DME Medicare News

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

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Region A DMERC Appoints New District Manager

We are pleased to announce that Fred Larsen, formerly District Manager of MetraHealth Government Operations in Salt Lake City, Utah, has been appointed District Manager of the Region A DMERC. In addition, Terrell Simmons, formerly Manager MetraHealth Railroad office in Augusta, GA, has joined our management team in Nanticoke as Senior Consultant. This new management team will continue the process of aligning our organization and people to most effectively address your expectations. Please join us in welcoming Fred and Terrell to the Region A DMERC.

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Revision of CMN Effective Dates

CMN Version .01 - Revised Instructions

Instructions regarding the use of the revised CMN's were published in the August special edition of "DME Medicare News," No. 22. A decision has been made to revise the transition dates from the Version .01 to the Version .02. The current .01 versions will not be accepted after April 1, 1996. The instruction paragraph, previously published, should be revised to say:

"Version .02 CMN's may be submitted with claims received by the DMERC on or after 10/1/95. Version .02 CMN's will be required with claims received by the DMERC on or after 4/1/96. The current .01 version will not be acceptable as certifying medical necessity with claims received on or after 4/1/96."

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

METRAHEALTH

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News From Region A

Letter from the District Manager

Dear Provider Community,

I want to take this opportunity to introduce myself and share my expectations for the Region A DMERC. Prior to accepting the position as District Manager, I was District Manager, MetraHealth Government Operations in Salt Lake City, Utah. I have a dedicated interest in customer service and demonstrated commitment to process improvement. In the short time I have been here, I have observed substantial changes which will lead to improved service for the provider community and for the beneficiaries you are committed to serving.

We will address areas where service levels need improvement, such as review timeliness and consistency. Given the complexity of this multi-faceted program and the volume of work we deal with, the improvement process will take some time, but it will be done.

You should expect to see a proactive, cooperative approach to DMERC Region A operations. I am confident we will achieve our goal to provide you with the highest degree of professionalism and efficiency.

Sincerely,

Frederic C. Larsen
District Manager
Region A DMERC

MetraHealth and United HealthCare Merger

We are pleased to announce that United HealthCare Corporation of Minneapolis and The MetraHealth Companies, Inc. of Vienna, Virginia, have signed a definitive agreement under which United HealthCare will acquire MetraHealth. The transaction will create the nation's largest health care management services company.

Together, United HealthCare and MetraHealth will have many unique strengths. The new company will greatly increase its ability to compete at all levels of the local and national markets with an optimal, integrated product line and service capability.

The MetraHealth Region A DMERC would like to personally inform you of this acquisition because this information is currently circulating within the business community. We would also like to assure you that it is business as usual here at the DMERC.

We at the MetraHealth Region A DMERC are looking forward to this new business endeavor. We will be supplying you with more information as it becomes available.

MetraHealth to Participate at Trade Show

MetraHealth - Region A DMERC will be in attendance at The Global Medical Products Trade Show (Medtrade) on November 15 - 18, 1995 at the Georgia World Congress Center in Atlanta, Georgia.

MetraHealth will be located at booth #5020. Be sure to stop by and visit our booth and bring your questions about durable medical equipment. There will be representatives available from the Professional Relations and EMC departments to answer any questions you may have.

Hope to see you there!!

Medical Policy

SUBJECT: Pressure Reducing Support Surfaces - Group 1

HCPCS CODES:

A4640 - Replacement pad for use with medically necessary alternating pressure pad owned by patient

A9270 - Noncovered item or service

E0180 - Pressure pad, alternating with pump

E0181 - Pressure pad, alternating with pump, heavy duty

E0182 - Pump for alternating pressure pad

E0184 - Dry pressure mattress

E0185 - Gel pressure pad for mattress

E0186 - Air pressure mattress

E0187 - Water pressure mattress

E0196 - Gel pressure mattress

E0197 - Air pressure pad for mattress

E0198 - Water pressure pad for mattress

E0199 - Dry pressure pad for mattress

E1399 - Durable medical equipment, miscellaneous

HCPCS MODIFIER:

ZX - Specific requirements found in the Documentation section of the medical policy have been met and evidence of this is available in the supplier's records.

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-9

DEFINITIONS:

Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe nonpowered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.

A gel mattress overlay (E0185) is characterized by a gel layer with a height of 2 inches or greater.

An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump.

A water mattress overlay (E0198) is characterized by a filled height of 3 inches or greater.

A foam mattress overlay (E0199) is characterized by all of the following:

1) Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g. eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay, and

2) Foam with a density and other qualities that provide adequate pressure reduction, and

3) Durable, waterproof cover.

Codes E0184, E0186, E0187 and E0196 describe nonpowered pressure reducing mattresses.

A foam mattress (E0184) is characterized by all of the following:

1) Foam height of 5 inches or greater, and

2) Foam with a density and other qualities that provide adequate pressure reduction, and

3) Durable, waterproof cover, and

4) Can be placed directly on a hospital bed frame.

An air, water or gel mattress (E0186, E0187, E0196) is characterized by all of the following:

1) Height of 5 inches or greater of the air, water, or gel layer (respectively), and

2) Durable, waterproof cover, and

3) Can be placed directly on a hospital bed frame.

Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss). They are characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of 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 2.5 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.

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

Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

COVERAGE AND PAYMENT RULES:

A group 1 mattress overlay or mattress (E0180-E0187, E0196-E0199, A4640) is covered if the patient meets:

a) criterion 1, or

b) criteria 2 or 3 and at least one of criteria 4-7.

1) Completely immobile - i.e. patient cannot make changes in body position without assistance.

2) Limited mobility - i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.

3) Any stage pressure ulcer on the trunk or pelvis.

4) Impaired nutritional status.

5) Fecal or urinary incontinence.

6) Altered sensory perception.

7) Compromised circulatory status.

When the coverage criteria for a group 1 overlay or mattress are not met, a claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case. A group 1 support surface billed without a ZX modifier (see Documentation section) will usually be denied as not medically necessary.

A foam overlay or mattress which does not have a waterproof cover is not considered durable and will be denied as noncovered.

The support surface provided for the patient should be one in which the patient does not "bottom out" (see Definition section).

A support surface which does not meet the characteristics specified in the Definition section of the support surface policies will usually be denied as not medically necessary. (See Coding Guidelines and Documentation sections concerning billing E1399.)

RELATED CLINICAL INFORMATION:

Patients needing pressure reducing support surfaces should have a care plan which has been established by the patient's physician or home care nurse, which is documented in the patient's medical records, and which generally should include the following:

1) Education of the patient and caregiver on the prevention and / or management of pressure ulcers.

2) Regular assessment by a nurse, physician, or other licensed healthcare practitioner.

3) Appropriate turning and positioning.

4) Appropriate wound care (for a stage II, III, or IV ulcer).

5) Appropriate management of moisture / incontinence.

6) Nutritional assessment and intervention consistent with the overall plan of care.

CODING GUIDELINES:

A foam overlay or mattress which does not have a waterproof cover should be coded using A9270. Other group 1 support surfaces which do not meet the characteristics specified in the Definition section should be coded using code E1399.

Either alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182, and A4640.

Code A4640 or E0182 should only be billed when they are provided as replacement components for a patient-owned powered pressure reducing mattress overlay system (E0180 or E0181).

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I	Column II
E0180	A4640 E0182
E0181	A4640 E0182

Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0180 or E0181), not as a powered mattress (E0277).

A supplier wanting to know which code to use to describe a particular product should contact the Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto Government Benefits Administrators.

DOCUMENTATION:

An order for the overlay or mattress which is signed and dated by the ordering physician must be kept on file by the supplier. The written order must be obtained prior to the delivery of the item.

The supplier must obtain information concerning which, if any, of criteria 1-7 listed in the Coverage and Payment Rules section of this policy the patient meets in a signed and dated statement from the physician. 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 anyone in a financial relationship with the supplier. This statement must be supported by information in the patient's medical record which would be available to the DMERC on request. Do not send this form to the DMERC unless specifically requested.

If a group 1 support surface is purchased and meets the criteria specified in situation (a) or (b) in the Coverage and Payment Rules section, the ZX modifier should be added to the code. If a group 1 support surface is rented and meets the criteria specified in situation (a) or (b) in the Coverage and Payment Rules section, the ZX modifier should be added to the code on all claims for that patient for the length of medical necessity established by the physician. When the initial claim for a rented group 1 support surface was submitted prior to 1/1/96 and was approved, the ZX modifier may be added to all subsequent claims. The ZX modifier may only be used when these requirements are met. If the requirements for the modifier are not met, the supplier can submit additional information with the claim to justify coverage but the ZX modifier should not be used.

If a support surface is billed using code E1399, the claim must include the following information: manufacturer and brand name of product, what support surface group (1, 2, or 3) the supplier considers it to be, why it doesn't fall into an existing code, and why it is necessary for that patient. The ZX modifier should also be added if the requirements for its use are met.

Refer to the Documentation section of the supplier manual for more information on orders, medical records, and supplier documentation.

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

This is a revision to a previously published policy.

Statement of Ordering Physician
Group 1 Support Surfaces

Patient name: _____

HIC #:_____

Cost information (to be completed by the supplier):

Supplier's charge_____

Medicare fee schedule allowance _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Indicate which of the following conditions describe the patient. Circle all that apply:

1) Completely immobile- i.e. patient cannot make changes in body position without assistance.

2) Limited mobility- i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.

3) Any pressure ulcer on the trunk or pelvis.

4) Impaired nutritional status.

5) Fecal or urinary incontinence.

6) Altered sensory perception.

7) Compromised circulatory status.

Estimated length of need (# of months):_____ (99=lifetime)

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Physician name (printed or typed): _____

Physician signature: _____

Physician UPIN:_____

Date signed: _____

SUBJECT: Pressure Reducing Support Surfaces Group 2

HCPCS CODES:

E0193 -Powered air flotation bed (low air loss therapy)
E0277 -Alternating pressure mattress
E1399 -Durable medical equipment, miscellaneous

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-9

DEFINITIONS:

Code E0277 describes a powered pressure reducing mattress (alternating pressure or low air loss) 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 mattress, and

2) Inflated cell height of the air cells through which air is being circulated is 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 mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and

4) A surface designed to reduce friction and shear, and

5) Can be placed directly on a hospital bed frame.

Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics defined above.

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.

Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the mattress and the patient's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

COVERAGE AND PAYMENT RULES:

A group 2 support surface (E0277 or E0193) is covered if the patient meets:

a) criterion 1 and 2 and 3, or

b) criterion 4, or

c) criterion 5 and 6.

1) Multiple stage II pressure ulcers located on the trunk or pelvis.

2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.

3) The ulcers have worsened or remained the same over the past month.

4) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.

5) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).

6) The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

The comprehensive ulcer treatment described in #2 above should generally include:

i) Education of the patient and caregiver on the prevention and/or management of pressure ulcers.

ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).

iii) Appropriate turning and positioning.

iv) Appropriate wound care (for a stage II, III, or IV ulcer).

v) Appropriate management of moisture/incontinence.

vi) Nutritional assessment and intervention consistent with the overall plan of care.

If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements.

The support surface provided for the patient should be one in which the patient does not "bottom out" (see Definition section).

When a group 2 surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to 60 days from the date of surgery.

When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case. A group 2 support surface billed without a ZX modifier (see Documentation section) will usually be denied as not medically necessary.

A support surface which does not meet the characteristics specified in the Definition section of the support surface policies will usually be denied as not medically necessary. (See Coding Guidelines and Documentation sections concerning billing of E1399.)

Continued use of a group 2 support surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management. In cases where a group 2 product is inappropriate, a group 1 or 3 support surface could be covered if coverage criteria for that group are met.

CODING GUIDELINES:

Group 2 support surfaces which do not meet the characteristics specified in the Definition section should be coded using code E1399.

Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.

Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0180 or E0181) not as a powered mattress (E0277).

A supplier wanting to know which code to use to describe a particular product should contact the Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto Government Benefits Administrators.

DOCUMENTATION:

An order for the mattress or bed which is signed and dated by the ordering physician must be kept on file by the supplier. The written order must be obtained prior to the delivery of the item.

The supplier must obtain information concerning which, if any, of criteria 1-6 listed in the Coverage and Payment Rules section of this policy the patient meets in a signed and dated statement from the physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to obtain this information may not be completed by the supplier or anyone in a financial relationship with the supplier. This statement must be supported by information in the patient's medical record which would be available to the DMERC on request. Do not send this form to the DMERC unless specifically requested.

If a group 2 support surface meets the criteria specified in situation (a), (b), or (c) in the Coverage and Payment Rules section, the ZX modifier should be added to the code on all claims for that patient for the length of medical necessity established by the physician. When the initial claim for a group 2 support surface was submitted prior to 1/1/96 and was approved, then (a) for subsequent claims with dates of service on or before 12/31/95, the ZX modifier may be added to the claim, or (b) for subsequent claims with dates of service on or after 1/1/96, the ZX modifier may be added to the claim if a stage II, III or IV ulcer on the trunk or pelvis is present on 1/1/96. The ZX modifier may only be used when these requirements are met. If the requirements for the modifier are not met, the supplier can submit additional information with the claim to justify coverage but the ZX modifier should not be used.

If a support surface is billed using code E1399, the claim must include the following information: manufacturer and brand name of product, what support surface group (1, 2, or 3) the supplier considers it to be, why it doesn't fall into an existing code, and why it is necessary for that patient. If the supplier considers the support surface to be a Group 2 surface, the ZX modifier should also be added if the requirements for its use are met.

Refer to the Documentation section of the supplier manual for more information on orders, medical records, and supplier documentation.

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

This is a revision to a previously published policy.

Statement of Ordering Physician
Group 2 Support Surfaces

Patient name: _____

HIC #: _____

Cost information (to be completed by the supplier):

Supplier's charge _____

Medicare fee schedule allowance _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Circle **Y** for Yes, **N** for No, **D** for Does not apply, unless otherwise noted.

Y N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?

Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of a nonpowered pressure reducing overlay or mattress or an alternating pressure or low air loss overlay?

1 2 3 3) Over the past month, the patient's ulcer(s) has / have:
1) Improved 2) Remained the same 3) Worsened?

Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery: _____

Y N D 6) Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated length of need (# of months): _____ (99=lifetime)

Physician name (Printed or typed): _____

Physician signature: _____

Physician UPIN: _____

Date signed: _____

SUBJECT: Pressure Reducing Support Surfaces Group 3

HCPCS CODE:

E0194 - Air-fluidized bed

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-19

DEFINITION:

An air fluidized bed is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.

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 tissues 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:

An air fluidized bed is covered only if all of the following criteria are met:

1) The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore.

2) The patient is bedridden or chair bound as a result of severely limited mobility.

3) In the absence of an air-fluidized bed, the patient would require institutionalization.

4) The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after conservative treatment has been tried without success.

   Treatment should generally include:

   a) Education of the patient and caregiver on the prevention and/or management of pressure ulcers,

   b) Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly,

   c) Appropriate turning and positioning,

   d) Use of a group 2 support surface, if appropriate,

   e) Appropriate wound care,

   f) Appropriate management of moisture/incontinence,

   g) Nutritional assessment and intervention consistent with the overall plan of care.

   The patient must generally have been on the conservative treatment program for at least one month prior to use of the air fluidized bed with worsening or no improvement of the ulcer. The evaluation generally must be performed within a week prior to initiation of therapy with the air fluidized bed.

5) A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.

6) A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.

7) All other alternative equipment has been considered and ruled out.

An air fluidized bed will be denied as not medically necessary under any of the following circumstances:

1) The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);

2) The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;

3) The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed;

4) Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);

5) Electrical system is insufficient for the anticipated increase in energy consumption; or

6) Other known contraindications exist.

Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement.

The medical necessity of an air fluidized bed must be recertified every month. Continued use of an air fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the bed is medically necessary for wound management.

If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case.

DOCUMENTATION:

An order for the bed which has been signed and dated by the attending physician who is caring for the patient's wounds must be kept on file by the supplier. The written order must be obtained prior to the delivery of the air fluidized bed.

A certificate of medical necessity (CMN) which has been filled out, signed and dated by the attending physician must be kept on file by the supplier. The CMN for air fluidized beds is DMERC 01. If the answer to Question 15 of the CMN is "yes", the physician must provide additional information about the prior conservative treatment which should include information about the duration of treatment, wound care (including products used and frequency of change), pressure reducing surfaces used within the last month and / or considered and ruled out (including an explanation of why it was anticipated they would not be effective), and nutritional support. The documentation of the comprehensive assessment should include information on the location of the ulcers, nutritional status, moisture control and other pressure ulcer risk factors as well as the date of the assessment and identification of the person performing the assessment. If the ulcer is less than 8 sq. cm surface area and / or it is on an area other than the posterior trunk or pelvis, there would need to be detailed documentation of why alternative treatment / equipment would not be effective.

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

The medical necessity for the bed must be recertified on a monthly basis. The documentation must include a revised CMN. If the answer to Question 22 indicates worsening or no improvement, additional documentation should be included which describes any changes in the treatment regimen which have been made or are planned.

Refer to the Documentation section of the Supplier Manual for more information on orders, CMN's, medical records, and supplier documentation.

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

This is a revision to a previously published policy.

SUBJECT: Pneumatic Compression Devices (Used for Lymphedema)

HCPCS CODES:

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

E0650 - Pneumatic compressor, non-segmental home model

E0651 - Pneumatic compressor, segmental home model without calibrated gradient pressure

E0652 - Pneumatic compressor, segmental home model with calibrated gradient pressure

E0655 - Non-segmental pneumatic appliance for use with pneumatic compressor, half arm

E0660 - Non-segmental pneumatic appliance for use with pneumatic compressor, full leg

E0665 - Non-segmental pneumatic appliance for use with pneumatic compressor, full arm

E0666 - Non-segmental pneumatic appliance for use with pneumatic compressor, half leg

E0667 - Segmental pneumatic appliance for use with pneumatic compressor, full leg

E0668 - Segmental pneumatic appliance for use with pneumatic compressor, full arm

E0669 - Segmental pneumatic appliance for use with pneumatic compressor, half leg

E0670 - Segmental pneumatic appliance, for use with pneumatic compressor, half arm

E0671 - Segmental gradient pressure pneumatic appliance, full leg

E0672 - Segmental gradient pressure pneumatic appliance, full arm

E0673 - Segmental gradient pressure pneumatic appliance, half leg

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-16

DEFINITIONS:

In this policy, the terms pneumatic compression device and lymphedema pump are considered to be the same.

A non-segmented pneumatic compressor (E0650) is a device which has a single outflow port on the compressor. The fact that the air from the single tube may be transmitted to a sleeve/appliance with multiple compartments or segments (E0671-E0673) does not affect the coding of the compressor.

A segmented pneumatic compressor (E0651, E0652) is a device which has multiple outflow ports on the compressor which lead to distinct segments on the appliance which inflate sequentially. A segmented device without calibrated gradient pressure (E0651) is one in which either (a) the same pressure is present in each segment or (b) there is a predetermined pressure gradient in successive segments but no ability to individually set or adjust pressures in each of several segments. In an E0651 device the pressure is usually set by a single control on the distal segment. A segmented device with calibrated gradient pressure (E0652) is characterized by a manual control on at least three outflow ports which can deliver an individually determined pressure to each segmental unit. The fact that the tubing and/or appliance is capable of achieving a pressure gradient does not classify the compressor as E0652 because this is not a calibrated gradient pressure.

Segmental gradient pressure pneumatic appliances (E0671-E0673) are appliances/sleeves which are used with a non-segmented pneumatic compressor (E0650) but which achieve a pressure gradient through the design of the tubing and/or air chambers.

COVERAGE AND PAYMENT RULES:

A pneumatic compression device is covered only for the treatment of refractory lymphedema involving one or more limbs. This condition is a relatively uncommon medical problem. Causes of lymphedema include:

1) radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy),

2) post-radiation fibrosis,

3) spread of malignant tumors to regional lymph nodes with lymphatic obstruction,

4) scarring of lymphatic channels,

5) onset of puberty (Milroy's Disease), and

6) congenital anomalies.

Pneumatic compression devices are only covered as a treatment of last resort, i.e., other less intensive treatments must have been tried first and found inadequate. Such treatments would include leg or arm elevation and custom fabricated gradient pressure stockings or sleeves.

Pneumatic compression devices may be covered only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient's condition to determine medical necessity of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

For patients in whom the cause of the lymphedema is scarring of the lymphatic channels (i.e., those with generalized, refractory edema from venous insufficiency which is complicated by recurrent cellulitis), a pneumatic compression device will be covered only if all of the following criteria have been met:

1) there is significant ulceration of the lower extremity(ies), and

2) the patient has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent, and

3) the ulcer(s) have failed to heal after 6 months of continuous treatment.

When a pneumatic compression device is covered, a non-segmented device (E0650) or segmented device without manual control of the pressure in each chamber (E0651) is generally sufficient to meet the clinical needs of the patient. A non-segmented compressor (E0650) with a segmented appliance/sleeve (E0671-E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667-E0669). When a segmented device with manual control of the pressure in each chamber (E0652) is ordered and provided, payment will be based on the allowance for the least costly medically appropriate alternative, E0651, unless there is clear documentation of medical necessity in the individual case. Full payment for code E0652 will be made only when there is a painful focal lesion (e.g. significant sensitive skin scar or contracture) of the extremity which requires a reduction in pressure over the affected segment that can only be provided by an E0652 device. There must be documentation that an E0651 device or its equivalent had been tried and had caused significant symptoms that were improved with this use of an E0652 device.

CODING GUIDELINES:

Code E0670 is valid only for services provided before 1/1/95. Codes E0671 - E0673 are valid only for services provided on or after 1/1/95.

A non-segmented pneumatic compressor (E0650) is used with appliances/sleeves coded by E0655-E0666 or E0671-E0673. Segmented pneumatic compressors (E0651 or E0652) are used with appliances/sleeves coded by E0667-E0669.

When a foot or hand segment is used in conjunction with a leg or arm appliance respectively, there should be no separate bill for this segment. It is considered included in the code for the leg or arm appliance.

A supplier wanting to know which code to use to describe a particular product should consult the Pneumatic Compression Device Product Classification List published by the DMERC. Questions concerning the coding of items not on the list should be directed to the Statistical Analysis DMERC (SADMERC) - Palmetto Government Benefits Administrators. For pneumatic compression devices not on the list, suppliers should use their knowledge of the product and the information in the Definition section of this policy to determine the correct code until a determination is published by the DMERC or they receive a response from the SADMERC to a coding inquiry.

DOCUMENTATION:

An order for the compressor and the appliance which has been signed and dated by the ordering physician must be kept on file by the supplier.

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 pneumatic compression devices/lymphedema pumps is DMERC 04.

The claim for a purchase or first month's rental 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 question #9 on the CMN is Yes and the patient has venous stasis ulcers, documentation supporting the medical necessity for the device should include a signed and dated statement from the ordering physician indicating:

1) the location and size of venous stasis ulcer(s),

2) how long each ulcer has been continuously present,

3) whether the patient has been treated with regular compression bandaging for the past 6 months,

4) whether the patient has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results,

5) other treatment for the venous stasis ulcer(s) during the past 6 months,

6) whether the patient has been seen regularly by a physician for treatment of venous stasis ulcer(s) during the past 6 months.

If E0652 is billed, additional documentation supporting the medical necessity for this device should include a signed and dated statement from the ordering physician indicating:

1) whether the patient has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results,

2) the treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode,

3) the location, size and etiology of the painful focal lesion which necessitates the use of this pump,

4) whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented appliance (E0671-E0673) had been tried and the results,

5) why the features of the system that was provided are needed for this patient,

6) the name, model number, and manufacturer of the device.

Questions pertaining to medical necessity on any form used to gather the above information may not be completed by the supplier or anyone in a financial relationship with the supplier. The information on the form must be supported by documentation in the patient's medical record which would be available to the DMERC upon request. If this additional information is present, the claim will generally have to be filed hard copy.

Refer to the Documentation section of the *Supplier Manual* for more information on orders, CMN's, medical records, and supplier documentation.

EFFECTIVE DATE: Claims received by the DMERC on or after 12/1/95 with dates of service on or after 6/1/95.

This is a revision to a previously published policy.

Additional Documentation Requirements

It is highly suggested for appropriate adjudication of initial claims, please submit medical documentation to support the medical necessity of the item(s) being billed for incontinence and ostomy supplies, surgical dressings, gastrostomy tubes and nasogastric tubes. For claims being submitted for individual consideration, all appropriate medical documentation must accompany the claim in question.

Example are:

If a gastrostomy tube/nasogastric tube is blocked and needs to be changed, documentation should be submitted for the date it was changed and measures taken to unblock the gastrostomy tube/nasogastric tube.

If a foley needs to be changed, documentation should be submitted with the date and reason it was changed.

If ostomy bags/pouches are changed frequently, documentation should be submitted as to date pouches are changed, medical necessity to show the reason why the pouches are changed frequently (e.g., diarrhea in excess) and length of time these supplies will be needed.

For surgical dressings, documentation should be submitted including size, location and amount of drainage from each surgical wound. Documentation should also be submitted if you are billing for different types of dressings to indicate which dressings are being used on each wound.

Certificates of Medical Necessity

Several questions have been raised recently about the appropriateness of residents signing CMN forms. Residents are allowed to sign CMNs. They are physicians. Their training licenses restrict their practice to their training program. This does not prevent them from signing CMNs. Use the UPIN RES000.

Clarification - Surgical Dressings

Surgical dressings used in conjunction with investigational wound healing therapy (e.g. platlet 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 were not being used.

Ostomy Irrigation Bags and Cones/Catheters

The current DMERC policy for Ostomy and Miscellaneous Supplies (9/93), allows billing for either A4398 (Irrigation Supply; bags) or A4399 (Irrigation Supply; Cone/Catheter). Effective immediately, the policy is being changed so that if the patient requires both items at the same time, suppliers may now bill for both codes simultaneously, if this accurately reflects necessary items dispensed to the beneficiary.

FDA Approves CellCept

Mycophenolate mofetil, CellCept (Roche), has received FDA approval as an immunosuppressive drug. It will be covered according to general policy guidelines when ordered by a physician following any Medicare covered organ transplant. Claims submitted for mycophenolate mofetil should be coded with HCPCS code XX010, Immunosuppressive Drug, Not Otherwise Classified. The name of the drug and the amount provided must also be listed in the narrative. One unit will equal 250 mg. A DMERC Information Form (DIF) or CMN must also accompany the initial claim. Effective date will be May 3, 1995, the date of FDA approval.

Enteral Nutrition

The new Enteral Nutrition policy information (page 16 of the June 1995 edition of "DME Medicare News") is an **ADDENDUM ONLY** to the existing policy.

The only changes are in the **Indications** and **General** sections of the policy. **ALL OTHER REQUIREMENTS AND GUIDELINES IN THE EXISTING POLICY STILL APPLY**.

Addition: Immunosuppressive Drugs Policy - Documentation

The following paragraph was inadvertently omitted in the Documentation Section of the Immunosuppressive Drugs Policy published in the Region A DMERC *Supplier Manual*:

A prescription (order) for the drugs which has been signed and dated by the ordering physician must be kept on file by the supplier. A new prescription would be needed if there were a change in dose or frequency of administration.

Pricing

Therapeutic Shoes

Pricing Information

The allowances, published in the March 1995 edition of "DME Medicare News" for therapeutic shoes, were made under the standard reasonable charge rules, subject to special limitations. These were the limits for codes A5500-A5507. This means there are allowances for each state, but they cannot allow more than the ceiling.

Revision

The December 1994 Issue of "*DME Medicare News*" stated that when therapeutic shoe claims for one shoe, insert or modification are provided, the appropriate modifier, right (RT) or left (LT) should be used. Please be advised that **the modifier MUST be used** for one shoe, insert or modification.

1995 Allowances for Therapeutic Shoes

	CT	DE	MA	ME	NH	NJ	NY	PA	RI	VT
A5500	58.00	59.00	59.00	59.00	59.00	59.00	56.50	59.00	56.50	59.00
A5501	169.00	169.00	178.00	169.00	169.00	175.00	169.00	175.00	169.00	169.00
A5502	29.36	28.50	28.50	28.50	28.50	35.00	28.50	30.00	28.40	28.50
A5503	28.50	28.50	28.50	28.50	28.50	30.00	28.50	20.00	28.50	28.50
A5504	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00	30.00
A5505	28.50	30.00	28.50	28.50	28.50	28.50	28.50	28.50	28.50	28.50
A5506	29.50	29.50	29.50	29.50	29.50	29.50	29.50	29.50	29.50	29.50
A5507	30.00	30.00	30.00	30.00	30.00	30.00	17.50	30.00	30.00	30.00

HCPCS Coding

DMERC Level III Code Update

Please add the following code to your Level III Code list:

XX071 Category V Enteral Product,
100 calories = 1 Unit, Propac Plus

New HCPCS Level II Codes

(Effective for Date of Service On or After October 1, 1995)

K0400 Adhesive skin support attachment for use with external breast prothesis, each

Code K0117 Deleted

Effective for date of service on or after July 1, 1995, Code K0117 (unlisted item, orthotic seating, back module) has been deleted from the HCPCS Coding System and is no longer valid for claims submission to the DMERC.

Surgical Dressing Modifiers Added

Surgical Dressing Modifiers X1 - X9 are effective and must be used with the new Surgical Dressings policy for claims received by the DMERC on or after October 1, 1995.

Urological Codes for Use with New Urological Policy

Added codes effective for date of service on or after October 1, 1995:

K0407 Urinary catheter anchoring device, adhesive skin attachment

K0408 Urinary catheter anchoring device, leg strap

K0409 Sterile water irrigation solution, 1000 ml.

K0410 Male external catheter, with adhesive coating, each

K0411 Male external catheter, with adhesive strip, each

Deleted Codes Effective for Date of Service On or After October 1,1995

K0132 Male external catheter with / without adhesive, with / without anti-reflux device, each

K0133 Intermittent urinary catheter, disposable; straight tip

K0134 Intermittent urinary catheter, disposable; coude (curved) tip

K0135 Intermittent urinary catheter, reusable; straight tip

K0136 Intermittent urinary catheter, reusable, coude (curved) tip

New codes K0410 and K0411 may be used to code items previously classified under code K0132 (after the October 1, 1995 effective date).

Verbiage Change

K0115 Seating system, back module, posterolateral control, with / without lateral supports, custom fabricated for attachment to wheelchair base

K0116 Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base

The word orthotic has been deleted from the nomenclature on the above codes.

SADMERC Helpline

SADMERC HCPCS Helpline representatives began answering fee schedule inquiries for DMEPOS on April 3, 1995. The representatives do not answer pricing questions for codes that are not on a fee schedule (i.e., reasonable charge, individually considered).

SADMERC HCPCS Helpline:
(803) 736-6809

1995 Medicare Redbook Generic Nebulizer Drugs

J7610 Acetylcysteine, 10%- $1.25 per ML

J7615 Acetylcysteine, 20%-$1.48 per ML

J7620 Albuterol Sulfate, 0.083%-$.41 per ML

J7625 Albuterol Sulfate, 0.5%-$.63 per ML

J7630 Cromolyn Sodium, per 20 MG-$.70 per 20 MG

J7640 Epinephrine, 2.25% per ML-$.69 per ML

J7650 Isoetharine Hydrochloride, 0.1% per ML-$.28 per ML

J7651 Isoetharine Hydrochloride, 0.125% per ML-$.25 per ML

J7652 Isoetharine Hydrochloride, 0.167% per ML $.30 per ML

J7653 Isoetharine Hydrochloride, .2% per ML-$.40 per ML

J7654 Isoetharine Hydrochloride, .25% per ML-$.45 per ML

J7655 Isoetharine Hydrochloride, 1% per ML-$.68 per ML

J7660 Isoproterenol Hydrochloride, 0.5% per ML-$1.91

J7665 Isoproterenol Hydrochloride, 1.0% per ML-$2.40

J7670 Metaproterenol Sulfate, 0.4% $1.23 per 2.5 ML or Unit Dose

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

J7675 Metaproterenol Sulfate, 5.0% per ML-$.80 per ML

J2545 Nebupent, $98.75 per 300 MG

XX001 Saline Solution,
.45%, 3 ML-$.08 per Unit Dose
.9%, 3 ML-$.08 per Unit Dose
.9%, 5 ML-$.08 per Unit Dose

Revised 1995 Fees for Surgical Dressing Codes

K0203, K0204, K0252, & K0253

The Statistical Analysis DME Regional Carrier (SADMERC) has calculated revised 1995 fees for the Surgical Dressing codes listed above. These fees were revised to correct errors in calculating the base fee amounts. Contractors were required to implement these changes by July 3, 1995. Please be advised, the Region A DMERC updated these fees as of June 7, 1995.

Claims with dates of service on or after January 1, 1995 which were reimbursed according to the previously established fees may be reconsidered. DO NOT RESUBMIT these claims. Please forward reconsideration requests in writing to:

Requests for Adjustment
Attention: Reconsideration Dept.

Claims with these dates of service which were originally denied may be resubmitted.

Please refer to the Region A "DME Medicare News," June 1995 edition, for the newly revised fees.

Lower Limb Prosthesis

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

When submitting a prosthetic claim to the DMERC, the billed code for knees, feet and ankles (HCPCS codes L5610-L5616, L5710-L5780, L5810-L5840, L5970-L5981, L5982-L5986) components must be submitted with modifiers K0-K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records.

Correction - K Code Listing

The following is a correction to the K Code listing published in the March 1995 edition of *DME Medicare News.*

The following K Codes are **valid** for submission to the DMERC as of **1/1/95,** per written verification from the SADMERC.

K0277 Skin barrier; solid 4X4 or equivalent, with built-in convexity, each

K0278 Skin barrier; with flange (solid, flexible, or accordion) with built-in convexity, any size, each

K0280 Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each

K0281 Lubricant, individual sterile packet, for insertion of urinary catheter, each

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

Valid K Code

The following code has been valid since January 1, 1993, for submission to the DMERC:

K0154 Wound pouch, each

Wheelchair Bases - Product Classification

Correction

The following is a correction to the Wheelchair Bases Product Classification List that was published in the June 1995 edition of *DME Medicare News.* The greater than (>) and less than (<) symbols were inadvertently omitted.

*NOTE (A): Use K0001 if seat height is greater than or equal to 19 inches and seat width is < 22 inches.

*NOTE (B): Use K0002 if seat height is less than 19 inches and seat width is < 22 inches.

*NOTE (C): Use K0006 if seat width is ô 22 inches.

*NOTE (D): Use K0001 if seat width is < 20 inches.

*NOTE (E): Use K0006 if seat width is ô 20 inches.

*NOTE (F): Use K0007 if seat width is ô 20 inches.

*NOTE (G): Use K0002 if seat width is < 20 inches.

*NOTE (H): Use code K0003 if seat height is less than 19 inches.

*NOTE (I): Code the reclining back separately using K0028.

*NOTE (J): Code the power recline/tilt separately using K0108.

Surgical Dressings Product Classification
(Partial Listing; Not All-inclusive - Updated 8/17/95)

(Editor's Note: The items in bold indicate additions since last publication)

New Codes

K0196-K0198 Alginate dressing, wound cover

Product	Manufacturer
ALGIDERM	ConvaTec
ALGOSTERIL	Johnson & Johnson
CURASORB	Kendall
FORTEX	Calgon Vestal
KALTOSTAT	Calgon Vestal
SORBSAN	Dow B. Hickam

K0199 Alginate dressing, wound filler

Product	Manufacturer
ALGIDERM	ConvaTec
ALGOSTERIL	Johnson & Johnson
CURASORB	Kendall
DERMASORB	ConvaTec
KALTOSTAT	Calgon Vestal
SORBSAN	Dow B. Hickam

K0203-K0205 Composite Dressing

Product	Manufacturer
AIRSTRIP	Smith & Nephew United
ALLDRESS	Scott
COVADERM PLUS	DeRoyal
COVERTELL	**Gentell**
CUTIFILM PLUS	Beiersdorf
TELFA EXTRA	**Kendall**
OPSITE POSTOP	Smith & Nephew United
VENTEX ABSORBENT DRESSING	Kendall
VIASORB	Sherwood

K0206-K0208 Contact Layer

Product	Manufacturer
CONFORMANT 2	Exu-Dry
DERMANET	DeRoyal
N-TERFACE	Winfield
OMIDERM	**ITG Labs**
TEGAPORE	3M
VENTEX VENTED DRESSING	Kendall

K0209-K0214 Foam Dressing, wound cover

Product	Manufacturer
ALLEVYN	Smith & Nephew United
EPIGARD	Ormed
EPI-LOCK	Calgon Vestal
HYDRASORB	Calgon Vestal
FLEXZAN	Dow B. Hickam
LYOFOAM	Acme United
LYOFOAM A	Acme United
LYOFOAM C	Acme United
MITRAFLEX PLUS	Calgon Vestal
MITRAFLEX SC	Calgon Vestal
NU-DERM	Johnson & Johnson
POLYMEN	**Ferris Manufacturing Corp.**

K0215 Foam Dressing, wound filler

Product	Manufacturer
ALLEVYN CAVITY WOUND DRESSING	Smith & Nephew United

K0217-K0221 Gauze, non-impregnated

Product	Manufacturer
GAUZE (WOVEN)	Multiple
COVERLET	Beiersdorf
EXCILON	Kendall
MIRASORB	Johnson & Johnson
NU-BREDE	Johnson & Johnson
NU-GAUZE	Johnson & Johnson
RELEASE	Johnson & Johnson
SOF-WICK	Johnson & Johnson
TELFA	Kendall
TELFA ISLAND DRESSING	Kendall
VERSALON	Kendall

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

Product	Manufacturer
ADAPTIC	Johnson & Johnson
AQUAPHOR	Beiersdorf
BIOLEX #5504 B	**Bard**
CURASALT	**Kendall**
CURITY OIL EMULSION DRESSING	Kendall
CURITY XEROFORM DRESSING	Kendall
DERMASSIST OIL EMULSION DRESSING	Wilshire
DERMASSIST PETROLATUM GAUZE	Wilshire
HYDROPHOR GAUZE	**Geritrex**
IODOFORM PACKING STRIPS	Multiple
KERLIX	**Kendall**
MESALT	Scott
PETROLATUM GAUZE	Multiple
SCARLET RED OINTMENT DRESSING	Sherwood
SPARTA HYPERTONIC SALINE DRESSING	**Sparta**
SPARTA OIL EMULSION DRESSING	Sparta
VASELINE PETROLATUM GAUZE	Sherwood
XEROFLO	Sherwood
XEROFORM PETROLATUM GAUZE	Multiple

K0228-K0230 Gauze, impregnated, water or normal saline

Product	Manufacturer
DERMAGRAN WET DRESSING	Derma Sciences
DERMASSIST WET DRESSING	Wilshire
GENTELL ISOTONIC SALINE	MKM Healthcare
GRX SALINE WET DRESSING	**Geritrex**
MPM WET SALINE DRESSING	MPM
SPARTA ISOTONIC SALINE DRESSING	**Sparta**
SPARTA STERILE WATER	**Sparta**
WET DRESSINGS	Sparta

K0234-K0239 Hydrocolloid dressing, wound cover

Product	Manufacturer
ACTIDERM	ConvaTec
COMFEEL	Coloplast
COMFEEL PLUS ULCER DRESSING	**Coloplast**
CURADERM	**Kendall**
CUTINOVA HYDRO	Beiersdorf
DERMATELL	MKM Healthcare
DUODERM	ConvaTec
HYDRAPAD	Baxter
INTACT	Bard
REPLICARE	Smith & Nephew United
RESTORE	Hollister
SWEEN-A-PEEL	Sween
TEGASORB	3M
ULTEC	Sherwood

K0240-K0241 Hydrocolloid dressing, wound filler

Product	Manufacturer
COMFEEL	Coloplast
DUODERM	ConvaTec
REPLICARE	Smith & Nephew United
TRIAD	Sween

K0242-K0247 Hydrogel dressing, wound cover

Product	Manufacturer
AQUASORB	DeRoyal
CARRAGAUZE	Carrington
CLEARSITE	New Dimensions in Medicine (NDM)
CLEARSITE HYDROGAUZE DRESSING	**New Dimensions in Medicine (NDM)**
CURAGEL	**Kendall**
CURAFIL	**Kendall**
DERMAGRAM HYDROGEL	**Derma Sciences**
DERMAGRAN HYDROPHILIC WOUND DRESSING	Derma Sciences
ELASTO-GEL	Southwest Technologies
GELIPERM WET/GRANULATE	Fougera
GENTELL HYDROGEL	MKM
GRX HYDROGEL	**Geritrex**
HYPERGEL	Scott Healthcare
MPM GEL PAD	MPM
NU-GEL	Johnson & Johnson
SECOND SKIN	Spenco
SOLO-SITE WOUND GEL	Smith & Nephew United
SPAND-GEL	Medi-Tech
THINSITE	**Braun**
TRANSORB	Brady Medical Products
VIGILON	Bard

K0248-K0249 Hydrogel dressing, wound filler

Product	Manufacturer
BARD ABSORPTION DRESSING	Bard
BIOLEX WOUND GEL	Bard
BIOLEX #5501 B	**Bard**
BIOLEX #5503 B	**Bard**
CARRASYN V	Carrington
CARRINGTON GEL WOUND DRESSING	Carrington
CURASOL GEL	Healthpoint
DUODERM HYDROACTIVE GEL	ConvaTec
GENTELL HYDROGEL	MKM Healthcare
HYPERGEL	Scott
INTRASITE GEL	Smith & Nephew United
NORMLGEL	Scott
ROYL-DERM	Acme United
SOLO-SITE WOUND GEL	**Smith & Nephew**
WOUN'DRES	Sween

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

Product	Manufacturer
DERMADROX OINTMENT	**Geritrex**
DERMADROX SPRAY	**Geritrex**

K0251-K0256 Specialty absorptive dressing

Product	Manufacturer
BAND-AID ISLAND DRESSING	Johnson & Johnson
BREAKAWAY	**Winfield Labs, Inc.**
COVADERM	DeRoyal
EXU-DRY	Frastec
GENTELL COVERTELL	MKM Healthcare
INTERSORB	Sherwood
MICRODON	3M
PRIMAPORE	Smith & Nephew
SOF-SORB	DeRoyal
SURGI-PAD	Johnson & Johnson

K0257-K0259 Transparent Film

Product	Manufacturer
ACU-DERM	Acme United
BIOCLUSIVE	Johnson & Johnson
BLISTERMFILM	Sherwood
DERMASSIST SITE DRESSING	Wilshire
ENSURE-IT	Deseret
HYDRODERM	Wilshire
OPRAFLEX	Professional Medical
OPSITE	Smith & Nephew United
POLYSKIN II	Kendall
PRO-CLUDE	Calgon Vestal
TEGADERM	3M
TRANSEAL	DeRoyal
UNIFLEX	Smith & Nephew United

K0261-K0262 Wound filler, not elsewhere classified

Product	Manufacturer
CHRONICURE	ABS Life Sciences
DEBRISAN	Johnson & Johnson
HYDRAGRAN	Baxter
IODOFLEX	**Oclassen Pharmaceuticals**
IODOSORB GEL & POWDER	**Oclassen Pharmaceuticals**
MEDIFIL	BioCore
MEDIFIL GEL	**BioCore**
MULTIDEX	Lange

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

Product	Manufacturer
SPARTA PLAIN PACKING STRIPS	**Sparta Surgical Corp.**
SPARTA IODOFORM PACKING STRIPS	**Sparta Surgical Corp.**

K0154 Wound Pouch

Product	Manufacturer
WOUND DRAINAGE COLLECTOR	Hollister
WOUND MANAGER	ConvaTec

A4649 Surgical Supply; miscellaneous

Product	Manufacturer
BIOBRANE II	Dow B. Hickam
DERMAGRAN OINTMENT	Derma Sciences
GRANULEX	Dow B. Hickam
INERPAN	Sherwood
MEDIFIL (PAD)	BioCore
SILON	Bio Med
SKIN TEMP	BioCore
SPANDAGE	**Medi-Tech International Corp.**

A9270 Non-covered item or service

Product	Manufacturer
DAMOR CREAM	**DAMOR**
DAMOR GAUZE	**DAMOR**
EPI-DERM	**Biodermics**
GRANULEX	**Dow B. Hickman**
SURGICEL	**Johnson & Johnson**

Dressings coded using A4649 should be limited to those listed. Other dressings should fall into established codes.

This appendix is a preliminary, not all-inclusive list of products falling into the new codes. Questions concerning the coding of items not on this list or the classification of a dressing on the list should be directed to the Statistical Analysis DME Regional Carrier (SADMERC), Palmetto Government Benefits Administrators. The SADMERC can be reached at (803) 736-6809, 9:00 a.m. - 12:00 p.m. and 1:00 p.m. - 4:00 p.m., Eastern Time, Monday through Friday.

Pneumatic Compression Devices/Lymphedema Pumps
Product Classification

Manufacturer / Brand Name	Model Name / #	HCPCS Code
Bio Compressions Systems / Sequential Circulator	2000	E0651
	3000	E0652
	3001	E0652
	3004	E0652
Huntleigh	Flowplus (AC330)	E0650
	Flowpress (AC300)	E0651
	Flowtron	E0650
	Lymphatron	E0651
	Lymphatron (AC340)	E0651
	Lymphatron Trio (AC350)	E0652
Jobst / Extremity Pump	Clinical Model	E0650
	System 7000	E0650
	System 7500 (II)	E0651
Kendall	Home Rx (5550)	E0651
Lympha Press	103A	E0651
	103M	E0652
	201A-Mini	E0651
	201-M	E0652
Talley / Hemaflow 2 Pump	Intermittent	E0650
	Sequential	E0651
Talley / Multicom	100	E0650
	200	E0650
	300	E0651
	300G	E0652
	500 (‘93 & ‘94 model)	E0652*
Talley / Multipulse	1000	E0652
Chattanooga	PreSsion	E0651
	PreSsion 4328 CGS	E0651
	PreSsion 4330 VGS	E0652
	4320	E0650
	4322	E0650
Advantage	2100	E0652
Wright Linear Pump	II	E0652
	IV	E0652
Ther-Con	Sequential	E0652

* Talley / Multicom model ‘92 or before = E0651

Fraud and Abuse

Doctors!
Do the Patients Need the Item(s) on the CMN/Order That You Are About to Sign?

Suggestions for Physicians

During Fraud and Abuse audits, we have found that physician's are not always aware of all the items that may be available to treat the patient's condition. All available codes are not always preprinted on the CMNs.

1. Before signing the CMN / Order, review it carefully and determine if the item is medically necessary to treat the patient.
2. Are you treating the patient for the diagnosis listed on the CMN?
3. Verify the length of medical necessity.
4. Complete the required areas on the CMN. Beware of preprinted forms which may omit available codes.
5. Did you prescribe this item for the beneficiary?
6. When did you last examine the patient for the condition requiring the DME?

Example: Item with Multiple Codes

Nebulizer Codes

E0570 Nebulizer; with compressor (e.g., Devilbiss pulmo-aid)

E0575 Nebulizer; Ultrasonic

Medical necessity varies between these two codes. Physicians should request items based on the patient's specific needs.

Rental Purchase Items

Some DME items may be rented prior to purchase. If it would be more beneficial for your patient, the rental option would allow time for the physician to determine and evaluate the effectiveness of the treatment. If appropriate, the item could be purchased.

Telephone Solicitation of Beneficiaries

Only a beneficiary's doctor should prescribe medical equipment for the beneficiary. Beware of requests to sign CMNs / Orders for DME items which you have not initiated.

Telephone solicitation of DME items is considered a fraudulent activity.

Medicare Oxygen Guidelines

The Region A DMERC Fraud and Abuse Unit recently received information that some oxygen suppliers and laboratories may be using questionable and / or fraudulent tactics in: (1) reporting of test results to physicians, and (2) violating Medicare guidelines with respect to certifying patient's needs for oxygen.

Specifically alleged are that some laboratories are requiring the patient to walk or climb stairs before or during oximetry testing; and that some suppliers are verbally reporting to physicians only partial test results which, in some cases, reflect sporadic oxygen deficiency and which results, when examined in totality, would not indicate the need for oxygen.

Initial certification or recertification claims for oxygen therapy must include the results of an arterial blood gas test or oxygen saturation measurement that has been ***ordered and the results evaluated by the according physician***.

In order for Medicare to reimburse for oxygen therapy, a physician must order the oxygen. Physicians are required to complete and sign a Certificate of Medical Necessity (CMN). The CMN for home oxygen therapy is the HCFA-484 form. By signing, the physician is acknowledging the information on the CMN to be correct and true. For physician's own protection, personal review of test results should always be done.

Moreover, it is recommended that physician's closely examine laboratory tests not only to verify needs based upon these tests, but to ensure retention of appropriate documentation in the patient's / physician's file.

The following is the medical policy regarding coverage criteria for Home Oxygen Therapy (Region A Medical Policy DMERC Manual Section 13.31).

The following conditions must be met:

- ❑ The attending physician has determined that the patient suffers a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy; and the patient's blood gas levels indicate the need for oxygen therapy; and alternative treatment measures have been attempted and considered clinically ineffective.

- ❑ Arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken at rest

- ❑ Arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken during sleep for a patient who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial saturation at or above 89%, while awake, or a greater than normal fail in oxygen level during sleep (a decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial saturation more than 5%) associated with symptoms or signs reasonable attributable to hypoxemia (e.g., corpulmonale, "P" pulmonate or EKG, documented pulmonary hypertension and erythrocytosis). In either of these cases, coverage is provided only for nocturnal use of oxygen.

- ❑ An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89% during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Group II

Coverage for patients whose arterial PO2 is 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89% *if any of the following are documented*:

- ❑ Dependent edema suggesting congestive heart failure, Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram or "P" pulmonale of EKG (P wave greater than 3 mm in Standard Leads II, III or AVF), or

- ❑ Erythrocythemia with a hematocrit greater than 56%.

Group III

In processing claims for home oxygen therapy, Medicare *must* presume that home use of oxygen is not medically necessary for patients with arterial PO2 at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Note: The conditions under which laboratory tests are preformed must be specified in writing and submitted with the initial claim. Examples of this documentation may include: at rest, while sleeping, while exercising on room air or if while on oxygen, the amount, body position during testing and similar information necessary for interpreting the evidence.

When a patient's initial certification for oxygen is approved based on an arterial PO2 of 56 mm Hg or greater or an oxygen saturation of 89% or greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

Moreover, it is recommended that physicians closely examine lab tests not only to verify needs based upon these tests, but as well to ensure retention of appropriate documentation in the patient's / physician's files.

See Region A Medical Policy of the "Supplier Manual," Section 13.31, Page 13-89, for more information on documentation criteria.

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

Medicare Secondary Payer

Are Your MSP Claims Denied or Paid Incorrectly?

A study of Medicare Secondary Payer claims has revealed the following common errors and reasons why your Medicare Secondary claims may be denied or paid incorrectly.

- ❑ 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's 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 we have on record as primary (we 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 would only be denied as a duplicate.

When you receive a Medicare Secondary Payer denial, please send a copy of our denial, along with the appropriate Explanation of Benefits from the primary insurance company, to:

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

Your original claim will be adjusted for proper payment.

Electronic Media Claims

Beneficiary Eligibility Data Implementation

The Beneficiary Eligibility Inquiry System for Region A suppliers, who meet all criteria, is now available. It is offered to participating physicians, suppliers, and their authorized billing agents, who bill the DMERC electronically. This system will help us provide better customer service to those suppliers who participate in the Medicare program.

Participating providers and their authorized billing agents will be able to request eligibility information by using an Asynch Telecommunications Connection, along with a predefined HCFA format. Access will be provided on a "toll" basis; that is, the EMC submitter will incur wire charges. The information made available includes:

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

Access to this information would require, at a minimum, the beneficiary's health claim insurance number (HICN), surname, first initial, and gender.

There was a new file format instruction booklet released on July 1, 1995. If you would like the new programming requirements or if you have any questions, please call the EMC Support Team at 717-735-9528 or 717-735-9532.

New Modems Available For Electronic Submitters

Attention owners of 14.4k and 28.8k modems. Four 28.8k modems have been added to the Bulletin Board System. These modems can be accessed at speeds of 14k and above, only. To connect to these lines, please call 717-735-9688.

Due to the limited number of 28.8k modems, the lines may be busy. If you receive a busy signal, call back at a later time or connect at 9600 baud on our regular lines.

To ensure the best performance from these modems, we suggest that you use a transfer protocol of Z-Modem, Y-Modem (batch) or SuperKermit. Questions concerning transmission on these new modems can be answered by our EMC Unit at 717-735-9530 or 717-735-9521.

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 will 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.

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	

National Standard Format - Version 2.0

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

As of July 1, 1995, Version 002.00 of the National Standard Format (NSF) Matrix became available. The implementation date for Version 002.00 is 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.

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 clerically processed in your office, deposited and then cleared by the bank. With EFT, however, Medicare determines the amount that needs to be paid on your claim and electronically notifies Citibank of the amount. At this point Citibank sends the payment to your bank, who, 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

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 receive EFTs, paper EOMBs will stop after 30 days.)

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

Please note that Region A has recently set up their first suppliers with EFTs.

"Zipped" EMC Files

The Region A DMERC EMC Unit can accept production files which are submitted in a compressed format. This allows for multiple files to be sent 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.

Advantages of Electronic Billing

A 13-Day vs. 27-Day Payment Floor for Clean Claims. This begins on the day of receipt of the claim(s). Claims can be submitted electronically 7 days a week, including holidays. The paper claim floor is 27 days. The 27 days begin after the mailroom receives the claim.

- ❑ Increased cash flow.
- ❑ Reduced Cost. Handling time and postage of paper claim submission is eliminated.
- ❑ Reduced Errors. Data is received precisely as input by your office, eliminating the chance of processing errors.
- ❑ Electronic CMNs. CMNs can be transmitted electronically.
- ❑ ERNs and EFTs. Electronic Remittance Notices and Electronic Funds Transfers are available for faster posting.
- ❑ On-Line Claims Status / Weekly Status Report. Pending claim status for assigned claims can be reviewed daily or weekly.
- ❑ Electronic File Acknowledgements.
- ❑ Electronic Eligibility for Participating Physicians and Suppliers.
- ❑ 28.8 Modem Capability for Faster Submission.
- ❑ Unit Dedicated Solely to EMC Support.

Revision to the Electronic Acknowledgement Specifications

There is a correction that needs to be made to file layout for electronic acknowledgements. If you are writing a program to read the acknowledgement reports that are on the Bulletin Board, please make a correction to your file layout booklet. Field 40 should be 20 characters in length - position 510-529. If you have any questions, please contact the EMC Department.

Additional Documentation for Wheelchairs

Additional documentation for EMC custom wheelchair claims should be sent to the attention of:

Region A DMERC
The MetraHealth Insurance Company
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Carol Menichillo, Wheelchair Unit

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. Region A 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.

Accelerate

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

EMC is available to both participating and non-participating suppliers. Assigned and non-assigned claims are accepted. For more information, complete the form below and return it to the EMC Department by mail or fax.

If you have specific questions, please call 717-735-9532 or 717-735-9531.

✂ -

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 ___________________________

Telephone ( ) ____

Contact Person ____

Volume of Medicare DMEPOS claims per month _______________________________________

Mail to:

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

FAX to:

Attn: EMC Department
717-735-9510

Professional Relations

Announcement

The Region A DMERC announces the following Ombudsman appointment:

Michele Healey
Professional Relations
Ombudsman - Maine, New Hampshire,
Rhode Island and Vermont
717-735-9415

Doris Spencer will be the Ombudsman for Connecticut and Massachusetts **only.**

Provider Phone Calls to the DMERC

The Region A DMERC Ombudsmen have been receiving phone calls that can be handled by our Provider Services Unit. Our Provider Services Unit is trained to accept calls that need immediate answers. The following types of questions should be directed to the Provider Services Unit:

- ❑ Allowed amounts for certain codes
- ❑ Coverage issues
- ❑ Denial code information
- ❑ Receipt of claim by the DMERC

This unit can be contacted Monday through Friday, from 8:00 a.m. to 4:00 p.m., at 717-735-9445.

If you are unable to resolve the problem or have not received satisfaction with the Provider Services Unit, then your next step is to call your Ombudsman. The Ombudsman will need to investigate the problem and call you back with a response. To avoid delay in resolving the problem, do not contact any other representative concerning the same issue. Also, the Ombudsman is available for educational purposes regarding billing procedures, medical policies and questions concerning multiple claims.

Please remember, your Ombudsman is the liaison between the Supplier Community and Medicare, therefore the Ombudsman's role is to achieve satisfaction for all parties. The Region A Ombudsmen are:

- ❑ Dan Fedor — 717-735-9414 — New York
- ❑ Amy Capece — 717-735-9409 — Pennsylvania
- ❑ Brian Thomas — 717-735-9407 — New Jersey and Delaware
- ❑ Doris Spencer — 717-735-9413, 203-639-3150 — Connecticut and Massachusetts
- ❑ Michele Healey — 717-735-9415 — Maine, New Hampshire, Rhode Island, Vermont

When you need the correct code to use for a certain DMERC item, call the Statistical Analysis DME Regional Carrier, SADMERC, at 803-736-6809.

If you are calling regarding the correct way to bill electronically or to see if electronic claims have been received, these calls should be directed to our EMC Unit. Phone numbers for the EMC Unit are 717-735-9517, 717-735-9518 and 717-735-9519.

DMERC Meets With Supplier Associations

During the past month, the Management staff of the Region A DMERC met with both The New York Medical Equipment Providers Association (NYMEP) and the New England Medical Equipment Dealers Association (NEMED). During these open discussions, the Associations were able to address their concerns to the DMERC. Both meetings proved to be effective in establishing an open line of communication between the DMERC and the Supplier community.

Educational Seminars Conclude

The Educational Seminars conducted by the Professional Relations Unit of the Region A DMERC will conclude the first week of October. Region A began these seminars in August of this year in order to educate Medical Professionals and Suppliers on such topics as Medical Policy and Documentation, the revised Certificates of Medical Necessity and Fraud and Abuse. Professional Relations is in the process of reviewing the seminar surveys and plans to publish questions submitted with corresponding answers. We thank all providers for your participation and feedback.

Miscellaneous

ICD-9-CM Addendum

The Government Printing Office (GPO) is no longer publishing the Addendum for International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). In the past, the GPO automatically sent out addendums to carriers and providers who originally purchased their ICD-9-CM books from them. We have recently been informed that the GPO will no longer provide this service.

The Bureau of Program Operations in Baltimore will be sending out copies of the addendum to all carriers as soon as they are received from the publisher. If you need to obtain copies of the addendum, please contact the American Hospital Association (AHA) at 1-800-242-2626. There is no cost for AHA members, however, for non-members, there will be a small fee.

Acknowledgment Letter Revision

The June 1995 issue of *DME Medicare News* and Supplier Notice 95-24, stated that acknowledgement letters would be sent on **all** claims received for review. Please be advised that when a package of claims is received in review, **all** reviews in the package are statused. However, the acknowledgement letter is issued only on the first claim in the package. Therefore, in order to maintain an accurate record of accounts receivable, please keep track of all claims submitted in the package with the initial claim. When calling in for claims status, you will need the beneficiary HIC numbers, claim control numbers and the dates of service.

Modernized Medical Equipment and Accessories Available

Attention:
Physicians, Suppliers and Medical Professionals

There has been a great advancement in the medical equipment being manufactured over the last several years. The technology continues to advance to make medical equipment easier, safer and more effective. The wheelchairs are smaller, sleeker, lighter and can turn around in small areas. More and more medical equipment has been manufactured to be consumer friendly. Physicians, suppliers and medical professionals need to keep updated on what medical products have changed over the years, so when they are prescribing/supplying these items, the right equipment will be given to the beneficiary.

There are many ways to keep abreast on the new products being produced, by: attending tradeshows; subscribing to journals; attending educational seminars, either local or national; or requesting literature (from manufacturers) to be sent on a regular basis.

Correction

The August edition of "DME Medicare News" has the effective date for the new interest rate as July 1, 1996. ***Please be advised that the correct effective date for this interest rate is July 1, 1995.***

Filing Clean HCFA-1500 Forms

Reminder

Before submitting your claim, please double-check the following items:

1. Correct HIC in Block 1A or record DA0 field 18, if electronic
2. Complete patient address information in Block 5 or record CA0 fields 11-16, if electronic
3. Correct Medigap documentation in Blocks 9, 9A, 9B, 9C, & 9D or record DA0 fields 10-11, 19-24 and record DA2 field 12, if electronic
4. Available MSP indication in Blocks 10A, 10B, & 10C or record EA0 field 4-5, if electronic
5. Correct ICD-9 diagnosis codes in Block 21 or record EA0 field 30-33, if electronic, along with correct diagnosis link in Block 24E or record FA0 fields 14-17, if electronic
6. Complete information in all of Block 24 or record FA0 fields 5-18, 20-21, 23 and record FB0 field 22, if electronic
7. Assignment indicator inside the choice square in Block 27 or record EA0 field 34, if electronic
8. Complete provider billing information in Blocks 31, 32, & 33 or record EA0 fields 35-37, record EA1 fields 4, 6-10, record BA0 fields 2 & 9, if electronic