OXYGEN CMN REVISED

Included in this issue is the corrected Certificate of Medical Necessity for oxygen, DMERC form 484.2.Originally printed in Palmetto GBA's Summer 1997 DMERC Medicare Advisory, the line in Section A should read

"Certification Type/Date: INITIAL __/___. REVISED __/___.
RECERTIFICATION __/___.”

Also included is information on Region C's DMERC oxygen medical policy and its certificate of medical necessity.

The Physician Information Sheets describe oxygen equipment, its usual clinical indications and Medicare's coverage criteria for reimbursement. Suppliers are encouraged to share these and other Physician Information Sheets with their physician referral services.

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

Comments and suggestions are welcome. Please direct them to Communications Specialists in the Professional Relations Department at the address listed above.
MEDICAL AFFAIRS BULLETIN

Billing of NOC surgical dressing codes

When submitting claims for surgical dressings, codes listed below, it is essential to include the brand name, manufacturer, product (stock) number and the size of the product provided. For wound fillers, there should be wound documentation included with the claim—the not otherwise classified (NOC) Codes used for various wound filler products may represent a wide variety of diverse properties including weight, consistency and amounts, thus requiring this documentation for each individual wound.

The codes requiring brand name, product number, manufacturer, and size of product include:

A6020  Collagen based wound dressing, wound cover, each dressing.
A6198  Alginate dressing, wound cover, pad size more than 48 square inches, each dressing.
A6205  Composite dressing, pad size more than 48 square inches with any size adhesive border, each dressing.
A6206  Contact layer, 16 square inches or less, each dressing.
A6208  Contact layer, more than 48 square inches, each dressing.
A6215  Foam dressing, wound filler, per gram.
A6218  Gauze, non-impregnated, non-sterile, pad size more than 48 square inches, without adhesive border, each dressing.
A6221  Gauze, non-impregnated, pad size more than 48 square inches, with any size adhesive border, each dressing.
A6228  Gauze, impregnated, water or normal saline, pad size 16 square inches or less, without adhesive border, each dressing.
A6230  Gauze, impregnated, water or normal saline, pad size more than 48 square inches, without adhesive border, each dressing.
A6239  Hydrocolloid dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing.
A6250  Skin sealants, protectants, moisturizers, ointments, any type, any size
A6256  Specialty absorptive dressing, wound cover, pad size more than 48 square inches, with any size adhesive border, each dressing.
A6260  Wound cleansers, any type, any size.
A6261  Wound filler not otherwise classified, gel/paste, per fluid ounce.
A6262  Wound filler, not elsewhere classified, dry form, per gram.
A6404  Gauze, non-impregnated, sterile, pad size more than 48 square inches, without adhesive border, each dressing.
Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC) Regional Medical Review Policy (RMRP) on oxygen and an explanation of the oxygen certificate of medical necessity. They describe the equipment, its usual clinical indications and Medicare's coverage criteria for reimbursement. Hopefully it will help you to better understand the criteria Medicare uses in adjudicating these claims.

The DMERC strongly believes that the physician is still the "Captain of the Ship." We require a physician's order before reimbursing any item. Sometimes we require a Certificate of Medical Necessity (CMN) and extra documentation. While this may inconvenience you with additional paperwork, it is only through your cooperation that Medicare can provide beneficiaries with the equipment and supplies they need. You are also helping to protect the Medicare Trust Fund from abusive and fraudulent claims for items that are not medically necessary or physician-ordered.

The following Physician Information Sheets (PHYISs) is only a summary of the RMRP published in the DMERC Region C DMEPOS Supplier Manual. The definitive and binding coverage policy will always be the RMRP itself, which reflects national Medicare policy, and upon which actual claims adjudication is based. The physician information sheets are intended only as an effort to educate the physician community on conditions of coverage for items of durable medical equipment, prostheses, orthoses, and supplies when ordered for the care of Medicare beneficiaries.
**OXYGEN POLICY**

*Physician Information Sheet*

For the year 1997, the cost to Medicare for oxygen and related equipment and supplies used in the home setting alone, will be greater than 2 billion dollars! Oxygen in the home setting represents the highest amount paid out by Medicare for any one item of durable medical equipment.

It is physicians who order and verify the need for oxygen being used in the home setting. Below, you will find the medical review policy by which Medicare reimburses or denies payment for this treatment modality. If you are familiar with our policy, it may help you to coordinate your therapeutic goals with the coverage criteria by which Medicare may pay for your patients’ true oxygen needs.

The Durable Medical Equipment Regional Carrier (DMERC) medical review policy on oxygen is based upon the HCFA national policy.

Medicare covers oxygen administration only for lung diseases associated with hypoxemia, and when this condition is substantiated by blood gas levels, and all other modalities of treatment have been tried or deemed clinically ineffective. This is an important concept because conditions such as angina pectoris or congestive heart failure that have not been completely stabilized by direct treatment with other appropriate medications and measures, or which are not associated with demonstrated hypoxemia, will not be eligible for Medicare coverage of oxygen, since supplemental oxygen in the absence of other more direct treatment, or in the absence of hypoxemia is not considered medically necessary. Similarly, examples of conditions not covered by Medicare for oxygen therapy are dyspnea in the absence of hypoxemia (e.g., psychogenic), terminal illnesses not affecting the respiratory system and peripheral vascular disease.

Oxygen may be delivered by three basic types of stationary delivery systems: storage tanks, concentrator (where an increased percentage of oxygen is extracted from the ambient atmosphere) or liquid system (oxygen cooled and stored in its liquid state). Portable delivery systems use smaller tanks filled with oxygen in gaseous or liquid state.

**Oxygen testing**

Demonstration of hypoxemia is accomplished by either arterial blood gases (ABGs) or measurement of oxygen saturation ($O_2$ Sat). If both tests are available, ABGs should be submitted with Medicare DMERC claims. It is no longer necessary that blood gas determinations be performed with the patient on room air only. If the patient’s levels are low enough to qualify for Medicare coverage even while breathing supplemental oxygen, then nothing more would be gained by depriving that patient of supplemental oxygen only to obtain even lower levels. However, conversely, there is rarely if ever a clinical contraindication to lowering the flow rate of supplemental oxygen (under carefully monitored conditions) to a level (even down to room air) in order to obtain blood gas levels which will qualify the patient for reimbursement.

Following the same logic, because Medicare reimburses at a higher monthly rental amount for oxygen flow rates greater than 4 liters per minute (LPM) (see payment below), it is necessary to submit blood gas results obtained while the patient is breathing oxygen at 4 LPM in order to demonstrate the need for the higher flow rate. Using the same blood gas levels as those listed below for basic oxygen coverage (1–4 LPM), if the results obtained on 4 LPM do not justify the higher flow rate, then only the basic oxygen rental amount will be allowed, so long as any blood gas levels justify even basic coverage.

The blood gas results used to certify the need for oxygen should only be those done on a patient in a chronic stable state. It is inappropriate to use tests done on a patient in an acute state of illness or decompensation, such as might be obtained in an emergency care unit or initially obtained after admission to the hospital since other modalities of treatment used to stabilize the patient might render supplemental oxygen administration on a chronic basis in the home setting unnecessary. This is why the initial Certificate of Medical Necessity (CMN) requires the test be done within two calendar...
OXYGEN POLICY
Physician Information Sheet

days before hospital discharge (presumably when the patient has achieved pre-discharge clinical sta-
tility), or when the patient is already in a chronic stable state as an outpatient. When certifying a
patient for Medicare coverage of oxygen therapy, only the last, most recent blood gas determination
should be submitted with a DMERC CMN.

Blood gas groupings for coverage

There are three basic groups of values for ABGs and O₂ Sat that will determine whether Medicare
will cover oxygen in the home:

♦ Group I:  **ABG PO₂ is less than or equal to 55 mm Hg. or the O₂ Sat is less
than or equal to 88%** (awake and at rest). If a patient has higher levels, but
demonstrates desaturation to these levels during sleep or exercise, then oxygen
may be reimbursed. Also, if during sleep, the levels are higher than 55 mm Hg. or
88%, but represent a drop of 10 mm Hg. (ABGs) or 5% (O₂ Sat) from awake, at
rest levels, and are associated with demonstrated cor pulmonale, pulmonary hyper
tension and erythrocytosis, the patient may qualify.

♦ Group II:  **If the ABG PO₂ is 56-59 mm Hg. or the O₂ Sat is at 89%** (awake and
at rest). However, to qualify for Medicare coverage with these values, there must be
documentation of dependent edema secondary to congestive heart failure, or
pulmonary hypertension, or cor pulmonale, or erythrocytosis (the hematocrit for
the erythrocytosis would have to be at least 56%).

♦ Group III: **If the ABG PO₂ is 60 mm Hg. or greater or the O₂ Sat is 90% or greater,**
Medicare will not reimburse supplemental oxygen, since according to these results
the patient is not truly hypoxemic, and supplemental oxygen is not considered
medically necessary.

Payment of oxygen

When Medicare covers oxygen, its reimbursement includes all equipment, contents, accessories, tub-
ing, administration kits, set-up and delivery fees. (For instance, if the physician orders use of a
transtracheal catheter, that too, is included in the monthly reimbursement amount.) Medicare reim-
burses for oxygen content, and not for the type of equipment used to deliver the oxygen. Back-up
tanks or equipment are not additionally reimbursed.

If the patient is receiving any flow rate between 1–4 LPM, Medicare pays a basic monthly rental
amount. If the patient is receiving less than 1 LPM, the payment is reduced by 50%, and if greater
than 4 LPM, the payment is increased by 50%. If the patient is receiving portable oxygen, an extra
amount is allowed for this delivery system. However, either the extra amount for the higher flow rate
or for the portable delivery is allowed, not both.

Documentation

A new CMN (DMERC FORM 484.2) is replacing the older Form 484. (See accompanying PHYSIS on
the oxygen CMN.) It is necessary for the physician to oversee completion and to sign a CMN when a
patient is initially placed on oxygen.

A recertification CMN is required 12 months after the initial CMN if the patient starts out with Group
I blood gas levels; a recertification is required within 3 months if the initial levels fall into Group II.
A recertification would also be due at the expiration of a period of estimated medical need as deter-
OXYGEN POLICY
Physician Information Sheet

mined by the ordering physician. Recertifications are required when due, whether or not there is any change in the patient’s condition or the physician’s order.

In addition, a revised CMN is required whenever the physician changes the oxygen prescription (e.g., flow rate) or if there is a change in the ordering physician.

Recertification blood gases

Patients who initially qualify for coverage with Group I blood gas levels, should submit the most recent available ABGs or O₂ Sat with the 12 month recertification CMN.

Patients who initially qualify for coverage with Group II levels, must have a repeat ABG or O₂ Sat performed within 30 days of the 3-month recertification CMN.

It's in your hands

Considering that Medicare is paying over two billion dollars a year for oxygen in the home setting, an amount coming from the same Trust Fund which reimburses physicians’ services, and that Medicare depends upon the treating physician to prescribe and certify the medical necessity of this treatment modality, it would seem self-evident that ordering physicians might have a heightened interest in the proper utilization of this medical resource, both as concerned tax payers, and as sharers in the same limited pool of national medical resources.

Paul D. Metzger, M.D.
Medical Director, Region C DMERC
Palmetto Government Benefits Administrators
Columbia, S.C.
OXYGEN CERTIFICATE OF MEDICAL NECESSITY (CMN)
Physician Information Sheet

The Certificate of Medical Necessity (CMN) for home oxygen therapy (HCFA Form 484) has been revised by the Durable Medical Equipment Regional Carriers (DMERCs). The reasons for this are:

♦ to add a section which lists the supplier's charge and Medicare fee schedule allowance for the equipment that is provided, as required by legislation,
♦ to make the format consistent with other DMERC CMNs, and
♦ to ask questions that will help the DMERCs determine whether coverage criteria for home oxygen therapy have been met. Instructions for completion of the CMN can be found on the back of the form.

The following comments highlight some instructions and provide additional explanation about the CMN for physicians. However, while serving as an educational tool on the CMN, this document does not represent nor replace the published DMERC Regional Medical Review Policy (RMRP) on oxygen. If physicians want a copy of the DMERC oxygen policy, they should contact the home oxygen supplier or the DMERC in their region (not the local carrier).

Section A

This section is usually filled out by the supplier. It must be completed before the physician signs the form. The physician should review it and correct any obvious inaccuracies, initialing any changes made. For example, if the patient is in a nursing facility this should be noted in the patient's address. However the physician is not expected to validate the accuracy of the HCPCS procedure codes listed.

Section B

This section may not be completed by the supplier. This section must be completed by the treating physician, that physician's employee, or another clinician involved in the care of the patient as long as that person is not the supplier. If someone other than the physician completes Section B, that person must enter their name, title and employer at the end of Section B. If someone other than the physician completes section B, the physician must review the answers to assure their correctness and make changes as needed.

Questions #1-8 provide information which allows the DMERCs to determine if the Medicare coverage criteria have been met. The test results in questions #1 and #7 should be the most recent test on or prior to the most recent date at the top of Section A. If both an arterial blood gas (ABG) and oximetry test are performed on that same day, only the ABG PO2 should be reported. An oxygen saturation from an arterial gas study should not be reported. The test in question 1 may be performed with the patient on oxygen. However in those cases, an attempt should be made to titrate the oxygen flow down to a level where Medicare criteria are clearly met, e.g. PO2 less than or equal to 55 mm Hg or an oxygen saturation less than or equal to 88%. If the Medicare coverage are not met (see Oxygen policy for details), the physician should provide additional information justifying the medical necessity of home oxygen therapy for the specific patient.

Question #2 asks whether the qualifying blood gas or oximetry test was performed EITHER with the patient in a chronic stable state as an outpatient OR within two calendar days prior to discharge from an inpatient facility to home. If the answer to the question is No, the physician should provide additional information justifying the medical necessity of home oxygen therapy for the specific patient.

The physician must enter the name and the address of the entity performing the oxygen test in question #4. Medicare does not accept a test performed by the oxygen supplier (except in the case where
**OXYGEN CERTIFICATE OF MEDICAL NECESSITY (CMN)**  
*Physician Information Sheet*

the supplier is a hospital-owned company and the test is performed by that hospital).

In question #6, the physician enters the prescribed oxygen liter flow. If different flow rates are prescribed in different situations (e.g. at rest, during exercise, during sleep), enter the highest value in this question. Other values can be noted in Section C - see discussion below.

If an oxygen flow rate of greater than 4 LPM is prescribed, question #7 on the CMN asks for test results taken on 4 LPM in order to justify the medical necessity of the high flow rate. If the prescribed flow rate in question #6 is less than or equal to 4 LPM, the answer spaces in question #7 may be left blank.

Questions #8-10 only have to be answered if the reported results in question #1 show a P02 greater than 55 or an oxygen saturation greater than 88%. In other situations, a "D" for Does Not Apply may be circled.

**Section C**

This section must be completed by the supplier prior to sending the CMN to the physician. The supplier’s charges and Medicare fee schedule allowance are provided for the physician’s information. The physician is not expected to validate the accuracy of these values.

Section C also may serve as the physician’s written order. The supplier must list the type of equipment being provided (e.g. concentrator, liquid, or gaseous; stationary and/or portable). The supplier may also enter information confirming the physician’s other oxygen orders. For example, if the physician has ordered oxygen at different flow rates during different situations, e.g. rest, during exercise, during sleep, etc., or has ordered a specific type of administration equipment, e.g. nasal cannula, mask, transtracheal catheter, etc., this could be entered by the supplier in Section C. If the information entered by the supplier is incorrect, the physician must either make the appropriate corrections, initialing the changes, or return the CMN unsigned to the supplier for correction. If the supplier has not entered the optional information, e.g. flow rates in different situations, type of administration equipment, the physician may enter that information. The information in Section C along with the answer to question #6 in Section B, can serve as the physician’s order.

**Section D**

If the information in Section B and the order information in Section C is correct, then a physician who is actively/presently treating the patient signs and dates the CMN and mails it to the supplier. It must be an original signature - signature stamps or other signature facsimiles are not acceptable. If the supplier asks the physician to fax the CMN the physician must still mail the original signed CMN to the supplier. The physician is encouraged to keep a copy of the CMN in the patient’s medical record.
### OXYGEN

**SECTION A** Certification Type/Date: INITIAL / / REVISED / / RECERTIFICATION / /

<table>
<thead>
<tr>
<th>PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER</th>
<th>SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(______) ___________ ___________ HICN ___________</td>
<td>(______) ___________ ___________ NSC # ___________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLACE OF SERVICE</th>
<th>HCPCS CODE</th>
<th>PT DOB / / Sex (M/F): HT (in.): WT (lbs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of Service</td>
<td>HCPCS Code</td>
<td>Physician Name, Address, Telephone and UPIN Number</td>
</tr>
<tr>
<td>________________</td>
<td>___________</td>
<td>_______________ ___________ UPIN # ___________</td>
</tr>
</tbody>
</table>

**SECTION B** Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

<table>
<thead>
<tr>
<th>EST. LENGTH OF NEED (# OF MONTHS):</th>
<th>(1-99 = LIFETIME)</th>
<th>DIAGNOSIS CODES (ICD-9):</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANSWERS a) mm Hg b) % c) / / / /</td>
<td>Yes (Y) No (N)</td>
<td>Print/type name and address below:</td>
</tr>
<tr>
<td>1 2 3</td>
<td>1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test. Enter date of test (c).</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>4. Physician/provider performing test in Question 1 and, if applicable, Question 7. Print/type name and address below: NAME: ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a 'X'.</td>
<td></td>
</tr>
<tr>
<td>1 2 3</td>
<td>7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).</td>
<td></td>
</tr>
</tbody>
</table>

**IF PO2 = 56–59 OR OXYGEN SATURATION = 99%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.**

| Y N D | 8. Does the patient have dependent edema due to congestive heart failure? |
| Y N D | 9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement? |
| Y N D | 10. Does the patient have a hematocrit greater than 55%? |

**NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):**

| NAME: | TITLE: | EMPLOYER: |

**SECTION C** Narrative Description of Equipment and Cost

1. Narrative description of all items, accessories and options ordered; 2. Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

**SECTION D** Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE

DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A:

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:
If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked “INITIAL.” If this is a revised certification (to be completed when the physician changes the order, based on the patient’s changing clinical needs), indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “REvised.” If this is a recertification, indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “RECERTIFICATION.” Whether submitting a REvised or a RECERTIFIED CMN, be sure to always furnish the initial date as well as the REvised or RECERTIFICATION date.

PATIENT INFORMATION:
Indicate the patient’s name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:
Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:
Indicate the place in which the item is being used, i.e., patient’s home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:
If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES:
List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:
Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS:
Indicate the physician’s name and complete mailing address.

UPIN:
Accurately indicate the ordering physician’s Unique Physician Identification Number (UPIN).

PHYSICIAN’S TELEPHONE NO:
Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B:

(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED:
Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:
In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:
This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, “D” for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:
If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietitian) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C:

(To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST:
Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier’s charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(To be completed by the physician)

PHYSICIAN ATTESTATION:
The physician’s signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE:
After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician’s signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0534. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to HCFA, P.O. Box 26804, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
According to the DMERC medical review policy on walkers, heavy duty, multiple braking system, variable wheel resistance walkers (E0147) are covered for patients who are documented as unable to use a standard walker due to obesity, severe neurologic disorders or restricted use of one hand.

With claims received for E0147 on or after January 1, 1998, the following additional documentation must be submitted:

♦ the name, address and correct phone number (including area code) of the physician ordering the E0147;

♦ if the medical necessity for the E0147 is obesity, the patient's height and weight must be indicated;

♦ if the medical necessity is for a severe neurologic disorder or restricted use of one hand, the diagnosis and patient's functional level must be described.

These conditions must also be reflected in the patient's medical chart for possible corroboration by the DMERC with the patient's physician.

Claims for E0147 lacking this extra documentation will be downcoded to E0141 (wheeled walker, without seat) if criteria for this, as listed in the policy, are met.
**ESRD Extension on Coordination Period**

Medicare benefits for End Stage Renal Disease (ESRD) remain secondary to benefits payable by a group health plan (GHP) under Section 4631(b) of the Balanced Budget Act of 1997. Furthermore, the coordination period required for individuals with ESRD has been permanently extended from 18 to 30 months for anyone whose coordination period began on or after March 1, 1996.

Individuals who have not completed an 18-month coordination by July 1, 1997, will have to fulfill a 30-month coordination period under the new law, in place of the original 18-month coordination period. The DMERC will deny claims for primary payment submitted for applicable individuals during their 30-month coordination period, unless the individual has reached the 18-month point on or before July 31, 1997.

A coordination period begins with the first month an individual is eligible for Medicare, whether or not the individual is actually entitled or enrolled. Medicare is secondary during this period even though the group policy or plan contains a provision stating its benefits are secondary to Medicare, or otherwise excludes or limits its payments to Medicare beneficiaries. Under this provision, the GHP must be billed first for services provided to a Medicare ESRD beneficiary.

If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries during the coordination period.

**Seat Lift Mechanism Billing Clarification**

When providing a seat lift mechanism incorporated into a chair, suppliers may bill the two items separately. As previously stated in medical policy, however, Medicare only covers the seat lift mechanism itself. The chair is a non-covered item and will be denied when billed separately. In such situations, suppliers may bill the seat lift mechanism with HCPCS code E0627 and the chair with HCPCS code A9270.

**National Provider Identifier Delayed**

The Notice of Proposed Rulemaking (NPRM) suggesting the National Provider Identifier (NPI) as the standard for Medicare transactions, originally scheduled for publication in February 1997, has been delayed. For this reason, the Health Care Financing Administration is delaying NPI implementation beyond December 1, 1997. HCFA anticipates it will take at least five months to publish the final regulation after the NPRM is published, and at least another five months to incorporate the NPI into Medicare operations.

For detailed information about the NPI, refer to the Spring 1997 *DMERC Medicare Advisory*, page 97-2. Suppliers also may check the HCFA web site for more information over the next several months at www.hcfa.gov.
Suppliers are reminded the Hearing Request Form and the Review Request Form are two different forms with two different purposes to expedite hearing and review processes through Palmetto GBA.

The Review Request Form, previously published in the Spring 1997 DMERC Medicare Advisory, page 28, is designed to collect all information needed to conduct a thorough and accurate review. The use of this form will enable suppliers to clearly identify their request, furnish the necessary information to be reviewed, and receive a prompt and accurate decision. Suppliers may photocopy the form from the Spring advisory as often as needed. Suppliers are reminded that reviews:

♦ must be requested within six (6) months of the date the claim was denied;

♦ should specify the item(s) to be reviewed and the reason for dissatisfaction with the original disposition;

♦ may be requested by phone if the supplier believes a processing error was made by the DMERC on the original claim and the issue does not involve medical necessity; and

♦ normally require forty-five (45) days for completion.

♦ Review request forms should be mailed to the supplier’s team address, which can be found in Chapter 10 of the Region C DMEPoS Supplier Manual.

The DMERC Hearing Request Form, found on page 12.4 of the DMEPoS Supplier Manual (released with the Spring 1997 revisions), is necessary for Palmetto GBA to promptly complete hearing request(s). Although this form is not mandatory, completion of this form may enable Palmetto GBA to respond to the hearing request more quickly.

Below are some helpful suggestions to ensure expedient and efficient processing of hearing request(s).

♦ A review must be completed on the claim in question prior to the hearing request. The only exception is for overpayments greater than $100. If the request for overpayment is more than $100, a review is not required. However, a copy of the overpayment letter must be attached to the hearing request.

♦ Provide all necessary information pertinent to the hearing request:

  - beneficiary’s name,
  - HIC number,
  - supplier number,
  - date(s) of service,
  - claim control number, and
  - document control number.

(The DMERC review response letter contains all of this information.)
HEARING REQUEST FORM VS. REVIEW REQUEST FORM

(continued)

♦ Be sure to direct hearing requests to the appropriate DMERC or Medicare carrier, i.e. the carrier who conducted the review.

♦ Specify the type of hearing on the request:
  - on the record,
  - telephone, or
  - in person.

♦ The amount in controversy must be at least $100. A single hearing request can be made on multiple claims to meet the $100 minimum requirement.

♦ A supplier cannot request a hearing on a non-assigned claim without forfeiting rights to reimbursement from the beneficiary.

♦ When multiple patients or claims are combined in one hearing request, your request may take longer to process.

Questions regarding these two forms should be directed to the Dedicated Work Teams at (803) 691-4300.

DATE OF SERVICE DEFINITION

Medicare law limits Part B payment for durable medical equipment to that which is used in the patient's home. Hospitals and nursing homes cannot be considered a patient's home for DME purposes.

Generally, for all durable medical equipment, prosthetics, orthotics and supplies, the supplier's date of service is the date of delivery to a beneficiary's home. For DMEPOS provided to a beneficiary immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the date of service is the date of final discharge to the beneficiary's home. For mail order DMEPOS provided immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the later of the actual shipping date or the date of discharge. Under no circumstance can the DOS be earlier than the date of delivery or, in the case of mail order DME, the shipping date.

PROMPT PAYMENT INTEREST RATE

Effective July 1, 1997, the Health Care Financing Administration established a new prompt payment interest rate of 6.75 percent. The interest rate is for scheduled Medicare payment dates of July 1, 1997, through December 31, 1997.
**PRESCRIPTION DRUG BILLING**

The Health Care Financing Administration has provided the following HCPCS code ranges subject to billing from entities licensed to dispense prescription drugs used with durable medical equipment or prosthetic devices. Effective December 1, 1996, only licensed entities are able to dispense prescription drugs used with durable medical equipment or prosthetic devices. (See page 96-352 of the December 1996 DMERC Medicare Advisory for further information on prescription drug billing.)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B4164-B4216, B5000-B5200</td>
<td>Parenteral nutrition solutions</td>
</tr>
<tr>
<td>J0120-J2914, J2950-J7130, J7610-J7799, J9000-J9390</td>
<td>Drugs administered other than oral method</td>
</tr>
<tr>
<td>K0283</td>
<td>Saline solution for use with inhalation drugs</td>
</tr>
<tr>
<td>K0453</td>
<td>Amphotericin B</td>
</tr>
<tr>
<td>K0503-K0528</td>
<td>Inhalation drugs (for dates of service on or after April 1, 1997)</td>
</tr>
<tr>
<td>Q0132</td>
<td>Dispensing fee for covered drug administered through DME nebulizer</td>
</tr>
</tbody>
</table>

**MASTECTOMY BILLING CLARIFICATION**

Suppliers billing the Softee post-surgery mastectomy undergarment should use HCPCS code L8499, a not-otherwise-classified code. A description of the undergarment, including manufacturer and model number, should accompany paper claims or be included in the HA0 record of electronic claims.

HCPCS code L8020 is appropriate for billing permanent mastectomy forms, and L8030 for silicone-type mastectomy prostheses.

**ELECTRONIC DATA INTERCHANGE (EDI)**

**Electronic remittance correction**

In the Summer 1997 DMERC Medicare Advisory, it was erroneously announced that all submitters who receive electronic remittances will no longer receive paper remittances.

DMERC providers who receive electronic remittance advices (ERAs) **will** continue to receive a paper copy of each remittance advice from Palmetto GBA indefinitely. We apologize for any confusion this article may have caused the supplier community.

Suppliers interested in receiving remittances electronically may contact the Palmetto GBA EDI Help Desk at (803) 788-9751 to request a Software Order Form. Software vendors also may offer software to view and/or post ERAs.