



**CIGNA Government
Services**

*DME MAC Jurisdiction C Supplier Manual
Summer 2009 Update*

June 2009

Dear Supplier:

Attached is the Summer 2009 update to the *DME MAC Jurisdiction C Supplier Manual*. Please read the enclosed material carefully. The *DME MAC Jurisdiction C Supplier Manual* is designed to provide vital, current DME MAC information. Supplier manual updates are issued quarterly.

A summary of the changes is listed on the following page. When updating a printed copy of the manual:

- Compare the new page numbers with the existing page numbers to ensure that you replace the correct pages for each chapter.
- Take out the old pages and replace with the updated pages. Make a final comparison of the page numbers, then discard or retain the old pages.

One other change to this quarter's revision is the addition of clickable links to the contents listing at the beginning of each chapter. This improvement will make it faster and easier to find the information you are looking for in each chapter.

REMINDER: Please be sure to read the *DME MAC Insider* (the Jurisdiction C newsletter) for additional information. The *DME MAC Jurisdiction C Supplier Manual* and *DME MAC Insider* are available on our Web site at www.cignagovernmentservices.com (select DME MAC Jurisdiction C). Also, visit "What's New" on the Web site for special notices concerning changes in regulations issued between publication releases. To receive automatic notification via e-mail of the posting of policies, publications and other important Medicare announcements, subscribe to the CIGNA Government Services electronic mailing ListServ at <http://www.cignagovernmentservices.com/jc/help/listserv/index.html>.

*DME MAC Jurisdiction C Supplier Manual
Summer 2009*

**Supplier Manual
Summary of Changes**

Revised/New Material	Replace Pages
Chapter 3	21
Chapter 4	1-3
Chapter 5	7, 12, 17, 19
Chapter 13	1-3, 5, 7, 11
Chapter 15	1
Chapter 16	3
Appendix A	50, 56, 129

3. A beneficiary requires one type of infusion pump for a particular drug (e.g., a pump with patient control features for parenteral morphine) and needs a different type of pump for another drug (e.g., continuous infusion chemotherapy).

Examples (not all-inclusive) of situations in which a second or other multiple piece of equipment would be considered a backup and therefore would not be covered are:

1. A ventilator-dependent beneficiary is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.
2. The drug epoprostenol (Flolan®) is administered using an ambulatory infusion pump, and a second infusion pump is provided and billed as a precaution in case of malfunction of the primary pump. Because interruption of a continuous infusion of this drug results in immediate life-threatening consequences, a unique code, K0455, has been established for an infusion pump used to administer this drug, and the code is in the frequent and substantial servicing payment category.

Miscellaneous HCPCS Codes

Unusual services and items are generally reported to the contractor with miscellaneous HCPCS codes. These miscellaneous HCPCS codes do not have established fee schedule reimbursement rates. Each item/service is processed based on individual consideration. In these situations you must furnish documentation describing the service or item, manufacturer name, product name and number, and the suggested retail price. If it is a customized option/accessory, the statement must clearly describe what was customized. When necessary, consultants' advice will be obtained.

If the description, manufacturer name, product name, product number and suggested retail price are not provided with the claim, the claim may be developed for additional information. If there is no response to the request for additional information, the claims will be denied for missing information and you will be responsible for resubmitting the claims with the appropriate information.

Claims for option/accessory codes as a replacement must be submitted with the make and model name of the equipment base the item is being added to, the date of the purchase of the equipment base, and documentation of the medical necessity for the item.

The definitions of HCPCS codes are meant to be broadly inclusive. All related components are included in the codes and should generally not be billed separately unless specifically allowed in the definition or description of a HCPCS code. If you choose to bill separately for an included component, HCPCS code A9900 (miscellaneous DME supply, accessory and/or service component of another HCPCS code) must be used and will be denied as not separately payable. If an included component is billed with a miscellaneous HCPCS code, then that claim line will be rejected as incorrect coding.

10. Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims

The use of CMNs for motorized wheelchairs, manual wheelchairs, and power operated vehicles was phased out for claims with dates of service (DOS) on or after May 5, 2005.

For claims with dates of service before May 5, 2005, claims shall be submitted and processed using the fully completed and signed CMNs (CMS-843 for motorized wheelchairs, CMS-844 for manual

Chapter 4 Contents

1. Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)
2. CMN and DIF Completion Instructions
3. CMNs as Orders and Claim Submission
4. Oxygen CMNs
5. CMN Common Scenarios

1. Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)

A Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required to help document the medical necessity and other coverage criteria for selected durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. The documentation section of the Local Coverage Determinations (LCDs) shows which items require one of these forms. See Chapter 9 of this manual for more information about LCDs.

CMNs contain four sections, A through D. You may complete sections A and C. Sections B and D must be completed by the beneficiary's physician.

A DIF does not require a physician signature or a narrative description of equipment and cost. You may complete and sign a DIF in its entirety.

For certain items or services billed to a DME MAC, you must receive a signed CMN from the treating physician. You must have a faxed, photocopied, original signed order or an electronic CMN in your records before you can submit a claim for payment to Medicare. CMNs and DIFs are referred to by their CMS form numbers. The CMS form number is located in the bottom left corner of the form. DME MAC form numbers identify the CMN on electronic claims submitted to the DME MAC.

The signature on the CMN or DIF must be handwritten or electronic only. Signature and date stamps are not acceptable.

You must maintain a faxed, photocopied, original signed order or an electronic signed CMN/DIF and it must be available to the DME MACs, PSCs, or ZPICs on request. When hardcopy CMNs/DIFs are submitted to the DME MACs, PSCs, or ZPICs, you must include a copy of the front side. When CMNs are submitted electronically to the DME MAC, information from sections A and B are required.

Types of CMNs

There are three types of CMNs:

1. **Initial** – Establishes the initial medical need for an item
2. **Revised** – Documents a change in the order (such as a change in the physician, a change in the number of units prescribed, etc.)
3. **Recertification** – Confirms that the medical need is still present for oxygen equipment

CMNs

The following table indicates the current DME MAC CMN forms.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
484.03	484	Oxygen
04.04B	846	Pneumatic Compression Devices
04.04C	847	Osteogenesis Stimulators
06.03B	848	Transcutaneous Electrical Nerve Stimulators (TENS)
07.03A	849	Seat Lift Mechanisms
11.02	854	Section C Continuation Form

DIFs

The following table indicates the DIFs for external infusion pumps and enteral/parenteral nutrition.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

Printable copies of CMNs and DIFs are available on the CMS Web site at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage>. To find the CMN/DIF you are looking for on the Web site, place a check next to the “Show only items containing the following word” field and enter the name of the CMN/DIF. For instance, if you are searching for the Oxygen CMN, enter the word “oxygen.” Be sure that you have selected the “Show only” option and then press the “Show Items” button.

2. CMN and DIF Completion Instructions

The "Initial Date" found in Section A of the CMN or DIF should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order.

The "Signature Date" is the date the physician signed and dated Section D of the CMN or that you signed the DIF (handwritten or electronic only—signature and date stamps are not acceptable). This date will usually not be the same as the "Initial Date."

The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within three months after the "Initial Date" of the CMN or DIF or three months from the date of the physician's signature. The DME MACs, PSCs, and ZPICS have the authority to request to verify the information on a CMN or DIF at any time. If the information contained either in your records or in the beneficiary's medical record maintained by the ordering physician fails to substantiate the CMN or DIF, or if it appears that the CMN or DIF has been altered, the DME MAC, PSC, or ZPIC will deny the service and initiate the appropriate administrative or corrective actions.

For revised and recertification CMNs, physicians must enter the total cumulative number of months from the initial date in which the item will be needed when entering the estimated length of need. For instance, if an initial CMN has an original length of need of five months and the physician wishes to extend the length of need for an additional three months, then the length of need on the revised CMN must be entered as eight months (the total number of months from the initial date).

In the event of a post pay audit, you must be able to produce the CMN or DIF and, if requested by the DME MAC, PSC, or ZPIC, produce information to substantiate the information on the CMN or DIF. If you cannot produce this information, the DME MAC, PSC, or ZPIC will deny the service and initiate the appropriate administrative or corrective actions.

CMN Cover Letters

The Social Security Act was amended in 1994 to specify the types of information that you may provide to physicians in a CMN. These are limited to an identification of the supplier and beneficiary, a description of the equipment and supplies being ordered, procedure codes for the equipment and supplies, and other administrative information not related to the medical condition of the beneficiary.

Cover letters may be used as a method of communication between you and the physician. It is not CMS's intent to restrict necessary communication between you and the physician. The CMS does not require nor regulate the cover letter.

Information contained in cover letters should address issues relating to CMS or Contractor regulation/policy changes, brief descriptions of the item(s) being provided, and changes in the patient regimen. You are encouraged to include language in your cover letters to remind physicians of their responsibility to determine both the medical need for, and the utilization of, all healthcare services and to assure that information relating to the beneficiary's condition is correct.

Section C of the CMN was designed not only to provide the physician with charge information, but also to function as a confirmation of the physician's order. However, if you wish to duplicate physician order information in a cover letter, you should feel free to do so.

Transmission of the CMN to and from the Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist

The CMN sent to the physician must be two-sided with instructions on the back. If the CMN is mailed to the physician, you must send the two-sided form. If the CMN is faxed, you must fax both the front and back of the form. It is in your interest to maintain a copy of what you faxed to the physician. You must maintain a copy of the completed CMN or DIF in your records; however, if the physician only faxes the front of the completed CMN, then you are only required to maintain the front portion of the CMN. The DIF must be two-sided with instructions on the back. Because these forms have been approved by the Office of Management and Budget (OMB), when a CMN or DIF is submitted with a paper claim, the hardcopy must be an exact reproduction of the CMS form.

Additional rental payments after the 15-month limit has been reached or after the pump has been purchased will only be considered if the attending physician changes the prescription between parenteral and enteral nutrients.

A change in suppliers during the 15-month rental period does not begin a new 15-month rental period. The new supplier is entitled to the balance remaining on the 15-month rental period.

The supplier that collects the last month of rental (i.e., the 15th month) is responsible for ensuring that the beneficiary has a pump for as long as it is medically necessary and for maintenance and servicing of the pump during the period of medical necessity.

All Other Capped Rental Items

For capped rental items furnished on or after January 1, 2006, rental payments will continue until a total of 13 continuous rental months have been paid (except for parenteral and enteral pumps). No additional payment beyond the 13th month will be made. On the first day after 13 continuous months have been paid, you must transfer title of the equipment to the beneficiary.

For capped rental items furnished to beneficiaries prior to January 1, 2006, you must give beneficiaries the option of converting their rental equipment to purchase during the tenth continuous rental month. No further rental payments may be made after the 11th rental month for capped rental items until you notify the DME MAC that the beneficiary has been given the purchase option. Beneficiaries have one month from the date you make the offer to accept the option. If the beneficiary declines purchase, rental payments will continue through the 15th month. If the beneficiary accepts the purchase option, rental payments will continue until a total of 13 continuous rental months have been paid. No additional payment beyond the 13th month will be made. On the first day after 13 continuous months have been paid, you must transfer title of the equipment to the beneficiary.

Modifiers used for the rent/purchase option are as follows:

BR	Beneficiary has elected to rent
BP	Beneficiary has elected to purchase
BU	Beneficiary has not informed supplier of decision after 30 days

You must use one of these modifiers to notify the DME MAC of the beneficiary's decision. Since HCPCS modifiers are used, it is not necessary for you to submit documentation signed by the beneficiary that he/she has been offered the rent/purchase option; however, you must maintain documentation in the files supporting the HCPCS modifier entered on the claim form.

The following is an example of the beneficiary's notification of the rent/purchase option:

The Rent/Purchase Option

You have been renting your (specify the item(s) or equipment) for 10 continuous rental months. Medicare requires (specify name of supplier) to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20% coinsurance amounts and,

36-month rental period unless the equipment is replaced because it is lost, stolen, or irreparably damaged or is replaced after the reasonable, useful lifetime expires.

As the supplier of the oxygen equipment, you are required to continue furnishing the equipment, supplies, and accessories for any period of medical need for the remainder of the reasonable, useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.

The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable, useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid (stationary or portable) oxygen equipment. You should use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents (see the section on oxygen contents below).

Medicare can pay for a general maintenance and servicing visit for concentrators or transfilling equipment in 2009, which must take place six months after the end of the 36-month rental period. Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment. Claims for maintenance and servicing of concentrators or transfilling equipment should be billed with the MS modifier.

You are responsible for furnishing all of the same items and services after the 36-month rental period as you furnished during the 36-month rental period. With the exception of oxygen contents and the general maintenance and servicing visit in 2009, you must furnish these items and services without charging Medicare or the beneficiary.

Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Replacement of Oxygen Equipment

If oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged, the beneficiary may elect to obtain a new piece of equipment. In these situations, a new 36-month rental period and a new reasonable, useful lifetime is started on the date that the new replacement item is furnished.

Note: Irreparable damage refers to a specific incident of damage to equipment, such as equipment falling down a flight of stairs, as opposed to equipment that is worn out over time.

When billing the first month of rental for replacement oxygen equipment, you should append either the RA modifier (for dates of service *on or after* January 1, 2009) or the RP modifier (for dates of service *prior to* January 1, 2009) to the appropriate HCPCS code for the equipment. You also must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in your files. For example, if equipment is stolen, you should keep a copy of the police report in your files. For lost or irreparably damaged equipment, you should maintain any documentation that supports the narrative account of the incident. For reasonable, useful lifetime replacements, the narrative explanation should include the date that the beneficiary received the equipment being replaced. *Note: please do not include the RA or RP modifier on the second or subsequent months of rental.*

For subsequent months, you do not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of three months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the date of service (anniversary date) on the claim; however, in order to bill for contents for a specific month, you must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. You are required to have proof of delivery for each actual delivery of oxygen, but as discussed above, this may be less often than monthly. For example, if you deliver 30 oxygen tanks on April 11th and the beneficiary only uses 15 tanks from April 11th through May 10th and 15 tanks from May 11th through June 10th, you may bill for contents on April 11th and again on May 11th for contents delivered on April 11th that were used for two months.

Oxygen Equipment and Contents Billing Chart

The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios.

Situation: Beneficiary Uses a Stationary System Only

1. Rental

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	No*	No	No
Liquid	No*	No	No

* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

2. Purchase (or Capped)

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	E0441	No	No
Liquid	E0442	No	No

4. Owns (or Capped) Stationary/Rents Portable

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	E1392	No
Gaseous	E0441	E0431	E0443**
Liquid	E0442	E0434	E0444**

** Effective with dates of service on or after January 1, 2007, both stationary and portable contents are billable. Prior to January 1, 2007, the portable contents reimbursement is included in the reimbursement for the stationary contents.

Situation: Beneficiary Uses a Portable System Only

1. Rents Portable System

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	E1392	No
Gaseous	No	E0431	E0443
Liquid	No	E0434	E0444

2. Owns (or Capped) Portable System

Type of System	Stationary Contents Code	Portable System Code	Portable Contents Code
Concentrator	No	No	No
Gaseous	No	No	E0443
Liquid	No	No	E0444

Chapter 13 Contents

1. Telephone Inquiries
2. Written Inquiries
3. Provider Outreach and Education (POE) Department
4. Reopenings for Minor Errors and Omissions
5. Appeals
6. Redeterminations
7. Reconsiderations
8. Administrative Law Judge (ALJ)
9. Departmental Appeals Board Review
10. Federal Court Review
11. Documentation in the Appeals Process

1. Telephone Inquiries**Interactive Voice Response (IVR) Unit**

CIGNA Government Services offers a toll-free Interactive Voice Response (IVR) unit for the exclusive use of DMEPOS suppliers in Jurisdiction C. The IVR is available by calling 1-866-238-9650. The IVR system is capable of responding to a variety of supplier inquiries and requests including:

- Claim status (line by line explanation of the payment/denial, expected payment amount and check date for claims on the payment floor, Claim Control Number, and appeal rights on denied claims)
- Pending claim information (payment floor information, pending claims at the Common Working File (CWF), and other pending claims)
- Redetermination status (pending, reversed, partially reversed, upheld, or dismissed)
- Ordering duplicate remittance notices
- Beneficiary eligibility (Part A and B entitlement dates, Medicare Advantage Plan enrollment, home health information, and Medicare Secondary Payer information)
- Beneficiary Part B Deductible (current and previous calendar year)
- CMN status (HCPCS code of same or similar equipment, initial, revised, and/or recertification date, length of need, previous supplier's phone number for rented items, and total months paid for rented items)
- Pricing information (fee schedules)
- Check information (Outstanding check dates and amount and the last five checks issued)
- Offset information
- EFT application status (pending, approved, or rejected)

- General information

The IVR is available 24 hours a day, seven days a week with the exception of periodic system upgrades or routine maintenance. The IVR menu options which require system access are available Monday through Friday 6:00 am – 6:00 pm CST and Saturday 6:00 am – 4:00 pm CST.

Customer Service Representatives (CSRs)

When the IVR system cannot answer your questions or provide the assistance you need, you may disconnect from the IVR and call 1-866-270-4909 to speak to a Customer Service Representative (CSR).

NOTE: CSRs are not able to provide you with information that is readily available on the IVR. You must contact the IVR for the types of inquiries listed above.

CSRs are trained to answer supplier questions and resolve problems. They should be your first contact with our office when you need assistance.

When calling, please have available your National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), the last five digits of your tax identification number (TIN) and, if appropriate, the beneficiary's name, Health Insurance Claim Number (HICN), and date of service. So that we may assist as many callers as possible, you are limited to three separate beneficiary inquiries per phone call. Lengthy requests should be submitted in writing.

CSRs are available to assist suppliers Monday through Friday from 7:00 am to 5:00 pm CST. CSRs are not available on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving holiday (Thursday and Friday), and Christmas Day. Please also note that the contact center is closed every Thursday morning from 8:30 am to 10:30 am CST for staff training (except for weeks in which there is a federal holiday closing). The contact center may also close to observe other Federal holidays. A ListServ message will be sent out informing you of additional closings or changes in availability. To join the ListServ, visit our Web site at www.cignagovernmentservices.com.

Customer Service Representatives are able to:

- Clarify the denial reason associated with a claim
- Provide general information regarding Medicare coverage
- Explain terminology and information published in issues of the DME MAC Jurisdiction C Insider and this Supplier Manual
- Assist with other complex issues

Customer Service Representatives are *not* able to:

- Provide claim status, beneficiary eligibility, or other information which is available through the IVR
- Give preauthorization of beneficiary entitlement for specific DMEPOS
- Adjust a claim, unless the claim was processed incorrectly by the DME MAC (please call Telephone Reopenings at 866.813.7878)
- Answer questions about supplier enrollment (please call the National Supplier Clearinghouse at 866.238.9652)

- Answer questions about electronic billing software or claims that have not been received in our claim processing system (please call CEDI at 866.311.9184)
- Answer inquiries from beneficiaries or their representatives (please call 1.800.MEDICARE – 800.633.4227)

Before You Call...

Before calling a Customer Service Representative, you should take the following steps:

- Consult your Medicare Remittance Notice (MRN)
- Consult the [ANSI Denial Guide](#) on the CIGNA Government Services Web site
- For medical necessity and coverage issues, consult the appropriate Local Coverage Determination (LCD)
- For general questions about DME MAC, consult this Supplier Manual

When calling Customer Service, please be sure to have the following information ready to give to the CSR:

- Your NPI number
- Your Provider Transaction Access Number (PTAN), also known as your Legacy number or NSC number
- The last five digits of your tax identification number (TIN)
- Beneficiary's HICN, name, date of service, and/or date of birth (if appropriate)

Three Levels of Customer Service

When calling Customer Service, you will initially speak to a Tier 1 CSR. Tier 1 CSRs are capable of handling most supplier inquiries. In some cases, Tier 1 CSRs may need to transfer the call to a Tier 2 CSR (also known as the Help Desk). If a callback is required, a Tier 2 CSR will return your call within 10 business days.

If you have a complex inquiry that goes above and beyond the normal scope of a Tier 1 or Tier 2 CSR, the inquiry will be forwarded to the third level of Customer Service, the Provider Relations Research Specialist (PRRS) team. The PRRS will research the inquiry and respond either by phone or by mail within 45 business days.

2. Written Inquiries

CIGNA Government Services is committed to providing the highest level of service to our Medicare suppliers. It is our goal to handle all written inquiries in a timely and efficient manner. When writing, please state your question or concern as clearly as possible including all pertinent information, i.e., your NPI, PTAN, last five digits of your TIN, and supplier name, and, if appropriate, the beneficiary's name and HICN. This will allow us to respond more specifically to your inquiry. Please also include your name and phone number.

Please send all general written inquiries to:

CIGNA Government Services

You can request a reopening either by telephone or by writing. Detailed instructions are provided below.

Telephone Reopenings

The DME MAC telephone reopening number is 1-866-813-7878. The line is available Monday through Friday, from 8 am to 10:30 am and from 12 noon to 3:30 pm CST.

1. Use the telephone reopening process to resolve minor errors or omissions involving:
 - Units of service
 - Service dates
 - Healthcare Common Procedure Code System (HCPCS) coding
 - Diagnosis codes and diagnosis reference
 - Modifiers
 - Place of service
 - Claim incorrectly denied as duplicate charges
2. Wait to call the telephone reopening line until you receive your Medicare Remittance Notice (MRN). No action can be taken until a final claim determination is issued.
3. Consult this Supplier Manual and applicable medical policy guidelines before calling. Failure to have appropriate information available when you call the telephone reopening line may result in an unfavorable decision.
4. Questions about the status of a claim or general Medicare payment and coding should not be directed through the telephone reopening line. You can obtain a claim status report through the Interactive Voice Response (IVR) unit or by using Claim Status Inquiry (CSI). See Chapter 8 of this manual for information about CSI.
5. You must have the following information on-hand before placing the call for a telephone reopening:
 - Your NPI, PTAN, and last five digits of your TIN
 - The Medicare Claim Control Number (CCN) and reason for denial
 - Beneficiary name and HICN
 - Any additional information to support why you believe the decision is not correct. This includes having the correct procedure code(s), modifier(s), diagnoses, units of service, etc.

All medical information provided to the DME MAC must be documented in the patient's file and available to the DME MAC should an audit be required.

If a previous reopening decision has been issued, a redetermination must be made in writing. If a previous redetermination decision has been issued, a reconsideration must be filed. See below for more information about redeterminations and reconsiderations.

To effectively service all callers, each call is limited to three claim issues.

Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ decision/dismissal	DAB or ALJ Hearing Office	None
Federal Court (Judicial) Review	60 days from the date of receipt of the DAB decision or declination of review by DAB		On or after January 1, 2008 at least \$1180 remains in controversy On or after January 1, 2009 at least \$1,220 remains in controversy

Parties to an Appeal

An appeal request must be submitted by someone who is considered a party to the appeal. The appeal will be dismissed if the person requesting is not a proper party. Any of the following are considered proper parties to an appeal:

- A beneficiary;
- A participating supplier;
- A non-participating supplier taking assignment for a specific item or service;
- A non-participating supplier of DME potentially responsible for making a refund to the beneficiary under Section 1834(a)(18) of the Act;
- A supplier of medical equipment and supplies not taking assignment and who is responsible for making a refund to the beneficiary under Section 1834(j)(4) of the Act;
- A Medicaid State agency or party authorized to act on behalf of the State; or
- Any individual whose rights may be affected by the claim being reviewed.

Appointment of Representative

A person/supplier/physician who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative. To act as the beneficiary’s representative, a person/supplier/physician must submit a properly executed appointment of representative form (Form CMS-1696); however, the appointment of representative form is not necessary. A written statement containing all the required elements is also acceptable as a valid appointment of representative. The following information must be included on a written statement:

- The name, address and phone number of the individual.
- The individual’s Medicare number when the party making the appointment is the beneficiary.
- A specific individual named as the representative. An organization or entity may not be named as the representative, but rather a specific member of that organization or entity must

Your request for reconsideration should be mailed to:

RiverTrust Solutions, Inc.
Qualified Independent Contractor (QIC)
P.O. Box 180208
Chattanooga, TN 37401-7208

Phone: 423.535.4386

Fax: 423.535.5239

www.rivertrustsolutions.com

8. Administrative Law Judge (ALJ) Hearing Officer – Third Level of Appeal

If you remain dissatisfied following the QIC reconsideration and the remaining amount in controversy is \$120.00 or more, you have the right to a hearing before an Administrative Law Judge (ALJ). The request for ALJ hearing must be in writing and must be received within 60 days from the date of the reconsideration. The ALJ hearing may be requested by submitting a written request or by using the CMS 5011A/B form located on the CMS Web site at <http://www.cms.hhs.gov/cmsforms/downloads/cms5011a-b.pdf>.

Requests for ALJ hearings must be filed to the Office of Medicare Hearings and Appeals (OMHA) at the following locations depending on the place of service (for DMEPOS claims, the place of service is defined as the beneficiary's address of record):

OMHA Field Office Locations

Arlington, Virginia

1700 N. Moore St., Suite 1600
Arlington, VA 22209
Phone: 866-231-3087

Cleveland, Ohio

BP Tower, Suite 1300
200 Public Square
Cleveland, OH 44114-2316
Phone: 866-236-5089

Irvine, California

27 Technology Drive, Suite 100
Irvine, CA 92618-2364
Phone: 866-495-7414

Miami, Florida

100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100
Phone: 866-622-0382

Chapter 15 Contents*Introduction*

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Introduction

The following addresses and telephone numbers are provided so that you will know where to obtain the information/materials you need or where to send inquiries.

1. Durable Medical Equipment Medicare Administrative Contractors (DME MACs)**Jurisdiction A**

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

National Heritage Insurance Company
P.O. Box 9146
Hingham, MA 02043-9146
Phone/IVR: 866.419.9458
Customer Service: 866.590.6731
Web site: www.medicarenhic.com

Jurisdiction B

Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin

National Government Services
PO Box 6036
Indianapolis, IN 46206-6036
Phone/IVR: 877.299.7900
Customer Service 866.590.6727
Web site: www.ngsmedicare.com

Jurisdiction C

Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia

CIGNA Government Services
PO Box 20010
Nashville, TN 37202-0010
Phone: 866.270.4909
IVR: 866.238.9650
Telephone Reopenings: 866-813-7878
Web site: www.cignagovernmentservices.com

AW	ITEM FURNISHED IN CONJUNCTION WITH A SURGICAL DRESSING. (EFFECTIVE DATE 1/1/2003)
AX	ITEM FURNISHED IN CONJUNCTION WITH DIALYSIS SERVICES. (EFFECTIVE DATE 1/1/2003)
BA	ITEM FURNISHED IN CONJUNCTION WITH PARENTERAL ENTERAL NUTRITION (PEN) SERVICES. (EFFECTIVE DATE 1/1/2003)
BO	ORALLY ADMINISTERED NUTRITION, NOT BY FEEDING TUBE. (EFFECTIVE DATE 1/1/2003)
BP	THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO PURCHASE THE ITEM.
BR	THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO RENT THE ITEM.
BU	THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND AFTER 30 DAYS HAS NOT INFORMED THE SUPPLIER OF HIS/HER DECISION.
CC	PROCEDURE CODE CHANGE (USE 'CC' WHEN THE PROCEDURE CODE SUBMITTED WAS CHANGED EITHER FOR ADMINISTRATIVE REASONS OR BECAUSE AN INCORRECT CODE WAS FILED). (SUPPLIERS SHOULD NOT SUBMIT MODIFIER CC.)
CG	POLICY CRITERIA APPLIED (EFFECTIVE DATE 07/01/2008)
EA	ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER CHEMOTHERAPY (EFFECTIVE DATE 1/1/2008)
EB	ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER RADIOTHERAPY (EFFECTIVE DATE 1/1/2008)
EC	ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA NOT DUE TO ANTI-CANCER RADIOTHERAPY OR ANTI-CANCER CHEMOTHERAPY (EFFECTIVE DATE 1/1/2008)
ED	HEMATOCRIT LEVEL HAS EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE (EFFECTIVE DATE 1/1/2008)
EE	HEMATOCRIT LEVEL HAS NOT EXCEEDED 39% (OR HEMOGLOBIN LEVEL HAS NOT EXCEEDED 13.0 G/DL) FOR 3 OR MORE CONSECUTIVE BILLING CYCLES IMMEDIATELY PRIOR TO AND INCLUDING THE CURRENT CYCLE (EFFECTIVE DATE 1/1/2008)
EJ	SUBSEQUENT CLAIMS FOR A DEFINED COURSE OF THERAPY, E.G., EPO, SODIUM HYALURONATE, INFLAXIMAB.
EM	EMERGENCY RESERVE SUPPLY (FOR ESRD BENEFIT ONLY).
EY	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE. (EFFECTIVE DATE 1/1/2003)
FB	ITEM PROVIDED WITHOUT COST TO PROVIDER, SUPPLIER OR PRACTITIONER, OR FULL CREDIT RECEIVED FOR REPLACED DEVICE (EXAMPLES, BUT NOT LIMITED TO, COVERED UNDER WARRANTY, REPLACED DUE TO DEFECT, FREE SAMPLES) (UPDATED 1/1/2008)

E0701	Helmet with face guard and soft interface material, prefabricated (Eff. Date 1/1/2003)	05	
E0705	TRANSFER DEVICE, ANY TYPE, EACH (Updated Description 1/1/2008)		
E0710	Restraints, any type (body, chest, wrist or ankle)		
E0720	Transcutaneous Electrical Nerve Stimulation (TENS) device, two lead, localized stimulation	05	06.03B
E0730	Transcutaneous Electrical Nerve Stimulation (TENS) device, four or more leads, for multiple nerve stimulation	05	06.03B
E0731	Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	05	
E0740	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer	05	
E0744	Neuromuscular stimulator for scoliosis	01	
E0745	Neuromuscular stimulator, electronic shock unit	01	
E0746	Electromyography (EMG), biofeedback device		
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications	05	04.04C
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications	05	04.04C
E0749	Osteogenesis stimulator, electrical, surgically implanted		
E0751	Implantable neurostimulator pulse generator, or combination of external transmitter with implantable receiver (includes extension)		
E0753	Implantable neurostimulator electrodes, per group of four (Deleted eff. 12/31/2001)		
E0755	Electronic salivary reflex stimulator (intra-oral/non-invasive)		
E0760	Ostogenesis stimulator, low intensity ultrasound, non-invasive	05	04.04C
E0761	Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device (Eff. Date 1/1/2003)	17	
E0762	Transcutaneous electrical joint stimulation device system, includes all accessories (Eff. Date 1/1/2006)	01	
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program (Eff. Date 1/1/2006, Updated Date 01/01/2009)	05	
E0765	FDA approver nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting (Eff. Date 1/1/2001)		

E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system (Eff. Date 1/1/2003)	05	
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system (Eff. Date 1/1/2003)	05	
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system (Eff. Date 1/1/2003)	05	
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system (Eff. Date 1/1/2003)	05	
E1239	Power wheelchair, pediatric size, not otherwise specified (Eff. Date 1/1/2005)	05	
E1300	Whirlpool, portable (overtub type)		
E1310	Whirlpool, non-portable (built-in type)	05	
E1340	Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes (Deleted eff. 03/31/2009)		
E1350	Repair or non-routine service (e.g., breaking down sealed components) requiring the skill of a technician (Deleted eff. 12/31/1996)		
E1353	Regulator		484.3
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH (Eff. Date 1/1/2009)		
E1355	Stand/rack		
E1356	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH (Eff. Date 1/1/2009)		
E1357	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH (Eff. Date 1/1/2009)		
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH (Eff. Date 1/1/2009)		
E1372	Immersion external heater for nebulizer	05	
E1375	Nebulizer portable with small compressor, with limited flow	05	
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater concentration at the prescribed flow rate (Eff. Date 1/1/2000)	06	484.3
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each (Eff. Date 1/1/2004)	05	484.3

K0738	Portable Gaseous Oxygen System, Rental, Home Compression Used to fill Portable Oxygen Cylinders; includes Portable Containers, Regulator, Flowmeter, Humidifier, Cannula or Mask, and Tubing (Eff. Date 10/01/2006)	06	484.3
K0739	Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes (Eff. Date 04/01/2009)		
K0740	Repair of Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes (Eff. Date 04/01/2009)		
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	05	
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds (Eff. Date 10/01/2006)	05	
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)	05	
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	05	
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)	05	
K0808	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)	05	
K0812	Power operated vehicle, not otherwise classified (Eff. Date 10/01/2006)	05	
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	
K0816	Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)	01	