HOME BLOOD GLUCOSE MONITORS

POLICY REVISION

The Home Blood Glucose Monitors Policy has been revised again and is contained in this issue of the Advisory. The revision involves changes in required documentation of utilization of blood glucose strips and lancets in excess of the amounts listed as usually medically needed. The effective date of the policy is retroactive to October 1, 1998, as the changes liberalize some of the requirements.

It is important to remember when submitting claims for monitors with special features (HCPCS code E0609), that physician documentation of visual acuity must specifically state:

- The specific numerical results of an eye examination (for example, 20/400), and
- That this result represents "best corrected" vision.

Statements such as, "visual acuity less than 20/200," are unacceptably vague, as this does not furnish the specific results of the eye examination of the particular beneficiary whose claim is being submitted. The documentation may be entered into the HAØ record on electronic claims, or attached to hard-copy claims.
If documentation involves use of the terms "legally blind," or "totally blind," and numerical results cannot be furnished, the claim must be submitted hard-copy and include a statement of the beneficiary's most recent eye examination from an ophthalmologist or optometrist.

Claims lacking these documentation details of the patient's impaired visual acuity will be paid at the least costly medically necessary alternative (HCPCS code E0607).

**HOME BLOOD GLUCOSE MONITORS MEDICAL POLICY**

**SUBJECT: 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

**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
**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.

A renewal of an order is the writing of a new order by the treating physician. A refill of an order is the actual dispensing of the item to the beneficiary based on an existing valid order.

Code A4256 describes control solutions containing high, normal, and low concentrations of glucose which can be applied to test strips to check the integrity of the test strips. This code does not describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor to that particular vial of test strips.

**COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must be reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. The determination of medical necessity for the items addressed by this policy will be based on the information contained in this section.

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.

For all glucose monitors and related accessories and supplies, if the basic coverage criteria (1)-(5) are not met, the items will be denied as not medically necessary.

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 basic coverage criteria (1)-(5) are met and the patient's physician certifies that he or she has a visual impairment severe enough to require use of this special monitoring system. If an E0609 glucose monitor is provided and basic coverage criteria
HOME BLOOD GLUCOSE MONITORS MEDICAL POLICY

(continued)

(1)-(5) are met but the additional criterion is not met, payment will be based on the allowance for the least costly medically appropriate alternative, E0607.

Lancets (A4259), blood glucose test reagent strips (A4253), glucose control solutions (A4256), 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 100 test strips and 100 lancets every 3 months are covered if criteria (a)-(c) are met:

- 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:

- For a patient who is not currently being treated with insulin injections, more than 100 test strips and 100 lancets every 3 months are covered if criteria (a)-(f) are met:

- For a patient who is currently being treated with insulin injections, more than 100 test strips and 100 lancets every month are covered if criteria (a)-(f) are met:

  a) Coverage criteria (1)-(5) listed above for a glucose monitor are met.

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

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

  d) The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional strips for that particular patient.

  e) The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines.

  f) If refills of quantities of supplies that exceed the utilization guidelines are dispensed: there must be documentation in the physician's records (e.g. a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g. a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every 6 months.

If criteria (a)-(c) are not met, all testing supplies will be denied as not medically necessary. If quantities of test strips or lancets that exceed the utilization guidelines are provided and criteria (d)-(f) are not met, the amount in excess will be denied as not medically necessary.
Home Blood Glucose Monitors Medical Policy

(continued)

A beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. 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 3-month supply of test strips and/or lancets at a time.

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 used with a glucose monitor.

Coding Guidelines

For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets.

Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor must 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>
</tr>
</tbody>
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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 that are to be dispensed and the frequency of testing. An order that only states “as needed” is not acceptable. 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 from the treating physician every 6 months. This renewal of the order must also contain the information specified above.

If the order indicates that the patient 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 must not be used for a patient who is not treated with insulin injections.

If the order indicates that the patient is not being treated with insulin injections, the KS modifier must be added to the code for the monitor and each related supply on every claim submitted.

Additional documentation requirements apply to: (1) a diabetic patient who is not insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day, or
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(continued)

(2) a diabetic patient who is insulin-treated (ZX modifier present) and whose prescribed frequency of testing is more often than three times per day.

When refills for quantities of supplies that exceed the utilization guidelines are dispensed, the documentation as described in criteria (d)-(f) in the Coverage and Payment Rules section must be available to the DMERC on request.

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 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.
**Power Wheelchairs**

A power wheelchair (K0010-K0014) is covered by Medicare when a patient’s condition is such that without the use of a wheelchair the patient would be otherwise bed or chair confined. Additionally, the patient is unable to operate a manual wheelchair due to a severe neurologic or muscular condition of both arms and legs.

Examples of severe neurologic conditions might include spinal cord injury, cerebral palsy, advanced multiple sclerosis, or stroke with dense hemiplegia. In addition to the diagnosis of such a condition, there must also be functional impairment involving paralysis or such severe weakness of arms as well as legs that the patient is unable to propel a manual wheelchair within the confines of their home or individual living quarters.

Non-neurologic diseases such as COPD, congestive heart failure, coronary artery disease, arthritis or obesity rarely would qualify for powered mobility, as these patients usually have sufficient strength in their arms and legs to propel a manual wheelchair (if even this is necessary) within their home.

The DMERC has received many claims with documentation of the need for power wheelchairs including statements signed by physicians, indicating a degree of functional impairment and use within the home or living quarters, which has not been corroborated when further investigated. In an effort to better determine the medical necessity for power wheelchairs (K0010-K0014), Region C DMERC may require information in addition to a CMN, which is normally submitted with the claim. Suppliers may be notified of the need for this extra documentation before a claim for a power wheelchair is adjudicated for payment. The extra documentation requested will include the following elements:

- **The manufacturer and model/number of the power wheelchair ordered, delivered and used by the patient**, which must be the same item for which the claim is being submitted.

- **Copies of the Progress Notes from the medical chart of the treating physician who is ordering the power wheelchair**. These notes must be relevant to the diagnoses listed on the CMN, and address functional levels justifying the need for the power wheelchair (according to the DMERC RMRP). One entry in the Progress Notes should certainly refer to the ordering of the power wheelchair along with reasons for its need, considering the severity of the conditions for which power wheelchairs are required. It is also expected that several Progress Notes (with different dates of entry) will be present within the treating physician’s medical chart, referring to the condition and associated limitations of function, and these notes are to be included as well. If hospital records such as a discharge summary adequately address a qualifying condition and functional level at the time of discharge justifying need for a power wheelchair in the home, these will also be helpful.

Physicians who express concerns about patient confidentiality may be reassured that when the patient signs the HCFA-1500 claim form which is submitted for the power wheelchair, the patient grants the Medicare Carrier (the DMERC) authority to secure medical records in order to establish the medical necessity of equipment for which Medicare is being billed. Since only Progress Notes pertaining to the
relevance of the need for the power wheelchair are required, this information should not be considered beyond the professional scope of the supplier, who must properly equip and fit the beneficiary with this item (as well as assess the particular home environment in which it is to be used).

Failure to provide adequate and relevant copies of the treating physician's Progress Notes from the physician's medical chart of the patient will be considered lack of adequate medical necessity documentation, and claims for K0010-K0014 will be denied as medically unnecessary.

• If the Progress Note entries of the treating physician do not address the following details of a thorough functional assessment of the patient, it may also be necessary to obtain an evaluation by one of these professionals: 1) a physiatrist (physician specializing in rehabilitation medicine), 2) a physical therapist licensed in the state where the evaluation is being performed, or 3) an occupational therapist certified by the national certifying board and who has met any regulations for licensure, certification, or registration by the state in which the evaluation is performed. From whichever of these professionals, the following details of functional ability should be addressed: condition necessitating use of a power wheelchair; date of onset of this condition; progression of the condition and prognosis; semi-quantitative assessment of strength in the extremities; the presence or absence of increased muscle tone or spasms; trunk stability and sitting posture; quantification of the patient's ability to ambulate and what assistance (e.g., cane, walker, other person, etc.) is needed for this (if applicable); ability to transfer from bed/chair to wheelchair (including the ability to stand and pivot); endurance; cognitive abilities; visual impairments; description of current wheelchair (if applicable), age of equipment, and why it is being replaced.

• Suppliers will also be asked to furnish a valid telephone number for the beneficiary, the ordering physician, and the physiatrist, physical therapist or occupational therapist who submitted the patient/wheelchair evaluation.

Failure to respond to a request for this extra documentation, or submitting documentation which is not complete in all of the requested details may result in claim denial if medical necessity cannot be established based on the information which is received.
Nebulizer Prescriptions

Suppliers must obtain renewed physician prescriptions for nebulizer drugs and accessories at least every 12 months, and sooner if the physician revises a prescription. When greater than the usual maximum amount (as described in medical policy) of drugs or supplies are being billed, the supplier must attach a copy of the physician prescription and physician narrative documentation supporting the medical necessity for the higher utilization. The prescription and statement must be that which was most recently issued by the physician. Older prescriptions or statements that have been replaced must not continue to be attached to claims for dates of service covered by newer prescriptions or statements. This is a clarification of existing policy.

DME Repair

HCPCS Code E1340

Claims for the labor component of repair of patient-owned durable medical equipment are billed using HCPCS code E1340 (repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes). This HCPCS code may be billed and can be covered only if the skill of a technician is required.

Charges for the replacement of items that do not require the skill of a technician (e.g., replacing batteries, etc.) must not be submitted with HCPCS code E1340. If a supplier chooses to submit a claim in this situation, HCPCS code A9270 (noncovered item or service) must be used.

Payment for any labor involved in assembling, preparing or modifying initially issued equipment is already included in the allowance for that equipment and its accessories. Also, payment for repair of rented DME is included in the monthly rental allowance. HCPCS code E1340 must not be used in either of these situations.

A claim for HCPCS code E1340 must be accompanied by an explanation of what is being repaired. If this information is not included with the claim, HCPCS code E1340 will be denied as not medically necessary. If charges are being submitted for replacement parts, the HCPCS codes for these parts must be entered on the same claim with the charge for E1340.
Dear Physician:

The following is a summary of the Durable Medical Equipment Regional Carrier's (DMERC) 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 physician cooperation that Medicare can provide beneficiaries with the appropriate 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. Funds lost to unnecessary utilization of and fraudulent claims for DME come from the same Part B Medicare Fund from which physicians are reimbursed for their own services.

The following Physician Information Sheet (PHYIS) 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.

If more detailed information is desired, the physician is encouraged to obtain a copy of the RMRP from the supplier servicing your patient, or directly from the Region C DMERC office of Professional Relations at (803) 735-1034, ext. 35707 or 35745.

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PARENTERAL NUTRITION

PHYSICIAN INFORMATION SHEET

The following is a summary for physicians of the Durable Medical Equipment Regional Carrier's Regional Medical Review Policy on Parenteral Nutrition.

Parenteral nutrition, the administration of nutrients intravenously, is covered by Medicare under the Prosthetic Benefit. This means that it is covered when being used to replace the malfunction of the primary organ that normally accomplishes nutrient intake, transport and absorption - the gastrointestinal (GI) system. If the GI system is functioning sufficiently to maintain the patient's weight and strength commensurate with the patient's overall health status, then parenteral nutrition is not covered (nor should it be, as the medically appropriate approach to insufficient nutritional status is to first use the more physiologically adapted GI system to its maximum capacity, before resorting to the more limiting avenue of intravenous nutrition, with its known complications.) For this reason, the Parenteral Benefit does not cover such conditions as swallowing disorders (tube feedings are covered under a separate Enteral Benefit), temporary defects in gastric emptying associated with metabolic or electrolyte disorders, psychological disorders impairing food intake such as depression, metabolic disorders inducing anorexia such as cancer, physical disorders impairing food intake such as the dyspnea of severe pulmonary or cardiac disease, side effects of medication, or renal failure with or without dialysis (another separate Medicare benefit).

If intravenous nutrients administered during dialysis treatments are to be covered (intradialytic parenteral nutrition or IDPN) there must be demonstration that all effort has been made to utilize the GI tract to its full potential (or that such effort is precluded by obvious functional impairment due to concurrent GI disease). This too is medically reasonable as patients in renal failure have strict fluid balance requirements and more concentrated nutrients may be introduced into a still functioning GI tract even using tube feedings, over a longer period of administration (up to 24 hours, seven days per week), than can be accomplished during only 3 or 4 dialysis sessions, lasting a few hours each, and using the vulnerable intravenous hemodialysis access port.

The GI impairment must not only be of sufficient degree to warrant intravenous nutrition, but it must also be of a permanent nature (of long and indefinite duration - ordinarily at least 3 months). It is not covered for temporary impairments and treatment regimens (less than 3 months) such as bowel rest associated with completed or anticipated surgical procedures.

For these reasons, all effort must be made to maximize the functional capacity of the GI tract before resorting to IV nutrient administration. Physicians, and other health care professionals should be attempting modifications in the composition of the oral (and enteral, tube-fed) diet, for example, using nutrients that are lactose free, gluten free, low in long-chain triglycerides, substituting medium chain triglycerides, providing protein as peptides or amino acids, etc. Therapeutic modalities should be fully utilized to address treatable causes of malabsorption, such as pancreatic enzymes or bile salts, broad spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, anti-ulcer medication, etc.

The following clinical conditions of either malabsorption or GI dysmotility would be covered for parenteral nutrition based on their degree of functional severity:

A. Recent (within the past 3 months) small bowel resection leaving 5 feet or less of small bowel beyond the ligament of Treitz, or

B. Short bowel syndrome severe enough to result in loss of fluids and electrolytes such that, even with an intake of at least 2.5 liters/day, GI loss exceeds 50% and urine output is less than 1 liter/day, or
C. For treatment of symptomatic pancreatitis (with or without pseudocyst), severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula is not possible, and bowel rest is needed for any of these for at least 3 months and IV nutrients will supply 20-35 Cal/Kg/day, or

D. Complete mechanical small bowel obstruction where surgery is not an option, or

E. Significant malnourishment (10% weight loss over 3 months or less and serum albumin < 3.4 gm/DL) along with severe fat malabsorption (fecal fat exceeds 50% of oral/enteral intake on a diet of at least 50 grams of fat/day as measured by a 72 hour fecal fat test), or

F. Significant malnourishment (defined in E above) along with severe motility disturbance of the stomach and/or small intestine, which is unresponsive to prokinetic medication and is demonstrated either (1) scintigraphically (solid meal gastric emptying study shows isotope failing to reach the right colon by 6 hours after ingestion) or (2) radiographically (barium or radiopaque pellets failing to reach the right colon by 6 hours after ingestion). These studies must be performed when the patient is not acutely ill (temporary ileus) and is not on any medication which would decrease bowel motility.

In cases where the above conditions exist but are not of a degree of functional severity to meet the parameters described above, the need for intravenous administration of nutrients would have to be demonstrated by means of a failed trial of tube feeding. Attempted successful introduction and maintenance of a feeding tube in appropriate stomach or intestinal position must reflect sufficient effort by qualified personnel, and gradually increasing introduction of appropriate enteral nutrients. More specific details of the tube feeding trial may be found in the DMERC RMRP, which is available from the supplier servicing your patient or directly from the Region C DMERC office of Provider Relations.

Patients who initially qualify for coverage of parenteral nutrition must be recertified for continued coverage after 6 months, as even many of the qualifying conditions often improve to a level where continued intravenous feeding is no longer necessary.

In addition to a properly completed certificate of medical necessity, other documentation is usually required to furnish the necessary details discussed above in order for the DMERC to determine payment for claims for parenteral nutrition. Physicians are encouraged to work with suppliers of this therapy in obtaining and conscientiously completing this documentation so that patients truly needing it may have it reimbursed by Medicare.

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A. Requirements of the Law

Effective January 1, 1999, section 4311(b) of the Balanced Budget Act of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of $100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues, (i.e., services not provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

Medicare contractors currently issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary (MSN). Information that may be listed include the following: date(s) of services, a description of services provided, number of services provided, benefit days used, noncovered charges, deductible and coinsurance, beneficiary liability, amount charged, claim number, name of provider/supplier submitting the claim, claim total paid by Medicare and referring physician (if applicable). Other information that may be included are deductibles, appeal of rights or notices, and explanatory notes and general information regarding the specific claim. On April 1, 1999, at most Medicare contractors, these notices will begin to include the following statement: “You have a right to request an itemized statement which details each Medicare item or service which you have received from your physician, hospital or any other health supplier or health professional. Please contact them directly if you would like an itemized statement.” The remaining Medicare contractors will print this message beginning July 1, 1999.

B. Guidance Concerning the Format and Substance of the Itemized Statement

Included below are suggestions regarding the types of information that might be helpful for the beneficiary to receive on an itemized statement. We hope this information will enable the beneficiary to reconcile the itemized statement with the Medicare notice. These are recommendations only. Since most providers/suppliers have established an itemized billing system for internal accounting procedures and billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. However, some providers/suppliers may not regularly create or furnish hardcopy itemized statements and may wish to reexamine their internal billing and tracking process to ensure that it has the capability to comply with this new requirement. Providers/suppliers should not charge beneficiaries for the itemized statement.

Itemized Statement Recommendations:

1. Name of beneficiary,
2. Date(s) of services,
3. Description of item or service furnished,
4. Number of services furnished,
5. Provider/supplier charges
6. An internal reference or tracking number
**Beneficiary Right to Itemized Statement**

If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are:

1. Amounts paid by Medicare
2. Beneficiary responsibility for co-insurance
3. Medicare claim number

The statement should also include a name and a telephone number for the beneficiary to call if there are further questions.

C. Reconciliation of the Itemized Statement with the MSN/EOMB

After receiving an itemized statement, beneficiaries may attempt to reconcile it with the MSN or EOMB. In situations where there are questions, especially involving some services and payment methods, providers/suppliers are requested to assist beneficiaries in understanding any difference between the two documents.

In addition, although Medicare contractor customer service representatives may not have a copy of the itemized statement, they will also answer any beneficiary inquiries regarding the EOMB/MSN and attempt to reconcile it with the itemized statement. Where appropriate, customer service representatives will attempt to resolve any questions by generally explaining applicable Medicare reimbursement rules, (prospective payment systems, revenue codes, bundling, interim rates, HCPC/CPT codes, etc.)

D. Beneficiary Right to Request Review of the Itemized Statement

Beneficiaries may submit a written request to their Medicare contractor for a review of a claim based on information they provide from the itemized statement. The request should identify the specific items or services that the beneficiary believes were not provided as claimed, or any other billing irregularity (including duplicate billing). A review will be conducted into the matter by the Medicare contractor and providers/suppliers may be requested to assist in the review of the itemized statement/Medicare claim. Contractors will review and take appropriate actions to resolve the complaint.
The Health Care Financing Administration has mandated that hardcopy claims received on or after April 5, 1999, be “returned as unprocessable” if they are not Y2K compliant. You must ensure that items 3, 9b, and 11a on the HCFA-1500 claim form contain eight-digit dates. For further details, please consult the Summer 1998 Supplement, page 65 of the DMERC Medicare Advisory.

**Y2K Contingency Plans**

The Health Care Financing Administration and its Medicare contractors are testing and certifying their readiness for the year 2000 (Y2K). At the same time, they are developing contingency plans to prepare for unforeseen problems. HCFA and Palmetto GBA strongly recommend that each Medicare supplier develop Y2K contingency plans tailored to unique business needs. Focus on the things that would be most problematic for supplier businesses and Medicare beneficiaries. For example, what alternatives exist if...

- Claims cannot be sent in the right format to an insurer
- Equipment required by Medicare beneficiaries does not function properly
- Laboratory or diagnostic facilities where patients are referred cannot identify and accurately report to an insurer the dates submitted on order forms
- Outputs from monitoring and reporting equipment are not accurate or complete
- Electronic remittances from Medicare or Medicaid are not retrievable
- Accounts receivable system does not work properly
- Checks cannot be deposited in banks or credited accurately
- Payroll system does not function appropriately?

By making Y2K contingency plans for unexpected problems, suppliers may prevent unfortunate consequences that would prevent them from efficiently operating their businesses or serving their Medicare beneficiaries.

**Sequential Billing**

In an effort to provide efficient service we would like to remind suppliers of a few correct ways to help ensure timely processing of claims:

1. If items are rendered for continuous periods of time, submit claims for those items no more frequently than monthly, or at the conclusion of medical need.
2. Submit claims in the sequence that services are rendered.
3. Claims should only be submitted when delivery has been made as a result of a request from the beneficiary, physician, or designated representative. The supplier should not automatically mail or deliver items on a predetermined dispensing basis.

These procedures will assist us in providing quality service to you, as well as preserve Medicare program resources.
The Statistical Analysis Durable Medical Equipment Regional Carrier provides assistance to suppliers and manufacturers to ensure the proper coding of durable medical equipment, prosthetics, orthotics, and supplies. When suppliers or manufacturers are unsure of the correct HCPCS code for a product, they should direct their inquiry to the SADMERC. A Coding Verification Review will be initiated (if we have not previously reviewed the product). To initiate a Coding Verification Review, you will be asked to submit, in writing, the information below for each product to be reviewed. After all necessary documentation is received, a review will be initiated and you will receive a letter advising you who to contact if you have questions while the product is in review. This also serves as a confirmation that the SADMERC has received the necessary documentation. An analyst at the SADMERC reviews the product and makes a recommendation. The four DMERCs also receive the product literature, review the product, and each makes an independent recommendation. The SADMERC and the four DMERCs will discuss the item and reach a consensus decision regarding coding. The SADMERC notifies the supplier or manufacturer of the determination. The Coding Verification Review process takes approximately 90 days.

If you have any questions concerning the Coding Verification Review or the SADMERC, please contact our Helpline at (803) 736-6809 from 9:00 a.m. - 4:00 p.m. EST.

Required Documentation Necessary for HCPCS Coding Verification Reviews

Please note that all reviews require five sets of all the following information:

1. Include wholesale and suggested retail cost of the item.
2. List the monthly/weekly/daily rental charges for item, if applicable.
3. Send documentation of the FDA's current classification of the item.
4. Provide the date that the item was available on the US market.
5. Include pictures of the item (marketing literature).
6. State the HCPCS code you feel best meets the description of your product.
7. List all Universal Product Codes (UPC) or Universal Product Numbers (UPN), if available, for each product to be reviewed.

In addition to the information above, please include five sets of the items listed below in the category that best describes your product.

A. Support Surfaces/Seating Cushions
   a. Provide a description and exact dimensions of the product. This should include the height, depth, and width of all components, and the combined total of all components. Include a cut-away diagram.
   b. Include a description of how the product functions and the indications for use of this product.
   c. Provide clinical studies and case studies that have been performed using the product.
   d. You may provide pressure testing results.
e. Send Warranty information for all parts and accessories of the product.

B. Surgical Dressings
   a. Include an exact description and sizes of all layers and component parts of the dressing.
   b. Include a listing of all ingredients of the product and the amounts present.
   c. List all sizes in which the dressing is available.
   d. List all indications for use of the product (for multiple layer dressings, include indications and purposes of each layer or component of the dressing).
   e. Include five samples of the dressing.

C. Medications and Enteral or Parenteral Nutrition Products
   a. Provide the generic name of all drugs and pharmaceutical items.
   b. Provide the following for all pharmaceutical items: manufacturer’s name, NDC number, indications, actions, dosage, administration recommendations, and how it is supplied.
   c. List all ingredients, and portions of each, for all enteral and parenteral products.
   d. List and describe similarities to other enteral or parenteral products on the market.

D. Orthotics and Prosthetics
   a. Provide an exact description including how it is made and what materials were used to make it.
   b. Include a description of where on the body the device or item is to be worn or used.
   c. List the indications for use of the item and how the patient is taught to apply it.

E. Durable Medical Equipment and Medical Supplies
   a. Provide an exact description of the item. Include all component parts and/or accessories.
   b. Provide a description of how this equipment operates and functions.
   c. List all supplies necessary for the use and operation of the equipment.
   d. List the indications for use of the equipment.
   e. Send Operations and Patient Instruction Manuals.
   f. Send Warranty information for the equipment and component parts.
   g. Provide the recommended duration of use for all supplies associated with the equipment.
   h. Include results of clinical studies that have been performed using this equipment.
Effective November 1, 1998, the HCPCS Helpline representatives at the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) will be available to answer your coding questions from 9:00 am - 4:00 pm EST. In addition to assisting with proper code recommendations, the representatives are able to address your fee schedule requests. Please note we are not able to assist customers with allowables for items not on a fee schedule (e.g. reasonable charge, individually considered).

Questions and inquiries regarding HCPCS code usage and allowables for items on a fee schedule should be directed to:

HCPCS Helpline (803) 736-6809

or

SADMERC/HCPCS Unit
P.O. Box 100143
Columbia, South Carolina 29202-3143

The treasury department has determined that the new prompt payment interest rate is 13.75 percent.

This rate is effective February 1, 1999. The rate applies to clean paper and electronic claims that have not been paid by the 30th day after receipt by Palmetto Government Benefits Administrators.

The prompt payment interest rate is now available on the Treasury Department Web site at:

www.fms.treas.gov/prompt/index.html

The Health Care Financing Administration has authorized the National Supplier Clearinghouse (NSC) to assign Medicare supplier numbers to providers of durable medical equipment, prosthetics, orthotics and supplies. The application form, HCFA form 855S (1/98), is available on Palmetto GBA’s Web site at www.pgba.com, or by contacting the NSC at:

National Supplier Clearinghouse
PO. Box 100142
Columbia, S.C. 29202-3142
(803) 754-3951

Any changes to the information provided on the HCFA 855S (1/98) should be reported to the NSC within 35 days of the occurrence of such changes.
**NSC UPDATE**

Region C is pleased to print the following article offered by the National Supplier Clearinghouse (NSC). As future NSC news items or updates are received, we will include them in our regularly scheduled Medicare Advisories.

For more NSC information, visit Palmetto Government Benefits Administrators' Web site at www.pgba.com. Click on "Frequently Asked Questions" and "Hot Topics" listed under "Medicare Partners."

The NSC receives many questions regarding site visits performed for new applications and re-enrollments. ChoicePoint inspectors, who execute most of our site visits, will display the following credentials upon arrival at a supplier's facility:

* photographic identification,
* a letter signed in blue ink by NSC Director William T. T. Hood, J r., and
* a prepared site visit form.

The best way to prepare for an NSC site visit is to review the 11 Medicare DMEPOS supplier standards and ensure that you meet all of them. The site inspector will also ask questions relating to the proposed new supplier standards; however, the NSC evaluates your success based only on your compliance with the current 11 standards. Please do pay attention to all issues covered during the site visit, because they are good preparation for the proposed new supplier standards.

ChoicePoint inspectors do not make decisions concerning assignment of a new supplier number, nor do they take action concerning a number currently assigned. They simply gather and forward information to the NSC where it is analyzed for appropriate course of action. The application process for a new Medicare supplier number currently takes 60+ days, 30 of which involve the site inspection itself. NSC staff continually strives to shorten the application process. Please help by ensuring that applications are complete (and signed) before sending them to us.

There is a new development regarding the proposed supplier standards and surety bond. The two proposals have been separated and are moving toward implementation as two distinct actions. It appears that the supplier standards will reach the finish line first, hopefully by early summer, and that the surety bond will probably take a little longer. The NSC will notify suppliers as soon as these issues are finalized, so please watch for future news bulletins. In the meantime, do not buy a bond for Medicare DMEPOS purposes until you hear from the NSC.

The NSC receives a large number of facsimile documents every day that we can not accept for action. Any changes to your NSC data file require an original signature by an authorized representative before the NSC can make a requested change. Call the NSC Service Center at (803) 754-3951 if you have questions concerning the acceptability of a "fax."

One last reminder: The Federal Law (OBRA 89) requires Medicare Part B Suppliers/Providers (participating and/or non-participating)
NSC UPDATE (cont.)

OXYGEN TESTING REMINDER

As a reminder to suppliers who provide home oxygen therapy, per the oxygen policy guidelines published in the Region C DMEPOS Supplier Manual (page 19.3), suppliers of durable medical equipment may not be involved in qualifying beneficiaries for oxygen services. A blood gas study must be ordered and evaluated by the attending or consulting physician. A measurement of pulse arterial oxygen saturation will also be acceptable when ordered and evaluated by the attending physician and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services. A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines.

ZX MODIFIER USAGE AND ON-SITE VISITS

Claims submitted using the ZX modifier are subject to random on-site record reviews by the Medical Review and/or Anti-Fraud Unit personnel at Palmetto GBA.

Region C conducted review audits during the summer of 1998. Medical Review and Anti-Fraud staff went on-site to supplier facilities and requested specific records for review. The outcome of this on-site audit resulted not only in the recoupment of overpayments, but also in several suppliers being referred to the Anti-Fraud Unit and the National Supplier Clearinghouse for investigation. Of the supplier records reviewed, 41% did not have the appropriate documentation to support the usage of the ZX modifier on their Medicare claims.

The Region C DMEPOS Supplier Manual specifically states that suppliers must have the supporting documentation in their records before they submit claims to the DMERC.
**Team Tips**

We are pleased to introduce this new section to the DMERC Medicare Advisory. Team Tips is a section created by your service teams (MFT) to assist you with claims filing, appeals and inquiries. These helpful tips will be provided by each team based on trends identified in their daily interaction with you, their customer.

**Team A:** When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

**Team B:** Please remember that maintenance and service may first be billed in the 22nd rental month during a capped rental period and is billable every six months thereafter.

**Team C:** When filing claims for diabetic supplies, please remember to use the appropriate modifier - ZX for insulin treated and KS for non-insulin treated. Please remember that use of a modifier indicates documentation to support medical necessity is present in the supplier files.

When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

**Team D:** Do not span dates on claims for rental equipment (e.g. oxygen, wheelchairs, hospital beds, etc.).

**Team E:** When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

The following items are covered when medically necessary and documented by the treating physician along with the use of the ZX modifier: tints (V2740-V2744), anti-reflective coating (V2750), UV lenses (V2755) and oversize lenses (V2780).

**Team F:** Please remember to use the following modifiers when filing claims for capped rental equipment: KH-1st month, KI- months 2-3 and KJ -months 4-15.

**Team G:** Please remember to use span dates when filing claims for the following items: continuous passive motion (CPM) unit, enteral and parenteral nutrition and administration supply kits.

**Team H:** When revising CMNs, please remember to provide the initial date of service on the CMN. Revised CMNs require two dates - the initial date of service and the date of the revision.

When providing equipment due to change in condition, please remember to provide a new CMN and additional documentation justifying the change in condition.

**Team I:** Please do not span dates over a calendar year (e.g. 12/30/1998 - 01/15/1999). Two separate claims need to be filed - one for date of service 12/30/1998 and one for 01/01/1999-01/15/1999.
**TEAM TIPS**

(cont.)

**Team I cont.:** Please refer to the July 1996 Region C DMERC Advisory for CMN guidelines.

**Team J:** When filing claims for diabetic supplies, please remember to use the appropriate modifier - ZX for insulin treated and KS for non-insulin treated. Please remember that use of a modifier indicates documentation to support medical necessity is present in the supplier files.

**Team K:** Please clearly indicate on reviews what item and date of service is in question.

**Team L:** When filing claims for capped rental equipment, do not use span dates.

Do not include multiple calendar years on one claim.

**Team M:** When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

**Team N:** When billing for HCPCS codes E1399 and K0108, please remember to provide a clear description of the item including the manufacturer, the model/name and number and the manufacturer's suggested list price. The claim must also include the statement of medical necessity.

When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

**Team P:** Always include your supplier number in Item 33 of the HCFA-1500 claim form.

**Team S:** Please remember to update your Region C DMEPOS Supplier Manual upon receipt of revisions.

**Team T:** Verify the beneficiary's Medicare number. If possible, verify with the beneficiary's Medicare card.

When submitting reviews, please remember to provide the claim control number on the review request. We recommend using the Review Request Form in the DMEPOS Supplier Manual (page 14.4).

**Team U:** When filing claims for diabetic supplies, please remember to file using the appropriate five-digit ICD-9 diagnosis code (250.00-250.93) indicated by the ordering physician.

**Team W:** Make sure all required areas on the CMN are completed before sending with the HCFA-1500 claim form.

**MSP Team:** Please remember to complete Item 11 on the HCFA-1500 claim form. If Medicare is primary, the word “NONE” must be indicated. If another insurance is primary, that insurance information must be provided in Item 11 and an EOB attached.

Primary insurance paid amount should not be indicated in Item 29. This is for money paid by the beneficiary.
**TEAM TIPS**

(cont.)

**Overpayment Team:** Please remember to include the Medicare number, claim control numbers and date of service when refunding overpayments. If you are sending a partial recoupment, address what and how much should be recouped.

**Data Entry Department (for hardcopy claims):**

Vision suppliers, when completing the HCFA-1500 claim form, should complete Item 11 on the HCFA-1500 claim form. If Medicare is primary, the word “NONE” must be indicated. If another insurance is primary, that insurance information must be provided in Item 11 and an EOB attached. The place of service should be 12 - not 11. You must indicate assignment in Item 27, charges in Items 28 and 30 and your complete ten-digit supplier number in Item 33.

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**ORAL ANIT-CANCER DRUG CORRECTION**

In the Winter 1998 DMERC Medicare Advisory (page 130), suppliers were notified that Medicare expanded coverage of certain oral anti-cancer drugs to included FDA approved oral anti-cancer prodrugs effective for claims with dates of service on or after Jan. 1, 1999. This benefit is expanded to include coverage for a 5-FU prodrug, Capecitabine, trade name: Xeloda, manufactured by Roche.

The NDC numbers published in that article are incorrect. The correct NDC numbers are as follows:

- 000004-1100-22 Capecitabine, 150 mg, oral, 1 tab per unit
- 000004-1100-51 Capecitabine, 150 mg, oral, 1 tab per unit
- 000004-1100-13 Capecitabine, 150 mg, oral, 1 tab per unit
- 000004-1101-51 Capecitabine, 500 mg, oral, 1 tab per unit
- 000004-1101-15 Capecitabine, 500 mg, oral, 1 tab per unit
- 000004-1101-31 Capecitabine, 500 mg, oral, 1 tab per unit
SUPPLIER SANCTIONS

Arkansas

Baker, Yvette Ketai
C/O 11825 Henson Rd., #101
Little Rock, AR  72212
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 10/13/98

Boyce, Marie Girtrue
503 Tindall Rd.
Searcy, AR  72143-9296
Specialty: Health Care Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/19/98

Porter, Rodney Wayne
1601 Lockwood Dr.
Corning, AR  72422
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Colorado

Advanced Rehab Concepts
PO Box 5000, #27834-013
Florence, CO  81226-0000
Specialty: Rehab Facility-
General Practice
Period of Exclusion: 10 yrs.
Effective Date: 10/20/98

Georgia

Kiser, Curtis
AKA D Curtis Kiser/Donald Kiser
215 Ashley Creek Dr.
Newnan, GA  30263
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Tyrrel, Robert Ty
AKA Bob Tyrrel
3910 W . Nancy Creek Court
Atlanta, GA  30319
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Florida

Bombino, Aesthor L.
9951 S W 28th St.
Miami, FL  33165-2901
Specialty: Licensed Practitioner
Period of Exclusion: 5 yrs.
Effective Date: 11/19/98

Dynamic Medical Equipment, Inc.
8428 S W 24th St. Ste. 229
Miami, FL  33155
Specialty: DME Company
Period of Exclusion: 10 yrs.
Effective Date: 11/19/98

Harvey-Porto, Donna
2600 Michigan - 216C
Pensacola, FL  32526
Specialty: Technician
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Lima, Susy
6900 Bay Dr, #8A
Miami, FL  33139
Specialty: Health Care Aide
Period of Exclusion: 5 yrs.
Effective Date: 11/19/98
**SUPPLIER SANCTIONS**

(continued)

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<td>3400 Bee Ridge Rd, Ste 200</td>
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<td>2366 Nicholasville Rd., #504</td>
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SUPPLIER SANCTIONS
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Wong, Sidney Harvey
18048 Dedeaux Clan Rd.
Gulfport, MS 39503
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 10/20/98

North Carolina

Nabors, Dennis R.
4890 Chimney Springs Dr.
Greensboro, N.C. 27407
Specialty: Physician Assistant
Period of Exclusion: Indefinite
Effective Date: 10/20/98

Stewart (Carballo), Charles
AKA Charles W. StewartCarballo
219 Wintergreen Dr.
Fayetteville, NC 28314
Specialty: Family Physician/
General Practice
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Oklahoma

Brown, William E.
PO Box 237
Atoka, OK 74525-0237
Specialty: Osteopath
Period of Exclusion: Indefinite
Effective Date: 11/19/98

Finley, Eddie
4005 Village Dr.
Enid, OK 73703-3633
Specialty: Health Care Aide
Period of Exclusion: 5 yrs.
Effective Date: 10/20/98

Horn, Steven Craig
1836 11th St., NW
Oklahoma City, OK 73106
Specialty: Osteopath
Period of Exclusion: Indefinite
Effective Date: 11/19/98

South Carolina

Irby, James H. Jr.
1301 McLees Rd.
Anderson, S.C. 29621
Specialty: Family Physician/
General Practice
Period of Exclusion: 5 yrs.
Effective Date: 10/20/98

Tennessee

Bolds, Arthur O.
112 Brentway Circle, Apt. 181
Knoxville, TN 37909
Specialty: Health Care Aide
Period of Exclusion: 5 yrs.
Effective Date: 10/20/98

Crittenden, James C.
4801 Lakeridge Dr.
Memphis, TN 38109
Specialty: Employee (Non-Govt.)
Period of Exclusion: 25 yrs.
Effective Date: 10/20/98

Freeman, David J.
6709 Knoll St.
Millington, TN 38053
Specialty: Technician
Period of Exclusion: 5 yrs.
Effective Date: 11/19/98

Lewis, Sandra F.
206 Jackson St.
Galloway, TN 38036
Specialty: Employee (Non-govt.)
Period of Exclusion: 5 yrs.
Effective Date: 11/19/98
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<td>Family Physician</td>
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<td>Vandycche, Andrew</td>
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<td>2302 Mast Ct., Kingwood, TX 77339-1018</td>
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<td>Dyke, Marshall J</td>
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<td>Ezeude, Christopher</td>
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<td>Ranelle, John</td>
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**Supplier Sanctions**

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**Supplier Reinstatement Actions**

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| Texas | Lopez, David Naranjo | Family Physician/General Practice | 10/20/98 | 10/26/98 |
| | 10508 Lost Bluff | | |
| | San Antonio, TX  78240 | | |

**Sanctions Web Address**

Sanction and Supplier Reinstatement Action Information can be accessed at:

www.hhs.gov/progorg/oig/cumsan/index.htm
**Fee Changes**

Effective for claims processed on or after April 1, 1999, for dates of service on or after January 1, 1999, HCPCS code A4265 (paraffin, per pound) will be processed as a fee schedule item. The fee schedule allowances for HCPCS code A4265 are listed below. Since HCPCS code A4265 (paraffin) is used as a supply with HCPCS code E0235 (paraffin bath), HCFA has changed the payment methodology from reasonable charge to fee schedule.

- Fees for HCPCS code E0147 - Heavy duty, multiple breaking system, variable wheel resistance walker have been revised due to policy changes. These fees are effective immediately for dates of service on or after January 1, 1999.
- Fees for HCPCS code L1843 - KO, Single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model were revised based upon receipt of retail market price lists. These fees are effective immediately for dates of service on or after January 1, 1999.

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### 1999 Fee Schedule Changes

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**HCPCS Code L3914 Revision for Puerto Rico**

The Region C DMERC has reviewed Puerto Rico’s Local Carrier base fee for HCPCS code L3914 (WHO, WRIST EXTENSION COCK-UP). In comparison to retail price lists and the current allowances for other area, the Local Carrier base fee is incorrect. Effective immediately, the 1999 allowance will change from $1,136.80 to $26.88. This change will affect allowables for beneficiaries residing in Puerto Rico only. If you have questions regarding this change, please send them in writing to: Medicare Reimbursement, P.O. Box 100190, AK-125, Columbia, S.C. 29202-3190.
OMBUDSMEN ADDRESSES AND THEIR TERRITORIES

**Alabama**
Lia Bunch  
P.O. Box 146  
Union Grove, Ala. 35175  
(256) 498-0205

**Arkansas/Oklahoma**
**IN THE INTERIM CONTACT:**  
Mary Jo Gochett  
P.O. Box 81850  
Conyers, Ga. 30208-9426  
(770) 761-0509

**Colorado/New Mexico**
**IN THE INTERIM CONTACT:**  
Gina Thore  
P.O. Box 100141  
Columbia, S.C. 29202-3141  
(803) 735-1034, Ext. 35781

**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  
PO. Box 436767  
Louisville, Ky. 40253-6767  
(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**
Christopher Gaura  
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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<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>
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<tr>
<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;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;Palmetto GBA, Medicare Region C DMERC&lt;br&gt;P.O. Box 100235&lt;br&gt;Columbia, S.C. 29202-3235</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. 35744</td>
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*Inquiries regarding hearings or Prior Authorization should be directed to the Dedicated Work Teams.*

#### National numbers

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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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<tr>
<td><strong>Region A DMERC</strong></td>
<td>(717) 735-9445</td>
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<tr>
<td><strong>Region B DMERC</strong></td>
<td>(317) 577-5722</td>
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<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>&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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