the extent permissible under State law. Surgical dressings must be ordered by a physician or a Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse-Midwife or Physician's Assistant who was acting within the scope of his or her legal authority as defined by State law or regulation.

Debridement of a wound may be any type of debridement (examples given are not all-inclusive): surgical (e.g. sharp instrument or laser), mechanical (e.g. irrigation or wet-to-dry dressings), chemical (e.g. topical application of enzymes), or autolytic (e.g. application of occlusive dressings to an open wound). Dressings used for mechanical debridement, to cover chemical debriding agents, or to cover wounds to allow for autolytic debridement are covered although the agents themselves are non-covered.

Surgical dressings are covered for as long as they are medically necessary. Dressings over a percutaneous catheter or tube (e.g. intravascular, epidural, nephrotomy, etc.) would be covered as long as the catheter or tube remains in place and after removal until the wound heals. (Refer to Coding Guidelines)

Examples of situations in which dressings are noncovered under the surgical dressing benefit are:

a) drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure;

b) a Stage I pressure ulcer;

c) a first degree burn;

d) wounds caused by trauma which do not require surgical closure or debridement - e.g. skin tear or abrasion;

e) a venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle

Surgical dressing codes billed without modifiers X1 - X9 (See Coding Guidelines) are non-covered under the Surgical Dressing Benefit. Certain dressings may be covered under other benefits (e.g., see Ostomy Supply Policy).

If a physician, Certified Nurse Midwife, Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist applies surgical dressings as part of a professional service that is billed to Medicare, the surgical dressings are considered incident to the professional services of the health care practitioner and are not separately payable. Claims for these dressings should not be submitted to the DMERC. Claims for the professional service which includes the dressings should be submitted to the local carrier. If dressing changes are sent home with the patient, claims for these may be submitted to the DMERC. In this situation, use the place of service corresponding to the patient's residence, and Place of Service Office (POS=11) should not be used.

Surgical dressings used in conjunction with investigational wound healing therapy (e.g., platelet derived wound healing formula) may be covered if all applicable coverage criteria are met based on the number and type of surgical dressings that are appropriate to treat the wound if the investigational therapy was not being used.

When a wound cover with an adhesive border is being used, no other dressing would be used on top of it and additional tape is usually not required. Reasons for use of additional tape would have to be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

Use of more than one type of wound filler or more than one type of wound cover in a single wound would rarely be medically necessary and the reasons would have to be well documented.

It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate).

Because composite dressings, foam and hydrocolloid wound covers, and transparent film, when used as secondary dressings, are meant to be changed at frequencies less than daily, appropriate clinical judgement should be used to avoid their use with primary dressings which would require more frequent dressing changes. When claims are submitted for these dressing for changes greater than once every other day, the quantity in excess of that amount will be denied as not medically necessary. While a highly exudative wound might require such a combination initially, with continued proper management the wound should progress to a point where the appropriate selection of these products should result in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination would be the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.

Dressing size should be based on and appropriate to the size of the wound. For wound covers, the pad size should usually be about 2 inches greater than the dimensions of the wound. For example, a 5 cm X 5 cm (2 in. X 2 in.) wound would require a 4 in. X 4 in. pad size.

The following are examples of wound care items which would not be covered under the surgical dressing benefit: skin sealants or barriers, wound cleansers or irrigating solutions, solutions used to moisten gauze (e.g. saline), topical antiseptics, topical antibiotics, enzymatic debriding agents, gauze or other dressings used to cleanse or debride a wound but not left on the wound. Also any item listed in the latest edition of the Orange Book is considered a drug and is not covered under the surgical dressing benefit. In general, Medicare Part B does not cover self-administered drugs. All of the above items will be denied as noncovered supplies. Codes K0250 and K0260 have been established to describe some of these products. These codes will be denied as noncovered.

The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change, and the recent use of dressings. Dressing needs may change frequently (e.g. weekly) in the early phases of wound treatment and / or with heavily draining wounds. Suppliers are also expected to have a mechanism for determining the quantity of dressings that the patient is actually using and to adjust their provision of dressings accordingly. No more than a one month's supply of dressings may be provided at one time, unless there is documentation to support the necessity of greater quantities in the home setting in an individual case. An even smaller quantity may be appropriate in the situations described above.

Surgical dressings must be tailored to the specific needs of an individual patient. This cannot be accomplished when dressings are provided as kits or trays containing fixed quantities and / or multiple types of dressings. Dressings must be individually provided to meet the needs of a specific patient. When surgical dressing kits as defined in this policy are used for the provision of surgical dressings, all components of the kit billed are denied as not medically necessary.

The following are some specific coverage guidelines for individual products when the products themselves are necessary in the individual patient. The medical necessity for more frequent change of dressing should be documented in the patient's medical record and submit-

ted with the claim to the DMERC (see Documentation section).

Alginate dressing (K0196-K0198)

Alginate dressing covers are covered for moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers); and alginate fillers for moderately to highly exudative full thickness wound cavities (e.g., stage III or IV ulcers). They are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to 2 units of wound filler (1 unit = 6 inches of alginate rope) would usually be used at each dressing change. It is usually inappropriate to use alginates in combination with hydrogels.

Composite dressing (K0203-K0205)

Usual composite dressing change is up to 3 times per week, one wound cover per dressing change.

Contact layer (K0206-K0208)

Contact layer dressings are used to line the entire wound; they are not intended to be changed with each dressing change. Usual dressing change is up to once per week.

Foam dressing (K0209-K0215)

Foam dressings are covered when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudate. Usual dressing change for a foam wound cover used as a primary dressing is up to 3 times per week. When a foam wound cover is used as a secondary dressing for wounds with very heavy exudate, dressing change may be up to 3 times per week. Usual dressing change for foam wound fillers is up to once per day.

Gauze, non-impregnated (K0216-K0221, K0402-K0404)

Usual non-impregnated gauze dressing change is up to 3 times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than 2 gauze pads on top of each other in any one area.

Gauze, impregnated, other than water or normal saline (K0222-K0224)

Usual dressing change for gauze dressings impregnated with other than water or normal saline is up to once per day.

Gauze, impregnated, water or normal saline (K0228-K0230)

There is no medical necessity for these dressings compared to non-impregnated gauze which is moistened with bulk saline or sterile water. When these dressings are billed, payment will be based on the least costly medically appropriate alternative, sterile non-impregnated gauze. Bulk saline or sterile water is noncovered under the surgical dressing benefit.

Hydrocolloid dressing (K0234-K0241)

Hydrocolloid dresssings are covered for use on wounds with light to moderate exudate. Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to 3 times per week.

Hydrogel dressing (K0242-K0248)

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudate (e.g., stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers(e.g., location of ulcer is sacro-coccygeal area). Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to 3 times per week.

The quantity of hydrogel filler used for each wound should not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Documentation must substantiate the medical necessity for code K0248 billed in excess of 3 units (fluid ounces) per wound in 30 days.

Use of both a hydrogel filler and a hydrogel cover on the same wound at the same time is not medically necessary. The cover is denied as not medically necessary.

Specialty absorptive dressing (K0251-K0256)

Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (e.g., stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border.

Transparent film (K0257-K0259)

Transparent film dressings are covered when used on open partial thickness wounds with minimal exudate

or closed wounds. Usual dressing change is up to 3 times per week.

Wound filler, not elsewhere classified (K0261-K0262)

Usual dressing change is up to once per day.

Wound pouch (K0154)

Usual dressing change is up to 3 times per week.

Tape (K0265)

Tape is covered when needed to hold on a wound cover, elastic roll gauze or non-elastic roll gauze. Additional tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations would need to be documented. Tape change is determined by the frequency of change of the wound cover. Quantities of tape submitted should reasonably reflect the size of the wound cover being secured. Usual use for wound covers measuring 16 square inches or less is up to 2 units per dressing change; for wound covers measuring 16 to 48 square inches, up to 3 units per dressing change; for wound covers measuring greater than 48 square inches, up to 4 units per dressing change.

Elastic bandage (A4460)

Elastic bandages are covered when used as a secondary dressing to hold wound cover dressings in place. When an elastic bandage is used over a wound cover with adhesive border or over a wound cover which is held in place by tape, elastic roll gauze or non-elastic roll gauze, or transparent film, the elastic bandage is noncovered. Elastic bandages are also noncovered when used for strains, sprains, edema, or situations other than as a secondary surgical dressing.

Most elastic bandages are reusable. Usual frequency of replacement would be no more than one per week.

Gauze, elastic (K0263, K0405)

Elastic gauze dressing change is determined by the frequency of change of the selected primary dressing. When a dressing is secured with tape or has an adhesive border, overlying elastic gauze is denied as noncovered.

Gauze, non-elastic (K0264, K0406)

Non-elastic gauze dressing change is determined by the frequency of change of the selected primary dressing. When a dressing is secured with tape or has adhesive border, overlying non-elastic gauze is denied as noncovered.

CODING GUIDELINES:

Codes A4190-A4205, A4454 and K0152 are not valid for claims submitted to the DMERC. Codes K0196-K0248, K0250-K0266 or K0402-K0406 should be used instead. Code K0249 is not valid for claims submitted to the DMERC. Code K0262 should be used instead.

Codes K0402-K0406 are valid for claims with date of service on or after 1/1/96. The revised narrative description for codes K0216-K0218 and K0263-K0264 (i.e. specifying non-sterile dressing) is effective for dates of service on or after 1/1/96. For claims with dates of service prior to 1/1/96, codes K0216-K0218, K0263, and K0264 will continue to be used for either sterile or non-sterile products, even for claims submitted on or after 1/1/96.

When dressings are covered under other benefits - e.g. durable medical equipment (infusion pumps) or prosthetic devices (parenteral and enteral nutrition, tracheostomy) - and are included in supply allowance codes - e.g. K0110 with a covered infusion pump, B4224 with parenteral nutrition, B4034-B4036 with enteral nutrition, A4625 or K0165 with a tracheostomy - they may not be separately billed using the surgical dressing codes. Dressings over infusion access entry sites not used in conjunction with covered use of infusion pumps, or over catheter/tube entry sites into a body cavity (other than tracheostomy) should be billed separately using the appropriate surgical dressing code.

Wound fillers come in hydrated forms (e.g. pastes, gels), dry forms (e.g. powder, granules, beads), or other forms such as rope, spiral, pillows, etc. For certain materials, unique codes have been established - e.g. alginate wound filler (K0199), foam wound filler (K0215), hydrocolloid wound filler (K0240-K0241), and hydrogel wound filler (K0248). Wound fillers not falling into any of these categories would be coded as K0261 or K0262.

The units of service for wound fillers are 1 gram, 1 fluid ounce, or 6 inch length depending on the product. If the individual product is packaged as a fraction of a unit (e.g. 1/2 fluid ounce), determine the units billed by multiplying the number dispensed times the individual product size and rounding to the nearest whole number. For example, if eleven (11) 1/2 oz. tubes of a wound filler are dispensed, bill 6 units (11 X 1/2 = 5.5; round to 6).

For some wound fillers, the units on the package do not correspond to the units of the new code. For example, some pastes or gels are labelled as grams (instead of fluid ounces), some wound fillers are labelled as cc. or ml. (instead of fluid ounces or grams), some are described by linear dimensions (instead of grams). In these situations, the supplier should contact the manufacturer to determine the appropriate conversion factor or unit of service which corresponds to the new code.

Some wound covers are available both without and with an adhesive border. For wound covers with an adhesive border, the code to be used is determined by the pad size, not by the outside adhesive border dimensions. For example, a hydrocolloid dressing with outside dimensions of 6 in. X 6 in. which has a 4 in. X 4 in. pad surrounded by a 1 in. border on each side is coded as K0237, " ... pad size 16 sq. inch or less ..."

Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing.

Gauze or gauze-like products are typically manufactured as a single piece of material folded into a several ply gauze pad. Coding must be based on the functional size of the pad as it is commonly used in clinical practice.

For all dressings, if a single dressing is divided into multiple portion / pieces, the code and quantity billed must represent the originally manufactured size and quantity.

Paste or powder commonly used with ostomies will continue to be coded using codes K0138 (Skin barrier; paste, per oz.) and K0139 (Skin barrier; powder, per oz.) and not one of the wound filler codes. (See Ostomy Supplies policy for details.)

Modifiers (X1 - X9) have been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. For example,

X1 Dressing used as a primary or secondary dressing on one surgical or debrided wound.

X2 Dressing used as a primary or secondary dressing on two surgical or debrided wounds.

X9 Dressing used as a primary or secondary dressing on nine or more surgical or debrided wounds.

The modifier number must correspond to the number of wounds on which the dressing is being used, not the total number of wounds treated. For example, if the patient has four (4) wounds but a particular dressing is only used on two (2) of them, the x2 modifier should be used with that HCPCS code.

If the dressing is not being used as a primary or secondary dressing on a surgical or debrided wound, do not use modifiers X1-X9. When dressings are provided in non-covered situations (e.g., use of gauze in the cleansing of a wound or intact skin), a ZY modifier must be added to the code and a brief description of the reason for non-coverage included - e.g. "K0216ZY - used for wound cleansing."

When dressing codes are billed for items covered under another benefit (e.g., gauze for a continent ostomy which is covered under the prosthetic device benefit)claims must be billed according to the documentation requirements specified in the applicable policy (See Ostomy Supplies policy for details.)

A supplier wanting to know which code to use for a particular dressing should refer to the Surgical Dressing Product Classification List published separately or contact the Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto Government Benefits Administrators. Surgical dressings listed under specific codes in the Surgical Dressing Product Classification List should not be coded using the miscellaneous code A4649. Impregnated roll gauze dressings designed for the treatment of venous stasis ulcers are examples of dressings that would be properly coded using A4649.

DOCUMENTATION:

An order for surgical dressings must be signed and dated by the patient's attending physician, by a consulting physician for the condition resulting in the need for the dressing, or by a Nurse Practitioner, Clinical Nurse Specialist, Certified Nurse-Midwife or Physician's Assistant who is directly involved with the care of the patient. The order from a nonphysician must be countersigned by the physician when required by State law. This order must be kept on file by the supplier.

The order must specify (a) the type of dressing (e.g. hydrocolloid wound cover, hydrogel wound filler, etc.), (b) the size of the dressing (if appropriate), (c) the number / amount to be used at one time (if more than one), (d) the frequency of dressing change, and (e) the expected duration of need.

A new order is needed if a new dressing is added or if the quantity of an existing dressing to be used is increased. A new order is not routinely needed if the quantity of dressings used is decreased. However a new order is required at least every 3 months for each dressing being used even if the quantity used has remained the same or decreased.

Information defining the number of surgical / debrided wounds being treated with a dressing, the reason for dressing use (e.g. surgical wound, debrided wound, etc.), and whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g. wound cleansing) should be obtained from the physician, nursing home, or home care nurse. The source of that information and date obtained should be documented in the supplier's records.

Current clinical information which supports the reasonableness and necessity of the type and quantity of surgical dressings provided must be present in the patient's medical records. Evaluation of a patient's wound(s) must be performed at least on a monthly basis unless there is documentation in the medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the patient's need for dressings. Evaluation would be expected on a more frequent basis (e.g. weekly) in patients in a nursing facility or in patients with heavily draining or infected wounds. The evaluation may be performed by a nurse, physician or other health care professional. This evaluation must include the type of each wound (e.g. surgical wound, pressure ulcer, burn, etc), its location, its size (length X width in cm.) and depth, the amount of drainage, and any other relevant information. This information does not have to be routinely submitted with each claim. However a brief statement documenting the medical necessity of any quantity billed which exceeds the quantity needed for the usual dressing change frequency stated in the policy must be submitted with the claim This statement may be attached to a hard copy claim or entered in the HA0 record of an electronic claim.

When surgical dressings are billed, the appropriate modifier (X1-X9 or ZY) must be added to the code when applicable. If X9 is used, information must be submitted with the claim indicating the number of wounds. If ZY is used, a brief description of the reason for non-coverage (e.g., "K0216ZY - used for wound cleansing") must be included. These statements should be included with a hard copy claim or entered into the HA0 record.

When codes A4649, A6020, K0261 or K0262 are used for a dressing, the appropriate modifier to indicate the number of wounds should be used and the claim must include the brand name, product number and size of the product provided. When code A4649 is used for a dressing, the claim should also include a statement describing the medical necessity for that dressing in that patient.

EFFECTIVE DATE: Claims received by the DMERC on or after October 1, 1995.

This is a revision to a previously published policy.

Support Surfaces: Powered Air Overlay - Coding Guidelines

A new code for support surfaces is being proposed. The proposed code narrative is, "Powered air overlay." This code will describe a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and

2) Inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and

3) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure, and prevent bottoming out, and

4) A surface designed to reduce friction and shear.

Until this code is established, these products may be billed using code E0277. All of the coverage and documentation requirements for code E0277 will apply, including the use of the ZX modifier when appropriate. See DMERC medical policy on Pressure Reducing Support Surfaces - Group 2, for more information.

Powered overlays that have a cell height of greater than or equal to 2.5 inches, but less than 3.5 inches should be coded as E0180 or E0181 if they meet all the other characteristics defined in the policy on Pressure Reducing Support Surfaces - Group 1.

Urological Supplies

(Editor's Note: Underlined codes indicate additions to the original policy)

Urinary Drainage Collection System (A4314-A4316, A4357, A4358, A5102, A5112)

Payment will be made for routine charges of the urinary drainage collection system as noted below. Additional charges will be allowed for medically necessary non-routine charges when the documentation substantiates the medical necessity, (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection).

Usual Maximum Quantity of Supplies

Code	*#/mo.*	*#/3 mo.*
A4314	2	-
A4315	2	-
A4316	2	-
A4357	2	-
A4358	2	-
A5102	-	1
A5112	1	-

Lower Limb Prosthesis

(Editor's Note: Underlined text indicates changes from the original policy)

Knees

A determination of the type of knee for the prosthesis will be made by the prescribing physician and / or the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a single axis, constant friction knee. Prosthetic knees are considered for coverage based upon functional classification.

Fluid, pneumatic, and certain mechanical knees (L5610-L5616, L5722-L5780, L5822-L5840) are covered for patients with a functional **Level 3** or above.

Other knee shin symptoms (L5710 - L5718, L5810 - L5818) are covered for patients with a functional **Level 1** or above.

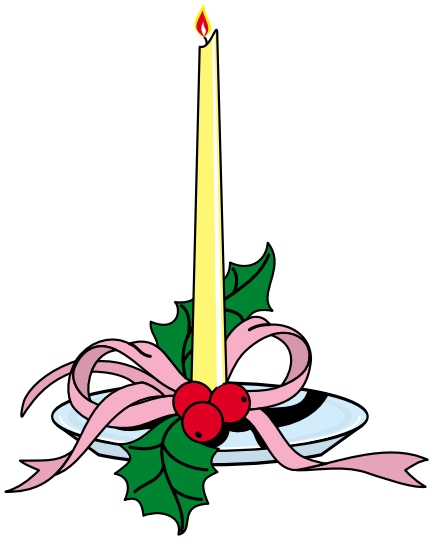
Coverage is extended only if there is sufficient clinical documentation of functional need for the technological design feature of a given type of knee. This information must be retained in the physician's or prosthetist's files.

Wheelchair Documentation

Effective February 1, 1996, when billing K0008, K0009, K0013, or K0014, if the documentation does not correspond to the make and model name or does not meet the code billed, the claim will be denied. The denied claim must be correctly coded and resubmitted as a new claim. Do not send the denied claim to Reconsiderations. A custom or other wheelchair code claim must have documentation indicating the make and model name, modifications, and / or customization to the wheelchair base, and why is it medically necessary for the beneficiary to have a custom or other wheelchair.

For EMC claims, documentation must be submitted in the HA0 record.

In order to facilitate timely processing, accessories to the wheelchair base should be billed on the same claim. If additional claim forms are needed, charges should be carried over and the total should be entered on the last page.



Certificates of Medical Necessity

CMN Completion

*** CMN ALERT ***

The following information serves as final instruction for completing the **CMN Section B (Version .01+.02), effective for dates of service on or after October 1, 1995**.

The following information ***may not*** be completed by the supplier of the items/supplies or anyone in a financial relationship with the supplier:

- ❑ Medical necessity questions
- ❑ Name of person answering Section B questions, if other than the physician
- ❑ Physician's UPIN number
- ❑ Physician's telephone number

Note:

Only the following information in Section B ***may be*** *completed by the supplier: Physician's Name and Physician's Address.*

Non-DME Items

Example: PEN Version .01 CMN

Section B ***may be*** completed by the supplier for claims that will be received by the DMERC prior to April 1, 1996.

All Items - Version .02 CMNs

Section B ***may not be*** completed by the supplier or anyone in a financial relationship with the supplier.

If further clarification is needed, please call 717-735-9445, from 8:00 a.m. to 4:00 p.m., Monday - Friday.

Suggestions for Writing CMN Cover Letters

The Social Security Act was amended in 1994 to specify the types of information that suppliers may provide, in a CMN, to physicians. These are limited to: an identification of the supplier and beneficiary, a description of the equipment and supplies being ordered, and procedure codes for the equipment and supplies. Suppliers are expressly prohibited from providing any information relating to the beneficiary's medical condition to the physician.

In addition to the above items, HCFA determined that it would be appropriate for the supplier to include only the following types of information in a cover letter which is attached to the CMN and sent to a physician. Because these letters are considered attachments to the CMN, they must be retained with the CMN in the supplier's file.

- ❑ Sections of the form that the physician must complete (e.g., "Sections B and D"), and/or specific questions that the physician must answer;
- ❑ Where to send the completed CMNs and the deadline for submission;
- ❑ A copy of test results or reports (e.g., blood gas report, wheelchair evaluation, discharge summary, nurses notes, etc.) obtained from a hospital, laboratory, outpatient facility, etc.; and
- ❑ A direct quote from the Medicare policy (e.g., "A wheelchair is covered if the patient's condition is such that without the use of a wheelchair he/she would otherwise be bed or chair confined"). A paraphrase of the policy is not appropriate.

HCFA encourages suppliers to assist in the process of educating physicians about the criteria and guidelines explained in the DMERC Regional Medical Review Policies (RMRPs). If a supplier wishes to use a cover letter as an avenue for educating physicians in this way, this would be appropriate. However, because of the recent amendments to the Social Security Act pertaining to CMNs, it is important that HCFA, the DMERCs, and suppliers work together to ensure that the process used is well within the intent of the law.

Legislative Changes Involving CMNs

Why You Have Received This Information

HCFA is providing you with this information to advise you of the provisions and requirements of Section 1834 of the Act, as amended in 1994. The law restricts information that suppliers may provide to physicians on CMNs, and requires suppliers to include relevant charge information for items and services they list on CMNs. These amendments supersede those of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). The provisions apply to any CMN revised by the DMERCs in 1995.

What the Law Prohibits

Section 1834 of the Act was amended in 1994 to allow suppliers to complete certain informational elements on CMNs when sending the forms to physicians. The information that suppliers may provider is limited to the following:

- ❑ An identification (name) of the supplier and the beneficiary receiving the medial equipment and supplies;
- ❑ A description of the medical equipment and supplies;
- ❑ Any HCPCS code identifying the medical equipment and supplies; and
- ❑ Any other administrative information (other than information relating to the beneficiary's medical condition) permitted by the Secretary.

Section 1834 of the Act prohibits the supplier or an employee of the supplier from completing the medical portion of the CMN. A clinician (not necessarily the attending physician), who is familiar with the medical condition of the beneficiary, may complete the medical section. This does not apply to a physician who is also the supplier of the item.

What the Law Requires

If a supplier is required to submit a CMN for the purpose of documenting medical necessity of a particular type of equipment or supply (including those used in the prior authorization process), the supplier must list on the CMN the fee schedule amount and the supplier's charge for the medical equipment or supplies being furnished before sending the CMN to the physician. If the item is not subject to a fee schedule amount, then the supplier must list his / her usual charge for the item. If the CMN lists more than one item, the supplier must itemize, for each item, the applicable fee schedule amount and charges on the CMN. Similarly, if an item includes accessories or supplies that are essential to the operation of the item, charges for these accessories must be listed. If the item is a capped rental, the supplier must show the monthly rental fee. If a CMN is accompanied by other forms before forwarding to a physician, this charge information may be listed. This applies to both participating and non-participating suppliers.

DME regional carriers are authorized to determine, for each CMN, if any related accessories require charge information.

CMNs and all attachments to them must be kept on file by suppliers for at least seven years after processing.

Items Subject to the Provisions

The following items are subject to the above prohibition and requirement:

- ❑ Durable Medical Equipment (see Section 1861 (n) of the Act);
- ❑ Prosthetic devices (see Section 1861 (s) (8) of the Act);
- ❑ Orthotics and prosthetics (see Section 1861 (s) (9) of the Act);
- ❑ Surgical dressings (see Section 1861 (s) (5) of the Act); and
- ❑ Other items the Secretary determines appropriate.

Items Not Included in the Provisions

The provision involving CMN requirements and prohibitions do not apply to the following items:

- ❑ Home dialysis supplies and equipment (see Section 1861 (s) (2) (F) of the Act);
- ❑ Immunosuppressive drugs (see Section 1861 (s) (2) (J) of the Act);
- ❑ Therapeutic shoes for diabetics (see Section 1861 (s) (12) of the Act);

- ❑ Oral drugs prescribed for use as an anti-cancer therapeutic agent (see Section 1861 (s) (2) (Q) of the Act); and

- ❑ Self-administered erythropoietin (see Section 1861 (s) (2) (P) of the Act).

DME regional carriers are authorized to determine, based on analysis of the utilization trends for equipment and supplies, any additional items that may require a CMN. Any new CMN will be implemented under the current provisions unless the item is among those not included in the provisions.

Codes Requiring CMNs - Addition

The August 1995 edition of "DME Medicare News" on CMN revisions included a list of codes requiring a CMN / DIF. The following are changes to that list effective for claims received on or after 1 / 1 / 96:

Additions: E0748, J7503, J7509, J7510, J7599, K0412

Deletions: E0180, E0181, E0277

Claim Entry

Join HCFA in Saving Medicare Trust Funds!!

The Health Care Financing Administration (HCFA) is continuing efforts to reduce costs and administrative waste. As of 4 / 1 / 96, a new editing process will be implemented for assigned claims which will save the Medicare Trust Fund millions of dollars. For some time, the denial of claims with incomplete or invalid information has resulted in claims surfacing inappropriately into the appeals process. This practice has not only been costly, it has resulted in an inappropriate use of the appeals system.

This new editing process will return paper or electronic claims to you as unprocessable if the claim contains certain incomplete or invalid information. No appeal rights will be afforded to these claims, or portion of these claims, because no "initial determination" can be made; rendering the claim unprocessable.

This new editing process not only saves Medicare Trust Funds, there is little change and no additional administrative burdens for you. You will not be denied any services you are accustomed to. You will be able to correct an unprocessable claim under the new editing system with the same ease as you did under the current system. If you are accustomed to submitting corrections via the telephone, on a development letter, as a new claim, or in any format, that process will continue. However, you will not be granted a review because "returned" claims have no appeal rights.

One caution: Please correct "returned" claims promptly because only when that is done will you have met your legal obligation for submitting a Medicare claim. If you are a non-participating provider and currently bill beneficiaries prior to submitting a claim, you may continue to do so.

What does Return as Unprocessable mean?

Returning a claim as unprocessable does not mean your Medicare Carrier / DMERC will physically return every claim you submit with incomplete or invalid information. The term "return as unprocessable" is used to refer to the many processes utilized by your Medicare Carriers / DMERCs today for notifying you that your claim cannot be processed, and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

1. Incomplete or invalid information is detected at the front-end of your Medicare Carrier's / DMERC's claims processing system. The claim is returned to you either electronically or in a hardcopy / checklist type form explaining errors and how to correct them.

2. Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed by your Medicare Carrier / DMERC. If corrections are submitted within a 45 day period, the claim is processed. Otherwise, the suspended portion is "returned as unprocessable" and you are notified by means of the remittance notice.

3. Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process by your Medicare Carrier / DMERC. You are notified of any error(s) through the remittance notice, as well as how to correct it.

Note: An incomplete claim is a claim with missing, required information (e.g., no UPIN). An invalid claim is a claim that contains complete and necessary information; however, the information is illogical or incorrect (e.g., incorrect UPIN).

What information will be provided to assist you in correcting a claim?

To assist you in furnishing the appropriate corrections, the following information will be supplied (as long as it is on the received claim):

1 Beneficiary's name;

2) HIC number;

3) Dates of service;

4) Patient account or control number

An explanation of the errors will also be provided. This explanation will either be in the form of a description or a code.

Which Incomplete or Invalid Information will be Returned as Unprocessable?

The following information will be returned as unprocessable if it is not completed and / or entered accurately on the claim. Please note that a required data element must always be present on a claim (Refer to Table I), a conditional data element must be present when certain condition(s) exist (Refer to Table II).

To assist you in completing your claim: for paper claims, refer to (the HCFA-1500 Instructions / the Regional DMERC Provider Manuals); for electronic claims, refer to (the National Standard Format Specifications / Carrier National Standard Format Matrix Document / DMERC National Standard Format Matrix / Medicare Part B Specifications for the ANSI X12 837). Please verify that your printing specifications are correct on a claim. Claims will be returned as unprocessable if the required information is submitted incorrectly.

Special Note: If you do not submit information for a required or conditional field(s) because the information is normally kept on file with your Medicare Carrier / DMERC, and can be supplied by your Medicare Carrier / DMERC, then the claim will not be returned as unprocessable.

Table 1

Claims will be returned as unprocessable if the following information is incomplete / invalid:

HCFA-1500	NSF	"PAPER"	"EMC"	*STATUS	Carrier/DMERC Action On Returned Claim **
1A	DAO 18.0	Insured I.D. Number	Insured I.D. Number	R	P - Suspended and developed E - Rejected at Front End
2	CAO 04.0	Patient Name	Patient Last Name	R	P - Suspended and developed E - Rejected at Front End
	CAO 05.0		Patient First Name	R	
4	DAO 19.0	Insured Name	Insured Last Name	C	Reject via Remittance E - Reject at Front End
	DAO 20.0		Insured First Name	C	
6	DAO 17.0	Patient Relationship to Insured	Same	C	Reject via Remittance E - Reject at Front End
7	DA2 04.0	Insured's Address	Insured Address Line 1	C	Reject via Remittance E - Reject at Front End
	DA2 06.0		Insured City	C	
	DA2 07.0		Insured State	C	
	DA2 08.0		Insured Zip Code	C	
	DA2 09.0		Insured Telephone Number	C	

11	DAO 10.0	Insured's Policy Group Number	Group Number	R	Reject via Remittance E - Reject at Front End
	DAO 05.0		Source of Payment	R	
11B	DA2 12.0	Employer's or School Name	Insured Employer Name	C	Reject via Remittance E - Reject at Front End
11C	DAO 11.0	Insurance Plan or Program Name	Group Name	C	Reject via Remittance E - Reject at Front End
12	DAO 16.0	Patient Signature Source	Patient Signature Source	R	Reject via Remittance E - Reject at Front End
	EAO 13.0		Release of Information Indicator	R	
14	EAO 07.0	Date of Current Illness, etc.	Accident/Symptom Date	C	N/A to the DMERC
OR					
	GCO 05.0			C	
17	EAO 22.0	Name of Refer/ Ordering Provider	Refer/Ordering Provider Last Name	C	Reject via Remittance E - Reject at Front End
OR					
17A	FB1 13.0	ID No of Refer/Ordering Provider	Refer/Ordering Provider UPIN	C	Reject via Remittance E - Reject at Front End
OR					
	EAO 20.0		Referring Provider I.D.	C	
	FB1 09.0		Refer/Ordering Provider UPIN	C	
19	EAO 46.0	Reserved for Local Use	Date Last Seen	C	N/A to the DMERC
	FB1 22.0		Supervising Provider UPIN	C	
	GCO 06.0		Date of Last x-Ray	C	
20	EAO 28.0	Outside Lab	Laboratory Indicator	C	N/A to the DMERC
	EAO 29.0		Lab Charges	C	
	FAO 26.0		Purchased Service Indicator	C	
	FBO 05.0		Purchased Service Charge	C	
21	EAO 30.0	Diagnosis	Diagnosis 1	C	Only Applies to Physician Claims
	EAO 31.0		Diagnosis 2	C	
	EAO 32.0		Diagnosis 3	C	
	EAO 33.0		Diagnosis 4	C	
24A	FAO 05.0	Dates of Service(s)	Service From Date	R	Reject via Remittance E - Reject at Front End if "from" date is missing or if "to" date if greater than "from"
24B	FAO 07.0	Place of Service	Place of Service	R	Reject via Remittance E - Reject at Front End if POS is missing/invalid

24D	FAO 09.0	Procedures, Services, etc.	HCPCS Procedure Code	R	Reject via Remittance if invalid E - Reject at Front End if Procedure Code blank Modifiers - Reject via Remittance
	FAO 10.0		HCPCS Modifier 1	C	
	FAO 11.0		HCPCS Modifier 2	C	
	FAO 12.0		HCPCS Modifier 3	C	
	FAO 36.0		HCPCS Modifier 4	C	
24F	FAO 13.0	$ Charges	Line Charges	R	P - Reject via Remittance E - Reject at Front End
24G	FAO 18.0	Days or Units of Service	Units of Service	R	P - Reject via Remittance E - Reject at Front End
OR					
	FAO 19.0			R	
24K	FAO 23.0	Reserved for Local Use	Rendering Provider I.D.	C	N/A to the DMERC
31	EAO 35.0	Provider Signature Indicator	Provider Signature Indicator	R	P - Reject via Remittance E - Reject at Front End
32	EAO 37.0	Facility Name and Address	Facility/Laboratory Name	C	Reject via Remittance Reject at Front End
	AND/OR		AND/OR		
	EA1 04.0		Facility/Laboratory I.D. Number	C	
OR					
	FBO 11.0		Laboratory I.D.		
	FAO 31.0		Mammography Certification Number	C	
33	BAO 19.0	Provider's Billing Name & Address	Provider Last Name	R	Reject via Remittance E - Reject at Front End
	BAO 20.0		Provider First Name	R	
OR					
	BAO 18.0		Payer Organ. Name (EMC)	R	
	BAO 09.0		Provider Medicare Number (Batch)	R	
	BA1 13.0		Provider's Pay to Address 1	R	
	BA1 15.0		Provider's Pay to City	R	
	BA1 16.0		Provider's Pay to State	R	
	BA1 17.0		Provider's Pay to Zip Code	R	
	BA1 18.0		Provider's Pay to Telephone No.	R	

* R = Required information which MUST always be on a claim.
NR = Not Required information which is required on a claim if certain conditions exist.

** Lists the action each Medicare Carrier or DMERC will take on a claim returned as unprocessable for instance, suspending a claim returned as unprocessable)

Table II
List of Conditional Edits

Note: Items from the HCFA-1500 form have been provided. These items are referred to as fields. Refer to Table I which crosswalks HCFA-1500 items with records and fields on the National Standard Format.

Your claim will be returned or rejected as unprocessable:

1. If a service was ordered or referred by a physician (other than those services specified below) and the physician's name and / or UPIN (or surrogate) is not present in Fields 17 or 17A.
2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and / or UPIN of the supervising physician is not entered in Fields 17 or 17A.
3. For diagnostic tests subject to purchase price limitations:

   ❑ If a "YES" or "NO" is not indicated in Field 20.

   ❑ If the "YES" box is checked in Field 20 and the purchase price is not entered under the word "$CHARGES."

   ❑ If the "YES" box is checked and the purchase price is entered under $CHARGES, but Field 32 is blank (no name or PIN number is provided or the word "SAME").
4. If a diagnosis in Field 21 is missing or incorrect.
5. If modifiers "QB" and "QU" are entered in Field 24D to refer to a Health Professional Shortage Area, but Field 32 is left blank, or contains no facility / laboratory name or carrier assigned PIN, or does not contain the word "SAME."
6. If a performing physician / supplier / or other practitioner is a member of a group practice and does not enter his or her carrier assigned Provider Identification Number (PIN) in Field 24K and the group number in Field 33.
7. If a primary insurer to Medicare is indicated in Field 11, but Fields 4, 6, and 7 are incomplete.
8. If there is insurance primary to Medicare that is indicated in Field 11 by either an insured / group policy number or the FECA number, but the insurance / program name in Field 11C is incomplete.
9. For chiropractor claims:

   a. If the x-ray date(s) is not entered in Field 19.

   b. If the initial date "actual" treatment began is not entered in Field 14.

   Note: Record GCO, Field 5 of the NSF.
10. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and they do not enter the group's name or billing number in Field 33 and their personal PIN number in Field 24K.
11. For durable medical, orthotic, and prosthetic claims, if the name or PIN of the location where the order was accepted is not entered in Field 32.
12. For physicians who maintain dialysis patients and receive a monthly capitation payment:

    a. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's PIN is not entered in Field 24K.

    b. If the name or PIN of the facility involved with the patient's maintenance of care and training is not entered in Field 32.
13. For foot care claims, if the date the patient was last seen and the attending physician's UPIN are not present in Field 19.
14. For immunosuppressive drug claims, if a referring / ordering physician was used and their name and / or UPIN are not present in Fields 17 or 17A.
15. For all laboratory services, if the services of a referring / ordering physician are used and his or her name and / or UPIN are not present in Fields 17 or 17A.
16. For laboratory services performed by participating hospital-leased laboratory or an independent laboratory (including services to a patient at home or in an institution), if the name or PIN of the laboratory where services were performed is not in Field 32.
17. For independent laboratory services involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if a prescribing physician does not validate any laboratory service(s) performed at home or in an institution by entering the appropriate annotation in Field 19 (i.e., "Homebound").
18. For mammography "screening" and "diagnostic" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved facility identification number in Field 32 when billing the technical or global component.

19. For physician assistant, nurse practitioner, and clinical nurse specialist claims, if services are performed in a hospital setting but neither the hospital's name or PIN is entered accurately in Field 32.

20. For parenteral and enteral nutrition claims, if the services of an ordering / referring physician(s) are used and their name and / or UPIN is not present in Field 17 or 17A.

21. For portable X-Ray services claims, if the ordering physician's name and / or UPIN are not entered in Fields 17 or 17A.

22. For radiology and pathology claims for hospital inpatients, if the referring / ordering physician's name and / or UPIN (if appropriate) are not entered in Fields 17 or 17A.

23. For outpatient services provided by a qualified, independent physical or occupational therapist:

    a. If the UPIN of the attending physician is not present in Field 19.

    b. If the date the patient was last seen by the attending physician is not present in Field 19.

24. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid.

If my claim is returned as unprocessable through the remittance notice, how will I be notified of the error(s)?

Table III contains the Medicare Inpatient Adjudication (MIA) / Medicare Outpatient Adjudication (MOA) / Reference Remark Codes that will be used if your claim is returned as unprocessable through the remittance process. Please note that MIA / MOA Code MA130 will be present on the remittance notice for any claim returned for incomplete or invalid information.

Table III
Incomplete or Invalid Information Codes

MA36 Incomplete / invalid patient's name.

M51 Incomplete / Invalid procedure code(s) and / or rates.

Refer to the HCFA Common Procedure Coding System.

If an appropriate procedure code does not exist, refer to Item 19 on the HCFA-1500 instructions.

M52 Incomplete / invalid date(s) of service.

M53 Did not complete or enter the appropriate number of days or unit(s) of service.

MA58 Incomplete release of information indicator.

MA60 Incomplete / invalid patient's relationship to insured.

MA61 Did not complete or enter correctly the patient's social security or health insurance claim number.

MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.

M76 Incomplete / invalid patient's diagnosis and condition.

M77 Incomplete / invalid place of service(s). Refer to Section 2010.3 in the HCFA-1500 instructions.

M78 Did not complete or enter accurately an appropriate HCPCS modifier(s).

M79 Did not complete or enter the appropriate charge for each listed service.

MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.

MA82 Did not complete or enter the correct physician / supplier's Medicare number or billing name, address, city, state, zip code, and phone number.

MA83 Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.

MA84 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the employer's name and / or the retirement date.

MA85 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insurance plan or group / program name.

MA86 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group number of the primary insurer.

MA87 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the correct insured's name.

MA88 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89 Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA91 Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employer location of the primary insurer.

MA92 Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information.

Refer to the HCFA-1500, instructions on how to complete MSP information.

MA93 Our records indicate that there is insurance primary to Medicare and is indicated properly on the claim; however, paper submissions require a copy of the primary payer's EOB to be attached to the claim.

MA99 Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100 Did not complete or enter accurately the date of current illness, injury, or pregnancy.

MA102 Did not complete or enter accurately the referring/ ordering/supervising physician's name and/or their UPIN (or surrogate).

MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of their attending physician.

MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if "no purchased tests are included on the claim."

MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 Our records indicate that the performing physician/ supplier is a member of a group practice; however, you did not complete or enter accurately their carrier assigned PIN.

MA114 Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished.

MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location where the service(s) was rendered.

MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services where performed at home or in an institution.

Chiropractor Claims

MA121 Did not complete or enter accurately the date the X-Ray was performed.

MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.

Mammography Screening

MA128 Did not complete or enter accurately the six-digit FDA approved, certification number.

Required Code

MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate fiscal intermediary or carrier.

Action Codes/EOMB Messages

The following "check list" of Action Codes/EOMB Messages are being provided to differentiate which method would be most appropriate to utilize for an expedient reprocessing of initial determinations. Please utilize this list to clarify when to resubmit your claim, have your claim adjusted, or request a written or fax review.

Code/EOMB Message: 221 Medicare does not pay for this service because the required criteria were not met.

CO Contractual Obligations

B5 Claim/service denied/reduced because coverage guidelines were not met or were exceeded.

Description of Problem: The claim was denied because the information on the claim did not indicate that you had documentation on your files that would support that the coverage criteria has been met for the procedure code that was billed. A modifier is required when billing for certain procedure codes to indicate that the coverage was met.

Steps to Take:

RESUBMIT If the coverage criteria was met and the modifier was omitted in error, resubmit the claim with the proper modifier.

ADJUST An adjustment can be done only if the denial was incorrect. Contact the Provider Services Unit. A representative will request a copy of the claim. If the modifier was on the claim and all of the coverage criteria has been met, an adjustment will be done.

REVIEW N/A

Code/EOMB Message: 271 This is a duplicate of a charge we have processed.

CO Contractual Obligations

18 Duplicate claim/service

Description of Problem: The claim was denied because there was a previous claim processed for the same date of service and same procedure code.

Steps to Take:

RESUBMIT N/A

ADJUST When billing for additional units than indicated on the original claim; e.g., a claim for one unit of the procedure code A4253 was paid for the date of service 10/01/95 and the customer received two units. Please contact Provider Services so that a representative can adjust the original claim to represent two units. A submission of a second claim for the unbilled unit will cause a duplicate denial.

REVIEW N/A

Code/EOMB Message: 272 Medicare records show that this is a duplicate of a claim previously processed by another carrier. You should receive an Explanation of Your Medicare Part B Benefits notice from the carrier that processed the claim.

CO Contractual Obligations

18 Duplicate claim/service.

Description of Problem: The claim was denied because there was a previous claim submitted to another Medicare carrier that has been processed for the same date of service and the same procedure code. Please call the carrier you originally submitted the claim to for more information.

Steps to Take:

RESUBMIT N / A

ADJUST N / A

REVIEW N / A

Code / EOMB Message:

307 Medicare does not pay for equipment that is the same or similar to equipment already being used.

CO Contractual Obligations

46 This (these) service(s) is (are) not covered.

M3 Equipment is the same or similar to equipment already being used.

Description of Problem: The claim was denied because the beneficiary's records reflect previous or current rental or ownership of equipment which is similar to equipment that you are now billing for.

Steps to Take:

RESUBMIT If you have determined that the previous equipment has been returned and that the new equipment is medically necessary; resubmit your claim with the appropriate documentation.

ADJUST N / A

REVIEW A written review would only be necessary if the claim can not be resubmitted. This would apply if there is conflicting information regarding the return of previous equipment, which cannot be resolved between the beneficiary and the providers of the similar equipment.

Code / EOMB Message:

311 This item has been rented up to the 15-month Medicare limit. No further Medicare payment can be made. Separate payments can be made for maintenance and servicing of the equipment. Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and / or servicing for every 6 month period after the end of the 15th paid rental month.

CO Contractual Obligations

35 Benefit maximum has been reached.

M6 You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and / or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.

Description of Problem: The claim was denied because 15 monthly payments have been made the procedure code being billed. Neither a change in address nor a change in suppliers will extend the 15-month rental period. If the beneficiary changes equipment to different or similar equipment, a new rental period does not begin unless the beneficiary's medical needs have substantially changed and the new equipment is necessary.

Steps to Take:

RESUBMIT N / A

ADJUST If 15 continuous months have not been made, contact Provider Services. A representative will research the number of months that have been paid. An adjustment will only be done is the denial was incorrect.

REVIEW If there is conflicting information regarding the number of months that have been paid continuously, send the denial notice, with supporting documentation, to review.

Code/EOMB Message: 321 Payment for this item is included in the monthly payment amount.

CO Contractual Obligations

97 Payment is included in the allowance for basic service/procedure.

Description of Problem: The claim was denied because the date of service being billed fell within dates of service that were previously paid. There is a monthly payment amount for oxygen.

Steps to Take:

RESUBMIT N/A

ADJUST An adjustment can only be done if the denial was incorrect. Contact Provider Services; They will research the beneficiary's records to verify that no payment was made within 30 days of the date of service being billed.

REVIEW A review would only be applicable to dispute an initial determination that was made due to payment having already been made within a 30-day period for the date of service that is being billed. This is common when a beneficiary changes providers. The monthly allowable for oxygen is not pro-rated.

Code/EOMB Message: 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.

PR Patient Responsibility

31 Claim denied as patient cannot be identified as our insured.

Description of Problem: The claim was denied because an invalid Medicare number was submitted on the HCFA-1500 claim form.

Steps to Take:

RESUBMIT Obtain the correct Medicare number from the Medicare recipient. and resubmit the claim with the correct number.

ADJUST An adjustment would not apply as there was no payment processed.

REVIEW A review would not apply as there was no payment processed.

Code/EOMB Message: 350 Medicare cannot pay for this service because we need an identification number for the provider who billed or performed this service.

CO Contractual Obligations

16 Claim/service lacks information that is needed for adjudication.

Description of Problem: The claim was denied because of missing, invalid or incomplete NSC number in block 33 of the HCFA-1500 claim form.

Steps to Take:

RESUBMIT Verify the NSC number. Put the correct NSC number in block 33 of the HCFA-1500 claim form when you are resubmitting.

ADJUST If the NSC number was on the original claim submitted, notify the Provider Services Unit. A representative will request a copy of the claim to verify this information. An adjustment can only be done if the denial was incorrect.

REVIEW N/A

Code/EOMB Message: 353 Medicare cannot pay for this service until we receive a new, revised or renewal prescription.

CO Contractual Obligations

B17 Claim / service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.

Description of Problem: The claim was denied because there was not a valid certificate of medical necessity on file or received with the claim for the dates of service or procedure code being billed.

Steps to Take:

RESUBMIT Resubmit the claim with a valid certificate of medical necessity.

ADJUST If there is a valid certificate of medical necessity on file or was submitted with the claim that was denied due to lack there of, notify Provider Services. A representative will request a copy of the claim and check the beneficiary's records. An adjustment can only be done if the denial was incorrect.

REVIEW N / A

Code / EOMB Message:

360 Medicare cannot pay for this because we have not received the information we requested.

CO Contractual Obligation

17 Claim / service denied because requested information was not provided or was insufficient / incomplete.

Description of Problem: The claim was denied because information requested to complete the processing of the claim was not received. The requested information must be received prior to the completion of the claim. When it is not, the claim is denied.

Steps to Take:

RESUBMIT If the information requested was not sent with the claim or with the letter that requested the information while the claim was pending, resubmit the claim with the requested information. Do not resubmit the claim if you have already sent in the information. Once the information you have sent is matched to the claim denied that was requesting that information, the denied claim will be reprocessed.

ADJUST If the information being requested was sent with the initial claim and not after, as may have been requested by a letter, contact Provider Services. A representative will request a copy of the claim to verify that all the requested information was sent initially. An adjustment can only be done if all the requested information was sent.

REVIEW N / A

Code / EOMB Message:

369 Medicare cannot pay for this because your provider did not give us the name and / or identification number of the physician who performed, ordered, or referred this service. You are not responsible for this charge.

CO Contractual Obligations

16 Claim / service lacks information that is needed for adjudication.

M33 Claims lacks the UPIN of the ordering / referring or performing physician, or the UPIN number is invalid.

Description of Problem: The claim was denied because of an incomplete, invalid, or missing UPIN number and / or name of referring physician.

Steps to Take:

RESUBMIT Obtain the complete and valid UPIN number from the physician. Put this number in block 17-A on the HCFA-1500 claim form when you are resubmitting the claim.

ADJUST If a valid UPIN number was on the original claim submitted, notify the Provider Services Unit. A representative will request a copy of the claim to verify this information. An adjustment can be done only if the denial is incorrect.

REVIEW N / A

Code / EOMB Message: 370 Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and / or modifier for the service you received.

CO Contractual Obligations

B18 Claim / service denied because this procedure code / modifier was invalid on the date of service or claim submission.

Description of Problem: The claim was denied because the procedure code and / or modifier was missing or invalid for the date of service being billed, or invalid at the time the claim was received. This claim would also have been denied if a miscellaneous procedure code was billed and there was not a narrative description accompanying the code.

Steps to Take:

RESUBMIT If an incorrect procedure code and / or modifier was used, resubmit the claim with the correct code or modifier.

ADJUST If the code or modifier you billed was correct, notify the Provider Services Unit. A representative will request a copy of the claim. An adjustment will only be done if the denial was incorrect.

REVIEW N / A

Code / EOMB Message: 394 Medicare cannot pay for this because the prescription on file is not in effect for this date of service.

CO Contractual Obligations

B17 Claim / service denied because this service was not prescribed by a physician, not prescribed prior to delivery, or the prescription is incomplete or not current.

Description of Problem: The claim was denied because there was not a valid certificate of medical necessity on file or received with the claim for the dates of service being billed.

Steps to Take:

RESUBMIT Resubmit the claim with a valid certificate of medical necessity.

ADJUST If there is a valid certificate of medical necessity on file or was submitted with the claim that was denied due to the lack there of; notify the Provider Services Unit, who will request a copy of the claim and check the beneficiary's record. An adjustment can only be done if the denial was incorrect.

REVIEW N / A

Code / EOMB Message: 522 Information we have in your case does not support the need for this equipment.

CO Contractual Obligations

50 These are non-covered services because this is not deemed a "medical necessity" by the payer.

Description of Problem: The claim was denied due to the lack of supporting documentation required to validate the medical necessity of the equipment being provided to the beneficiary. Commonly, the question sets on the certificates of medical necessity are not answered in conjunction with the medical necessity guidelines established in our medical policies.

Steps to Take:

RESUBMIT N / A

ADJUST N / A

REVIEW If you do not agree with the initial claim determination and the claim cannot be resubmitted; send a copy of the denial notice with all documentation that will support the medical necessity of the equipment being provided. A claim form is not required for a review request.

Code / EOMB Message:

531 The information we have in your case does not support the need for this supply.

CO Contractual Obligations

50 These are non-covered services because this is not deemed a "medical necessity" by the payer.

Description of Problem: The claim was denied do to the lack of supporting documentation required to validate the medical necessity of the type or quantity of supplies provided to the beneficiary.

Steps to Take:

RESUBMIT N / A

ADJUST N / A

REVIEW If you do not agree with the initial claim determination and the claim cannot be resubmitted, send a copy of the denial notice, along with all documentation that will support the medical necessity of the supplies being provided. A claim form is not required for a review request.

Code / EOMB Message:

545 Medicare cannot pay for this because the name and address of the place of service were not shown on the claim. You are not responsible for this charge.

CO Contractual Obligations

16 Claim / service lacks information that is needed for adjudication.

Description of Problem: The claim was denied because block 32 on the HCFA-1500 claim form, or the corresponding field on an EMC submission, was not completed. Other facility information must be completed when billing with place of service other than the patient's home (12) or provider's office (11).

Steps to Take:

RESUBMIT Complete the name and address of the facility which corresponds with the place of service indicated on the claim form. Resubmit the claim with this completed information.

ADJUST If Block 32 was filled out correctly on the original claim submission, notify the Provider Services Unit. A representative will request a copy of the claim. An adjustment will be done only if the original claim determination was incorrect.

REVIEW N / A

Code / EOMB Message:

577 Medicare does not pay for these services or supplies.

PR Patient Responsibility

46 This (these) service(s) is (are) not covered.

Description of Problem: The claim was denied because the procedure code being billed was for a non-covered service.

Steps to Take:

RESUBMIT Resubmit the claim only if an incorrect procedure code was used and the procedure code that should have been used is for a covered service.

ADJUST An adjustment can only be done if the denial was incorrect. Notify the Provider Services Unit. A representative will check the accuracy of the denial.

REVIEW N / A

*A review of a non-covered service is not applicable, as a review determination cannot be used to change Medicare guidelines on coverage issues.

Code / EOMB Message:

586 We have corrected our records about the processing of your Medicare claim and / or deductible. This notice is being sent to you as a result of a request for a reopening claim.

OA Other Adjustments

93 No claim level adjustments.

Description of Problem: The claim was adjusted on the basis that the original claim determination was incorrect.

Steps to Take:

RESUBMIT N / A

ADJUST If the adjustment was done incorrectly, notify the Provider Services Unit. The claim will be readjusted only if the claim adjustment was done incorrectly.

REVIEW N / A

Code / EOMB Message:

825 Your provider did not file this claim on time. You can be billed only 20 percent of the charges that would have been covered by Medicare. This is true even though no Medicare payment can be made.

CO Contractual Obligations

29 The time limit for filing has expired.

Code / EOMB Message:

858 Medicare pays for only one pair of glasses after cataract surgery with lens insertion.

PR Patient Responsibility

57 Claim / service denied / reduced because the payer deems the information submitted does not support the: level of service, number of services, length of service, or dosage.

Description of Problem: The claim was denied because our records reflect the patient already received the glasses.

Steps to Take:

RESUBMIT Resubmit only if the required diagnosis was omitted from the claim form and all other coverage criteria was met.

ADJUST An adjustment can only be done if the denial was incorrect. Contact the Provider Services Unit. A representative will verify the claim information, surgery information, and check for previous Medicare approved payments for glasses.

REVIEW A review would only be advisable if a resubmittal or an adjustment cannot be done due to conflicting information on the beneficiary's records.

Description of Problem: The claim was denied because the date of service being billed is past the time limit for submission.

Steps to Take:

RESUBMIT Resubmit the claim only if the date of service that was billed was incorrect and is actually within the time limit.

ADJUST N / A

REVIEW A review can be done if there is supporting documentation as to why the claim could not have been submitted within the time limit.

Code / EOMB Message:

880 Our records show that you are a member of an employer sponsored group health plan. A claim must be sent to your group health plan first. After the claim has been processed by the 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 received from the other insurance company. The services will then be considered toward meeting your deductible and for possible Medicare payment.

PR Patient Responsibility

22 Claim denied because this care may be covered by another payer per coordination of benefits.

Description of Problem: The claim was denied because our records reflect the beneficiary has insurance primary to Medicare. If Medicare is secondary, a copy of the Explanation of Benefits from the primary insurer must accompany the claim being submitted to Medicare as the beneficiary's secondary insurer.

Steps to Take:

RESUBMIT N / A

ADJUST The only way to resolve this denial is to send the following information to the Medicare Secondary Payor Unit. If Medicare is secondary, send a copy of the denial notice, along with a copy of the Explanation of Benefits form the beneficiary's primary insurer. If Medicare is primary according to the information you have received from the beneficiary, send a copy of the denial notice, along with a letter from the beneficiary, indicating when Medicare became the beneficiary's primary insurer.

REVIEW N / A

Code / EOMB Message:

930 We have received you claim and determined that we can pay the Medicare approved amount minus any applicable deduct and co-payment. IF you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this letter and meet the limit. You may combine amounts on other claims that have been reviewed. This includes reopened reviews, if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence that could affect our decision. If you need assistance, you local Social Security Office will help you request a hearing.

CR Correction to / or Reversal

64 Denial reversed per Medical Review.

MA03 If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. To meet the $100, you may combine amounts on other claims that have been reviewed / reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence that could affect our decision.

Description of Problem: A review was done on the initial determination of a claim. Based on the content of the initial documentation and review request, the Medicare approved amount was paid.

Steps to Take:

RESUBMIT	N / A
ADJUST	N / A
REVIEW	N / A

Quick Reference Chart for Action Code Denial

Action Code:	EOMB Message:	Resubmit:	Adjust:	Review:
221	CO-B5	Y	Y	N
271	CO-18	N	Y	N
272	CO-18	N	N	N
307	CO-46, M3	Y	N	Y
311	CO-35, M6	N	Y	Y
321	CO-97	N	Y	Y
347	PR-31	Y	N	N
350	CO-16	Y	Y	N
353	CO-B17	Y	Y	N
360	CO-17	Y	Y	N
369	CO-16, M33	Y	Y	N
370	CO-B18	Y	Y	N
394	CO-B17	Y	Y	N
522	CO-50	N	N	Y
531	CO-50	N	N	Y
545	CO-16	N	N	Y
577	PR-46	Y	Y	N
586	OA-93	N	Y	N
825	CO-29	Y	N	Y
858	PR-57	Y	Y	Y
880	PR-22	N	Y	N
930	CR-64, MA03	N	N	N

Action Code Change

Action Code 329

"Medicare does not pay more than the monthly maximum allowed for this home dialysis equipment and supplies. The provider cannot bill you for the supplies over this limit."

The Group Reason code for Action code 329 will be changed from PR - Patient Responsibility to CO - Contractual Obligations effective 2-1-96.

Pricing

Resolving Claim Denials - Action Code "307"

307	Medicare does not pay for equipment that is same or similar to equipment already being used.
CO	Contractual Obligations
46	These services are not covered.
M3	Equipment is the same or similar to equipment already being used.

Effective October 1, 1995, providers can call the Provider Services Department, at 717-735-9445, to verbally notify the Region A DMERC when equipment has been picked up or returned. The Region A DMERC will except the verbal information from the previous provider or the new provider. This will alleviate the obligation of submitting a "Pick-Up Slip." Beneficiary notification that their equipment has been returned will also be accepted. Beneficiaries may call 1-800-842-2052.

"Pick-Up Slips" for returned equipment would only be required to dispute a request from the Accounting Department regarding an overpayment case; or to be used as additional supporting documentation in a situation where a claim cannot be resubmitted and requires an appeal. A "Pick-Up Slip" will also be required during a post-pay audit.

The representative will document your NSC number, name, procedure code for the equipment being returned, and the date of the return**.** The representative will further instruct new providers to resubmit claims that were denied with Action Code 307.

60-Day Break in Service

When the interruption of a capped rental period is more than 60 consecutive days and the same equipment is being prescribed that the patient had prior to the break in service; a new Certificate of Medical Necessity is required along with a statement describing the reason for the interruption. If the supplier does not submit this documentation, a new 15-month period does not begin.

Change in Suppliers

If the beneficiary changes suppliers during or after the 15-month rental period, this does not result in a new rental episode. The new supplier is entitled to the remaining monthly rental or maintenance fees.

Overpayment Offset Information

When an overpayment refund is not received within 40 days of the initial request, Medicare guidelines state that procedures must be started to begin recouping the money through offset. This is explained, to the supplier, in the original request for refund.

Effective immediately, the Region A DMERC will no longer provide individual claim information involved in the offset of an overpayment. These new guidelines were established because the individual claim would not have contributed toward the overpayment being withheld. We are withholding funds from the supplier, not the beneficiary for whom that claim was submitted. Claims data for the beneficiary should not be implicated in collection of a third party overpayment.

On the day the provider remittance is mailed indicating an offset amount, a separate letter is also sent informing the supplier of the offset and the overpayment case it is being applied toward. The individual beneficiary's name, health insurance claim number, the amount of the offset, the amount of the overpayments established and any remaining balance are indicated. Some overpayments do involve multiple beneficiaries, and the letter would only reference the overpayment as being for multiple beneficiaries, the offset amount, the full overpayment amount and the remaining balance due.

To avoid being assessed interest, you may refund the overpayment amount, in full, within 30 days of the initial request for the refund. To avoid being assessed interest and having the amount offset, you may refund the overpayment amount in full, plus applicable interest, within 40 days of the initial request for the refund.

ZX Modifiers

For claims submitted on or after October 1, 1995, the ZX modifier is required for Glucose Monitors and Supplies, Therapeutic Shoes and Modifications, and Incontinence Supplies. Claims that have been received prior to October 1, 1995, may have the ZX modifier attached to the codes by the DMERC in order for these claims to pay. The application of the ZX modifier by the DMERC in no way certifies that the beneficiary qualifies for the supplies. The supplier is ultimately responsible for having the qualifying information on file.

Ventilators

Effective immediately, if you are billing for two (2) ventilators for the same date of service, the following procedure ***must be*** followed:

- ❑ Both units ***must*** be submitted on the same claim, otherwise, the second unit will deny as a duplicate. If duplicate denial occurs, you must send a written request for adjustment to:

  MetraHealth Insurance Company
  Region A DMERC
  PO Box 6800
  Wilkes-Barre, PA 18773-6800
  Attn: Reconsiderations

- ❑ Do not use the miscellaneous code E1399 for the second ventilator.

Example:

	Date of Service:	*Procedure Code:*	*Days or Units:*
Line 1	11/1/95	E0450	1
Line 2	11/1/95	E0450	1

Epoetin

Epoetin (EPO) is a covered drug under the Medicare program when used to treat anemia associated with chronic renal failure. Patients with this condition are those who require renal dialysis and are eligible for Medicare under the end-stage renal disease (ESRD) provisions of the law. The purpose of this article is to clarify the instructions that govern the furnishings of EPO to Method II ESRD beneficiaries.

The *Medicare Carriers Manual* Section 4271 defines the home dialysis beneficiary's options for billing under the ESRD provision. Under Method I, the dialysis facility is required to provide any and all home dialysis equipment, supplies, and home support surfaces. Under Method II, the beneficiaries deal directly with a single supplier of home dialysis equipment and supplies that are not a dialysis facility.

Under Method I, claims for EPO are submitted to the fiscal intermediary (FI) by dialysis facilities for payment outside the composite rate. Under Method II, suppliers with a valid Medicare supplier billing number issued by the National Supplier Clearinghouse submit EPO claims to the appropriate durable medical equipment regional carrier (DMERC) for payment in the amount determined in the same manner as the amount payable to a renal dialysis facility (Social Security Act, Section 1881).

Confusion can result when determining whether a dialysis facility can routinely furnish EPO to an ESRD Method II beneficiary. Originally, it was felt that only the supplier chosen by the Method II beneficiary may routinely supply the EPO. However, following discussion with policy staff, this interpretation has been modified to include dialysis facilities as a routine supplier of EPO for the Method II beneficiaries. Under Method II, the FI processes claims from dialysis facilities.

Nebulizer Drug Code Correction

The September 1995 issue of the "DME Medicare News" contained a typographical error on page 17. The description for HCPCS J7672 should read:

J7672 Metaproterenol Sulfate, 0.6%, $1.23 per 2.5 ML or Unit Dose

Please note that J7670 and J7672 units are per 2.5 ML, not per ML.

Correction of HCPCS Code

Please be advised that a typographical error occurred in the March 1995 issue of "DME Medicare News" in regard to the HCPCS Codes for Orthopedic Footwear. On page 3, the code published as K3580 should have been published as **L**3580.

Immunosuppressive Drug - Neoral

Neoral is a new formulation of oral cyclosporine. At this time, this drug should be coded using the existing code K0121 - cyclosporine, 25 mg.

New Codes Effective for Dates of Service on or after 1/1/96

A4575 Topical Hyperbaric Oxygen Chamber, Disposable

A6020 Collagen-based wound dressing, wound cover, each dressing

E0748 Osteogenic Stimulator, noninvasive, spinal applications

J1250	Injection, Dobutamine Hydrochloride, per 250 mg
J7503	Cyclosporine, parenteral, per 50 mg
J7509	Methylprednisolone Oral, per 4 mg
J7510	Prednisone Oral, per 5 mg
J7599	Immunosuppressive Drug, Not Otherwise Classified
K0400	Adhesive Skin Support Attachment for use with external breast prosthesis, each
K0401	For Diabetic only, deluxe off-the shelf Depth inlay shoe or custom molded shoe, per shoe
K0412	Mycophenolate Mofetil, oral, 250 mg (Cellcept)
L1885	KO, Single or Double Upright, thigh and calf, with functional active resistance control
L5617	Addition to lower extremity quick change self-aligning unit, above knee or below knee, each
L5845	Addition, Endoskeletal, Knee-shin system, stance flexion feature, adjustable
L5846	Addition, Endoskeletal, Knee-shin system, microprocessor control feature, swing phase only
L5930	Addition, Endoskeletal System, high activity knee control frame
L5985	All Endoskeletal lower extremity prosthesis, dynamic prosthesis pylon
L8619	Cochlear Implant External Speech Processor, replacement
XX010	Immunosuppressive Drug, NOC will change to code J7599, Immunosuppressive Drug, NOC, effective 1/1/96

Dynamic Splint Codes Become Permanent E Codes

Effective for dates of service on or after January 1, 1996

Level III Code:	**Level II "E" Code:**	**Description:**
YY001	E1800	Dynamic adjustable elbow extension/flexion device
YY002	E1805	Dynamic adjustable wrist extension/flexion device
YY003	E1810	Dynamic adjustable knee extension/flexion device
YY004	E1815	Dynamic adjustable ankle extension/flexion device
YY005	E1820	Soft interface material, dynamic adjustable extension/flexion device
YY006	E1825	Dynamic adjustable finger extension/flexion device
No Previous YY Code	E1830	Dynamic adjustable toe extension/flexion device

CPAP with Humidifier - New Codes

The following codes will be effective in Region A for claims with dates of service on or after 1/1/96:

K0193	Continuous positive airway pressure device, with humidifier
K0194	Intermittent assist device with continuous positive airway pressure, with humidifier

Code K0193 is used when a nonheated, pass-over humidifier is provided at the same time that a single pressure level CPAP device is initially provided.

Code K0194 is used when a nonheated, pass-over humidifier is provided at the same time that a variable pressure level CPAP device is initially provided. This type of CPAP device is one which is capable of providing variable pressure levels in the inspiratory and expiratory phases of the respiratory cycle.

If a nonheated, pass-over humidifier is provided at the time of the first month's rental of a CPAP device, codes K0193 or K0194 are used for the combined items. Code K0268 (pass-over humidifier used with a CPAP device) should never be billed in addition to K0193 or K0194.

If a nonheated, pass-over humidifier is subsequently added to a single pressure level (E0601) or variable pressure level (E0452) CPAP device, code K0268 should be used for the humidifier. Codes K0193 or K0194 cannot be used in this situation. If an initial claim has already been submitted for a patient using code E0601 or E0452, billing must continue using those codes. For a given patient, the code should not be switched to K0193 or K0194.

Codes K0193 and K0194 are in the capped rental payment category.

Change in Jurisdiction of Cochlear Implant External Speech Processor

Code L8619, cochlear implant external speech processor replacement, has been added to the 1996 HCPCS codes. This code describes a component part of the cochlear device / system (code L8614). The DME regional carriers have been processing claims for this item on a temporary basis. On January 1, 1996, the jurisdiction for these claims will transfer to the local carriers. Local carriers are to process all claims received for code L8619 on or after January 1, 1996. Local carriers should work with the DME regional carriers to establish medical review guidelines for this item, and until a fee schedule is established for this code, local carriers should pay claims for this code on an individual basis. Claims for code L8614 are currently processed by local carriers and paid on an individual consideration basis.

Level III Enteral Nutrient Codes Deleted

The following Level III Nutrient Codes will be deleted effective for the dates of service on or after January 1, 1996:

XX054 Category IV Enteral Product,
100 Calories = 1 unit, Traum-Aid HBC

XX060 Category V Enteral Product,
100 Calories = 1 unit, Controlyte

XX063 Category V Enteral Product,
100 Calories = 1 unit, Lipomul

XX067 Category V Enteral Product,
100 Calories = 1 unit, NutriSource

Per the manufacturers, the above products have been discontinued for at least two years.

If suppliers have any of the above listed nutrients provided after January 1, 1996, they are advised to use code B4154.

Gauze Dressings - Code Changes

Effective with dates of service on or after January 1, 1996, coding for non-impregnated gauze pads without an adhesive border and for roll gauze will be changed. The revised / new codes will make a distinction between sterile products and non-sterile products. Existing codes (K0216-K0218, K0263, and K0264) will designate non-sterile products for dates of service on or after January 1, 1996. New codes (K0402-K0406) will be used for sterile products provided on or after January 1, 1996. For claims with dates of service prior to January 1, 1996, codes K0216-K0218, K0263, and K0264 will continue to be used for either sterile or non-sterile products, including claims submitted on or after January 1, 1996. These coding changes apply to all uses of gauze dressings; e.g., surgical dressing, ostomy, etc. The revised / new narratives for the codes for dates of service on or after January 1, 1996 are as follows:

K0216 Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing

K0217 Gauze, non-impregnated, non-sterile, pad size more than 16 but less than or equal to 48 sq. in.., without adhesive border, each dressing

K0218 Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing

K0263 Gauze, elastic, non-sterile, all types, per linear yard

K0264 Gauze, non-elastic, non-sterile, per linear yard

K0402 Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing

K0403 Gauze, non-impregnated, sterile, pad more than 16 but less than or equal to 48 sq. in., without adhesive border, each dressing

K0404 Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing

K0405 Gauze, elastic, sterile, all types, per linear yard

K0406 Gauze, non-elastic, sterile, per linear yard

Surgical Dressings
Product Classification List

Please add the following products to the Classification List published in the September 1995 edition of "DME Medicare News," pages 19-24.

K0251-K0256 — Specialty Absorptive Dressing

Product	Manufacturer
EXU-Dry	EXU-Dry

K0248-K0249 — Hydrogel Dressing, Wound Filler

Product	Manufacturer
Spand-Gel	Medi-Tech

K0242-K0247 — Hydrogel Dressing, Wound Cover

Product	Manufacturer
Acryderm	AcryMed

K0265 — Tape, per 18 sq. inches

Product	Manufacturer
Blenderm Surgical Tape	3M
3M Cloth Adhesive Tape	3M
Durapore Surgical Tape	3M
3M Medipore Soft Cloth Surgical Tape	
Microfoam Surgical Tape	3M
3M Micropore Surgical Tape	3M
Transpore Surgical Tape	3M

A4649 — Surgical Supply; Miscellaneous

Product	Manufacturer
3M Medipore Pre-Cut Dressing Covers	3M

A4460 — Elastic Bandage, per roll (e.g., compression bandage)

Product	Manufacturer
3M Coban Self Adherent Wrap	3M

Corrections to September 1995 Surgical Dressing Classification List

K0264 — Gauze, non-elastic, per linear yard

Product	Manufacturer
Sparta Plain Packing Strips *	Sparta Surgical Corp.

* The above product was erroneously listed under code K0266.

K0242-K0247 — Hydrogel Dressing, wound cover

Product	Manufacturer
Biolex #5504 B **	Bard
Biolex #5508 B **	Bard

** The above products were erroneously listed under codes K0248-K0249.

Temporary K Codes Advance to Permanent Level II Codes Effective 1/1/96

The following K codes will be changed to Permanent Level II codes for dates of service on or after January 1, 1996:

Temporary K Code:	Level II Code Use after 1/1/96:	Description:
Enteral Nutrition Supply		
K0147	B4085	Gastrostomy tube, silicone with sliding ring
Tracheostomy Care Supplies		
K0164	A4628	Oropharyngeal Suction catheter, each
K0165	A4629	Tracheostomy care kit for established tracheostomy
Glucose Monitors		
K0131	A4258	Spring-powered device for lancets
K0267	A4254	Replacement battery, any type, for use with medically necessary home glucose monitor owned by patient, each
Trancutaneous Electrical Nerve Stimulator (TENS)		
K0118	A4595	TENS Supplies - one month supply for TENS, 2 lead
Vision		
K0162	V2781	Progressive lens, each lens

Description Changes to Codes Effective for Dates of Service on or After January 1, 1996

A4259 Lancets, per box of 100

A4322 Irrigation syringe, bulb or piston, each

A4330 Perianal fecal collection pouch with adhesive, each

A4338 Indwelling catheter, Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each

A4340 Indwelling catheter, specialty-type (e.g.; Coude, Mushroom, Wing, etc.) each

A4344 Indwelling catheter, Foley type, two-way, all silicone, each

A4346 Indwelling catheter, Foley type, three-way for continuous irrigation, each

A4351 Intermittent urinary catheter, straight tip, each

A4352 Intermittent urinary catheter; Coude (curved) tip, each

A4355 Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter clamp, each

A4356 External urethral clamp or compression device (not to be used for catheter, each

A4357 Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each

A4358 Urinary leg bag, vinyl, with or without tube, each

A4359 Urinary suspensory without leg bag, each

A4361 Ostomy faceplates, each

A4367 Ostomy belt, each

A4397 Irrigation supply; sleeve, each

L5610 Addition to Lower Extremity, Endoskeletal System, Above - Knee Hydracadence System

L5611 Addition to Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, with Friction Swing Phase Control

L5613 Addition to Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, with Hydraulic Swing Phase Control

L5614 Addition to Lower Extremity, Exoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, with Pneumatic Swing Phase Control

L5616 Addition to Lower Extremity, Endoskeletal System, Above Knee, Universal Multiplex System, Friction Swing Phase Control

Revised L Codes

The verbiage "USMC or Equal" has been replaced with "Non-alignable system" on codes L5500-L5590:

L5500 Initial, below knee "PTB" type socket, non-alignable system, Pylon, no cover, Sach foot plastic socket, direct formed

L5505 Initial, above knee - knee disarticulation, Ischial level socket, non-alignable system, Pylon, no cover, Sach foot, plaster socket, direct formed

L5510 Preparatory, below knee "PTB" type socket, non-alignable system, Pylon, no cover, Sach foot, plaster socket, molded to model

L5520 Preparatory, below knee "PTB" type socket, non-alignable system, Pylon, no cover, Sach foot, thermoplastic or equal, direct formed

L5530 Preparatory, below knee "PTB" TYPE socket, non-alignable system, Pylon, no cover, Sach foot, thermoplasic or equal, molded to model

L5535 Preparatory, below knee "PTB" type socket, non-alignable system, Pylon, no cover, Sach foot, Prefabricated adjustable open end socket

L5540 Preparatory, below knee "PTB" type socket, non-alignable system, Pylon, no cover, Sach foot, laminated socket, molded to model

L5560 Preparatory, above knee - knee disarticulation, Ischial Level socket, non-alignable system, Pylon, no cover, Sach foot, plaster socket, molded to model

L5570 Preparatory, above knee - knee disarticulation, Ischial level socket, non-alignable system, Pylon, no cover, Sach foot, thermoplastic or equal, direct formed

L5580 Preparatory, above knee - knee disarticulation, Ischial Level socket, non-alignable system, Pylon, no cover, Sach foot, thermoplastic or equal, molded to model

L5585 Preparatory, above knee - knee disarticulation, Ischial Level socket, non-alignable system, Py-

lon, no cover, Sach foot, prefabricated adjustable open end socket

L5590 Preparatory, above knee - knee disarticulation, Ischial Level socket, non-alignable system, Pylon, no cover, Sach foot, laminated socket, molded to model

Codes L3850-L3974 have been revised with correct identifying terminology:

L3850 WHO, addition to short and long opponens, action wrist, with dorsiflexion assist

L3906 WHO, wrist gauntlet, molded to patient model

L3908: WHO, wrist extension control cock-up, non molded

L3912 HFO, Flexion glove with elastic finger control

L3914 WHO, wrist extension cock-up

L3918 HO, knuckle bender

L3920 HFO, knuckle bender, with outrigger

L3922 HFO, knuckle bender, two segment to flex joints

L3928 HFO, finger extension, with clock spring

L3932 FO, safety pin, spring wire

L3934 FO, safety pin, modified

L3942 HFO, reverse knuckle bender

L3944 HFO, reverse knuckle bender, with outrigger

L3946 HFO, compsite elastic

L3948 FO, finger knuckle bender

L3954 HFO, spreading hand

L3964 SEO, mobile arm support attached to wheelchair, balanced and fitted to patient, adjustable

L3965 SEO, radial arm support, attached to wheelchair, balanced and fitted to patient, adjustable Rancho type

L3966 SEO, mobile arm support attached to wheelchair, balanced and fitted to patient, reclining

L3968 SEO, mobile arm support attached to wheelchair, balanced and fitted to patient, friction arm support (friction dampening to proximal and distal joints)

L3969 SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support

L3970 SEO, addition to mobile arm support, elevating proximal arm

L3972 SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control

L3974 SEO, addition to mobile arm support, supinator

Modified Verbiage on Code K0125 (Prednisone)

The word "tab" has been deleted from K0125 effective for dates of service on or after date, 1/1/96. The modified description is: K0125 Prednisone, oral 5mg.

New Correct Coding Combinations

In August, HCFA awarded a contract to AdminaStar Federal to define correct coding practices that would be the basis of national Medicare policy for payment of claims using the American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) - 4 system.

Policy Development Process

AdminaStar Federal developed correct coding combinations based upon review of CPT code descriptors, CPT coding instructions, review of existing local and national coding edits, and review of Medicare billing history.

AdminaStar Federal developed a comprehensive narrative policy (the correct coding policy) which outlines general and specific guidelines for the appropriate use of CPT coding for physician claims.

AdminaStar Federal distributed the narrative policy, containing 94,000 coding combinations, in December, 1994, to physician specialty societies through the American Medical Association and to other national specialty societies that represent physicians and non-physicians who may be impacted by this policy. The draft policy was also shared with the Medicare Carrier Medical Directors.

After reviewing and incorporating the comments, and receiving HCFA's approval, AdminaStar Federal developed a "code matrix" - correct coding combinations - and sent it directly to the standard system maintainers to be incorporated into the Medicare carriers' claims processing systems. This matrix based on the correct coding policy, will automatically identify inappropriate CPT code combinations and will properly de-

termine payment. Existing national Medicare payment policies are not changed by the correct coding policy.

There will be two main types of code combinations implemented in January, 1996:

- ❑ Comprehensive and component code combinations
- ❑ "Mutually exclusive" coding combinations that represent services or procedures that would not or could not be performed at the same time based on the CPT code description or standard medical practice.

Summary of Correct Coding Policy

CPT Procedure Coding Definition

The CPT procedure code definition, or descriptor, is based upon the procedure being consistent with current medical practice. In order to submit a CPT code to Medicare, the provider must have performed all of the services included in the code descriptor. Otherwise, the provider must submit a less comprehensive code. Providers must not submit codes describing components of a comprehensive code in addition to the comprehensive code. Components are services necessary to accomplish the more comprehensive procedure / service. In the rare instances where the national Medicare policy differs from instructive language in the CPT descriptor, providers should follow the national Medicare policy.

Mutually Exclusive Code Pairs

These codes represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be submitted together.

Separate Procedures

Although certain CPT codes are identified as "separate procedures", HCFA has determined that these codes may be occasionally provided as part of a more comprehensive procedure and at those times these codes with a designation of "separate procedure" should be submitted with their related and more comprehensive codes.

Most Extensive Procedures

When CPT descriptors designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed should be submitted.

"With/Without" Services

Certain CPT descriptors designate procedures performed "with" or "without" other services. Submit only the code describing the service actually performed.

Sex Designation

Certain CPT code descriptors identify procedures requiring a designation for male or female. Submit only the appropriate one of these designations for an individual patient.

Standards of Medical Practice

Medicare considers all of the services necessary to accomplish a given procedure to be included in the description of that procedure as defined by CPT. Ancillary services necessary to accomplish the procedure are considered included, although independent CPR codes may exist for these ancillary services. Medicare considers billing for these independent CPT codes unbundling, which is prohibited.

Anesthesia Performed During Medical/Surgical Procedures

The Medicare Physician's Fee Schedule precludes payment of a separate fee for anesthesia when provided by the same physician performing the medical / surgical procedure. Therefore, do not submit CPT codes describing anesthesia services or services necessary to provide anesthesia with primary procedure / services codes.

Laboratory Panels

When CPT describes laboratory services performed as a panel or grouping, submit the appropriate code describing the panel or grouping. Do not submit codes for individual laboratory tests when a code for grouping or panel exists for the services performed.

Sequential Procedures

These are several different instances addressed regarding sequential procedures:

- ❑ For those patient encounters where the provider finds it necessary to attempt several procedures in direct succession to accomplish the same end, submit only the procedure that is successfully accomplished. This policy generally applies to limited procedures that are unsuccessful, mandating a more comprehensive procedure.

- ❑ Procedures performed at the same session that are diagnostic in nature and establish the decision to perform the more comprehensive service may be separately submitted.

Codes added, revised, or deleted after 1994 have not been addressed in the correct coding policy. Therefore, additional instructions will be given regarding those codes at a later date.

Beginning October 15, 1995, anyone who wants to receive information on paper and electronic options to order the correct coding should call the National Technical Information Service. To receive the information by Fax, please call (703) 487-4140 and enter Code 8657. To receive the information by mail, please call (703) 487-4650 and ask for PR-1030.

Please submit concerns about coding edits in writing to:

The Correct Coding Initiative
AdminaStar Federal
PO Box 50469
Indianapolis, IN 46250-0469

The correct coding edits will be revised quarterly as part of the refinement process.

Use of the Temporary National Level II HCPCS Modifier "GB"

"Distinct procedural service: the physician may need to indicate that a procedure or service was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate liaison, or separate injury (or area of injury in extensive injuries)."

In those instances where it is necessary to indicate that a procedure or service was distinct or separate from other services performed on the same day, such as:

- ❑ Different session or patient encounter

- ❑ Different procedure or surgery

- ❑ Different site, separate lesion, or separate injury (or area of injury);

Application of the "GB" modifier will prevent erroneous denials of claims for several procedures preformed on different anatomical sites, on different sides of the body or at different sessions on the same date of service. The medical record must reflect that the modifier is being used appropriately to describe separate services.

Convex Ostomy Supplies

Please note that two additional K codes can be used for Convex Ostomy Supplies:

K0277	Skin Barrier, sold 4 x 4 or equivalent, with built- in convexity, each
K0278	Skin Barrier, with flange (solid, flexible or accordion) with built-in convexity, any size, each.

Codes K0277 and K0278 are valid for dates of service on or after 1/1/95. Also, code A5093 can be used for a Convex Ostomy insert.

A5093	Ostomy Accessory; Convex insert

All other Convex Ostomy supplies should be code A4421, Ostomy supply, miscellaneous.

Clarification of SADMERC HCPCS Function

The SADMERC frequently receives items such as claims, medical documentation, overpayment checks, and supplier number applications in error. Coding requests and/or questions should be sent to the SADMERC HCPCS Unit; however, it is not necessary to send a claim or patient medical documentation. You may contact the SADMERC by writing to:

SADMERC/HCPCS Unit
P.O. Box 100143
Columbia, SC 29202-3143

A HCPCS helpline is available at 803-736-6809. Remember, the helpline can assist you with the correct coding of items but cannot answer billing or coverage information.

Medicare Secondary Payer

When a claim indicates Medicare is the Secondary Payer and the necessary information to process the claim as secondary payer is missing, the claim will be denied with CO-16 ("Claim / Services lacks information that is needed for adjudication"). An informational letter, indicating the exact information needed to process the claim, will be sent to the supplier. The letter helps the supplier community understand what information is needed with a Medicare Secondary Payer claim.

Common reasons for Medicare Secondary Payer claims denials include:

- ❑ An explanation of benefits, or denial, from the primary insurance company was not attached to the claim.
- ❑ The explanation of the denial code on the primary explanation of benefits is missing. Please copy the back of the primary EOB if these definitions are indicated there.
- ❑ Date of service billed to Medicare does not match the explanation of benefits from the primary insurance company.
- ❑ Charges submitted on the Medicare claim do not match the submitted charges on the primary insurance company explanation of benefits.
- ❑ Submitted charges to Medicare are for the coinsurance amount only, not the actual charge for the service.
- ❑ The explanation of benefits attached to the claim is not from the insurance company on record as primary (the DMERC will develop this claim to update our records).

If a claim is denied for Medicare Secondary Payer reasons, please do not resubmit a new HCFA-1500 claim form. This claim will be denied as a duplicate.

When you receive a Medicare Secondary Payer denial, please send a copy of the denial, along with the appropriate explanation of benefits from the primary insurance company, to the attention of the MSP Unit, MetraHealth Insurance Company, Region A DMERC, P. O. Box 6800, Wilkes-Barre, PA 18773-6800. Your original claim will then be adjusted for proper payment.

Electronic Media Claims

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 below, the EMC Team can start today to help you with electronic billing, even with a vendor or billing service.

For Accelerate Users

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.

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 agreement, the EMC Department will issue a submitter number. Contact your vendor / billing service to arrange for testing of at least 20-30 claims. Once these tests are passed, you are ready to transmit DMEPOS claims.

4. Our EMC Team will be glad to assist you in setting up transmission of 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 below for more information, and return it to the EMC Department by mail (DMERC Region A, Attn: EMC Department, P.O. Box 6800, Wilkes-Barre, PA 18773) or FAX (717-735-9510). If you have specific questions, please call 717-735-9532 or 717-735-9528.

Accelerate Software Information Request

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 _____

Return this form to the EMC Department:

Mail to:

The MetraHealth Insurance Company
DMERC Region A
P.O. Box 6800
Wilkes-Barre, PA 18773
Attn: EMC Department

or

FAX to:

The MetraHealth Insurance Company
DMERC Region A
Attn: EMC Department
FAX Number: 717-735-9510

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

Important EMC Numbers

Bulletin Board

- ❑ Non-Participating Suppliers: 717-735-9515
- ❑ Participating Suppliers: 800-842-5713
- ❑ 14.4 Modems or Faster 717-735-9688

EMC Help Desk

717-735-9517 717-735-9532 717-735-9518
717-735-9528 717-735-9519 717-735-9530
717-735-9521

Submitters Must Convert to NSF Version 02.00 by April 1, 1996

Attention:
Suppliers, Billing Services, and In-house Programmers

As of July 1, 1995, Version 002.00 of the National Standard Format (NSF) Matrix is now available. The implementation date for Version 002.00 was October 1, 1995. A copy of the new matrix was mailed to all certified vendors and billing services. Please contact your vendor if you have any questions on upgrading to Version 002.00. In-house programmers may contact the EMC Unit and request a copy of the new matrix. If you have any questions regarding the update or would like a copy please contact the EMC Unit at 717-735-9521 or 717-735-9530.

Everyone that submits claims electronically must be converted to NSF Version 02.00 by April 1, 1996. If you are using Accelerate, MetraHealth's free software program, you will be receiving new disks by mail. These disks will be mailed at the beginning of 1996, and a manual explaining how to update your system will also be included. If you are not using our software, you must contact your vendor for the update.

ERNs - Version 01.03

ERN Version 01.03 will be discontinued, effective January 1, 1996. The Region A DMERC will return ERN Version 01.03 for a grace period of about 60 days after that target date. As of March 1, 1996 we will be returning only ERN versions 01.04 and 02.00. The ERN matrix for Version 02.00 is now available and can be obtained by contacting the EMC Department at 717-735-9528 or 717-735-9518.

Electronic Fund Transfers

Electronic Fund Transfer (EFT) is a long-established technology that is widely used because it is more reliable and less expensive than mailing paper checks. Paper checks travel through the mail, and need to be processed clerically in your office, deposited and then cleared by the bank. With EFT, however, Medicare determines the amount to be paid on your claim and electronically notifies Citibank of the amount. Citibank then sends the payment to your bank which, in turn, deposits the funds into your account, whether it is a checking or savings account.

- ❑ No U.S. Mail involved
- ❑ No deposit forms to fill out and balance
- ❑ No trips to the bank to make deposits
- ❑ No waiting period for the checks to clear before the funds are available.

EFT Requirements

The Region A DMERC recently set up their first suppliers with EFT. If you are interested in electronic fund transfer, there are a few requirements that must be met:

- ❑ *Electronic Billing* - Only suppliers who bill Medicare electronically are eligible to receive ERNs and EFT.
- ❑ *Ninety Percent (90%) Rule* - To receive EFT, Medicare requires electronic submission of at least 90% of your Medicare claims. If during a twelve-month period, the submission rate is less than 90% for two (2) consecutive or three (3) non-consecutive months, payments will be made via hardcopy checks, beginning with the following calendar quarter. Paper payment will continue until the required percentage of Electronic Media Claims is maintained for three (3) consecutive months.
- ❑ *Electronic Remittance Notices (ERNs)* - The supplier has been receiving ERNs for the past three (3) months and have not experienced any balancing difficulties. Once you start receiving EFTs, paper EOMBs will stop after 30 days.

Please contact the EMC Unit if you meet the above requirements and are interested in EFTs.

Compressed EMC Files

The EMC Unit can accept production files which are submitted in a compressed (i.e., "zipped") format. This allows for the transmission of multiple files at once and cuts down on transmission time. For more information on compressed files, please contact the EMC Unit at 717-735-9521 or 717-735-9530.

Downloading ERN Files

If you are receiving ERN files, you must download them within ten days. These files only remain on the Bulletin Board for ten days; after that, they are automatically deleted from the system. Due to time and system resources, the Region A DMERC can only recreate these files in extreme emergencies.

Zipped Output Files are Now Available!!

The ability to receive a zipped ERN file or a zipped weekly status file is now available from the DMERC's Bulletin Board System. This option must be requested on an individual basis. If you have any questions or would like to be set up to receive zipped files, please call the EMC Department at 717-735-9521.

Update to Remittance Advice on Bulletin Board

A file containing the update to the remittance advice approved codes and messages is now located on the Bulletin Board. These changes are effective for all electronic remittance transactions issued on or after January 2, 1996, and for all paper remittance notices issued in the standard format on or after January 2, 1995. This file is located under menu selection G, "System Support Files." The name of the file is REMITCDE.WP5.

Bulletin Board Questionnaire

Attention Electronic Claim Submitters

If you are an electronic claim submitter, a new option has been added to the Bulletin Board System (BBS). A series of questionnaires that enables Providers to direct inquiries to various departments of the DMERC is now available.

Currently, there are questionnaire forms for both the MSP / Accounting and Professional Relations Departments. This listing will expand to include other departments at the DMERC as well.

Questionnaires can be found under menu option <1>, "Ask the DMERC." If you have a question for a department that is currently not listed, you may use the BBS General Mail Messages to forward your question. The alternate message system may be found under M - Message System, Option A, "Ask the E-Team."

Please feel free to use these questionnaires as an alternative form of correspondence with the DMERC, and use them as often as you need. This system offers a good way to save time and money. The BBS uses less phone time, and your inquiry does not have to be limited to 8:00 a.m. to 5:00 p.m. Your inquiry can be transmitted 24 hours a day, except for when the BBS shuts down to download files onto the host system. Downloading occurs daily between 1:00 p.m. and 1:30 p.m.. In addition, you will receive an acknowledgment or response to your inquiry within 48 hours (2 working days).

If you currently are not submitting claims to the DMERC electronically, this communication option is an enhancement that makes it more valuable for providers to go electronic. If you are interested in learning more about how to submit claims electronically, please call one of the numbers listed below.

Any questions regarding the "Ask the DMERC" option may be directed to the EMC Unit via the BBS mail system or by calling:

717-735-9532	717-735-9528	717-735-9518
717-735-9519	717-735-9521	717-735-9530

Attention Accelerate Users

If you have been using MetraHealth's free software program, Accelerate, for more than six months, you must delete your old transmission files. This should be done periodically. If you do not delete these old transmission files, free space on your computer's hard drive may decrease to the point that you may not be able to build additional transmission files. Additionally, if these files are not deleted on a periodic basis, you run the risk of transmitting an old file that was previously processed.

Please call the EMC Unit if you need help deleting these files.

Fraud and Abuse

The DMERC Fraud and Abuse Unit has seen an increasing number of assignment violations. Please read the following information regarding Participating Medicare Providers.

Participating Suppliers

Suppliers choosing to be a participating supplier, voluntarily agree to accept assignment for **all** items and services furnished to Medicare beneficiaries. Accepting assignment means accepting Medicare's approved amount as payment in full. Of course, non-participating suppliers may accept assignment on a case-by-case basis.

Penalties for Participating Suppliers Who Breach the Assignment Agreement (Assignment Violation)

Section 14025 of the Medicare Carriers Manual outlines the actions that may be pursued if a participating provider does not accept assignment:

A. **Criminal Penalty** - The law provides that any person who accepts assignment of benefits under Medicare and who "knowingly, willfully, repeatedly" violates the assignment agreement shall be guilty of a misdemeanor and subject to a fine of not more than $2,000 or imprisonment of not more than 6 months or both.

B. **Administrative Action** - HCFA may revoke the right of a physician (or other supplier, or the qualified reassignee of a physician or other supplier), to receive assigned benefits if the Physician (or other party) who has been notified of the impropriety of the practice :

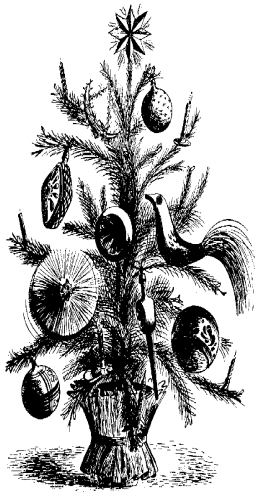
- ❑ Collects or attempts to collect more than the Medicare allowed charge as determined by you for covered services after accepting assignment of benefits for such items or services; or
- ❑ Fails to desist from collection efforts already begun on monies incorrectly collected.

C. **Civil Monetary Penalties** - The statute provides for civil monetary penalties of up to $2,000 per item or service against any provider who violates an assignment agreement.

Reminder

All participating Medicare providers must accept assignment on **all** claims submitted to Medicare. When a provider chooses the assigned method of payment on a Medicare claim / he / she agrees to accept the carrier's determination of the allowable charges for a service as his full charge for that service. This means that, for services covered under the assignment, the physician or supplier cannot bill the patient for any more than the difference between the allowable charge determined by the carrier and the payment received from the carrier.

Payment should not be demanded or accepted from the beneficiary in assignment cases for the difference between the allowable charge and the actual charge, if a reduction of the actual charge has been made by the Medicare carrier. You, may of course, bill the beneficiary for any portion of the allowable charge which is applied to the deductible, the 20% coinsurance, and any charges for services not covered by Medicare. The terms of the "assignment agreement" are explained briefly on each HCFA-1500 request for Medicare Payment form.



Professional Relations

Provider Partnering Outreach

The Provider Partnering Program was designed to seize the opportunity to improve the effectiveness of the Medicare program by improving two-way communications between providers and MetraHealth and increasing provider understanding of the Medicare program. The pilot was a collaboration of eight MetraHealth Government Operations field offices. They include four Part B offices in: Meriden, CT, Richmond, VA, Bloomington, MN, and Jackson, MS; one Part A office located in Meriden, CT; two Railroad Part B offices located in Augusta, GA and Salt Lake City, UT; and our Region A Durable Medical Equipment Regional Carrier (DMERC) located in Nanticoke, PA. Individuals from each field office were chosen to "champion" this pilot. The Region A DMERC "champion" is Daniel Fedor, NY Ombudsman, along with Brian Thomas, DE/NJ Ombudsman as an alternate.

The champions laid the foundation by developing customer service surveys that were mailed to selected providers from each field office. The surveys consisted of a wide variety of questions, including customer service levels, electronic media claim submissions, and outreach/educational seminar effectiveness. Additionally, providers were asked to evaluate the effectiveness and scope of the Medicare Program by submitting suggestions and comments that could pave the way to strengthened communications and enhanced customer service.

Meetings were scheduled with providers after the surveys were returned. While face-to-face meetings were preferred, others were accomplished over the telephone or via conference call.

Subsequently, the findings of the surveys and the provider meetings were compiled. Provider recommendations were reviewed and an action plan developed for each item where improvement was possible. Answers to specific questions, requested information, and notification of improvements implemented by MetraHealth as a result of the provider's input were communicated to the providers. This feedback was the most important and appreciated aspect of the Provider Partnering Program. It helped to build strong working relationships and customer satisfaction.

Because of the pilot's overwhelming success, MetraHealth's has implemented the Provider Partnering Program in all field offices as of October 1, 1995. Each quarter, new providers will be selected. Results and actions will be reported quarterly.

Region A DMERC to Hold Educational Seminars

The Region A DMERC has developed a workshop for new Providers, as well as those with years of experience. "Back to Basics" has been designed to include various topics on billing for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) items. Some of these topics include, but are not limited to:

- ❑ Claims accepted at the DMERC
- ❑ Information needed to submit claims
- ❑ Assigned vs. non-assigned
- ❑ HCFA-1500 Form Completion, including EMC comparable fields
- ❑ Key points of medical policy and using your Provider Manual
- ❑ Filing claims (paper vs. EMC)
- ❑ Life of a claim
  - ❑ How your claim travels through the DMERC
  - ❑ How to interpret claim status
  - ❑ Denials - what to do?

More information, along with procedures to register, will be available through the upcoming months. Please utilize the Bulletin Board System if you are an electronic claim submitter, the Automatic Response Unit at 717-735-9445, and in addition, check with your state's Supplier Association for updates on these seminars.

Seminar Schedule

March 06, 1996	Monroeville	PA
March 08, 1996	Cherry Hill	NJ
March 11, 1996	Poconos	PA
March 13, 1996	TBA	CT
March 15, 1996	New York City	NY
March 18, 1996	Rochester	NY
March 20, 1996	TBA	NY
March 22, 1996	Burlington	VT
March 25, 1996	Augusta	ME
March 28, 1996	Bedford	NH
March 29, 1996	Milford	MA

Seminar Questions

The following is a composite listing of questions the Region A DMERC received during the educational seminars.

MSP

Q1 Will handwritten "MSP" claims be returned to EMC billers whose software will not allow claims to print correctly?

Handwritten claims are acceptable, as long as they are legible.

Beneficiary

Q2 Have beneficiaries been notified of the phase-in policy on immunosuppressive drugs?

Yes, beneficiaries received notification through our newsletters (which are received by beneficiary organizations) and through our beneficiary outreach meetings throughout Region A.

Supply

Q3 Can we bill for one month if delivery is within that month?

Supplies can be billed once within the month. Please refer to specific policies when dealing with wheelchairs, parenteral nutrition, and oxygen items.

Q4 What HCPCS code is used for the following surgical dressing: packing of surgical wounds with either gauze 2x2 or packing " x 5 yards.

Refer to classification listing in the September 1995 edition of "DME Medicare News," No. 23. If the supply you are looking for is not listed, contact the SADMERC at 803-736-6809.

General

Q5 For E0935-CPAP, is a CMN necessary, and will more generalized or specific forms for items such as this be provided to suppliers?

Please refer to the listing of codes requiring CMNs in the August 1995 Special Edition of "DME Medicare News," No 22, page 4.

Q6 What documentation is required for E0192 - low pressure/positioning pad for wheelchair?

This item requires a written order prior to delivery. Please reference pages 12-23 and 12-24 of the *Supplier Manual* for a detailed explanation.

Q7 When will footnotes on wheelchairs be corrected? Example: K0001(D) and K0007(F) seem to be the same.

The footnotes were corrected in the September 1995 edition of "DME Medicare News," No 23, page 18. Footnote D states: Use K0001 if seat width is < 20 inches. Footnote F states: Use K0007 if seat width is $\geq$ 20 inches.

Q8 Are there going to be changes in coverage issues for support surfaces?

Yes, the new policies were published in the September 1995 edition of "DME Medicare News," No. 23.

Q9 We are a nonparticipating provider and would like to know how to get complementary crossovers to automatically crossover EMC claims?

At this time, the only complementary crossovers available are those listed in the March 1995 edition of "DME Medicare News," No. 17, pages 14 - 15. Complementary crossovers are based on the eligibility notification we receive from the insurance carrier. Complementary crossover occurs automatically for both participating and non-participating providers.

Q10 Do you need to carry certain diagnosis codes to the fifth digit?

The exact ICD-9 code must be used for the specific diagnosis of the patient.

Q11 I need HCFA specifications on billing aphakic contact lenses. This is for patients who have had cataract surgery but no lens implant. How often can I bill for aphakic contact lenses?

You can bill for these lenses as medically necessary. Please refer to the policy on Refractive Lenses in the *Supplier Manual*, page 13-40.

Q12 When the purchase option is chosen for the first month's submission on a power wheelchair base, is payment made in a lump sum?

Yes, payment will be made in a lump sum.

Q13 If a patient starts out on oxygen in 1993 as a Group I patient and is retested in 1995 as a Group II, does that patient need to be retested after two months?

The patient must be retested between the 61st and 90th day, following initial certification when in Group II.

Q14 Is there a prorated rate for rental wheelchairs and beds when a patient only has it for two weeks?

The supplier is entitled to bill one month rental fee for equipment used less than a month as long as the patient meets the given criteria. There is no provision for pro-rating these items.

Q15 Can you request an appeal on a prior authorization denial?

Yes, you can request one appeal on a prior authorization.

Q16 Does Medicare pay for polycarbonate lenses? If so, what code is used and what is the allowable?

No, Medicare does not pay for polycarbonate lenses.

Q17 Do rental codes BR, BU, and BP have to be used every month for months 11, 12, and 13 or only one time during these months?

The code only needs to be used once during these three months.

Q18 Does the patient need to sign an extra charge form for noncovered items; for example, coverage on a frame, noncovered lenses, tints, UV, etc.?

No, the beneficiary is responsible for noncovered charges. No waiver of liability is required.

Q19 What is the proper use of the ZX modifier?

Please refer to the particular policy in question. The proper use of the ZX modifier is explained within the policy. For further information, please refer to supplier notice #95-66.

Q20 What are the incentives to becoming a participating provider?

In addition to the information provided on page 3-18 of the *Supplier Manual*, participating providers have toll-free bulletin board access which provides numerous advantages, including access to the new beneficiary eligibility information. For further information on the bulletin board, please contact the EMC Department.

Q21 If a patient is in a skilled nursing facility, may a DME supplier bill for enteral nutrients and related supplies to Part B?

Please refer to the coverage issues listed in the *Supplier Manual* on page 13-112.

Q22 Some of our claims for KAFO are being denied as not medically necessary. How is determination currently made, and how will it be made in the future?

Determination is made by policy guidelines and criteria.

Q23 Is there a way to designate on a claim that the purpose in billing Medicare is to obtain a denial to allow the supplier to bill the proper insurer, i.e., Medical Assistance?

Procedure Code A9270 should be used for a non-covered item denial. If a procedure is covered given medical criteria, then a non-covered denial cannot be given.

Q24 If a DME item is ordered by a physician's assistant, what UPIN# is used?

The UPIN# of the physician ordering the item has to be used.

Q25 Could the reason an item is denied for prior authorization be spelled out on denial letters?

No, items are denied based on medical necessity without proper authorization or documentation.

Q26 When an individual is purchasing blood glucose testing supplies but the supplier does not know if Medicare has previously been billed for the machine, will the supplies be covered if a physician's order is present for supplies only?

As long as they meet the coverage criteria, the correct ZX modifier is used, and the beneficiary does not reside in a nursing home.

Q27 What is the proper code to bill for IPPB Circuits? The circuits will be used for an IPPB machine.

These items are not billed separately, they are included in the rental allowable for the machine, under Procedure Code E0500.

Q28 Can a visiting nurse, who is changing the dressing in a patient's home, order surgical dressing supplies and then have a physician countersign?

Surgical dressings must be ordered by a physician or a nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant acting within the scope of his or her legal authority as defined by state law or regulation.

Q29 If a nurse changes dressings in the home for a patient and trains the patient to do some of the changes themselves, are those dressings covered by Medicare?

Yes, the dressings are covered, as long as policy guidelines and criteria are met and the dressings are not considered incident to the professional services of the health care practitioner.

Q30 Why was an electronic supplier allowed to combine equipment and questions on their own CMN using DMERC questions and format but not allowed to do so on Version .02? What happened with the "Paper Reduction Act"?

At this time, a supplier can still use their own format as long as all of the required information is included.

Q31 Can a podiatrist be both the prescriber and supplier of Medicare services?

No. Podiatrists are generally prohibited by state law to treat/subscribe for systemic diabetics. Podiatrists can supply the patient as long as there is a prescription from the primary care physician.

CMNs

Q32 Does the name of the person completing the CMN, if other than the physician, need to be submitted on the EMC claims?

This information is not transmitted for EMC claims; however, it must be kept on file.

Q33 What will be done regarding grandfathering of items requiring a CMN when the Version .01 CMN expires? Will it be necessary to get Version .02 for recertification?

Version .01 CMNs will be in effect until they expire. Upon expiration, if after the April 1, 1996 cut off for Version .01 CMNs, a Version .02 CMN will need to be submitted for any required recertification.

Q34 What will happen if a fee is placed in Section C of the CMN when there is reasonable charge? Is the supplier locked into that fee?

Section C is for informational purposes to let the physicians know the charges involved. The supplier is not locked into the fee reported in Section C.

Q35 Even though the CMN for surgical dressings has been previously eliminated, will the supplier still have to have a CMN on file for audit purposes?

Please refer to "Documentation" section of the new policy on surgical dressings.

Q36 What recourse do suppliers have for equipment, time, and delivery costs when a doctor orders equipment, the supplier delivers the equipment, and then the doctor, after receiving the DMERC CMN, decides that the equipment is too expensive and refuses to sign the CMN? Can an appeal be submitted for the first-month rental, cost of drugs, etc., or can the patient be billed?

There is no recourse on this issue. There is also no appeal process and the patient cannot be billed for this reason after the fact. We suggest the supplier notify the doctor of all costs when taking the order.

Q37 Do we need a new Section C if the Medicare allowable increases; i.e., rental items during the CMN covered period?

No, Section C is for informational purposes.

Q38 For Version .02 CMNs, please clarify the financial implications that result when the attending physician is the medical director of a nursing facility and the staff completes the CMNs when supplies are provided at no cost to the facility.

A medical director who is also the attending physician for nursing home residents is permitted to fill out the CMNs on his/her patients. Any other staff employed by the nursing home is not permitted to fill out the CMN information. The medical director is the only exemption to the policy in the case where he/she is both the primary care physician and medical director. The medical director can only fill out CMNs for patients under his/her care and not for those being cared for by another physician.

Q39 When submitting a CMN to the physician, can suppliers highlight Section B and D to identify, for the physician, the sections that must be completed and signed?

Yes, as long as no answers are influenced. For example, answers to questions themselves cannot be highlighted, circled, etc.

Q40 The date that a physician prescribed a therapy for a patient was the date last seen for initial certification. Why can't this information be filled out by the supplier?

This information is in Section B of Version .01 CMN and falls within the prohibition guidelines that became effective on October 1, 1995. It has been deleted from the Version .02 CMN.

Q41 Is the warranty information required when a supplier begins to use Version .02 CMNs, or is the implementation to begin on April 1, 1996? Or, is this optional?

The warranty information is required as specified on the CMN when using Version .02. It is not optional. Instructions are on the back of the CMN.

Oxygen

Q42 Are blood gases taken on oxygen acceptable? What is the policy?

Please refer to Oxygen policy on page 13-87 of the *Supplier Manual.*

PEN

Q43 Why are separate CMN revisions required for each caloric amount? Can the DMERC policy be amended to allow for an initial CERT/CMN with the "final" caloric value?

Reimbursement is based on caloric intake; therefore, any change in calories is pertinent to the claim.

Wheelchair

Q44 Is there a time limit (2 years) for the purchase of a new wheelchair if the old chair no longer meets the patient's medical need?

There is no specific time limit. The need for a new wheelchair is based on the patient's medical necessity which must be documented, along with an explanation of what is done with the present chair.

Q45 Why aren't Tuffcare wheelchairs included in your wheelchair list?

The manufacturer must consult the SADMERC at 803-736-6809 for inclusion on the classification listing.

Coding

Q46 K0110 has no allowance in pricing for maintenance of a double/triple lumen catheter that requires daily flushes. Is there any documentation that could produce a higher weekly allowance?

No, this is the allowable for the item.

Q47 Has the coverage for Vancomycin been limited to the two conditions listed in the bulletin or has this not been determined?

No, the drug can be used where it is medically appropriate and where use applies to the criteria given for Vancomycin.

Q48 When the supplier submits a claim for a non-covered service that the patient wants, will a waiver of liability for non-assigned claims cover the supplier??

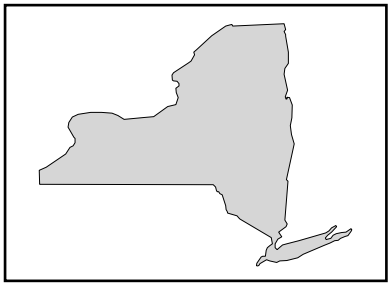
A Waiver of Liability is not required for non-assigned claims.

Ombudsmen Territories - States and Area Codes

Please refer inquiries to the appropriate Ombudsman

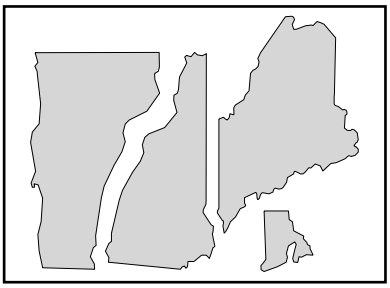
NY State
Area Codes:
315, 518, 607, 716

Tom O'Connor
717-735-9527



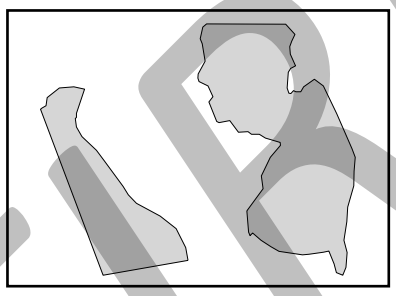
NY City and Long Island
Area Codes:
212, 516, 718, 917, 914

Dan Fedor
717-735-9414



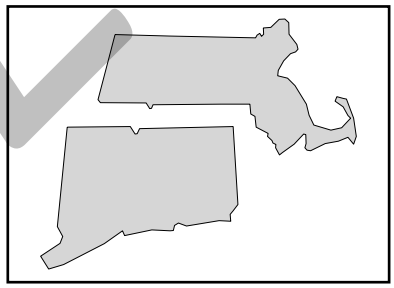
ME, NH, VT, RI
Area Codes:
207, 401, 603, 802

Michele Healey
717-735-9415



NJ, DE
Area Codes:
201, 302, 609, 908

Brian Thomas
717-735-9407

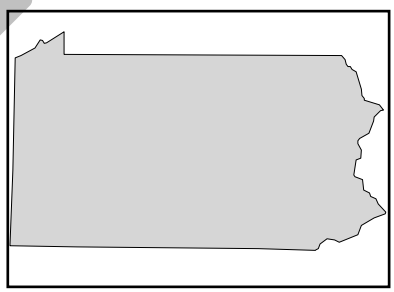


MA, CT
Area Codes:
203, 413, 508, 617, 860

Doris Spencer
717-735-9413

PA
Area Codes:
215, 412, 610

Amy Capece
717-735-9409



PA
Area Codes:
717, 814

Tracy Gusditis
717-735-9411

Miscellaneous

Important Notice to Suppliers

If you have changed your address, you must notify the National Supplier Clearinghouse (NSC) of the change. A change of address form is required and can be requested by calling the NSC at 803-754-3951. Or, you may notify the NSC by writing to:

Palmetto Government Benefits Administrators
National Supplier Clearinghouse
P.O. Box 100142
Columbia, SC 29202-3142

Failure to notify the NSC of all address changes can result in the post office not delivering DMERC correspondence to you.

Educational Seminar Booklet Correction

Please be advised that there was an error contained in the Wheelchair Options / Accessories Section of the Region A DMERC Medical Professionals and Supplier Educational Seminar Handout Booklet:

- ❑ In Attachment 2 on page 126, codes **K0019 and K0020** under Manual Wheelchair Bases, should be in **Column II**, not Column I as published.
- ❑ In addition, on page 127, codes **K0019 and K0042** under Power Wheelchair Bases, should fall under **Column II**.

Ordering HCFA-1500 Forms

If you need to order HCFA-1500 forms or negatives, please call the U.S. Government Printing Office at (202) 512-1800. The Health Care Financing Administration (HCFA) does not print these forms. In addition, there is a charge for the forms.

Post Office Box Now Available for Reconsiderations and Hearings

Please be advised that the Region A DMERC now has a P.O. Box specifically for Reconsiderations and Hearings. If you are mailing claims for reconsideration, please use the following address:

The MetraHealth Insurance Company
Region A DMERC
P.O. Box 6300
Wilkes-Barre, PA 18773-6300
Attn: Reconsiderations