ATTENTION PHYSICIANS AND SUPPLIERS

CERTIFICATES OF
MEDICAL NECESSITY
(CMNs) REVISED

Over the past year, the DMERCs have worked together to revise existing Certificates of Medical Necessity (CMNs). The goals of the process were: 1) to delete CMNs or individual questions/fields on the CMNs when possible; 2) to revise the format to make them more user friendly to suppliers and physicians; 3) to revise the remaining questions as needed to make them clearer; 4) to comply with new requirements of the law and Medicare regulations.

September 1, 1995 Palmetto GBA mailed, first class, a DMERC Medicare Advisory Special Bulletin to all Region C billers regarding this CMN revision. The Special Bulletin provides complete CMN revision instructions along with originals of the revised CMNs for you to photocopy and use as appropriate.

Reminder

You may begin using version .02 of the CMNs on 10/1/95. For dates of service on or after 10/01/95, the grace period ends in which suppliers have been allowed to answer Section B questions for physicians on the .01 versions of CMNs for DME items. If a supplier chooses to continue using the .01 version of CMNs for dates of service on or after 10/01/95, only the physician or physician employee (OBRA '90) may answer Section B questions for hospital beds, manual wheelchairs, power wheelchairs, CPAP, osteogenesis stimulators, and external infusion pumps (.01 versions of CMNs for support surfaces, lymphedema pumps, TENS, seat lift mechanisms, POVs, and oxygen, have already been requiring physician or physician employee completion).
MEDICAL POLICIES

The following DMERC Medical Policy releases include a revised DMERC Medical policy on Lymphedema Pumps, and on Support Surfaces. These two medical policies will be published in the next Palmetto GBA DMEPOS Supplier Manual revision.

PNEUMATIC COMPRESSION DEVICES (USED FOR LYMPHEDEMA)

SUBJECT: Pneumatic Compression Devices (Used For Lymphedema)

HCPCS CODES:

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

- E0650 - Pneumatic compressor, non-segmental home model
- E0651 - Pneumatic compressor, segmental home model without calibrated gradient pressure
- E0652 - Pneumatic compressor, segmental home model with calibrated gradient pressure
- E0655 - Non-segmental pneumatic appliance for use with pneumatic compressor, half arm
- E0660 - Non-segmental pneumatic appliance for use with pneumatic compressor, full leg
- E0665 - Non-segmental pneumatic appliance for use with pneumatic compressor, full arm
- E0666 - Non-segmental pneumatic appliance for use with pneumatic compressor, half leg
- E0667 - Segmental pneumatic appliance for use with pneumatic compressor, full leg
- E0668 - Segmental pneumatic appliance for use with pneumatic compressor, full arm
- E0669 - Segmental pneumatic appliance for use with pneumatic compressor, half leg
- E0670 - Segmental pneumatic appliance, for use with pneumatic compressor, half arm
- E0671 - Segmental gradient pressure pneumatic appliance, full leg
- E0672 - Segmental gradient pressure pneumatic appliance, full arm
- E0673 - Segmental gradient pressure pneumatic appliance, half leg

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-16

DEFINITIONS:

In this policy, the terms pneumatic compression device and lymphedema pump are considered to be the same. A non-segmented pneumatic compressor (E0650) is a device which has a single outflow port on the compressor. The fact that the air from the single tube may be transmitted to a sleeve/appliance with multiple compartments or segments (E0671-E0673) does not affect the coding of the compressor.

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

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

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

1) radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy),
2) post-radiation fibrosis,
3) spread of malignant tumors to regional lymph nodes with lymphatic obstruction,
4) scarring of lymphatic channels,
5) onset of puberty (Milroy’s Disease), and
6) congenital anomalies.

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

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

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

1) there is significant ulceration of the lower extremity(ies), and
2) the patient has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent, and
3) the ulcer(s) have failed to heal after 6 months of continuous treatment.

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

CODING GUIDELINES:

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

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

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

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

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

A certificate of medical necessity (CMN) which has been filled out, signed and dated by the ordering physician must be kept on file by the supplier. The CMN for pneumatic compression devices/lymphedema pumps is DMERC 04.

The claim for a purchase or first month’s rental must include a copy of the CMN if filed hard copy. If the claim is filed electronically, the information on the CMN must be transcribed exactly into the GUØ record. (See DMEPOS National Standard Format Matrix for details.) If additional medical necessity information is included, it must be transcribed into the HAØ record.

If question #9 on the CMN is Yes and the patient has venous stasis ulcers, documentation supporting the medical necessity for the device should include a signed and dated statement from the ordering physician indicating:

1) the location and size of venous stasis ulcer(s),
2) how long each ulcer has been continuously present,
3) whether the patient has been treated with regular compression bandaging for the past 6 months,
4) whether the patient has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results,
5) other treatment for the venous stasis ulcer(s) during the past 6 months,
6) whether the patient has been seen regularly by a physician for treatment of venous stasis ulcer(s) during the past 6 months.

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

1) whether the patient has been treated with custom fabricated gradient pressure stockings/sleeves, approximately when, and the results,
2) the treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode,
3) the location, size and etiology of the painful focal lesion which necessitates the use of this pump,
4) whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented appliance (E0671-E0673) had been tried and the results,
5) why the features of the system that was provided are needed for this patient,
6) the name, model number, and manufacturer of the device.

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

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

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

This is a revision to a previously published policy.
PRESSURE REDUCING SUPPORT SURFACES POLICY

SUBJECT: Pressure Reducing Support Surfaces - Group 1

HCPCS CODES:

- A4640: Replacement pad for use with medically necessary alternating pressure pad owned by patient
- A9270: Noncovered item or service
- E0180: Pressure pad, alternating with pump
- E0181: Pressure pad, alternating with pump, heavy duty
- E0182: Pump for alternating pressure pad
- E0184: Dry pressure mattress
- E0185: Gel pressure pad for mattress
- E0186: Air pressure mattress
- E0187: Water pressure mattress
- E0196: Gel pressure mattress
- E0197: Air pressure pad for mattress
- E0198: Water pressure pad for mattress
- E0199: Dry pressure pad for mattress
- E1399: Durable medical equipment, miscellaneous

HCPCS MODIFIER:

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

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-9

DEFINITIONS:

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

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

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

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

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

1) Base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g. eggcrate) or an overall height of at least 3 inches if it is a non-convoluted overlay, and
2) Foam with a density and other qualities that provide adequate pressure reduction, and
3) Durable, waterproof cover.

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

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

1) Foam height of 5 inches or greater, and
2) Foam with a density and other qualities that provide adequate pressure reduction, and
3) Durable, waterproof cover, and
4) Can be placed directly on a hospital bed frame.

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

1) Height of 5 inches or greater of the air, water, or gel layer (respectively), and
2) Durable, waterproof cover, and
3) Can be placed directly on a hospital bed frame.
Codes E0180, E0181, E0182, and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss). They are characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and
2) Inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and
3) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out.

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

- **Stage I** - nonblanchable erythema of intact skin
- **Stage II** - partial thickness skin loss involving epidermis and/or dermis
- **Stage III** - full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
- **Stage IV** - full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures

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

**COVERAGE AND PAYMENT RULES:**

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

- **a)** criterion 1, or
- **b)** criteria 2 or 3 and at least one of criteria 4-7.

1) Completely immobile - i.e. patient cannot make changes in body position without assistance.
2) Limited mobility - i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
3) Any stage pressure ulcer on the trunk or pelvis.
4) Impaired nutritional status.
5) Fecal or urinary incontinence.
6) Altered sensory perception.
7) Compromised circulatory status.

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

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

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

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

**RELATED CLINICAL INFORMATION:**

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

1) Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
2) Regular assessment by a nurse, physician, or other licensed healthcare practitioner.
3) Appropriate turning and positioning.
4) Appropriate wound care (for a stage II, III, or IV ulcer).
5) Appropriate management of moisture/incontinence.
6) Nutritional assessment and intervention consistent with the overall plan of care.
CODING GUIDELINES:

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

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

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

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

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
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<tbody>
<tr>
<td>E0180</td>
<td>A4640</td>
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<td>E0182</td>
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<tr>
<td>E0181</td>
<td>A4640</td>
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<td></td>
<td>E0182</td>
</tr>
</tbody>
</table>

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

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

DOCUMENTATION:

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

The supplier must obtain information concerning which, if any, of criteria 1-7 listed in the Coverage and Payment Rules section of this policy the patient meets in a signed and dated statement from the physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to collect this information may not be completed by the supplier or anyone in a financial relationship with the supplier. This statement must be supported by information in the patient’s medical record which would be available to the DMERC on request. Do not send this form to the DMERC unless specifically requested.

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

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

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

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

This is a revision to a previously published policy.
Statement of Ordering Physician  
Group 1 Support Surfaces  

Patient name: _____________________________________________  

HIC #: ____________________________________________________  

Cost information (to be completed by the supplier):  

Supplier’s charge __________________________________________  

Medicare fee schedule allowance _____________________________  

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

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

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

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

3) Any pressure ulcer on the trunk or pelvis.  

4) Impaired nutritional status.  

5) Fecal or urinary incontinence.  

6) Altered sensory perception.  

7) Compromised circulatory status.  

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

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

Physician name (printed or typed): ________________________________________  

Physician signature: ________________________________________________  

Physician UPIN: ________________  

Date signed: ____________________
PRESSURE REDUCING SUPPORT SURFACES POLICY (Cont’d)

SUBJECT: Pressure Reducing Support Surfaces - Group 2

HCPCS CODES:

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

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-9

DEFINITIONS:

Code E0277 describes a powered pressure reducing mattress (alternating pressure or low air loss) which is characterized by all of the following:

1) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and
2) Inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and
3) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and
4) A surface designed to reduce friction and shear, and
5) Can be placed directly on a hospital bed frame.

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

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

Stage I - nonblanchable erythema of intact skin
Stage II - partial thickness skin loss involving epidermis and/or dermis
Stage III - full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
Stage IV - full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures.

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

COVERAGE AND PAYMENT RULES:

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

a) criterion 1 and 2 and 3, or
b) criterion 4, or

1) Multiple stage II pressure ulcers located on the trunk or pelvis.
2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.
3) The ulcers have worsened or remained the same over the past month.
4) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.
5) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).
6) The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

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

i) Education of the patient and caregiver on the prevention and/or management of pressure ulcers.
ii) Regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with a stage III or IV ulcer).
iii) Appropriate turning and positioning.
iv) Appropriate wound care (for a stage II, III, or IV ulcer).
v) Appropriate management of moisture/incontinence.
vi) Nutritional assessment and intervention consistent with the overall plan of care.
If the patient is on a group 2 surface, there should be a care plan established by the physician or home care nurse which includes the above elements.

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

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

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

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

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

CODING GUIDELINES:

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

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

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

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

DOCUMENTATION:

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

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

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

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

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

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

This is a revision to a previously published policy.
Statement of Ordering Physician
Group 2 Support Surfaces

Patient name: ____________________________

HIC #: ____________________________

Cost information (to be completed by the supplier):

Supplier’s charge ____________________________

Medicare fee schedule allowance ____________________________

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

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

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

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

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

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

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

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

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

Physician name (Printed or typed): ____________________________

Physician signature: ____________________________

Physician UPIN: __________________

Date signed: __________________
PRESSURE REDUCING SUPPORT SURFACES POLICY (Cont'd)

SUBJECT: Pressure Reducing Support Surfaces - Group 3

HCPCS CODE:

E0194 - Air-fluidized bed

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60-19

DEFINITION:

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

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Nonblanchable erythema of intact skin</td>
</tr>
<tr>
<td>II</td>
<td>Partial thickness skin loss involving epidermis and/or dermis</td>
</tr>
<tr>
<td>III</td>
<td>Full thickness skin loss involving damage or necrosis of subcutaneous tissues that may extend down to, but not through, underlying fascia</td>
</tr>
<tr>
<td>IV</td>
<td>Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures</td>
</tr>
</tbody>
</table>

COVERAGE AND PAYMENT RULES:

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

1. The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore.
2. The patient is bedridden or chair bound as a result of severely limited mobility.
3. In the absence of an air-fluidized bed, the patient would require institutionalization.
4. The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after conservative treatment has been tried without success.

Treatment should generally include:

a) Education of the patient and caregiver on the prevention and/or management of pressure ulcers,
b) Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly,
c) Appropriate turning and positioning,
d) Use of a group 2 support surface, if appropriate,
e) Appropriate wound care,
f) Appropriate management of moisture/incontinence,
g) Nutritional assessment and intervention consistent with the overall plan of care.

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

5. A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.
6. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.
7. All other alternative equipment has been considered and ruled out.
An air fluidized bed will be denied as not medically necessary under any of the following circumstances:

1) The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);
2) The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;
3) The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed;
4) Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);
5) Electrical system is insufficient for the anticipated increase in energy consumption; or
6) Other known contraindications exist.

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

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

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

**DOCUMENTATION:**

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

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

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

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

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

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

This is a revision to a previously published policy.
When the prescribed amount of supplemental oxygen furnished to a Medicare beneficiary exceeds 4LPM, the QF modifier, as defined below, must be used to denote this on every claim submitted to the DMERC in order to receive the appropriate reimbursement. Even though a CMN submitted with a previous claim may have indicated the need for a flow rate greater than 4LPM, and previous claims may have been reimbursed at the higher level, any one claim submitted without the QF modifier will result in reimbursement only at the monthly rental allowance.

When a patient's oxygen prescription changes, a revised CMN is required. If the flow rate increases or decreases, a revised CMN indicating the current flow rate must be submitted to the DMERC.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QF</td>
<td>Prescribed amount of oxygen exceeds four LPM and portable oxygen is prescribed.</td>
</tr>
</tbody>
</table>

Patients tested on 4LPM whose lab values qualify according to national policy guidelines do not need additional lab values obtained from testing on room air. However, if patients tested on 4LPM have lab values which would not justify oxygen coverage according to national policy guidelines, testing done on less than 4LPM or room air would be necessary for the patient to qualify for the basic oxygen benefit.

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

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

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

HCPCS codes A4631, E0950-E0954, E0959, E0961, E0966, E0967, E0969-E1001, E1065-E1069, E1226, E1227, E1296-E1298, for wheelchair accessories, are not valid for claims submitted to the DMERC. The appropriate HCPCS codes, K0015-K0108 must be used instead when submitting claims for these items.

HCPCS codes E0958, E0968, E1225, and E1228 should not be used to bill for wheelchair options/accessories to the DMERC unless it is for the continued rental of an item that had been approved by the local carrier. (See section three of the July 1995 DMEPOS Supplier Manual on Grandfathering for more details.) The appropriate K codes must be used for all new rentals and purchases submitted to the DMERC.

HCPCS code E0972 (transfer board or device) is an invalid code for submission to the DMERC. Code K0103 (transfer board, less than 25 inches) should be used for claims to the DMERC only when such a board has been supplied. Any other types of patient transfer devices must be coded as E1399, along with a description of the product.

ENTERAL NUTRIENTS

According to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Help-line, there has been confusion regarding the renaming of the Replete product. The following chart has been provided by the SADMERC to help clarify this issue.

<table>
<thead>
<tr>
<th>Old Product Code</th>
<th>New Product Name</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replete</td>
<td>Nutren VHP</td>
<td>B4150</td>
</tr>
<tr>
<td>&quot;New&quot; Replete Unflavored</td>
<td>Replete Vanilla*</td>
<td>XX040</td>
</tr>
<tr>
<td>&quot;New&quot; Replete Unflavored with Fiber</td>
<td>Replete Vanilla* with Fiber</td>
<td>XX041</td>
</tr>
</tbody>
</table>

* Vanilla flavoring is being added to the Replete Unflavored Diets.
HCFA 1500 (12/90) FORM

Revised Claim Filing Instructions

The Health Care Financing Administration (HCFA) recently revised the filing instructions for the HCFA 1500 (12/90) form. You may begin using the new instructions on claims filed on and after October 1, 1995. However, you must be following these new instructions no later than March 1, 1996. Claims filed after March 1, 1996 which do not comply with these new instructions will be returned.

Changes to the HCFA 1500 (12/90) claim filing instructions effect Items 12, 19, 24b, 24d, 24e, 24g, and 29. As we recently published the entire listing of claim filing instructions in the revised Palmetto GBA DMEPOS Supplier Manual, July 1995 issue, beginning on page 1.25, we are only indicating below those Items which are changing and are applicable to DMEPOS.

Each of the affected Items will be listed here in its entirety. Changes to the current claims filing instruction appear in bold and italic type. These changes will also be released in the next revision to the Palmetto GBA DMEPOS Supplier Manual.

Item 12

The patient or authorized representative must sign and date this time unless the signature is on file. In lieu of signing the claim, the patient may file a statement in accordance with SS3047.1-3047.3. If the patient is physically or mentally unable to sign, a representative specified in S3008 may sign on the patient’s behalf. In this event, the statement’s signature line must indicate the patient’s name followed by the word “by”, the representative’s name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient’s representative revokes this arrangement.

The patient’s signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the physician or supplier, when the provider accepts assignment on the claim.

Signature by Mark (X): Where an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 19

Enter the date the patient was last seen and the UPIN of his/her attending physician when an independent physical or occupational therapist, psychotherapist, or physician providing routine foot care submits claims.

Enter the drug’s name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter the statement “Patient refuses to assign benefits” when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.
Item 24b - 24g

Item 24b

Enter the appropriate place of service (POS) code from the list provided below. Identify the location where the item is used or the service is performed.

NOTE: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

Place of Service Codes and Definitions

00-10 Nonassigned
11 Office
*12 Home
13-20 Nonassigned
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory surgical Center
25 Birthing Center
26 Military Treatment Facility
27-30 Nonassigned
*31 Skilled Nursing Facility
*32 Nursing Facility
*33 Custodial Care Facility
34 Hospice
35-40 Nonassigned
41 Ambulance
42 Ambulance
43-49 Nonassigned
50 Federally Qualified Health Center
51 Impatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57-60 Nonassigned
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
63-64 Nonassigned
*65 End-Stage Renal Disease Treatment Facility
66-70 Nonassigned
71 State or Local Public Health Clinic
72 Rural Health Clinic
73-80 Nonassigned
81 Independent Laboratory
82-98 Nonassigned
99 Other Unlisted Facility

* These codes are the POS codes applicable to the Durable Medical Equipment Regional Carrier (DMERC).

Item 24d

Enter the procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when you enter an unlisted procedure code, include a narrative description in Item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.
Item 24e

Enter the diagnosis code reference number, as shown in Item 21, to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed enter the primary reference number for each service; either a 1, or a 2, or a 3, or a 4.

Item 24g

Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages or allergy testing procedures.) When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in Item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

♦ For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in Item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in Item 24g.

♦ For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10 pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month bill, the unit entry "06" is entered in Item 24g.

♦ For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound, respectively.

Item 32

Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. When the name and address of the facility where the services were furnished is the same as the biller's name and address shown in Item 33, enter the word "SAME." Physicians must identify the supplier's name, address and South Carolina Medicare Provider Identification Number when billing for purchased diagnostic tests. When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier.
As part of our continuing efforts to meet your educational needs, Palmetto GBA is pleased to announce three new ombudsmen and the reassignment of a current ombudsmen. These ombudsmen are profiled below. A complete directory of Palmetto GBA ombudsmen and their territories can be found on page 95-134 of this DMERC Medicare Advisory.

Teresita Ortiz is the new ombudsman for Southern Florida. She will be relocating to Florida upon completion of her Palmetto GBA training. After obtaining her Bachelor of Arts degree, Terry went on to complete her Master of Arts degree in Labor Relations from the InterAmerican University in Puerto Rico. Terry brings to Palmetto GBA thirteen years of valuable experience in the insurance field. She began her career as a claims/benefits analyst, facilitating the successful resolution of contested claims. Terry relocated to North Carolina and served in management as an International Markets Service Coordinator. In this capacity she serviced the company's South and Central American, and Puerto Rican customer base. Terry then transferred to the Puerto Rican branch of the company where she assumed new duties as an underwriter, ultimately being promoted to Underwriting Supervisor. In this role, Terry implemented a consistent training program to offer support to agents and brokers, focusing primarily on the effective application and administration of guidelines and policies. Terry looks forward to using her training and experience to support the Region C DMEPOS suppliers in Southern Florida. Until her relocation, Terry can be reached at (803) 735-1034 Ext. 37282.

Adie Fuentes is the new ombudsman for Puerto Rico. She will be relocating to Puerto Rico, her native state, upon completion of her Palmetto GBA training. Adie brings to Palmetto GBA an extensive background in education and training. She obtained her Bachelor of Arts degree in Secondary Education from the University of Puerto Rico. Prior to joining Palmetto GBA Adie worked for the Governor's Office for Elderly Affairs, in Puerto Rico. In this position, Adie was responsible for designing and carrying-out the educational campaign for the Health Insurance Counseling Program, island-wide. She trained and supervised the customer service staff. Adie wrote press releases regarding Medicare, Medicaid and Medigap issues and participated on radio and television talk shows as the guest speaker. Adie developed and implemented training sessions on Elder Abuse Prevention. Before joining the Governor's Office for Elderly Affairs, Adie was a Recreational Therapist. In this capacity, she developed and implemented a comprehensive and diversified, goal-oriented treatment program treating elder patients with physical, emotional and social dysfunctions. Prior to her physical therapist role, Adie was the supervisor for three Durable Medical Equipment stores, handling commercial accounts and problem resolution. Adie looks forward to returning to Puerto Rico and the challenge to successfully support Puerto Rico based DMEPOS suppliers. Until her relocation to Puerto Rico, Adie can be reached at (803) 735-1034 Ext. 35780.
Dana Causey is the new ombudsman for the state of Texas. Dana brings to Palmetto GBA a background in regional training. Prior to joining Palmetto GBA, Dana worked for a homecare company where she was named Employee of the Year for her successful training efforts. Consequently, Dana was selected as Regional Field Trainer for Medicare guidelines. In this role Dana was responsible for overseeing all claim submissions including coding and follow-through of recording payments to patient records. Dana also served as the liaison between the physician community and the homecare company staff, helping to ensure a high standard of care for their patients. Before her work with the homecare company, Dana was a Patient Service Coordinator. In this role she was directly responsible for taking and securing the orders generated by physicians for patients' needs in the home. She maintained all patient records, verified insurance coverage and managed large contract billing. Prior to this position, Dana was an Office Manager, where she managed the entire business operation including estimating, invoicing, buying and maintaining inventory, payroll and customer relations. Dana is in the process of obtaining her Bachelor Degree in Business Administration from the University of Texas. Born and raised in Texas, Dana looks forward to applying her knowledge and supporting her fellow Texan DMEPOS suppliers. Dana can be reached at (210) 598-4882.

Alison Santoro is the new ombudsman for Tennessee. Prior to being reassigned to Tennessee, Alison was the ombudsman for southern Florida and Puerto Rico. She has moved to Nashville, TN, to better serve her Tennessee DMEPOS suppliers. After obtaining her Bachelor of Arts degree, Alison continued her education to complete her Master of Business Administration degree from the University of South Carolina. An avid traveler, Alison has lived and studied in Ecuador, Chile and Venezuela, and is fluent in Spanish. After her schooling, Alison secured a position as a Sales Representative for a company in Atlanta, GA. Her responsibilities included servicing a seven-state territory, providing technological support to her customers. In recent years, she has held a number of Marketing Consultant and Public Relation positions. While in these roles, she successfully coordinated several national projects, as well as planned and implemented a series of focus group meetings as part of an international networking venture. Alison is excited about applying her talents in her new position as Palmetto GBA ombudsman for Tennessee. Alison can be reached at (615) 353-8851.

(Alison Santoro's photograph was previously published in the March 1995 issue of the DMERC Medicare Advisory, page 95-8.)
The following grid is provided to offer the proper selection of HCPCS codes when billing for lymphedema pumps.

<table>
<thead>
<tr>
<th>Manufacturer/Brand Name</th>
<th>Model Name/No.</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio Compressions Systems/Sequential Circulator</td>
<td>2000</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>3000</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>3001</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>3004</td>
<td>E0652</td>
</tr>
<tr>
<td>Huntleigh</td>
<td>Flowplus (AC330)</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>Flowpress (AC300)</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>Flowtron</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>103M</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>201A - Mini</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>201-M</td>
<td>E0652</td>
</tr>
<tr>
<td>Talley/Hemaflow 2 Pump</td>
<td>Intermittent</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>Sequential</td>
<td>E0651</td>
</tr>
<tr>
<td>Talley/Multicom</td>
<td>100</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>300</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>300G</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>500 ('93 &amp; '94 model)</td>
<td>E0652*</td>
</tr>
<tr>
<td></td>
<td>1000</td>
<td>E0652</td>
</tr>
<tr>
<td>Talley/Multipulse</td>
<td>PresSsion</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>4328 CGS</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>4330 VGS</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>4320</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>4322</td>
<td>E0650</td>
</tr>
<tr>
<td>Wright Linear Pump</td>
<td>II</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>E0652</td>
</tr>
<tr>
<td>Chattanooga</td>
<td>PresSsion</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>4328 CGS</td>
<td>E0651</td>
</tr>
<tr>
<td></td>
<td>4330 VGS</td>
<td>E0652</td>
</tr>
<tr>
<td></td>
<td>4320</td>
<td>E0650</td>
</tr>
<tr>
<td></td>
<td>4322</td>
<td>E0650</td>
</tr>
<tr>
<td>Advantage</td>
<td>2100</td>
<td>E0652</td>
</tr>
<tr>
<td>Thera-Con</td>
<td>Sequential</td>
<td>E0652</td>
</tr>
</tbody>
</table>

* Talley/Multicom model '92 or before = E0651
Providing answers to your questions/concerns on an on-going basis.

These questions were submitted to Palmetto GBA by Region C suppliers, and the answers are being published so that all may benefit.

1. **Q** When do suppliers have to begin submitting the attachment to the HCFA 484 from?
   
   **A** Oxygen suppliers are encouraged to begin submitting the attachment to the HCFA 484 form on and after October 1, 1995. This attachment is, however, mandatory on and after July 1, 1996.

2. **Q** Are suppliers required to use the DMERC CMNs or can they use their own modifications to the CMNs?
   
   **A** Suppliers are strongly encouraged to use the DMERC CMN forms to avoid potential claims processing delays. If suppliers choose to submit a "modified" paper CMN, it must contain all of the same questions (as well as instructions) as on the DMERC CMN forms, with questions numbered in the same order. Electronically filed CMNs can only be submitted in the National Standard Format (NSF) provided by the DMERCs.

3. **Q** Do suppliers have to send physicians the CMNs with instructions on the back, or can they send just the front pages?
   
   **A** Suppliers must provide physicians with both the front and back pages of the CMNs. The instructions on the back pages are essential to both physicians and suppliers.

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**HCPCS CODE DELETION: K0117**

Effective July 1, 1995, HCPCS Code K0117 (Unlisted item, orthotic seating, back module) is no longer valid for submission to the DMERC. Use HCPCS Code K0108 (other accessory) to submit claims for wheelchair seating systems.

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**HCPCS HELP-LINE (SADMERC)**

Effective April 3, 1995 the HCPCS Help-Line representatives at the Statistical Analysis Durable Medical Equipment Carrier, (SADMERC), began answering fee schedule inquiries for DMEPOS HCPCS codes, in addition to assisting with proper code selection. However, these representatives do not answer pricing questions for HCPCS codes that are not on a fee schedule, (i.e., reasonable charge, individually considered).

Only questions and inquiries regarding coding, HCPCS code usage and pricing for items on a fee schedule should be directed to:

HCPCS Help-Line: (803) 736-6809

SADMERC/HCPCS Unit
P.O. Box 100143
Columbia, SC 29202-3143
DMERC MEDICARE ADVISORY UPDATE

♦ **DMERC Medical Policy Correction:** On page 95–216 of the December issue of the DMERC Medicare Advisory, and on page 18.29 of the July 1995 DMEPOS Supplier Manual Revision, regarding the Lower Limb Prosthesis Medical Policy, the last paragraph in the DOCUMENTATION section of the policy inadvertently left out HCPCS codes series L5982-L5986. The paragraph should read:

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

♦ **Effective Date Clarification:** On page 95-46 of the June 1995 issue of the DMERC Medicare Advisory, the End Stage Renal Disease and Medicare Secondary Payer article inadvertently does not indicate an effective date. The information in this article only applies to services furnished on and after April 25, 1995.

♦ **Date Correction:** On page 95-47 of the June 1995 issue of the DMERC Medicare Advisory, under the Month of Discharge column, the date of 1/93 should correctly read 1/94.

♦ **HCPCS Code Clarification:** On page 95-49 of the June 1995 issue of the DMERC Medicare Advisory, HCPCS code XX005 incorrectly indicated 1000ml. The correct definition for HCPCS code XX005 is:

```
XX005  Therapeutic agent for urinary catheter irrigation
```

♦ **Surgical Dressing Product Name Clarification:** On page 95-68 of the June 1995 issue of the DMERC Medicare Advisory, the Surgical Dressing Product Clarification Chart incorrectly listed the product name of Winfield’s Break Away. The correct product name is Brake Away and the Manufacturer name is Winfield.

♦ **Surgical Dressing Category Clarification:** On page 95-68 of the June 1995 issue of the DMERC Medicare Advisory, the correct category of the Woun’dres by Sween is Hydrogel Dressing/Filler. The correct HCPCS code is K0248.

♦ **DMERC CMN Reference Correction:** On page 95-71 of the DMERC Medicare Advisory, the last bullet under the notes which follow the new Home Blood Glucose Monitor Medical Policy incorrectly listed DMERC CMN 04.01. That bullet should correctly refer to DMERC CMN 09.01 and read as follows:

**Effective October 1, 1995, DMERC Certificate of Medical Necessity (CMN) 09.01 is not needed, but the ZX modifier is required.**

♦ **Electronic Claim Submission Clarification:** On page 94-192 of the September 1994 issue of the DMERC Medicare Advisory, the introductory paragraph incorrectly implies that electronic billers can enter the Medigap company name and address in data fields DA0.07 and DA0.08 when the OCNA number is not available. To clarify, when the OCNA number is not available, these claims should be submitted on paper. Data fields DA0.07 and DA0.08 are exclusively reserved for the OCNA number.
Beginning October 1, 1995, the only charge for PACES claims entry software will be a $25.00 annual distribution fee. The Health Care Financing Administration (HCFA) recently mandated this cost change for the claims entry software of all four Durable Medical Equipment Regional Carriers (DMERCs). There will continue to be nominal one-time charges for communications command files and software licenses. The annual distribution fee will be collected on the first of October of each fiscal year. Current PACES users will not be assessed the $25.00 annual distribution fee until October 1, 1996.

Example:

- **PACES Claims Entry Software**
  - Initial Fee: $25.00
  - Annual Distribution Fee: $25.00 (payable on 10/1 annually)

- **Passport/Advantis Software with command File**
  - One time Fee: $15.00

- **ProComm Software with Command File**
  - One time Fee: $40.00

- **ProComm Command File Only**
  - One Time Fee: $15.00

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**TEAM TIPS**

- When sending in a written request for the review of a claim, please refrain from highlighting the Explanation of Medicare Benefits (EOMB), to indicate which claim you want Palmetto GBA to review. You may circle the claim number or put an asterisk by the claim number that should be reviewed. An electronic image is made of all correspondence received by Palmetto GBA for our records. When these electronic images are prepared, any portion of the copy which has been highlighted appears black, blocking out the information underneath. Your cooperation in this matter will help Palmetto GBA to expedite your claim reviews.

- Change printer ribbons often. Our equipment that makes the electronic image of your claim does not pick up light printed ink well, and could result in either incorrect processing or returned claims.

- Please do not use extremely small (e.g., 15-pitch and smaller) type fonts to complete claims.

- Although not required by law, if the physician will include the HCPCS code on Oxygen CMNs, as well as the Revised/Recertification date (if applicable), it will greatly facilitate your claims processing.

- If you are filing a paper claim involving MEDIGAP, make sure you spell out the word MEDIGAP, as well as include proper OCN and policy numbers.

- Primary insurance information belongs in Item 11 of the HCFA 1500 (12/90) form.
**INTEREST RATE PAYABLE ON CLEAN CLAIMS UPDATE**

The Treasury Department has announced, effective July 1, 1995, the new Prompt Payment interest rate is 6.375 percent. The new rate is effective for scheduled Medicare payment dates of July 1 through December 31, 1995. The rate is applicable to clean paper and electronic claims that have not been paid by the 30th day after the date of receipt. The new rate has been approved by the Secretary of the Treasury and was published in the Federal Register prior to July 1, 1995.

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**PRICING: DRUG UPDATES**  
(Effective July 5, 1995)

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<td>Atrovent 0.02% UD*</td>
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*UD = Unit Dose
*Ombudsman Addresses and Their Territories

**To Be Announced**
In the interim, please contact Melissa White (803) 735-1034, Ext. 35781

**Sharon Briggman**
P.O. Box 37624-7424
Raleigh, NC 27615
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(502) 753-3511

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Jackson, MS 39286
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**Keith Smith**
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Suite 139
Jacksonville, FL 32223
(904) 287-6860

**Cris Taylor**
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(803) 735-1034, Ext. 35789

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Roswell, GA 30076
(404) 663-7644

**Sheri Thompson**
P.O. Box 100141
Columbia, SC 29202-3141
(803) 735-1034, Ext. 35726


The portion of the state (Florida) which the ombudsman covers.

* Ombudsmen are those who investigate reported complaints, report findings, and help to achieve equitable settlements, through training and education of the supplier community.
Please retain the list below as your new DMERC telephone directory.

Dedicated Work Teams and DMERC General Information

Professional Relations (PR)
Palmetto GBA
Professional Relations, Medicare Region C DMERC
P.O. Box 100141
Columbia, SC 29202-3141

PR General Information Number: (803) 735-1034

Individual extensions in Professional Relations may be reached by adding the number three in front of the person’s extension. (Ombudsmen addresses and telephone numbers can be found in this advisory in the Professional Relations section.)

Anti-Fraud Unit
Palmetto GBA
Anti-Fraud Unit, Medicare Region C DMERC
P.O. Box 100236
Columbia, SC 29202-3236

Anti-Fraud Hot-Line: (803) 788-5414

Individual extensions in the Anti-Fraud Unit may be reached by adding the number four in front of the person’s extension.

Hearings
Palmetto GBA
Hearings Department, Medicare Region C DMERC
P.O. Box 100249
Columbia, SC 29202

Written Prior Authorization
Palmetto GBA
Prior Authorization Dept., Medicare Region C DMERC
P.O. Box 100235
Columbia, SC 29202-3235

Electronic Data Interchange (EDI)
Palmetto GBA
Electronic Data Interchange, Medicare Region C DMERC
P.O. Box 100145
Columbia, SC 29202-3145

EDI Help-Line: (803) 788-9751

DMERC Region A (717) 735-9445
DMERC Region B (317) 577-5722
DMERC Region D (615) 251-8182

National Supplier Clearinghouse (NSC)
Palmetto GBA
National Supplier Clearinghouse
P.O. Box 100142
Columbia, SC 29202-3142
803) 754-3951

Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)
Palmetto GBA
Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)
P.O. Box 100143
Columbia, SC 29202-3143

HCPCS Help-Line: (803) 736-6809