Oxygen Policy Revised

A revision of the Oxygen and Oxygen Equipment policy is included in the accompanying Region C DMERC DMEPOS Supplier Manual update. This revision incorporates changes previously published in Region C advisories. Suppliers should be aware that this is the first revision of the Oxygen policy since 1993 and numerous changes will be found in all sections of the policy. Therefore, we encourage you to read the entire policy carefully. Also note that the Documentation Section has been reorganized for easier determination of when initial, revised and recertification Certificates of Medical Necessity (CMNs) are needed.

Two coding changes should be noted and are effective for claims with dates of service on or after 7/1/00.

1) HCPCS codes E1405 and E1406 (oxygen and water vapor enriching system) are invalid for claim submission to the DMERC. The DMERCs have determined that the devices for which these HCPCS codes were established are no longer in production.
OXYGEN POLICY REVISED
(continued)

Oxygen concentrators which are capable of delivering 85% or greater oxygen concentration at the prescribed flow rate and which are used with a humidifier are correctly billed using HCPCS code E1390. (There is no separate billing or payment for a humidifier used in conjunction with rented oxygen equipment.) If a manufacturer or supplier has an oxygen concentrator that they thought should be coded as E1405 or E1406, they should contact the SADMERC for a coding determination.

2) HCPCS Code ZZ010 (transtracheal oxygen catheter for patient-owned equipment) is invalid for claim submission to the DMERC. As noted in the policy, accessories are separately payable only when they are used with a patient-owned system that was purchased prior to June 1, 1989. Accessories used with a patient-owned system that was purchased on or after 6/1/89 are non-covered.

ORAL ANTICANCER DRUGS

The Spring 2000 DMERC Medicare Advisory announced expanded coverage to include two additional drugs - busulfan (Myleran) and temozolomide (Temodar). Suppliers were instructed to temporarily use the miscellaneous HCPCS code J8999 to submit claims for these drugs. Effective for claims received on or after July 1, 2000, suppliers may submit claims for these drugs using the appropriate NDC numbers. (Refer to the Spring 2000 DMERC Medicare Advisory for a listing of the NDC numbers and the effective date of coverage for each drug.) If HCPCS code J8999 is used for these drugs on claims received after 10/1/00, the claim will be processed as a return/reject and the supplier should resubmit using the NDC number.

Two additional NDC numbers have been added for methotrexate products:

Methotrexate, 2.5 mg, oral
00378-0014-50
51285-0509-02

These numbers are valid for claims received on or after July 1, 2000.

As new NDC numbers for covered drugs are established, the DMERC will announce in its bulletin when those numbers can be accepted by our claim processing system. Until such time as a new NDC number can be accepted, suppliers may submit claims using HCPCS code J8999 (Prescription drug, oral, chemotherapeutic, not otherwise specified). Claims using this HCPCS code must include the name of the drug, the NDC number, and the number of tablets/capsules dispensed in the HAØ record of an electronic claim or attached to a hard copy claim. Claims using HCPCS code J8999 for drugs with NDC numbers that are valid for submission to the DMERC will be processed as return/reject claims.
**Levalbuterol**

Levalbuterol is the R-isomer of standard racemic albuterol, used as a beta-adrenergic bronchodilator administered through nebulizers. According to available literature, this form of albuterol has no clinically significant advantage over standard albuterol. Therefore, when billing for levalbuterol, use HCPCS codes J7618 or J7619, and payment will be based upon these HCPCS codes' billing units - per 1 mg.

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**Oral Antiemetic Drugs**

Effective for dates of service on or after October 1, 2000, claims for drugs which are addressed by the DMERC policy on Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) and which are dispensed by a physician must be submitted to the DMERC. Claims from physicians for these drugs with dates of service prior to 10/1/00 must continue to be submitted to the local carrier, regardless of the date of claim submission. Physicians must obtain a supplier number from the National Supplier Clearinghouse before they can submit claims to the DMERC. Refer to the DMERC policy for information on coverage and payment rules, coding guidelines, and documentation requirements.

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**Surgical Dressings - Hydrogel**

Three new HCPCS codes have been established for surgical dressings:

- **K0535** Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, without adhesive border, each dressing
- **K0536** Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
- **K0537** Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., without adhesive border, each dressing

These new K codes are effective for claims with dates of service on or after July 1, 2000. Currently the products that will be billed using these new K codes are coded using the hydrogel wound cover codes A6242-A6244; the A codes should continue to be used for claims with dates of service prior to July 1, 2000.

In the medical policy on Surgical Dressings, the definition of impregnated gauze dressings is modified as follows: Impregnated gauze dressings are woven or non-woven materials in which substances such as hydrogel, iodinated agents, petrolatum, zinc compounds, crystalline sodium chloride, chlorhexidine gluconate (CHG), bismuth tribromophenate (BTP), water, aqueous saline, or other agents have been incorporated into the dressing material by the manufacturer. HCPCS codes A6228-A6230 will continue to be used for gauze
dressings impregnated with water or normal saline. HCPCS codes A6222-A6224 will continue to be used for gauze dressings impregnated with substances other than water, normal saline, or hydrogel. Refer to the medical policy on Surgical Dressings for information on coverage and payment rules, coding guidelines, and documentation requirements. General coverage criteria for hydrogel dressings apply to these new codes. An amorphous hydrogel wound filler (A6248) or a hydrogel wound cover (A6242-A6247) used in the same wound at the same time as hydrogel-impregnated gauze dressings will be denied as not medically necessary. An appropriate wound cover (i.e., one which is appropriate for a wound with minimal or no exudate), other than a hydrogel wound cover, would be allowed in addition to impregnated hydrogel gauze.

SURGICAL DRESSINGS - COMPOSITE DRESSINGS

The 1999 HCPCS Update established HCPCS codes A6200-A6202 for composite dressings without an adhesive border. (These HCPCS codes are in addition to existing codes for composite dressings with an adhesive border, A6203-A6205.) As a result of this, the definition of composite dressings in the Surgical Dressings policy is modified to remove the requirement for an adhesive border for all composite dressings. The revised definition is: Composite dressings are products combining physically distinct components into a single dressing that provides multiple functions. These functions must include, but are not limited to: (a) a bacterial barrier, (b) an absorptive layer other than an alginate, foam, hydrocolloid, or hydrogel, and (c) either a semi-adherent or nonadherent property over the wound site.
Dear Physician:

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

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

While this may inconvenience physicians with additional paperwork, it is only through 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.

Paul D. Metzger, M.D.
Medical Director, Region C DMERC
Palmetto GBA
Columbia, SC
EXTERNAL INFUSION PUMPS

PHYSICIAN INFORMATION SHEET

This PHYIS has been revised from one originally issued in December, 1996. It contains the following important changes:

♦ Added coverage of epoprostenol sodium for the treatment of primary pulmonary hypertension or pulmonary hypertension which is secondary to a connective tissue disease;

♦ Added coverage of insulin infusion pumps and insulin administered through them as of 4/1/2000 for type 1 diabetics. For the purposes of this policy, type 1 diabetes mellitus is identified by a serum C-peptide level < 0.5 mcg/L.

See below for further details of coverage.

Coverage:

The Medicare benefit under which pumps are covered comes under the category of Durable Medical Equipment (DME). Medicare does not usually cover self-administered medications. However, the Durable Medical Equipment Regional Carrier (DMERC) does cover the use of external infusion pumps when they are medically necessary, and therefore, will also cover those medications administered through these pumps in the home setting only if strictly controlled infusion of the medication is medically necessary. Though a physician may order medication to be delivered through a pump, this alone will not suffice to justify Medicare coverage of the pump and medication. The primary criterion for coverage is the necessity of the pump, defined by the medication requiring strictly controlled infusion; once the pump's medical necessity is established, the medication is covered as a "supply" of the pump.

National HCFA policy has defined specific situations in which infusion pumps will be covered. The DMERC Regional Medical Review Policy (RMRP) on external infusion pumps incorporates National policy coverage criteria and further defines situations in which the medical necessity of strictly controlled infusion is established.

According to National Policy criteria the following situations requiring an external infusion pump are covered:

♦ Administration of deferoxamine for the treatment of chronic iron overload;

♦ Chemotherapy for the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable or where the patient refuses surgical excision of the tumor;

♦ Morphine when used in the treatment of intractable pain caused by cancer;

♦ Continuous subcutaneous administration of insulin through an external insulin infusion pump to a type 1 diabetic with further coverage criteria discussed below.

National policy explicitly excludes from coverage infusion pumps in the home setting used for:

♦ Heparin for the treatment of thromboembolic disease and/or pulmonary embolism;

DMERC RMRP lists additional coverage criteria based on two situations where strictly controlled infusion are considered a medical necessity:

(1) Where prolonged infusion time (greater than 8 hours per infusion) affords proven increased treatment efficacy over shorter duration infusions (which can be accomplished using bolus injections, gravity drip with calibrated controllers, or non-durable, disposable infusion systems, such as elastomeric pumps), or
(2) Where too rapid an infusion could be systemically harmful to the patient because of drug toxicity, unless strictly controlled by use of an infusion pump (as indicated in the Physician's Desk Reference, or the U.S. Pharmacopoeia Drug Information).

In all of the above situations, administration of a particular drug within the home setting must be reasonable, necessary and safe.

Some examples where drugs are covered, according to the above criteria are:

(A) The administration of cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin, vincristine or vinblastine by continuous infusion over at least 8 hours when the regimen is proven or generally accepted to have significant advantages over intermittent administration regimens. (Because National HCFA Policy supersedes DMERC RMRP, should chemotherapeutic regimens be used in the treatment of primary hepatocellular carcinoma or liver metastases from colorectal carcinoma, the regimen would not have to meet the test of proven increased efficacy over shorter duration protocols.)

(B) The administration of narcotic analgesics (except meperidine) in place of morphine to a patient with intractable pain caused by cancer who has not responded to an adequate oral/transdermal therapeutic regimen and/or cannot tolerate oral/transdermal narcotic analgesics. There are two types of morphine, that which is preservative-free, and that which contains preservatives. The preservative-free morphine is far more expensive and is only necessary for epidural infusions.

(C) The administration of foscarnet, amphotericin B, acyclovir and ganciclovir. Liposomal amphotericin B (J0286) is covered for patients who meet one of the following criteria:

1) The patient has suffered some significant toxicity that would preclude the use of standard amphotericin B and is unable to complete the course of therapy without the liposomal form, or

2) The patient has significantly impaired renal function.

(D) Administration of parenteral inotropic therapy, using the drugs dobutamine, milrinone and/or dopamine for patients with congestive heart failure and depressed cardiac function if a patient has all of the following conditions:

1) Dyspnea at rest despite treatment with maximum or near maximum tolerated doses of digoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g. hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and

2) Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):

   a) Dobutamine 2.5 - 10 mcg/kg/min
   b) Milrinone 0.375 - 0.750 mcg/kg/min
   c) Dopamine < 2 mcg/kg/min, and

3) Invasive hemodynamic studies performed within 6 months prior to the initiation of home inotropic therapy show (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b) at least a 20 % increase in CI and/or at least a 20 % decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion, and

4) An improvement in patient well being (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the treating physician at least monthly, and
5) In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in a hospital, or

In the case of intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and

6) Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and

7) The patient is maintained on the lowest practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first 3 months of therapy, and

8) The patient's cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the patient's medical record.

(E) Administration of parenteral epoprostenol sodium for patients with primary pulmonary hypertension (PPH) or pulmonary hypertension which is secondary to a connective tissue disease if the patient meets all of the following criteria:

1) Pulmonary hypertension is evidenced by a mean pulmonary artery pressure of greater than 25 mm Hg at rest, or greater than 30 mm Hg with exercise, in the absence of any clinically important left-sided cardiac valvular disease, myocardial disease, congenital heart disease, respiratory disease, or chronic thromboembolic disease, and

2) The patient has significant symptoms from the pulmonary hypertension (i.e., dyspnea on exertion, and either, fatigueability, angina, or syncope), and

3) A clinical trial of oral calcium channel blocking agents has been conducted or considered prior to long term commitment to chronic intravenous epoprostenol therapy.

(F) Administration of continuous subcutaneous insulin for the treatment of diabetes mellitus, type 1 (ICD-9 CM codes 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.41, 250.43, 250.51, 250.53, 250.61, 250.63, 250.71, 250.73, 250.81, 250.83, 250.91, 250.93), which has been documented by a serum C-peptide level < 0.5 mcg/L, if either of the following criteria (1) or (2) are met:

1) The patient has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e. at least 3 injections per day), with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria (a - e) while on the multiple injection regimen:

(a) Glycosylated hemoglobin level (HbA1C) > 7%
(b) History of recurring hypoglycemia
(c) Wide fluctuations in blood glucose before mealtime
(d) Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
(e) History of severe glycemic excursions

2) The patient with type 1 diabetes has been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.
For patients who have purchased an external insulin infusion pump prior to April 1, 2000, insulin and supplies used with the pump are covered during the period of covered use of the pump provided the patient is a type 1 diabetic as evidenced by a serum C-peptide level < 0.5 mcg/L.

Continued coverage of an external insulin pump requires that the patient be seen and evaluated by the treating physician at least every 3 months. In addition, the external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple patients on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

**External insulin infusion pumps for type 2 diabetics, including insulin-treated type 2 diabetics, will be denied as not medically necessary.**

**Equipment:**

When an infusion pump is covered, the drug necessitating the use of the pump and necessary supplies are also covered. When a pump has been purchased by the Medicare program, other insurer, or the patient, or the rental cap has been reached, the drug necessitating the use of the pump and supplies are covered as long as the coverage criteria for the pump continue to be met.

Disposable drug delivery systems, including elastomeric infusion pumps, are non-covered devices because they do not meet the Medicare definition of durable medical equipment. Drugs and supplies used with disposable drug delivery systems are also non-covered items.

All dressings and solutions used in the care of the infusion site, such as a peripheral or centrally inserted intravenous site, peripherally inserted central catheter (PICC), or an epidural catheter, are covered as a single kit per week during the time a pump is being used for medication infusions, as well as for the weeks between infusions, not to exceed four weeks at a time. Supplies should not be separately billed aside from the kit.

An administration kit includes all items associated with administration of the medication, including the cassette or bag which holds the medication, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges, and preparation charges. These items should not be separately billed aside from the administration kit. The number of administration kits covered is based on the number of cassettes or bags that are medically necessary to appropriately administer the medication.

**CMNs:**

For an item(s) to be considered for coverage and payment by Medicare, the information on the CMN or order submitted by the physician to the supplier must be corroborated by documentation in the patient's medical records that Medicare coverage criteria have been met. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records or records from other healthcare professionals.

The Certificate of Medical Necessity (CMN) for external infusion pumps is DMERC CMN 09 (OMB Form 851). Physicians are expected to review Section A of the CMN for accuracy of patient and physician name, address, physician identification number, etc.

He or she must complete or review for accuracy, answers to the questions # 1-7 in Section B, including the correct diagnoses codes, and estimated length of need. **Section B should not have been completed by the supplier of the items/supplies, nor should the physician sign an incomplete CMN.**

The physician should also examine Section C, to ascertain that only the equipment and supplies he or she has actually ordered are accurately listed, along with the charges associated with the pump, accessories, supplies, and drugs.
The physician attests to all of the above by signing and dating the CMN in **Section D.** Signature stamps are not to be used.

For external insulin infusion pumps, an ICD-9-CM diagnosis code (specific to the 5th digit), describing the condition which necessitates the pump, must be included on each order and CMN for the pump, insulin and/or supplies. On initial orders for external insulin infusion pumps, insulin and/or supplies, the results of the patient’s C-peptide level must be included.

If the infusion pump is being ordered for home infusion of dobutamine or epoprostenol extra documentation instructions are available from the supplier which will be necessary to assure proper claims adjudication for medical necessity.

Paul D. Metzger, M.D.
Medical Director, Region C DMERC
Palmetto GBA
Columbia, SC
EDI ADDRESSES CUSTOMER ISSUES

Palmetto GBA Electronic Data Interchange takes the issues customers mention in the annual Supplier Survey seriously. Customer input helps us to work toward continuous improvement of EDI products and services. Following are the issues most often mentioned in the 1999 Supplier Survey.

“**You need to update your electronic software.**”

All Medicare contractors are required to provide a basic low-cost software product to facilitate data entry of Medicare claims. The majority of submitters using such software are smaller companies, and many do not have the latest in computer technology available to them. For this reason, our product is a simple, no “bells and whistles” application that serves the needs of the majority of its users. Submitters with more complicated needs from their application software may wish to consult the Certified Vendor List compiled jointly by the four DMERCs. It is also important to understand that the implementation of the Health Insurance Portability and Accountability Act of 1996 will require substantial changes to all claims data entry software products, and contractors are already beginning to renovate their products. Palmetto GBA is working toward development of a state-of-the-art Web-based claims data entry product that will support all lines of Medicare business in the future.

“**Many times, Medicare will say no claim on file when transmission has been successful.**”

Palmetto GBA EDI has always tried to stress the importance of downloading and reviewing your Medicare error reports. Some vendor software programs, billing services and clearinghouses provide reports of their own creation to apprise users of a successful transmission. A successful transmission does not mean that any or all of the claims within that transmission have been accepted for adjudication. Suppliers should download and review their transmission error reports to determine claim acceptance or rejection. Accepted claims display claim control numbers (CCNs) and can be monitored through Claims Status Inquiry.

“**We have had a problem with our software, and no one informed us that our claims were not being sent electronically until I called to check on the status and found out.**”

If your claims were not actually sent, no one at Palmetto GBA would be aware of your attempts to submit them! This kind of problem may also occur when a provider uses a billing service or clearinghouse to submit claims. The claims may have been transmitted to the billing service, but not transmitted by the billing service to Palmetto GBA. Again, downloading and reviewing your Medicare error reports and using Claim Status Inquiry would let you know the day after your transmission whether or not your claims were received at Palmetto GBA.

“**There is no EDI representative who speaks Spanish.**”

Palmetto GBA EDI Operations is pleased to announce that we now provide bilingual support. Please apprise the Help Desk when you place your call that you would like to speak to a bilingual communications technician.
EDI ADDRESSES CUSTOMER ISSUES

“We are often referred to our software vendor, rather than Palmetto GBA fixing our problem.”

Palmetto GBA cannot fix problems in software that we did not develop or provide. Your software vendor has the expertise and responsibility to resolve your claim formatting and file transfer problems. Palmetto GBA EDI is happy to assist users in identifying EDI problems, and often works with software vendors to diagnose and resolve customer problems.

Were the responses to these customer issues helpful and informative to you? Do you have a question or comment about Palmetto GBA Electronic Data Interchange you would like addressed in a future Advisory? If so, please send your question or comment to:

Palmetto GBA Electronic Data Interchange
Department AQ
P.O. Box 100145, AG-420
Columbia, South Carolina 29202

CONTINUOUS PASSIVE MOTION (CPM)

Use of continuous passive range of motion machines (CPM) is covered by Medicare only after a total knee replacement. CPMs are not covered after any other type of knee or joint surgery. Coverage is limited to 21 days from the date of surgery, and the CPM must be applied within 48 hours of surgery to be eligible for Medicare coverage. The DMERC should be billed only for those days of CPM treatment after discharge from the hospital.

When billing for a CPM (HCPCs code E0935, passive motion exercise device), all of the following documentation must be included with the claim:

♦ type of knee surgery performed;
♦ date of surgery;
♦ date of application of CPM; and
♦ date of discharge from the hospital.

If any of these four facts are not documented, the claim will be denied for lack of medical necessity.

OUTSTANDING CHECKS

Effective immediately, Palmetto GBA will no longer reissue outstanding checks that are over a year old. To request the reissue of an outstanding check, please call your dedicated team at (803)691-4300.
# Overpayment Refund Form

**Use this form when sending Palmetto GBA, LLC unsolicited/voluntary refund checks:**

| To Be Completed by Palmetto Government Benefits Administrators, LLC |
|---|---|
| Date: | Date of Deposit: |
| Contractor Deposit Control Number: | |
| Contractor Contact Name: | Phone Number: |
| Contractor Address: | |
| Contractor Fax Number: | |

**To Be Completed by Provider/Physician/Supplier**

Please complete and forward to Palmetto Government Benefits Administrator, LLC at the address below. This form, or a similar document containing the following information should accompany every voluntary refund so that receipt of check is properly recorded and applied.

Provider Name:

Address:

Provider Number: 

Contact Person: 

Phone Number: 

Amount of Check: $

**Refund Information**

For each claim, provide the following:

**Patient Name:**

**Medicare Claim Number:** 

**HIC Number:** 

**Date(s) of Service:** 

**Claim Amount Refunded:** $

**Reason for Code Claim Adjustment:**

(Select reason from list below. Use one reason per claim.)

(Please list all claim numbers involved. Attach a separate sheet, if necessary.)

**Note:** If specific Patient/HIC/Claim Amount data is not available for all claims due to Statistical Sampling, indicate method and formula used to determine amount and reason for overpayment.

**For Institutional Facilities Only:**

Cost Report Year(s):

(If multiple years are involved, provide a breakdown by amount and corresponding cost report year.)

**For OIG Reporting Requirements:**

Do you have a Corporate Integrity Agreement with OIG? (circle one)

Yes  No

**Reason Codes:**

<table>
<thead>
<tr>
<th>Billing/Clerical Error</th>
<th>MSP/Other Payer Involvement</th>
<th>Miscellaneous</th>
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</thead>
<tbody>
<tr>
<td>01 - Corrected Date of Service</td>
<td>08 - MSP Group Health Plan Insurance</td>
<td>13 - Insufficient Documentation</td>
</tr>
<tr>
<td>02 - Duplicate</td>
<td>09 - MSP No Fault Insurance</td>
<td>14 - Patient Enrolled in an HMO</td>
</tr>
<tr>
<td>03 - Corrected CPT Code</td>
<td>10 - MSP Liability Insurance</td>
<td>15 - Services Not Rendered</td>
</tr>
<tr>
<td>04 - Not Our Patient(s)</td>
<td>11 - MSP Workers Comp. (Including Black Lung)</td>
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</tr>
<tr>
<td>05 - Modifier Added/Removed</td>
<td></td>
<td>17 - Other (Specify such as deductible not due, corrected billing, noncovered services, etc.)</td>
</tr>
<tr>
<td>06 - Billed in Error</td>
<td>12 - Veterans Administration</td>
<td>18 - Did not accept assignment</td>
</tr>
</tbody>
</table>

Mail this form with your check to:

Medicare DMERC Overpayment Department AG-342
Palmetto GBA, LLC
P.O. Box 100183
Columbia, S.C. 29202-3183
Suppliers may now have overpayments automatically offset by submitting the following Request for Offset form. This form should be submitted via facsimile to Palmetto GBA DMERC Overpayments Department at (803) 935-0072.

Submission of this form does not guarantee an offset will occur prior to interest being accrued. The amount offset depends upon suppliers’ outstanding payments in process.

For more information, call DMERC Overpayments Department at (803) 788-0222, extension 42907 or write to:

Part B/DMERC Overpayments Department  
P.O. Box 100183  
Columbia, S.C. 29202-3183

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**REQUEST FOR OFFSET**

Print legibly and complete all information.

To: DMERC Overpayments Department  
FAX: (803) 935-0072

Date: ____________________________

Supplier number: __________________________________________________________

FCN: ____________________________

Amount of overpayment: _____________________________________________________

Approved by: ____________________________
HCFA-1500 (12-90) forms submitted to the DMERC are scanned and imaged into the claims processing system. Here are a few tips to ensure that paper claims can be properly scanned:

♦ For best results, use a printer that produces dark, sharp print quality with font size 12.

♦ For best results, use standard, red HCFA-1500 (12-90) forms. Do not use photocopies.

♦ Do not type or write narrative next to an ICD-9-CM diagnosis code or HCPCS code.

♦ Ensure proper alignment of characters within each box.

♦ Follow the HCFA-1500 (12-90) instructions on the back of the form.

♦ Do not apply labels or text information at the top right hand corner of the claim form. This space is reserved for the bar code and claim control number (CCN).

♦ For best results, do not submit handwritten claims or partially handwritten claims. Handwritten claims are difficult to scan and may require special handling or additional review.

♦ Staple attachments behind the HCFA-1500 (12-90) form in the upper left-hand corner. Only one staple is needed; industrial staples can damage the document when removed.

♦ Write "continued" in Item-28 of each HCFA-1500 (12-90) form when a claim requires more than one HCFA-1500 (12-90) form. Write the claim total in Item-28 of the last form. This will ensure that forms will be processed as one claim.

♦ Claims consisting of more than 3-4 sheets of paper should be mailed in a large, flat envelope.

For additional questions regarding the submission of claims, please contact your dedicated work team at (803) 691-4300. For information on how to submit your claims electronically, please visit the EDI/Electronic Commerce section of our web site at www.PalmettoGBA.com, or contact the DMERC EDI Help Desk at (803) 788-9751.
Apartment/Suite/Unit Numbers in Address
If you are filling out a HCFA 855S application (for new location, re-enrollment, reactivation, etc) or mailing in correspondence, please include your apartment/suite/unit numbers, if applicable. Without this information, we cannot assure that you will receive important information.

Multiple Location Information
IMPORTANT NOTE TO SUPPLIERS: A supplier who has more than one location is not required to bill out of each location; however, the supplier MUST submit claims using the supplier number for the location where the service was rendered. If a supplier has two or more locations and all of the billing is filed from the main location, the supplier cannot bill under the "main" number. Supplier numbers are NOT billing-location specific, but supplier physical-location specific.

NSC Web page
Please note that the NSC web page address has changed from www.pgba.com to www.PalmettoGBA.com. You still must enter "Other Medicare Partners" before accessing the National Supplier Clearinghouse home page.

HCFA Update
Currently, we have no new information regarding the Proposed 20 Supplier Standards or the Surety Bond. The Standards may be finalized at any time; however, we do not expect to finalization of the Surety Bond until October of this year. Through our web site and mass mailings, the NSC will notify all suppliers once the changes receive final approval.

Changes of Information
Please notify the NSC of any changes (address, phone, ownership, etc.) within 30 days of the change.

To notify the National Supplier Clearinghouse of address changes, you have two options:

♦ Call our customer service lines at (803) 754-3951 and request a Change of Address form.


Other changes (except for ownership) can be requested on letterhead, signed by an authorized representative.

If you have any questions or comments, you can email them to medicare.nsc@PalmettoGBA.com or call our Service Center line at (803)754-3951.
NSC Update
Branch Locations

Do you have a branch location? Follow these easy steps to determine if you do:
1. Do beneficiaries call this location for service?
2. Does the location have its own business phone line?
3. Are supplies kept here for patient use?
4. Are patient records stored here?
5. Does this location have a sign outside?
6. Do you have a designated location manager at this site and/or full or part time employees?
7. Did this location have local, state or federal licenses issued to it?

If you answered “yes” to any of these questions, you MAY need to apply for a Medicare DMERC supplier number for that location. Some examples of locations that do not need separate numbers are warehouses used for supplies and central offices that only maintain records, but do not service beneficiaries. If you are unsure if your branch or satellite location will require a separate number, please call the NSC Customer Service Representatives at (803) 754-3951.

FDA Classification of Medical Devices

Medical devices vary widely and do not require the same degree of FDA regulation. Class I and certain Class II medical devices are exempt from FDA premarket notification and approval. However, all manufacturers of medical devices must comply with FDA “General Controls.” These controls include, in part, establishment registration and device listing.

Establishment registration is an annual process. The initial registration is submitted by the manufacturer using form FDA-2891 and annual renewal is completed on form FDA-2891A.

Device listing is filed using form FDA-2892. Device listing is a one-time filing completed prior to putting a medical device on the market. This is a separate filing and should not be confused with premarket notification. Device listing is required for each classification of medical device that the manufacturer produces.

For further information regarding device listing, please contact:

Division of Small Manufacturers Assistance (HFZ-220)
Office of Health and Industry Programs
Center for Devices and Radiological Health
Food and Drug Administration
1350 Piccard Drive
Rockville, MD 20850
Phone: (800) 638-2041 or (301) 443-6597  FAX (301) 443-8818

Additional information and a list of Class I and exempt Class II medical devices may be found at:

www.fda.gov
Select "Medical Devices/Radiological Health"
SADMERC REVIEW PROCESS

The function of the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) HCPCS Unit is to determine the appropriate HCPCS code to use when billing Medicare for durable medical equipment, prosthetics, orthotics and supplies.

The SADMERC conducts a review of all product literature received through written correspondence requesting HCPCS coding assistance. The Medicare HCPCS coding determination is based on submitted product literature, a previous review of the product, or a previous review of similar products. SADMERC will respond to the requestor in writing with the appropriate Medicare HCPCS coding determination. Please allow approximately 30 days for completion of the review.

Currently, there are nine product categories requiring specific documentation to complete a product review. This information includes, but is not limited to, FDA information, wholesale and retail costs, and date the item became available for sale on the US market. A complete list of the required documentation necessary for the review may be found on our web site at


or in the Spring 2000 DMERC Medicare Advisory. SADMERC will respond to the requestor in writing with the appropriate Medicare HCPCS coding determination. Please allow approximately 90 days for completion of the review. If additional information is required during the review, the time needed to complete the review may be extended.

The nine product categories requiring specific documentation are as follows:

- Enteral Nutrition
- Surgical Dressings
- Wheelchairs
- Wheelchair Cushions
- Support Surfaces
- Pneumatic Compressors/Lymphedema Pumps
- Nebulizer Compressors
- CPAPs And BiPAPs
- Walkers (E0147)

If you have any questions regarding product reviews, please contact the SADMERC at (803) 736-6809 between the hours of 9:00 AM and 4:00 PM, Eastern Time.

PROMPT INTEREST RATES

Prompt interest rates are established semi-annually by the U.S. Treasury Department and are effective January - June and July - December. For the latest prompt interest rate, please consult the following web site:

www.publicdebt.treas.gov/opd/opdprmt2.htm
Fee Update

Oral Anticancer Drug Fees

The following drug allowables are effective April 1, 2000, and are subject to change on a quarterly basis. Currently, these drugs meet the requirements for coverage under OBRA '93. Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

Unlike other drugs billable to the DMERC, these oral anti-cancer drugs are not submitted with HCPCS codes. Oral Anticancer drugs are billed using the National Drug Code (NDC) number.

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Second Quarter Drug Fee Update

The allowance for drugs is based on the National Average Wholesale Price (AWP) for all sources of the pharmaceutical. If more than one available source of a drug exists, 95% of the median of the national wholesale generic prices is used, unless a brand AWP is lower. If a generic source of a drug does not exist, 95% of the brand product with the lowest AWP is used to calculate the allowance. The fee changes are bolded.

The unit of measure for the fee amounts noted corresponds to the unit of measure noted in the descriptions published in the 2000 HCPCS coding manual. Please report the same unit of measure in the Days/Unit field (Item 24g) of the HCFA-1500 (12-90) claim form as is listed in your HCPCS manual. For example, if the HCPCS manual lists one unit as 50 mg, be sure to report 50 mg as one unit on the claim form. If you administered 100 mg, you would list two units on the claim form.
**SECOND QUARTER DRUG FEE UPDATE**

(continued)

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* Denotes new Drug

Note: The above drug allowables are effective April 1, 2000, and are subject to change on a quarterly basis.
Due to the variance in fees between Puerto Rico and a neighboring geographic location, i.e., the Virgin Islands, Palmetto GBA has reviewed the following HCPCS code:

L6872 Terminal device, hand, NYU child hand.

Our review indicates the base fee allowance for this HCPCS code was established using the gap-filled methodology due to insufficient historical claims data. Since the gap-filled data used by the previous carrier is inconclusive, to correct the variance in fees, Palmetto GBA will revise Puerto Rico’s base fee ($1760.00) for L6872 using the Virgin Island’s base fee ($732.54). The revised 2000 fee of $862.65 will be implemented July 1, 2000.

This change will affect allowances for beneficiaries residing in Puerto Rico only. If you have any questions regarding these changes or would like other fees to be reviewed, please send your inquiries to:

Palmetto GBA
Medicare Reimbursement
P.O. Box 100190, AG-311
Columbia, SC 29202-3190

Note: Fee reviews can be expedited more efficiently if supporting documentation is included with the request. Documentation must include, but is not limited to the following:

♦ Product Information (Manufacturer, Product Numbers, Description)
♦ Manufacturer Invoice
♦ Manufacturer Wholesale/Retail Price Lists
♦ Comparable Products

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**NEW HCPCS CODE ALLOWANCE**

Following are the 2000 fee schedule allowances for new HCPCS codes effective July 1, 2000. Inclusion or exclusion of a fee schedule amount or service does not imply Medicare coverage.

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</table>
It was brought to our attention that the fee for HCPCS code L2430 was established using the wholesale and not the retail price list. In examining this HCPCS code we decided to review the other sequence of “Addition to knee joint” HCPCS codes. The base fees for HCPCS codes L2405, L2415 and L2425 were initially gap-filled by the previous local carriers. The result of this review increased base fees for HCPCS code L2405 and L2430. The current fees for HCPCS codes L2415 and L2425 were found to actually reflect the cost of a pair of joints instead of per each joint, as described below. Therefore, the base fees for these two HCPCS codes will decrease.

In our Spring 2000 DMERC Medicare Advisory, we indicated that L2425 and L2430 would be limited to the L2415 allowance. We have since re-evaluated the complexity of each HCPCS code. As stated above, L2430 fees will increase; L2415 and L2425 will decrease.

Palmetto GBA will revise the year 2000 fees for all four HCPCS codes for claims with dates of service January 1, 2000 and after that are processed on or after July 1, 2000. The revised fees for these HCPCS codes were developed using available price lists.

♦ L2405  Addition to knee joint, drop lock, each joint
♦ L2415  Addition to knee joint, cam lock (Swiss, French, bail types) each joint.
♦ L2425  Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint.
♦ L2430  Addition to knee joint, ratchet lock for active and progressive knee extension, each joint

### Year 2000 Fee Revisions for L2405 and L2415

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YEAR 2000 FEE REVISIONS
L2405, L2415, L2425 AND L2430

(continued)

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If you have any questions regarding these changes, please send them to:

Palmetto GBA
Medicare Reimbursement
P.O. Box 100190, AG-311
Columbia, SC 29202-3190

Note: Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

YEAR 2000 FACIAL PROSTHESSES FEE SCHEDULE

Listed on the following page are Year 2000 fee schedules for the facial prostheses HCPCS codes. When a replacement prosthesis is fabricated starting with a new impression/moulage, use the KM modifier. When a replacement prosthesis is fabricated using a previous master model, use the KN modifier. When a replacement involves a new impression/moulage (KM) rather than use of a previous master model (KN), the reason for the new impression/moulage must be clearly documented in the supplier's records and be available to the DMERC on request. Please refer to your Region C DMERC DMEPOS Supplier Manual, Autumn 1998, Chapter 59, page 59.1 for the Facial Prostheses Policy.
Year 2000 Facial Prosthesis Fee Schedule

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HCPCS Codes A4232, E0784RR - Correction

The Spring 2000 DMERC Medicare Advisory, page 27, indicated that HCPCS codes A4232 and E0784 processed on or after April 1, 2000, for dates of service on or after January 1, 2000. Please note that these HCPCS codes are effective for dates of service on or after April 1, 2000, as indicated in the External Infusion Pump policy revision previously released.
Team Tips is a section created by your dedicated teams 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**: Reviews must be requested within six months of the date on the remittance notice.

**Team B**: Please remember that there are mandated payment floors for Medicare claims. The payment floor for EMC claims is 13 days and 26 days for paper claims. Submission of an EMC claim does not guarantee payment in 13 days, as HCFA guidelines give Palmetto GBA 30 days to process a claim.

**Team D**: A break in medical need is an end to the medical need of an item of DME. The break in medical need is a result of the beneficiary's condition improving and no longer needing the item. A break in medical need must be at least 60+ days for a new capped rental period to begin. A new rental period cannot be considered unless a) 60+ days have elapsed, b) evidence is provided on why the need stopped, c) evidence is provided on why a new period of medical need began.

**Team E**: Covered diagnoses for refractive lenses are limited to pseudophakia (ICD-9 V43.1), aphakia (ICD-9 379.31) and congenital aphakia (ICD-9 743.35). Lenses provided for other diagnoses will be denied as non-covered.

**Team F**: When filing claims for a new capped rental period after a break in medical need (60+ days), please provide evidence on why the need stopped and why the need started again. Clinical notes and physician statements are the most compelling justification. Beneficiary statements may also be provided.

**Team I**: Remember to use the revised oxygen CMN, HCFA 484 (11/99), with initial claims submitted on or after October 1, 2000.

**Team J**: Please remember to send your overpayment letters along with your payment to us to ensure accurate and timely posting to the correct provider and beneficiary.

**Team L**: Associates cannot provide initial dates of service to suppliers. That information is protected under the Privacy Act.

**Team N**: All documents received at Palmetto GBA are stamped with a “document control number” in the top right margin. Please leave at least a one-inch space to help ensure that your documents are processed correctly.

**Team P**: If you are having problems transmitting claims electronically, please contact EDI.

**Team S**: When filing claims for supplies or repairs for beneficiary-owned equipment, please remember to write “patient-owned equipment” on the HCFA-1500 (12-90) claim form or in the HA0 narrative record.

**Team U**: Please remember that associates cannot provide eligibility information. If you are a participating provider, you can obtain eligibility information via the VRU and CSI.

**Team W**: If revising a CMN to extend the length of need, the total length of need should be on the revised CMN, rather than just for the period it is being extended.
Team Y: When sending correspondence to the Medicare Secondary Payer Team, please use the following address:

Palmetto GBA
Medicare Secondary Payer Team
PO Box 100209, AG-530
Columbia, SC  29202-3209

Team MSP: Please remember that for all beneficiaries with insurance primary to Medicare, regardless of type (i.e., HMO, Group Health Plan, etc.), filing and/or documentation requirements for the primary insurance company must be followed. Failure to follow primary insurance filing/documentation requirements could lead to Medicare denial. If your claim is denied for this reason, you should appeal the primary insurance denial with the primary insurance company. Should the primary insurance company reverse its decision, you may refile with Medicare by submitting a new claim with the updated Explanation of Benefits.

Appeals Preparation: To request a Carrier Fair Hearing or an Administrative Law Judge (ALJ) hearing, please use the following addresses.

Hearing Request (The Review decision letter must indicate that the amount in controversy is at least $100):

Hearings Department
Palmetto GBA
PO Box 100249, AG-510
Columbia, SC  29202-3249

ALJ Request (The Hearing decision letter must indicate that the amount in controversy is at least $500):

ALJ Department
Palmetto GBA
PO Box 100106, AG-510
Columbia, SC  29202-3106

Data Entry: If you must handwrite your claims, please print instead of using cursive handwriting. When using type set, do not use a font less than 12.
## New Product Classification

The following are product classification additions for 2000:

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>HCPCS Code</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebulizer</td>
<td>Hi-Flow 70 Compressor with the PercussiveTech HF</td>
<td>VORTTRAN Medical Technology 1, Inc.</td>
<td>E1399</td>
</tr>
<tr>
<td>Pneumatic Compression Devices</td>
<td>651 Series</td>
<td>Thera-Con</td>
<td>E0651</td>
</tr>
<tr>
<td>Walkers</td>
<td>Merry Walker Ambulation Device (E0143 &amp; E0156 prior to 1/1/00)</td>
<td>Merry Walker Company</td>
<td>E0144</td>
</tr>
<tr>
<td></td>
<td>U-Step Walking Stabilizer (Model US-PC)</td>
<td>In-Step Mobility</td>
<td>E0147 &amp; E0156</td>
</tr>
<tr>
<td></td>
<td>Wenzelite SR 1000 Safety Roller</td>
<td>Wenzelite</td>
<td>K0459</td>
</tr>
</tbody>
</table>

## New Product Classification Correction

The following product was listed with an incorrect HCPCS code in the Spring 2000 DMERC Medicare Advisory:

<table>
<thead>
<tr>
<th>Product</th>
<th>Manufacturer</th>
<th>HCPCS Code</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteral Nutrients</td>
<td>XPHEN Maxamaid, Cat. IV</td>
<td>SHS</td>
<td>B4154</td>
</tr>
<tr>
<td><strong>SUPPLIER SANCTIONS</strong></td>
<td><strong>Alabama</strong></td>
<td><strong>Arkansas</strong></td>
<td><strong>Florida</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Darty, Gwendolyn W</td>
<td>Specialty: Social Worker</td>
<td>Martin, Frank</td>
</tr>
<tr>
<td></td>
<td>1017 Regal Dr. Mobile, AL 36609</td>
<td>Effective Date: 5/18/00</td>
<td>5704 Ridgeview Dr. Jonesboro, AR 72404-9043</td>
</tr>
<tr>
<td></td>
<td>Floyd, Reginald J. 3250 Doris Circle Montgomery, AL 36105</td>
<td>Specialty: Family Physician/General Practice</td>
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</tr>
<tr>
<td></td>
<td>Effective Date: 3/20/00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jenkins, David Richard 2119 East South Blvd. Montgomery, AL 36116</td>
<td>Specialty: Family Physician/General Practice</td>
<td></td>
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<tr>
<td></td>
<td>Effective Date: 12/20/99</td>
<td></td>
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<tr>
<td></td>
<td><strong>Arkansas</strong></td>
<td><strong>Florida</strong></td>
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<tr>
<td></td>
<td><strong>Florida</strong></td>
<td><strong>Florida</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABC Eureka Medical Rentals 1800 W 49th St, #115 Hialeah, FL 33016</td>
<td>Specialty: DME Company</td>
<td>Green Express Medical Equipment 855 East 10th Ave Hialeah, FL 33010</td>
</tr>
<tr>
<td></td>
<td>Effective Date: 5/18/00</td>
<td>Effective Date: 3/20/00</td>
<td>Effective Date: 3/20/00</td>
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<tr>
<td></td>
<td>Cole, Perry J. 1656 San Marco Blvd Jacksonville, FL 32207</td>
<td>Specialty: Family Physician/General Practice</td>
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<td>Effective Date: 3/20/00</td>
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<tr>
<td></td>
<td>Granda, Agustin F. 1450 S Bayshore Dr., #1911 Miami, FL 33131</td>
<td>Specialty: Family Physician/General Practice</td>
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<td>Effective Date: 12/20/99</td>
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<tr>
<td></td>
<td>Gibson, Geoffrey J. 1621 Gulf Blvd, #1605 Clearwater, FL 33767</td>
<td>Specialty: Osteopathic Practice</td>
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<td>Effective Date: 4/20/00</td>
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<tr>
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<td>Gomez, Gerardo 7818 Grand Canal Dr Miami, FL 33144</td>
<td>Specialty: DME Company</td>
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<td>Effective Date: 4/20/00</td>
<td>Effective Date: 4/20/00</td>
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<tr>
<td></td>
<td>Hosea, Claude Thomas 2543 Edgewater Ave New Smyrna Beach, FL 32168</td>
<td>Specialty: Medical Practice</td>
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<td>Effective Date: 4/20/00</td>
<td>Effective Date: 4/20/00</td>
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<td></td>
<td>Howard, Dawnne P. 2857 Alameda Del Norte Dr Eustis, FL 32726</td>
<td>Specialty: Pharmacy</td>
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<td></td>
<td>Effective Date: 4/20/00</td>
<td>Effective Date: 4/20/00</td>
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</tbody>
</table>
SUPPLIER SANCTIONS
(continued)

Medmaster Service, Inc.
19003 Sunlake Blvd.
Lutz, FL 33549
Specialty: DME Company
Effective Date: 12/28/99

Mucci, Julie Ann Haymaker
10463 Rosemount Dr
Tampa, FL 33624
Specialty: Pharmacy
Effective Date: 4/20/00

Y & I Rental Medical Equipment
2955 S W 8th St, #203-A
Miami, FL 33135
Specialty: DME Company
Effective Date: 4/20/00

Georgia

Blount, Ronnie
4582 Oxford Circle
Macon, GA 31210
Specialty: Medical Practice
Effective Date: 4/20/00

Dube, Philippe Abel
215 College St, S E
Edison, GA 31746
Specialty: Medical Practice
Effective Date: 4/20/00

Jaczynski, Daniel William
P O Box 469
Camilla, GA 31730
Specialty: Family Physician/
General Practice
Effective Date: 3/20/00

Martinez, Pamela M.
2062 Mulkey Rd.
Marietta, GA 30060
Specialty: Technician
Effective Date: 12/20/99

Nelson, Robert L.
2766 Graham Rd
Macon, GA 31201
Specialty: Family Physician/
General Practice
Effective Date: 3/20/00

Resource Mgmt Group Of S FL
2276 Ashley Wood Dr.
Tucker, GA 30084
Specialty: Consulting Firm
Effective Date: 3/20/00

Robinson, Kenneth E.
723 E Forsyth St.
Americus, GA 31709
Specialty: Family Physician/
General Practice
Effective Date: 3/20/00

Kentucky

Bohn, Ralph R.
11509 Shelbyville Rd.
Louisville, KY 40243
Specialty: Podiatrist
Effective Date: 5/18/00

Louisiana

Ayers, Stephen C.
4703 Taimer Lane
Lake Charles, LA 70605
Specialty: Family Physician/
General Practice
Effective Date: 3/20/00
SUPPLIER SANCTIONS

(continued)

Sulaiman, Ihab Tayseer
P O Box 5010
Oakdale, LA  71463

Specialty: DME Company
Effective Date: 4/20/00

Wilson, Richard E.
1931 Hwy 749
Opelousas, LA  70570

Specialty: Family Physician/
General Practice
Effective Date: 12/20/99

New Mexico

Maibenco, Thomas A.
8401 Spain, N E
Albuquerque, NM  87111

Specialty: Family Physician/
General Practice
Effective Date: 3/20/00

North Carolina

Gergen, David W
119 W Woodhill Dr.
Nags Head, NC  27959

Specialty: Podiatrist
Effective Date: 5/18/00

Mijanovich, James R.
2975 Jackson Grove Rd.
Columbus, NC  28722

Specialty: Medical Practice
Effective Date: 4/20/00

Puerto Rico

Farmacia Nuevo Modelo
Centro Comercial Herman
Bayamon, PR  00958

Specialty: Pharmacy
Effective Date: 3/20/00

Maldonado, Bernardo
Calle 20, Block 25, #26
Santa Rosa, PR  00659

Specialty: DME Company
Effective Date: 4/20/00

Rivera-Cruz, Carlos
Ave Lauro Pinero 205
Ceiba, PR  00735

Specialty: Family Physician/
General Practice
Effective Date: 12/20/99

South Carolina

Midlands Medical, Inc.
320 Governors Grant Blvd.
Lexington, SC  29072

Specialty: DME Company
Effective Date: 6/24/99

Tennessee

Denton, Stephen L.
P.O.Box 1208
Athens, TN  37371-1208

Specialty: Family Physician/
General Practice
Effective Date: 12/20/99

Gipson, Bruce M.
P.O. Box 809
Shelbyville, TN  37160

Specialty: Family Physician/
General Practice
Effective Date: 12/20/99
SUPPLIER SANCTIONS (continued)

Hawks, Charles Franklin
16 Field Chase
Jackson, TN 38305
Specialty: Family Physician/
General Practice
Effective Date: 3/20/00

Jones, Sherry R.
806 C Yeager Place
Lebanon, TN 37090
Specialty: Physical Therapist
Effective Date: 12/20/99

Meagher, Patrick A.
12116 W. Kingsgate
Farragut, TN 37922
Specialty: Physical Therapist
Effective Date: 12/20/99

Nunn, Craig R.
6428 Brownlee Dr
Nashville, TN 37205
Specialty: Family Physician/
General Practice
Effective Date: 3/20/2000

Sullentrap, Charles L.
3061 Altruria
Bartlett, TN 38134
Specialty: Technician
Effective Date: 12/20/99

Yood, Steven H.
4000 Anderson Rd., #21
Nashville, TN 37217
Specialty: Family Physician/
General Practice
Effective Date: 12/20/99

Texas

Guttierrez, Oscar V.
1502 Logan, Ste 104
Laredo, TX 78040
Specialty: Family Physician/
General Practice
Effective Date: 12/20/99

Holland, Quinton Demond
1503 Burleson (Non-Government)
San Antonio, TX 78202-1520
Effective Date: 12/20/99

Igbokwe, Ndubuisi A.
9700 Court Glen Dr., #3403
Houston, TX 77099
Specialty: Podiatrist
Effective Date: 12/20/99

Smythe, William R.
2110 Meadow Park Circle
Missouri City, TX 77459
Specialty: Family Physician/
General Practice
Effective Date: 3/20/2000

SUPPLIER REINSTATEMENT ACTIONS

Florida

Lauer, Michael S.
148 Serena Ct.
North Ft. Myers, FL 33903
Specialty: Family Physician
General Practice
Sanction Date: 12/20/98
Reinstatement Date: 11/26/99
<table>
<thead>
<tr>
<th>SUPPLIER REINSTATEMENT ACTIONS (continued)</th>
<th>Georgia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandford, Thomas C.</td>
<td>Specialty: Podiatrist</td>
</tr>
<tr>
<td>131 Memorial Dr.</td>
<td>Sanction Date: 11/18/92</td>
</tr>
<tr>
<td>Reidsville, GA 30453</td>
<td>Reinstatement Date: 3/13/00</td>
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<table>
<thead>
<tr>
<th>Kentucky</th>
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</thead>
<tbody>
<tr>
<td>James, Gary D.</td>
<td>Specialty: Osteopath</td>
</tr>
<tr>
<td>254 E Main St, 31</td>
<td>Sanction Date: 11/18/99</td>
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<tr>
<td>Cadiz, KY 42211</td>
<td>Reinstatement Date: 2/10/00</td>
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<tr>
<th>Mississippi</th>
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<tbody>
<tr>
<td>Anazia, Victor O.</td>
<td>Specialty: Pharmacist</td>
</tr>
<tr>
<td>300 Marion Ave, Ste C</td>
<td>Sanction Date: 8/16/89</td>
</tr>
<tr>
<td>McComb, MS 39648</td>
<td>Reinstatement Date: 2/01/00</td>
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<tr>
<th>North Carolina</th>
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<tbody>
<tr>
<td>Hogue, Arquita Lynette</td>
<td>Specialty: Therapist</td>
</tr>
<tr>
<td>1122 Shroyer Circle</td>
<td>Sanction Date: 8/10/94</td>
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<tr>
<td>Jacksonville, NC 28540</td>
<td>Reinstatement Date: 11/02/99</td>
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<tr>
<td>Mays, Fredrick A.</td>
<td>Specialty: Pharmacist</td>
</tr>
<tr>
<td>12007 Fox Glen Rd.</td>
<td>Sanction Date: 10/26/88</td>
</tr>
<tr>
<td>Charlotte, NC 28269</td>
<td>Reinstatement Date: 4/12/00</td>
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<table>
<thead>
<tr>
<th>South Carolina</th>
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<tbody>
<tr>
<td>McDonald, Victoria Mosely</td>
<td>Specialty: Family Physician/ General Practice</td>
</tr>
<tr>
<td>1 Kirk Court</td>
<td>Sanction Date: 6/17/99</td>
</tr>
<tr>
<td>Bluffton, SC 29910</td>
<td>Reinstatement Date: 2/08/00</td>
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<tbody>
<tr>
<td>Douglas, Howard Thomas III</td>
<td>Specialty: Family Physician/ General Practice</td>
</tr>
<tr>
<td>1922 S Buckner St.</td>
<td>Sanction Date: 9/20/98</td>
</tr>
<tr>
<td>Dallas, TX 75217</td>
<td>Reinstatement Date: 11/05/99</td>
</tr>
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</table>
OMBUDSMEN ADDRESSES AND THEIR TERRITORIES

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

Arkansas/Oklahoma
Eric Kast
P.O. Box 720313
Norman, Okla. 73070
(405) 292-8234

Colorado/New Mexico
IN THE INTERIM CONTACT
Teresa Camfield
P.O. Box 436767
Louisville, Ky. 40253-6767
(502) 254-5011

Florida (south)
(covers the southern portion of Florida to include Manatee, Hardee, Highlands, Okeechobee and Indian River counties, and all points south)
Teresita Ortiz
PMB 220
1253 University Drive
Coral Springs, FL 33071
(954) 757-3925

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
IN THE INTERIM CONTACT
Dana Carnish
P.O. Box 100141
Columbia, S.C. 29202-3141
(803) 735-1034, Ext. 35781

Kentucky
Teresa Camfield
P.O. 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 Brigman
P.O. Box 97424
Raleigh, N.C. 27624-7424
(919) 846-3552

Out of Region C
Dana Carnish
P.O. Box 100141
Columbia, S.C. 29202-3141
(803) 735-1034, Ext. 35781

Puerto Rico/Virgin Islands
Adie Fuentes
PMB 50
53 Ave. Esmeralda
Guaynabo, P.R. 00969-4429
(787) 782-0544

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

Tennessee
Ronja Fayne
53411 Mt. View Rd., Suite 122
Antioch, Tenn. 37013
(615) 717-0840

Texas (south)
(covers the southern portion of Texas to include El Paso, Seminole, Abilene, Austin, San Antonio, Corpus Christi, and all points south and Temple, Killeen and Waco)
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, Dallas, Amarillo, and all points north)
Peggy Miller
2601 Cartwright Rd., Suite D392
Missouri City, Texas 77459
(281) 416-9688

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

Please retain this list as your new DMERC telephone directory.

### Palmetto GBA contacts

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-Fraud Unit</strong>&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>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
<td>(803) 691-4300</td>
</tr>
<tr>
<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

<table>
<thead>
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<th>Mailing Address</th>
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<tbody>
<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>
</tr>
<tr>
<td><strong>Region A DMERC</strong></td>
<td>(570) 735-9445</td>
</tr>
<tr>
<td><strong>Region B DMERC</strong></td>
<td>(317) 577-5722</td>
</tr>
<tr>
<td><strong>Region D DMERC</strong></td>
<td>(615) 251-8182</td>
</tr>
<tr>
<td><strong>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)</strong>&lt;br&gt;Palmetto GBA&lt;br&gt;17 Technology Circle&lt;br&gt;Columbia, S.C. 29203</td>
<td>(803) 736-6809</td>
</tr>
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</table>