GLUCOSE MONITORS AND ACCESSORIES/SUPPLIES

Coverage change effective July 1, 1998

[What appears below is in addition to the DMERC Regional Medical Review Policy (RMRP) on home blood glucose monitors and their associated supplies and accessories for insulin-treated diabetics found in the Region C DMEPOS Supplier Manual, pages 16.51-16.52a.]

Effective for dates of services on or after July 1, 1998, Medicare coverage for glucose monitors and related accessories and supplies is being expanded to include patients who are not being treated with insulin injections. (Prior to this date, Medicare only covered these items for patients who were being treated with insulin injections.)

continued on page 41
The following publications are needed to have an updated Region C DMEPOS Supplier Manual. Manual revisions are mailed in conjunction with quarterly DMERC Medicare Advisory issues. Inquiries into missing publications should be directed to Palmetto Government Benefits Administrators’ Dedicated Work Teams at (803) 691-4300.

<table>
<thead>
<tr>
<th>Publication Title</th>
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<td>July 1995 Region C DMEPOS Supplier Manual</td>
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</table>

The Region C DMEPOS Supplier Manual is designed to guide suppliers in the submission of DMEPOS claims. Pages which are replaced by the revisions should not be discarded. Because billing guidelines may vary with date(s) of service, Palmetto GBA advises DME suppliers to retain previous versions and/or pages of the supplier manual.
The patient must meet at least the following basic criteria:

1) The patient has diabetes (ICD-9 codes 250.00–250.93) which is being treated by a physician; and,

2) The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient’s diabetes; and,

3) The device is designed for home use.

The physician treating the beneficiary’s diabetes must state on the prescription to the supplier, the diagnosis (ICD-9-CM or narrative) of diabetes, whether or not the beneficiary is being treated with insulin injections, the item/supplies/accessories needed, the quantity to be dispensed, and the frequency with which the beneficiary should use them. A prescription which merely states, “as needed,” will not be considered valid for Medicare.

This prescription will be valid for six months, at which time the physician will have to renew it for the beneficiary to continue to receive covered test strips and lancets. Renewal of the prescription must be initiated by either the treating physician, the beneficiary or the beneficiary’s caregiver. A supplier may not initiate an order for these items. Initiation of the renewal should be dependent upon the beneficiary’s use of these supplies, and the renewal prescription must contain the same information as described above for initial prescriptions.

DMERCs will only pay for glucose monitoring supplies that are medically necessary. Medical necessity requires that the beneficiary be under the care of a physician and the frequency of testing be determined by the physician treating the beneficiary’s diabetes.

Quantities of home glucose monitor supplies that are not prescribed according to the above criteria will be denied as not medically necessary.

**Documentation requirements**

The supplier must have an original order which is signed and dated by the physician who is treating the beneficiary’s diabetes. For supplies, the order must list the items that are to be dispensed and the frequency of testing. A narrative diagnosis and/or ICD-9-CM diagnosis code must be present on each order for a glucose monitor or related accessory or supply. The order must also include a statement indicating whether or not the patient is being treated with insulin injections. The supplier must obtain a new written order from the treating physician every six months.

An ICD-9-CM diagnosis code describing the condition which necessitates glucose testing must be included on each claim for the monitor, accessories, and supplies. The supplier should continue to use the ZX modifier for insulin-treated diabetics as described in the current DMERC RMRP for home blood glucose monitors.
INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors

The preceding article provides a general description of the expanded benefit for non-insulin-treated diabetics, which went into effect for dates of service on or after July 1, 1998. In addition, the current DMERC policy on Home Blood Glucose Monitors remains in effect (except for the statements that indicate that coverage is limited to insulin-treated diabetics).

In addition, an Interim Medical Policy on Glucose Monitors is included on the next several pages. This is a revision of the existing policy and establishes coverage criteria and documentation requirements which implement the expanded benefit. The interim policy is effective for claims with dates of service on or after October 1, 1998.

As with all new or revised policies, this policy has been sent for comment to national organizations representing manufacturers, suppliers, physicians, and other healthcare professionals involved in the ordering, provision, or use of glucose monitors in the home. If, based on comments received from these groups, the DMERCs decide to revise this policy, the revision will be published in a future revision to the Region C DMEPOS Supplier Manual.

INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors

HOME BLOOD GLUCOSE MONITORS

HCPCS CODES

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

Equipment

E0607   Home blood glucose monitor
E0609   Blood glucose monitor with special features (e.g., voice synthesizers, automatic timers, etc.)

Accessories/Supplies

A4244   Alcohol or peroxide, per pint
A4245   Alcohol wipes, per box
A4246   Betadine or pHisohex solution, per pint
A4247   Betadine or iodine swabs/wipes, per box
A4250   Urine test or reagent strips or tablets (100 tablets or strips)
A4253   Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4254   Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each
A4255   Platforms for home blood glucose monitor, 50 per box
A4256   Normal, low and high calibrator solution/chips
A4258   Spring-powered device for lancet, each
A4259   Lancets, per box of 100
INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors
(continued)

HCPCS MODIFIERS

KS Glucose monitor supply for diabetic beneficiary not treated by insulin

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

BENEFIT CATEGORY: Durable Medical Equipment

REFERENCE: Coverage Issues Manual 60–11 (addresses insulin-treated diabetics)
Program Memorandum B98–26 (addresses non-insulin-treated diabetics)

DEFINITIONS

Insulin-treated means that the patient is receiving insulin injections to treat their diabetes. Insulin does not exist in an oral form and therefore patients taking oral medication to treat their diabetes are not insulin-treated.

A severe visual impairment is defined as a best corrected visual acuity of 20/200 or worse.

COVERAGE AND PAYMENT RULES

Home blood glucose monitors are covered for patients who are diabetics and who can better control their blood glucose levels by checking these levels and appropriately contacting their attending physician for advice and treatment.

To be eligible for coverage, the patient must meet the following basic criteria:

1) The patient has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician; and,

2) The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes; and,

3) The patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancets; and,

4) The patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control; and,

5) The device is designed for home use.

Blood glucose monitors with such features as voice synthesizers and specially designed arrangements of supplies and materials to enable the visually-impaired to use the equipment without assistance (E0609) are covered when the following conditions are met:

1) The patient and device meet the conditions listed above for coverage of standard home blood glucose monitors; and,

2) The patient's physician certifies that he or she has a visual impairment severe enough to require use of this special monitoring system.
Lancets (A4259), blood glucose test reagent strips (A4253), and spring powered devices for lancets (A4258) are covered for patients for whom the glucose monitor is covered. More than one spring powered device (A4258) per 6 months will rarely be medically necessary.

The quantity of test strips (A4253) and lancets (A4259) that are covered depends on the usual medical needs of the diabetic patient according to the following guidelines:

- For a patient who is not currently being treated with insulin injections, up to 50 test strips every 2 months and 100 lancets every 4 months are covered if criteria (a) – (c) are met:
  
a) The coverage criteria (1–5) listed above for a glucose monitor are met; and

b) The supplier of the test strips and lancets maintains in its records the order from the treating physician; and

c) The beneficiary has nearly exhausted the supply of test strips and lancets that have been previously dispensed.

- For a patient who is currently being treated with insulin injections, up to 100 test strips and 100 lancets every month are covered if criteria (a) – (c) are met:
  
a) The coverage criteria (1–5) listed above for a glucose monitor are met; and

b) The supplier of the test strips and lancets maintains in its records the order from the treating physician; and

c) The beneficiary has nearly exhausted the supply of test strips and lancets that have been previously dispensed.

- For a patient who is not currently being treated with insulin injections, more than 50 test strips every 2 months and 100 lancets every 4 months are covered if, in addition to criteria (a)-(c) listed above, criteria (d) – (f) are met:
  
d) The treating physician justifies (see Documentation section) the need for the additional strips for that particular patient; and

e) The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering the additional strips and lancets; and

f) The treating physician has maintained documentation in the patient's medical record of blood glucose test results and any change in the beneficiary's diabetes medication over one full month within 6 months prior to dispensing the additional strips and lancets. (The documentation must consist of a copy of a written log recorded by the patient or caregiver or a print-out from the monitor’s memory, if applicable, which includes the date, approximate time, and result of each test).

For quantities of test strips or lancets that exceed the utilization guidelines, if documentation that criteria (d-f) listed above does not accompany the claim (see Documentation section), payment will be based on 50 test strips every 2 months and 100 lancets every 4 months for a patient who is not insulin-treated or 100 test strip and lancets per month for a patient who is insulin-treated.

A beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The request must be initiated by the beneficiary or their caregiver. A supplier may not initiate a refill of an order. If the request is in the form of a verbal, fax, mail, or similar request, the supplier must maintain documentation of this in their records. If the request is in the form of a purchase in person at a retail establishment, the supplier does not have to maintain
INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors (continued)

documentation of this. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has “authorized” this in advance.

A supplier should not dispense more than a 2-month supply of test strips and/or lancets at a time (except that a 4-month supply of lancets may be dispensed to a non-insulin-treated patient).

Alcohol or peroxide (A4244, A4245), Betadine or pHisohex (A4246, A4247) are noncovered since these items are not required for the proper functioning of the device.
Urine test reagent strips or tablets (A4250) are noncovered since they are not related to this equipment.

CODING GUIDELINES

Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor should be coded A9270 (noncovered item or service). Do not use code A4253 for these items.

In the following table, a Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
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<tbody>
<tr>
<td>E0607</td>
<td>A4254, A4256, A4258</td>
</tr>
<tr>
<td>E0609</td>
<td>A4254, A4256, A4258</td>
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DOCUMENTATION

The supplier must have an original order which is signed and dated by the physician who is treating the patient's diabetes. For supplies, the order must list the items and number that are to be dispensed and the frequency of testing. A narrative diagnosis and/or ICD-9-CM diagnosis code must be present on each order for a glucose monitor or related accessory or supply. The order must also include a statement indicating whether the patient is being treated with insulin injections. The supplier is required to have a new written order containing the same information from the treating physician every 6 months.

The ICD-9-CM diagnosis code describing the condition which necessitates glucose testing must be included on each claim for the monitor, accessories, and supplies.

If the order indicates that the patient is: 1) diabetic and 2) is being treated with insulin injections, the ZX modifier must be added to the code for the monitor and each related supply on every claim submitted. The ZX modifier may only be used when requirements 1 and 2 are met. The ZX modifier must not be used for a patient who is not treated with insulin injections.

For those patients who are not insulin treated, the KS modifier must be added to the code for the monitor and supplies on each claim submitted.

If the claim is for more than 50 test strips every 2 months or 100 lancets every 4 months for a patient who is not insulin-treated (KS modifier present) or more than 100 test strip or lancets per month for a patient who is insulin-treated (ZX modifier present), and if the supplier has a copy of signed and dated documentation from the treating physician which indicates whether criteria (d), (e), and (f) listed above have been met, the claim must be sent hard copy, accompanied by a copy of that documentation. A suggested form for collecting the information in (d) and (e) is attached. Answers on any form used to obtain this information may not be completed by the supplier or anyone in a financial relationship with the supplier. The information on any form must be supported by information in the patient’s medical record. A copy of the written log of home blood glucose test results, as described in criterion (f), must be reviewed by the treating physician, forwarded to the supplier, and must also accompany the claim. All
INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors (continued)

of the information described must be submitted with each claim for more than the usual quantity of supplies in order for coverage of the additional supplies to be considered. (Note: the data collection form and extra documentation are only required on claims seeking Medicare coverage for more than the usual quantity of test strips or lancets.)

The medical necessity for E0609 must be documented by a narrative statement from the physician which includes the patient’s visual acuity.

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

EFFECTIVE DATE: Claims with dates of service on or after October 1, 1998.

This is a revision to a previously published policy.
INTERIM MEDICAL POLICY DRAFT FOR NOTICE AND COMMENT

Home blood glucose monitors
(continued)

Statement of Treating Physician
Glucose Monitor Test Strips Exceeding Policy Guidelines

Patient name: _______________________________  HIC #: __________________________

This information must be completed by the treating physician only if the patient:

♦ is being treated with insulin and is expected to use more than 100
  test strips per month,

or

♦ is not being treated with insulin and is expected to use more than 50 test strips per 2 months.

If these conditions are met, this information must be provided to the patient or to the supplier of the
test strips and lancets every 6 months along with a copy of a recent one month's log of the patient's
home blood glucose test results.

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

Circle Y for Yes, N for No, unless otherwise noted

Y  N  1) Do you treat this patient for diabetes?
Y  N  2) Is the patient currently using insulin injections to control their diabetes?
_____  3) What was the date of the last time you saw the patient for their diabetes?

4) Give specific reasons for quantities of test strips which exceed the policy
guidelines listed above. (If the reason is related to the initiation or dosage
change of a drug, give name and date.)

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Physician name (printed or typed): ____________________________________________

Physician signature: _________________________________________________________

Physician UPIN: ___________________________  Date signed: ______________________
HEAVY DUTY WALKERS

New HCPCS codes

Two new HCPCS codes have been established for Heavy Duty Walkers. The new HCPCS codes are:

♦ K0458–Heavy Duty Walker without wheels, each
♦ K0459–Heavy Duty Wheeled Walker, each

Heavy Duty Walkers are defined as those capable of supporting patients who weigh more than 300lbs. They may be fixed height or adjustable height.

HCPCS codes K0458 and K0459 are effective for claims with dates of service on or after July 1, 1998. These HCPCS codes are in the Inexpensive and Routinely Purchased (IRP) payment category, and therefore, require the modifiers NU, UE or RR to indicate purchase or rental.

Claims for HCPCS codes K0458 and K0459 must include documentation of the patient's weight. If the patient weight is less than 300 lbs or not included on the claim, payment will be based on the allowance for the least costly medically appropriate alternative, HCPCS code E0130 or E0141, respectively.

TEMPORARY REPLACEMENT OF PATIENT-OWNED EQUIPMENT

New HCPCS code

Effective for claims with dates of service on or after July 1, 1998, a new HCPCS code has been established for the temporary replacement of beneficiary-owned equipment which is being repaired. The new HCPCS code is:

♦ K0462–Temporary Replacement for Patient Owned Equipment Being Repaired, any type.

The monthly allowance of the beneficiary-owned item is payable for one month only, while it is being repaired. This HCPCS code should not be billed and will not be reimbursed for equipment which has not been purchased by the beneficiary.

A claim for HCPCS code K0462 must include a narrative description of the equipment being used as a temporary replacement, the manufacturer, brand name, model name or number of the temporary replacement item, and a statement of why the replacement is needed. Claims without this information will be denied as not medically necessary.
HEAVY DUTY COMMODE CHAIR

New HCPCS code

A new HCPCS code has been established for an extra wide/heavy duty commode chair. The new HCPCS code is:

♦ K0457-Extra Wide/ Heavy Duty Commode Chair, each

HCPCS code K0457 is effective for claims with dates of service on or after July 1, 1998. HCPCS code K0457 is in the Inexpensive and Routinely Purchased (IRP) payment category, and therefore, requires the modifiers NU, UE or RR to indicate purchase or rental.

Extra Wide/Heavy Duty Commodes are defined as those that have a width of $\geq 23$ inches. This type of commode is also capable of supporting patients who weigh 300 lbs or more.

Claims for HCPCS code K0457 must include documentation of the patient's weight. If patient weight is less than 300 lbs, payment will be based on the least costly medically appropriate alternative, HCPCS code E0163.

If the patient has a body configuration that requires extra width but weighs less than 300 lbs, a commode with detachable arms (HCPCS code E0165) is covered if other coverage criteria are met.

For dates of service on or after July 1, 1998, HCPCS code K0457 must be used when submitting claims for an extra wide/heavy duty commode chair to the DMERC.

For dates of service prior to July 1, 1998, claims for extra wide/heavy duty commodes should be billed using HCPCS code E1399 (Miscellaneous DME). Documentation must include the manufacturer, brand name/model of the commode and information on why it is necessary for the patient.
NEW HCPCS CODES FOR POWER ADD-ON ATTACHMENTS FOR MANUAL WHEELCHAIR BASES

Two new HCPCS codes for power add-on attachments that convert manual wheelchairs to powered products are effective for dates of service on or after July 1, 1998:

♦ K0460–Power add on, to convert manual wheelchair to motorized wheelchair, joystick control.
♦ K0461–Power add on, to convert manual wheelchair to power operated vehicle, tiller control.

Power wheelchair HCPCS codes, K0010–K0014, are not to be used for manual wheelchairs with power add-on attachments.

For dates of service on or after July 1, 1998, power add-on attachments are billed using HCPCS codes K0460 or K0461. Documentation must include:

♦ Motorized Wheelchairs CMN 02.03A, signed and dated by the treating physician.

For dates of service prior to July 1, 1998, power add-on attachments are to be billed using the HCPCS codes K0108 or E1399. Claims coded using HCPCS codes K0108 or E1399 must also include a narrative description of the power add-on attachment, including the manufacturer, brand name and model number of the item.

CERVICAL TRACTION

HCPCS code E0855

In the Spring/Summer 1998 DMERC Medicare Advisory, Issue 24, we incorrectly announced on page 5 under cervical traction that, “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.”

The correct HCPCS code is E0855. We regret the misprint.
HEAVY DUTY HOSPITAL BEDS

New HCPCS code

Effective for claims with dates of service on or after July 1, 1998, a new HCPCS code has been established for Heavy Duty Hospital Beds. The new HCPCS code is:

♦ K0456–Hospital Bed, Heavy Duty, Extra Wide, Semi-Electric (head and foot adjustment) with any type side rails, with mattress.

HCPCS code K0456 is a hospital bed that is capable of supporting a patient who weighs more than 350 lbs, but less than or equal to 600 lbs. Initial claims for HCPCS code K0456 must be accompanied by a Hospital Bed CMN 01.02, which must include the patient's weight. If coverage criteria are not met, payment will be based on the least costly, medically appropriate alternative, HCPCS code E0260.

These beds will be considered capped rental items. (Payment will only be made on a rental basis.) The appropriate modifier (KH, KI, KJ) must be used and the rent/purchase option must be offered in the tenth rental month, as with all capped rental items.

Claims for these items with dates of service prior to July 1, 1998, are to be submitted using the miscellaneous HCPCS code E1399. For claims with dates of service on or after July 1, 1998, HCPCS code K0456 must be used when submitting claims for heavy duty hospital beds to the DMERC.

If the patient weighs more than 600 lbs, HCPCS code E1399 (Miscellaneous DME) is still to be used. Initial claims must be accompanied by:

♦ a Hospital Bed CMN 01.02 that must include the patient's weight; and,
♦ the manufacturer and model/product name/number of the bed; and,
♦ information which describes the necessity for the bed.

If coverage criteria are not met, payment will be based on the least costly, medically appropriate alternative, HCPCS code E0260.
**HCPCS CODE A9270**

**Proper usage**

HCPCS code A9270 is to be used only for non-covered items or services when a code does not exist to define the item or service. HCPCS code A9270 is used to describe those items or services non-covered by Medicare or when the Coding Guidelines section of a Regional Medical Review Policy instructs usage of HCPCS code A9270 for a particular item or service. When a specific HCPCS code does exist for a supply, material, injection, or service, the designated code must be used.

Suppliers must not use HCPCS code A9270 in order to obtain a “coverage” denial, when billing with the appropriate HCPCS code might result in a medical necessity denial. Such an erroneous coverage denial might shift the liability for payment to a secondary insurer or the beneficiary. Such miscoding represents abusive billing.

Examples of situations where HCPCS code A9270 is used improperly:

- Using HCPCS code A9270 to bill for items which do not meet the Coverage and Payment criteria outlined in medical policy even though a valid HCPCS code exists to define the item.
- Using HCPCS code A9270 to bill for items classified as DME, such as wheelchairs, when they are being supplied in a place of service where DME is not covered (e.g. POS 31).
- Using HCPCS code A9270 to bill for items lacking a specific HCPCS code, but for which a Not Otherwise Classified (NOC) HCPCS code should be used.
- Using HCPCS code A9270 to bill for wheelchairs and repairs to wheelchairs which are used as back-ups.

A supplier may always call the Statistical Analysis DMERC (SADMERC) to obtain information on the proper coding of an item (see Region C DMEPOS Supplier Manual).

When a code exists to define an item or service, that HCPCS code must be used.
BILLING FOR HIGHER LEVEL EQUIPMENT AND/OR SIMILAR EQUIPMENT

Higher level equipment

There are times when a beneficiary who is using a certain level of equipment (such as a manual wheelchair), may develop a new or worsened medical condition, and may then require a higher level of equipment (such as a power wheelchair or POV). Some examples (though not necessarily all inclusive) of different level equipment that might be seen as being duplicative or even contradictory are manual wheelchairs, powered wheelchairs and POVS, seat lift mechanisms, walkers, canes, crutches.

When this happens, the supplier billing for the higher level equipment must attach extra documentation to the claim. This extra documentation (in addition to any required CMN) should indicate the nature of the medical condition, and how the beneficiary's functional level has changed to warrant the need for new equipment.

Without such extra documentation, the DMERC will deny the extra equipment as being duplicate and medically unnecessary.

The extra documentation may be entered into the HAØ record of electronically submitted claims or attached to paper claims.

Similar equipment

The DMERC may also receive claims for equipment similar to that which the beneficiary is already renting or owns, and offers no proven greater medical benefit. Such "like" equipment, though having different HCPCS codes, is often grouped together in DMERC RMRPs. Merely changing a beneficiary from one of these products to another is not considered medically necessary, and therefore, is not warranted. Claims for such similar equipment would be denied as being not medically necessary.

Some examples of like equipment include:

♦ similarly grouped or coded support surfaces, for example:
  - Group I overlays (E0185, E0197, E0198, E0199);
  - Group I mattresses (E0184, E0186, E0187, E0196);
  - Group II overlays (E0371, E0372);
  - Group II other support surfaces (E0277, E0193, E0373).

♦ ambulatory and stationary IV infusion pumps.
SUPPLIER MANUAL
MEDICAL POLICY REVISION

Pressure Reducing Support Surfaces - Group 3

The following two pages (16.40i–16.40l) are a revision to the Pressure Reducing Support Surfaces - Group 3 medical policy, found in the Region C DMEPOS Supplier Manual. It is effective with dates of service on or after August 1, 1998. The most significant policy change is that suppliers no longer must send a monthly Certificate of Medical Necessity (CMN) with each claim. Although the physician must continue to document the necessity of the air-fluidized bed every month, suppliers need only send a revised CMN with the seventh month’s claim after initial certification.

Please insert this new policy into your Region C DMEPOS Supplier Manual.

SUPPLIER MANUAL
CORRECTIONS

Wheelchair options/accessories

Following the Pressure Reducing Support Surfaces - Group 3 medical policy are three revision pages to your Region C DMEPOS Supplier Manual. They include pages 16.22a-b (Wheelchair Options/Accessories), 18.8g-h (Urological Supplies), and 19.14a-b (Surgical Dressings).

Urological supplies

The highlighted text on these pages was inadvertently left out of the Spring/Summer 1998 Region C DMEPOS Supplier Manual revisions. Please insert them into your manual.

Surgical dressings

Medical affairs bulletin and Physician Information Sheets are printed as received from Palmetto GBA’s Medical Director.
**MEDICAL POLICY**

**SUBJECT:** Pressure Reducing Support Surfaces-Group 3

**HCPCS CODE**

E0194 Air-fluidized bed

**BENEFIT CATEGORY:** Durable Medical Equipment

**REFERENCE:** Coverage Issues Manual 60-19

**DEFINITION**

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

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

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

**COVERAGE AND PAYMENT RULES**

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

1) The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore.

2) The patient is bedridden or chair bound as a result of severely limited mobility.

3) In the absence of an air-fluidized bed, the patient would require institutionalization.

4) The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after conservative treatment has been tried without success. Treatment should generally include:

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

The patient must generally have been on the conservative treatment program for at least one month prior to use of the air fluidized bed with worsening or no improvement of the ulcer. The evaluation generally must be performed within a week prior to initiation of therapy with the air fluidized bed.
5) A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.

6) A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis.

7) All other alternative equipment has been considered and ruled out.

An air-fluidized bed will be denied as not medically necessary under any of the following circumstances:

1) The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions);

2) The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material;

3) The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed;

4) Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more);

5) Electrical system is insufficient for the anticipated increase in energy consumption; or,

6) Other known contraindications exist.

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

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

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

**DOCUMENTATION**

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

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

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

On a monthly basis, the treating physician must document the continued need for the equipment with a written statement (not a CMN), specifying: (1) the size of the ulcer; (2) if the ulcer is not healing, what other aspects of the care plan are being modified to promote healing; (3) continued use of the bed is medically necessary for wound management. This monthly physician statement must be kept on file by the supplier and be available for inspection at the request of the DMERC.

In the sixth month, the medical necessity for the bed must be documented using a revised CMN that is to be submitted with the seventh month’s claim. If the answer to Question 22 indicates worsening or no improvement, additional documentation should be included which describes any changes in the treatment regimen which have been made or are planned.

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

EFFECTIVE DATE: Claims with dates of service on or after August 1, 1998.

This is a revision to a previously published policy.
RESERVED FOR FUTURE USE
When options or accessories are billed as a replacement of a previously used part of the same type which has been worn or damaged, add modifier RP to the code for the part.

The right (RT) and left (LT) modifiers must be used when appropriate.

Code K0028 is for a fully reclining back which is manually operated. A power reclining back is coded using the miscellaneous accessory code K0108.

A prefabricated back seating module which is incorporated into a wheelchair base is coded using the wheelchair back accessory codes – K0023, K0024, or K0108.

Elevating legrests that are used with a wheelchair that is purchased or owned by the patient are coded K0048. This code is per legrest. Elevating legrests that are used with a capped rental wheelchair bases should be coded K0195. This code is per pair of legrests.

When a wheelchair is provided with seat dimensions that are different than those included in the wheelchair base code, use the code for the appropriate wheelchair base plus a code or codes for the nonstandard seat dimensions (K0054–K0058). Other combinations, which are listed in the manufacturer’s order form or price list, should be coded K0108. The submitted charge for code K0108 should represent the incremental additional charge for the nonstandard dimensions not included in other submitted codes. If the seat dimensions needed for the patient are not listed on the manufacturer’s order form or price list and require unique fabrication, then a custom wheelchair base code (K0008 or K0013) may be used.

Miscellaneous options, accessories, or replacement parts for wheelchairs that do not have a specific HCPCS code should be coded K0108. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108. When billing more than one line item with code K0108, ensure that the additional information can be matched to the appropriate line item on the claim. It is also helpful to reference the line item to the submitted charge.

Seating systems in which distinct back and seat cushion components are connected do not meet the definition of code K0116. If a custom fabricated two-piece seating system is provided, the back component is coded K0115. The seat component is coded K0108.

**DOCUMENTATION**

Wheelchair options/accessories which require a CMN are: K0016–K0018, K0020, K0028, K0046–K0048, K0053, and K0195. For these items, a certificate of medical necessity (CMN) which has been filled out, signed and dated by the ordering physician must be kept on file by the supplier. Depending on the type of wheelchair, the CMN for these options/accessories is either HCFA Form 843 (power wheelchairs) or HCFA Form 844 (manual wheelchairs). For items not requiring a CMN, an order for the item which has been signed and dated by the ordering physician must be kept on file with the supplier.

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

Accessories to the wheelchair base should be billed on the same claim as the wheelchair base itself. If additional claim forms are needed, charges should be carried over and the total should be entered only on the last page.

When billing option/accessory codes as a replacement (modifier RP), documentation of the medical necessity for the item, make and model name of the wheelchair base it is being added to, and the date of purchase of the wheelchair should be submitted with the claim.

Claims for codes K0115 and K0116 must include the following documentation:
1) The patient's diagnosis and description of the spinal problem including a detailed evaluation of the patient,
2) A description of the features of the device and medical necessity of each,
3) An explanation of why a prefabricated seating system is not adequate for the patient,
4) A statement of the number of hours per day that the patient is expected to be in the wheelchair,
5) The manufacturer's name and model name/number, if applicable, otherwise, a photograph of the device, a brief description of materials used, and an estimate of the fitting/fabrication time. (The requirement for a photograph can be eliminated or modified with DMERC approval for an individual supplier if they send information to the Medical Director describing their fabrication process and the way they report the items provided.)

A claim for code K0108 must include a narrative description of the item, the brand name and model name/number of the item and a statement defining the medical necessity of this item for the particular patient. If it is a customized option/accessory, the statement must clearly describe what was customized. If a formal wheelchair evaluation has been done, it would be appropriate to include this information as documentation.

Documentation for individual consideration might include information on the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment (e.g. degree of independence/dependence, frequency and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment.

Refer to the Region C DMEPOS Supplier Manual for more information on orders, CMN's, medical records, and supplier documentation.

**EFFECTIVE DATE:** Claims with dates of service on or after January 1, 1998.

This is a revision of a previously published policy.
Code A5149 is not valid for claims submitted to the DMERC. Use code A4335 for miscellaneous incontinence supplies.

An external catheter that contains a barrier for attachment should be coded using A4335.

Codes A5113 and A5114 are for replacement leg straps used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter.

Codes for ostomy barriers (A5119, K0137-K0139) should not be used for skin care products used in the management of urinary incontinence.

In the following table, the column I code includes the items identified by the codes in column II. The Column I code must be used instead of multiple column II codes when the items are provided at the same time.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4310</td>
<td>K0281</td>
</tr>
<tr>
<td>A4311</td>
<td>A4310, A4338, K0281</td>
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<tr>
<td>A4312</td>
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</tr>
<tr>
<td>A4313</td>
<td>A4310, A4346, K0281</td>
</tr>
<tr>
<td>A4314</td>
<td>A4310, A4311, A4338, A4354, A4357, K0280, K0281</td>
</tr>
<tr>
<td>A4315</td>
<td>A4310, A4312, A4344, A4354, A4357, K0280, K0281</td>
</tr>
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<td>A4316</td>
<td>A4310, A4313, A4346, A4354, A4357, K0280, K0281</td>
</tr>
<tr>
<td>A4353</td>
<td>A4310, A4351, A4352, K0281</td>
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<td>A4310, A4357, K0280, K0281</td>
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<tr>
<td>A4357</td>
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<td>A4358</td>
<td>A5113, A5114, K0280</td>
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<td>A5112</td>
<td>A5113, A5114</td>
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<td>A5105</td>
<td>A4358, A4359, A5112, A5113, A5114, K0280</td>
</tr>
<tr>
<td>K0411</td>
<td>A6265</td>
</tr>
</tbody>
</table>

If a code exists that includes multiple products, that code should be used in lieu of the individual codes.

**DOCUMENTATION**

An order for the supplies which has been signed and dated by the treating physician must be kept on file by the supplier. The order must include the type of supplies ordered and the approximate quantity to be used per unit of time. On the order, there must be a statement indicating whether the patient has permanent or temporary urinary incontinence or retention or other indication for use of a catheter or urinary collection device. If the order indicates permanent urinary incontinence or urinary retention, and if the item is a catheter, an external urinary collection device or a supply used with one of these items, the ZX modifier should be added to the code for each urological supply on each claim submitted. The ZX modifier may only be used when these requirements are met. If the requirements for the modifier are not met, the supplier can submit additional information with the claim to justify coverage.

If a supplier is billing for items which are noncovered, this must be indicated on the claim. The recommended way of doing this is to add the ZY modifier to the code.

When billing for quantities of supplies greater than those described in the policy as the usual replacement frequency (e.g. more than one indwelling catheter per month, more than two bedside drainage bags per month, more than 35 male external catheters per month, etc.), the claim must include documentation supporting the medical necessity for the higher utilization. This information should be attached to a hard copy claim or entered in the HAØ record of an electronic claim.

The initial claim for catheters or kits used for sterile intermittent catheterization in the home must be accompanied by documentation supporting the medical necessity for sterile technique.
Refer to the Region C DMEPOS Supplier Manual for additional information on orders, medical records and supplier documentation.

**EFFECTIVE DATE:** Claims for dates of service on or after April 1, 1998.

*This is a revision of a previously published policy.*

**NOTE:** When sterile intermittent catheterization is performed in the home setting (outside of skilled nursing facilities), there must be documentation of the medical necessity for sterile technique as described in the Urological Supplies policy. This documentation must be supplied by the physician, reflected in the patient's medical record and accompany every claim (not just the first claim) for sterile catheterization supplies. A *copy of the physician's original letter* must be used for subsequent claims.

**NOTE:** A physician letter is a document written or dictated by the ordering physician on the physician's letterhead. Its composition pertains to the particular patient for whom the claim is being submitted. It is signed by the physician. The date on such a letter should be no older than six months prior to the claim date. Copies of the letter may be submitted on subsequent claims.

**Items affected by this requirement are:**

- A4351 Intermittent urinary catheter, straight tip;
- A4352 Intermittent urinary catheter, coude (curved) tip;
- K0281 Lubricant, individual sterile packet, each; and
- XX004 Urinary intermittent catheter with insertion tray.

**NOTE:** Effective 4/1/97, HCPCS code A4353 replaces HCPCS code XX004 for a urinary intermittent catheter with insertion tray.
indicate the number of wounds should be used and the claim must include the brand name, product number and size of the product provided. When code A4649 is used for a dressing, the claim should also include a statement describing the medical necessity for that dressing in that patient.

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

**EFFECTIVE DATE:** Claims for dates of service on or after January 1, 1998.

This is a revision of a previously published policy.

**NOTE:** The DMERC receives many single-line surgical dressing claims where multiple claims for the same beneficiary and the same dressing codes are submitted within a short time frame. This is an inefficient billing practice. Suppliers are advised to bill surgical dressing codes only once per calendar month, per beneficiary, so claims processing efficiency and accuracy can be increased and the supplier community better served.

**NOTE:** New surgical dressing codes distinguishing sterile from non-sterile dressings have been introduced into the regional medical policy for surgical dressings. The definitions for codes K0216–K0218 have been changed to reflect non-sterile dressings, while codes K0402–K0406 have been added. There has been a corresponding change in the “Coding Guidelines” section, describing proper billing using these new codes.

**NOTE:** Claims for surgical dressings using modifiers equal to X5 or greater (indicating that a particular dressing is being used for 5 or more wounds) will require extra documentation indicating wound:

- size
- stage
- location
- amount of wound exudate
- which dressing is being used on which wounds of the patient
- (if billing for multiple dressings and wounds.)

This documentation must accompany each claim with X equal to or greater than 5, every month. It may be entered into the HAØ records or be sent hard copy with each claim. This documentation will help clinicians adjudicate claims more efficiently and consistently. Claims received lacking this documentation will be denied for lack of medical necessity documentation.

It is important to remember that the number used with the X modifier should reflect only the number of wounds on which that particular dressing (that HCPCS code) is being used. DO NOT USE A NUMBER REFLECTING THE TOTAL NUMBER OF WOUNDS OF THE PATIENT unless that dressing is being used on all those wounds.

This requirement becomes effective with claims received on or after October 15, 1996.
# SURGICAL DRESSINGS PRODUCT CLASSIFICATION

<table>
<thead>
<tr>
<th>MANUFACTURER/BRAND NAME</th>
<th>MODEL NAME/NUMBER</th>
<th>HCPCS CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3M</td>
<td>3M Blenderm Surgical Tape</td>
<td>A6265</td>
</tr>
<tr>
<td></td>
<td>3M Cloth Adhesive Tape</td>
<td>A6265</td>
</tr>
<tr>
<td></td>
<td>3M Coban Self-Adherent Wrap</td>
<td>A4460</td>
</tr>
<tr>
<td></td>
<td>3M Medipore Pre-Cut Dressing Covers</td>
<td>A4649</td>
</tr>
<tr>
<td></td>
<td>3M Medipore Soft Cloth Surgical Tape</td>
<td>A6265</td>
</tr>
<tr>
<td></td>
<td>3M Microdon</td>
<td>A6251–A6256</td>
</tr>
<tr>
<td></td>
<td>3M Micropore Surgical Tape</td>
<td>A6265</td>
</tr>
<tr>
<td></td>
<td>3M No Sting Barrier</td>
<td>K0137</td>
</tr>
<tr>
<td></td>
<td>3M Opticlude Orthoptic Eye Patches</td>
<td>A4649</td>
</tr>
<tr>
<td></td>
<td>3M Soft Cloth Adhesive Wound Dressing</td>
<td>A6219–A6221</td>
</tr>
<tr>
<td></td>
<td>3M Stomaseal Adhesive Disk</td>
<td>A5126</td>
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<tr>
<td></td>
<td>3M Tegaderm</td>
<td>A6257–A6259</td>
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<tr>
<td></td>
<td>3M Tegaderm HP Transparent Dressing</td>
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<tr>
<td></td>
<td>3M Tegaderm Plus #9524</td>
<td>A6257–A6259</td>
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<tr>
<td></td>
<td>3M Tegaderm Transparent Dressing w/absorbent pad</td>
<td>A6233–A6205</td>
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<td></td>
<td>3M Tegagel HG Wound Cover</td>
<td>A6196–A6198</td>
</tr>
<tr>
<td></td>
<td>3M Tegagel HG Wound Filler</td>
<td>A6199</td>
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<tr>
<td></td>
<td>3M Tegagen HI Wound Cover</td>
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<td>3M Tegagen HI Wound Filler</td>
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<tr>
<td></td>
<td>3M Tegagel Hydrogel Wound Filler</td>
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</tr>
<tr>
<td></td>
<td>3M Tegagel Hydrogel Wound Filler w/Gauze</td>
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<tr>
<td></td>
<td>3M Tegapore</td>
<td>A6206–A6208</td>
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<td></td>
<td>3M Tegasorb</td>
<td>A6234–A6239</td>
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<td>ABS Life Sciences</td>
<td>Chronicure</td>
<td>A6261–A6262</td>
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<td>Acme United</td>
<td>Acu-derm</td>
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<td>Lyofaom</td>
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<tr>
<td></td>
<td>Lyofaom A</td>
<td>A6209–A6214</td>
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<tr>
<td></td>
<td>Lyofaom C</td>
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<td>Royl-derm</td>
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<td>Acrymed</td>
<td>AcryDerm</td>
<td>A6242–A6247</td>
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<td></td>
<td>AcryDerm Absorbent Wound Strands</td>
<td>A6262</td>
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<tr>
<td>Amerx</td>
<td>Amerigel Topical Ointment</td>
<td>A6250</td>
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<tr>
<td>Bard</td>
<td>Biolex #5504B</td>
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<td>Biolex #5508B</td>
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<tr>
<td></td>
<td>Biolex #5503B</td>
<td>A6248</td>
</tr>
</tbody>
</table>
Effective October 1, 1998, you will be required to enter eight-digit birth dates on Form HCFA-1500 for Medicare, Part B claims. This includes entering two-digit months (MM) and days (DD), and four-digit years (CCYY). The reporting requirement for eight-digit birth dates will not require a revision to the HCFA-1500 claim form. However, the instructions and printing specifications for the HCFA-1500 claim form were changed so eight-digit birth dates can be reported.

HCFA-1500 claim form fields affected by the new reporting requirement:

- Item 3 – patient’s birth date
- Item 9b – other insured’s date of birth
- Item 11a – insured’s date of birth

Please note that eight-digit birth dates must be reported with a space between month, day and year, i.e., MM_DD_CCYY. On the HCFA-1500 claim form, the space between month, day and year is delineated by a dotted, vertical line.

To illustrate, if the patient’s birth date is January 21, 1935, then you would enter the following in Item 3 of the HCFA-1500 claim form:

```
01 21 1935
```

If you do not submit eight-digit birth dates as of October 1, 1998, your claim will be returned to you as unprocessable.

HCFA-1500 claim form fields not affected by the new reporting requirement:

- Item 11b – employer’s name or school name
- Item 12 – patient or authorized person’s signature date
- Item 14 – date of current illness, injury or pregnancy
- Item 16 – dates patient unable to work in current occupation
- Item 18 – hospitalization dates related to current illness
- Item 19 – reserved for local use
- Item 24a – date(s) of service
- Item 31 – signature of physician/supplier

Note: Item 15 is not required for Medicare Part B services.

You may enter either a six- or eight-digit date for these fields (Items 11b, 12, 14, 16, 18, 19, 24a or 31) as of October 1, 1998.

If you choose to enter eight-digit dates for these fields, please note the following:

- **Form HCFA-1500 does not have to be revised** to capture eight-digit dates for the above fields.
**Millennium Initiative**

**Detailed HCFA-1500 instructions (continued)**

- All date fields, except for Item 24a, must be reported with a space between month, day and year, i.e., MM_DD_CCYY. On Form HCFA-1500, the space between month, day and year is delineated by a dotted, vertical line.

- Item 24a must be reported as one continuous number, i.e., MMDDCCYY, without any spaces between month, day and year. By entering a continuous number, the date(s) in Item 24a will penetrate the dotted, vertical lines used to separate month, day and year. Our claims processing system will be able to process your claim if you penetrate these vertical lines. However, all eight-digit dates reported must stay within the confines of Item 24a.

- Do not compress or change the font of the “year” field in Item 24a to keep the date within the confines of Item 24a. If you enter a continuous number in Item 24a without spaces between month, day and year, you will not need to compress the “year” field to remain within the confines of Item 24a.

- The “from” date in Item 24a must not run into the “to” date field, and the “to” date must not run into Item 24b.

- Dates reported in Item 24a must not be reported with a slash between month, day and year.

- If you decide to enter eight-digit dates for Items 11b, 12, 14, 16, 18, 19, 24a or 31, you must enter eight-digit dates for all these fields. For instance, you are not permitted to enter eight-digit dates for items 11b, 12, 14, 16, 18, 19 and 31 and a six-digit date for Item 24a. The same applies to those who wish to submit six-digit dates for these fields.

If you do not adhere to the above requirements, your claim will be returned to you as unprocessable as of October 1, 1998.

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**EDI Millennium Update**

The Year 2000 (Y2K) poses a serious challenge to many computer systems that were originally designed to accommodate a two-digit year. At Palmetto GBA, we are working diligently to ensure that our systems are able to handle this change without disrupting operations. Below is a brief review of our efforts:

- PACES, the Palmetto GBA DMERC billing software, is millennium-ready and accommodates eight-digit dates.
- The ANSI X12 835 version 3051.4 will also be updated to accommodate eight-digit dates.
- The ANSI X12 270/271 (Health Care Eligibility/Benefit Inquiry and Information) version 3051 will be updated to accommodate eight-digit dates.

If you would like a copy of the ANSI X12 835 or 270/271 specifications, you can download them from the HCFA web site.

[www.hcfa.gov/medicare/edi/edi.htm](http://www.hcfa.gov/medicare/edi/edi.htm)
**ITEM 11 OF THE HCFA-1500 CLAIM FORM**

The purpose of Item 11 on the HCFA-1500 claim form is to identify whether Medicare is the beneficiary’s primary or secondary payer. Suppliers are required to ask the beneficiary for primary insurer information and to complete Item 11 of the HCFA-1500 claim form.

The correct procedures for completing Item 11 are covered in the Region C DMEPOS Supplier Manual on pages 1.24b and 1.25. If you complete this section incorrectly, your claim may be rejected or denied. Remember, if Medicare is the beneficiary's primary insurance, write "NONE" in Item 11 and leave Items 11a, 11b and 11c blank. Section 11d is not required by Medicare.

<table>
<thead>
<tr>
<th>Item/Line</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Insured's Policy Group or FECA Number</td>
<td>If Medicare is primary, enter “NONE.” Do not complete Items 11a, 11b or 11c. These must be blank. For insurance primary to Medicare, enter the insured’s policy or group number. Complete Items 11a, 11c. Attach a Primary Payer’s EOB.</td>
</tr>
<tr>
<td>11b. Insured’s Date of Birth</td>
<td>If Medicare is primary, leave blank. For insurance primary to Medicare, enter the insured’s birth date and sex if different from Item 3.</td>
</tr>
<tr>
<td>11b. Employer’s Name or School Name</td>
<td>If Medicare is primary, leave blank. For insurance primary to Medicare, enter the employer’s name if applicable. If there is a change in the insured’s insurance status within the past 30 days, e.g., retired, enter the retirement date preceded by the word “RETIRED.”</td>
</tr>
<tr>
<td>11c. Insurance Plan Name/Program Name</td>
<td>If Medicare is primary, leave blank. Enter complete plan or program name. Attach a copy of the Primary Payer’s EOB. If the EOB does not contain the claims processing address, enter the address directly on the EOB.</td>
</tr>
</tbody>
</table>
IMPLEMENTATION OF INTERLOCUTORY ORDER

National Medical Care v. Shalala

On January 9, 1998, the Court issued a memorandum and an interlocutory order in National Medical Care (NMC) v. Shalala. Essentially, the Court barred the Health Care Financing Administration from requiring the plaintiff to apply HCFA's April 24, 1995, clarification of its interpretation of the Omnibus Budget Reconciliation Act of 1993 change in the Medicare Secondary Payer (MSP) ESRD provision to services provided on or after August 10, 1993 and prior to April 24, 1995. This bulletin advises providers and suppliers of the decision that HCFA has made regarding implementation of this interlocutory order.

HCFA had previously extended until December 31, 1997, the time period during which initial claims for services, provided between August 10, 1993, and April 23, 1995, and related to the issue in this case, must be filed. Claims related to the issue are those that involve services that were provided to Medicare beneficiaries who:

a) were entitled on the basis of ESRD as well as age or disability;

b) had GHP coverage at the time the services were provided;

and,

c) received the services during their first 18 months of entitlement based on ESRD.

The time period for providers and suppliers to file claims for services provided between August 10, 1993, and April 23, 1995, related to the issue in the NMC case will not be extended further at this time. (HCFA never extended timely filing for services provided after April 23, 1995.) In addition, Medicare will not reopen, at this time, any claims for services provided between August 10, 1993, and April 23, 1995, where the basis for the requested reopening is related to the issue in the NMC case. Following ultimate disposition of this case, HCFA will afford all providers and suppliers an opportunity to submit initial claims affected by the ultimate orders in this case, and will provide further guidance on reopening claims.

EXPANDED ROLE

Nurse practitioners/clinical nurse specialists

The Health Care Financing Administration has revisited the role of nurse practitioners' and clinical nurse specialists' ability to order durable medical equipment items and sign the Certificate of Medical Necessity. Section 1861(s)(2)(K)(iii) of the Social Security Act indicates that services which would be physician's services if furnished by a physician, but were rendered by a nurse practitioner or clinical nurse specialist in a rural setting would be considered physician's services if they are authorized to perform such services by the state in which the services are performed and would be covered under the Medicare program. Under the Balanced Budget Act of 1997, the rural setting restriction was removed from this section of the Social Security Act. This revision to the statute is effective for services rendered by nurse practitioners and clinical nurse specialists on or after January 1, 1998.

After considerable review, it is now HCFA's position that services rendered by a nurse practitioner or clinical nurse specialist working in collaboration with, but independent of, a physician, would be
**EXPANDED ROLE**

**Nurse practitioners/clinical nurse specialists (continued)**

Considered covered services, as defined in Section 1861(s)(1) and 1861(s)(2)(A). As a result, under the limitations described in §1861(s)(2)(K)(iii), a nurse practitioner or clinical nurse specialist that is treating the beneficiary is not restricted from ordering DME items or completing Section D on Certificates of Medical Necessity, if they are permitted to do so in the state in which the services are being rendered. The nurse practitioner or clinical nurse specialist must bill using their own provider number and they must attest, the same as the physician, that they have treated the beneficiary and that all information found in Section B is true, accurate and complete, to the best of their knowledge.

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**SURGICAL DRESSING**

**HCPCS codes requiring documentation**

There are several surgical dressing HCPCS codes that require additional documentation when filing claims to Palmetto Government Benefits Administrators. In order for Palmetto GBA to consider these items, the brand name, product number and exact size should be provided. This information must be submitted with every claim either in the HAØ record of electronic claims or attached to paper claims. Claims submitted without this information will be denied for lack of documentation. The HCPCS codes are:

- A6198
- A6217
- A6205
- A6218
- A6206
- A6239
- A6208
- A6256
- A6213
- A6404

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**BATTERIES AND BATTERY CHARGERS**

**HCPCS coding information**

Batteries and battery chargers are included in the allowable for the purchase of a Power Operated Vehicle, HCPCS code E1230. Medicare may cover replacement batteries and battery chargers. According to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC), these items should be billed under HCPCS code E1399 using the RP modifier (E1399RP) when billed for use with a POV. When filing claims, please include a description of the item, manufacturer’s make/model number and pricing.
Gratuities

If you want to thank a Medicare associate who has given you exceptional service, a simple “thank you” is enough. Although we appreciate your good intentions, Palmetto Government Benefits Administrators employees may not accept any type of gift, no matter how small. If you want to say more than “thanks,” a letter to the employee’s supervisor is always a welcome recognition of a job well done. In turn, we thank you!

Standard Electronic Formats

Effective July 1, 1998, all Medicare carriers must be able to issue electronic remittance advice transactions in NSF versions 1.04, 2.0, and 2.01, and ANSI ASC X12 835 versions 3030M, 3051.3 and 3051.4, as selected by their providers.

Consolidated Billing Delay

Skilled nursing facilities

The Balanced Budget Act (BBA) of 1997 requires consolidated billing for skilled nursing facilities (SNFs). Under this mandate, a SNF must submit all Medicare claims for all but certain excluded services, both Part A and Part B, that its residents receive. July 1, 1998, was originally scheduled as the implementation date. However, the Health Care Financing Administration has announced a delay of this BBA provision until further notice. Only those SNFs on the prospective payment system for residents in a Part A stay are required to follow consolidated billing instructions.
Fee Update

New code allowances

Following are the 1998 fee schedule allowances for new HCPCS codes effective July 1, 1998. Please remember 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.

New 1998 fee schedule allowances

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Fee changes

The following fees for HCPCS codes L3000-L3640 supersede allowances previously published in the 1998 Region C DMEPOS Fee Schedule Catalog. Fees are effective for dates of service January 1, 1998.
SUPPLIER SANCTIONS

Alabama

Chambless, William House
2032 Poplar St.
Montgomery, Ala. 36106
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Harden, Clifford Bruce
15299 Four Winds Loop
Tuscaloosa, Ala. 35476
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

McCormack, Kris Anthony
11387 Center Plant Rd.
Wetumpka, Ala. 36092
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Peterson, Edward James Jr.
2670 Eastern Valley Rd.
Leeds, Ala. 35094
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 3/19/98

Simmons, Timothy Keith
1326 21st Way South, #8
Birmingham, Ala. 35205
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 3/19/98

Colorado

Hesser, Robert J.
1250 S. Clermont, #3301
Denver, Colo. 80222
Specialty: Podiatrist
Period of Exclusion: Indefinite
Effective Date: 12/22/97

Verbrugge, Joseph J. Jr.
6390 S Locust Way
Englewood, Colo. 80111
Specialty: Family Physician/
General Practice
Period of Exclusion: 5 yrs.
Effective Date: 4/20/98

Florida

A T N S, Inc.
4875 N. Federal Hwy., #9D
Fort Lauderdale, Fla. 33308
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

American Medical Holding Co.
3775 N W 16th St.
Lauderhill, Fla. 33313
Specialty: Medical Group
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Amaya, Carlos Ernesto
19101 Mystic Pt. Dr., #200-210
Aventura, Fla. 33180
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 3/19/98

Angell, Walter Frederick
597 Maitland Ave.
Altamonte Springs, Fla. 32701
Specialty: Surgeon
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Aryan Patient Care
222 NW 45th Ave.
Miami, Fla. 33126
Specialty: DME Company
Period of Exclusion: 5 yrs.
Effective Date: 4/20/98
SUPPLIER SANCTIONS (continued)

Ask Medical & Surgical Supplies
2173 NE 167th St.
North Miami Beach, Fla. 33162
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Atlantic Medical Equipment
3380 NW 194 Terrace
Miami, Fla. 33056
Specialty: DME Company
Period of Exclusion: Permanent
Effective Date: 8/14/97

Bear Love Medical Equipment
C/o 4120 W 18th Ln.
Hialeah, Fla. 33012
Specialty: DME Company
Period of Exclusion: Permanent
Effective Date: 11/4/97

Bulldog Medical of Kissimmee
5368 Whispering Pine Cr.
St. Cloud, Fla. 34771
Specialty: DME Company
Period of Exclusion: 15 yrs.
Effective Date: 4/20/98

Charity Medical Supply
13800 SW 8th St., Ste 153
Miami, Fla. 33184
Specialty: DME Company
Period of Exclusion: 5 yrs.
Effective Date: 4/20/98

Cho, Lucy Okhi
1723 S Rio Grande Ave.
Orlando, Fla. 32805
Specialty: Family Physician/General Practice
Period of Exclusion: Indefinite
Effective Date: 3/19/98

Comp-Care of Florida, Inc.
6741 W Sunrise Blvd., Ste 12
Plantation, Fla. 33313
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

CompCare of Florida, Inc.
3779 NW 16th St.
Lauderhill, Fla. 33311
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

CompCare of Manatee County
5534 Cortez Rd.
Bradenton, Fla. 34210
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Comp-Care Oxygen Services
6741 W Sunrise Blvd., Ste 12
Plantation, Fla. 33313
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Comp-Care Respiratory Services
3779 NW 16th St.
Lauderhill, Fla. 33311
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Comp-Care USA, Inc.
5534 Cortez Rd., West
Bradenton, Fla. 34210
Specialty: DME Company
Period of Exclusion: 25 yrs.
Effective Date: 4/20/98

Concord Medical Supply
13800 SW 8th St., Ste 170-A
Miami, Fla. 33184
Specialty: DME Company
Period of Exclusion: 5 yrs.
Effective Date: 4/20/98

Crist Yiret Medical Supply
C/o 6040 NW 201 Ln.
Miami Lakes, Fla. 33015
Specialty: DME Company
Period of Exclusion: Permanent
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<td>Datalogic Technologies, Inc. 6741 W Sunrise Blvd., Ste 12 Plantation, Fla. 33313</td>
<td>Specialty: Family Physician/ General Practice</td>
<td>Period of Exclusion: 5 yrs.</td>
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<td>Elneser, Rafael 7398 S Waterway Dr. Miami, Fla. 33155</td>
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<td>Fernandez-Cano, Orestes 351 NW 42nd Ave. Miami, Fla. 33126</td>
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<td>Finney, Deirdre L. 2005 Howard Dr. Winterpark, Fla. 32789</td>
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<td>Good Choice Med Supplies 19901 NW 86 Ct. Miami, Fla. 33015</td>
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<td>Gross, Marie Midler 2831 Sunrise Lakes Dr. East Sunrise, Fla. 33322</td>
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<td>Jormer Specialty Corporation c/o 9181 Fountainbleau, #5 Miami, Fla. 33172</td>
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<td>Karpo, Stanley 10260 Reflections Blvd., #101 Sunrise, Fla. 33351</td>
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<td>Medical &amp; Nutritional Support 3775 NW 16th St. Lauderhill, Fla. 33313</td>
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SUPPLIER SANCTIONS
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Georgia
Beltz, Charles Robert III
21 Georgetown Dr.
Athens, Ga. 30653
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Sorohan, Jonathan Griffin
2394 Country Club Dr., SE
Conyers, Ga. 30208
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Kentucky
Crabbs, Jerry
116 University Cr.
Crestview Hills, Ky. 41017
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 5/20/98

Harris, Albert B.
769 Greenbridge Ln.
Louisville, Ky. 40407
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Logsdon, John T.
611 El Dorado Dr.
Elizabethtown, Ky. 42701
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Moses, William M.
803 Green Spur Ln.
Louisville, Ky. 40407
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Pant, Bhanu
2467 N Peterson Ct.
Louisville, Ky. 40206
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Vasquez, Javier A.
103 Main St.
Manchester, Ky. 40962
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 5/20/98

Mississippi
Ellis, Terry Kent
1084 Campbell Dr.
Biloxi, Miss. 39532
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 4/20/98

Hicks, Herbert Hollis
Bldg. 1044, 55 Sgt. Prentiss Dr.
Natchez, Miss. 39120
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 3/19/98
SUPPLIER SANCTIONS
(continued)

North Carolina

Clark, Douglas H.  
219 Le Phillip Ct. NE  
Concord, N.C. 28025  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 5/20/98

Landon, Mark Terry  
810 Sherwood Ave.  
Asheboro, N.C. 27203  
Specialty: Physician Assistant  
Period of Exclusion: Indefinite  
Effective Date: 5/20/98

Stewart-Carballo, Charles W.  
219 Wintergreen Dr.  
Fayetteville, N.C. 28314  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 5/20/98

Ward, David Townsend  
3834 Brownstone Ln.  
Winston-Salem, N.C. 27106  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 4/20/98

Watford, Douglas E.  
Rt. 2, Box 245A  
Ahoskie, N.C. 27910  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 1/14/98

Puerto Rico

St. Jean, Polux Enrique Dilo  
Calle 33AH #4  
Caguas, P.R. 00726  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 2/19/98

South Carolina

Alessi, Thomas J.  
2209 Bob White Ln.  
West Columbia, S.C. 29169  
Specialty: Family Physician/General Practice  
Period of Exclusion: 5 yrs.  
Effective Date: 3/19/98

Geriatric Health of S Carolina  
1836 Ashley River Rd., #302  
Charleston, S.C. 29407  
Specialty: DME Company  
Period of Exclusion: 15 yrs.  
Effective Date: 3/19/98

Hendricks, David Martin  
4 Cumberland Way  
Sumter, S.C. 29150  
Specialty: Family Physician/General Practice  
Period of Exclusion: Indefinite  
Effective Date: 5/20/98

Tennessee

Burks, Osborne David J r.  
4043 Hanna Dr.  
Memphis, Tenn. 38128  
Specialty: Pharmacist  
Period of Exclusion: Indefinite  
Effective Date: 5/20/98
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<td>c/o 4101 22nd Pl. Lubbock, Texas 79410</td>
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<td>Bracks, Oscar J.</td>
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<td>1 yr.</td>
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<td>Gibbons, Stacey L.</td>
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<td>c/o John Sealy, Ste 2A Galveston, Texas</td>
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<td>Longview Prosthetics Center</td>
<td>Medical Practice, MD</td>
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<td>Smith, Art G.</td>
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<tr>
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## Supplier Sanctions (continued)

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<td>Cadogan, Robert V.</td>
<td>Podiatrist</td>
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<td>3330 Canal St., Ste 105</td>
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<td>New Orleans, La. 70119</td>
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<td>Yukon, Okla. 73099</td>
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<td>Haverly, David E.</td>
<td>Podiatrist</td>
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<td>115 Easter Dr.</td>
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<td>Rockwood, Tenn. 37845</td>
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<td>c/o John Sealy, Ste 2A</td>
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<td>Galveston, Texas 77555</td>
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<td></td>
<td>1627 Glenbrook</td>
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<td>Nacogdoches, Texas 75961</td>
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<td>Lovoi, Michael S.</td>
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<td>1350 Bandera Hwy., #802</td>
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<td>Kerrville, Texas 78028</td>
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<td>Taylor, Emma June</td>
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<td></td>
<td>8026 Hertfordshire Cr.</td>
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<td></td>
<td>Spring, Texas 77379</td>
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</tbody>
</table>
OMBUDESMEN 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
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

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

South Carolina
Dana Church
P.O. Box 100141
Columbia, S.C. 29202-3141
(803) 735-1034, Ext. 35714

Tennessee
IN THE INTERIM CONTACT
Lia Bunch
P.O. Box 146
Union Grove, Ala. 35175
(205) 498-0205

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

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

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>
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<tbody>
<tr>
<td><strong>Anti-Fraud Unit</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100236&lt;br&gt;Columbia, S.C. 29202-3236</td>
<td>(803) 788-5414</td>
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<tr>
<td><strong>Dedicated Work Teams/DMERC General Information</strong></td>
<td>(803) 691-4300</td>
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<td><strong>Electronic Data Interchange (EDI)</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100145&lt;br&gt;Columbia, S.C. 29202-3145</td>
<td>(803) 788-9751</td>
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<td><strong>Hearings Department</strong>&lt;br&gt;<em>Inquiries regarding hearings or Prior Authorization should be directed to the Dedicated Work Teams.</em>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100249&lt;br&gt;Columbia, S.C. 29202</td>
<td>(803) 691-4300</td>
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<td><strong>Prior Authorization Department</strong>&lt;br&gt;<em>Inquiries regarding hearings or Prior Authorization should be directed to the Dedicated Work Teams.</em>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100235&lt;br&gt;Columbia, S.C. 29202-3235</td>
<td>(803) 691-4300</td>
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<td><strong>Professional Relations Department</strong>&lt;br&gt;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100141&lt;br&gt;Columbia, S.C. 29202-3141</td>
<td>(803) 735-1034, ext. 35729</td>
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## National Numbers

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