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Meet Your DMERC at Medtrade in New Orleans

Are you going to Medtrade in New Orleans? If so, please stop by booth number 133 to meet representatives from the four DMERCs, EDI and NSC. Please plan to join us on Thursday, October 25 from 8:00 to 9:00 a.m. at the Meet the DMERCs session where you will receive the latest DMERC information.

Commentary and suggestions are welcome. Please direct them to Communications Specialists in the Professional Relations Department at the address listed above.
OSTOMY POLICY REVISED

Included in the Region C DMERC DMEPOS Supplier Manual update is a revision to the Ostomy policy. Revisions include updates to HCPCS codes since the policy's last publication, definitional changes to help with clarity, and inclusion of material from various previously published bulletins.

HOSPITAL BEDS POLICY REVISED

A revision, with consolidation of the DMERC policies for all types of hospital beds and their accessories, is published in the accompanying Region C DMERC DMEPOS Supplier Manual update. The revisions involve HCPCS coding guidelines and the newer HCPCS codes for heavy duty and extra heavy duty beds. In the last DMERC Medicare Advisory was a summary of the hospital bed HCPCS codes and a history of their previous or current valid dates for billing to the DMERC.

GROUP 1 PRESSURE REDUCING SUPPORT SURFACES POLICY - REVISION

Included in the accompanying Region C DMERC DMEPOS Supplier Manual update is a revision to the Group 1 Pressure Reducing Support Surfaces regional medical review policy. This policy revision incorporates a recent coverage determination by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) that reclassified synthetic sheepskin pads and lambs wool sheepskin pads (HCPCS codes E0188 and E0189, respectively) as durable medical equipment and placed them in the inexpensive or routinely purchased payment category. Effective for dates of service on or after January 1, 2001, HCPCS codes E0188 and E0189 will be given coverage consideration by the DMERC.

As noted in the Summer 2001 DMERC Medicare Advisory, CMS instructions included a directive to the DMERC not to process previously denied claims unless requested by the supplier. Therefore, suppliers with claims for HCPCS codes E0188 and E0189 with dates of service on or after January 1, 2001 that have previously been denied should request adjustments for those claims. Claims submitted for adjustment must comply with the requirements outlined in the Group 1 Pressure Reducing Support Surfaces RMRP. Do not simply resubmit the claim. Resubmitted claims will be denied as duplicates.

VOICE AMPLIFIERS COVERED BY MEDICARE

The Centers for Medicare and Medicaid Services (CMS) has determined that voice amplifiers used for beneficiaries with impaired function of their larynx (which is still present) are eligible for coverage by Medicare. This decision is retroactive, and therefore applies to any dates of service on which these items were/are provided.

When billing for these items use HCPCS code L8499 (Unlisted procedure for miscellaneous prosthetic services), and include the name, model number and manufacturer of the device.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Because a voice amplifier is not the same as a voice prosthesis, do not use the HCPCS codes that describe an artificial larynx (HCPCS code L8500), or tracheostomy speaking valve (HCPCS code L8501).

Effective for dates of service on or after October 1, 2001, a new DIF will no longer be required when a new drug is added to or replaces an existing drug in a beneficiary's immunosuppressive drug regimen or if an immunosuppressive drug's HCPCS code changes. This applies to beneficiaries who are currently receiving medications covered under the Medicare immunosuppressive drug benefit.

For additional details on the Coverage and Payment rules, Coding Guidelines and Documentation requirements, refer to the regional medical review policy on immunosuppressive drugs in the Region C DMERC DMEPOS Supplier Manual.

Measurement of oxygen saturation in the capillary blood using an oximeter is an option for documenting medical necessity of home oxygen and respiratory assist devices. Suppliers are reminded that in order to be considered acceptable documentation, this test must be performed by a Medicare-approved provider.

A Medicare-approved provider may be a physician, hospital, nursing facility, home health agency, laboratory, or independent diagnostic testing facility (IDTF) that is enrolled with a local carrier, local intermediary, or regional home health intermediary (RHHI). Entities that just perform the technical component of a test (e.g., providing the oximeter for home sleep studies) which is then purchased by a physician and billed by the physician to the local carrier must also be an enrolled Medicare provider - even though they will not bill Medicare directly.

In addition, in order to be considered acceptable documentation, the test may not be performed by a DMEPOS supplier or anyone financially associated with or related to the supplier.

The Medicare allowance for a POV includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc. When these items are provided at the time of initial issue, they must not be billed separately. Medically necessary replacement accessories for beneficiary-owned POVs meeting Medicare coverage criteria are separately payable. Effective for claims with dates of service on or after January 1, 2002, a replacement item for a beneficiary-owned POV, including but not limited to replacement batteries, should be billed using the specific wheelchair option or accessory HCPCS code if one exists. (Refer to the Wheelchair Options and Accessories medical policy in...
POWER OPERATED VEHICLES (POVs) - OPTIONS AND ACCESSORIES cont.

the Region C DMERC DMEPOS Supplier Manual for a list of specific HCPCS codes. If a specific HCPCS code does not exist, use HCPCS code K0108 (wheelchair component or accessory, not otherwise specified). Do not use HCPCS code E1399 for miscellaneous replacement POV accessories.

BIOFEEDBACK FOR URINARY INCONTINENCE

In a recent National Coverage Determination published in the Medicare Coverage Issues Manual, Section 35-27.1, coverage criteria are defined for biofeedback therapy for the treatment of urinary incontinence. The policy specifies that coverage can be considered when the therapy is rendered by a practitioner in an office or other facility setting. The policy specifically states that home use of biofeedback therapy for urinary incontinence is not covered. Biofeedback devices for home use for the treatment of urinary incontinence will be denied as not medically necessary.

If these devices are provided for home use, they must be billed to the DMERC using HCPCS code E1399 - durable medical equipment, miscellaneous. The claim should include the manufacturer and brand name/number of the device and information describing the condition for which it is being used. This information should be entered in the HAØ record of an electronic claim or attached to a paper claim.

Physicians and suppliers should refer to information published by their local carriers and intermediaries for details concerning coding and coverage of biofeedback therapy in the office or other facility setting.

Medicare does cover home use of non-implantable pelvic floor electrical stimulators (PFES) (HCPCS code E0740) for the treatment of urinary incontinence. See the article in the Spring 2001 DMERC Medicare Advisory for additional information about PFES devices.

SPEECH GENERATING DEVICES POLICY - CORRECTION

In a recent Region C DMERC DMEPOS Supplier Manual update, the regional medical review policy on speech generating devices (SGDs) was published. In the Coding Guidelines section, there is a typographical error. The coding of mounting systems should read "Mounting systems necessary to place the SGD devices, switches and other access devices within reach of the patient must be coded K0546" and not K0547 as published. Please make a note of this change. The DMERCs will incorporate this correction in this revision of the SGD policy.
**DMERC Region C Physician Information Sheet (PHYS):**

**The Purpose and Value of Physician Documentation for DME**

**Why Should a Physician Care About Completing Documentation for DME Suppliers?**

Many physicians by now realize that the Durable Medical Equipment Carriers (DMERCs) do not interact directly with physicians and other health care providers. Whereas physicians bill and receive payment from local Part B Medicare carriers for their services to Medicare patients, the DMERCs are responsible for processing the claims of suppliers of durable medical equipment (DME), prosthetics, orthotics, and miscellaneous supplies used by Medicare beneficiaries within their homes and (in some cases) nursing homes.

With so many requests for the busy physician to complete forms, why should physicians bother with documentation needed for DME suppliers' bills and payment? There are several reasons, the most primary of which is the benefit of their patients. If a supplier cannot obtain adequate physician documentation to assure payment for goods and services delivered in good faith to patients, based upon the orders of physicians, claims are denied and the patient must ultimately bear the financial responsibility for DME, which is not inexpensive.

Physicians have been trained to write sufficiently detailed documentation and orders for pharmaceuticals. Pharmacists bill Medicare for medications that are covered by the Medicare program. Why should physicians' approach to pharmaceuticals be any different than for DME, which can be just as critical for the function and benefit of their Medicare patients? One reason is that, traditionally, physicians are better educated in pharmacology than in the technological details of DME. However, that should be all the more reason for physicians to be receptive to information suppliers offer concerning equipment the physician is authorizing.

In the dialogue between the supplier and physician about the technological distinctions among various items of DME and their accessories, the supplier may also indicate Medicare's coverage criteria upon which payment is based, as well as necessary documentation requirements, some of which are incumbent upon the physician ordering DME.

As with all aspects of medical care, documentation of medical necessity is critical. Medicare accounts for expenditures based on that documentation. There are basically two sources of medical necessity documentation upon which the DMERCs rely to justify payment for DME: the patient's medical record and Certificates of Medical Necessity (CMNs).

**CMNs:**

When required, suppliers submit CMNs with their Medicare claims to the DMERC. Given that the DMERC must somehow ascertain that it is appropriately reimbursing Medicare funds for needed equipment, the CMN offers many advantages that may not be apparent to the physician, who might view it as being a redundant document.

- **Aid to the DME Supplier:** A physician relies upon pharmacists as part of the health care team to service the patient. In like manner, s/he depends upon suppliers to furnish needed supplies and equipment, fulfilling critical logistical needs of the patient outside of health care facilities. It is suppliers who deliver needed items such as oxygen, beds, mobility aids, intravenous medications, and enteral and parenteral nutrition. It is suppliers who service what they deliver, educating the patient in its use, facilitating discharges from hospitals, etc. While the supplier exerts efforts to educate the physician as to when and if Medicare will pay for ordered equipment, s/he also needs reassurance that the physician's records confirm that the patient's condition meets coverage criteria for payment of that same equipment. If lacking, it is the supplier who is at risk for returning Medicare funds, even though s/he delivered goods and services in good faith based upon a physician order.

- **An Efficient, Consistent Payment Tool:** In addition to requested diagnosis codes, the CMN poses a
minimum of "yes / no" medical necessity questions addressing the functional status of the patient, helping to determine that payment may be made. The short set of responses allows for automated and rapid claims processing, with increased consistency of claims adjudication.

- **A Physician Educational Tool:** The CMN is the only direct interface between the physician and the DMERC. Just as with other continuing medical education (CME) instruments, the brief series of questions in CMN Section B directs the physician's attention to aspects of the patient's condition that are pertinent to Medicare's coverage criteria for that equipment. Suppliers are encouraged to have dialogue with physicians based upon DMERC medical policy, explaining the technical distinctions in the equipment and Medicare's reimbursement criteria. The CMN's questions reinforce this information by confirming the patient's qualifications for reimbursement.

**The Patient's Medical Record:**

As in every other area of medicine, the patient's medical chart, including the physician's progress notes, laboratory and other entries, is the definitive repository of the patient's documented medical condition. Physicians are taught, "If it isn't documented in the chart, it never happened." The CMN is a prepayment tool that eliminates for most situations, the need for the DMERC to refer to the patient's chart for every claim submitted. Its virtues of succinctness, efficiency, consistency and educational feedback are listed above. However, when it becomes necessary to corroborate the CMN responses, the DMERC may need to obtain portions of the patient's medical chart relevant to the DME in question, including diagnostic and treatment information pertaining to that equipment.

When the patient signs the Medicare claim form, s/he agrees to release information to the DMERC to assure that items and services are medically necessary. The supplier may request copies of these portions of the chart from the physician. Please cooperate with the supplier, as it is s/he who is at financial risk if medical necessity cannot be established or corroborated.

It is certainly appropriate for the supplier, as a member of the health care team, to receive and convey to the DMERC those portions of the physician's chart dealing with furnished equipment. Furthermore, the DMERC follows stringent procedures to ensure the confidentiality of any requested medical records.

Hopefully, this explanation of the important role of the physician in providing critical medical necessity documentation for patients' equipment will encourage the physician's cooperation in this endeavor.

Paul D. Metzger, M.D.
Medical Director
Region C DMERC
Palmetto GBA
Columbia, S.C.
Every year Palmetto GBA strives to meet the challenges of balancing supplier needs with budget limitations. The new fiscal year is no exception. Effective October 1, 2001, Region C will charge a fee to recoup costs for ombudsman visits to supplier offices. The fees will be reasonable, designed only to cover actual costs of travel. Region C suppliers enjoy a distinct benefit: local ombudsmen to educate, train and troubleshoot for them. We encourage you to continue taking advantage of these unique visits.

To appeal initial determinations of Medicare claims, suppliers should use either of the two forms listed below to request a review. They should complete the form in its entirety and mail it to their Palmetto GBA dedicated work team within six months of the date on their remittance notice.


Suppliers and other authorized parties should submit any additional documentation with the request to support the contention that the initial determination was incorrect under Medicare coverage and payment policies.

Review requests received by Palmetto GBA that do not meet these guidelines will be returned to sender.

For an item(s) to be considered for coverage and payment by Medicare, the information submitted by 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. This documentation must be available to the DMERC upon request.
Diabetes Outpatient Self-Management Training is now a covered Medicare service for a wider variety of Medicare providers/suppliers. To qualify for payment under this benefit, the supplier of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must first be enrolled in the Medicare program and currently eligible to receive reimbursement for Medicare-covered services. All suppliers must meet the American Diabetes Association's (the successor to the National Diabetes Advisory Board) National Standards for Diabetes Self-Management Education Programs that was published in Diabetes Care, Volume 23 Number 5. If you are a DMEPOS supplier that wants to receive Medicare reimbursement for diabetes education, and meet the above qualification, you should contact the local Medicare carrier who services your area. See http://www.hcfa.gov/Medicare/incardir.htm to determine the local carrier for your area. The carrier will require you to submit a completed Form HCFA-855, along with your ADA recognition certificate. After it has been determined that you meet the quality standards, you will be sent your billing number. Once you have received your billing (PIN) number, you can begin receiving reimbursement for this service.

In order to more accurately adjudicate claims for refractive lenses, it is necessary to document the date(s) of cataract surgery on the HCFA-1500 (12-90) claim form. The surgery date must be entered in Item 19. Claims received without dates of cataract surgery included on the claim will be denied for lack of sufficient documentation. Suppliers filing EMC may enter the surgery date information in the HAØ record.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
**CAPPED RENTAL PURCHASE OPTION**

The capped rental purchase option is a binding agreement between the beneficiary and the supplier. Once the decision is made to rent or purchase the equipment, the decision cannot be changed by either party. Beneficiaries have one month from the date the supplier makes the offer to make their decision and notify the supplier.

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**NSC SUPPLIER STANDARD REMINDER**

Standard 18 (of the new 21 Supplier Standards) says, in short, "A supplier must not convey or reassign a supplier number, i.e., the supplier may not sell or allow another entity to use its Medicare billing number."

Standard 2 states, "A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days."

Regardless of the terms of the sale of a company, a supplier number can never be sold or transferred from one company to another. When a person or company purchases the business, a new supplier number must be assigned. The supplier who is selling his/her business must notify the NSC within 30 days of the sale that the business has been sold. Currently, the supplier may send a letter to the NSC with the appropriate signature, informing them of the sale of the business. (Note: The signer of this letter must be one of the individuals on file with the NSC as authorized signers. Company officials should review their copy of the last HCFA-855s form sent to the NSC to verify who is officially listed as authorized signers.) By the end of 2001 when the new HCFA-855s application form is completely rolled out, all suppliers must fill out the appropriate parts of the new HCFA-855s form along with the appropriate signature when they sell their business. A letter will no longer be accepted. The new form will be used for changes as well as enrollments and re-enrollments.

The new owners purchasing a business must complete a new HCFA-855s application form and send it to the NSC within 30 days of the sale. Along with all of the appropriate licenses and other required attachments, they should include the bill of sale. If the bill of sale is attached, their new supplier number will be retroactive to that date of sale. If there is no bill of sale attached, the NSC will regard this as a brand new business and the effective date of the supplier number will be the date that the number is assigned to that supplier. It may take eight to 12 weeks to process the application. Therefore, it behooves the new owner to attach the bill of sale since s/he cannot provide services to Medicare beneficiaries without filing claims for those services, and s/he cannot bill if the number is not in effect.

Q. Why can’t the SADMERC give me the replacement HCPCS code for a deleted one without verification of product information?
A. SADMERC has the responsibility of accurately coding products billed to the DMERCs based on the description of the product or a previous review of the product.

Q. How do I determine if a HCPCS code requires modifiers?
A. The fee schedule lists pricing categories and modifiers. Some policies require specific modifiers to indicate certain information such as required documentation on file, functional level, or number of wounds dressed. This information can be found under the heading “HCPCS Modifier” in these policies. Additional information regarding modifiers and their verbiage can be found in Chapter 68 of the Region C DMERC DMEPOS Supplier Manual.

Q. Why can’t I get a HCPCS code for an item that is not billable to DMERC? What does “not billable to DMERC” mean?
A. The SADMERC is responsible for the coordination of all HCPCS coding activities for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) used in the patient’s home. SADMERC does not code items billable to Medicare Part A or to Medicare Part B (Local Carrier).

Q. Why can’t SADMERC give me a diagnosis code?
A. The function of the SADMERC is to code DMEPOS used in the patient’s home. SADMERC does not give diagnosis codes. Please refer to the patient’s physician for assistance in using the correct diagnosis code for the patient’s condition.

Q. What do you mean when you say, “the product needs to be reviewed?”
A. The SADMERC, in conjunction with the four Durable Medical Equipment Regional Carriers (DMERCs), conducts a HCPCS Coding Verification Review to determine appropriate HCPCS coding for the following categories: enteral nutrition, surgical dressings, wheelchairs, wheelchair cushions, support surfaces, pneumatic compressors/lymphedema pumps, nebulizers, walkers (HCPCS code E0147), thoracic lumbar supports (TLSOs), CPAP systems and respiratory assist devices. The manufacturer must submit the information required for this review. To access the application format for a HCPCS Coding Verification Review, visit the Palmetto GBA Web site at www.PalmettoGBA.com. Select Other Partners/ SADMERC/Product Classification Lists.

Q. Why can’t SADMERC provide allowables for all HCPCS codes?
A. SADMERC cannot answer pricing questions for HCPCS codes that are individually considered, priced by reasonable charge,
Effective for services furnished on or after January 1, 2002, suppliers will use modifier "QV" to identify and report routine care for Medicare qualifying clinical trial services. The reporting of diagnosis code V70.5 as a secondary diagnosis on the HCFA-1500 (12-90) claim form will no longer be required for dates of service on or after January 1, 2002. For dates of service on or after January 1, 2002, the QV modifier constitutes the biller's attestation that a service, supply or equipment meets the Medicare qualifying coverage criteria for clinical trial services processed by carriers and DMERCS.

EXCEPTION: Routine care clinical trial services furnished on or after January 1, 2002 to healthy, control group volunteers participating in Medicare qualifying diagnostic clinical trials are to be coded and billed in the following manner:

- The "QV" modifier is reported at the line item level.
- Diagnosis code V70.7 (Examination of participant in clinical trial) is reported as the primary diagnosis for applicable line items on the HCFA-1500 (12-90) claim form.

When submitting claims for routine items and services furnished in qualifying clinical trials, the billing provider should include information in the beneficiary’s medical record about the clinical trial such as: the trial name, sponsor and sponsor-assigned protocol number. This information should not be submitted with the claim but should be provided if requested for medical review. A copy of routine items and services should also be made available if requested for medical review activities.

Q. What should I do if SADMERC says a HCPCS code is valid, but DMERC says it is not?
A. It is the responsibility of the SADMERC to code using valid HCPCS codes. If there is a conflict in coding information, please refer the matter to a DMERC supervisor. It would be beneficial to have the names of any associates with whom you have spoken.
REMITTANCE ADVICE REMARK CODES

UPDATED APRIL 12, 2001

Included in the accompanying Region C DMERC DMERPOS Supplier Manual Update is a revision to the remittance ANSI remark codes.

As the initial user of 835 remark codes, HCFA became the de facto maintainer of this code set with ASC X12N approval. Since HIPAA applies to virtually all U.S. health care payers, and will result in much more extensive use of the 835 format, many payers other than Medicare will also begin to use remark codes. Remark code wording must be generic. Language referring to Medicare as the source of decisions in many remark code messages has been replaced by references to "we." Since the remittance advice identifies the issuer (Medicare for a claim processed by a carrier or DMERC), the meaning is the same. Existing message numbers have also stayed the same.

Remark codes are used in a remittance advice to relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by CMS, but may be used by any healthcare payer when they apply. Medicare contractors may use their discretion to determine when certain remark codes apply to a payment decision, but a Medicare contractor must report any remark codes that do apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version. To eliminate duplication, the following remark code messages have been made inactive and should no longer be used effective with implementation of version 4010 of the X12 835: M34 (duplicates MA120), M72 (duplicates MA52), MA05 (information included in MA30, or MA40 or MA43), N41 (duplicates reason code 39), and N44 (duplicates reason code 137).

Rather than renumber existing M (prior service level) and MA (prior claim level) codes, and possibly confuse providers, "old" code numbers have been retained. All new post-consolidation remark codes, however, will begin with an N. The "N" is used to quickly differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in the X12 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable.

Due to the growing number of remark codes, the codes have been classified according to subject matter to make it easier to locate particular remark codes. Some codes are listed under multiple classes. Class does not have any bearing on remark code identifiers, however. No intelligence is built into the number issued a remark code.

 Remark Code Changes/Additions

The following M codes contain changes or are new since release of the October 1998 version of this list: M51, M109, M110, M116, M118, M120-M144. Codes M122-137 are substitutes for the D series reason codes, which will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D1-15 will be conveyed with reason code 16 and the appropriate remark code. The information in D98 will be conveyed with reason code 96 and remark code M137.
**Remittance Advice Remark Codes**

The following MA codes have changed or been added since release of the October 1998 version of this list: MA06, MA44, MA52, MA118, MA119, MA125, MA130-MA134.

Codes MA131 and 132 are substitutes for the D series reason codes D97 and D99 which will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D97 and D99 will be conveyed with reason code 96 and the applicable remark code.

The following N codes have been changed or added since October 1998: N3, N10, N16 ff.

**Remark Code Classifications:**

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.

**Remittance Advice Remark Codes**

| Missing/ Invalid Information Remarks | MA68, MA69, MA70, MA71, MA75, MA76, MA81, MA82, MA83, MA85, MA86, MA87, MA88, MA89, MA90, MA92, MA94, MA95, MA96, MA97, MA98, MA99, MA100, MA102, MA104, MA105, MA107, MA108, MA110, MA111, MA112, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA128, MA129, MA130, MA134, N3, N4, N5, N8, N21, N24, N26, N27, N28, N29, N31, N33, N34, N37, N38, N39, N40, N42, N46, N49, N50, N51, N53, N54, N56, N57, N60, N64, N65, N66, N75, N76, N77, N78, N80, N81 |

**Fee Updates**

**Oral Anti-Cancer Drugs**

The following drug allowables are effective July 1, 2001, and are subject to change on a quarterly basis. Currently, these drugs meet the requirements for coverage under OBRA '93.

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

Changes to the Average Wholesale Price (AWP) sources for temozolomide resulted in fee changes.

The fees are as follows:

<table>
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<th>Drug Name</th>
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<th>7/1/2001 Per Tablet Fee</th>
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<td>Cyclophosphamide</td>
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<td>Melphalan</td>
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<tr>
<td>Methotrexate</td>
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<td><strong>$6.05</strong></td>
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<td>Temozolomide</td>
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<td><strong>$302.44</strong></td>
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Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.
**FEE UPDATES**

**Third 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 code descriptions published in the 2001 HCPCS coding manual. Please be sure to 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.

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<th>Region C</th>
<th>HCPCS Code</th>
<th>Region C</th>
<th>HCPCS Code</th>
<th>Region C</th>
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</tr>
</tbody>
</table>
Dana Causey, the ombudsman for Southwest Texas, has changed her business address and telephone number. Her new address is:

PMB 302
2935 Thousand Oaks Suite 6
San Antonio, TX  78247-3312

Her new phone number is:
(210) 490-6186
# Ombudsmen Addresses and Their Territories

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

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

## Colorado/New Mexico
Eric Carlson  
P.O. Box 2027  
Littleton, CO  80161-2027  
(720) 493-5301

## 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 Dr.  
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  
PMB 139  
10991-30 San J ose Blvd.  
J acksonville, FL  32223  
(904) 886-2887

## Georgia
Sharon Briggman  
1820 Hwy. 20, Ste 132, #303  
Conyers, GA  30013  
(770) 388-7380

## Kentucky
Teresa Camfield  
P.O. Box 436767  
Louisville, KY  40253-6767  
(502) 254-5011

## Louisiana/Mississippi
Bobby Smith  
P.O. Box 9225  
J axkson, MS  39286  
(601) 856-4368

## Missouri
Peggy Miller  
2601 Cartwright Rd., Suite D392  
Missouri City, TX  77459  
(281) 416-9688

## North Carolina
Makisha Pressley  
4558-B Capital Blvd., Box 124  
Raleigh, NC  27604  
(919) 212-9881

## Out of Region C
J ane Crosby  
P.O. Box 100141, AG-520  
Columbia, SC  29202-3141  
(803) 735-1034, Ext. 35170

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

## Southern California
Andrea Stark  
P.O. Box 720313  
Norman, OK  73070  
(405) 292-8234, Ext. 35714

## Tennessee
Ronja Fayne  
5341 Mt. View Rd., Suite 122  
Antioch, TN  37013  
(615) 793-6873

## 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  
PMB 302  
2935 Thousand Oaks Suite 6  
San Antonio, TX  78247-3312  
(210) 490-6186

## 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, TX  77459  
(281) 416-9688

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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><strong>MAILING ADDRESS</strong></th>
<th><strong>TELEPHONE NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Integrity Unit</td>
<td>(877) 867-4852</td>
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<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
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<tr>
<td>P.O. Box 100236</td>
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<tr>
<td>Columbia, SC 29202-3236</td>
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<tr>
<td>Dedicated Work Teams/ DMERC General Information</td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td>Technology Support Center (Formerly EDI Help Desk)</td>
<td>(866) 749-4301</td>
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<td>Palmetto GBA, Medicare Region C DMERC</td>
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<tr>
<td>P.O. Box 100145</td>
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<tr>
<td>Columbia, SC 29202-3145</td>
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<tr>
<td>Hearings Department*</td>
<td>(866) 238-9650</td>
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<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
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<tr>
<td>P.O. Box 100249</td>
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<tr>
<td>Columbia, SC 29202</td>
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<tr>
<td>ADMC Department*</td>
<td>FAX: (803) 424-2622</td>
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<tr>
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<tr>
<td>Professional Relations Department</td>
<td>(803) 763-5744</td>
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<td>Palmetto GBA, Medicare Region C DMERC</td>
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<tr>
<td>P.O. Box 100141</td>
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*Inquiries regarding hearings or Advance Determination of Medicare Coverage should be directed to the Dedicated Work Teams.

### National numbers

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<tbody>
<tr>
<td>National Supplier Clearinghouse (NSC)</td>
<td>(866) 238-9652</td>
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<tr>
<td>P.O. Box 100142</td>
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<tr>
<td>Columbia, SC 29202-3142</td>
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<td>Region A DMERC</td>
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<td>Region B DMERC</td>
<td>(877) 299-7900</td>
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<tr>
<td>Region D DMERC</td>
<td>(877) 320-0390</td>
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<tr>
<td>Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)</td>
<td>(877) 735-1326</td>
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<td>17 Technology Circle</td>
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AG-520
Palmetto GBA
PO Box 100141
Columbia, SC  29202-3141