DME Medicare News

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

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Important Message from Medicare

The purpose of this letter is to advise you that on January 1, 1996, the Health Care Financing Administration (HCFA), through its Medicare carriers, implemented a national coding initiative (edits apply only to dates of services on or after January 1, 1996). The goal of the initiative is to identify and eliminate the incorrect coding of medical services. This initiative was implemented via the installation of a set of new "edits" into each of the Medicare Carrier's automated claims processing systems.

The new package of claims processing "edits" primarily focuses on comparing the CPT codes for those situations where two or more services are provided to one beneficiary on the same day. These edits identify situations where outdated codes are being used, the CPT definitions for some services may have been misunderstood or misinterpreted, mutually exclusive procedures have been coded together, or simply a mistake has been in the coding. Additionally, a new "GB" modifier has been established to help the Medicare carriers identify when distinct procedures have been performed by the same physician on the same day. Appropriate use of this modifier permits payment for services that would otherwise be deemed as incorrect coding.

Physicians and others who have been correctly coding for their services and routinely keep abreast of changes in the CPT coding system should experience little or no disruption in the processing of their Medicare claims.

HCFA developed the package of "edits" under a contract with a Medicare contractor. The contractor has reviewed the code definitions for all CPT codes. In addition, we sought the advice of a broad range of physicians and specialists concerning current standard medical and surgical practices. We will be making periodic revisions and updates to the coding package. Therefore, we would encourage you to work through your local specialty society to make suggestions concerning corrections and / or improvements to this initiative.

We are confident that the implementation of this initiative will greatly facilitate our efforts to ensure that Medicare claims are processed quickly and paid correctly. Any questions you may have about specific claims or this initiative should be directed to your local Medicare carrier.

Additional Information

Medicare's Correct Coding Initiative for 1996

Coding Edits are Categorized Under the Following General Principles:

- ❑ Coding based on standards of medical/surgical practice;
- ❑ Coding included in medical/surgical packages;
- ❑ Coding within CPT definitions;
  - Separate procedures
  - Families of codes
  - Most extensive procedures
  - Sequential procedures
- ❑ Coding with designation of sex;
- ❑ Coding mutually exclusive procedures

Reasons Some Claims May be Affected

- ❑ Unclear understanding or misinterpretation of some CPT coding definitions of services;
- ❑ Use of an outdated version of CPT to code services;
- ❑ Mistake in coding; and/or
- ❑ A belief that providing the services in question is a legitimate way to represent the services provided to the beneficiary. In these cases, physicians and others should contact their local Medicare carrier directly with their concerns.

Note: We will be updating the coding edits package periodically. Your comments concerning the package will be taken into consideration.

We re-processed a sample of 1993 Medicare claims against the new package of edits. The following are some examples of the edits that occurred most frequently in this sample:

Example of Edits

CPT Code for Comprehensive Service	CPT Code for Component Service Billed on the Same Day as the Comprehensive Service	Explanation
90780-IV Infusion	36000-Introduction of Needle or Intra Catheter	The comprehensive code describes services involving infusion. Because the placement is of peripheral vascular access devices integral to vascular infusions, the CPT code or placement of needle or intra catheter is not to be billed separately.
93731-93736-Pacemaker Analysis	93041 EKGs 93042 EKGs 93012 EKGs 93014 EKGs	The codes for pacemaker evaluation and analysis include in their definition the electrocardiographic recordings and interpretation of recordings.
71020-Radiologic examination, chest, two views	71010-Radiologic examination, chest, single view	The frontal view is included in the two view chest x-ray.

How to Order?

- ❑ To order HCFA's National Coding Policy Manual for Part B Medicare Carriers, by mail, please call the National Technical Information service (NTIS) Sales Desk at (703) 487-4650.
  - Ask for a paper copy of the base manual by asking for PB96-957699LMJ at $189.00 plus handling fee.
  - Ask for diskette copy by asking for PB96-500111LMJ at $90.00 plus handling fee (WordPerfect 5.0 in compressed files).
  - For specific chapters, refer to the section titled Individual Chapters.
- ❑ RUSH service is available for an additional fee. Call 1-800-553-NTI.
- ❑ Updates to the base manual in paper are available in Standing Order as PB96-957600LMJ. To receive the updates automatically, call the NTIS Subscription Department at (703) 487-4630.

"Individual Chapters" National Medicare Correct Coding Policy Manual

The manual consists of two volumes. These volumes include a table of contents, 12 chapters, an index and two attachments. The chapters are organized by CPT coding for medical procedures and services except for Chapter I, which contains general correct coding policies and Chapter XII, which addresses HCPCS Level II codes under the Part B carrier's jurisdiction.

Ask for Individual Chapters as Follows:

Chapter I & XII (includes Introduction and Attachments) General Correct Coding Policies, Index, Deleted Codes, and HCPCS Level II Codes by PB96-127014MJ at $36.50 plus handling	(CPT CODE)
Chapter II - Anesthesia Services by PB96-127022LMJ at $112.00 plus handling	00100-01999
Chapter III - Surgery: Integumentary System by PB96-127030LMJ at $19.50 plus handling	10000-19999
Chapter IV - Surgery: Musculoskeletal System by PB96-127048-LMJ at $36.50 plus shipping and handling	20000-29999
Chapter V - Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic System by PB96-127055LMJ at $19.50 plus handling	30000-29999
Chapter VI - Surgery: Digestive System by PB96-127063LMJ at $19.50 plus handling	40000-49999
Chapter VII - Surgery: Urinary, Male Genital, Female Genital, Maternity Care, and Delivery System by PB96-127071LMJ	50000-59999
Chapter VIII - Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, Auditory System by PB96-127089LMJ at $17.50 plus handling	60000-69999
Chapter IX - Radiology Service by PB96-127097LMJ at $19.50 plus handling	70000-79999
Chapter X - Pathology and Laboratory Services by PB96-127105LMJ at $17.50 plus handling	80000-89999
Chapter XI - Medicine, Evaluation and Management Services	90000-99999

Attention

Updates to the paper base manual are available on Standing Order as PB96-957600LMJ. To receive updates automatically, please call the NTIS Subscription Department at (703) 487-4630.

Rebundling Edits for Comprehensive Codes A0000-V9999

Editor's Note: The codes published below are those applicable to the DMERC. The presence of a code does not automatically guarantee coverage. If you order Specific chapters of the Coding Policy Manual, you will have all the codes included in that range.

Correspondence Language

Comprehensive	Component	Standard Policy Statement
A5071	A5072	"With" versus "without" procedures
A5074	A4361	CPT procedure code definition

Mutually Exclusive Codes Table

Correspondence Language

Column I	Column II	Standard Policy Statement
E0781	E0782	Mutually Exclusive Procedures
J2270	J2275	Mutually Exclusive Procedures
J9000	J9010	Mutually Exclusive Procedures
J9060	J9062	Mutually Exclusive Procedures
J9070	J9080	Mutually Exclusive Procedures
J9070	J9090	Mutually Exclusive Procedures
J9080	J9090	Mutually Exclusive Procedures
J9091	J9092	Mutually Exclusive Procedures
J9093	J9094	Mutually Exclusive Procedures
J9093	J9095	Mutually Exclusive Procedures
J9094	J9095	Mutually Exclusive Procedures
J9096	J9097	Mutually Exclusive Procedures
J9100	J9110	Mutually exclusive Procedures
J9130	J9140	Mutually Exclusive Procedures
J9181	J9182	Mutually Exclusive Procedures
J9250	J9260	Mutually Exclusive Procedures
J9280	J9290	Mutually Exclusive Procedures
J9280	J9291	Mutually Exclusive Procedures
J9290	J9291	Mutually Exclusive Procedures
J9370	J9375	Mutually Exclusive Procedures
J9370	J9380	Mutually Exclusive Procedures
J9375	J9380	Mutually Exclusive Procedures

Medical Policy

Editor's Note: Text shown in italics indicates revisions from previously published policies.

Enteral Nutrition

HCPCS CODES

B4034 Enteral feeding supply kit; syringe, per day

B4035 Enteral feeding supply kit; pump fed, per day

B4036 Enteral feeding supply kit, gravity fed, per day

B4081 Nasogastric tubing with stylet

B4082 Nasogastric tubing without stylet

B4083 Stomach tube - levine type

B4084 Gastrostomy/jejunostomy tubing

B4150 Enteral formulae; category I; semi-synthetic intact protein/isolates(e.g., Enrich, Ensure, Ensure HN, Ensure Powder,Isocal, Lonalac Powder, Meritene, Meritene Powder, Osmolite, Osmolite HN, Portagen Powder, Sustacal, Renu, Sustagen Powder, Travasorb) 100 calories = 1 unit

B4151 Enteral formulae; category I: natural intact protein/protein isolates (e.g., Compleat B, Vitaneed, Compleat B Modified) 100 calories = 1 unit

B4152 Enteral formulae; category II: intact protein/protein isolates (calorically dense) (e.g., Magnacal, Isocal HCN, Sustacal HC, Ensure Plus, Ensure Plus HN) 100 calories = 1 unit

B4153 Enteral formulae; category III: hydrolized protein/amino acids (e.g., Criticare HN, Vivonex T.E.N. (Total Enteral Nutrition), Vivonex HN, Vital (Vital HN), Travasorb HN, Isotein HN, Precision HN, Precision Isotonic) 100 calories = 1 unit

B4154 Enteral formulae; category IV: defined formula for special metabolic need, (e.g., Hepatic-Aid, Travasorb Hepatic, Travasorb MCT, AminAid) 100 calories = 1 unit

B4155 Enteral formulae; category V: modular components (protein, carbohydrates, fat) (e.g., Propac, Gerval Protein, Promix, Casec, Moducal, Controlyte, Polycose liquid or powder, Sumacal, Microlipids, MCT Oil, Nutri-source) 100 calories = 1 unit

B4156 Enteral formulae; category VI: standardized nutrients Vivonex STD., Travasorb STD. Precision LR and Tolerex) 100 calories = 1 unit

B9000 Enteral nutrition infusion pump - without alarm

B9002 Enteral nutrition infusion pump - with alarm

B9998 NOC for enteral supplies

E0776 IV pole

K0147 Gastrostomy tube, silicone with sliding ring

XX030 Category IV enteral product, 100 calories = 1 unit, Accupep HPF

XX031 Category IV enteral product, 100 calories = 1 unit, AminAid

XX032 Category IV enteral product, 100 calories = 1 unit, Entera OPD

XX033 Category IV enteral product, 100 calories = 1 unit, Glucerna

XX034 Category IV enteral product, 100 calories = 1 unit, Hepatic Aid

XX035 Category IV enteral product, 100 calories = 1 unit, Impact

XX036 Category IV enteral product, 100 calories = 1 unit, Impact with Fiber

XX037 Category IV enteral product, 100 calories = 1 unit, Immun-Aid

XX038 Category IV enteral product, 100 calories = 1 unit, Lipisorb

XX039 Category IV enteral product, 100 calories = 1 unit, Nepro

XX040 Category IV enteral product, 100 calories = 1 unit, Replete

XX041 Category IV enteral product, 100 calories = 1 unit, Replete with Fiber

XX042 Category IV enteral product, 100 calories = 1 unit, NutriHep

XX043 Category IV enteral product, 100 calories = 1 unit, NutriVent

XX044 Category IV enteral product, 100 calories = 1 unit, Peptamen

XX045 Category IV enteral product, 100 calories = 1 unit, Perative

XX046 Category IV enteral product, 100 calories = 1 unit, Pregestimil

XX047 Category IV enteral product, 100 calories = 1 unit, Protain XL

XX048 Category IV enteral product, 100 calories = 1 unit, Provide

XX049 Category IV enteral product, 100 calories = 1 unit, Pulmocare

XX050 Category IV enteral product, 100 calories = 1 unit, Reabilan HN

XX051 Category IV enteral product, 100 calories = 1 unit, Suplena

XX052 Category IV enteral product, 100 calories = 1 unit, Stresstein

XX053 Category IV enteral product, 100 calories = 1 unit, Traumacal

XX054 Category IV enteral product, 100 calories = 1 unit, Traum-Aid HBC

XX055 Category IV enteral product, 100 calories = 1 unit, Travasorb Hepatic

XX056 Category IV enteral product, 100 calories = 1 unit, Travasorb MCT

XX057 Category IV enteral product, 100 calories = 1 unit, Travasorb Renal

XX058 Category IV enteral product, 100 calories = 1 unit, Vivonex T.E.N.

XX059 Category V enteral product, 100 calories = 1 unit, Casec

XX060 Category V enteral product, 100 calories = 1 unit, Controlyte

XX061 Category V enteral product, 100 calories = 1 unit, Elementra

XX062 Category V enteral product, 100 calories = 1 unit, Fibrad

XX063 Category V enteral product, 100 calories = 1 unit, Lipomul

XX064 Category V enteral product, 100 calories = 1 unit, MCT Oil

XX065 Category V enteral product, 100 calories = 1 unit, Microlipid

XX066 Category V enteral product, 100 calories = 1 unit, Moducal

XX067 Category V enteral product, 100 calories = 1 unit, Nutrisource

XX068 Category V enteral product, 100 calories = 1 unit, Polycose

XX069 Category V enteral product, 100 calories = 1 unit, Promod

XX070 Category V enteral product, 100 calories = 1 unit, Promix

XX071 Category V enteral product, 100 calories = 1 unit, Propac

XX072 Category V enteral product, 100 calories = 1 unit, Sumacal

XX073 Category IV enteral product, 100 calories = 1 unit, Advera

XX074 Category IV enteral product, 100 calories = 1 unit, Crucial

XX075 Category IV enteral product, 100 calories = 1 unit, Diabetisource

XX076 Category IV enteral product, 100 calories = 1 unit, Isosource VHN

XX077 Category IV enteral product, 100 calories = 1 unit, Vivonex Plus

XX078 Category IV enteral product, 100 calories = 1 unit, Sandosource Peptide

XX079 Category IV enteral product, 100 calories = 1 unit, L-Emental Plus

XX080 Category IV enteral product, 100 calories = 1 unit, Pro-Peptide

XX081 Category IV enteral product, 100 calories = 1 unit, Peptamen VHP

XX082 Category IV enteral product, 100 calories = 1 unit, Impact 1.5

XX083 Category IV enteral product, 100 calories = 1 unit, Renalcal

XX084 Category IV enteral product, 100 calories = 1 unit, Pro-Peptide VHN

REFERENCE: Coverage Issues Manual 65-10

BENEFIT CATEGORY: Prosthetic Device

DEFINITION:

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine.

HCPCS MODIFIERS:

XA IV pole used in conjunction with parenteral or enteral nutrition

ZY Potentially noncovered item or service billed for denial or at beneficiary's request (not to be used for medical necessity denials).

COVERAGE AND PAYMENT RULES:

General:

Enteral nutrition is covered for a patient who has (a) permanent nonfunction or disease of the structures that normally permit food to reach the small bowel or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.

The patient must have a permanent impairment. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Enteral nutrition will be denied as noncovered in situations involving temporary impairments.

The patient's condition could be either anatomic (e.g., obstruction due to head and neck cancer or reconstructive surgery, etc.) or due to a motility disorder (e.g., severe dysphagia following a stroke, etc.). Enteral nutrition is noncovered for patients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.

The patient must require tube feedings to maintain weight and strength commensurate with the patient s overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements. Coverage is possible for patients with partial impairments - e.g., a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome a problem with absorption.

Enteral nutrition products that are administered orally and related supplies are noncovered.

If the coverage requirements for enteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

No more than one month's supply of enteral nutrients, equipment or supplies is allowed for one month's prospective billing. Claims submitted retroactively, however, may include multiple months.

The ordering physician is expected to see the patient within 30 days prior to the initial certification. If the physician did not see the patient within this timeframe, he/she must document the reason why and describe what other monitoring methods were used to evaluate the patient s enteral nutrition needs.

Enteral nutrition provided by a skilled nursing facility (SNF) to a Part A covered patient is billed by the SNF to the fiscal intermediary. No payment from Part B is available to a SNF when the SNF furnishes enteral nutrition services to a beneficiary in a stay covered by Part A. However, enteral nutrition provided by an outside supplier to a Part A covered patient is eligible for Part B coverage and is billed to the DMERC. Furthermore, if a beneficiary is not covered by Part A, enteral nutrition is eligible for coverage under Part B and is billed to the DMERC regardless of whether it is furnished by a SNF or an outside supplier.

Nutrients:

Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150) are appropriate for the majority of patients requiring enteral nutrition. Formulas consisting of natural intact protein/protein isolates, code B4151, are covered for patients with an allergy or intolerance to semi-synthetic formulas (B4150). Calorically dense formulas (B4152) are covered if they are ordered and are medically necessary. The medical necessity for special enteral formulas (products other than B4150 or B4152) will need to be justified in each patient. If the medical necessity for these formulas is not substantiated, payment will be based on the allowance for the least costly alternative, usually code B4150.

Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as noncovered.

A total daily caloric intake of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate

body weight in most patients. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual patient. This information must be available to the DMERC on request.

Equipment and Supplies:

Enteral nutrition may be administered by syringe, gravity, or pump. Some enteral patients may experience complications associated with syringe or gravity method of administration. If a pump (B9000-B9002) is ordered, there must be documentation accompanying the CMN to justify its use (e.g., gravity feeding is not satisfactory due to reflux and / or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml / hr, blood glucose fluctuations, circulatory overload). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.

The feeding supply kit (B4034-B4036) must correspond to the method of administration. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based on the allowance for the least costly alternative, B4036.

More than three nasogastric tubes (B4081-B4083), or one gastrostomy or jejunostomy tube (B4084, K0147) every three months is rarely medically necessary.

CODING GUIDELINES:

When enteral nutrition is covered, dressings used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit code (B4034-B4036) and should not be billed separately using dressing codes.

Categories of enteral nutrition are based on the composition and source of ingredients in each enteral nutrient product. A supplier wanting to know which code to use for a particular product may contact the Statistical Analysis DME Regional Carrier (SADMERC) - Palmetto Government Benefits Administrators.

When an IV pole (E0776) is used for enteral nutrition administered by gravity or a pump, the XA modifier should be added to the code.

DOCUMENTATION:

With initial claims for enteral nutrition formulas, pumps and IV poles, a certificate of medical necessity (CMN) must be submitted to the DMERC. Section B of the CMN for enteral nutrition may be completed by someone other than the ordering physician, so long as it is not anyone in a financial relationship with the supplier. However, the CMN must be reviewed for the accuracy of the information and signed and dated by the ordering physician to indicate agreement. The CMN for enteral nutrition is DMERC 10.

Regularly scheduled recertifications are no longer necessary with the effective date of this policy. However, recertifications may be requested on an individual basis at the discretion of the DMERC.

A new Initial Certification would be required when (1) a formula billed with a different code which has not been previously certified is ordered, or (2) enteral nutrition services are resumed after they have not been required for two consecutive months.

A Revised Certification would be required when, for a formula which has been previously certified, (1) the number of calories per day is changed, or (2) number of days per week administered is changed, or (3) the method of administration (syringe, gravity pump) changes, or *(4) route of administration is changed from tube feedings to oral feedings (if billing for denial).*

The Initial Certification must be accompanied by adequate documentation to support the medical necessity of the following orders, if applicable:

1) *the need for special nutrients (products other than B4150 or B4152),*

2) *the need for a pump.*

If a supplier is billing for items that are noncovered, this must be indicated on the claim. The recommended way of doing this is to add the ZY modifier to the code. If ZY is used, a brief description of the reason for noncoverage should be included (e.g., B4150ZY - nutrient given orally; no tube).

When certification is required, the 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 GU0 record. (See DMEPOS National Standard Format Matrix for details.) The HA0 record can be used for additional narrative documentation that will not fit on the GU0 record.

Refer to 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 July 1, 1996.

This is a revision to a previously published policy.

Parenteral Nutrition

HCPCS CODES:

B4164 Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) - homemix

B4168 Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) - homemix

B4172 Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) - homemix

B4176 Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) - homemix

B4178 Parenteral nutrition solution, amino acid, greater than 8.5%, (500 ml = 1 unit) - homemix

B4180 Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml=1 unit) - homemix

B4184 Parenteral nutrition solution; lipids, 10% with administration set (500 ml = 1 unit)

B4186 Parenteral nutrition solution, lipids, 20% with administration set (500 ml = 1 unit)

B4189 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix

B4193 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix

B4197 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix

B4199 Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix

B4216 Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) homemix per day

B4220 Parenteral nutrition supply kit; premix, per day

B4222 Parenteral nutrition supply kit; home mix, per day

B4224 Parenteral nutrition administration kit, per day

B5000 Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal - Aminosyn RF, Nephramine, Renamin - premix

B5100 Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic - Freamine HBC, Hepatamine - premix

B5200 Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress - branch chain amino acids - premix

B9004 Parenteral nutrition infusion pump, portable

B9006 Parenteral nutrition infusion pump, stationary

B9999 NOC for parenteral supplies

E0776 IV pole

HCPCS MODIFIER:

XA IV pole is used in conjunction with parenteral or enteral nutrition

REFERENCE: Coverage Issues Manual 65-10

BENEFIT CATEGORY: Prosthetic Device

DEFINITIONS:

Parenteral nutrition is the provision of nutritional requirements intravenously.

COVERAGE AND PAYMENT RULES:

Parenteral nutrition is covered for a patient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

General:

The patient must have a permanent impairment. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Parenteral nutrition will be denied as noncovered in situations involving temporary impairments.

The patient must have (a) a condition involving the small intestine and / or its exocrine glands which significantly impairs the absorption of nutrients or (b) disease of the stomach and / or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the GI system. There must be objective evidence supporting the clinical diagnosis.

Parenteral nutrition is noncovered for the patient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:

a) a swallowing disorder,

b) a temporary defect in gastric emptying such as a metabolic or electrolyte disorder,

c) a psychological disorder impairing food intake such as depression,

d) a metabolic disorder inducing anorexia such as cancer,

e) a physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease,

f) a side effect of a medication,

g) renal failure and / or dialysis.

In order to cover intradialytic parenteral nutrition (IDPN), documentation must be clear and precise to verify that the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. Records should document that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the patient must be intravenously infused with nutrients. Infusions must be vital to the nutritional stability of the patient and not supplemental to a deficient diet or deficiencies caused by dialysis. Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted. Patients receiving IDPN must meet the parenteral nutrition coverage criteria listed below.

Maintenance of weight and strength commensurate with the patient's overall health status must require intravenous nutrition and must not be possible utilizing all of the following approaches:

1) modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.), and

2) utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.).

Parenteral nutrition is covered in any of the following situations:

A) The patient has undergone recent (within the past 3 months) massive small bowel resection leaving 5 feet of small bowel beyond the ligament of Treitz, or

B) The patient has a short bowel syndrome that is severe enough that the patient has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters / day the enteral losses exceed 50% of the oral / enteral intake and the urine output is 1 liter / day, or

C) The patient requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal / kg / day for treatment of symptomatic pancreatitis with / without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible, or

D) The patient has complete mechanical small bowel obstruction where surgery is not an option, or

E) The patient is significantly malnourished (10% weight loss over 3 months or less and serum albumin 3.4 gm / DL) and has very severe fat malabsorption (fecal fat exceeds 50% of oral / enteral intake on a diet of at least 50 gm of fat / day as measured by a standard 72 hour fecal fat test), or

F) The patient is significantly malnourished (10% weight loss over 3 months or less and serum albumin 3.4 gm / Dl) and has a severe motility disturbance of the small intestine and / or stomach which is unresponsive to prokinetic medication and is demonstrated either (1) scintigraphically (solid meal gastric

emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion), or (2) radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration). These studies must be performed when the patient is not acutely ill and is not on any medication which would decrease bowel motility.

Unresponsiveness to prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses

For criteria A-F above, the conditions are deemed to be severe enough that the patient would not be able to maintain weight and strength on only oral intake or tube enteral nutrition.

Patients who do not meet criteria A-F above must meet criteria 1-2 above (modification of diet and pharmacologic intervention) plus criteria G and H below:

G) The patient is malnourished (10% weight loss over 3 months or less and serum albumin 3.4 gm / Dl), and

H) A disease and clinical condition has been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).

The following are some examples of moderate abnormalities which would require a failed trial of tube enteral nutrition before parenteral nutrition would be covered:

- ❑ moderate fat malabsorption fecal fat exceeds 25% of oral / enteral intake on a diet of at least 50 gm of fat / day as measured by a standard 72 hour fecal fat test)
- ❑ diagnosis of malabsorption with objective confirmation by methods other than 72 hour fecal fat test (e.g., Sudan stain of stool, d-xylose test, etc.)
- ❑ gastroparesis which has been demonstrated (a) radiographically or scintigraphically as described in F above with the isotope or pellets failing to reach the jejunum in 3-6 hours, or (b) by manometric motility studies with results consistent with an abnormal gastric emptying, and which is unresponsive to prokinetic medication
- ❑ a small bowel motility disturbance which is unresponsive to prokinetic medication, demonstrated with a gastric to right colon transit time between 3-6 hours
- ❑ Small bowel resection leaving 5 feet of small bowel beyond the ligament of Treitz
- ❑ short bowel syndrome which is not severe (as defined in B)
- ❑ mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula
- ❑ partial mechanical small bowel obstruction where surgery is not an option

Definition of a Tube Trial: A concerted effort must be made to place a tube. For gastroparesis, tube placement must be post-pylorus, preferably in the jejunum. Use of a double lumen tube should be considered. Placement of the tube in the jejunum must be objectively verified by radiographic studies or fluoroscopy. Placement via endoscopy or open surgical procedure would also verify location of the tube, however they are not required.

A trial with enteral nutrition must be made, with appropriate attention to dilution, rate, and alternative formulas to address side effects of diarrhea.

Examples of a failed tube trial would be:

- ❑ A person who has had documented placement of a tube in the post-pyloric area continues to have problems with vomiting and on radiographic recheck the tube has returned to the stomach.
- ❑ After an attempt of sufficient time (5-6 hours)to get a tube into the jejunum, the tube does not progress and remains in the stomach or duodenum. An attempt of enteral tube feeding with a very slow drip was made. It was initially tolerated well but vomiting occurred when the rate was increased.
- ❑ After placement of the tube in the jejunum and 1-2 days of enteral tube feeding, the person has vomiting and distension.

- ❑ A tube is placed appropriately and remains in place. Enteral nutrition is initiated and the concentration and rate are increased gradually. Over the course of 3-4 weeks, attempts to increase the rate and/or concentration and/or to alter the formula to reach the targeted intake are unsuccessful, with increase in diarrhea, bloating or other limiting symptoms, and the person is unable to meet the needed nutritional goals (stabilize at desired weight or gain weight as needed).

Parenteral nutrition can be covered in a patient with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral (or even oral/enteral/parenteral) intake as long as the following criteria are met: 1a) a permanent condition of the alimentary tract is present which has been deemed to require parenteral therapy because of its severity (criteria A-F); or 1b) a permanent condition of the alimentary tract is present which is unresponsive to standard medical management (criterion H); and 2) the person is unable to maintain weight and strength (criterion G).

Parenteral nutrition would rarely be medically necessary for patients who do not meet these criteria but will be considered on an individual case basis if detailed documentation is submitted.

The medical necessity of continued parenteral nutrition must be recertified 6 months after the initial claim. Patients covered under criteria A or B should have documentation that adequate small bowel adaptation had not occurred which would permit tube enteral or oral feedings. Patients covered under C should have documentation of worsening of their underlying condition during attempts to resume oral feedings. Patients covered under D should have documentation of the persistence of their condition. Patients covered under E-H should have documentation that sufficient improvement of their underlying condition had not occurred which would permit discontinuation of parenteral nutrition. Coverage for these patients would be continued if the treatment had been effective as evidenced by an improvement of weight and/or serum albumin. If there had been no improvement, subsequent claims will be denied unless the physician clearly documents the medical necessity for continued parenteral nutrition and any changes to the therapeutic regimen that are planned - e.g., an increase in the quantity of parenteral nutrients provided.

If the coverage requirements for parenteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

No more than one month's supply of parenteral nutrients, equipment or supplies is allowed for one month's prospective billing. Claims submitted retroactively, however, may include multiple months.

The ordering physician is expected to see the patient within 30 days prior to the initial certification or required recertification (but not revised certifications). If the physician does not see the patient within this time frame, he/she must document the reason why and describe what other monitoring methods were used to evaluate the patient's parenteral nutrition needs.

Parenteral nutrition provided by a skilled nursing facility (SNF) to a Part A covered patient is billed by the SNF to the fiscal intermediary. No payment from Part B is available to a SNF when the SNF furnishes parenteral nutrition services to a beneficiary in a stay covered by Part A. However, parenteral nutrition provided by an outside supplier to a Part A covered patient is eligible for Part B coverage and is billed to the DMERC. Furthermore, if a beneficiary is not covered by Part A, parenteral nutrition is eligible for coverage under Part B and is billed to the DMERC regardless of whether it is furnished by a SNF or an outside supplier.

Nutrients:

Parenteral nutrition solutions containing little or no amino acids and/or carbohydrates would be covered only in situations A, B, or D (above).

A total daily caloric intake (parenteral, enteral and oral) of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual patient. This information must be available to the DMERC on request.

The ordering physician must document the medical necessity for protein orders outside of the range of 0.8-1.5 gm/kg/day, dextrose concentration less than 10%, or lipid use greater than 15 units of a 20% solution or 30 units of a 10% solution per month.

Special parenteral formulas (B5000-B5200) are rarely medically necessary. If the medical necessity for these formulas is not substantiated, payment will be made for the medically appropriate formula.

EQUIPMENT AND SUPPLIES:

Infusion pumps (B9004-B9006) are covered for patients in whom parenteral nutrition is covered. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as not medically necessary.

When parenteral nutrition is administered in an outpatient facility, the pump used for its administration and IV pole will be denied as not separately payable. The pump and pole are not considered as rentals to a single patient but rather as items of equipment used for multiple patients.

If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used.

RELATED CLINICAL INFORMATION:

When nutritional support other than the oral route is needed, tube enteral nutrition is usually preferable to parenteral nutrition for the following reasons: (1) In a fluid restricted patient, tube enteral nutrition permits delivery of all necessary nutrients in a more concentrated volume than parenteral nutrition and (2) tube enteral nutrition allows for safer home delivery of nutrients.

CODING GUIDELINES:

When homemix parenteral nutrition solutions are used, the component carbohydrates (B4164, B4180), amino acids (B4168-B4178), additives (B4216), and lipids (B4184, B4186) are all separately billable. When premix parenteral nutrition solutions are used (B4189-B4199, B5000-B5200) there must be no separate billing for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids are separately billable with premix solutions.

When an IV pole (E0776) is used in conjunction with parenteral nutrition, the XA modifier should be added to the code.

For codes B4189-B4199, one unit of service represents one day's supply of protein and carbohydrate regardless of the fluid volume and / or the number of bags. For example, if 60 grams of protein are administered per day in two bags of a premix solution each containing 30 grams of amino acids, correct coding is one (1) unit of B4193, not two units of B4189.

For codes B5000-B5200, one unit of service is one gram of amino acid.

Parenteral nutrition solutions containing less than 10 grams of protein per day are coded using the miscellaneous code B9999.

DOCUMENTATION:

The Certificate of Medical Necessity (CMN) for parenteral nutrition may be completed by someone other than the ordering physician. The person completing the information on the form may not be the supplier. However the CMN must be reviewed for the accuracy of the information and signed and dated by the ordering physician to indicate agreement. The CMN for parenteral nutrition is DMERC 10.

Additional documentation must be included with the first claim for parenteral nutrition. The type of documentation relates to which situation (A-H) in Coverage and Payment Rules, General serves as the basis for coverage. For situations A-D, the documentation should include copies of the operative report and / or hospital discharge summary and / or x-ray reports and / or physician letter which document the condition and the necessity for parenteral therapy. For situations E and H (when appropriate), include the results of the fecal fat test and dates of the test. For situations F, and H (when appropriate), include a copy of the report of the small bowel motility study and a list of medications that the patient was on at the time of the test. For situations E-H, include results of serum albumin and date of test (within 1 week prior to initiation of parenteral nutrition, PN) and a copy of a nutritional assessment by a physician, dietitian or other qualified professional within 1 week prior to initiation of PN, to include the following information:

1) current weight with date and weight 1-3 mo. prior to initiation of PN;

2) estimated daily calorie intake during the prior month and by what route (e.g., oral, tube);

3) statement of whether there were caloric losses from vomiting or diarrhea and whether these estimated losses are reflected in the calorie count;

4) description of any dietary modifications made or supplements tried during the prior month (e.g., low fat, extra medium chain triglycerides, etc.);

For situations described in H, include a statement from the physician, copies of objective studies, and excerpts of the medical record giving the following information:

1) specific etiology for the gastroparesis, small bowel dysmotility, or malabsorption;

2) a detailed description of the trial of tube enteral nutrition including the beginning and ending dates of the trial, duration of time that the tube was in place, the type and size of tube, the location of tip of the tube, the name of the enteral nutrient, the quantity, concentration, and rate of administration, and the results;

3) a copy of the x-ray report or procedure report documenting placement of the tube in the jejunum;

4) prokinetic medications used, dosage, and dates of use;

5) nondietary treatment given during prior month directed at etiology of malabsorption (e.g., antibiotic for bacterial overgrowth);

6) any medications used that might impair GI tolerance to enteral feedings (e.g., anticholinergics, opiates, tricyclics, phenothiazines, etc.) or that might interfere with test results (e.g., mineral oil, etc.) and a statement explaining the need for these medications.

Any other information which supports the medical necessity for parenteral nutrition may also be included.

For the Initial Certification and for Revised Certifications or Recertification involving a change in the order, there must be additional documentation to support the medical necessity of the following orders, if applicable.

1) the need for special nutrients (B5000-B5200),

2) the need for dextrose concentration less than 10%,

3) the need for lipids more than 15 units of a 20% solution or 30 units of a 10% solution per month.

After the Initial Certification of parenteral nutrition items, Recertification is required after 6 months of therapy to document the patient's continued need for therapy. After the recertification at 6 months, further routine recertifications will not generally be required. However, additional recertifications may be requested on an individual basis at the discretion of the DMERC.

For patients who have had their initial certification and at least one routine recertification approved by the DMERC prior to 7/1/96, no further routine recertification will be required.

A Revised Certification would be required when (1) nutrients billed with a different code are ordered, or (2) the number of days per week administered is decreased. A Revised Certification does not change the schedule for the required Recertification.

A new Initial Certification would be required when parenteral nutrition services are resumed when they are not required for two consecutive months. In this situation the required recertification schedule would start again.

The 6 month recertification must include a physician's statement describing the continued need for parenteral nutrition. For situations E-H, the recertification must include the results of the most recent serum albumin (within 2 weeks of recertification) and the patient's most recent weight with the date of each. If the results indicate malnutrition, there should be a physician's statement describing the continued need for parenteral nutrition and any changes to the therapeutic regimen that are planned.

When a certification is required, the 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 GU0 record. (See DMEPOS National Standard Format Matrix for details.) The HA0 record can be used for additional narrative documentation that will not fit on the GU0 record.

When code B9999 is billed, the claim must include a clear description of the item, the quantity provided, and the medical necessity of the item for the patient.

Refer to 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 July 1, 1996.

This is a revision to a previously published policy.

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
K0417	*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
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg
XX00	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 device used to deliver solutions containing parenteral medication under pressure at a constant flow rate determined by the tubing with which it is used. 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.

Code K0417 describes a mechanical infusion pump which is similar to a K0284 pump, but which is only capable of a single infusion cycle of less than 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 flush 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 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) intermittent bolus administration regimens or (b) infusions lasting less than 8 hours.

4) The drug is administered by intermittent 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.

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 continuous 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 intermittent 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, *K0417*) 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.

Code XX009 is invalid for claims with dates of service on or after 1/1/96; code J1250 should be used instead.

Code K0417 is valid for claims with dates of service on or after 4/1/96.

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 GU0 record. (See DMEPOS National Standard Format Matrix for details.) If additional medical necessity information is included, it must be transcribed into the HA0 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.

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
K0413	*Nonpowered adjustable zone pressure - reducing air mattress overlay*
K0414	*Powered air overlay for mattress*

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-9

DEFINITIONS:

Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without 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.

Code K0413 describes a nonpowered pressure-reducing mattress overlay which is characterized by all of the following:

1) At least 3 independent sections in which the air pressure is custom adjusted for each patient.

2) Each section contains numerous air cells connected by restrictive manifolding that provides constant force equalization.

3) Each cell is displaceable and low surface tension over the entire body is continually maintained.

4) A surface which reduces friction and shear.

5) Cell height of 3 inches or greater.

Code K0414 describes 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 to provide adequate patient lift, reduce pressure and prevent bottoming out, and

4) A surface designed to reduce friction and shear.

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 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.

Appropriate use of the ZX modifier (see Documentation section) is the responsibility of the supplier billing the DMERC. The supplier should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the ZX modifier still reflects the clinical conditions which meet the criteria for coverage of a group 2 support surface, and that adequate documentation exists in the medical record reflecting these conditions. Such documentation should not be submitted with a claim but should be available for review if requested by the DMERC.

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:

Codes K0413 and K0414 are valid for dates of service on or after 4/1/96.

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.

When the initial claim for a group 2 support surface is received on or after 1/1/96, if it 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 the initial claim. On subsequent claims for situations (a) and (b), the ZX modifier should be added to the code until the ulcer has healed. Once the ulcer has healed, the ZX modifier should not be used. On subsequent claims for situation (c), the ZX modifier may only be added to claims with dates of service within 60 days of the surgery.

When the initial claim for a group 2 support surface was received prior to 1/1/96 and was approved, then for subsequent claims with dates of service on or before 12/31/95, the ZX modifier may be added to the claim. When the initial claim for a group 2 support surface was received prior to 1/1/96 and was approved, then 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 April 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 an alternating pressure or low air loss overlay which is less than 3.5 inches, or a nonpowered pressure reducing overlay or mattress?*

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: _____

Osteogenesis Stimulators

HCPCS CODES:

E0747 Osteogenesis stimulator, noninvasive, other than spinal applications

E0748 Osteogenesis stimulator, noninvasive, spinal applications

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 35-48

DEFINITIONS:

An osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair. A noninvasive stimulator is characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.

A multilevel spinal fusion is one which involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc).

COVERAGE AND PAYMENT RULES:

A nonspinal osteogenesis stimulator (E0747) is covered if any of the following criteria are met:

1) Nonunion of a long bone fracture after six months have elapsed without healing of the fracture, or

2) Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery, or

3) Congenital pseudarthrosis.

A spinal osteogenesis stimulator (E0748) is covered if any of the following criteria are met:

1) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery, or

2) Following a multilevel spinal fusion surgery, or

3) Following spinal fusion surgery where there is a history of a previously failed spinal fusion.

An osteogenesis stimulator will usually be denied as not medically necessary if none of the criteria above are met.

The DMERC does not process claims for an invasive osteogenesis stimulator.Code E0748 is valid for claims with dates of service on or after 1/1/96. Revised wording for code E0747 became effective for dates of service on or after 1/1/96. For dates of service prior to 1/1/96, code E0747 was used for either nonspinal or spinal noninvasive stimulators.

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 signed and dated by the ordering physician must be kept on file by the supplier. The CMN for osteogenesis stimulators is DMERC 04.

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 GU0 record. (See DMEPOS National Standard Format Matrix for details.) If additional medical necessity information is included, it must be transcribed into the HA0 record.

Additional documentation is required in the following situations. If a spinal stimulator is ordered following a multilevel spinal fusion, the claim must include the date of the surgery and level of the fusion. If a spinal stimulator is ordered when there is a history of a previously failed spinal fusion, the claim must include the date and level of the previous fusion and that fact that the fusion failed. This additional documentation should be attached to a hard copy claim or entered in the HA0 record of an electronic claim.

Refer to the Supplier Manual for more information on orders, CMNs, medical records and supplier documentation.

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

This is a revision to a previously published policy.

Prosthesis Sheath/Sock - New Code

A new code has been established for a lower extremity prosthesis accessory:

XX015 Prosthetic sheath / sock, including gel cushion layer, below knee or above knee, each

This code is valid for dates of service on or after 4/1/96.

Correct coding using this code would include the following products manufactured by Silipos: Silosheath, Silosheath Active, Double Cushion Silosheath, Extra Life Silosheath, Silosheath Plus, Single Socket Gel Liner, Double Soft Socket Gel Liner. Suppliers or manufacturers desiring a coding determination on other products may contact the Statistical Analysis DME Regional Carrier (SADMERC).

Urological Supplies - Correction

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

The usual maximum amounts allowed per month for codes A4314, A4315 and A4316 published in the December 1995 issue of DME Medicare News (p.16) were incorrect. This issue stated that A4314, A4315 or A4316 were allowed at a usual maximum quantity of 2/month.

The correct chart is as follows:

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

When billing A4314, A4315 or A4316, which contain an insertion tray, Foley catheter and drainage bag, the allowable quantity is 1/month. To accommodate the total monthly allowable for drainage bags, A4357 would be allowed at a quantity 1/month, in addition to billing for A4314, A4315 or A4316. Therefore, the total allowable per month for A4357 would be satisfied at 2/month.

Grandfathering Policy

Editor's Note: This is a revision to the Coverage Issue section of Chapter 12 of your Supplies Manual regarding grandfathering.

5) Parenteral/Enteral Nutrition

For parenteral nutrition, *if it had been approved by the prior regional carrier, consistent with the then existing policy,* before transition to the DMERC, payment will be continued as long as it is ordered by the physician. When parenteral nutrition therapy is grandfathered, further routine recertifications with a fully completed CMN will not be required, though revised certifications should continue to be submitted as required in the Parenteral Nutrition policy.

For enteral nutrition, if it had been approved by the prior regional carrier before transition to the DMERC, payment will be continued for as long as it is ordered by the physician. When enteral nutrition therapy is grandfathered, further routine recertifications with a fully completed CMN will not be required, though revised certifications should continue to be submitted as required in the Enteral Nutrition policy.

When enteral nutrition coverage is grandfathered, payment for the specific enteral product that the patient was on at the time of transition will be continued if it had been approved by the prior carrier. This payment will continue until such time as revised national coverage policy for special enteral formulae becomes effective. If the patient is subsequently changed to a different specialty formula, the DMERC policy for the specialty formula applies.

Billing for Multidex Surgical Dressing (K0262)

When billing for Multidex, code K0262 (wound filler, not elsewhere classified, dry form, per gram), claims for more than 90 grams per wound per month must be accompanied by extra documentation explaining characteristics of the wound which require greater amounts. As stated in the medical review policy on surgical dressings, usual frequency of change is once per day. Amounts utilized should reflect the wound size.

Antiemetic Drugs: New Coverage

Effective with dates of service on or after January 24, 1996, self-administered antiemetic drugs are covered when they are necessary for the administration and absorption of Medicare covered oral anticancer chemotherapeutic agents. At the present time the only covered oral anticancer drugs are cyclophosphamide, etoposide, melphalan and methotrexate.

This article only relates to claims processed by the DMERC for self-administered antiemetic drugs. Claims for parenteral antiemetic drugs administered incident to a physician's service are processed by the local carrier under different coverage rules.

Self-administered antiemetic drugs are covered when it is likely that the patient will vomit one of the covered oral anticancer drugs if the antiemetic is not administered. Coverage would be limited to antiemetics administered within 2 hours before the oral anticancer drug. Oral preparations or rectal suppositories would be covered. Antiemetics are noncovered when they are given to treat nausea or vomiting which is caused by the oral anticancer drug (or other etiology) but which does not affect the absorption of the anticancer drug. Antiemetics are also noncovered when they are used in conjunction with only parenteral chemotherapy drugs or with noncovered oral anticancer drugs.

The following new codes have been established:

K0415 Prescription antiemetic drug, oral, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified

K0416 Prescription antiemetic drug, rectal, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified

These codes are effective for dates of service on or after April 1, 1996. For claims with dates of service from January 24, 1996 through March 31, 1996, use code J3490 - Unclassified drugs.

The claim for these codes must be accompanied by the name of the drug, formulation (e.g., tablet, rectal suppository, etc.), and dosage strength (mg.) of each tablet, suppository, etc. Only quantities of these drugs which meet the coverage criteria listed above should be billed using these codes. The claim must also indicate which oral anticancer drug is being used and the prescribed frequency of administration of the anticancer drug. This information should be attached to a hard copy claim or entered in the HA0 record of an electronic claim. The ICD-9 diagnosis code for the cancer should be listed on the claim.

Ostomy Supplies

Editor's Note: The following are additions/deletions to the current medical policy regarding Ostomy Supplies. Deletions from the current policy are denoted with a "strike-thru" and the additions (revisions) are shown in bold.

Usual Maximum Quantity of Supplies

Code	*#/month*	*#/6 month*
A4399		**2**

~~Replacement of an irrigation cone/catheter every three months would be covered. This would be billed either using Code A4398, if the irrigation bag were replaced at the same time, or using Code A4399, if just the cone/catheter were being replaced.~~

Coding Guidelines

Code A4400 for an irrigation kit is not valid for claims submitted to the DMERC. Necessary components should be billed by individual codes A4367, A4397, A4398. ~~Note that the code for the irrigation bag (A4398) includes an irrigation cone/catheter (A4399) and a brush.~~ A brush is included with irrigation supplies and should not be billed separately.

Column I	*Column II*
~~A4398~~	~~A4399~~
A5064	A4361, A5065
A5074	A4361, A5075

Documentation

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

This is a revision to a previously published policy.

Crossover

Complementary Insurers

The following is a list of Complementary insurers with the Region A DMERC which accept participating/assigned and non-participating/non-assigned and assigned claims:

AARP/Prudential	18936A002
Aetna Life & Casualty	06457A001
Amer General Group Ins.	37250A001
APWU Health Plan	20904A001
BCBS of Alabama	35244B001
BCBS of CT - Constitution Health Care, Inc.	06473C001
BCBS of Delaware	19899B001
BCBS of Michigan	48226B001
BCBS of Missouri	63108B001
BCBS of Pennsylvania	17089B001
BCBS of Rhode Island	02903B001
BCBS of Western New York	14240B001
Central States Health & Life Co. of Omaha	66134C001
Empire Blue Cross Blue Shield of NY	10016B001
Government Employees Hospital Assoc. Inc.	64111G001
Group Health Inc.	10036G001
Hartford Life & Acc. Co.	22312I001
Medical Service Corp.	99220M001
MetraHealth Insurance Company	08807M001
Mutual of Omaha Insurance Co.	68131M001
National Association of Letter Carriers	22093N001
Olympic Health Management System	98227O001
Pioneer Life Insurance Co. of Illinois	61105P001
Providian Insurance Companies	19355N001
Prudential Insurance Company	07068P001
Standard Life Insurance Co. of America	73125S001
United American Insurance	75221U001
CT Dept. of Income Maintenance	DIMCT
NJ Dept. of Income Maintenance	08625D001
PA Dept. of Income Maintenance	17105D001
RI Dept. of Human Services	02920D001

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:

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

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

q 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

EMC Help Desk

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

ERNs - Version 01.03

ERN Version 01.03 will be eliminated. As of March 1, 1996 we will only be returning ERN versions 01.04 and 02.00. If you convert to Version 01.04 or 02.00 of the ERNs you must contact our office. 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 clerically processed in your office, deposited and then cleared by the bank.

On the other hand with EFT, 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 US 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 ERN's 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 (12) 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 (ERN's) - The supplier has been receiving ERN's for the past three (3) months and have not experienced any balancing difficulties. (Once receiving EFT's paper EOMBS will stop after 30 days.)

Please contact the EMC Unit if you meet the above requirements and are interested in EFT's.

Please note that region A has recently set up their first suppliers with EFT's.

Correction to Return/Reject Table

Attention Electronic Submitters: Please note the following corrections to the Return / Reject Table found on pages 20-22 of the December 1995 issue of DME Medicare News :

- ❑ Refer / Ordering Provider Last Name

  For the DMERC, this information must be in the FB1 06.0, not the EA0 22.0 Refer / Ordering Provider UPIN

- ❑ Refer / Ordering Provider UPIN

  For the DMERC, this information must be in the FB1 09.0, not the EA0 20.0 or FB1 13.00

- ❑ Rendering Provider ID was indicated as "Not Used Field for DMERC", but this is incorrect. The Rendering Provider ID is required for the DMERC and should be in field FA0 23.0

Please make these corrections to this table. EMC claims submitted with incorrect information will reject.

Modem Upgrade

The Region A DMERC Bulletin Board System modems have been upgraded. All 9600 baud modems have been replaced with 28.8K baud modems . All suppliers can connect at 28.8 K baud on the main toll number (717-735-9515) and the toll-free line (800-842-5713-).

Please note that you must own 14.4K or 28.8K baud modem to benefit from the upgraded modems. If you have a faster modem and are not connecting above 9600 baud please contact your vendor to change your communication software settings. Calls of 1200, 2400 and 9600 baud will continue to be accepted. 300 baud modem calls have not and will not be accepted.

Shorter transmission times may also be achieved by using a faster protocol such as Z-Modem (The Best) or SuperKermit. If you have a question about protocols or modems please call the EMC Unit at : 717-735-9521, 9530, or 9528.

Accelerate-Version 02.00

The new version of MetraHealth's free software program-Accelerate has been released to all suppliers that are using our software to submit claims. This version is programmed in National Standard Format 02.00 and contains the new CMNs. If you are using our software and did not receive the update you must contact our office at 717-735-9532.

New Acknowledgment Reports

The EMC Unit is now returning acknowledgment reports in a new layout. The acknowledgment reports will now end with an AKS extension. Genacks2 is MetraHealth's free print program. If you are using MetraHealth's Accelerate program you have the option of installing this program on your initial install. If you are not using our software Genacks2 is located on the Bulletin Board for you to download. If you are using a vendor's software you should contact your vendor for information on how to download and print your acknowledgment reports. If you are a programmer that needs a copy of the file layout for the new acknowledgments please call our office at 717-735-9528.

Zipped EMC Files

The DMERC EMC Unit can accept production files which are submitted in a zipped format. This allows for multiple files to be sent at once and cuts down on transmission time. For more information on zipped files, please contact the EMC Unit at 717-735-9521 or 717-735-9530.

Peak Hours on the BBS

If you are experiencing trouble connecting to our Bulletin Board or you are getting a busy signal it may be that all of our lines are busy. You may want to consider transmitting after 4 p.m. or on weekends if at all possible. MetraHealth's BBS is active seven days a week.

X-Modem Protocol

Suppliers using X-Modem Protocol to download various files may experience problems processing these files for reports or may not retrieve a complete file. We suggest you use one of the following protocols: Kermit, Superkermit, Y-Modem, Sealink, or Z-Modem. Accelerate users cannot use Z-Modem.

Internet Account

The Region A DMERC now has an Internet EMail account-186433@ibmmail.com. You may direct questions to any department at the DMERC using this account. You may reach us through any On-Line service that provides Internet EMail accounts. This account is provided as an additional means to obtain information from the DMERC. You may also use the BBS mail functions for communications. The menu pick is (A)sk the E-Team.

Claim Entry

Response to Requested Information

Occasionally, you may receive a development letter requesting additional information for a claim that has recently been submitted. You have **30 day**s to respond to this request. If we do not **receive** the information requested within 30 days from the date on the letter, the claim in question will be denied with EOMB message, CO17.

CO17 Claim/service denied because requested information was not provided or was insufficient/incomplete.

Any additional information received after the 30th day will be returned to the supplier.

Clarification - Lymphedema Pumps and Accessories

The Region A DMERC is providing the following information to expedite processing of claims for Lymphedema pumps and accessories. This notice clarifies the correct accessories which should accompany each pump. Please be advised that billing incorrect codes for accessories will result in denials.

E0650 Non-segmented pneumatic compressor is used with appliances/sleeves coded E0655, E0666 and E0671-E0673

E0651 & E0652 Segmented pneumatic compressors are used with appliances/sleeves coded E0667 and E0669

Further information pertaining to the above can be found in the September 1995 issue of "DME Medicare News," page 12.

Clarification of Place of Service (POS)

This is to clarify the use of Place of Service (POS) code 54 in comparison to POS codes 31 & 32.

Medicare may cover DME provided in a beneficiary's home. An institution which is primarily engaged in providing skilled nursing care or rehabilitation services cannot be considered a beneficiary's home(Sect. 1861(n) and 1819(a)(1) of the Social Security Act). If a beneficiary is in such an institution, a skilled nursing facility (SNF) would be coded as POS 31. An intermediate care facility (ICF), nursing facility(NF) and similar institutions would be coded as POS 32.

POS code 54 (ICF/MR) is used to identify a facility which is primarily engaged in the care and treatment of mental diseases rather than in providing skilled nursing care. An ICF/MR may be considered a beneficiary's home. ICF/MR's usually emphasize psychological and custodial care rather than skilled nursing care.

The deciding factor in distinguishing between POS 31, 32, 33 (Custodial Care Facility) and 54 is the primary service provided by the facility, not the service provided to a specific patient. For example; POS 32 should be used when an individual is receiving custodial mental rehabilitation services in a nursing facility (NF) because the facility's primary service is nursing care.

Additional Documentation

Please use the following cover sheet when providing additional documentation to our office. Use of this cover sheet will insure proper routing and expedite processing of your claim. This cover sheet should be used for extra documentation on both paper (unless it is attached to the original claim) and electronic claims.

If you are submitting additional documentation on electronically billed claims, the documentation must be received by our office at least 48 hours (2 business days) before the claim is transmitted. If we do not receive the documentation in that time frame, there is no guarantee that the claim will be matched with the documentation. You must indicate in the HA0 record (Documentation Record) the date that the additional documentation was faxed or mailed. The fax number that should be used is 717-735-9510 and the cover sheet must be attached. If documentation will be mailed, please allow enough time so that we receive it at least 48 hours before the claim is transmitted.

In order to facilitate this process, any documentation received which is not necessary to adjudicate the claim will be returned. This will reduce future efforts on your part to submit documentation which is not necessary.

Extra Documentation

MetraHealth - DMERC Region A

All information below must be completed

Company Name / Supplier # : _____

Beneficiary Name: _____

HIC # : _____

Procedure Code: _____

Date of Service: _____

Number of Services: _____

Check one of the following

What is documentation for: _____

Documentation for new claim: _____

Review: _____

Individual Consideration: _____
(new claim)

Prior Authorization: _____

Over Utilization: _____

Requested By: _____
(Name of MetraHealth employee requesting information , if applicable)

Is documentation for: ❑ Electronic Claim ❑ Paper Claim

Mail To: MetraHealth Insurance Company
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773

Electronic Submitters may fax 48 hours before claims are transmitted (717) 735-9510.

Please use this cover sheet for any documentation sent to our office.
This will help in the timely processing of your claim.

Pricing

Fee Schedule for Level II Permanent E Codes

The Level II Permanent E Codes were published on page 37 of the December 1995 issue of "DME Medicare News." The fees for these codes were inadvertently omitted from the 1996 Fee Schedule that was published in the same issue. The fees for these codes are as follows:

	CT	DE	ME	MA	NH	NJ	NY	PA	RI	VT	FLR	CEIL
E1800 RR	91.92	91.92	91.92	91.92	91.92	91.92	91.92	91.92	91.92	91.92	91.92	108.14
E1805 RR	109.67	101.12	110.98	110.98	107.94	97.20	100.46	99.29	94.33	109.55	94.33	110.98
E1810 RR	92.05	101.12	92.05	92.05	107.94	97.20	100.46	99.29	92.05	108.29	92.05	108.29
E1815 RR	109.67	101.12	110.98	110.98	107.94	97.20	100.46	99.29	94.33	109.55	94.33	110.98
E1825 RR	109.67	101.12	110.98	110.98	107.94	97.20	100.46	99.29	94.33	109.55	94.33	110.98
E1830 RR	109.67	101.12	110.98	110.98	107.94	97.20	100.46	99.29	94.33	109.55	94.33	110.98
E1820 NU	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	75.85	64.47	75.85
E1820 RR	7.58	7.58	7.58	7.58	7.58	7.58	7.58	7.58	7.58	7.58	6.44	7.58
E1820 UE	56.89	56.89	56.89	56.89	56.89	56.89	56.89	56.89	56.89	56.89	48.36	56.89

Updates to Wheelchair Product Classification List

The following information is an update to the wheelchair product classification list published in the June issue of "DME Medicare News."

Electric Mobility Power	K0010	Rascal #250 (K) Rascal #255 (K) Rascal #270 (K) Rascal #275 (K)
Hoveround Power	K0011	LTV, MPV
Quickie Power	K0014	P-320

Note (K): Use K0010 only if these models come equipped with a joystick control. Use E1230 if these models come equipped with a side-mounted tiller control.

Coding Corrections

The following information is a revision to the codes listed on page 37 of the December 1995 edition of "DME Medicare News." The corrected information is shown in bold:

K0401 For diabetics only, deluxe **feature of** off-the shelf depth inlay shoe or custom molded shoe, per shoe

J7510 **Prednisolone** oral, per 5 mg

Please make the necessary changes to your copy of the newsletter.

Frequently Asked Questions from the HCPCS Helpline

Q1 What information is to be sent in with a claim when a miscellaneous code is filed and why is it necessary to sent it in?

The same miscellaneous codes can be used for a wide variety of products and supplies. For instance, the HCPCS code E1399, *Durable Medical Equipment miscellaneous*, may be used for an extra large hospital bed or a tube added to a patient owned ventilator. Therefore, a complete description of the item needs to accompany each claim for the service. This description may include the following information: product name, size, amount or volume, materials or substances it is made of, manufacturer's name, or an NDC number if it is a drug. Also necessary is the reason this item is being used by the patient to determine coverage and medical necessity. For instance, if you are a supplying an extra large, reinforced commode for a patient with a diagnosis of a stroke, using the code E1399, you would want to explain that the patient requires this non standard commode due to the size or weight of the patient. Remember, the diagnosis alone may not explain why the patient has been given a non-standard product.

Q2 When asking for a fee schedule amount on certain codes, we are often told it is an individually considered item. What does this mean?

"Individually considered" codes have no fee schedule amount assigned to it. Each time a claim for that item is filed, it will be manually priced by the DMERC on an individual basis. All miscellaneous codes will be individually considered for coverage, medical necessity, and pricing.

It would be helpful to the DMERC if you sent in pricing information with your claim.

Q3 What is the modifier ZX used for and what does it mean?

The modifier "ZX" states "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."

The documentation should be available if the DMERC determines it is necessary for a review.

This modifier is used with durable medical equipment, prosthetic devices, and supplies within the following categories:

- ❑ Therapeutic Shoes for Diabetics
- ❑ Urological Supplies
- ❑ Epoetin Alpha (EPO) for Dialysis
- ❑ Orthopedic Footwear
- ❑ Home Blood Glucose Monitors
- ❑ Support Surfaces

Q4 How do I bill for oxygen tubing and oxygen masks for patients that rent oxygen equipment?

These items are not billable separately. The contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing are included in the code for the monthly rental of the system.

Q5 How do I determine if the orthotic I give a patient is custom fitted or custom fabricated?

A custom fabricated orthotic is made on an individual basis by using actual measurements or positive molds for each patient. Generally, only the patient that was measured for the orthotic could wear the orthotic.

A custom fitted orthotic is a premanufactured orthotic that can be adjusted to fit a patient.

New Code for Milrinone, Effective 1/1/96

Effective for date of service on or after 1/1/96:

J2260 Injection, Milrinone Lactate, per 5 ml

For billing purposes, 1 mg = 1ml. Therefore, one unit of J2260 (5 ml) will equal a 5 mg dose.

Battery Charger

The battery charger is a standard part of an electric wheelchair. The price of the electric wheelchair includes the standard parts. Therefore, the pricing of the electric wheelchair reflects reimbursement of the battery charger. No additional allowance can be made for the battery charger.

Effective for dates of service April 30, 1996, claims where the battery charger is being billed separately will be denied. The denial will be: "The payment of this item is included in the allowance for other equipment."

Secondary Payments of Purchases of Rental Items

When Medicare is the primary payer, it can pay for certain DME items only when rented. Medicare cannot make secondary payments to purchase DME items for which Medicare rules permit payment only on a rental basis. When rental items are billed to the primary insurance as a purchase and paid by the primary insurance as a purchase, Medicare will not make a secondary payment.

Claims submitted for rental items, oxygen, and frequently serviced items as purchases, will be denied with code CO10B, "Claim/service denied/reduced because rent/purchase guidelines were not met."

Code J7645

The Region A DMERC is receiving numerous claims for Atrovent under code J7699.

Please note that there is a specific code for Atrovent effective for dates of service on or after 1/1/95.

Code J7645 Ipratropium Bromide 0.02%, per ml, inhalation solution administered through a DME (Atrovent), should be used for claims with dates of service in 1995.

For dates of service prior to January 1, 1995, use code, J7699 (NOC) drugs, inhalation solution administered through DME.

When billing using code J7645, note that the code is for 1 ml, and any amounts dispensed over 1 ml must be accurately reflected in the units of service column.

Note: Claims submitted with code J7699 for Atrovent 0.02%, with 1995 dates of service will be denied as using an invalid code.

Replacement Batteries for TENS Unit

HCPCS Codes

A4630	Replacement batteries, medically necessary TENS owned by patient
K0118	TENS supplies, one month supply for TENS 2 lead

Code A4630, Replacement Batteries, medically necessary TENS owned by patient is **invalid** for submission to the DMERC. (Per Medical Policy 13.14, effective for claims received on or after October 1, 1993.)

Suppliers should use code K0118 when providing replacement supplies used in conjunction with a TENS unit that has been purchased and/or approved by Medicare.

Replacement batteries for apnea monitors and bone growth stimulators should be billed with code E1399, miscellaneous durable medical equipment.

Thirty (30) days from the date of this notice, any claims submitted with code **A4630** will be **denied** as using an invalid code.

New Modifier

Please be advised, effective for claims with dates of service on or after 10-01-95, the ZU modifier has been replaced with the new GA modifier.

The GA modifier should be used in instances where a waiver of liability is on file.

Pricing Updates for Oral Anti-cancer Drugs

Company	Strength	Quantity	NDC#	Jan. 1996 Price
Etoposide, "Vepesid," Caps, 50 mg				
Bristol-Myers	50 mg	20	00015-3091-45	34.75
Mephalan, "Alkeran," TABs, 2 mg				
Burr-Welcome	2 mg	50	00081-0045-35	1.55
Cyclosphosphamide, "Cytoxan," TABs, 25 mg				
Bristol-Myers	25 mg	100	00015-0504-01	1.59
Bristol-Myers	50 mg	100	00015-0503-01	3.17
Bristol-Myers	50 mg	1000	00015-0503-02	3.17
Methotrexate, TABs, 2.5 mg				
Aligen	2.5 mg	100	00405-4643-01	3.05
Aligen	2.5 mg	36	00405-4643-36	3.05
Barr	2.5 mg	100	00555-0572-02	3.05
Barr	2.5 mg	36	00555-0572-35	3.05
Barr	2.5 mg	8	00555-0572-45	3.05
Barr	2.5 mg	12	00555-0572-46	3.05
Barr	2.5 mg	16	00555-0572-47	3.05
Barr	2.5 mg	20	00555-0572-48	3.05
Barr	2.5 mg	24	00555-0572-49	3.05
Geneva	2.5 mg	100	00781-1076-01	3.05
Geneva	2.5 mg	36	00781-1076-36	3.05
Goldline	2.5 mg	100	00182-1539-01	3.05
Goldline	2.5 mg	36	00182-1539-95	3.05
Lederle	2.5 mg	100	00005-4507-23	3.05
Major	2.5 mg	100	00904-1749-60	3.05
Major	2.5 mg	36	00904-1749-73	3.05
Mylan	2.5 mg	100	00378-0014-01	3.05
Qualitest	2.5 mg	100	00603-4499-21	3.05
Roxane	2.5 mg	36	00054-4550-15	3.05
Roxane	2.5 mg	100	00054-4550-25	3.05
Roxane	2.5 mg	8	00054-8550-03	3.05
Roxane	2.5 mg	12	00054-8550-05	3.05
Roxane	2.5 mg	16	00054-8550-06	3.05
Roxane	2.5 mg	20	00054-8550-07	3.05
Roxane	2.5 mg	24	00054-8550-10	3.05
Roxane	2.5 mg	100	00054-8550-25	3.05
Rugby	2.5 mg	100	00536-3998-01	3.05
Rugby	2.5 mg	36	00536-3998-36	3.05
Schein	2.5 mg	100	00364-2499-01	3.05
UDL	2.5 mg	20	51079-0670-05	3.05
UDL	2.5 mg	12	51079-0670-86	3.05
UDL	2.5 mg	16	51079-0670-87	3.05
UDL	2.5 mg	20	51079-0670-88	3.05
UDL	2.5 mg	24	51079-0670-89	3.05

Correction to 1996 Fee Schedule

Please be advised that the 1996 Fee Schedule which was published in the December 1995 issue of "DME Medicare News" contained misinformation with regard to the fees for certain codes.

The correct fees for these codes are as follows:

		CT	DE	ME	MA	NH	NJ	NY	PA	RI	VT	FLR	CEIL
E0180	RR	20.16	19.66	20.16	20.16	20.16	18.90	19.53	19.29	17.14	20.16	17.14	20.16
E0181	RR	22.34	21.79	22.34	22.34	22.34	20.96	21.65	21.40	18.99	22.34	18.99	22.34
E0193	RR	830.48	782.08	838.28	838.28	838.28	806.68	831.19	838.28	712.54	838.28	712.54	838.28
E0277	RR	704.57	598.88	704.57	704.57	704.57	598.88	704.57	598.88	704.57	704.57	598.88	704.57
E0781	RR	254.76	208.90	208.90	208.90	208.90	208.90	208.90	208.90	214.58	208.90	208.90	245.76
K0011	RR	470.74	461.94	470.74	470.74	470.74	470.74	458.90	453.53	413.34	470.74	400.13	470.74
K0012	RR	302.24	296.58	302.24	302.24	302.24	302.24	294.64	291.19	265.37	302.24	256.90	302.24
K0195	RR	16.51	19.42	16.51	16.51	16.51	16.51	16.51	19.42	16.51	18.74	16.51	19.42
A4326		9.62	10.01	9.62	9.62	9.62	10.01	8.51	10.01	9.62	9.62	8.51	10.01
A4327		39.22	39.22	39.22	39.22	39.22	39.22	39.22	39.22	39.22	39.22	35.19	41.40
A4328		8.25	9.70	8.25	8.25	8.25	9.70	9.70	9.70	9.14	8.25	8.25	9.70
A4329		23.64	23.64	23.64	23.64	23.64	23.64	23.64	23.64	23.64	23.64	20.09	23.64
A4340		29.46	29.46	29.46	29.46	28.16	29.46	29.46	29.46	29.46	29.46	25.04	29.46
A4398		12.81	12.81	12.58	12.58	11.96	12.81	12.81	12.81	11.96	12.43	10.89	12.81
A4399		11.38	11.38	11.38	11.38	11.01	11.38	11.38	11.38	10.23	11.38	9.67	11.38
A5051		1.96	2.15	1.95	1.95	1.85	2.15	2.09	2.15	2.15	1.93	1.83	2.15
A5055		1.31	1.31	1.33	1.33	1.33	1.31	1.31	1.31	1.31	1.33	1.13	1.33
A5061		2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.46	2.89
A5064		4.20	4.02	4.20	4.20	4.20	4.02	4.20	4.02	4.20	4.20	3.57	4.20
A5065		3.04	2.73	3.04	3.04	3.04	2.73	3.04	3.04	3.04	3.04	2.58	3.04
A5071		3.96	4.04	3.96	3.96	3.96	4.04	4.04	3.96	3.96	3.96	3.43	4.04
A5072		3.18	3.29	3.29	3.29	3.27	3.29	3.29	3.29	3.18	3.29	2.80	3.29
A5073		2.91	2.96	2.96	2.96	2.96	2.96	2.83	2.96	2.91	2.88	2.52	2.96
A5074		4.25	4.25	4.25	4.25	4.25	4.25	4.25	4.25	3.94	4.25	3.61	4.25
A5075		4.48	4.48	4.48	4.48	4.48	4.48	4.45	4.48	4.48	4.48	3.81	4.48
A5102		20.94	20.81	20.81	20.81	20.81	20.81	20.94	20.81	20.81	20.81	17.80	20.94
A5112		32.12	27.30	27.76	27.76	27.76	27.30	28.46	27.30	32.12	27.76	27.30	32.12
A4258		16.74	16.74	16.74	16.74	16.74	16.74	16.74	16.74	16.74	16.74	16.74	14.23
A4259		11.82	10.05	10.05	10.05	10.05	11.82	11.82	10.05	10.05	10.05	10.05	11.82
A4595		26.73	26.73	26.73	26.73	26.73	26.73	26.73	26.73	26.73	26.73	26.73	22.72
A4628		3.74	3.40	3.47	3.47	3.40	3.40	3.40	3.40	3.40	3.47	3.47	2.95
A4629		4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	4.30	3.66

Proper Usage of ZX Modifier

The ZX modifier is only intended for use when all coverage criteria of the policy is met. Documentation to indicate this must be present in the patient's record and kept on file by the provider. If a certain supply is being billed in quantities which exceed the published utilization guidelines, the ZX modifier would still be used to indicate general coverage criteria are met. In such cases, additional medical necessity documentation to support usage beyond the guidelines must be submitted with the claim. Any claims submitted, relative to the policies listed on page 33, without the ZX modifier will be denied as not medically necessary.

The ZX modifier must not be used in lieu of a CMN, unless the particular policy has been revised to require this modifier. There are policies where the CMN has been deleted, but the ZX modifier has not been implemented. If this is the case, the provider must maintain a physician order on file which complies with the coverage criteria of that policy.

E0776 with an XA Modifier - PEN Poles

When billing for E0776 with an XA modifier - PEN Poles, please put the initial date of service on the claims. If billing electronically, place the information in the HA0 field; if billing paper, write the dates of service on the claim form.

Professional Relations Update

PR Omsbudsman

Your Ombudsman is the liaison between the Provider Community and Medicare. One of their primary responsibilities is to educate the provider community. This may require Ombudsmen to be out of the office.

We recognize that because of this, it may occasionally be difficult for you to reach your Ombudsmen.

Please Note: Our Provider Services Unit is trained to accept phone calls that need immediate answers. Routine questions, such as coverage issues, claim status, and coding issues should be directed to Provider Services at 717-735-9445, Monday through Friday, 8:00 a.m. to 4:00 p.m.

PR Support Staff

The following individuals serve as support staff for the DMERC Ombudsmen:

Erin Groblewski - NY
Bob Wright - New England
Derek Zemanek - DE, NJ & PA

They are knowledgeable, work closely with their respective Ombudsman, and communicate with the Ombudsmen on a continual basis. We know this addition to the Professional Relations Unit has improved the response to your questions and concerns.

Provider Education Project (PEP)

Beginning with the first quarter of 1996, the Professional Relations department implemented a proactive educational program entitled Provider Education Project (PEP). The purpose of this project is to target providers with top denial rates and educate them regarding correct billing practices and procedures.

The goal of the project is to reduce the number of denials that these providers are experiencing and at the same time initiate a dialogue with those providers who are in most need of the DMERCs assistance.

To date, there have been many positive responses to this initiative. Participants found the education to be beneficial for new employees and have stated that they are now experiencing fewer problems.

By the end of March, Region A Ombudsmen will have contacted 21 providers to participate in this program.

Physician Education

As part of the DMERCs continuing education for physicians, the Professional Relations Department has produced a video outlining the revisions to the Certificates of Medical Necessity. The video, along with a CMN Reference Guide, has been sent to Region A's State Medical Societies, Hospital Discharge Planners, State and other Supplier Associations and other medical professionals.

CMN Videos can be purchased through the DMERC for only $10.00 each. Interested providers should mail a check or money order for the appropriated amount (made payable to MetraHealth) to:

MetraHealth Insurance Co.
Attn: Michelle Zawatsky
PO Box 6800
Wilkes-Barre, PA 18773-6800

Please include an address and contact name indicating where the video should be sent. Quantity is limited and videos will be mailed on a first-come, first-served basis.

DMERC to be in Attendance at Supplier Association Conventions

Representatives from the Region A DMERC Professional Relations Unit will be in attendance at the following State Associations Conventions. If you are a member —— we look forward to seeing you there!

JAMES	April 15 & 16, 1996
NEMED	June 5-7, 1996
NYMEP	May 15-17, 1996
PAMS	April 22 & 23, 1996

Hearing and Reviews

The Appeals Process

The appeals process gives the beneficiary/provider/supplier the opportunity to exercise their rights to due process if they do not agree with the initial determination given on their claim. The process is as follows:

- ❑ Review
- ❑ Hearing
- ❑ Administrative Law Judge
- ❑ The Appeals Council of the Office of Hearings and Appeals
- ❑ United States District Court

A brief description of each segment of the process is listed below.

Review

We commonly refer to the review as a recon or reconsideration. This is the first level of appeal available to concerned parties. The Recon Unit has experienced personnel who perform an independent review of the claim(s) in question. If there is any additional information available regarding the claim, it should be submitted and will be evaluated in accordance with Medicare law regulating the process. The time limit for filing a request for a review is **six months** from the date of the EOMB. We will render a decision within 45 days. You must ask, in writing, for the review, or, if you are an EMC submitter, by fax. When requesting a review, please use language stating as precisely as possible, what you would like done. For instance: Please review this claim or Please reconsider this claim. This will assure you, and assist us, in making sure the claim is assigned to the proper unit. Also, inclusion of the following will help us to process your request quicker:

- ❑ Date of the service,
- ❑ Issue in question,
- ❑ Control number of the claim, and
- ❑ A copy of the Explanation of Medicare Benefits (EOMB).

If our decision is a partial reversal or affirmation of our original decision, we will issue a letter to the requester addressing the concerns raised in the review request. If the decision is a reversal, you will receive additional payment and a new EOMB.

Hearings

If you are dissatisfied with your review (or recon) decision, the next step in the appeals process is to request a hearing. An impartial hearing officer is assigned the case and they will hear testimony regarding the claim. The request for a hearing must be made within **six months from the date of the review decision notification.** To be eligible for a hearing, the amount in controversy must be at least $100. If the claim in question does not reach the $100 threshold:

- ❑ You may combine other claims that have already been through the review process for a dollar value that will meet the $100 threshold;
- ❑ If you do this, all claims must belong to the same beneficiary or assignee, and
- ❑ All claims must be within the six month time limit after the initial review determination.

If a beneficiary is requesting the hearing, claims from more than one physician / supplier may be combined. If the provider is requesting the hearing, the provider may combine claims involving more than one beneficiary.

Note: The amount in controversy is the difference between the amount billed and the amount paid minus any deductible and / or coinsurances charged.

Example: $1000 is billed. $640 is paid based on an $800 reasonable charge. The amount in controversy is ($1000 - $640) - $160 (20% of $800 allowed) = $200.

There are three types of hearings:

- ❑ On the Record - a hearing officer renders a decision based on the facts in the file. New information substantiating the claim may be submitted.
- ❑ Telephone - a hearing officer holds the hearing with the concerned party via telephone.
- ❑ In Person - a date is set for the hearing officer to meet with the claimant or assignee to discuss the facts about the case.

The hearing may be requested in much the same way as the review. A written request stating exactly what you are requesting, will assist both you and us in expediting the process and assuring accurate assignment of your material.

You will receive a decision from the hearing officer within 120 days of the date the hearing request was received. A copy of the decision will subsequently be mailed to each of the involved parties at his / her last known address.

Administrative Law Judge (ALJ)

The hearing officer's decision is final and binding unless the amount in controversy is at least $500. An ALJ hearing may be requested within **60 days** of the date of receipt of the hearing officer's decision. You must submit your written request to the hearing officer or carrier who rendered your decision. This request, with its accompanying material, will be sent to the ALJ, and a hearing will be scheduled. Please be sure to denote whether or not you wish to attend your hearing.

Office of Hearings and Appeals

If you are dissatisfied with the ALJ's decision, you may request a review by the appeals Council of the Office Of Hearings and Appeals of the Social Security Administration. The written request must specify the issues and findings of fact and conclusion of law made by the ALJ with which you disagree, as well as your basis for contending that the findings and conclusions are incorrect. You will be afforded rights similar to those aforementioned in the process.

United States District Court

If, at this point, you remain dissatisfied, you have the right to a judicial review in United States District Court. The amount in controversy must be at least $1000.

A "reopening" (a reevaluation of the claim determination) is not an Appeal Right. It is a discretionary action in response to the identification of an error, fraud, or the submittal of new and material information not available at the time of the last adjudication. There is no time limit on reopenings.

Closing

If there exits a pervasive problem and a meeting is required to rectify the problem, we will gladly schedule one. Educating you on our process benefits all parties involved. It helps keep your office work flowing, your reimbursement quick, and headaches to a minimum. It also helps us keep work directed to the proper area in our office, expediting turnaround.

This brief explanation of the appeals process and its components is , by no means, exhaustive by way of content. It should serve to better educate you on the process and, perhaps, give you an overview while answering any questions you might have.

The preceding information can be found in the 12000 section of the Medicare Carriers Manual (MCM).

Clarification on Same or Similar Equipment Denials

This article contains vital information regarding same or similar equipment issues. Please read carefully. The instructions below will aid in preventing unnecessary denials and will assist you should this type of denial occur.

Definition:

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: When a claim is submitted for same or similar equipment, it must be determined by the DMERC that the beneficiary no longer has the same or similar equipment. There may be instances where verification is needed to determine if there has been a change in medical necessity. When these determinations can not be made on the basis of the information provided, the claim is denied.

Prevention: Specific information is required to alleviate discrepancies in the beneficiary record regarding the rental or purchase of same or similar equipment. Supplying appropriate documentation will aid in preventing unnecessary denials.

To avoid this type of denial, we are suggesting the use of the attached form. Please obtain the necessary information from the beneficiary and forward it to us.

Submission: There are four (4) options by which this information may be provided.

A) Contact Provider Services at (717) 735-9445. A Customer Service Representative will record the information and route to the appropriate unit to update the beneficiary's record. You may then submit your initial claim.

B) For paper claims, providers may fill out the attached form and submit it with the claim.

C) EMC submitters may include the information in the documentation text and transmit the initial claim.

D) EMC submitters may download the form from the Bulletin Board System and fax the completed form to the EMC Unit, (717) 735-9510. Please forward the information 48 hours prior to transmitting the claim electronically. This will allow us ample time to update the beneficiary's record.

Resolution: Once this denial has been issued, the only recourse for resolution is to request a review. **Do not resubmit the claim.**

Please utilize the attached form to accompany your review request. Submit adequate documentation to substantiate your request. Please address review requests for same or similar equipment denials to:

MetraHealth Insurance Company
PO Box 6300
Wilkes-Barre, PA 18773-6300
Attn: Similar Equipment

Your request will be processed within 45 days. Please **do not** resubmit review requests that were already forwarded to this office.

Returned/Picked-Up Equipment Form

1. Informant Information

Your Name _____

Business Address _____

Contact Name _____ Contact Phone # _____

2. Beneficiary Information

Beneficiary Name _____ Beneficiary HIC # _____

3. Return/Pick-Up Information

- Can Be Utilized for Up to Three Pieces of Equipment Per Beneficiary
- All Information **Is Required** for each Piece of Equipment
- Attach Any Additional Documentation as Necessary

Piece 1 *(Attach Pick Up Slip If Available)*

Procedure Code / Equipment Type _____

Return / Pick-Up Date _____

Company Returned To Or Picked Up By _____

Statement describing the reason for the interruption of service or information which indicates a change in medical necessity and supports the beginning of a new capped rental period. _____

_____

_____

Piece 2 *(Attach Pick Up Slip If Available)*

Procedure Code / Equipment Type _____

Return / Pick-Up Date _____

Company Returned To Or Picked Up By _____

Statement describing the reason for the interruption of service or information which indicates a change in medical necessity and supports the beginning of a new capped rental period. _____

_____

_____

Piece 3 *(Attach Pick Up Slip If Available)*

Procedure Code / Equipment Type _____

Return / Pick-Up Date _____

Company Returned To Or Picked Up By _____

Statement describing the reason for the interruption of service or information which indicates a change in medical necessity and supports the beginning of a new capped rental period. _____

_____

_____

Miscellaneous

Correction

The June 1995 issue of the DME Medicare News contains a typographical error in the **Prevailing Charge Information**, page 26. The charge of XX001 (Sterile Saline, Unit Dose, Up to %ML, each) was listed incorrectly.

The following information should clarify the correct charge for this code:

	50th Prev.	75th Prev.	PIIC
Incorrect	.15	.15	.15
Correct	.08	.08	.08

We regret any inconvenience this error may have caused.

Fax Number for Reconsiderations

Please be advised, we have recently installed an additional FAX machine for Reconsiderations. Providers who bill electronically may now FAX requests for review to:

717-735-9402 or 717-735-9599.

Please do not fax more than six pages at a time.

Do not use the EMC fax number for submitting review requests.

Certificate of Medical Necessity

Duplicate Claims and CMNs

Sending duplicate claims and CMNs will cause unnecessary delays in processing your claims. Following the guidelines listed below will enable us to process your claims as quickly as possible.

1) Only submit the initial CMN with the initial claim.

   Submitting a CMN with every claim will only slow down the turnaround time for payment.

2) Providers may wait until payment is received or call Provider Services (717-735-9445) to see if the CMN has posted to the Common Working File before submitting subsequent claims. This will prevent the claims submitted without CMNs from being processed before the initial claim with the CMN.

3) On items being purchased or rented, be sure the modifier on the claim matches the modifier on the CMN.

4) When submitting a **revision**, be sure the CMN is marked as a revision. If submitting electronically be sure to use **"2**" in the **cert type** field and that **initial date** field is the date of the initial CMN that is being revised.

   Remember a revision is only going to revise the information on the current CMN we have on file. The end date will remain the same.

5) When submitting a **recertification**, be sure to mark as such. If submitting electronically be sure to use **"3**" in the **cert type** field and that the **initial date** field is the date of the initial CMN being recertified.

6) Initial CMNs for oxygen with group 1 levels are certed for a maximum of 12 months even if submitted for life. A recertification is needed with the **13th** month claim and will be added from the end date of the initial CMN for the number of months specified on the recertification. A recertification will be needed in the last month of that CMN.

7) Once oxygen is certified for life, each revision submitted should be marked for life - **not for 12 months**.

8) Oxygen CMNs submitted with group II levels will be certified for **3** months maximum. These beneficiaries will require a **new test "no sooner than 61 days and no later than 90 days from the from date of the initial CMN."** At this time, if the new test levels qualify, the beneficiary will be certified for life or the amount of months marked on the recertification.

9) If a beneficiary changes suppliers for equipment that has a **15** month capped rental period, the supplier will be reimbursed only for the number of months remaining in that capped rental period.

   A CMN should not be submitted for another 15 months.

10) When a CMN's rental period needs to be extended because of a hospital stay, the CMN should be submitted with documentation and only for the number of months of the hospital stay.

Fraud and Abuse

Enrollment Task Force Formed

In the Summer of 1994, the Health Care Financing Administration (HCFA) formed a Task Force which included the Florida Medicare contractors and the Florida Medical State Agency to provide facts, support, and recommendations about what could be done to combat Medicare / Medicaid fraud and abuse.

In addition to a number of recommendations, the Task Force determined that one of the best ways to avoid fraudulent billings is to prevent illegitimate health care providers and suppliers from entering the programs. Controlling entry to Medicare and Medicaid requires establishing more effective provider / supplier enrollment procedures and more effective approaches for verifying information.

To meet this challenge, HCFA is moving forward with a plan to improve the process for enrolling providers and suppliers into the Medicare and Medicaid programs. The improved process will also enhance the nationwide uniformity by which providers / suppliers of health care are enrolled.

Goal of the Enrollment Initiative

The major goal of the standard provider / supplier enrollment initiative is to enhance HCFA's control over the entry of provider / suppliers in the Medicare program, as well as instituting ongoing, periodic monitoring to ensure that all providers / suppliers continue to meet program requirements. An essential element of achieving uniformity and preventing fraud / abuse is issuing the National Provider Identifier (NPI). The NPI is part of a new enumeration process that will uniquely identify all physicians, non-physician practitioners and organizations that are eligible to provide health care services. We will capture all data elements needed for the Medicare enrollment and enumeration in a single application. Both the NPI and the Standard Provider Enrollment initiatives will be fully implemented prior to the MTS transition.

Components of the Enrollment Process

The improved Medicare provider / supplier enrollment process will be implemented through three instructions / components:

- The **Conditions of Enrollment** establish that the provider / supplier is a legitimate entity that can participate in the Medicare program;
- The new **Enrollment Application** for all providers / suppliers will collect the information we need to ensure that the Conditions of Enrollment are met and that the provider is entitled to be assigned an NPI;
- **Re-Enrollment Procedures** will ensure that, once enrolled, all providers / suppliers remain compliant under the Conditions of Enrollment.

We are also planning to verify information on all providers / suppliers currently in the Medicare program. This initiative allows HCFA to update provider information, ensure compliance with program requirements, and remove inactive or invalid provider billing numbers from our systems.

Implementation

We intend to involve the customer to the fullest extent possible to ensure successful implementation of the improved enrollment process. HCFA has already collaborated with its contractors, Regional Offices, and provider organizations in developing the Conditions of Enrollment and the Enrollment Application. Currently our implementation plans include:

- Conditioning to work with Medicare contractors and health care providers / suppliers to obtain their input and ideas during all the stages of the initiative.
- Inviting comments from various sources on the draft Enrollment Application.

We have already initiated these steps by circulating the draft enrollment package to within HCFA. Using focus groups, we will test the new application once the comments have been compiled. Monthly update notices will be issued to all Regional Offices and contractors on the progress. Implementation is scheduled for April 1, 1996. Training providers / suppliers and Medicare contractors on the new improved process has started in November of 1995 and is ongoing.

Outreach

We will submit articles to a wide distribution of provider newsletters and other established publications to keep providers informed of the changes in the enrollment process, as well as communicating regularly through the Regional Offices and contractors.