IN THIS ISSUE

2001 Claims Filing Reminder ......................101
2002 HCPCS Code Update
   Additions ...........................................113
   Changes ...........................................115
   Deletions ..........................................117
2002 Payment Changes for DMEPOS ..............107
ABN Form for DMEPOS Upgrades ..................84
Appeals
   Hearing and Administrative Law Judge
   (ALJ) Appeal Requests ............................110
   Review Reminder ..................................110
Clinical Trials ........................................98
Consolidated Billing for Skilled Nursing
   Facility (SNF) Residents .........................103
Dementia Patients: Claims Filing .................102
DMERC Publications on the Internet .............111
Fee Updates - Fourth Quarter 2001
   Anti-Cancer Drug Fees ...........................107
   Drug Fee Update .................................106
   HIPAA .............................................109
Audit Fraud Alert ....................................109
Claim Submission Testing Delayed ................109
Home Dialysis Supplies and Equipment
   Payment ..........................................101
   Home Health Consolidated Billing .............103

Mandatory Assignment Drug HCPCS Codes .........104

Medical Affairs Updates
   New and Revised HCPCS Codes
   Gastrostomy Tubes .................................93
   Heating Device ....................................89
   Home Blood Glucose Monitors and Supplies
   Home Dialysis Supplies and Equipment .........87
   Joint Contracture Devices.......................91
   Lower Extremity Prostheses ......................92
   Multiple Density Shoe Inserts .................93
   Nebulizer Drugs (Inhaled Steroids and
   Levalbuterol) ......................................87
   Non-Contact Wound Warming System ............94
   Pessary Change in Jurisdiction .................97
   Spinal Orthoses .................................90
   Tracheo-esophageal Voice Prosthesis ...........94
   Noncovered Items, Not Medically Necessary
   Items, and Advance Beneficiary Notices .......95
   Policy Revisions
   Breast Prostheses ................................86
   Insulin Pumps .................................86

Manual and Power Wheelchairs, POVs .............85
TENS ..............................................87
Walkers ............................................87
RMRPs Have a New Name ............................97
Suction Catheters: Oropharyngeal vs.
   Tracheoesophageal ................................97

Medicare HMO Transfers ............................108
MSP Correspondence Address ......................110
NSC Quick Tips ......................................110
Ombudsmen
   Address Changes: Alabama and North
   Florida .........................................119
   Addresses/Territories ............................120
   Kentucky Interim Ombudsman .................119
   Ombudsman In-services ........................112
   Online Workshop Schedule ......................112
   Prior Authorization/ADMC Reminder ..........102
   Region C Directory ............................121
   Rental Items: New Modifier .....................103
   SADMERC HCPCS Coding Verification
   Reviews ..........................................102
   Sanction Report Publication ....................109
   Statement of Intent .............................101
An Advance Beneficiary Notice (ABN) is a written notice you can give to a Medicare beneficiary before providing an item or service that you expect Medicare will deny for the following reasons:

- lack of medical necessity
- prohibited, unsolicited telephone contacts
- no supplier number
- denial of an Advanced Determination of Medicare Coverage (ADMC) request

The purpose of an ABN is to inform the beneficiary that Medicare will probably not pay for a certain item or service in a specific situation, even if Medicare might pay for the item or service under different circumstances. This allows the beneficiary to make an informed consumer decision about whether or not to receive the items or services for which s/he may have to pay out of pocket or through other insurance.

DMEPOS suppliers have been using an ABN form (HCFA-R-131) when they expect that Medicare may not pay for an item. The Office of Management and Budget (OMB) recently cleared a new, optional ABN form (CMS-R-131-G) that you can use for the same purpose. This form is available online at www.hcfa.gov/medicare/bni/.

For example, you may believe that the DMERC will deny an item as not medically necessary, or that the quantities of an item exceed the quantity that Medicare allows. On the ABN, you must explain why Medicare will deny the specific item in terms the beneficiary can understand. You may not simply give ABNs to every Medicare beneficiary you serve, unless there is a specific reason why you feel Medicare will deny payment (e.g., you only sell items that Medicare never covers). Statements such as "I never know when Medicare will pay" are not acceptable on ABNs.

**ABNs for upgrades**

Medicare will accept ABNs on upgrades. For Medicare purposes, CMS defines an upgrade as an item that is more expensive, contains more components or features, or is greater in quantity than what the physician ordered. The upgraded item may be from one HCPCS code to another, or within the same HCPCS code. However, the upgraded item must be within the range of services that are appropriate for the beneficiary's medical condition. For example, the beneficiary can upgrade from a standard manual wheelchair to an ultralight wheelchair, but not from a cane to a wheelchair. Whether or not to upgrade is the beneficiary's choice.

CMS does not include items that a physician ordered, but which the supplier believes to be more than what Medicare considers medically necessary. You may still use an ABN in this situation, but must continue to follow the current operating procedures for ABNs that are already in place, and bill them as you have billed them in the past (i.e., bill the item that the physician ordered on one line with the GA modifier).

If a beneficiary agrees to be financially liable by signing an ABN, you may collect the difference between the charges for the upgraded item and the charges for the non-upgraded item from the beneficiary.
NEW PROCEDURES TO USE THE ABN FORM FOR DMEPOS UPGRADES
cont.

In some cases, you may choose to provide a free upgrade for a beneficiary (e.g., to lower costs by maintaining an inventory of only one type of manual wheelchair that can supply all of your manual wheelchair needs). When providing a free upgrade, you should not have the beneficiary sign an ABN, because you will not be charging more than the normal deductible and co-payment for the non-upgraded item.

ABNs for upgrades can apply to both assigned and unassigned claims.

Filing claims when ABN is used for upgrades

To provide a free upgrade: Use the appropriate HCPCS code for the non-upgraded item that the physician ordered. You must only charge for the non-upgraded item. Use a **GL** modifier with the HCPCS code. In Item 19 of the claim, or as an attachment to the claim, specify the make and model of the upgraded item you actually furnished, and describe why this item is an upgrade (e.g., you provided an ultralight wheelchair when the physician ordered a standard wheelchair). Electronic media claim filers should use the HA0 record for this purpose.

To charge for the difference between the Medicare allowable for a non-upgraded item and an upgrade: List two lines on your claim. On the first line, list the upgraded item with a **GA** or **GZ** modifier. Use the **GA** modifier if the beneficiary signed an ABN, and the **GZ** modifier if the beneficiary did not sign an ABN. A certificate of medical necessity (CMN) is not required for this item. On the second line, list the item the physician actually ordered. Use a **GK** modifier on this line. A CMN is required for this item.

If you are upgrading from one item to another within the same HCPCS code, this will be the same HCPCS code you put on line one, but with a different charge amount. You must indicate the full charge for each item on the claim form, not the difference between the two.

You may include more than one upgraded item on a claim. However, for items where you provide an upgrade, you must list the non-upgraded item on the line immediately following the upgraded item.

The following are examples on how to file claims with an ABN and without an ABN:

<table>
<thead>
<tr>
<th>Upgrade with an ABN:</th>
<th>K0004RRKHGA</th>
<th>100.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item ordered by the physician:</td>
<td>K0001RRKHGK</td>
<td>50.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Upgrade without an ABN:</th>
<th>K0004RRKHGZ</th>
<th>100.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item ordered by the physician:</td>
<td>K0001RRKHGK</td>
<td>50.00</td>
</tr>
</tbody>
</table>

MANUAL AND POWER WHEELCHAIRS, POVs

Policy Revisions

Revisions of the medical policies on Manual Wheelchair Bases, Motorized/Power Wheelchair Bases, and Power Operated Vehicles (POVs) are included in the accompanying DMEPOS Supplier Manual update. The revisions include changes in HCPCS codes, coverage and payment rules, coding guidelines, and documentation requirements, including Advance Determination of Medicare Coverage.
**Revised Insulin Pump Requirements**

An external insulin infusion pump is now covered for the administration of continuous subcutaneous insulin for the treatment of diabetes mellitus (ICD-9-CM HCPCS codes 250.00-250.93), which has been documented by a fasting serum C-peptide level that is less than or equal to (≤) 110 percent of the lower limit of normal of a particular laboratory's measurement method. This represents an increase in the allowable amount of C-peptide found in the patient's blood, and will result in more beneficiaries having access to Medicare coverage of the insulin infusion pump.

For patients who have obtained an external insulin infusion pump that was not eligible for reimbursement by Medicare prior to January 1, 2002, insulin and supplies used with the pump are covered for dates of service on or after January 1, 2002 provided the patient has a fasting C-peptide level that is less than or equal to (≤) 110 percent of the lower limit of normal of a laboratory's measurement method.

For all claims for external insulin infusion pumps, insulin and/or supplies, if the results of the patient's C-peptide level meet the requirements outlined in Section IV of the Coverage and Payment Rules, a ZX modifier should be added to the HCPCS code.

Refer to the External Infusion Pump policy for additional information regarding reimbursement for these items.

These revised criteria are effective for claims with dates of service on or after January 1, 2002.

---

**Useful Lifetime Expectancy for External Breast Prosthesis**

**Policy Revision**

Effective for dates of service on or after April 1, 2002, the Centers for Medicare and Medicaid Services (CMS) has determined that a period shorter than five years more accurately reflects the useful lifetime expectancy for an external breast prosthesis.

The useful lifetime expectancy for silicone breast prostheses is two (2) years. For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six (6) months. Replacement sooner than the useful lifetime because of ordinary wear and tear will be denied as non-covered.

An external breast prosthesis of the same type may be replaced at any time if it is lost or is irreparably damaged (this does not include ordinary wear and tear). An external breast prosthesis of a different type may be covered at any time if there is a change in the patient's medical condition necessitating a different type of item.

The Medicare program will pay for only one breast prosthesis per side at any one time. More than one external breast prosthesis per side at any one time will be denied as not medically necessary.

Suppliers must use the RT and LT modifiers to delineate the side or sides being billed.

A revised External Breast Prosthesis policy is included in the accompanying DMEPOS Supplier Manual update.
**Transcutaneous Electrical Nerve Stimulators (TENS)**

**Policy Revision**

A revised Transcutaneous Electrical Nerve Stimulation (TENS) policy is included in the accompanying DMEPOS Supplier Manual update. The revisions include changes in coverage and payment rules, coding guidelines, and documentation requirements, as well as elimination of availability for prior authorization for this item.

---

**Walkers**

**Policy Revision**

Revisions of the medical policy on Walkers is included in the accompanying DMEPOS Supplier Manual update. The revision incorporates the new HCPCS codes for heavy duty walkers which were established in January 2001.

---

**Home Dialysis Supplies and Equipment**

**New HCPCS Codes**

Effective January 1, 2002, suppliers will be required to separately identify dialysis supplies and equipment being furnished to the patient. Suppliers have billed for dialysis supplies using HCPCS codes describing "kits" of supplies (for example, HCPCS codes A4820, A4900, A4901, A4905 and A4914). Several new HCPCS codes describing separate dialysis equipment and supplies become effective for dates of service on or after January 1, 2002.

Under the standard grace period, suppliers may use the discontinued HCPCS codes for dates of service on or after January 1, 2002 for claims received by March 31, 2002. However, claim lines with these HCPCS codes for dates of service on or after January 1, 2002 received on or after April 1, 2002 will be rejected as invalid coding.

Please see the 2002 HCPCS Code Update section of this Advisory for dialysis equipment and supply HCPCS codes.

---

**Nebulizer Drugs (Inhaled Steroids and Levalbuterol)**

**New and Revised HCPCS Codes**

**New HCPCS codes**

Effective for claims with dates of service on or after January 1, 2002, new HCPCS codes have been established:

- J7622  Beclomethasone, inhalation solution administered through DME, unit dose form, per milligram
- J7624  Betamethasone, inhalation solution administered through DME, unit dose form, per milligram
- J7626  Budesonide, inhalation solution administered through DME, unit dose form, 0.25 mg
- J7641  Flunisolide, inhalation solution administered through DME, unit dose, per milligram
These medications have been being billed using HCPCS code J7699. For dates of service on or after January 1, 2002, they should be billed using the new HCPCS codes. Under the standard grace period, HCPCS code J7699 (used to bill for the steroid drugs) will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. However, use of HCPCS code J7699 to describe these drugs, for dates of service on or after January 1, 2002 received on claims on or after April 1, 2002 will be rejected as invalid coding.

Revised HCPCS codes

Effective for claims with dates of service on or after January 1, 2002, the HCPCS codes for concentrated and unit dose albuterol have been revised:

- **J7618** Albuterol, all formulations including separated isomers, inhalation solution administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

- **J7619** Albuterol, all formulations including separated isomers, inhalation solution administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

These HCPCS code revisions were made to accommodate billing for levalbuterol (Xopenex®), a separated isomer of albuterol. Note the change in billing units for HCPCS codes J7618 and J7619 and levalbuterol before and after the January 1, 2002 effective date.

**Dates of Service prior to January 1, 2002**
1 mg levalbuterol = 1 unit J7619

**Dates of Service on or after January 1, 2002**
1 mg levalbuterol = 2 units J7619

The billing for the standard formulation of albuterol is not affected by this change in HCPCS codes J7618 and J7619.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these supply items.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Nebulizers and Nebulizer Drugs in the DMEPOS Supplier Manual.
HOME BLOOD GLUCOSE MONITORS AND SUPPLIES

New HCPCS Codes

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for laser skin lancing devices.

A4257 Replacement lens shield cartridge for use with laser skin piercing device, each

E0620 Skin piercing device for collection of capillary blood, laser, each

Laser skin lancing devices use laser technology to pierce the skin in order to obtain capillary blood for use in home blood glucose monitors. Suppliers are reminded that the establishment of a unique HCPCS code for a particular product does not necessarily indicate coverage.

Also effective for dates of service on or after January 1, 2002, HCPCS code E0609 (blood glucose monitor with special features (e.g. voice synthesizers, automatic timers, etc.)) is discontinued and crosswalked to the following HCPCS codes:

E2100 Blood glucose monitor with integrated voice synthesizer

E2101 Blood glucose monitor with integrated lancing/blood sample collection

Home blood glucose monitors previously meeting the description of HCPCS code E0609 must be coded E2100 or E2101, whichever is applicable. The coverage and payment rules associated with HCPCS code E0609 will also apply to HCPCS codes E2100 and E2101. Under the standard grace period, HCPCS code E0609 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with HCPCS code E0609 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding. Suppliers should contact the SADMERC for guidance on the correct coding of these devices.

HEATING DEVICE

New HCPCS Code

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for an infrared heating pad.

E0221 Infrared heating pad system

HCPCS code E0221 is in the inexpensive or routinely purchased payment category. This HCPCS code includes both the power source and the infrared therapy pads. Manufacturers or suppliers should contact the SADMERC for guidance on whether a particular device meets the definition of this HCPCS code.

Suppliers are reminded that the establishment of a unique HCPCS code for a particular product does not necessarily indicate coverage.
SPINAL ORTHOSES  
New and Revised HCPCS Codes

Effective for dates of service on or after January 1, 2002, several new HCPCS codes are established for prefabricated spinal orthoses and one existing HCPCS code (L0515) is being revised. The new/revised HCPCS codes are:

L0321 Thoracic-lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0331 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0391 Thoracic-lumbar-sacral orthosis, anterior-posterior-lateral-rotary control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0515 Lumbar-sacral orthosis, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0561 Lumbar-sacral orthosis, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)

L0986 Addition to spinal orthosis, rigid or semi-rigid abdominal panel, prefabricated

Also effective for dates of service on or after January 1, 2002, HCPCS codes L0315 (TLSO, flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel) and L0317 (TLSO, flexible dorso-lumbar surgical support, hyperextension, elastic type, with rigid posterior panel) will be invalid for claim submission to the DMERC. HCPCS code L0321 should be used instead. In accordance with the standard grace period, HCPCS codes L0315 and L0317 will be accepted for claims with dates of service on or after January 1, 2002 that are received by March 31, 2002.

In the HCPCS codes listed above, anterior-posterior control is achieved by a rigid or semi-rigid posterior panel. Lateral control is achieved by a rigid or semi-rigid panel in the mid-axillary line which is either an integral part of a posterior panel or a separate panel. Rotary control is achieved by a rigid or semi-rigid panel in the upper chest area which is attached by a rigid connection to a posterior, lateral, or abdominal panel.

HCPCS code L0986 would be used in addition to any of the other HCPCS codes listed if the prefabricated orthosis had a rigid or semi-rigid abdominal panel.

As defined in the Spinal Orthoses policy, HCPCS codes L0320-L0340 and HCPCS codes L0520-L0540 may only be used for custom fabricated spinal orthoses.

Refer to the Spinal Orthoses medical policy for definitions of prefabricated and custom fabricated orthoses.
Several new HCPCS codes have been established for devices used in the management of joint contractures:

- **E1801** Bi-directional static progressive elbow stretch device with range of motion adjustment, includes cuffs
- **E1806** Bi-directional static progressive wrist stretch device with range of motion adjustment, includes cuffs
- **E1811** Bi-directional static progressive knee stretch device with range of motion adjustment, includes cuffs
- **E1816** Bi-directional static progressive ankle stretch device with range of motion adjustment, includes cuffs
- **E1818** Bi-directional static progressive pronation/supination stretch device with range of motion adjustment, includes cuffs
- **E1821** Replacement soft interface material/cuffs for bi-directional static progressive stretch device

These HCPCS codes are effective for dates of service on or after January 1, 2002. Claims for these items for dates of service prior to January 1, 2002 will continue to be billed using HCPCS codes E1800 (elbow), E1805 (wrist), E1810 (knee), E1815 (ankle), E1399 (forearm pronation/supination), E1820 (replacement cuffs). The new HCPCS codes are considered durable medical equipment and are in the capped rental payment category (except for HCPCS code E1821, which is in the inexpensive or routinely purchased category). The rental allowance for HCPCS codes E1801, E1806, E1811, E1816, and E1818 includes cuffs and any other interface material that is needed.

HCPCS code E1821 would be payable only in situations in which a medically necessary device is owned by the patient. Examples of products billed using these HCPCS codes are the JAS devices by Joint Active Systems. For coding verification of other devices that may be billed using these HCPCS codes, manufacturers or suppliers should contact the SADMERC. Suppliers are reminded that the establishment of a unique HCPCS code for a particular product does not necessarily indicate coverage or full payment.

Changes have also been made in the related series of HCPCS codes describing dynamic adjustable extension/flexion devices - E1800, E1805, E1810, E1815, E1825, and E1830. Effective for dates of service on or after January 1, 2002, the phrase "or equal" has been removed from the HCPCS code narrative and the phrase "includes soft materials" has been added to each HCPCS code. In addition, a new HCPCS code has been added, effective for dates of service on or after January 1, 2002:

- **E1840** Dynamic adjustable shoulder flexion/extension/rotation device, includes soft interface material

Beginning with dates of service on or after January 1, 2002, the rental allowance for all these HCPCS codes includes the soft interface material.
**JOINT CONTRACTURE DEVICES**

**New and Revised HCPCS Codes**

cont.

HCPCS code E1825 (replacement soft interface material, dynamic adjustable extension/extension device) would be payable only in situations in which a medically necessary device is owned by the patient. Examples (not all-inclusive) of products billed using these HCPCS codes are joint contracture devices manufactured by Dynasplint Systems, Ultraflex, and Empi. For coding verification of devices that are billed using these HCPCS codes, manufacturers or suppliers should contact the SADMERC.

**LOWER EXTREMITY PROSTHESES**

**New HCPCS Code**

Effective for dates of service on or after January 1, 2002, a new HCPCS code has been established for suspension socket locking mechanisms.

L5671  Addition to lower extremity, below the knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert

Also effective for dates of service on or after January 1, 2002, HCPCS code L5669 (addition to lower extremity, below knee/above knee, suction suspension without locking mechanism) is discontinued. Items previously coded L5669 should be coded L5660, L5662, L5663 and L5664, whichever is applicable. Under the standard grace period, HCPCS code L5669 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with HCPCS code L5669 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

HCPCS code L5667 (addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism) is also discontinued effective for dates of service on or after January 1, 2002. Items previously coded L5667 should be coded with the combination of HCPCS code L5671 and the HCPCS code describing the applicable suspension socket insert. Under the standard grace period, HCPCS code L5667 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with HCPCS code L5667 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

Suppliers should contact the SADMERC for information on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Lower Extremity Prosthetics in the DMEPOS Supplier Manual.
MULTIPLE DENSITY SHOE INSERTS

New HCPCS Codes

Effective for dates of service on or after January 1, 2002, HCPCS code A5502 (For diabetics only, multiple density insert(s), per shoe) is discontinued and the following HCPCS codes are established for multi-density inserts covered under the Therapeutic Shoes for Diabetics benefit category:

- **A5509** For diabetics only, direct formed, molded to foot with external heat source (i.e. heat gun) multiple density insert(s), prefabricated, per shoe
- **A5510** For diabetics only, direct formed, compression molded to foot without external heat source, multiple density insert(s), prefabricated, per shoe
- **A5511** For diabetics only, custom molded from model of patient’s foot, multiple density insert(s), custom fabricated, per shoe

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Therapeutic Shoes for Diabetics in the DMEPOS Supplier Manual.

GASTROSTOMY TUBES

New HCPCS Code

A new HCPCS code has been created for use with gastrostomy and jejunostomy tubes.

- **B4086** Gastrostomy/jejunosotmy tube, any material, any type, (standard or low profile), each

This HCPCS code is effective for claims with dates of service on or after January 1, 2002. This HCPCS code replaces HCPCS codes B4084 (Gastrostomy/jejunosotmy tubing) and B4085 (Gastrostomy tube, silicone with sliding ring, each).

Under the standard grace period, HCPCS codes B4084 and B4085 will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with HCPCS codes B4084 and B4085 with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

Suppliers should contact the SADMERC for guidance on the correct coding of these devices.

For further details on the coverage and payment rules, coding and documentation guidelines, refer to the local medical review policy on Enteral Nutrition in the DMEPOS Supplier Manual.
Tracheo-Esophageal Voice Prostheses

New HCPCS Codes

Two new HCPCS codes have been established for tracheo-esophageal voice prostheses:

- L8507 Tracheo-esophageal voice prosthesis, patient inserted, any type, each
- L8509 Tracheo-esophageal voice prosthesis, inserted by licensed health care provider, any type, each

These HCPCS codes are effective for dates of service on or after January 1, 2002. Claims for these items with dates of service prior to January 1, 2002 must continue to be submitted with the miscellaneous HCPCS code L8499. The new HCPCS codes are in the prosthetic devices payment category.

The new HCPCS codes describe small tubes that are placed in a surgically created opening between the trachea and esophagus in selected patients who have had a laryngectomy. The tubes have a one-way valve that allow the flow of air from the trachea, through the tube, and into the esophagus, enabling the patient to speak.

HCPCS code L8509 describes a device that is designed to be removed and replaced only by a physician or other health care provider.

HCPCS code L8507 describes a device that is designed to be removed and replaced by the patient for cleaning. Even if this type of device is inserted by a physician, HCPCS code L8507 must be used.

Non-Contact Wound Warming System

New HCPCS Codes

Effective for dates of service on or after January 1, 2002, new HCPCS codes have been established for a non-contact wound warming system.

- E0231 Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover
- E0232 Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover
- A6000 Non-contact wound warming cover for use with the non-contact wound warming device and warming card

HCPCS code E0231 is in the capped rental payment category. HCPCS codes E0232 and A6000 are in the miscellaneous durable medical equipment payment category. Suppliers are reminded that the establishment of a unique HCPCS code for a particular product does not necessarily indicate coverage.

Suppliers should contact the SADMERC for guidance on the correct coding of these devices.
NONCOVERED ITEMS, NOT MEDICALLY NECESSARY ITEMS, AND ADVANCE BENEFICIARY NOTICES

New Modifiers

**Noncovered items**

Effective for dates of service on or after January 1, 2002, a new modifier has been established to describe situations in which an item or service with a specific HCPCS code is noncovered.

**GY** Item or service statutorily excluded or does not meet the definition of any Medicare benefit

The GY modifier replaces the current ZY modifier for dates of service on or after January 1, 2002. The ZY modifier should continue to be used for claims with dates of service on or before December 31, 2001, regardless of the date of submission. Under the standard grace period, the ZY modifier will continue to be accepted on claims with dates of service on or after January 1, 2002 that are received by March 31, 2002. Claim lines with the ZY with dates of service on or after January 1, 2002 that are received on or after April 1, 2002 will be rejected as invalid coding.

It is important to distinguish situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit from those situations in which an item is denied because it is not reasonable and necessary (see below). Some examples of statutorily excluded items or situations include, but are not limited to:

- Hearing aids
- Eyeglasses or contact lenses - except those provided following cataract removal or other cause of aphakia
- Durable medical equipment and related accessories and supplies provided to patients in nursing facilities
- Dental items
- Personal comfort items
- Orthopedic shoes or shoe inserts - other than those covered under the Therapeutic Shoes for Diabetics benefit or those that are attached to a covered leg brace
- Replacement of items that have not reached their useful lifetime and were not lost, stolen, or irreparably damaged (not including ordinary wear and tear)

Some examples of items or situations which do not meet the definition of a Medicare benefit include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition
- Enteral nutrients that are administered orally
- Infusion drugs that are not administered through a durable infusion pump
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin
- Irrigation supplies that are used to irrigate the skin or wounds
- Immunosuppressive drugs when they are used for conditions other than following organ transplants
- Most oral drugs
- Oral anti-cancer drugs when there is no injectable or infusion form of the drug
- Nondurable items (that are not covered under any other benefit category) - e.g., compression stockings and sleeves
Noncovered Items, Not Medically Necessary Items, and Advance Beneficiary Notices

New Modifiers

cont.

- Durable items that are not primarily designed to serve a medical purpose - e.g., exercise equipment

Use of the GY modifier is usually limited to situations in which there is a HCPCS code to describe the item or service. If there is no specific HCPCS code to describe the item or service, then HCPCS code A9270 (Noncovered item or service) is usually used. The GY modifier is not needed with HCPCS code A9270. HCPCS code A9270 must not be used in situations in which an item is expected to be denied as not reasonable and necessary (see below).

An Advance Beneficiary Notice (ABN) is not required for items that are statutorily excluded from coverage or that do not meet the definition of any Medicare benefit category since the DMERC does not make limitation of liability determinations for these types of denials.

Not medically necessary items

Effective for dates of service on or after January 1, 2002, a new modifier, GZ, has been established to describe certain situations in which an item or service is expected to be denied as not medically necessary. The new modifier will complement the existing GA modifier which is used in other situations in which an item or service is expected to be denied as not medically necessary.

<table>
<thead>
<tr>
<th>GZ</th>
<th>Item or service expected to be denied as not reasonable and necessary (Used when an Advance Beneficiary Notice is not on file)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>Waiver of liability statement on file (Used when an item or service is expected to be denied as not reasonable and necessary and an Advance Beneficiary Notice is on file)</td>
</tr>
</tbody>
</table>

It is important to distinguish situations in which an item is denied because it is not reasonable and necessary from those situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit (see above). Some examples of items or situations which are medical necessity denials include, but are not limited to:

- Items which are not ordered by a physician or qualified nurse practitioner, clinical nurse specialist, or physician assistant
- Items which do not meet medical necessity coverage criteria or frequency guidelines specified in national or DMERC medical policies
- Items which are the same as or similar to covered items that the beneficiary is already using
- Items whose safety and effectiveness in the home setting has not been established
- Experimental or investigational items - other than Category B IDE devices

It would never be correct to place both modifiers on the same claim line. If both modifiers are used on the same claim line, it will be denied as invalid coding.
Suction Catheters: Oropharyngeal vs. Tracheoesophageal

HCPCS code A4624 describes a tracheal suction catheter (Illustration A). These are long, flexible catheters typically contained in a sterile package. Suppliers should distinguish HCPCS code A4624 from an oropharyngeal suction catheter (HCPCS code A4628), commonly referred to as a Yankauer suction tube (Illustration B). These are short, rigid, plastic suction instruments of durable construction. For additional information on the coverage and payment rules, coding and documentation guidelines, suppliers should consult the local medical review policy on Suction Pumps in the DMEPOS Supplier Manual.

Illustration A
Illustration B

Pessary HCPCS Codes: Change in Jurisdiction

Effective for dates of service on or after January 1, 2002, jurisdiction for processing claims for the following pessary HCPCS codes will change from the durable medical equipment regional carriers (DMERCs) to the local carriers:

A4561  Pessary, rubber, any type
A4562  Pessary, non-rubber, any type

Suppliers and physicians should contact the local carrier in their area for instructions on how to submit claims for these items.

Regional Medical Review Policies (RMRPs) Have a New Name

The CMS has instructed the DMERCs to change the name of their policies. Local Medical Review Policies (LMRPs), formerly RMRPs, will now be used when referring to policies published by the DMERCs.
The amount of Medicare payment for home dialysis supplies and equipment may not exceed $1,490.85 per month for patients on all forms of dialysis except continuous cycling peritoneal dialysis (CCPD). For CCPD, total payment may not exceed $1,974.45 per month. It has been determined that the DMERCs have been paying incorrectly for home dialysis supplies and equipment. In most cases, DMERCs have based payment on the supplier’s actual charges limited by the monthly cap instead of the reasonable charges limited by the monthly cap.

In addition, most suppliers have been billing for dialysis supplies using HCPCS codes describing “kits” of supplies. The use of kit HCPCS codes such as A4820, A4900, A4901, A4905 and A4914 allows suppliers to bill for supply items without separately identifying the supplies that are being furnished to the patient. Effective January 1, 2002, these kit HCPCS codes will be deleted and suppliers will be required to bill for dialysis supplies using existing and newly developed HCPCS codes for individual dialysis supplies. The following are the HCPCS codes for dialysis supplies and equipment that will be effective for claims received on or after January 1, 2002:

<table>
<thead>
<tr>
<th>A4651</th>
<th>A4712</th>
<th>A4737</th>
<th>A4801</th>
<th>E1520</th>
<th>E1610</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4652</td>
<td>A4714</td>
<td>A4740</td>
<td>A4802</td>
<td>E1530</td>
<td>E1615</td>
</tr>
<tr>
<td>A4656</td>
<td>A4719</td>
<td>A4750</td>
<td>A4860</td>
<td>E1540</td>
<td>E1620</td>
</tr>
<tr>
<td>A4657</td>
<td>A4720</td>
<td>A4755</td>
<td>A4870</td>
<td>E1550</td>
<td>E1625</td>
</tr>
<tr>
<td>A4660</td>
<td>A4721</td>
<td>A4760</td>
<td>A4911</td>
<td>E1560</td>
<td>E1630</td>
</tr>
<tr>
<td>A4663</td>
<td>A4722</td>
<td>A4765</td>
<td>A4913</td>
<td>E1570</td>
<td>E1632</td>
</tr>
<tr>
<td>A4680</td>
<td>A4723</td>
<td>A4766</td>
<td>A4918</td>
<td>E1575</td>
<td>E1635</td>
</tr>
<tr>
<td>A4690</td>
<td>A4724</td>
<td>A4770</td>
<td>A4927</td>
<td>E1580</td>
<td>E1636</td>
</tr>
<tr>
<td>A4706</td>
<td>A4725</td>
<td>A4771</td>
<td>A4928</td>
<td>E1590</td>
<td>E1637</td>
</tr>
<tr>
<td>A4707</td>
<td>A4726</td>
<td>A4772</td>
<td>A4929</td>
<td>E1592</td>
<td>E1638</td>
</tr>
<tr>
<td>A4708</td>
<td>A4730</td>
<td>A4773</td>
<td>E1500</td>
<td>E1594</td>
<td>E1639</td>
</tr>
<tr>
<td>A4709</td>
<td>A4736</td>
<td>A4774</td>
<td>E1510</td>
<td>E1600</td>
<td>E1699</td>
</tr>
</tbody>
</table>

The DMERCs are to gap-fill reasonable charge amounts for 2002 for all of the HCPCS codes above other than A4913 and E1699, the HCPCS codes used for miscellaneous supplies and equipment that don’t fall under any of the other HCPCS codes. The gap-filled amounts should be established using price lists in effect as of December 31, 2000 if available. These gap-filled payment amounts will apply to all claims with dates of service from January 1, 2002 through December 31, 2002.

On June 7, 2000, the President of the United States issued an executive memorandum directing CMS to "explicitly authorize [Medicare] payment for routine patient care costs...and costs due to medical complications associated with participation in clinical trials." In keeping with the President’s directive, this National Coverage Decision (NCD) serves to define the routine costs of clinical trials and identify the clinical trials for which payment for such routine costs should be made for eligible services furnished on or after September 19, 2000.

The CMS has developed a National Coverage Determination (NCD)
CLINICAL TRIALS cont.

which can be accessed and downloaded from the CMS web page at www.cms.hhs.gov/quality/8d.htm. This NCD states that Medicare covers: 1) the routine costs of qualifying clinical trials as well as 2) reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. This instruction addresses routine costs of qualifying clinical trials including complications resulting from qualifying clinical trials. All other Medicare rules apply.

Clinical trial services that qualify for coverage

Clinical trial services covered by Medicare must meet both the following requirements:

1. Qualifying Trial. In order to be covered, the service must be part of a trial that meets all of the following criteria in order to be considered a qualifying trial:

   a. Evaluates a Medicare Benefit. The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physician's service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).

   b. Has a Therapeutic Intent. The trial must have a therapeutic intent (i.e., is not designed exclusively to test toxicity or disease pathophysiology).

   c. Enrolls Diagnosed Beneficiaries. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

   d. Has Desirable Characteristics. The desirable characteristics are listed in the NCD.

   • Deemed Trials. Some trials are automatically deemed as having desirable characteristics. They include:

   Effective September 19, 2000

   - Trials funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), CMS, Department of Defense (DOD), and Department of Veterans Affairs (VA);

   - Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD and VA;

   - Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration (FDA); and

   - Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) are deemed until the qualifying criteria are developed and the certification process is in place. At this time the principal investigators of
CLINICAL TRIALS

these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status.

Until the Medicare clinical trials registry is established, the sponsors of both IND trials and IND-exempt trials must identify themselves by e-mail to clinicaltrials@cms.hhs.gov for administration, payment and program integrity purposes.

- **Self-Certified Trials.** In the future, a multi-agency Federal panel (see NCD for further details) will develop qualifying criteria that will indicate a strong probability that a trial exhibits the desirable characteristics as stated in the NCD. No trials are covered based upon self-certification at this time.

2. **Routine Costs.** Routine costs of a clinical trial include all items and services that are provided in either the experimental or the control arms of a trial except those listed below as not covered. Services provided to Medicare beneficiaries in both the experimental group and the control group are eligible for coverage provided that all other criteria in this instruction are met.

Routine costs do NOT include (and are therefore not covered):
- The investigational item or service itself;
- Items and services:
  - For which there is no Medicare benefit category; or
  - Which are statutorily excluded; or
  - That fall under a national noncoverage policy;
- Items and services furnished solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items and services provided solely to determine trial eligibility.

Routine costs DO include (and are therefore covered):
- Items or services that are typically provided absent a clinical trial (e.g., medically necessary conventional care);
- Items and services required for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent);
- Items and services required for the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.
**Purpose of a Statement of Intent**

The purpose of a statement of intent (SOI) is to extend the timely filing period for the submission of an initial claim. An SOI by itself does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim.

An SOI to claim Medicare benefits must be postmarked on or before, or be received by Palmetto GBA or the CMS regional office, no later than the last day of the timely filing period that pertains to the service(s) covered by the SOI.

After a valid SOI has been filed, a completed claim must be submitted to Palmetto GBA within six months after the month in which Palmetto GBA notifies the supplier who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later.

An SOI must be signed, and the person signing must indicate the capacity in which he/she is signing (e.g., beneficiary or authorized representative, provider or supplier).

A valid SOI must be submitted to the appropriate contractor and must contain the following information:

- Beneficiary name;
- Medicare HICN;
- Name, address and Medicare supplier number at time of service;
- Dates of service for which a specific claim will be filed;
- Applicable HCPCS code and appropriate modifiers for each service.

In order for an SOI submitted to the CMS regional office to be valid, it must include all of the above information and must also include the correct name and address of the Medicare contractor that will be responsible for processing the subsequent claim(s).

---

**2001 Claims Filing Reminder**

December 31, 2001 is an important date for Region C suppliers. It marks not only the end of the calendar year, but also the end of the claims filing year.

Federal law requires that Part B suppliers file claims for Medicare beneficiaries within one year of the date of service. Failure to comply with this mandate carries monetary penalties for both assigned and non-assigned claims. In addition, claims not filed by December 31, 2001 for services rendered from October 1, 1999 through September 30, 2000 will be denied for timely filing. For detailed claims filing information, refer to Chapter 5 of the Region C DMERC DMEPOS Supplier Manual.
**Dementia Patients: Claims Filing**

Claims should be filed with the primary diagnosis or condition as well as secondary diagnoses or conditions that most closely reflect the medical necessity of the billed service on Item 21 of Form HCFA-1500 (12-90).

When a beneficiary with dementia experiences an illness or injury unrelated to the dementia, the claim should be submitted with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer’s Disease, a durable medical equipment supplier should submit a claim using ICD-9-CM code V43.64 (Hip joint replacement by artificial or mechanical device or prosthesis) as the primary diagnosis, not ICD-9-CM code 331.0 (Alzheimer’s Disease).

---

**Prior Authorization/ADMC Reminder**

Effective September 1, 2001, prior authorization is no longer available for power operated vehicles (POVs), seat lift mechanisms, and transcutaneous electrical nerve stimulators (TENS). Prior authorizations received after September 1, 2001 will be returned to the requester.


---

**SADMERC HCPCS Coding Verification Reviews: Product Samples**

One of the functions of the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is to ensure uniform coding by manufacturers and suppliers nationally. In order to facilitate this process, SADMERC requires specific documentation and/or samples of products to conduct a HCPCS Coding Verification Review. Documentation required for a review is identified on the "Required Documentation Necessary for HCPCS Coding Verification Reviews" form, which can be accessed at www.PalmettoGBA.com. From the home page, click Other Partners/SADMERC/HCPCS Coding Verification Reviews.

Effective October 1, 2001, SADMERC requires applicants to submit samples of the following types of products when requesting a HCPCS Coding Verification Review:

- Diabetic shoes and/or inserts
- Group II support surfaces (specifically gel overlays)
- Orthotics (specifically AFOs, KAFOs, KOs, WHAOs, TLSOs)
- Surgical dressings
- Wheelchair cushions

Please be aware that it is not the policy of the SADMERC to return submitted product samples. These products are often dismantled, tested and rendered unusable during the review process. Therefore, these samples will not be returned.
CONSOLIDATED BILLING FOR SKILLED NURSING FACILITY (SNF) RESIDENTS REMINDER

Services provided to a SNF resident in a Medicare Part A stay must be provided and billed by the SNF to the appropriate Medicare Part A fiscal intermediary. To correspond with the annual and quarterly coding and payment updates, the common working file will be provided with files of HCPCS codes that are not included in consolidated billing and can be paid through the DMERC. The carrier SNF coding files (CSCF) will be made available to suppliers for informational purposes on the CMS Web site at www.CMS.HHS.CSCF.gov.

HOME HEALTH CONSOLIDATED BILLING

The CMS provides annual updates to the list of non-routine medical supply and therapy HCPCS codes included in home health consolidated billing (CB) to reflect the annual HCPCS code revisions. These HCPCS codes in these lists are bundled into the prospective payment system (PPS) rate. Therefore, providers and suppliers may not bill for these HCPCS codes separately while a Medicare beneficiary is in an open home health episode.

The following are the changes to the non-routine medical supply list for dates of service beginning January 1, 2002:

New HCPCS code subject to CB:
A6010  Collagen based wound filler, dry foam

Discontinued HCPCS code, no longer subject to CB:
A4329  External catheter start set

RENTAL ITEMS

Effective for dates of service on or after April 1, 2002, a new modifier has been established to indicate billing of durable medical equipment for a partial month of service.

KR    Rental item - billing for partial month

Suppliers who wish to exercise the option of billing Medicare for a partial month(s) of rental on DME should use the KR modifier. Although suppliers are entitled to bill and receive a full month's reimbursement for rented DME provided to qualifying beneficiaries, suppliers now have the option of billing for a partial month of service and receiving reimbursement on a prorated basis by using the KR modifier.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the HCFA-1500 (12-90) claim form for each partial month of billing. The modifier RR, indicating rental, must also be appended to the claim line for the partial month rental item(s).
Mandatory Assignment Drugs HCPCS Codes

Under the Benefits Improvement and Protection Act of 2000, suppliers must accept assignment on Medicare-covered drugs. This ruling went into effect on February 1, 2001. Following are the HCPCS codes and applicable benefits and policies for those drugs covered by Medicare.

**Benefit: PROS**
Policy: Parenteral

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B4164</td>
<td>B4176</td>
</tr>
<tr>
<td>B4168</td>
<td>B4178</td>
</tr>
<tr>
<td>B4172</td>
<td>B4180</td>
</tr>
<tr>
<td>B4184</td>
<td>B4186</td>
</tr>
<tr>
<td>B4193</td>
<td>B4197</td>
</tr>
<tr>
<td>B4216</td>
<td>B5000</td>
</tr>
<tr>
<td>B5200</td>
<td></td>
</tr>
</tbody>
</table>

**Benefit: DME**
Policy: External Infusion Pump

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J0285</td>
<td>J1325</td>
</tr>
<tr>
<td>J0286</td>
<td>J1455</td>
</tr>
<tr>
<td>J2895</td>
<td>J1570</td>
</tr>
<tr>
<td>J1170</td>
<td>J1820</td>
</tr>
<tr>
<td>J1250</td>
<td>J2175</td>
</tr>
<tr>
<td>J2260</td>
<td>J2270</td>
</tr>
<tr>
<td>J0900</td>
<td>J0940</td>
</tr>
<tr>
<td>J0905</td>
<td>J0965</td>
</tr>
<tr>
<td>J1010</td>
<td>J1030</td>
</tr>
<tr>
<td>J1110</td>
<td>J1120</td>
</tr>
<tr>
<td>J1170</td>
<td>J1180</td>
</tr>
<tr>
<td>J1250</td>
<td>J1260</td>
</tr>
<tr>
<td>J1325</td>
<td>J1335</td>
</tr>
<tr>
<td>J1455</td>
<td>J1465</td>
</tr>
<tr>
<td>J1570</td>
<td>J1580</td>
</tr>
<tr>
<td>J1820</td>
<td>J1830</td>
</tr>
<tr>
<td>J2175</td>
<td>J2180</td>
</tr>
</tbody>
</table>

**Benefit: Immuno**
Policy: Immunosuppressive Drugs

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J2920</td>
<td>J2930</td>
</tr>
<tr>
<td>J7502</td>
<td>J7504</td>
</tr>
<tr>
<td>J7503</td>
<td>J7505</td>
</tr>
<tr>
<td>J7506</td>
<td>J7507</td>
</tr>
<tr>
<td>J7512</td>
<td>J7513</td>
</tr>
<tr>
<td>J7520</td>
<td>J7525</td>
</tr>
<tr>
<td>J7522</td>
<td>J7525</td>
</tr>
<tr>
<td>J7526</td>
<td>J7530</td>
</tr>
</tbody>
</table>

**Benefit: DME**
Policy: Nebulizer

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J2545</td>
<td>J2628*</td>
</tr>
<tr>
<td>J7051</td>
<td>J7029*</td>
</tr>
<tr>
<td>J7608*</td>
<td>J7631*</td>
</tr>
<tr>
<td>J7618*</td>
<td>J7635*</td>
</tr>
<tr>
<td>J7619*</td>
<td>J7636*</td>
</tr>
<tr>
<td>J7637*</td>
<td>J7642*</td>
</tr>
<tr>
<td>J7643*</td>
<td>J7658*</td>
</tr>
<tr>
<td>J7659*</td>
<td>J7682*</td>
</tr>
<tr>
<td>J7664*</td>
<td>J7683*</td>
</tr>
<tr>
<td>J7668*</td>
<td>J7684*</td>
</tr>
<tr>
<td>J7680*</td>
<td>J7684*</td>
</tr>
<tr>
<td>J7681*</td>
<td>K0283</td>
</tr>
<tr>
<td>J7682*</td>
<td></td>
</tr>
</tbody>
</table>

*Include KO, KP, KQ modifiers if applicable.

**Benefit: EPO**
Policy: Epoetin Alpha

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9920</td>
<td>Q9921</td>
</tr>
<tr>
<td>Q9922</td>
<td>Q9923</td>
</tr>
<tr>
<td>Q9924</td>
<td>Q9925</td>
</tr>
<tr>
<td>Q9926</td>
<td>Q9927</td>
</tr>
<tr>
<td>Q9928</td>
<td>Q9928</td>
</tr>
<tr>
<td>Q9932</td>
<td>Q9932</td>
</tr>
<tr>
<td>Q9933</td>
<td>Q9933</td>
</tr>
<tr>
<td>Q9934</td>
<td>Q9934</td>
</tr>
<tr>
<td>Q9935</td>
<td>Q9935</td>
</tr>
<tr>
<td>Q9936</td>
<td>Q9936</td>
</tr>
<tr>
<td>Q9940</td>
<td>Q9940</td>
</tr>
</tbody>
</table>

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

**DRUGS HCPCS CODES**

*cont.*

<table>
<thead>
<tr>
<th>Benefit: OACD</th>
<th>Policy: Oral Anti-Cancer Drugs</th>
<th>HCPCS and NDC Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0415</td>
<td>59911-5874-01</td>
<td>00405-4643-36</td>
</tr>
<tr>
<td>K0416</td>
<td>00005-4507-04</td>
<td>00405-4643-01</td>
</tr>
<tr>
<td>00085-1248-01</td>
<td>00005-4507-05</td>
<td>00904-1749-73</td>
</tr>
<tr>
<td>00085-1252-02</td>
<td>00005-4507-07</td>
<td>00054-4550-25</td>
</tr>
<tr>
<td>00085-1252-01</td>
<td>00005-4507-09</td>
<td>00054-8550-03</td>
</tr>
<tr>
<td>00085-1259-02</td>
<td>00054-4550-15</td>
<td>00054-8550-05</td>
</tr>
<tr>
<td>00085-1244-02</td>
<td>00054-8550-25</td>
<td>00054-8550-06</td>
</tr>
<tr>
<td>00085-1244-01</td>
<td>00005-4507-91</td>
<td>00054-8550-07</td>
</tr>
<tr>
<td>00085-1259-01</td>
<td>00536-3998-01</td>
<td>00054-8550-10</td>
</tr>
<tr>
<td>00085-1248-02</td>
<td>00536-3998-36</td>
<td>00555-0572-45</td>
</tr>
<tr>
<td>00015-0504-01</td>
<td>00005-4507-23</td>
<td>00555-0572-46</td>
</tr>
<tr>
<td>00015-0503-01</td>
<td>00555-0572-35</td>
<td>00555-0572-47</td>
</tr>
<tr>
<td>00015-0503-02</td>
<td>00555-0572-02</td>
<td>00555-0572-48</td>
</tr>
<tr>
<td>00054-4129-25</td>
<td>00781-1076-36</td>
<td>00555-0572-49</td>
</tr>
<tr>
<td>00054-4130-25</td>
<td>00781-1076-01</td>
<td>00182-1539-95</td>
</tr>
<tr>
<td>00173-0713-25</td>
<td>00182-1539-01</td>
<td>00081-0045-35</td>
</tr>
<tr>
<td>00015-3091-45</td>
<td>00904-1749-60</td>
<td>00173-0045-35</td>
</tr>
<tr>
<td>51285-0509-02</td>
<td>00378-0014-01</td>
<td>00004-1100-22</td>
</tr>
<tr>
<td>62701-0940-36</td>
<td>58469-3998-30</td>
<td>00004-1100-13</td>
</tr>
<tr>
<td>62701-0940-99</td>
<td>00603-4499-21</td>
<td>00004-1101-51</td>
</tr>
<tr>
<td>00677-1610-01</td>
<td>00364-2499-01</td>
<td>00004-1101-16</td>
</tr>
<tr>
<td>00364-2499-36</td>
<td>51079-0670-05</td>
<td>00004-1101-13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit: OAED</th>
<th>Policy: Oral Anti-Emetic Drugs</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0163</td>
<td>Q0167</td>
<td>Q0171</td>
</tr>
<tr>
<td>Q0164</td>
<td>Q0168</td>
<td>Q0172</td>
</tr>
<tr>
<td>Q0165</td>
<td>Q0169</td>
<td>Q0173</td>
</tr>
<tr>
<td>Q0166</td>
<td>Q0170</td>
<td>Q0174</td>
</tr>
</tbody>
</table>
2001 FOURTH 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 in bold text.

The unit of measure for the fee amounts noted corresponds to the unit of measure noted in the HCPCS 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.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Region C</th>
<th>HCPCS</th>
<th>Region C</th>
<th>HCPCS</th>
<th>Region C</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0285</td>
<td>$10.28</td>
<td>J7629KO</td>
<td>$0.33</td>
<td>J7681KQ</td>
<td>$2.13</td>
</tr>
<tr>
<td>J0286</td>
<td>$88.66</td>
<td>J7629KP</td>
<td>$0.33</td>
<td>J7682KP</td>
<td>$44.69</td>
</tr>
<tr>
<td>J0895</td>
<td>$13.50</td>
<td>J7629KQ</td>
<td>$0.25</td>
<td>J7684KP</td>
<td>$0.04</td>
</tr>
<tr>
<td>J1170</td>
<td>$1.49</td>
<td>J7631KO</td>
<td>$0.27</td>
<td>J7684KO</td>
<td>$0.14</td>
</tr>
<tr>
<td>J1250</td>
<td>$2.97</td>
<td>J7631KP</td>
<td>$0.27</td>
<td>J7684KQ</td>
<td>$0.04</td>
</tr>
<tr>
<td>J1325</td>
<td>$12.04</td>
<td>J7631KQ</td>
<td>$0.16</td>
<td>J7684KO</td>
<td>$0.14</td>
</tr>
<tr>
<td>J1455</td>
<td>$12.00</td>
<td>J7635</td>
<td>$0.10</td>
<td>J9000</td>
<td>$50.96</td>
</tr>
<tr>
<td>J1570</td>
<td>$33.89</td>
<td>J7636KO</td>
<td>$0.37</td>
<td>J9040</td>
<td>$289.37</td>
</tr>
<tr>
<td>J1820</td>
<td>$2.29</td>
<td>J7636KP</td>
<td>$0.37</td>
<td>J9065</td>
<td>$56.09</td>
</tr>
<tr>
<td>J2175</td>
<td>$0.56</td>
<td>J7636KQ</td>
<td>$0.16</td>
<td>J9100</td>
<td>$5.94</td>
</tr>
<tr>
<td>J2260</td>
<td>$46.34</td>
<td>J7637</td>
<td>$0.10</td>
<td>J9110</td>
<td>$23.75</td>
</tr>
<tr>
<td>J2270</td>
<td>$0.62</td>
<td>J7638KO</td>
<td>$0.21</td>
<td>J9190</td>
<td>$2.47</td>
</tr>
<tr>
<td>J2271</td>
<td>$13.85</td>
<td>J7638KP</td>
<td>$0.21</td>
<td>J9200</td>
<td>$129.56</td>
</tr>
<tr>
<td>J2275</td>
<td>$2.00</td>
<td>J7638KQ</td>
<td>$0.10</td>
<td>J9360</td>
<td>$4.10</td>
</tr>
<tr>
<td>J2545</td>
<td>$93.81</td>
<td>J7639KO</td>
<td>$15.87</td>
<td>J9370</td>
<td>$33.98</td>
</tr>
<tr>
<td>J2920</td>
<td>$1.58</td>
<td>J7639KP</td>
<td>$15.87</td>
<td>J9375</td>
<td>$67.96</td>
</tr>
<tr>
<td>J2930</td>
<td>$1.92</td>
<td>J7639KQ</td>
<td>$15.79</td>
<td>J9380</td>
<td>$169.91</td>
</tr>
<tr>
<td>J3010</td>
<td>$1.96</td>
<td>J7642</td>
<td>$0.31</td>
<td>J9548</td>
<td>$2.27</td>
</tr>
<tr>
<td>J7051</td>
<td>$0.23</td>
<td>J7643KO</td>
<td>$0.84</td>
<td>Q0163</td>
<td>$0.02</td>
</tr>
<tr>
<td>J7500</td>
<td>$1.24</td>
<td>J7643KP</td>
<td>$0.84</td>
<td>Q0164</td>
<td>$0.57</td>
</tr>
<tr>
<td>J7501</td>
<td>$118.95</td>
<td>J7643KQ</td>
<td>$0.31</td>
<td>Q0165</td>
<td>$0.86</td>
</tr>
<tr>
<td>J7506</td>
<td>$5.23</td>
<td>J7644KO</td>
<td>$3.34</td>
<td>Q0166</td>
<td>$44.69</td>
</tr>
<tr>
<td>J7507</td>
<td>$0.02</td>
<td>J7644KP</td>
<td>$3.34</td>
<td>Q0167</td>
<td>$3.28</td>
</tr>
<tr>
<td>J7508</td>
<td>$2.91</td>
<td>J7644KQ</td>
<td>$2.93</td>
<td>Q0168</td>
<td>$7.66</td>
</tr>
<tr>
<td>J7509</td>
<td>$14.55</td>
<td>J7648</td>
<td>$0.17</td>
<td>Q0169</td>
<td>$0.26</td>
</tr>
<tr>
<td>J7510</td>
<td>$0.51</td>
<td>J7649KO</td>
<td>$0.21</td>
<td>Q0170</td>
<td>$0.02</td>
</tr>
<tr>
<td>J7513</td>
<td>$397.29</td>
<td>J7649KP</td>
<td>$0.21</td>
<td>Q0171</td>
<td>$0.07</td>
</tr>
<tr>
<td>J7515</td>
<td>$1.31</td>
<td>J7649KQ</td>
<td>$0.17</td>
<td>Q0172</td>
<td>$0.09</td>
</tr>
<tr>
<td>J7517</td>
<td>$2.40</td>
<td>J7658</td>
<td>IC</td>
<td>Q0173</td>
<td>$0.43</td>
</tr>
<tr>
<td>J7520</td>
<td>$6.51</td>
<td>J7659KO</td>
<td>IC</td>
<td>Q0174</td>
<td>$0.56</td>
</tr>
<tr>
<td>J7608KO</td>
<td>$5.05</td>
<td>J7659KP</td>
<td>IC</td>
<td>Q0175</td>
<td>$0.57</td>
</tr>
<tr>
<td>J7608KP</td>
<td>$5.05</td>
<td>J7659KQ</td>
<td>IC</td>
<td>Q0176</td>
<td>$0.93</td>
</tr>
<tr>
<td>J7608KQ</td>
<td>$4.54</td>
<td>J7669KO</td>
<td>$1.09</td>
<td>Q0177</td>
<td>$0.34</td>
</tr>
<tr>
<td>J7618</td>
<td>$0.14</td>
<td>J7669KP</td>
<td>$1.09</td>
<td>Q0178</td>
<td>$0.29</td>
</tr>
<tr>
<td>J7619KO</td>
<td>$0.47</td>
<td>J7669KQ</td>
<td>$0.25</td>
<td>Q0179</td>
<td>$25.15</td>
</tr>
<tr>
<td>J7619KP</td>
<td>$0.47</td>
<td>J7680</td>
<td>$2.13</td>
<td>Q0180</td>
<td>$69.64</td>
</tr>
<tr>
<td>J7619KQ</td>
<td>$0.14</td>
<td>J7681KO</td>
<td>$2.34</td>
<td>Q9920</td>
<td>$10.00</td>
</tr>
<tr>
<td>J7628</td>
<td>$0.25</td>
<td>J7681KP</td>
<td>$2.34</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: The above drug allowables are effective October 1, 2001 and are subject to change on a quarterly basis.

Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.
The following drug allowables are effective October 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, busulfan, etoposide and melphalan resulted in fee changes.

The fees are as follows:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>STRENGTH</th>
<th>10/1/2001 PER TABLET FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Busulfan</td>
<td>2 mg</td>
<td>$1.91</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>150 mg</td>
<td>$2.43</td>
</tr>
<tr>
<td>Capecitabine</td>
<td>500 mg</td>
<td>$8.11</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>25 mg</td>
<td>$1.98</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>50 mg</td>
<td>$3.64</td>
</tr>
<tr>
<td>Etoposide</td>
<td>50 mg</td>
<td>$52.43</td>
</tr>
<tr>
<td>Melphalan</td>
<td>2 mg</td>
<td>$2.29</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>2.5 mg</td>
<td>$2.92</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>5 mg</td>
<td>$6.17</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>20 mg</td>
<td>$24.68</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>100 mg</td>
<td>$123.40</td>
</tr>
<tr>
<td>Temozolomide</td>
<td>250 mg</td>
<td>$308.49</td>
</tr>
</tbody>
</table>

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

As mandated by the Balanced Budget Refinement Act of 1999, the fee schedule for DME will be receiving a temporary increase of 0.6 percent for 2002. In accordance with §1833(o)(2) of the Social Security Act, this 0.6 percent temporary increase for 2002 also applies to the national payment limit for therapeutic shoes. Because this 0.6 percent increase applies only to 2002, it will not be carried over into future years (e.g., 2003, 2004).

Furthermore, as outlined in §§425 and 426 of the Benefits Improvement and Protection Act (BIPA) of 2000, the July 1, 2001 temporary update factors of 3.28 percent (which was applied to the fee schedules for DME, surgical dressings, ostomy supplies, tracheostomy supplies, and urologicals, and therapeutic shoe payment limits), and 2.6 percent (which was applied to prosthetics and orthotics) will not be carried over into 2002. Thus, in most cases, the fee schedule amounts will receive a decrease from 2001 to 2002.

As mandated by the Balanced Budget Act of 1997, the fee schedules for surgical dressings, ostomy supplies, tracheostomy supplies, and urologicals are to be frozen for 2002. The fee schedule for prosthetic and orthotic devices (excluding ostomy supplies, tracheostomy supplies and urologicals) will be increased by 1 percent for 2002.
2002 Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Parenteral and enteral nutrition (PEN) items and services are now in fee schedule

The Secretary, as authorized by §4315 of the Balanced Budget Act of 1997, has implemented a fee schedule for parenteral and enteral nutrition (PEN) items and services. These items and services were previously paid on a reasonable charge basis. The new fee schedule amounts are effective for claims with dates of service on or after January 1, 2002.

Elimination of DMEPOS fee schedules for repair HCPCS codes E1340, L4205, L7520 and L8049

The fee schedules established for HCPCS codes E1340, L4205, L7520 and L8049 are being discontinued. Effective for services furnished on or after January 1, 2002, CMS has instructed contractors to revert repair HCPCS codes from national fee schedule payment to previous regional carrier payment amounts.

Pricing changes to dynamic and bi-directional devices

Medicare payment for DME capped rental items includes payment for any essential accessories. Effective January 1, 2002, the descriptions of HCPCS codes E1800-E1818, E1825 and E1830 have been modified to include the interface material. The 2002 fee schedule for HCPCS codes E1800-E1818, E1825 and E1830 has been updated to include payment for the interface material accessory HCPCS codes E1820 and E1821. Separate payment for interface material (E1820 and E1821) will only be considered for coverage as a replacement item for beneficiary owned equipment (HCPCS codes E1800-E1818, E1825 and E1830).

The fee schedule for 2002 will be available through the CMS Web site (www.hcfa.gov/stats/pufiles.htm) after December 7, 2001 or through the Palmetto GBA Web site (www.PalmettoGBA.com) by the end of December 2001.

Medicare HMO Transfers

Beneficiaries receiving oxygen who transfer from a Medicare HMO to Medicare fee for service (FFS) are subject to all coverage criteria of the DMERC medical policy. Therefore, beneficiaries must qualify under FFS guidelines as though they are entering the program for the first time with all policy criteria being met.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
For security and privacy reasons, CMS will not publish the printed copy of the Sanction Report, also known as Publication 69, after September 2001, and the electronic version will be discontinued after December 2001. The information contained in this publication without Social Security numbers is available on the List of Excluded Individuals and Entities (LEIE) at the Office of the Inspector General’s (OIG) Web site at www.dhhs.gov/oig/cumsan/index.htm.

The LEIE is available in two formats, a downloadable database file and an online searchable database. The online searchable database allows users to enter a Social Security number in order to verify that the provider in question is currently excluded. The user will receive either a positive or a negative response as to whether the Social Security number entered matches a Social Security number in the database. The CMS recommends using this site to access the type of information you have been getting through Publication 69.

We have received notification from CMS that contractors are not required to begin provider/submitter testing of the inbound 837 (4010) claim transaction on October 1, 2001, as previously specified. Contractors have been instructed to complete testing of their standard system release of the inbound 837 (4010) claim no later than January 2, 2002.

An informational meeting outlining the steps necessary to effect the simultaneous transition to the Palmetto GPNet Gateway and the ANSI 837 (4010) format will be mailed November 1, 2001. The implementation date for new HIPAA-ready low-cost billing software has been extended to April 1, 2002. Palmetto GBA will begin distribution in February 2002.

Please direct questions regarding HIPAA implementation to the Technology Support Center toll-free at (866) 749-4301.

There are currently no on-site HIPAA audits being conducted by CMS or its carriers. You should never allow any individuals access to your computers, medical records, billing information, etc., who fail to produce identification and proper documentation from the auditing entity. If you are approached by an individual who is attempting to gain access to your facilities and/or information, please contact Vicky Quinonez-Cruz at (803) 763-8310. For any other fraud issues, contact the Provider Hotline at (877) 867-4852.
Review Reminder

Palmetto GBA only conducts reviews on the specific items that are referenced on the HCFA-1964 or DMERC Review Request form.

Hearing and Administrative Law Judge (ALJ) Appeal Requests

If you combine multiple claims to meet the minimum amount in controversy for a hearing ($100) or ALJ ($500) appeal request, you must specify in your appeal request the specific claims that are being combined. If your request does not specifically state or list the designated claims that are being combined, each claim will be treated as an individual request and those not meeting the amount in controversy will be dismissed.

MSP Correspondence Address

Please use the mailing address below for all Medicare Secondary Payer (MSP) correspondence. This will help expedite your response.

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

Claims, appeals and non-MSP issues should continue to be sent to your designated team. If you need help identifying your team, call (866) 238-9650.

NSC Quick Tips

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

All changes must be made on the CMS-855S form. To access the form:

- Call the customer service lines at (866) 238-9652 and request the CMS-855S form, or

Please refer to page 5 of the form and indicate why the form is being submitted.

If you have any questions or comments, you can e-mail them to medicare.nsc@PalmettoGBA.com or call the NSC Service Center line at (866) 238-9652.
DMERC PUBLICATIONS ON THE INTERNET

Palmetto GBA is exploring the use of technology available on our Website (www.PalmettoGBA.com). If you are interested in receiving the DMERC Medicare Advisory and Region C DMERC DMEPOS Supplier Manual revisions via the Internet instead of via postal service, please let us know by mailing or faxing us a copy of the form below:

<table>
<thead>
<tr>
<th>DMERC PUBLICATIONS ON THE INTERNET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I wish to access the DMERC Medicare Advisory and the Region C DMERC DMEPOS Supplier Manual updates solely via the Internet. Please stop sending me paper copies.</td>
</tr>
<tr>
<td>Company Name</td>
</tr>
<tr>
<td>Contact Person</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
<tr>
<td>NSC Supplier Number(s)</td>
</tr>
</tbody>
</table>

Copy and return this form to Palmetto GBA by fax to (803) 935-0200 (Attn: Internet) or by mail to:  
Palmetto GBA, AG-520  
Attn: Internet  
P.O. Box 100141  
Columbia, SC  29203-3141
**OMBUDSMAN IN-SERVICES**

Palmetto GBA, in an effort to provide improved one-on-one customer service, is now offering specialty in-services to DME suppliers located in Region C. Please contact your ombudsman to arrange a visit. The in-service fee is $50 per visit and includes a one- to two-hour session dedicated to your individual Medicare billing concerns.

There are many types of in-services available. You may wish to have an ombudsman come to your office on a monthly or quarterly basis to take advantage of all the available educational opportunities. The following are the most frequently requested topics:

- Basic Billing
- Documentation Guidelines/Requirements
- Understanding Appeals/Denials
- Pharmacy Billing
- Medical Policies:
  - External Infusion
  - Wheelchair and Mobility
  - Respiratory
  - Prosthetics & Orthotics
  - Parenteral/Enteral
  - Vision

In-services are perfect for training new employees, billing managers and customer service personnel. When you need more than just a phone call, request a personal onsite visit. Customized in-services are available with advance notice. After establishing a convenient date and time with your ombudsman, please complete the form provided in Chapter 13 of the accompanying Winter 2001 DMEPOS Supplier Manual revisions and send it with your check to the address indicated on the form.

---

**ONLINE WORKSHOP SCHEDULE**

The following is a list of Palmetto GBA’s DMERC-related online workshops through April 2002. Online workshops are a great way to get answers to your Medicare questions in an interactive workshop environment without leaving your office.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 15, 2002</td>
<td>DMERC Diabetic Coverage</td>
</tr>
<tr>
<td>January 29, 2002</td>
<td>DMERC Oxygen Policy</td>
</tr>
<tr>
<td>February 12, 2002</td>
<td>DMERC Basic Billing, Part 1</td>
</tr>
<tr>
<td>February 13, 2002</td>
<td>DMERC Basic Billing, Part 2</td>
</tr>
<tr>
<td>February 26, 2002</td>
<td>DMERC Wheelchair Coverage</td>
</tr>
<tr>
<td>March 12, 2002</td>
<td>DMERC Hospital Beds and Support Surfaces</td>
</tr>
<tr>
<td>March 26, 2002</td>
<td>DMERC Infusion Therapy</td>
</tr>
<tr>
<td>April 11, 2002</td>
<td>DMERC Parenteral and Enteral Nutrition</td>
</tr>
<tr>
<td>April 23, 2002</td>
<td>DMERC Basic Billing, Part 1</td>
</tr>
<tr>
<td>April 24, 2002</td>
<td>DMERC Basic Billing, Part 2</td>
</tr>
</tbody>
</table>

All workshops begin at 2 p.m. EST and are free of charge. System requirements and instructions for attending the workshops can be found at www.PalmettoGBA.com. From the home page, go to Providers/DMERC/General Information.

Register on Palmetto GBA’s Web site to be notified as these workshops and handouts are made available.
2002 HCPCS Code Update: Additions, Changes, and Deletions

The new HCPCS codes are effective with dates of service on or after January 1, 2002. There is a three-month grace period that applies to discontinued HCPCS codes for claims with dates of service January 1, 2002 through March 31, 2002. Claims received on or after April 1, 2002 with dates of service on or after January 1, 2002 must contain the new and correct HCPCS codes as they are outlined on the following pages.

2002 HCPCS Code Additions

A4257 Replacement lens shield cartridge for use with laser skin piercing device, each
A4360 Adult incontinence garment (e.g. brief, diaper) each
A4651 Calibrated microcapillary tube, each
A4652 Microcapillary tube sealant
A4656 Needle, any size, for dialysis, each
A4657 Syringe, with or without needle, for dialysis, each
A4706 Bicarbonate concentrate, solution, for hemodialysis, per gallon
A4707 Bicarbonate concentrate, powder, for hemodialysis, per packet
A4708 Acetate concentrate, solution, for hemodialysis, per gallon
A4709 Acid concentrate, solution, for hemodialysis, per gallon
A4719 "Y set" tubing for peritoneal dialysis
A4720 Dialysate solution, any concentration of dextrose, fluid volume of greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis
A4721 Dialysate solution, any concentration of dextrose, fluid volume of greater than 999 cc but less than or equal to 1999 cc, for peritoneal dialysis
A4722 Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc but less than or equal to 2999 cc, for peritoneal dialysis
A4723 Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc but less than or equal to 3999 cc, for peritoneal dialysis
A4724 Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc but less than or equal to 4999 cc, for peritoneal dialysis
A4725 Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc but less than or equal to 5999 cc, for peritoneal dialysis
A4726 Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis
A4736 Topical anesthetic, for dialysis, per gram
A4737 Injectable anesthetic, for dialysis, per 10 ml
A4766 Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml
A4801 Heparin, any type, for hemodialysis, per 1,000 units
A4802 Protamine sulfate, for hemodialysis, per 50 mg
A4911 Drain bag/bottle, for dialysis, each
A4928 Surgical mask, for dialysis, per 20
A4929 Tourniquet, for dialysis, each
A5509 For diabetics only, direct formed, molded to foot with external heat source (i.e. heat gun) multiple density insert(s), prefabricated, per shoe
A5510 For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple density insert(s), prefabricated, per shoe
A5511 For diabetics only, custom molded from model of patient's foot, multiple density insert(s), custom-fabricated, per shoe
A6000 Non contact wound warming wound cover for use with the non contact wound warming device and warming card
A6010 Collagen based wound filler, dry form, per gram of collagen
B4086 Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each
E0169 Commode chair with seat lift mechanism
E0221 Infrared heating pad system
E0231 Non contact wound warming device (temperature control unit, AC adapter and power cord) for use with the warming card and wound cover
E0232 Warming card for use with the non contact wound warming device and non contact wound warming wound cover
2002 HCPCS Code Additions (cont.)

E0316 Safety enclosure frame/canopy for use with hospital bed, any type
E0481 Intrapulmonary percussive ventilation system and related accessories
E0482 Cough stimulating device, alternating positive and negative airway pressure
E0603 Breast pump, electric (AC and/or DC), any type
E0604 Breast pump, heavy duty, hospital grade, piston operated, pulsatile vacuum suction/release cycles, vacuum regulator, supplies, transformer, electric (AC and/or DC)
E0620 Skin piercing device for collection of capillary blood, laser, each
E0752 Implantable neurostimulator electrode, each
E0754 Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
E0759 Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
E1500 Centrifuge, for dialysis
E1637 Hemostats, for dialysis, each
E1638 Heating pad, for peritoneal dialysis, any size, each
E1639 Scale, for dialysis, each
E1801 Bi-directional static progressive stretch elbow device with range of motion adjustment, includes cuffs
E1806 Bi-directional static progressive stretch wrist device with range of motion adjustment, includes cuffs
E1811 Bi-directional static progressive stretch knee device with range of motion adjustment, includes cuffs
E1816 Bi-directional static progressive stretch ankle device with range of motion adjustment, includes cuffs
E1818 Bi-directional static progressive stretch pronation/supination device with range of motion adjustment, includes cuffs
E1821 Replacement soft interface material/cuffs for bi-directional static progressive stretch device
E1840 Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material
E1902 Communication board, non-electronic augmentative or alternative communication device
E2000 Gastric suction pump, home model, portable or stationary, electric
E2100 Blood glucose monitor with integrated voice synthesizer
E2101 Blood glucose monitor with integrated lancet/blood sample collection
J0587 Botulinum Toxin Type B, per 100 units
J0692 Injection, Cefepime Hydrochloride, 500 mg
J0706 Injection, caffeine citrate, 5 mg
J0744 Injection, ciprofloxacin for intravenous infusion, 200 mg
J1056 Injection, Meprobamate/estradiol cypionate, 5 mg/25 mg
J1270 Injection, doxycycline, 1 mcg
J1590 Injection, gatifloxacin, 10 mg
J1655 Injection, tinzaparin sodium, 1000 I.U.
J1755 Injection, iron sucrose, 20 mg
J1835 Injection, itraconazole, 50 mg
J2020 Injection, linezolid, 200 mg
J2940 Injection, somatrem, 1 mg
J2941 Injection, somatropin, 1 mg
J3100 Injection, tenecteplase, 50 mg
J3395 Injection, verteporfin, 15 mg
J7193 Factor IX (antihemophilic factor, purified, non-recombinant) per I.U.
J7195 Factor IX (antihemophilic factor, recombinant) per I.U.
J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
J7308 Aminolevulinic acid HCl for topical administration, 20%, single unit dosage form (354 mg)
J7316 Sodium Hyaluronate, 5 mg for intra-articular injection
J7340 Dermal and epidermal, tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter
J7511 Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral, 25 mg
J7622 Beclomethasone, inhalation solution administered through DME, unit dose form, per milligram
2002 HCPCS Code Additions (cont.)

J 7624  Betamethasone, inhalation solution administered through DME, unit dose form, per milligram
J 7626  Budesonide inhalation solution, administered through DME, unit dose form, 0.25 mg
J 7641  Flunisolide, inhalation solution administered through DME, unit dose, per milligram
J 9017  Arsenic trioxide, 1 mg
J 9300  Gemtuzumab ozogamicin, 5 mg
L0321  TLSO, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0331  TLSO, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0391  TLSO, anterior-posterior-lateral-rotary control, with rigid or semi-rigid posterior panel, prefabricated (includes fitting and adjustment)
L0561  LSO, anterior-posterior-lateral control, with rigid or semi-rigid posterior panel, prefabricated
L0986  Addition to spinal orthosis, rigid or semi-rigid, abdominal panel, prefabricated
L1005  Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment
L2768  Orthotic side bar disconnect device, per bar
L3677  Shoulder orthosis, hard plastic, shoulder stabilizer, pre-fabricated, includes fitting and adjustment
L5301  Below knee, molded socket, shin, SACH foot, endoskeletal system
L5311  Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot, endoskeletal system
L5321  Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee
L5331  Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
L5341  Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot
L5671  Addition to lower extremity, below the knee/above knee suspension locking mechanism (Shuttle, Lanyard or equal) excludes socket insert
L5847  Addition, endoskeletal knee-shin system, microprocessor control feature, stance phase
L5989  Addition to lower extremity prosthesis, endoskeletal system, pylon with integrated electronic force sensors
L5990  Addition to lower extremity prosthesis, user adjustable heel height
L6881  Automatic grasp feature, addition to upper limb prosthetic terminal device
L6882  Microprocessor control feature, addition to upper limb prosthetic terminal device
L8001  Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral
L8002  Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral
L8505  Artificial larynx replacement battery/accessory, any type
L8507  Tracheo-esophageal voice prosthesis, patient inserted, any type, each
L8509  Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type
L8510  Voice amplifier

2002 HCPCS Code Description Changes

A4300  Implantable access catheter (e.g., venous, arterial, epidural, subarachnoid, or peritoneal, etc.)
         external access
A4301  Implantable access total system; catheter, port/reservoir (e.g., venous, arterial, epidural, or subarachnoid, etc.)
         percutaneous access
A4351  Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each
A4352  Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each
A4358  Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each
A4660  Sphygmomanometer/blood pressure apparatus with cuff and stethoscope, for dialysis
A4663  Blood pressure cuff only, for dialysis
A4670  Automatic blood pressure monitor, for dialysis
A4680  Activated carbon filter for hemodialysis, each
A4690  Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each
### 2002 HCPCS Code Description Changes (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4712</td>
<td>Water, sterile, for injection for dialysis, per 10 ml</td>
</tr>
<tr>
<td>A4714</td>
<td>Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon</td>
</tr>
<tr>
<td>A4730</td>
<td>Fistula cannulation set for hemodialysis, each</td>
</tr>
<tr>
<td>A4740</td>
<td>Shunt accessory, for hemodialysis, any type, each</td>
</tr>
<tr>
<td>A4750</td>
<td>Blood tubing, arterial or venous, for hemodialysis, each</td>
</tr>
<tr>
<td>A4755</td>
<td>Blood tubing, arterial and venous combined, for hemodialysis, each</td>
</tr>
<tr>
<td>A4760</td>
<td>Dialysate solution test kit, for peritoneal dialysis, any type, each</td>
</tr>
<tr>
<td>A4765</td>
<td>Dialysate concentrate, powder, additive for peritoneal dialysis, per packet</td>
</tr>
<tr>
<td>A4770</td>
<td>Blood collection tube, vacuum, for dialysis, per 50</td>
</tr>
<tr>
<td>A4771</td>
<td>Serum clotting time tube, for dialysis, per 50</td>
</tr>
<tr>
<td>A4772</td>
<td>Blood glucose test strips, for dialysis, per 50</td>
</tr>
<tr>
<td>A4773</td>
<td>Occult blood test strips, for dialysis, per 50</td>
</tr>
<tr>
<td>A4774</td>
<td>Ammonia test strips, for dialysis, per 50</td>
</tr>
<tr>
<td>A4780</td>
<td>Disposable catheter tips for peritoneal dialysis, per 10</td>
</tr>
<tr>
<td>A4782</td>
<td>Plumbing and/or electrical work for home hemodialysis equipment</td>
</tr>
<tr>
<td>A4913</td>
<td>Miscellaneous dialysis supplies, not otherwise specified</td>
</tr>
<tr>
<td>A4918</td>
<td>Venous pressure clamp, for hemodialysis, each</td>
</tr>
<tr>
<td>A4927</td>
<td>Gloves, non-sterile, for dialysis, per 100</td>
</tr>
<tr>
<td>A6196</td>
<td>Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing</td>
</tr>
<tr>
<td>A6197</td>
<td>Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each dressing</td>
</tr>
<tr>
<td>A6198</td>
<td>Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in., each dressing</td>
</tr>
<tr>
<td>A6199</td>
<td>Alginate or other fiber gelling dressing, wound filler, per 6 inches</td>
</tr>
<tr>
<td>A6270</td>
<td>Non-covered item or service (used only when no specific code available)</td>
</tr>
<tr>
<td>E0600</td>
<td>Respiratory suction pump, home model, portable or stationary, electric</td>
</tr>
<tr>
<td>E0602</td>
<td>Breast pump, manual, any type</td>
</tr>
<tr>
<td>E1520</td>
<td>Heparin infusion pump for hemodialysis</td>
</tr>
<tr>
<td>E1530</td>
<td>Air bubble detector for hemodialysis, each, replacement</td>
</tr>
<tr>
<td>E1540</td>
<td>Pressure alarm for hemodialysis, each, replacement</td>
</tr>
<tr>
<td>E1550</td>
<td>Bath conductivity meter for hemodialysis, each</td>
</tr>
<tr>
<td>E1560</td>
<td>Blood leak detector for hemodialysis, each, replacement</td>
</tr>
<tr>
<td>E1575</td>
<td>Transducer protectors/fluid barriers, for hemodialysis, any size, per 10</td>
</tr>
<tr>
<td>E1580</td>
<td>Unipuncture control system for hemodialysis</td>
</tr>
<tr>
<td>E1600</td>
<td>Delivery and/or installation charges for hemodialysis equipment</td>
</tr>
<tr>
<td>E1610</td>
<td>Reverse osmosis water purification system, for hemodialysis</td>
</tr>
<tr>
<td>E1615</td>
<td>Deionizer water purification system, for hemodialysis</td>
</tr>
<tr>
<td>E1620</td>
<td>Blood pump for hemodialysis, replacement</td>
</tr>
<tr>
<td>E1625</td>
<td>Water softening system, for hemodialysis</td>
</tr>
<tr>
<td>E1632</td>
<td>Wearable artificial kidney, each</td>
</tr>
<tr>
<td>E1636</td>
<td>Sorbent cartridges, for hemodialysis, per 10</td>
</tr>
<tr>
<td>E1699</td>
<td>Dialysis equipment, not otherwise specified</td>
</tr>
<tr>
<td>E1800</td>
<td>Dynamic adjustable elbow extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1805</td>
<td>Dynamic adjustable wrist extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1810</td>
<td>Dynamic adjustable knee extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1815</td>
<td>Dynamic adjustable ankle extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1820</td>
<td>Replacement soft interface material, dynamic adjustable extension/flexion device</td>
</tr>
<tr>
<td>E1825</td>
<td>Dynamic adjustable finger extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>E1830</td>
<td>Dynamic adjustable toe extension/flexion device, includes soft interface material</td>
</tr>
<tr>
<td>J2993</td>
<td>Injection, reteplase, 18.1 mg</td>
</tr>
<tr>
<td>J7504</td>
<td>Lymphocyte immune globulin, antithymocyte globulin, equine, parenteral, 250 mg</td>
</tr>
<tr>
<td>J7618</td>
<td>Albuterol, all formulations including separated isomers, inhalation solution administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)</td>
</tr>
<tr>
<td>J7619</td>
<td>Albuterol, all formulations including separated isomers, inhalation solution administered through DME, unit dose form, per 1 mg (albuterol) or per 0.5 (levalbuterol)</td>
</tr>
</tbody>
</table>
2002 HCPCS Code Description Changes (cont.)

K0184  Nasal single piece interface, replacement for nasal application device, pair or single piece interface
L0100  Cranial orthosis (helmet), with or without soft interface, molded to patient model
L0110  Cranial orthosis (helmet), with or without soft interface, non-molded
L0515  LSO, anterior-posterior control, with rigid or semi-rigid posterior panel, prefabricated
L1510  THKAO, standing frame, with or without tray and accessories
L2415  Addition to knee lock with integrated release mechanism, (bail, cable, or equal), any material, each joint
L2755  Addition to lower extremity orthosis, high strength, lightweight material, all hybrid laminate/prepreg composite, per segment
L4000  Replace girdle for spinal orthosis (CTLSO or SO)
L4396  Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, pre-fabricated, includes fitting and adjustment
L5704  Custom shaped protective cover, below knee
L5705  Custom shaped protective cover, above knee
L5706  Custom shaped protective cover, knee disarticulation
L5707  Custom shaped protective cover, hip disarticulation

2002 HCPCS Code Deletions

A5075  Pouch, urinary; for use on faceplate; plastic or rubber
A5502  For diabetics only, multiple density insert(s), per shoe
A4329  External catheter starter set, male/female, includes catheters/urinary collection device, bag/pouch and accessories (tubing, clamps, etc.), seven-day supply
A4650  Centrifuge (includes calibrated microcapillary tubes and sealease)
A4655  Needles and syringes for dialysis
A4700  Standard dialysate solution, each
A4705  Bicarbonate dialysate solution, each
A4735  Local/topical anesthetic for dialysis only
A4780  Sterilizing agent for dialysis equipment, per gallon
A4790  Cleansing agent for equipment for dialysis only
A4800  Heparin for dialysis and antidote, any strength, porcine or beef, up to 1000 units, 10-30 ml
A4820  Hemodialysis kit supply
A4850  Hemostats with rubber tips for dialysis
A4880  Storage tank utilized in connection with water purification system, replacement tank for dialysis
A4900  Continuous ambulatory peritoneal dialysis (CAPD) supply kit
A4901  Continuous cycling peritoneal dialysis (CCPD) supply kit
A4905  Intermittent peritoneal dialysis (IPD) supply kit
A4910  Nonmedical supplies for dialysis, (i.e., scale, scissors, stop-watch, etc.)
A4912  Gomco drain bottle
A4914  Preparation kit
A4919  Dialyzer holder, each
A4920  Harvard pressure clamp, each
A4921  Measuring cylinder, any size, each
A5064  Pouch, drainable; with faceplate attached; plastic or rubber
A5074  Pouch, urinary; with faceplate attached; plastic or rubber
A9160  Noncovered service by podiatrist
A9170  Noncovered service by chiropractor
A9190  Personal comfort item
B4084  Gastrostomy/jejunostomy tubing
B4085  Gastrostomy tube, sillicone with sliding ring, each
E0298  Hospital bed, heavy duty, extra wide, with any type side rails, with mattress
E0609  Blood glucose monitor with special features (e.g., voice synthesizers, automatic timers, etc.)
E0753  Implantable neurostimulator electrodes, per group of four
E1640  Replacement components for hemodialysis and/or peritoneal dialysis machines that are owned or being purchased by the patient
### 2002 HCPCS Code Deletions (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1900</td>
<td>Synthesized speech augmentative communication device with dynamic display</td>
</tr>
<tr>
<td>J 0340</td>
<td>Injection, nandrolone phenpropionate, up to 50 mg</td>
</tr>
<tr>
<td>J 0400</td>
<td>Injection, trimethaphan camsylate, up to 500 mg</td>
</tr>
<tr>
<td>J 0510</td>
<td>Injection, benzquinamide HCl, up to 50mg</td>
</tr>
<tr>
<td>J 0590</td>
<td>Injection, ethynorepinephrine HCl, 1 ml</td>
</tr>
<tr>
<td>J 0695</td>
<td>Injection, cefonicid sodium, 1 gram</td>
</tr>
<tr>
<td>J 0730</td>
<td>Injection, chlorpheniramine maleate, per 10 mg</td>
</tr>
<tr>
<td>J 0810</td>
<td>Injection, cortisone, up to 50 mg</td>
</tr>
<tr>
<td>J 1090</td>
<td>Injection, testosterone cypionate, 1 cc, 50 mg</td>
</tr>
<tr>
<td>J 1362</td>
<td>Injection, erythromycin gluceptate, per 250 mg</td>
</tr>
<tr>
<td>J 1690</td>
<td>Injection, prednisolone tebutate, up to 20 mg</td>
</tr>
<tr>
<td>J 1739</td>
<td>Injection, hydroxyprogesterone caproate 125 mg</td>
</tr>
<tr>
<td>J 1741</td>
<td>Injection, hydroxyprogesterone caproate, 250 mg/ml</td>
</tr>
<tr>
<td>J 1930</td>
<td>Injection, propiomazine HCL, up to 20 mg</td>
</tr>
<tr>
<td>J 1970</td>
<td>Injection, methotrimeprazine, up to 20 mg</td>
</tr>
<tr>
<td>J 2240</td>
<td>Injection, metocurine iodide, up to 2 mg</td>
</tr>
<tr>
<td>J 2330</td>
<td>Injection, thiothizene, up to 4 mg</td>
</tr>
<tr>
<td>J 2350</td>
<td>Injection, niacinamide, niacin, up to 100 mg</td>
</tr>
<tr>
<td>J 2480</td>
<td>Injection, hydrochlorides of opium alkaloids, up to 20 mg</td>
</tr>
<tr>
<td>J 2512</td>
<td>Injection, pentagastrin, per 2 ml</td>
</tr>
<tr>
<td>J 2640</td>
<td>Injection, prednisolone sodium phosphate, to 20 mg</td>
</tr>
<tr>
<td>J 2675</td>
<td>Injection, progesterone, per 50 mg</td>
</tr>
<tr>
<td>J 2860</td>
<td>Injection, secobarbital sodium, up to 250 mg</td>
</tr>
<tr>
<td>J 2970</td>
<td>Injection, methicillin sodium, up to 1 gm</td>
</tr>
<tr>
<td>J 3080</td>
<td>Injection, chlorprothizene, up to 50 mg</td>
</tr>
<tr>
<td>J 3270</td>
<td>Injection, imipramine HCL, up to 25 mg</td>
</tr>
<tr>
<td>J 3390</td>
<td>Injection, methozamine HCL, up to 20 mg</td>
</tr>
<tr>
<td>J 3450</td>
<td>Injection, mephentermine sulfate, up to 30 mg</td>
</tr>
<tr>
<td>J 7315</td>
<td>Sodium hyaluronate, 20 mg, for intra articular injection</td>
</tr>
<tr>
<td>L5300</td>
<td>Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finish</td>
</tr>
<tr>
<td>L5310</td>
<td>Knee disarticulation (or through knee), molded socket, SACH foot, endoskeletal system, including soft cover and finishing</td>
</tr>
<tr>
<td>L5320</td>
<td>Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing</td>
</tr>
<tr>
<td>L5330</td>
<td>Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finish</td>
</tr>
<tr>
<td>L5340</td>
<td>Hemipelvectomy, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing</td>
</tr>
<tr>
<td>L5667</td>
<td>Addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism</td>
</tr>
<tr>
<td>L5669</td>
<td>Addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism</td>
</tr>
</tbody>
</table>
OMBUDSMAN ADDRESS CHANGES

Lia Bunch, Alabama
Keith Smith, North Florida

Lia Bunch, Alabama ombudsman, has changed her business address and telephone number. Her new address and phone number are:

PMB 425
459 Main Street, Suite 101
Trussville, AL 35173
(205) 661-6988

Keith Smith, the ombudsman for northern Florida, has changed his business address. His new address is:

PMB 112
11111-70 San Jose Blvd.
Jacksonville, FL 32223-7946
(904) 886-2887

KENTUCKY INTERIM OMBUDSMAN

Jane Crosby is the interim Kentucky ombudsman. She can be contacted at:

P.O. Box 100141, AG-520
Columbia, SC 29202-3141
(803) 763-5170
### Ombudsmen Addresses and Their Territories

**Alabama**
- Lia Bunch
  - PMB 425
  - 459 Main Street, Suite 101
  - Trussville, AL 35173
  - (205) 661-6988

**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 112
    - 11111-70 San Jose Blvd.
    - Jacksonville, FL 32223-7946
    - (904) 886-2887

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

**Kentucky**
- In the interim contact
  - Jane Crosby
    - P.O. Box 100141, AG-520
    - Columbia, SC 29202-3141
    - (803) 763-5170

**Louisiana/Mississippi**
- Bobby Smith
  - P.O. Box 9225
  - Jackson, MS 39286
  - (601) 856-4368

**North Carolina**
- Makisha Pressley
  - 4558-B Capital Blvd., Box 124
  - Raleigh, NC 27604
  - (919) 212-9981

**Out of Region C**
- Jane Crosby
  - P.O. Box 100141, AG-520
  - Columbia, SC 29202-3141
  - (803) 763-5170

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

**South Carolina**
- Andrea Stark
  - P.O. Box 100141, AG-520
  - Columbia, SC 29202-3141
  - (803) 763-5714

**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

Ombudsmen investigate complaints, report findings and facilitate problem solving through training and education of the supplier community.
Please retain this list as your new DMERC telephone directory.

**Palmetto GBA contacts**

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Integrity Unit</td>
<td>(877) 867-4852</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100236</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3236</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100145</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3145</td>
<td></td>
</tr>
<tr>
<td>Hearings Department*</td>
<td>(866) 238-9650</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100249</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202</td>
<td></td>
</tr>
<tr>
<td>ADMC Department*</td>
<td>FAX: (803) 424-2622</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100235</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3235</td>
<td></td>
</tr>
<tr>
<td>Professional Relations Department</td>
<td>(803) 763-5744</td>
</tr>
<tr>
<td>Palmetto GBA, Medicare Region C DMERC</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 100141</td>
<td></td>
</tr>
<tr>
<td>Columbia, SC 29202-3141</td>
<td></td>
</tr>
</tbody>
</table>

*Inquiries regarding hearings or Advance Determination of Medicare Coverage should be directed to the Dedicated Work Teams.

**National numbers**

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