Speech Generating Devices (SGD) - New Policy

The Speech Generating Devices (SGD) policy is published in the accompanying Supplier Manual update and posted on the Palmetto GBA Web site at www.PalmettoGBA.com. In addition, the Web site also includes a "Response to Comments" document that summarizes the comments received from clinical organizations, suppliers, manufacturers, and beneficiary organizations during the 60-day public comment period that ended on December 19, 2000. The DMERC medical directors' response to each comment is also detailed in this document. The SGD policy reflects changes adopted by the DMERCs in response to comments and is effective for dates of service on or after July 1, 2001.

As noted in the Winter 2000...

Comments and suggestions are welcome. Please direct them to Communications Specialists in the Professional Relations Department at the address listed above.
Speech Generating Devices (SGD) - New Policy

DMERC Medicare Advisory (page 118), the development of this policy reflects a change in HCFA's national coverage of "communicators" and HCFA's issuance of Coverage Issues Manual 60-23, which was effective for dates of service on or after January 1, 2001. Therefore, claims submitted for these devices between January 1, 2001 and June 30, 2001 will be adjudicated based on individual consideration.

Osteogenesis Stimulators

Ultrasonic Models Covered

A revision of the Osteogenesis Stimulators medical policy is included in the accompanying Region C DMERC DMEPOS Supplier Manual update. The major changes are:

2. Use of a ZX modifier to indicate that coverage criteria for an ultrasonic osteogenesis stimulator are met. (The ZX modifier will not be used with electrical osteogenesis stimulators - HCPCS codes E0747 and E0748.) The Certificate of Medical Necessity (CMN) will not be used for ultrasonic osteogenesis stimulators, but will continue to be used for electrical osteogenesis stimulators.
3. Requirement for diagnosis coding for all osteogenesis stimulators, electrical and ultrasonic. For nonunions of fractures, in addition to the generic code for nonunion (733.82) the policy also requires the ICD-9 code specifying the fracture site.

Coverage for ultrasonic osteogenesis stimulators became effective for claims with dates of service on or after January 1, 2001. The revised documentation requirements for all osteogenesis stimulators are effective for claims with dates of service on or after July 1, 2001.

The ultrasonic osteogenesis stimulator is in the Inexpensive or Routinely Purchased (IRP) payment category.

Immunosuppressive Drugs Following Transplants

Coverage Extension

Effective for immunosuppressive drugs furnished on or after December 21, 2000, there is no longer any time limit for this Medicare benefit. This policy applies to all Medicare beneficiaries who meet all of the other program requirements for coverage under this benefit. Beneficiaries who satisfy all eligibility requirements for immunosuppressive drug coverage but for whom coverage expired prior to December 21, 2000, due to time limitations imposed by Medicare statute may have immunosuppressive drug coverage reinstated on or after December 21, 2000. However, there is no provision for coverage between the time of previous benefit expiration and the resumption of the benefit on or after December 21, 2000. Therefore, claims for dates of service after expiration of benefits but...
IMMUNOSUPPRESSIVE DRUGS FOLLOWING TRANSPLANTS

Coverage Extension cont.

prior to December 21, 2000 will be denied as noncovered.

A new DMERC Information Form (DIF) for Immunosuppressive Drugs is not required for beneficiaries who had previously received coverage for immunosuppressive drugs and are now resuming coverage under this benefit extension unless there has been a change in the drug regimen since the initial DIF was filed. If there has been a change in the drug regimen, a new initial DMERC Information Form (DIF) for Immunosuppressive Drugs must be completed when claim submission resumes for these beneficiaries.

In the accompanying Region C DMERC DMEPOS Supplier Manual update, the regional medical review policy on Immunosuppressive Drugs has been updated to reflect this change in coverage time limits.

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Effective April 1, 2001, Medicare covers intestinal transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Coverage of immunosuppressive drugs is being extended to include patients who meet all of the following criteria:

- The patient receives a Medicare-covered intestinal transplant on or after April 1, 2001; and,
- The patient was enrolled in Medicare Part A at the time of the transplant and is enrolled in Medicare Part B at the time that the drugs are dispensed; and,
- The drugs are medically necessary to prevent or treat rejection of the organ transplants in the particular patient; and,
- The drugs are furnished on or after discharge from the hospital following the intestinal transplant.

Suppliers billing for immunosuppressive drug(s) related to an intestinal transplant must, for question #5 on the DIF, answer "7" (Reserved For Future Use) if this correctly identifies the patient's situation. For hard copy claims, enter the statement "Intestinal Transplant" in the blank space on the DIF next to Item 7 in question #5. If the claim is filed electronically, enter "intestinal transplant” in the HAØ record.

Refer to the Immunosuppressive Drugs policy in the Region C DMERC DMEPOS Supplier Manual for more information on Coverage and Payment Rules, Coding Guidelines, and Documentation Requirements.
**Pelvic Floor Electrical Stimulator (PFES) - HCPCS Code E0740**

Effective for dates of service on or after April 1, 2001, the Coverage Issues Manual (CIM) is being revised to permit coverage for non-implantable pelvic floor electrical stimulators (PFES). Reference to non-implantable pelvic floor electrical stimulators has been moved from CIM §65-9 (Incontinence control devices) to CIM §60-24 (Non-Implantable Pelvic Floor Electrical Stimulator).

Section 60-24, Non-Implantable Pelvic Floor Electrical Stimulator, permits coverage for non-implantable pelvic floor electrical stimulators for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing 4 weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Suppliers submitting claims to the DMERC for PFES should use HCPCS code E0740 (Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer). This HCPCS code is in the Inexpensive or Routinely Purchased (IRP) reimbursement category. Suppliers are reminded that there must be documentation in the patient's medical record that the coverage criteria outlined in the national policy have been met. This documentation does not have to be routinely sent with the claim but must be available to the DMERC upon request.

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**Oral Antiemetic Drugs - Physician Billers/Licensure Requirements**

The regional medical review policy on Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) is published in the accompanying Region C DMERC DMEPOS Supplier Manual update. The revision reflects a change in jurisdiction for claim submission by physicians who are also DMEPOS suppliers. In addition, the policy incorporates instructions from the Health Care Financing Administration (HCFA) regarding entities qualified to dispense and bill for Medicare-covered drugs (see accompanying article entitled "Medicare-covered Drug Payment Requirement"). The revised policy is effective for dates of service on or after April 1, 2001.

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**Medicare-Covered Drug Payment Requirement**

Medicare's licensure requirement for suppliers and physicians who bill for Medicare-covered drugs has been expanded. Effective for dates of service on or after December 11, 2000, suppliers and physicians who desire to bill the DMERC for any Medicare-covered drug (prescription or non-prescription) must have a state license to dispense the drug. Previously the licensure requirement had applied only to Medicare-covered prescription drugs used in conjunction with durable medical equipment or prosthetic devices. This included

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Medicare-Covered Drug Payment Requirement
cont.

New HCPCS Code for Insulin Lispro

Effective for claims with dates of service on or after April 1, 2001, a new HCPCS code has been established for insulin lispro: HCPCS code K0548 (Injection, insulin lispro, up to 50 units). For dates of service prior to April 1, 2001, this form of insulin should be coded as HCPCS code J1820 (Injection, insulin, up to 100 units). After April 1, 2001, all forms of insulin other than lispro must continue to be coded as HCPCS code J1820. Insulin is only covered by Medicare if administered through an insulin pump, and in accordance with the coverage and payment rules of the External Infusion Pump Policy found in the Region C DMERC DMEPOS Supplier Manual.

Physician Corrections of CMNs

In the Autumn 1999 DMERC Medicare Advisory ("Faxed CMNs and Physician Orders," page 86), information was provided on how to correctly identify changes on a CMN once the physician had signed Section D. In that article, instructions for corrections indicated that the physician should draw a line through the erroneous information, sign in full and provide the date of the change.

Effective for dates of service on or after November 22, 2000, physicians may indicate changes to information on the CMN by drawing a line through the erroneous information, initialing the change and providing the date of the change. Suppliers also have the option of having the physician complete a new CMN.
The DMERC medical policy on Oxygen and Oxygen Equipment says that for Initial Certifications, the blood gas study reported on the CMN must be obtained within 30 days prior to the Initial Date on the CMN. A special exception was made for beneficiaries who transferred from a Medicare HMO to traditional Medicare fee-for-service in the month of January 2001. An Initial CMN still had to be submitted to the DMERC. However, for these beneficiaries, the blood gas study reported on the Initial CMN did not have to be obtained within 30 days prior to the Initial Date, but had to be the most recent study obtained while the patient was in the HMO under the testing guidelines specified in the DMERC policy. The original notice of this exemption was first posted on Palmetto GBA's Web site (www.PalmettoGBA.com) in December 2000.
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) 763-5707 or 763-5745.

Paul D. Metzger, M.D.
Medical Director, Region C DMERC
Palmetto GBA
Columbia, S.C.
RESPIRATORY ASSIST DEVICES (RAD)

PHYSICIAN INFORMATION SHEET

The Durable Medical Equipment Regional Carrier (DMERC) Respiratory Assist Devices (RAD) medical review policy became effective for dates of service on or after October 1, 1999. It was created after a substantial effort to review all available published literature on the use of these devices, as well as significant input by medical specialty societies and the respiratory care industry. It is somewhat lengthy and complex, and physicians are encouraged to obtain a copy of the policy itself, from the supplier(s) to whom they refer their patients, or to contact the Region C DMERC directly (Palmetto GBA, Columbia, S.C.) (803) 763-5744 for a copy, or to view it on Palmetto GBA’s Web Site at www.PalmettoGBA.com.

The RAD policy is separate from the DMERC CPAP medical review policy, and does not change or address in any way, coverage criteria mentioned in the CPAP policy. (Please see below under Obstructive Sleep Apnea for important distinctions between the two policies.)

As with all Physician Information Sheets, this will present a summary of the concepts contained within the DMERC RAD medical policy, with emphasis on matters felt most relevant to treating physicians. Should there be any perceived contradictions between this PHYSIS and the published medical review policy, it is the full policy which is the official document upon which claims adjudications and appeals are based.

Definitions:

“Treating Physician:" Because the use of RADs for patients with sleep-associated hypoventilation should be prescribed only by physicians who are qualified by virtue of experience and training in non-invasive respiratory assistance, physicians who are not so qualified, but may be treating their patients for other medical conditions, are not considered the treating physician for the prescription (and Medicare coverage) of this therapy.

Noninvasive Positive Pressure Respiratory Assistance (NPPRA): is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy). It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is to be distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of ventilatory support would lead to imminent demise of the patient.

A respiratory assist device (RAD) without backup rate (HCPCS billing code K0532) delivers adjustable, variable levels (within a single respiratory cycle) of positive air pressure by way of tubing and a noninvasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs (i.e., NPPRA). (An example of such a device would be a bilevel positive airway pressure device.)

A respiratory assist device (RAD) with backup rate (HCPCS billing code K0533) has exactly the same definition as stated for K0532, except that in addition, it has a timed backup feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

Medicare pricing of durable medical equipment is statutorily established; the Health Care Financing Administration must establish fee schedules accordingly. As may be seen above, the main feature distinguishing a K0532 from a K0533 is the availability of a backup rate in the latter. Yet there is a considerable difference in the amounts allowed for these two types of devices:
K0532 has an allowed rental amount of approximately $240/month for 15 months, after which that amount is allowed twice a year for maintenance.

K0533 has an allowed rental amount of approximately $550-$600/month, paid indefinitely, as it is in a different payment category.

For this reason the RAD medical policy establishes not only when a RAD is medically reasonable and necessary, but also distinguishes when it is appropriate to require a backup rate on a RAD.

**Coverage and Payment Rules:**

For a respiratory assist device to be covered, the treating physician must fully document in the patient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnia, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

Polysomnographic and blood gas studies may not be performed by the supplier of the RAD. An exception to this rule is hospitals certified to do such tests.

The DMERC RAD medical review policy recognizes four groupings of diseases that may be helped by application of a RAD.

- **Group I: Restrictive Thoracic Disorders:** a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB).
- **Group II: Severe COPD**
- **Group III: Central Sleep Apnea (CSA):** i.e., apnea not due to airway obstruction.
- **Group IV: Obstructive Sleep Apnea (OSA)**

These disease categories are based on available evidence of whether RAD effectiveness has been either well, or only tenuously, established. The type and level of test results required for each disease category similarly reflects those levels of evidence of effectiveness.

As is commonly known, the treatment of sleep-associated hypoventilation is made more difficult by frequently encountered poor patient compliance in acceptance and continued use of the device. Medicare does not pay for equipment that is not being used by the Medicare beneficiary. Because non-compliance is such a concern with this therapy, the medical review policy establishes criteria for initiation of Medicare coverage, and also (at 3 months) for continued coverage.

**Initial Coverage (First 3 months):**

For Group I Diseases (where COPD disease does not contribute significantly to the patient's pulmonary limitation): In addition to the documented diagnosis itself, the following test is required:

- **either** an awake arterial blood gas (done with the patient breathing their usual FIO₂) with a PaCO₂ > 45 mm Hg.
- **or** a sleep oximetry (done with the patient breathing their usual FIO₂) showing desaturation for at least five continuous minutes < 88%.
- **or** (and only if the disease is a progressive neuromuscular disease) a maximal inspiratory pressure < 60 cm H₂O or forced vital capacity < 50% predicted.

Note that only one test (and no polysomnogram) is required.

If a patient in this disease group meets a criterion, Medicare will cover either a K0452 or a K0453, depending on the judgment of the physician.
For Group II Disease (Severe COPD): In addition to the documented diagnosis itself, both of the following tests are required:

- an awake arterial blood gas (done with the patient breathing their usual FIO₂) with a PaCO₂ ≥ 52 mm Hg, and
- a sleep oximetry (done with the patient breathing their usual FIO₂) showing desaturation for at least five continuous minutes ≤ 88%.

While obstructive sleep apnea (and use of CPAP) should be considered and ruled out, a polysomnogram is not required to obtain coverage for a RAD for COPD.

If all of the above criteria are met, a K0532 device will be covered for the first three months of NPPRA therapy. A K0533 device will not be covered for a patient with COPD during the first two months, because therapy with a K0532 device with proper adjustments of the device’s settings and patient accommodation to its use will usually result in sufficient improvement without the need of a backup rate. (See below under Continued Coverage for coverage of a K0533 for COPD).

For Group III Disease (Central Sleep Apnea):

Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following:

- The diagnosis of central sleep apnea (CSA), and
- The exclusion of obstructive sleep apnea (OSA) as a primary cause of sleep-associated hypoventilation, and
- The ruling out of CPAP as effective therapy if OSA is a component of the sleep-associated hypoventilation, and
- Oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient’s usual FIO₂ (whichever is higher), and
- Significant improvement of the sleep-associated hypoventilation with the use of a K0532 or K0533 device on the settings that will be prescribed for initial use at home, while breathing the patient’s usual FIO₂.

If a patient in this disease group meets all the above criteria, Medicare will cover either a K0452 or a K0453, depending on the judgment of the physician.

For Group IV Disease (Obstructive Sleep Apnea):

- A complete facility-based, attended polysomnogram, has established the diagnosis of obstructive sleep apnea, and
- A single level device (HCPCS code E0601, Continuous Positive Airway Pressure Device) (CPAP) has been tried and proven ineffective.

Important Note about OSA: Please note that the DMERC policy on CPAP is directed by HCFA national policy to specify exactly how many episodes of apnea must be documented within a 6-7 hour period of sleep. That policy is separate from the RAD policy. Note that no specific criteria are explicitly listed for establishing a diagnosis of OSA in the RAD policy, only that a sleep study has been performed. Therefore, for K0532 devices, the use of hypopneic episodes and respiratory distress indices are not excluded from being used to establish a diagnosis of OSA. Furthermore, parameters of the CPAP trial are not specified, nor is it necessary to bill Medicare for a CPAP trial. It is only necessary that a trial be documented in which a CPAP failed to adequately treat the patient’s OSA.

By definition, OSA never requires a backup rate. Therefore, a K0533 is never covered for this disease group.

Continued Coverage (Beyond 3 months):

Patients covered for the first 3 months of a K0532 or K0533 device must be re-evaluated to establish the
medical necessity of continued coverage by Medicare beyond the first three months. While the patient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which Medicare will base a decision to continue coverage beyond this time must occur within 61 to 90 days of initiating therapy by the treating physician. There must be documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. Failure of the patient to be consistently using the K0532 or K0533 device for an average of 4 hours per 24-hour period by the time of this 61-90 day re-evaluation would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason for Medicare to deny continued coverage as not medically necessary.

Aside from the above documentation in the patient's medical records, the following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months:

1) a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the patient is compliantly using the device (an average of 4 hours per 24-hour period) and that the patient is benefiting from its use, and

2) a Medicare beneficiary statement completed by the patient no sooner than 61 days after initiating use of the device indicating how often the device is being used and whether the patient is inclined to continue using it.

The supplier of the device will request the first statement from the treating physician. The beneficiary statement is the responsibility of the supplier, and not the physician. With only one exception, no further testing is required for continued coverage, just the two statements assuring that the device continues to be used. That exception is, if after treating a patient with severe COPD with a K0532 device for two months, the physician believes that a K0533 device (with backup rate) is needed.

**COPD and a K0533:**

It is necessary to demonstrate that compliant usage of a K0532 has not helped improve the signs and symptoms of hypoventilation secondary to COPD, before a device with a backup rate (K0533) may be covered.

For Group II patients (COPD) who qualified for a K0532 device, if at a time no sooner than 61 days after initial issue and compliant use of a K0532 device, the treating physician believes the patient requires a K0533 device, the K0533 device will be covered if the following criteria are met:

In addition to completion of the two above compliant usage statements (regarding the K0532), there must be obtained:

- an arterial blood gas PaCO₂, repeated no sooner than 61 days after initiation of compliant use of the K0532, done while awake and breathing the patient's usual FIO₂, still remains ≥ 55 mm Hg, and
- a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a K0532 device, and while breathing with the K0532 device, demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO₂ [whichever is higher].

**Important HCPCS Coding Note:**

The physician should never sign an order for a ventilator with HCPCS code K0534 or E0450 as being used for NIPPRA (non-invasive), since these codes are only to be used for devices that ventilate patients through tracheostomies.
**Documentation:**

There is no Certificate of Medical Necessity required by this policy.

**Patient's Medical Records:**

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.

Paul D. Metzger, M.D.
Medical Director
Region C DMERC
Palmetto GBA
Columbia, S.C.
**Mandatory Assignment on All Drugs**

Under Section 114 of the Benefits Improvement and Protection Act of 2000, payment for any drug or biological covered under Part B of Medicare may be made only on an assignment-related basis. Therefore, no charge or bill may be rendered to anyone for these drugs and biologicals for any amount except for any applicable unmet Medicare Part B deductible and coinsurance amounts.

For claims with dates of service on or after February 1, 2001, suppliers must accept assignment on all claims for drugs.

This notice was posted on the Palmetto GBA Web site, www.PalmettoGBA.com, in February.

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**Elimination of HCFA Free Billing Software**

Since the late 1980s, the Health Care Financing Administration (HCFA) has required Palmetto GBA to offer free electronic billing software to Region C providers upon request. These generally simple pieces of software allowed providers to submit electronic claims to Medicare, using Medicare-specific electronic data interchange formats, either the National Standard Format, the UB-92, or the X12N 837 format. Palmetto GBA was required to offer this software in order to increase electronic claim submissions. The software gave providers an opportunity to try electronic billing at low cost, with the expectation that providers would experience the benefits and procure or develop more sophisticated practice management or billing software that would perform additional functions. Additionally, use of this software reduced processing costs to the Medicare program as providers switch from paper to electronic claims.

With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare-specific electronic formats. The same format will be used by providers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for providers, and should encourage more providers to use electronic transactions. These changes have prompted HCFA to assess whether or not to continue offering the free billing software in the post-HIPAA environment. HCFA will require Palmetto GBA to begin phasing out the free billing software requirement effective FY2004, approximately one year after HIPAA standards are implemented. This will give Region C providers enough time to find substitute software that can work with all payers. We will notify you when the transition period begins to phase out the free billing software.
The Health Care Financing Administration (HCFA) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. HCFA awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations will be initiated from and researched at the COB contractor. This will no longer be a function of your local Medicare fiscal intermediary (FI) or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB contractor will provide customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses first before Medicare. The table below describes a few of these methods and programs:

<table>
<thead>
<tr>
<th>Method/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Enrollment Questionnaire (IEQ)</td>
<td>Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.</td>
</tr>
<tr>
<td>IRS/SSA/HCFA Data Match</td>
<td>Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.</td>
</tr>
<tr>
<td>MSP Claims Investigation</td>
<td>This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.</td>
</tr>
<tr>
<td>Voluntary MSP Data Match Agreements</td>
<td>Voluntary agreements allow for the electronic data exchange of GHP eligibility and Medicare information between HCFA and employers or various insurers.</td>
</tr>
</tbody>
</table>
Provider Requests for Claims Payment

FIs and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local FI or carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local FI or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in HCFA's Database

The COB contractor will be the sole authority in ensuring the accuracy and integrity of the MSP information contained in HCFA's database (i.e., Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary and/or spousal changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB contractor. HCFA also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare Program.

Contacting the COB Contractor

Effective January 1, 2001, please refer all MSP inquiries including: the reporting of potential MSP situations, changes in a beneficiary's insurance coverage, changes in employment, and general MSP questions/concerns to the COB Contractor. Continue to call your local FI and/or carrier regarding claims-related questions. The COB Contractor's Customer Call Center toll free number is:

1-800-999-1118 or TDD/TYY 1-800-318-8782.

Customer Service Representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Standard Time, except holidays.
**Development of Claims by Medical Review**

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to:

- duration of the patient's condition,
- clinical course (worsening or improvement),
- prognosis, nature, and extent of functional limitations,
- other therapeutic interventions and results,
- past experience with related items, etc.

If an item requires a CMN, we recommend that the original completed CMN be kept in the patient's record. However, neither a physician's order nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. **There must be clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or information on a supplier-prepared statement or physician attestation (if applicable).**

The documentation in the patient's medical record does not have to be routinely sent to the DMERC. However, the DMERC may request this information in selected cases. If the DMERC does not receive the information when requested or if the information in the patient's medical record does not adequately support the medical necessity for the item, the claim may be denied. If a supplier receives a denial in this instance, the supplier may not resubmit the claim to the DMERC. If the supplier re-files the claim to the DMERC she or he may receive a denial of services for duplicate claims submission.

If the supplier disagrees with the determination made by the medical review area, the supplier should request an informal review and follow the normal appeals process outlined in Chapter 14 of the DMERC Region C DMEPOS Supplier Manual.

**Medical Necessity Duplicate Claim Denials**

Palmetto GBA has always educated suppliers to file appeals rather than resubmit claims denied for medical necessity reasons. Such resubmitted claims will be denied as duplicates of the original claim. Claims denied as duplicates do not have appeal rights and will be dismissed if submitted for review.
ADDITIONAL DEVELOPMENT REQUESTS FOR DMERC MEDICAL REVIEW

When the Medical Review department selects a claim for development, they send the supplier a request for medical records. Providers have 35 days from the date of the development request to respond to the Medical Review unit.

IMPORTANT INFORMATION FOR RESPONDING TO AN ADDITIONAL DEVELOPMENT REQUEST FOR MEDICAL RECORDS

♦ Suppliers must mail all replies to:

   Palmetto GBA
   P.O. Box 100283, Mail Code AG-255
   Columbia, SC 29202-3283

♦ Attach all documentation to the request letter to support the claim in question. Documentation includes:

1. Orders for services rendered (Orders must be detailed and signed and dated by the treating physician)
2. Certificate of Medical Necessity (if applicable)
3. Clinical information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable). It may also include information on a supplier-prepared statement or physician attestation (if applicable).
4. Product information, manufacturer, brand name, model, etc.
5. Proof of delivery

♦ If you receive separate requests for the same beneficiary but with different dates of service you will need to respond separately for each request.

COVERAGE ISSUES MANUAL REVISION

Air-Fluidized Beds

Originally printed in the Winter 2000 DMERC Medicare Advisory, we are re-publishing this article to highlight only the recent coverage changes.

Section 60-19, Air-Fluidized Beds, is revised to define what is meant by conservative treatment that must be tried before a patient can qualify for coverage of an air-fluidized bed. Effective for services rendered on or after July 30, 1990.

An air-fluidized bed uses warm air under pressure to set small ceramic beads in motion which simulate the movement of fluid. When the patient is placed in the bed, his body weight is evenly distributed over a surface area which creates a sensation of “floating.” Medicare payment for home use of the air-fluidized bed for treatment of pressure sores can be made if such use is reasonable and necessary for the individual patient.
A decision that use of an air-fluidized bed is reasonable and necessary requires that:

- The patient has a stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure sore;
- The patient is bedridden or chair-bound as a result of severely limited mobility;
- In the absence of an air-fluidized bed, the patient would require institutionalization;
- The air-fluidized bed is ordered in writing by the patient’s attending physician based upon a comprehensive assessment and evaluation of the patient after completion of a course of conservative treatment designed to optimize conditions that promote wound healing. This course or treatment must have been at least one month in duration without progression toward wound healing. This month of prerequisite conservative treatment may include some period in an institution as long as there is documentation available to verify that the necessary conservative treatment has been rendered.
- Use of wet-to-dry dressing for wound debridement, begun during the period of conservative treatment and which continues beyond 30 days, will not preclude coverage of an air-fluidized bed. Should additional debridement again become necessary, while a patient is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to become non-covered. In all instances documentation verifying the continued need for the bed must be available.
- Conservative treatment must include:
  - Frequent repositioning of the patient with particular attention to relief of pressure over bony prominences (usually every 2 hours);
  - Use of a specialized support surface (Group II) designed to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation;
  - Necessary treatment to resolve any wound infection;
  - Optimization of nutrition status to promote wound healing;
  - Debridement by any means (including wet to dry dressings-which do not require an occlusive covering) to remove devitalized tissue from the wound bed;
  - Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.
- A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care,

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

Air-Fluidized Beds

cont.

repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage;

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

◦ All other alternative equipment has been considered and ruled out.

Home use of the air-fluidized bed is not covered under any of the following circumstances:

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

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

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

◦ Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1,600 pounds or more);

◦ Electrical system is insufficient for the anticipated increase in energy consumption; or

◦ Other known contraindications exist.

Coverage of an air-fluidized bed is limited to the equipment itself. Payment for this covered item may only be made if the written order from the attending physician is furnished to the supplier prior to the delivery of the equipment. Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement. Cross reference: Carriers Manual, §5102.2.

Blood Glucose Test Strips

Marketing to Medicare Beneficiaries

Marketing practices may influence Medicare beneficiaries who utilize medical supplies, such as blood glucose strips, on a repeated basis. Beneficiaries are advised to report any instances of fraudulent or abusive practices, such as misleading advertising and excessive or non-requested deliveries of test strips, to their Durable Medical Equipment Regional Carriers. Suppliers are reminded that beneficiaries must specifically request refills of supplies before they are dispensed.
BLOOD GLUCOSE TEST STRIPS

Advertising incentives that indicate or imply a routine waiver of coinsurance or deductibles could be in violation of 42 U.S.C. 1320a-7b(b). Routine waivers of coinsurance or deductibles are unlawful because they could result in (1) false claims, (2) violation of the anti-kickback statute, and/or (3) excessive utilization of items and services paid for by Medicare.

In addition, 42 U.S.C. 1320a-7a(a) (5) prohibits a person from offering or transferring remuneration. Remuneration is a waiver of coinsurance and deductible amounts with exceptions for certain financial hardship waivers that are not prohibited.

Suppliers should seek legal counsel if they have any questions or concerns regarding waivers of deductibles and/or coinsurance of the propriety of marketing or advertising material. Any supplier who routinely waives co-payments or deductibles can be criminally prosecuted and excluded from participating in federal health care programs.

TOLL-FREE NUMBERS FOR PROVIDERS

The following are toll-free numbers for each DMERC, as well as the National Supplier Clearinghouse (NSC) and Statistical Analysis DMERC (SADMERC):

- DMERC Region A  HealthNow NY, Inc. (866) 419-9458
- DMERC Region B  AdminaStar Federal (877) 299-7900
- DMERC Region C  Palmetto GBA (866) 238-9650
- DMERC Region D  CIGNA Medicare (877) 320-0390
- National Supplier Clearinghouse (NSC) (866) 238-9652
- Statistical Analysis DMERC (877) 735-1326

PRODUCT CLASSIFICATION LISTS


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

- DMERC Review Request Form found on page 14.4 of the Region C DMERC DMEPOS Supplier Manual and on Palmetto GBA’s Web site at www.PalmettoGBA.com

Select “DMERC,” “Publications and Information,” “Supplier Manual.”

If these forms are not used, the request for review must contain all of the following information:

- Signed written statement expressing disagreement with the initial determination;
- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of the supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and
- Which item(s), if any, and/or service(s) are at issue in the appeal.

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.

The Benefits Improvement and Protection Act of 2000 amended §1834(h)(1) of the Social Security Act by adding a provision (1834(h)(1)(G)(ii)) that requires Medicare payment to be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary.
Payment may be made for the replacement of a prosthetic device which is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:

1. A change in the physiological condition of the patient;
2. An irreparable change in the condition of the device, or in a part of the device; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

This provision supersedes any rule that as of the date of enactment of this Act, may have applied to a five-year replacement rule with regard to prosthetic devices. In addition, this provision shall apply to items replaced on or after April 1, 2001.

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**Reminder to EMC Filers**

Effective January 8, 2001, changes involving electronic filing of MSP claims were implemented. A letter concerning these changes was sent on October 31, 2000 to all software vendors. This letter contained information that standard systems must be updated to accept MSP claims for services at the line level. These changes will allow submission of MSP information at the line level and other related fields. If you have questions concerning necessary system changes, please call the Palmetto GBA EDI Help Desk at (803) 788-9751. Only those claims filed after January 8, 2001 will have the ability for line-level entry. This change will not be applied to claims filed prior to January 8, 2001.

**Changes:**

- **DMERC NSF versions 2.00 and 3.01.**
- One change for the electronic remittance file - all versions 1.04, 2.00 and 2.01
- FA0 35.0 Primary Paid Amount for that line item
- FA0 48.0 Obligated To Accept Amount for that line item
- FB0 06.0 Allowed Amount for that line item
- DA1 11.0 Allowed Amount for that claim
- DA1 14.0 Payer Paid Amount for that claim
- ERN Record 450 field 26.0 Amount Paid by Other Payer will be primary paid amount for that line item.

Filers please note that the Obligated to Accept Amount is used only when you have contracted or negotiated a set price for an item with the primary insurer; otherwise this field should be filled with 0's.

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Makisha Pressley is the new ombudsman for North Carolina. Her experience includes over three years with Medicare, including team associate for Multi-Functional Team G, Overpayment team, Beneficiary Call Center, and Data Entry. Makisha earned her Bachelor of Arts in corporate communication from the College of Charleston and a Master of Arts in human resources development from Webster University.

A native of "low-country" South Carolina, Makisha looks forward to providing educational and training services to her suppliers. Makisha brings excellent customer service and communication skills as well as knowledge of the Medicare program to her position.

The following drug allowables are effective January 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. Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.
Effective for claims processed on or after April 1, 2001, for dates of service on or after April 1, 2001: HCPCS code E0617 (External defibrillator with integrated electrocardiogram analysis) will be located in the payment category for Capped Rental, HCPCS code E0740 (Incontinence treatment system pelvic floor stimulator, monitor, sensor and/or trainer) and HCPCS code E0765 (FDA-approved nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting) will be located in the payment category for Inexpensive and Routinely Purchased, and HCPCS code E0760 (Osteogenesis stimulator, low intensity ultrasound, non-invasive) will be moved from the Capped Rental category to the payment category for Inexpensive and Routinely Purchased. The fee schedule allowances for these HCPCS codes are listed below:

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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
2001 Region C DMEPOS Fee Schedule Online

The 2001 Region C DMEPOS Fee Schedule is available on the Palmetto GBA Web site, www.PalmettoGBA.com. To access the Fee Schedule, follow these steps:

From the homepage, click on “Providers”. Then, click on “DMERC.” Next, click on “Publications and Information.” At this screen, click on “Advisories.” The Fee Schedule will be listed near the top. Click on the title, “2001 Region C DMEPOS Fee Schedule.”

From the introductory page, click on the words “Click here.” Look at the left-hand column. Under the words “View By” there are two choices — “By HCPCS code” or “Download.”

To view the fees on-line: Click on “By HCPCS code.” A table of contents, with HCPCS codes indexed by their letter prefix, will appear. Click on the letter to view that particular HCPCS code. To view supplementary charts (PEN controlling allowables, Oral Anti-Cancer, etc., click on the title of the chart.

To download the chart: Click on “Download.” Follow the instructions on the page which appears. The main chart will download to your computer in Excel format.

Register for Web Workshops and Other DMERC Information

Are you keeping up to date on the latest Medicare publications and information?

Interested in participating in a Region C Web workshop?

By registering on the Palmetto GBA Web site (www.PalmettoGBA.com) and completing a user profile, you can be notified by e-mail when workshops will be conducted on the Web site, and when new or important information is added to the site. You only need to register once to use many extra features. It is quick and easy. You do not have to register to use our Web site, but registration lets you:

♦ Receive weekly e-mail notification of Medicare news and updates (including Web workshops)
♦ Fully participate in our Discussion Forums such as Newsgroup and CHAT (These features will be implemented in the future. We will send e-mail notification to our registered users when these features are implemented)
♦ Update your e-mail profile at any time

To register, access the DMERC section of the Palmetto GBA Web site. From the Web site homepage, select “Providers,” then “DMERC.” From the left side of the screen, select the “Register/Profile” option.

Follow the on-screen instructions. Here are some helpful tips:
**Register for Web Workshops and Other DMERC Information**

cont.

1. Make note of your User name and Password, as these items are case sensitive.

2. Check your topics of your interest and check the Every Week notification frequency box. Otherwise you will not be notified, although your profile will be noted in the system.

3. Be sure to fill out all required fields.

4. After you register the first time, you only need to login when you want to use the features for registered users: participating in discussion forums, changing passwords, or updating profiles.

If you have questions about this process, please e-mail the Palmetto GBA webmaster by selecting the Feedback button from the Web site's homepage. Be sure to mark the box entitled “Send to webmaster.”

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**Free Workshops May 30, June 1, 8 and 11th**

Mark your calendars now! Palmetto GBA will be conducting free all-day workshops at the Government Programs Complex in Columbia, S.C. The dates of the workshops are May 30, June 1, 8 and 11. At press time, the workshop agenda was not complete. Watch for upcoming agenda and registration information on the Palmetto GBA Web site, as well as on your remittance notices and electronic claims reports.

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**NSC Quick Tips**

**Changes of Information**

Please notify the National Supplier Clearinghouse (NSC) of any changes (address, phone, ownership, etc.) within 30 days of the change.

To notify the NSC of address changes, suppliers have two options:

♦ Call the customer service lines at (866) 238-9652 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 e-mail them to [medicare.nsc@PalmettoGBA.com](mailto:medicare.nsc@PalmettoGBA.com) or call the NSC Service Center line at (866) 238-9652.
Palmetto GBA offers weekly check-in sessions for all individuals who are currently enrolled in one or more of our online workshop events. These sessions will be available every Friday at 2 p.m. Eastern Standard Time and last from 30 minutes to an hour. The goal of these sessions is to familiarize yourself with the interactive online training tools and to make sure that you do not have any technical issues before the actual training session.

You may attend any check-in session you like to prepare for a future event or just to learn how to use our interactive workshop tools. You do not need to attend more than one session unless you need additional help or want extra practice.

There is no password required. Just select the date you would like to attend and enroll.

To enroll in the check-in session simply go to our Web site at www.PalmettoGBA.com and click on the "training" button in the bottom right-hand corner. This will bring you to the workshop registration page. Once you sign-in, click on "View Event" list and look for "Workshop Check-in Session." Find the date that you would like to attend. Click on "ENROLL." You should now see the word "ENROLLED." You are ready to attend the class.

On the day of the check-in session, go to "View My Schedule" and select "ATTEND." This may take a few minutes. Please start signing on 10 or 15 minutes before the session begins. All classes are for Eastern Standard Time.

Please take a minute to go the registration page and select "System Check" in the top right-hand corner. This will let you know in advance if your computer is properly configured to attend Palmetto GBA online workshops.

The minimum system requirements are listed below:

- Windows 95, 98, NT 4.0 with SP4+, 2000
- Netscape 4.06+, Internet Explorer 4.01+
- 28.8 kbps or faster network connection
- Pentium 133 MHz, 32 MB memory (64 MB is using AppShow)
- 800x600, 16-bit color display resolution
- 16-bit sound card, speakers/microphone or headset

If you have questions during the registration or enrollment process, please use the help menu that is available. More technical questions can be addressed by utilizing the feedback button on the Palmetto GBA Web site.
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
Eric Carlson
P.O. Box 2027
Littleton, Colo. 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 267
1253 University Dr.
Coral Springs, Fla. 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 Jose Blvd.
Jacksonville, Fla. 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
Jackson, Miss. 39286
(601) 856-4368

North Carolina
Makisha Pressley
P.O. Box 124
Raleigh, N.C. 27604
(919) 212-9881

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
5341 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)
Dana Causey
P.O. Box 7891
Horseshoe Bay, Texas 78657
(830) 598-4882

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

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

Please retain this list as your new DMERC telephone directory.

## Palmetto GBA Contacts

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>
| Benefits Integrity Unit  
P.O. Box 100236  
Columbia, S.C.  29202-3236 | (877) 867-4852 |
| Dedicated Work Teams/DMERC General Information  
P.O. Box 100145  
Columbia, S.C.  29202-3145 | (866) 238-9650 |
| Electronic Data Interchange (EDI)  
P.O. Box 100249  
Columbia, S.C.  29202 | (803) 788-9751 |
| Hearings Department*  
P.O. Box 100235  
Columbia, S.C.  29202-3235 | (866) 238-9650 |
| Prior Authorization Department*  
P.O. Box 100141  
Columbia, S.C.  29202-3141 | (866) 238-9650 |
| Professional Relations Department  
P.O. Box 100142  
Columbia, S.C.  29202-3142 | (803) 763-5744 |

*Inquiries regarding hearings or Prior Authorization should be directed to the Dedicated Work Teams.

## National Numbers

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>
| National Supplier Clearinghouse (NSC)  
P.O. Box 100142  
Columbia, S.C.  29202-3142 | (866) 238-9652 |
| Region A DMERC | (866) 419-9458 |
| Region B DMERC | (877) 299-7900 |
| Region D DMERC | (877) 320-0390 |
| Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)  
Palmetto GBA  
17 Technology Circle  
Columbia, SC  29203 | (877) 735-1326 |