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OXYGEN

Certificate of Medical Necessity

The Office of Management and Budget has approved continued use of the revised oxygen Certificate of Medical Necessity (CMN) through August 31, 1999. This extension is in accordance with the Paperwork Reduction Act.

For your convenience, a camera-ready DMERC 484.2 CMN was published in the Autumn 1997 issue of your DMERC Medicare Advisory.
**HCPCS codes L1680, L1685 and L1686**

Region C has been denying hip abduction control devices with HCPCS codes L1680, L1685 and L1686. These devices may be used to restrict abduction of the hip after surgery or dislocation. When they are applied post-operatively within the hospital setting, these codes should not be billed to the DMERC, as they are considered part of the Part A covered hospital expense. However, occasionally they are applied after reduction of a hip dislocation in the outpatient setting; in this case they may be properly billed to the DMERC.

These devices should not be confused with hip abduction devices which force hip abduction, such as those devices cited in the December 1996 *DMERC Medicare Advisory*, page 340. These latter devices are sometimes applied to treat hip contractures, and have an opposite effect from devices with HCPCS codes L1680, L1685 and L1686. The devices which force hip abduction should be billed using HCPCS code L2999.

If suppliers are aware of claims for HCPCS codes L1680, L1685 or L1686 which were dispensed to beneficiaries who were not inpatients at the time of delivery, and that were erroneously denied by Region C, they may resubmit those claims for consideration of payment.

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**Oxygen testing**

**Timeliness**

Use of the new oxygen certificates of medical necessity, HCFA-484 (DMERC 484.2), became mandatory April 1, 1998. The instructions printed on the reverse of the new forms are consistent with those printed on other DMERC CMNs. It is important to note that instructions on the previous form tell physicians and suppliers that blood gas determinations used to qualify beneficiaries for the oxygen benefit must be done within 30 days prior to the initial certification for all oxygen claims.

Additionally, for beneficiaries who initially qualify for oxygen coverage with Group II blood gases, or for those whose doctors’ estimated length of need is less than lifetime, repeat blood gas determinations must be performed within 30 days prior to recertification. Although there are new CMN forms, these requirements for timely blood gas determinations have not changed.

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**Fecal fat testing**

**For malabsorption**

The DMERC RMRP for parenteral nutrition discusses results obtained from the 72 hour fecal fat test as documentation to determine coverage of parenteral nutrition under the prosthetic benefit. This is a quantitative test which is used to establish the diagnosis of malabsorption. In this test, the patient is placed on a controlled diet containing a specified amount of fat; all stools are collected over a 72 hour period, and analysis of the entire stool specimen for fat content is performed by a qualified laboratory.
Fecal Fat Testing

For malabsorption (continued)

When the quantitative amount of fat found within the 72 hour collection of stools is high enough, it may document the condition of malabsorption adequately, when accompanied by other signs, symptoms and diagnoses consistent with this condition.

The policy also establishes criteria for the determination of malabsorption when lesser amounts of fat are found in stools using the 72 hour fecal fat test, or when using other less quantitative but still established tests of malabsorption, in combination with a tube trial. Examples of less quantitative tests for malabsorption, such as sudan staining of stools for fat and the d-xylose test, are listed in the policy.

Some tests for stool fat, whose validity has not been established in the medical literature and whose results cannot be reliably correlated with the standard 72 hour fecal fat test, are being submitted to the DMERC to document the condition of malabsorption. These unproven tests involve collection of single random stool samples after dietary interventions involving patients taking extra amounts of olive oil which will increase the resulting stool fat content. Such tests, which are not evaluated in peer reviewed literature, will not suffice as adequate documentation to establish the condition of malabsorption as defined in the published DMERC policy, when used as substitutes for standard tests of malabsorption.

Certificates of Medical Necessity

Physician coercion

Durable Medical Equipment Regional Carrier (DMERC) Certificates of Medical Necessity (CMNs) have two sections that require physician input. Section B has questions concerning the medical condition of the patient, the answers to which guide the DMERC as to the medical necessity of the item being ordered. The other section is for the signature of the physician, attesting to the accuracy of the answers in Section B. The supplier is neither permitted to complete Section B nor tell the physician what answers to give. Suppliers have been known to engage in such activity and even coerce physicians into changing their answers in Section B. Incidentally, Section C of the CMN must be completed by the supplier before the physician signs the document, and should list the charges for the equipment being ordered.

At times, physicians become targets of coercive pressure or harassment by suppliers to justify medical equipment through their orders or CMNs. They are encouraged not to betray their better medical judgment by acquiescing to such pressure, and to report this behavior to the following DMERC contact.

DMERC Program Integrity Department
Provider Hot-Line
(803) 788-5414

Physicians are also encouraged to request copies of the relevant DMERC medical policies directly from the supplier of the items in
CERTIFICATES OF MEDICAL NECESSITY

Physician coercion (continued)

Physicians may always discuss aspects of medical policy concerning coverage of this equipment with the DMERC medical director, Paul D. Metzger, M.D., at (803) 735-1034, ext. 35706.

Faxed copies of originals

The DMERCs have received many questions about whether faxed Certificates of Medical Necessity (CMNs) are considered valid forms for suppliers to use when preparing claims for submission to the DMERC. A supplier must send a double-sided CMN to the physician for their signature and obtain back a signed hard copy of that double-sided CMN from the physician. If the supplier needs the CMN on an urgent basis, the supplier may receive a faxed copy of the original CMN from the physician. However, the supplier must subsequently receive for their files the signed, hard copy, original CMN from the physician.

SLINGS AND RIB BELTS

Noncovered

Slings (HCPCS code A4565) and rib belts (HCPCS code A4572) belong to neither the category of DME nor orthoses (true braces), but rather are miscellaneous supplies. They are, therefore, not covered by Medicare for reimbursement by the DMERC. For dates of service on or after June 1, 1998, these items will be denied as noncovered.

CERVICAL TRACTION

HCPCS code E0855

Effective with dates of service on or after January 1, 1998, a new HCPCS code, E0855, was established with the description: "Cervical traction equipment not requiring additional stand or frame". The DMERCs have determined that the medical evidence submitted to them is not sufficient to establish any increased effectiveness of the known products included in this code compared to a standard over-the-door cervical traction device (HCPCS code E0860). Therefore, for dates of service on or after January 1, 1998, payment for HCPCS code E0855 will be based on the allowance for the least costly medically appropriate alternative, HCPCS code E0860.

At the present time, the known products that should be billed using HCPCS code E0860 are the Pronex pneumatic traction device manufactured by Glacier Cross and the Saunders Cervical HomeTrac manufactured by The Saunders Group. If a supplier or manufacturer thinks that another product meets the description of the code, they may contact the Statistical Analysis DMERC (SADMERC) for a written coding determination.
Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC's) Regional Medical Review Policy (RMRP) upon which Medicare bases reimbursement decisions for some of the equipment physicians might order for patients. It describes the equipment, its usual clinical indications, Medicare's coverage criteria for reimbursement, and the adjudication criteria for claims.

The DMERC strongly believes that the physician is still the “Captain of the Ship.” Palmetto Government Benefits Administrators (Palmetto GBA) requires a physician’s order before reimbursing any item. Sometimes Palmetto GBA requires a Certificate of Medical Necessity (CMN) and extra documentation.

While this may inconvenience physicians with additional paperwork, it is only through cooperation that Medicare can provide beneficiaries with the equipment and supplies they need. Physicians 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 Sheet (PHYS) 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 sheet is 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.

____________________

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

Physician Information Sheet

Manual wheelchairs

A wheelchair is covered if the patient’s condition is such that without the use of it, the patient would otherwise be bed or chair confined.

There are different grades of wheelchairs based upon their lightness or upon their capacity to accommodate obese patients. These are classified according to HCPCS codes. If a higher grade wheelchair (lighter or heavier capacity) is prescribed primarily to allow a patient to perform leisure or recreational activities, it will be reimbursed at the level of the least costly medically necessary level, or possibly denied totally. Following are the categories of manual wheelchairs with some of their more significant features, indications and costs to the Medicare Program.

K0001  Standard Wheelchair: chair weighs greater than 36 lbs.

Approximate Medicare Reimbursement = $492

K0002  Standard Hemi-wheelchair: chair weighs greater than 36 lbs, but the seat is lower to the floor to accommodate shorter stature or for a patient who self-propels with his feet on the floor.

Approximate Medicare Reimbursement = $664

K0003  Lightweight Wheelchair: chair weighs less than 36 lbs. It is covered for a patient who cannot self-propel in a standard weight wheelchair, but can self-propel in this weight chair.

Approximate Medicare Reimbursement = $816

K0004  High strength, lightweight wheelchair: chair weighs less than 34 lbs, and there is a lifetime warranty on the side frames and cross braces. It is covered for a patient who self-propels while engaging in frequent activities (not recreational or leisure) that cannot be performed in a standard or lightweight chair. It is also covered if the patient requires seat dimensions that cannot be accommodated in a standard, hemi, or lightweight chair, and the patient spends at least 2 hours per day in the wheelchair. It would not be covered if the patient would need it for less than 3 months (e.g., post-operative recovery).

Approximate Medicare Reimbursement = $1,213

K0005  Ultra lightweight wheelchair: chair weighs less than 30 lbs, and there is a lifetime warranty on the side frames and cross braces. The need for these is rare and requires individual consideration of additional documentation submitted with the Medicare claim.

Approximate Medicare Reimbursement = $1,763

K0006  Heavy duty wheelchair: chair can accommodate and support a patient weighing greater than 250 lbs, or who has severe spasticity.

Approximate Medicare Reimbursement = $1,148
**Manual and Motorized Wheelchairs and Accessories**

*Physician Information Sheet*

**K0007**  
Extra heavy duty wheelchair: chair can accommodate and support a patient weighing greater than 300 lbs.

*Approximate Medicare Reimbursement = $1,682*

**K0008**  
Custom manual wheelchair base: chair base is uniquely constructed for the individual patient and is like no other. It is not customized merely by the assemblage of modular components, nor the addition of various accessories to a base which could otherwise be classified into one of the other above codes. It would only be covered if it offered features not otherwise available on already manufactured chair bases.

*Approximate Medicare Reimbursement = Individually priced*

**K0009**  
Other manual wheelchair base: because of modular construction to accommodate unusual patient measurements or requirements, the base cannot be adequately classified using one of the above codes.

*Approximate Medicare Reimbursement = Individually priced*

**Motorized wheelchairs**

There are various classifications of motorized wheelchairs paralleling the division existing among manual wheelchairs, based upon weight of the chair, customization or modular construction. The standard and lightweight motorized wheelchairs are reimbursed by Medicare at approximately **$3,600** and **$3,000** respectively. The customized and modularly constructed chairs are individually priced. One particular model, coded K0011, represents models that have additional programmable controls that allow for speed adjustment, limits on acceleration and braking, and control dampeners for patients with tremors or poor coordination. These models reimburse at approximately **$5,000**.

There has been a significant increase in the ordering of K0011 models. Interestingly, many of the K0011s being sold look very similar to power operated vehicles (or scooters), coded E1230, which normally reimburse at approximately **$2,000**. While these models do furnish the control features allowing them to be properly coded as K0011, **it is important for physicians to ascertain that these motorized wheelchairs are being prescribed for the indications listed below, and not being used by patients who would otherwise be sufficiently served by the ordering of scooters (see PHYIS on Power Operated Vehicles).**

A power wheelchair is covered when all of the following criteria are met:

1. The patient’s condition is such that without the use of a wheelchair the patient would otherwise be bed or chair confined, and
2. The patient’s condition is such that a wheelchair is medically necessary and the patient is unable to operate a wheelchair manually, and
3. The patient is capable of safely operating the controls for the power wheelchair.

**Usually, a patient who requires a power wheelchair is totally nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular condition.**
MANUAL AND MOTORIZED WHEELCHAIRS AND ACCESSORIES
Physician Information Sheet

Similar to a power wheelchair (K0011), a power operated vehicle (or scooter) (E1230) is not covered by Medicare if the patient does not require it for mobility within the home. However, the physician should try to determine if a power operated vehicle (E1230) will serve the needs of the patient (who might have the upper trunk stability and neurologic or muscular ability to operate a scooter), as opposed to a power wheelchair (K0011).

The K0011 reimburses $5,000; the E1230 reimburses $2,000. Physicians should remember that reimbursements made for durable medical equipment are drawn from the same Part B Medicare pool of funds available for payment of physician services. No claims for durable medical equipment may be reimbursed without there being an order or certificate of medical necessity completed by a physician.

Wheelchair options and accessories

There are some underlying principles which apply to all options and accessories for wheelchairs:

1) In order to cover accessories, the patient must have a wheelchair base which meets Medicare coverage criteria,

2) The accessory must be necessary for the patient to function in the home environment, and

3) The accessory must be necessary to enable the patient to perform an activity of daily living.

There are three accessories which have related questions on the wheelchair certificate of medical necessity, and for which there are indications specified in our published policy:

**Fully reclining back:** to justify this feature, the patient should have one or more of the following conditions: quadriplegia, fixed hip angle, trunk or lower extremity casting or bracing requiring reclining back for positioning, excessive extensor tone of trunk muscles, or the need to rest in a recumbent position 2 or more hours during the day with transfer between wheelchair and bed being very difficult.

**Adjustable arm height:** patient requires an arm height that is different than that available using nonadjustable arms and the patient spends a least 2 hours per day in the wheelchair.

**Elevating leg rests:** patient has a musculoskeletal condition or has a cast or brace which prevents 90 degree flexion at the knee, or has significant edema of the lower extremities that requires leg elevation, or meets the criteria for and has a reclining back on the wheelchair.

There are many other options and accessories that may be added to wheelchairs to accommodate the individual needs of patients. These are also listed in the DMERC medical policy, a copy of which you may obtain from a supplier of wheelchairs or directly from the Region C DMERC by contacting:

**Professional Relations**
**Palmetto GBA DMERC Region C**
P.O. Box 100141
*Columbia, S.C. 29202-3141*
MANUAL AND MOTORIZED WHEELCHAIRS AND ACCESSORIES
Physician Information Sheet

Certificate of Medical Necessity

The supplier of your patient’s equipment must submit a Certificate of Medical Necessity (CMN) (DMERC 02) with the claim in order to obtain Medicare reimbursement. Section B of the CMN contains questions pertaining to the medical necessity of the equipment which may not be completed by the supplier. The physician or another health care clinician may complete Section B, BUT ONLY THE PATIENT’S TREATING PHYSICIAN MAY SIGN THE CMN, INDICATING THAT HE/SHE HAS REVIEWED SECTION B OF THE CMN FOR ACCURACY AND COMPLETENESS.

The patient’s medical records must contain documentation substantiating that the patient’s condition meets the above coverage criteria and the answers given in Section B of the CMN. These records may be requested by the DMERC to confirm concurrence between the medical record and the information submitted to the DMERC.
**BENEFICIARY ELIGIBILITY**

**Claims Status Inquiry**

Participating durable medical equipment suppliers who submit claims electronically can check beneficiary eligibility while on-line with the Claims Status Inquiry (CSI) system (see “Claims Status Inquiry” on page 18). As a result, we can process your requests for beneficiary information immediately.

Instructions for accessing beneficiary eligibility information using CSI appear below. If you are interested in ordering CSI, please call (803) 788-9751 to request an order form. The Palmetto Government Benefits Administrators (Palmetto GBA) Electronic Data Interchange (EDI) Help Desk will be happy to provide you with the appropriate form.

**Accessing beneficiary eligibility information**

To access the main menu screen, enter “VPIQ” after you have signed on. The provider claims display selection screen will include a BENEFICIARY ELIGIBILITY field.

![Provider claims display selection screen](image)

Provider claims display selection screen (menu)

Enter your supplier number in the PROVIDER NO field and a “Y” in the BENEFICIARY ELIGIBILITY field. Press <Enter>. The beneficiary eligibility inquiry screen will appear as shown on the next page.

**Beneficiary eligibility inquiry screen**

To use the beneficiary eligibility inquiry screen, enter the information requested on the first line of the screen. Use the <Tab> key to move from one field to the next.

- **HICN**: Enter the beneficiary’s Medicare number
- **LAST NAME**: Enter the first six characters of the beneficiary’s last name
- **FIRST INITIAL**: Enter the first initial of the beneficiary’s first name
- **SEX**: Enter the beneficiary’s sex. Valid values are “M” (male) or “F” (female)
**Beneficiary Eligibility**

After entering the information, press <Enter>. Information may appear in the following fields.

**Claims Status Inquiry (continued)**

**NAME**  The beneficiary’s full name

**MSP**  If a “D” is listed in this field, the supplier must develop Medicare Secondary Payer (MSP) activity

**ENTITLEMENT DATE**  The beneficiary’s Medicare Part B entitlement date

**TERMINATION DATE**  The beneficiary’s Medicare Part B termination date, if applicable

**DEDUCTIBLES MET**  Indicates whether or not the beneficiary’s deductible for the current and prior year have been met. Valid codes are “Y” (yes) or “N” (no)

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**Beneficiary Eligibility Inquiry Screen**

**HICN:**  **LAST NAME:**  **FIRST INIT.:**  **SEX:**

(ENTER FIRST 6 LETTERS OF LAST NAME)

**NAME:**

**ENTITLEMENT DATE:**

**DEDUCTIBLES MET:**

**HMO DATA**

**NAME:**

**ZIP:**  **CODE:**

**ENTITLEMENT DATE:**

**TERMINATION DATE:**

PI22-HICN/LAST NAME/FIRST NAME INITIAL/SEX CODE REQUIRED

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**Health Maintenance Organization data**

If the beneficiary has Health Maintenance Organization (HMO) coverage, information may appear in the following fields.

**NAME**  The beneficiary’s full name

**ZIP**  The zip code for the HMO

**CODE**  Valid codes are “C” (cost), “Blank” (non-HMO), or “R” (risk)

**ENTITLEMENT DATE**  The beneficiary’s most current HMO enrollment date

**TERMINATION DATE**  The beneficiary’s most recent HMO termination date, if applicable
Please remember that the information found through the inquiry function does not guarantee a beneficiary's eligibility for Medicare. Eligibility can only be determined once a claim has been submitted for that person.

**INTERNET WEB SITES**

**Palmetto Government Benefits Administrators**

Palmetto Government Benefits Administrators (Palmetto GBA) launched its Medicare web site May 1, 1998. This site includes a complete, interactive library of Medicare provider and beneficiary publications, and includes several unique features.

- **Chat Room**
  Attend on-line specialty seminars

- **Interactive Calendar**
  Find out about the latest workshops, conferences, and on-line events

- **Palmetto GBA Newsgroup**
  Read, post, or reply to the latest Medicare issues

- **Information Push**
  Receive updates on the topic of your choice via e-mail

- **Audience Driven Design**
  Customize your view and see only content relevant to you

- **Publications Library**
  Browse through a comprehensive directory of Medicare publications including supplier manuals, and MEDPARD directories

You may access the Palmetto GBA web site at the following address.

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http://www.pgba.com
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**Transactions over the Internet**

The Internet may not be used to transmit beneficiary or provider sensitive data at this time. Even with the high level of security and encryption available today, data transmitted across the Internet is susceptible to interception.

Until information can be transmitted securely, Palmetto GBA will not accept any Electronic Data Interchange transactions through the Internet including file upload, file download, and claim status inquiry.
INTERNET WEB SITES

Other Medicare addresses

Our Electronic Data Interchange (EDI) department frequently receives calls from suppliers asking how to locate certain information over the Internet. To help you access the information you need, we have published a series of web site addresses which may prove useful.

♦ How can I look up Unique Provider Identification Numbers (UPINs) over the Internet?

You can access UPINs over the Internet at the address shown below.

http://wwwfps.mcw.edu

Select the physician’s state, then type his or her name. The database will provide the physician’s UPIN.

♦ How can I find Medicare EDI materials over the Internet?

You can find facts about Medicare EDI on the Health Care Financing Administration (HCFA) home page at the address printed here.

http://www.hcfa.gov

1) Select “Medicare”
2) Then “Professional/Technical Information”
3) Finally, “Electronic Data Interchange”

You will be able to access EDI news and updates, format descriptions, formats for downloading, and detailed instructions for completing UB-92 and HCFA-1500 forms.

♦ Where can I find fee schedules over the Internet?

You may download DMEPOS fee schedules, Prospective Payment System fee explanations, and many other types of pricing information at the following address.

http://www.hcfa.gov/stats/pufiles.htm

♦ How can I find HCFA Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD-9-CM), and current procedural terminology over the Internet?

The HCPCS and ICD-9-CM codes are available through HCFA’s home page at the address shown below.

http://www.hcfa.gov/stats/pufiles.htm

The HCPCS file includes codes, descriptions, and pricing. Common Procedural Terminology (CPT-4) codes are proprietary and owned by the American Medical Association (AMA). You may order CPT-4 coding information from the AMA by calling (800) 621-8335.
INTERNET WEB SITES

Other Medicare addresses (continued)

♦ Can I download the HCFA-1500 form from the Internet or obtain software to print it?

The HCFA-1500 form is not available over the Internet since it is a proprietary document created by the AMA. However, the HCFA-1500 form can be purchased. Call the telephone numbers shown below to order your supply of HCFA-1500 forms.

1) The Government Printing Office at (214) 767-0076
2) The American Medical Association at (800) 621-8335

__________________________________________________________

ELECTRONIC TRANSMISSIONS

National standards

What impact does the Health Insurance Portability and Accountability Act of 1996 have on you? More than you may have realized.

The administrative simplification provisions of the Act mandate that the Secretary of Health and Human Services adopt national standards for the electronic transmission of health care transactions.

Suppliers who use electronic data interchange, clearinghouses, and all health plans must meet these standards. The provisions also require national standards for the following.

♦ Medical code sets

♦ Identifiers for providers, health plans, employers, and individuals

♦ Security and privacy

The Secretary has made recommendations to Congress for privacy legislation which protects individually identifiable health information. In addition, standards for claims attachments will be proposed within the next year.

These national standards are scheduled to go into effect two years after they are adopted by the Secretary. At that time, Palmetto Government Benefits Administrators will be able to accept standard electronic transactions from you.

There will be clear benefits to those of you who use electronic transactions: With a national standard, you can send the same claim to any insurance company for payment.

The Department of Health and Human Services (DHHS) and other Federal and State agencies have been hard at work since the Act was passed. The standards to be adopted will build on the voluntary consensus standards already developed by the private sector.
**Electronic Transmissions**

National standards (continued)

The DHHS has received extensive industry input but continues to look for comments on these standards. The Notices of Proposed Rule Making (NPRMs), the first official publication of the proposed standards, are to be published in the Federal Register. In addition, the NPRMs will be available from the Department’s administrative simplification World Wide Web (WWW) site.

http://aspe.os.dhhs.gov/admnsimp

Because you will be directly affected by these standards, the DHHS urges you to read the proposed rules carefully and provide your comments to the addressees noted in the NPRMs. Your comments are critical in determining the final set of standards to be adopted. In addition, the DHHS recommends that associations work with their members to provide input to the Department.

The implementation guides for the proposed national standards are to be available on the WWW. The guides can be downloaded free of charge from the Washington Publishing Co. web site.

http://www.wpc-edi.com/HIPAA

Now is the time to begin planning for implementation of these new standards. The advent of a national standard is an opportunity to move from paper transactions to electronic transactions and from proprietary systems to open systems. So watch the Federal Register, watch the web sites, and start the implementation process.
**SUPPLIER MANUAL REVISIONS**

*Medical policies*

The Region C DMEPOS Supplier Manual pages which accompany this advisory contain revisions of the Regional Medical Review Policies listed below.

- External breast prostheses
- External infusion pumps
- Enteral nutrition
- Lower limb prostheses
- Pneumatic compression devices
- Pressure reducing support surfaces (I)
- Pressure reducing support surfaces (II)
- Surgical dressings
- Therapeutic shoes for diabetics
- Urological supplies
- Walkers
- Wheelchair options and accessories

Please pay special attention to these medical policies when inserting the revisions into your supplier manual.

---

**1998 HCPCS CODES UPDATE**

*Additions*

The following are additions to the HCFA Common Procedure Coding System for 1998. These new codes were effective January 1, 1998. You should use them appropriately for dates of service April 1, 1998, and after.

- L8039  Breast prosthesis, not otherwise specified
- L8239  Elastic support, not otherwise specified
**NEBULIZER**

The DMERC will continue coverage for the following HCPCS codes until further notice.

- E0565
- K0269
- K0501

This article supersedes the one published in the Winter 1997 *DMERC Medicare Advisory*, page 120, which stated that coverage for these codes would cease April 1, 1998.

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**EPOETIN**

Coverage reminder

The Health Care Financing Administration (HCFA) has explicitly changed the Regional Medical Review Policy addressed in the Winter 1997 *DMERC Medicare Advisory*, page 122, and is permitting payment for EPO therapy in a month in which the average hematocrit exceeds 36.5 percent. The article advised no payment would be made for Epoetin (EPO) during a month if the 90 day average hematocrit exceeded 36.5 percent. It also described how the three month rolling average hematocrit was to be determined.

Payment may be made on claims for monthly billing periods beginning on or after March 10, 1998, when the three month rolling average exceeds 36.5 percent. Payment is based on the lower of either the actual dosage billed for the current month or 80 percent of the prior month’s allowable EPO dosage.

In addition, HCFA has reestablished authorization to make payment for EPO during a month when the patient’s hematocrit exceeds 36 percent. To receive payment, the claim must be accompanied by documentation from the patient’s treating physician or dialysis facility establishing medical necessity for the higher hematocrit. Payment is based on the actual dosage billed.

---

**CLAIMS STATUS INQUIRY**

Palmetto Government Benefits Administrators recommends you use Claims Status Inquiry (CSI) to access information on multiple claims.

- CSI is an on-line transaction enabling electronic submitters to access a six month history of their pending and resolved claims. It displays data for assigned and non-assigned claims.

However, CSI does not display payment amounts for non-assigned claims.
CLAIMS STATUS INQUIRY (continued)

♦ CSI allows you to view the total dollar amount pending on the payment floor, the dates and amounts of your last three payments, and claims which have been crossed over to secondary insurers.

Participating suppliers have the additional advantage of verifying beneficiary eligibility information (see “Beneficiary eligibility” on page 11).

If you wish to use CSI, please complete an enrollment form; billing services and clearinghouses should have their clients complete an additional form authorizing CSI access by a third-party. Corporate offices who have branches with individual supplier numbers should complete the CSI Addendum for corporate offices.

To request these forms, or to order CSI software, contact the Electronic Data Interchange Help Desk at (803) 788-9751.

MEDICARE AS SECONDARY PAYER

To expedite the processing of your claims, please include a copy of the Explanation of Benefits (EOB) from the primary insurer when submitting a claim to Medicare as the secondary insurer.

♦ If the item billed to the primary insurer was denied, the denial code and denial reason or description should be included on the EOB

♦ If the denial reason is on the back of the EOB, or on an attached page, please include a copy of the back of the EOB or attached page with the claim

♦ If no denial reason is provided on or with the EOB, Medicare will deny the claim for missing information

For electronic media claims submissions, use the DA0 record to complete the Medicare Secondary Payer data. Be sure the Zero Pay field has been completed with one of the following codes.

♦ N = EOB on file. Payment amount > zero

♦ Z = EOB on file. Zero payment

If you enter Z in the Zero Pay field, enter the denial reason in the HA0 record. If the denial reason is not entered in the HA0 record, the claim will be denied for missing information.

If the Zero Pay field is left blank, we must assume the claim has not been filed or payment notification has not yet been received from the primary payer. As a result, Medicare will deny the claim.
MEDICARE SUMMARY NOTICE

Your patients’ Explanation of Medicare Benefits (EOMB) for Medicare Part B has been replaced by the Medicare Summary Notice (MSN). It serves the same function as the EOMB, but is designed to be easier for Medicare beneficiaries to understand. The following information is included on every MSN.

♦ The date the MSN was sent
♦ The beneficiary’s Medicare number, name, and address
♦ Whether or not the claim is assigned or unassigned
♦ The date(s) of service
♦ The claim number
♦ A brief description of the item(s) or service(s) you provided
♦ The amount charged
♦ The amount Medicare approved
♦ The amount Medicare paid either you or the beneficiary
♦ The total amount you are allowed to bill the beneficiary
♦ Your name and address
♦ How much of the beneficiary's annual deductible has been met

The MSN replaced the EOMB effective April 1, 1998.

PROMPT PAYMENT

Interest rate

The Treasury department has determined that the new prompt payment interest rate is 6.25 percent.

This rate is effective for scheduled Medicare payment dates of January 1, 1998, through June 30, 1998. The rate applies to clean paper and electronic claims that have not been paid by the 30th day after having been received by Palmetto Government Benefits Administrators.

PORTABLE OXYGEN

The oxygen allowable reductions mandated by the Balanced Budget Act of 1997 have resulted in questions regarding portable oxygen. In response to oxygen suppliers’ concerns, Palmetto Government Benefits Administrators has published answers to your most common questions.

♦ Can we charge for delivery of portable systems?
PORTABLE OXYGEN  
(continued)  
No. Delivery charges should not be billed to the beneficiary. According to §5105 of the Medicare Carriers Manual, delivery and service are an integral part of the cost of doing business for oxygen and other DMEPOS supplies.

♦ Can we charge the beneficiary for additional tanks?

No. Beneficiaries should not be charged for additional tanks. They should receive services that are medically necessary to maintain their daily living activities. There is no limit to the number of portable oxygen tanks beneficiaries may receive per month.

♦ Can we request a beneficiary pick up his portable oxygen tanks from us?

No. Supplier standards state that suppliers must oversee the delivery of items ordered by a physician for the beneficiary.

Medicare pays a monthly rate for oxygen and oxygen equipment which includes the following items.

♦ Oxygen contents
♦ System for furnishing the oxygen
♦ Vessels that store the oxygen
♦ Tubing and administration sets that allow safe delivery of oxygen in the home

Once information on the HCFA-484 (DMERC 484.2) form establishes the need for portable or ambulatory oxygen in the home, use outside the home may be covered as well.

RECORD UPDATES  
Palmetto Government Benefits Administrators cannot update the following information.

♦ End Stage Renal Disease (ESRD) beneficiary selection records
♦ Hospice enrollment or disenrollment dates
♦ Health Maintenance Organization (HMO) effective and termination dates

Requests to update a beneficiary’s ESRD selection records should be sent to the beneficiary’s local Part A intermediary.
**RECORD UPDATES (continued)**

Requests to update a beneficiary’s Hospice enrollment or disenrollment dates should be sent, by the Hospice unit, to the beneficiary’s local Part A intermediary.

Requests to update a beneficiary’s HMO effective and termination dates should be directed, by the beneficiary, to the Social Security Administration.

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**REFRACTIVE LENSES**

The revised Regional Medical Review Policy for refractive lenses, effective for dates of service on or after March 1, 1998, contains important information for vision suppliers. The complete policy revision was published in the Winter 1997 manual revision and is found on pages 18.2 – 18.6a of your Region C DMEPOS Supplier Manual. The most significant changes affecting Medicare coverage in the revised policy are listed here.

- The importance of specific diagnosis codes
- The relevance of the time period in which lenses and frames are supplied after cataract surgery
- The use of the ZX modifier to indicate medical necessity for tints, anti-reflective coating, U-V lenses, and oversize lenses

**Diagnosis codes**

Covered diagnoses for refractive lenses are limited to the following specific diagnosis codes.

- Pseudoaphakia (ICD-9-CM V43.1)
- Aphakia (ICD-9-CM 379.31)
- Congenital aphakia (ICD-9-CM 743.35)

**Time period to dispense lenses and frames**

If a beneficiary does not receive corrective lenses between cataract surgeries for each eye, Medicare only covers one pair of eyeglasses or contact lenses after the second surgery. Likewise, if the beneficiary receives lenses but not frames after cataract surgery, the frames are not covered at a later date (unless it follows subsequent cataract extraction in the other eye).

**ZX modifier**

The following items are covered when medically necessary and the medical necessity is documented by the treating physician.
REFRACTIVE LENSES (continued)

- Tints (HCPCS codes V2740 – V2744)
- Anti-reflective coating (HCPCS code V2750)
- U-V lenses (HCPCS code V2755)
- Oversize lenses (HCPCS code V2780)

If documentation exists, you should indicate its presence by applying the ZX modifier to the appropriate HCPCS code on the claim, e.g. HCPCS + LTRTZX.

If no such documentation is present, or if the feature is provided as a patient preference, you should not use the ZX modifier. The item would then be denied as not medically necessary. For assigned claims without the necessary documentation and ZX modifier, you may obtain a waiver of liability (see your Region C DMEPOS Supplier Manual pages 11.1 – 11.2).

The presence of the GA modifier, e.g. HCPCS + LTRTGA, indicates the patient's acceptance of financial responsibility for the items denied as not medically necessary.

Frequently asked questions

- Should I file for the deluxe frame (HCPCS code V2025) or the progressive feature of lenses (HCPCS code V2781)?

  Yes. If you do not file the claim to Medicare, you may prevent your patients from obtaining appropriate reimbursement from secondary insurance. These services are non-covered under the Medicare program and, therefore, may be reimbursed separately by a patient's secondary insurance.

- Does Medicare require the date of the cataract surgery on the HCFA-1500 form?

  Yes. You should include the date of cataract surgery in Item 21 of the HCFA-1500 form or in the HAØ record for electronically submitted claims.

- Are polycarbonate lenses and hi-index lenses covered by Medicare?

  No. Medicare does not cover these features for lenses. You should bill the appropriate lens (i.e. bifocal or trifocal) and on the next line item bill vision service, miscellaneous (HCPCS code V2799), with your charge for either the polycarbonate or hi-index lens.

  Medicare will base its allowance on the lens code and deny the vision service as non-covered. Be sure when billing for vision service, miscellaneous (HCPCS code V2799), that you describe the service fully in the HAØ record or on the paper claim.
SUPPLIER SATISFACTION SURVEY

Results

The 1997 supplier survey results have been received and tabulated. Sixty-seven percent of you rank Palmetto Government Benefits Administrators favorably. Areas in which you rated us above average are shown below.

♦ Claims processing
♦ Electronic Data Interchange
♦ Medical Review
♦ Professional Relations
♦ Team services

Survey questionnaires were mailed to 4,400 suppliers selected at random, or approximately 10 percent of Region C's active supplier population. Responses were received from approximately 25 percent of the suppliers polled.

We appreciate your feedback. Your responses and written comments assist us in better service to you.

MAIL ALERT

Effective June 1, 1998, all correspondence (including claims and review requests) sent to Palmetto Government Benefits Administrators at obsolete mailboxes will be returned to sender.

If you are unsure of your team assignment and mailing address, call Team Services at (803) 691-4300. The manual revisions (Spring/Summer 1998) which accompany this Advisory contain the proper address for each team on page 10.2.

SUPPLIER ADDRESSES

The National Supplier Clearinghouse (NSC) and Palmetto Government Benefits Administrators (Palmetto GBA) maintain three addresses for each supplier.

♦ Physical (Street) Address
  Where you service customers

♦ Mailing Address
  Where correspondence and your Region C DMERC publications are sent

♦ Pay To (Payee) Address
  Where your checks and remittance notices are sent
These three addresses allow you to control where you receive information from the DMERC. The information for your addresses is taken directly from the Medicare DMEPOS Supplier Enrollment Application.

♦ The Physical Address comes from Section 3, “Practice Location”

♦ The Mailing Address comes from Section 5, “Mailing Address”

♦ The Pay To address comes from Section 6, “Pay To’ Address”

You may list something different for each of these addresses, or they may be exactly the same.

If you need to change one or more of your addresses after having been assigned your 10-digit supplier number, please use the Change of Address Notification form on page 1.10 of your Region C DMEPOS Supplier Manual. The form allows for only one address change, therefore, you must submit a separate form for each address you want changed. To change all three addresses, you should submit three forms.

Also, please be sure to send the completed form(s) to the NSC at the following address.

National Supplier Clearinghouse
P.O. Box 100142
Columbia, S.C.  29202-3142

The NSC forwards suppliers’ address changes to Palmetto GBA daily which allows us to maintain current records.
**SUPPLIER SANCTIONS**

**Alabama**

Foster, Lebaron  
866 Sommerville St.  
Mobile, Ala. 36617  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 11/20/97

Purdom, Bertha L Pritchett  
6805 5th Court N.  
Birmingham, Ala. 35206  
Specialty: Employee (Non-Government)  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

**Arkansas**

Jones, Henry Lee  
7500 Correction Circle  
Pine Bluff, Ark. 71603  
Specialty: Employee (Non-Government)  
Period of Exclusion: 10 yrs.  
Effective Date: 11/20/97

Keister, Jerry  
616 Hill St.  
Jacksonville, Ark. 72076  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 10 yrs.  
Effective Date: 11/20/97

McCloud, Anna Sue  
2620 Jackson Rd. 22  
Newport, Ark. 72112  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

**Florida**

B&V Medical Supply  
1716 S.W. 13th St.  
Miami, Fla. 33131  
Specialty: DME Company  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Broyles, Stephen R  
10941 Brightside Dr.  
Tampa, Fla.  
Specialty: Owner/Operator  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Ciggs, Jimmy D.  
724 W. 7th St.  
Riviera Beach, Fla. 33404  
Specialty: Employee (Non-Government)  
Period of Exclusion: 10 yrs.  
Effective Date: 11/20/97

Coto’s Pharmacy  
2900 W. 12th Ave.  
Hialeah, Fla. 33012  
Specialty: Pharmacy  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Egozl, Anochka  
19931 N.W. 36th Pl.  
North Miami Beach Fla. 33180  
Specialty: Owner/Operator  
Period of Exclusion: 98 yrs.  
Effective Date: 11/20/97

Egozl, Maurice  
19931 N.W. 36th Pl.  
North Miami Beach, Fla. 33180  
Specialty: Owner/Operator  
Period of Exclusion: 98 yrs.  
Effective Date: 07/29/97

Ferris, Sam  
4995 Sable Pine Circle #D-2  
West Palm Beach, Fla. 33407  
Specialty: Employee (Non-Government)  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97
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<td>11/20/97</td>
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<td>Gonzalez, Yohanka</td>
<td>210 Fountainbleu Blvd. #401 Miami, Fla. 33172</td>
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<td>Green, Tony Gerald</td>
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<td>Harte, Brian K.</td>
<td>7815 Hearthstone Circle Pensacola, Fla. 33180</td>
<td>Nurse/Nurse's Aide</td>
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<td>11/20/97</td>
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<td>Hatcher, Krisstie</td>
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<td>Lim, Millian K.</td>
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<td>Marrero, Maria Del Carman</td>
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<td>Medix Physician Inc.</td>
<td>389 E. 8th St. Hialeah, Fla. 33010</td>
<td>Medical Practice</td>
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### Supplier Sanctions (continued)

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<td>Muktar, Junaid</td>
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<td>Nawrocki, Raymond</td>
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<td>Nodal, Raul Froilan</td>
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<td>PR Medical Services</td>
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<td>DME Company</td>
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<td>Ponder, Kathy Ann</td>
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<td>Prohias, Mara Lourdes</td>
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<td>Sacasa, Roberto</td>
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<td>Swan, Robert N.</td>
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<td>Vergel, Jaime</td>
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</table>
**SUPPLIER SANCTIONS (continued)**

**Louisiana**

Lawrence, Teri Tyler  
P.O. Box X  
Pine Grove, La. 70453  
Specialty: Owner/Operator  
Period of Exclusion: 10 yrs.  
Effective Date: 11/20/97

Stewart, Susie Mae  
4036 Elliot St.  
Shreveport, La. 71109  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

**Mississippi**

Dantzler, Deborah  
P.O. Box 3  
Heidelberg, Miss. 39439  
Specialty: Health Care Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Davis, Latisha  
14 Marie Dr.  
Laurel, Miss. 39440  
Specialty: Health Care Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Fox, Betty  
Fox Ave. Strong St.  
Derma, Miss. 38839  
Specialty: Health Care Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Roberts, Donald  
303 Northside Dr.  
Starkville, Miss. 39759  
Specialty: Health Care Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

**New Mexico**

Provencio, Michelle  
222-55th St. N.W.  
Albuquerque, N.M. 87105  
Specialty: Health Care Aide  
Period of Exclusion: 3 yrs.  
Effective Date: 11/20/97

**North Carolina**

Lowe, Linda K.  
114 Center Dr.  
Bessemer City, N.C. 28016  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

McBroom, William David  
Seymour AFB Caller Box 8004  
Goldboro, N.C. 27533  
Specialty: Owner/Operator  
Period of Exclusion: 10 yrs.  
Effective Date: 11/20/97

Middleton, Tonja G.  
6290 Withers Dr.  
Fayetteville, N.C. 28304-2727  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97

Roberts, Ifor John  
814 Vickers Ave.  
Durham, N.C. 27701  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 11/20/97

**Oklahoma**

Foreman, Robin Lynn Chastain  
101 E. Main Apt 201  
Durant, Okla. 74701  
Specialty: Nurse/Nurse’s Aide  
Period of Exclusion: 5 yrs.  
Effective Date: 11/20/97
SUPPLIER SANCTIONS
(continued)

Martinez, Jay
1221 N. Lee St.
Altus, Okla. 73521
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

South Carolina

Harris, Steffany T.
201 #5 Saratoga St.
Clinton, S.C. 29325
Specialty: Health Care Aide
Period of Exclusion: 3 yrs.
Effective Date: 11/20/97

Solomon, Smith
4265 Williamsburg Dr.
Columbia, S.C. 29203
Specialty: Medical Doctor
Period of Exclusion: Indefinite
Effective Date: 09/02/97

Tennessee

Hoyle, Jacqueline D
206 Mobile St.
Jackson, Tenn. 38301
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

Johnson, Michael D.
42 Clearfield Dr.
Jackson, Tenn. 38305
Specialty: Employee
(Non-Government)
Period of Exclusion: 3 yrs.
Effective Date: 11/20/97

Noe, Albert D.
138 Old Stage Rd.
Jackson, Tenn. 38305
Specialty: Employee
(Non-Government)
Period of Exclusion: 3 yrs.
Effective Date: 11/20/97

Texas

Alexander, Edna Denise
36 Squirrel Run
Devine, Texas 78016
Specialty: Accountant/
Bookkeeper/Auditor
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

Alter, Don E.
5018 92nd St.
Lubbock, Texas 79423
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite

Danley, Melanie Rebecca
1526 Chukka Dr. Apt. 506
Arlington, Texas 76012
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

Jordan, Joy F.
Route 2 Box 208-B
Hillsboro, TX 76645
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

Martinez, Martha O.
209 S. Texas Ave.
Big Lake, Texas 76932
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

Murray, Linda Sue Pierce
P.O. Box 1752
Bowie, Texas 76230
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97
**SUPPLIER SANCTIONS (continued)**

Paige, Lakisha K.
506 Harkem
Sweeny, Texas 77480
Specialty: Nurse/Nurse’s Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/20/97

**SUPPLIER REINSTATEMENT ACTIONS**

**Florida**

Figueroa, Pablo E.
C/o P.O. Box 909
Inverness, Fla. 34451
Specialty: Family Physician/General Practice
Sanction Date: 09/03/97
Reinstatement Date: 10/17/97

**Mississippi**

Scale Drug Co.
C/o 132 E. College Ave.
Holly Springs, Miss. 38635
Specialty: Pharmacy
Sanction Date: 10/02/97
Reinstatement Date: 10/14/97
DRUG UPDATE

Changes in allowables for drugs are revised quarterly and published below. These changes occurred April 1, 1998, and are effective for all dates of service.

Currently, the following drugs are among those which meet requirements for coverage under the Omnibus Budget Reconciliation Act of 1993. Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

**Oral anti-cancer**

<table>
<thead>
<tr>
<th>MANUFACTURER</th>
<th>HOW SUPPLIED</th>
<th>PACKAGE SIZE</th>
<th>NATIONAL DRUG CODE (NDC)</th>
<th>ALLOWANCE PER UNIT</th>
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<tbody>
<tr>
<td>Glaxo Wellcome</td>
<td>2mg/Oral</td>
<td>50</td>
<td>00173-0045-35</td>
<td>$1.81</td>
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</table>

Please use the specified National Drug Code numbers to bill for the oral anti-cancer drugs shown above. (Unlike other drugs billable to the DMERC, oral anti-cancer drugs are not submitted with HCFA Common Procedure Coding System [HCPCS] codes.)

**Immunosuppressive**

<table>
<thead>
<tr>
<th>HCPCS code</th>
<th>Price</th>
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<tbody>
<tr>
<td>J7509</td>
<td>$0.50</td>
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<tr>
<td>K0121</td>
<td>$1.45</td>
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<td>K0412</td>
<td>$1.94</td>
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<tr>
<td>K0418</td>
<td>$5.80</td>
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</table>

**Nebulizer**

<table>
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<tr>
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<th>Modifier</th>
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<td>K0514</td>
<td>KO, KP</td>
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<td>K0525</td>
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<td>$2.37</td>
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<tr>
<td>K0526</td>
<td>KQ</td>
<td>$2.15</td>
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**Infusion therapy**

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<tr>
<td>J9040</td>
<td>$289.37</td>
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<tr>
<td>J9065</td>
<td>$49.02</td>
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</table>

**NOTE:** "Drug update" outlines allowables as of April 1, 1998, for drugs billable to the DMERC. The listing of a HCPCS drug code along with its allowables does not constitute coverage for that HCPCS code by Palmetto Government Benefits Administrators. All drugs reimbursable as DMEPOS items (i.e. immunosuppressive, bronchodilator drugs and other DMEPOS drugs) are reimbursable based on the national average wholesale price of the drug. If a drug has multiple sources, the median of the average national wholesale generic prices is used (Region C DMEPOS Supplier Manual, July 1996 revision, page 6.3).
**Fee Changes**

The following fees are updates made by the Health Care Financing Administration (HCFA) during the first quarter. Please remember that the listing of a HCFA Common Procedure Coding System (HCPCS) code along with its allowable does not constitute coverage for that HCPCS code by Palmetto Government Benefits Administrators.

These fees supersede allowances previously published in the 1998 Region C DMERC Fee Schedule Catalog effective January 1, 1998.

- With the exception of HCPCS code L1844, the following prices apply to claims processed on or after **February 17, 1998**.

- The price for HCPCS code L1844 applies to claims processed on or after **January 19, 1998**.

### 1998 Fee Schedule Changes

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<th>S.C.</th>
<th>Tenn.</th>
<th>Texas</th>
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<td>2,731.36</td>
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OMBUDSMEN

South Carolina

Palmetto Government Benefits Administrators is pleased to announce the newest member of its Professional Relations department: Dana Church, South Carolina ombudsman.

Dana has four years of experience with Medicare, working as a team associate for the DMERC and a provider education consultant for Part A providers in South Carolina. She specialized in End Stage Renal Disease Facilities, Skilled Nursing Facilities and Outpatient Rehabilitation during her time with Medicare Part A.

With a bachelor’s degree in education from Morehead State University in Morehead, Ky., Dana has the additional educator experience of three years as a public school teacher. Please welcome Dana to the DMERC; she looks forward to serving you. Her address and telephone number are listed on the next page.

Two for Texas

Because of the large supplier population in Texas, Palmetto Government Benefits Administrators (Palmetto GBA) has divided the state into two areas. Suppliers in each of these areas now have their own Palmetto GBA ombudsman.

♦ Dana Causey is responsible for educating suppliers in Southern Texas. She has faithfully represented Palmetto GBA in Texas since she joined the DMERC in 1995.

Suppliers whose area codes are 210, 512, 830, 915, or 956 should contact Dana Causey for educational assistance.

♦ Peggy Miller is responsible for educating suppliers in Northern Texas. She joined Palmetto GBA in 1997 as the ombudsman for Colorado and New Mexico. Peggy’s past professional highlights include positions as billing specialist and reimbursement supervisor for DME suppliers in Texas.

Suppliers whose area codes are 214, 254, 281, 409, 713, 806, 817, 903, 940, or 972 should contact Peggy Miller for educational assistance.

We hope you will welcome Peggy Miller as a new ombudsman for the state of Texas. Addresses and telephone numbers for the Texas ombudsmen are shown on the following page.

Colorado and New Mexico

Mariellen Deving will be the Palmetto Government Benefits Administrators representative for suppliers in Colorado and New Mexico until a new ombudsman is selected to serve those states. Her address and telephone number are also published on the next page.
Ombudsmen addresses and their territories

**Alabama**
Lia Bunch  
P.O. Box 146  
Union Grove, Ala. 35175  
(205) 498-0205

**Arkansas/Oklahoma**
Brooke Dieterlen  
6528 E. 101st St., Suite 376  
Tulsa, Okla. 74133-6754  
(918) 252-4481

**Colorado/New Mexico**
**In the interim contact**
Mariellen Deyling  
P.O. Box 100141  
Columbia, S.C. 29202-3141  
(803) 735-1034, Ext. 35726

**Florida (south)**
(covers the southern portion of Florida to include Manatee, Hardee, Highlands, Okeechobee and Indian River counties and all points south)
Teresita Ortiz  
Suite 328  
9737 N.W. 41st  
Miami, Fla. 33178  
(305) 418-5009

**Florida (north)**
(covers the northern portion of Florida to include Pinellas, Hillsborough, Polk, Osceola and Brevard counties and all points north)
Keith Smith  
Suite 139  
10991-55 San Jose Blvd.  
Jacksonville, Fla. 32223  
(904) 886-2887

**Georgia**
Mary Jo Gochett  
P.O. Box 81850  
Conyers, Ga. 30208-9426  
(770) 761-0509

**Kentucky**
Teresa Camfield  
207 La Ruisseau Rd.  
Louisville, Ky. 40223  
(502) 254-5011

**Louisiana/Mississippi**
Bobby Smith  
P.O. Box 9225  
Jackson, Miss. 39286  
(601) 856-4368

**North Carolina**
Sharon Briggman  
P.O. Box 97424  
Raleigh, N.C. 27624-7424  
(919) 846-3552

**Out of Region C**
Mariellen Deyling  
P.O. Box 100141  
Columbia, S.C. 29202-3141  
(803) 735-1034, Ext. 35726

**Puerto Rico/Virgin Islands**
Adie Fuentes  
Urb. Muñoz Rivera  
Ave. Esmeralda #53  
Call Box 50  
Guaynabo, PR 00969  
(787) 782-0544

**South Carolina**
Dana Church  
P.O. Box 100141  
Columbia, S.C. 29202-3141  
(803) 735-1034, Ext. 35726

**Tennessee**
Elaine Hensley  
Box 317  
2000 Mallory Ln., Suite 130  
Franklin, Tenn. 37067  
(615) 771-6722

**Texas (south)**
(covers the southern portion of Texas to include El Paso, Seminole, Abilene, Austin, San Antonio, Corpus Christi, and all points south)
Dana Causey  
P.O. Box 7891  
Horseshoe Bay, Texas 78657  
(830) 598-4882

**Texas (north)**
(covers the northern portion of Texas to include La Grange, Houston, Killeen, Dallas, Amarillo, and all points north)
Peggy Miller  
2601 Cartwright Rd., Suite D392  
Missouri City, Texas 77459  
(281) 416-9688

---

Ombudsmen investigate complaints, report findings and facilitate problem solving through training and education of the supplier community.
### Region C Directory

Please retain this list as your new DMERC telephone directory.

#### Palmetto GBA contacts

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-Fraud Unit</strong></td>
<td>(803) 788-5414</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100236</td>
<td></td>
</tr>
<tr>
<td>Columbia, S.C. 29202-3236</td>
<td></td>
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<tr>
<td><strong>Dedicated Work Teams/DMERC General Information</strong></td>
<td>(803) 691-4300</td>
</tr>
<tr>
<td>Electronic Data Interchange (EDI)</td>
<td></td>
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<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
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</tr>
<tr>
<td>P.O. Box 100145</td>
<td></td>
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<tr>
<td>Columbia, S.C. 29202-3145</td>
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<tr>
<td><strong>Hearings Department</strong></td>
<td>(803) 691-4300</td>
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<tr>
<td>P.O. Box 100249</td>
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<tr>
<td>Columbia, S.C. 29202</td>
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<tr>
<td><strong>Prior Authorization Department</strong></td>
<td>(803) 691-4300</td>
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<td>Palmetto GBA, Medicare Region C DMERC</td>
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<tr>
<td>P.O. Box 100235</td>
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<td>Columbia, S.C. 29202-3235</td>
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<tr>
<td><strong>Professional Relations Department</strong></td>
<td>(803) 735-1034,</td>
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<td>Palmetto GBA, Medicare Region C DMERC</td>
<td>ext. 35744</td>
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</tr>
<tr>
<td>Columbia, S.C. 29202-3141</td>
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*Inquiries regarding hearings or Prior Authorization should be directed to the Dedicated Work Teams.*

#### National numbers

<table>
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<tr>
<td><strong>National Supplier Clearinghouse (NSC)</strong></td>
<td>(803) 754-3951</td>
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<td>P.O. Box 100142</td>
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<tr>
<td>Columbia, S.C. 29202-3142</td>
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<tr>
<td><strong>Region A DMERC</strong></td>
<td>(717) 735-9445</td>
</tr>
<tr>
<td><strong>Region B DMERC</strong></td>
<td>(317) 577-5722</td>
</tr>
<tr>
<td><strong>Region D DMERC</strong></td>
<td>(615) 251-8182</td>
</tr>
<tr>
<td><strong>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)</strong></td>
<td>(803) 736-6809</td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td></td>
</tr>
<tr>
<td>400 Arbor Lake Drive, Suite A 900</td>
<td></td>
</tr>
<tr>
<td>Columbia, S.C. 29223</td>
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