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LOCAL MEDICAL REVIEW POLICY (LMRP)
RECONSIDERATION PROCESS

The LMRP Reconsideration Process is a mechanism by which interested parties can request a revision of an LMRP. In order to be considered a valid request, the following requirements must be met:

- Requestor must be qualified;
- Subject must be appropriate;
- Information submitted must be adequate; and
- Process for submission must be followed.

Any request for LMRP reconsideration that, in the judgment of the DMERC, does not meet these requirements is invalid.

cont.
Requestor

The DMERC will consider all LMRP reconsideration requests from:

- Beneficiaries residing in our jurisdiction; or
- Suppliers doing business in our jurisdiction.

We may consider LMRP reconsideration requests from any other interested party doing business in our jurisdiction.

Subject

The LMRP Reconsideration Process is available only for final LMRPs. The whole LMRP or any part of the LMRP may be reconsidered. Requests are not accepted for other documents including:

- National Coverage Decisions (NCD) - for example, Coverage Issues Manual;
- Coverage provisions in interpretive manuals - for example, Medicare Carrier Manual;
- Draft LMRPs;
- Retired LMRPs;
- Individual claim determinations;
- Bulletins, articles, training materials;
- Any instance in which no LMRP exists, i.e., requests for development of an LMRP.

If modification of the LMRP would conflict with an NCD, the request is not valid. Refer to the NCD reconsideration process at [http://www.cms.hhs.gov/coverage/8a1.asp](http://www.cms.hhs.gov/coverage/8a1.asp).

Information to be Submitted

The request must identify the language that the requestor wants added to or deleted from an LMRP. Requests must include a justification supported by new evidence, which may materially affect the LMRP’s content or basis. When articles or textbooks are cited, copies of the published documents must be included.

The level of evidence required for LMRP reconsideration is the same as that required for new/revised LMRP development. As described in the Medicare Program Integrity Manual, LMRPs are to be based on the strongest evidence available. In order of preference, LMRPs are based on:

- Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies;
- General acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:
  - Scientific data or research studies published in peer-reviewed medical journals; or
  - Consensus of expert medical opinion (i.e., recognized authorities in the field); or
  - Medical opinion from medical associations or other health care experts.
Acceptance by individual health care providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with financial interest in the outcome, are not sufficient evidence of general acceptance by the medical community. The broad range of available evidence will be considered and its quality will be evaluated before a conclusion is reached.

**Submission Process**

In order to be valid, the request for LMRP reconsideration must be in writing and must include the name and mailing address of the requestor. Inclusion of a telephone number and/or e-mail address is optional. If the requestor is a beneficiary, the HIC number must be included. If the requestor is a supplier, the supplier number must be included. If the requestor is neither a beneficiary nor a supplier, the requestor must identify the nature of their business and who they are representing (if applicable).

Requests may be submitted by mail or e-mail:

Paul D. Metzger, M.D.
Medical Director
Palmetto GBA Region C DMERC
P.O. Box 100141, AG-250
Columbia, SC  29202-3141

or: dmerc.C.lmrp.recon@palmettogba.com

**DMERC Response**

Within 30 days after the request is received, the DMERC will determine whether the request is valid or invalid and will notify the requestor of that determination. If the request is invalid, we will explain why it was invalid.

If the request is valid, within 90 days after the request is received, the DMERC will make a reconsideration decision and will notify the requestor of the decision with its rationale. Decision options include: no revision, revision to a less restrictive policy, revision to a more restrictive policy, or retiring the policy.

Any revision to the policy will then be published in a future update to the Region C DMERC DMEPOS Supplier Manual.
Suppliers are reminded that because of processing system requirements, physicians must be instructed to enter the total cumulative number of months since the Initial Date needed when entering estimated length of need (ELN) on recertifying and revised CMNs.

Although not frequent, some physicians may insist on re-evaluating their patients for continuation of a Medicare-covered service (e.g., oxygen therapy) before or beyond the DMERC’s required recertification schedule.

Remember that a “Recertification” is a CMN due when required by the DMERC; e.g., the 12-month recertification for Group 1 oxygen patients. However a “Revised” CMN is one that becomes necessary because the physician changes certain orders or wishes to reevaluate the patient for continued certification of medical necessity.

This system requirement may seem counterintuitive to what a physician would be inclined to enter as an ELN on the CMN. The following examples may help clarify this requirement:

1. A patient begins oxygen therapy as a Group 1 patient. He is not required to have a recertification for 12 months. However, the physician enters 6 months in the ELN field of the initial CMN. Therefore, the patient will need a revised CMN in 6 months. At that time, if the physician wishes to reevaluate the patient in another year in order to continue certification of medical necessity, he must put an “18” in the ELN field (6 + 12 months from date initially needed). The 12-month recertification would still be necessary, as required by the DMERC.

2. A physician requires his oxygen patients to be reevaluated for continued certification on a yearly basis. On the Initial CMN, he enters a “12” as the ELN (coinciding with the DMERC’s scheduled recertification). However, he must enter a “24” on the recertification’s ELN. On subsequent revised CMNs he must enter consecutively, “36,” “48,” etc.

3. The physician certifies the patient for lifetime need. He enters a “99” in the ELN of the initial certification and/or the DMERC required recertification.

Suppliers may wish to show this DMERC Medicare Advisory to physicians to convince them of this requirement.

Suppliers are reminded that if a physician requires a revised certification in addition to the DMERC scheduled recertifications, it is necessary for the patient to have a repeat blood gas determination within 30 days prior to the date when the physician has ordered the revised certification.
In the medical policy on Respiratory Assist Devices, the covered conditions are divided into four categories. The first category listed is Restrictive Thoracic Disorders. This category includes patients with either neuromuscular disorders (e.g., ALS) or severe chest wall deformities. It does not include patients with various interstitial lung diseases that often lead to pulmonary fibrosis and are sometimes referred to as restrictive lung diseases. RADs are not part of the treatment for restrictive lung diseases.

Similarly, obesity is not included in the Restrictive Thoracic Disorders category. Patients with severe obesity may qualify under the Obstructive Sleep Apnea category if they have that diagnosis or under the Central Sleep Apnea category if they have that diagnosis or some other type of sleep-disordered breathing. Many severely obese patients do not develop this syndrome. To make this diagnosis, a polysomnogram is mandatory.

Refer to the local medical review policy for more details concerning coverage criteria.

In May 2002, the Food and Drug Administration (FDA) approved treprostinil for the treatment of pulmonary artery hypertension. Treprostinil is administered via continuous subcutaneous injection using a type of infusion pump similar to the pump used for subcutaneous insulin infusion.

Coverage of this therapy, effective for dates of service on or after May 21, 2002, will be considered under the DMERC local medical review policy (LMRP) for external infusion pumps. Beneficiaries with pulmonary artery hypertension must meet the same coverage criteria as for the administration of parenteral epoprostenol:

A. The pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g., left-sided atrial or ventricular disease, left-sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.); and

B. The patient has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, diet drugs, congenital left to right shunts, etc. If these conditions are present, the following criteria must be met:

1. The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; and
2. The mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion; and
3. The patient has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and
4. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.
Treprostinil should be billed using the miscellaneous drug code J7799. The infusion pump is billed using HCPCS code K0455 (Infusion pump used for uninterrupted administration of epoprostenol). HCPCS code K0455 is reimbursed in the frequent and substantial service payment category because treprostinil, similar to epoprostenol, requires uninterrupted infusion to avoid potential life-threatening side effects associated with abrupt discontinuation of the drug. Therefore, following the policy established for epoprostenol, Medicare will only pay for one unit of service of HCPCS code K0455. The supplier is responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment, which may include a back-up pump. Payment for this is included in the allowance for HCPCS code K0455.

Supplies for the pump are coded A4221 (Supplies for maintenance of drug infusion catheter, per week, [list drug separately]). HCPCS code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. HCPCS code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the drug reservoir) related to continuous subcutaneous treprostinil infusion. Catheter insertion devices for use with subcutaneous infusions are included in the allowance for HCPCS code A4221 and are not separately payable. More than one unit of service of HCPCS code A4221 per week will be denied as not medically necessary.

HCPCS code A4232 (Syringe with needle for external insulin pump, sterile, 3 cc) describes the drug reservoir for use with the infusion pump (HCPCS code K0455). The reservoir may be either glass or plastic and includes the needle for drawing up the treprostinil. This HCPCS code does not include the drug for use in the reservoir.

The current DMERC LMRP on Repairs is being retired effective for dates of service on or after October 1, 2002. A revised policy containing updated information will be published in a future Region C DMERC DMEPOS Supplier Manual update.

Effective for dates of service on or after January 1, 2003, the jurisdiction for HCPCS code A4575 (topical hyperbaric oxygen chamber, disposable) will change from local carriers to the Durable Medical Equipment Regional Carriers (DMERCs).

In accordance with instructions in the Coverage Issues Manual § 35-10 (D), claims for topical hyperbaric oxygen will continue to be denied as not medically necessary.
SUPPLIER MANUAL POLICY REVISIONS

Revisions of the following policies are included in the accompanying Region C DMERC DMEPOS Supplier Manual update. A brief summary of the major changes in each policy is described. Suppliers are advised to review each policy for complete details.

Oral Anti-cancer Drugs (Effective for dates of service on or after October 1, 2002)

- Updated list of NDC codes
- Addition of HCPCS codes A9270 and J8999 and instructions for their use

Home Blood Glucose Monitors (Effective for dates of service on or after October 1, 2002)

- Revised definitions of order renewal and order refill
- Clarified that coverage of HCPCS code E2101 for beneficiaries with manual dexterity impairments is not dependent on visual impairment
- Emphasized that suppliers have an obligation to monitor a beneficiary's utilization of supplies and dispense supplies accordingly
- Stated specific elements required for orders
- Clarified the DMERC position on the use of data collection forms
- Removed bundling table

CPAP DOCUMENTATION AND KX MODIFIER USAGE

Recently the local medical review policy on CPAP Devices was published and included documentation requirements for the use of the KX modifier. Questions have arisen regarding the use of the KX modifier for beneficiaries with CPAP therapy initiated prior to the July 1, 2002, effective date of the policy.

The policy stipulates that in order to use the KX modifier for the fourth month's claim and any month thereafter, evidence of continued use of the device must be obtained from either the beneficiary or the treating physician. Therefore, regardless of the start date of CPAP therapy, in order to bill Medicare and use the KX modifier, suppliers must ascertain that the beneficiary is continuing to use the CPAP device. This requirement is not new or unique to the CPAP policy but rather applies to all capped rental payment category items. This information does not have to be submitted with the claim but must be retained in the supplier's files and be available to the DMERC upon request.

HOME HEALTH CONSOLIDATED BILLING

CMS has determined that more frequent updates of the Home Health consolidated billing HCPCS code lists are necessary. To account for any mid-year coding changes, CMS will update the Home Health consolidated billing HCPCS code lists as frequently as quarterly. The following are ostomy replacement HCPCS codes subject to Home Health consolidated billing October 1, 2002:
### Home Health Consolidated Billing

**New HCPCS Codes and Descriptions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0561</td>
<td>Non-pectin based ostomy paste</td>
</tr>
<tr>
<td>K0562</td>
<td>Pectin based ostomy paste</td>
</tr>
<tr>
<td>K0563</td>
<td>Extended wear ostomy skin barrier &lt;4sq”</td>
</tr>
<tr>
<td>K0564</td>
<td>Extended wear ostomy skin barrier &gt;4sq”</td>
</tr>
<tr>
<td>K0565</td>
<td>Ostomy skin barrier with flange &lt;4sq”</td>
</tr>
<tr>
<td>K0566</td>
<td>Ostomy skin barrier with flange &gt;4sq”</td>
</tr>
<tr>
<td>K0567</td>
<td>1 piece drainable ostomy pouch</td>
</tr>
<tr>
<td>K0568</td>
<td>1 piece convexity drainable ostomy pouch</td>
</tr>
<tr>
<td>K0569</td>
<td>2 piece drainable ostomy pouch</td>
</tr>
<tr>
<td>K0570</td>
<td>Ostomy skin barrier with flange &lt;4sq”</td>
</tr>
<tr>
<td>K0571</td>
<td>Ostomy skin barrier with flange &gt;4sq”</td>
</tr>
</tbody>
</table>

**Deleted HCPCS Codes and Descriptions**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4370</td>
<td>Skin barrier paste per ounce</td>
</tr>
<tr>
<td>A4374</td>
<td>Skin barrier extended wear</td>
</tr>
<tr>
<td>A4386</td>
<td>Ostomy skin barrier with flange extended wear</td>
</tr>
<tr>
<td>A5061</td>
<td>Pouch drainable with barrier attached</td>
</tr>
<tr>
<td>A5123</td>
<td>Skin barrier with flange</td>
</tr>
</tbody>
</table>

The following new 'K' codes are added to the Home Health consolidated billing HCPCS code list, without a replacement:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0569</td>
<td>2 piece drainable ostomy pouch</td>
</tr>
<tr>
<td>K0574</td>
<td>Ostomy pouch filter</td>
</tr>
<tr>
<td>K0575</td>
<td>Ostomy pouch rustle-free material</td>
</tr>
<tr>
<td>K0576</td>
<td>Ostomy pouch comfort panel</td>
</tr>
<tr>
<td>K0577</td>
<td>Ostomy pouch odor barrier</td>
</tr>
<tr>
<td>K0578</td>
<td>Urinary pouch faucet/drain</td>
</tr>
<tr>
<td>K0579</td>
<td>Ostomy pouch absorbent material</td>
</tr>
<tr>
<td>K0580</td>
<td>Ostomy pouch locking flange</td>
</tr>
</tbody>
</table>

CMS has determined that the following HCPCS codes are not subject to Home Health consolidated billing:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0572</td>
<td>Non-waterproof tape</td>
</tr>
<tr>
<td>K0573</td>
<td>Waterproof tape</td>
</tr>
</tbody>
</table>

---

### Sulzer Inter-Op Acetabular Shell Recall Settlement with CMS

The Centers for Medicare & Medicaid Services (CMS) and Sulzer Orthopedics have resolved a dispute concerning the application of the Medicare Secondary Payer (MSP) laws to a Sulzer recall of certain Inter-Op acetabular shells for hip implants. This article summarizes the dispute and its resolution and provides guidance to physicians and other suppliers on the actions the physicians and other suppliers need to take as a result.

In December 2000, Sulzer Orthopedics recalled approximately 17,500 Inter-Op acetabular shells used in connection with hip implant proce-
Sulzer Inter-Op Acetabular Shell Recall Settlement with CMS

cont.

Sulzer advised providers, physicians and recipients that it would cover the cost of “unreimbursed medical expenses” related to the monitoring and possible replacement of the hip implants and related services. The MSP laws preclude Medicare payment for services when payment has been made, or can reasonably be expected to be made, under a liability insurance policy or plan (including a plan of self-insurance). The CMS considered Sulzer’s initial assurance of payment for “unreimbursed medical expenses” to constitute a “reasonable expectation of payment under a liability insurance policy or plan” and held that Sulzer (and its insurers) were the primary payers for these services. Sulzer disagreed and takes the position that it is not subject to recovery under the MSP provisions.

The CMS and Sulzer agreed to try to resolve the dispute through negotiation. The CMS asked its Medicare contractors to advise providers and suppliers to hold claims while it determined whether the claims should be sent to Sulzer or the appropriate Medicare contractor for processing. If a physician or other supplier did not wish to await such guidance from CMS, it could submit a paper claim with the annotation that the claim was related to the Sulzer recall. Such claims were to be held by the Medicare contractors until CMS determined whether Medicare should process the claims.

The CMS and Sulzer have reached a final settlement regarding the processing of claims related to medical services provided to Medicare beneficiaries in conjunction with a revision of a recalled Inter-Op acetabular shell. Under the settlement, Medicare will process any claims for such services and should not look to Sulzer, its liability insurance plans, the Sulzer Class Action Settlement, or the Medicare beneficiaries for repayment of any claims in connection with the hip implant devices. Other Medicare payment and coverage rules for these services will be applied. The CMS has further agreed that Medicare will consider there to exist “good cause” for failure to submit an assigned physician or other supplier claim within one year of the date of service but filed before November 30, 2002, if the supplier submits a hard copy claim and includes with the claim a signed statement that the services delineated on the claim were related to a revision of a Sulzer Inter-Op acetabular shell that was recalled in December 2000; and the delay in submitting the claim was attributable to CMS’s advice to hold claims. Physicians and other suppliers are encouraged to submit claims related to the Sulzer recall as soon as possible.

If a physician or other supplier submits an initial claim to Medicare for primary payment and receives such primary payment, under the terms of the settlement, physicians or other suppliers may bill Sulzer for Medicare deductibles, Medicare coinsurance and services not covered by Medicare under applicable Medicare coverage guidelines. If a physician or other supplier receives a payment from Sulzer, its liability insurance plans or the Sulzer Class Action Settlement, it may not bill Medicare on a secondary payer basis.
NEW LOWER LIMB PROSTHETIC HCPCS CODES

The following codes listed below are being added to the Healthcare Common Procedure Coding System (HCPCS) effective October 1, 2002. These HCPCS codes fall under the fee schedule category for prosthetics and orthotics. The fee schedule amounts for these HCPCS codes will be calculated by CMS central office. These HCPCS codes replace HCPCS codes L5660, L5662, L5663, and L5664, which are invalid for Medicare use effective October 1, 2002.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0556</td>
<td>Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism</td>
</tr>
<tr>
<td>K0557</td>
<td>Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism</td>
</tr>
<tr>
<td>K0558</td>
<td>Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use HCPCS codes K0556 or K0557)</td>
</tr>
<tr>
<td>K0559</td>
<td>Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use HCPCS codes K0556 or K0557)</td>
</tr>
</tbody>
</table>

SADMERC DATA ANALYSIS

It has come to our attention that suppliers may be inappropriately billing socket design HCPCS codes L5647 (for a below knee prosthesis) and HCPCS L5652 (for an above knee prosthesis) each time a replacement socket insert (HCPCS codes L5660, L5662, L5663, or L5664) is furnished. The socket design HCPCS code (L5647 or L5652) should be billed only at the time that the initial prosthesis is furnished to the patient, and not every time a replacement socket insert is furnished.

CLAIMS FOR IMPLANTED DME

Claims for implanted DME, implanted prosthetic devices, replacement parts (external or internal), accessories and supplies for the implanted DME must be filed to the local carriers. Claims filed to the DMERCs will be denied.
BILLING MISCELLANEOUS HCPCS CODES

When filing for miscellaneous HCPCS codes E1399 and K0108, please make sure to include all of the information necessary for processing. HCPCS code E1399 is used when billing miscellaneous durable medical equipment not classified by a specific HCPCS code. The HCPCS code K0108 is appropriate when billing wheelchair accessories not assigned a specific HCPCS code.

Claims filed for HCPCS codes E1399 and K0108 must include a narrative description of the item the brand name and model name/number of the item and a statement defining the medical necessity of the item for the particular patient. If it is a customized option/accessory, the statement must clearly describe what was customized.

Because the manufacturer suggested retail price is also helpful in processing, it is suggested that the actual invoice from the manufacturer be submitted with the claim. Please clearly indicate on the invoice and other documentation which items correspond with individual lines on the CMS-1500 claim form.

Claims for option/accessory codes as a replacement (modifier RP) must be submitted with the make and model name of the wheelchair base the item is being added to, the date of the purchase of the wheelchair, and documentation of the medical necessity for the item.

MEDICAL NECESSITY
DUPLICATE CLAIM DENIALS

Did you know that claims denied as duplicates have no appeal rights? Claims denied as duplicates will be dismissed if submitted for review.

If your claim is denied for lack of medical necessity, you must file an appeal rather than resubmit your claim. Resubmitted claims will be denied as duplicates of the original claim.

Please remember that you have six (6) months from the date on your remittance notice to request an appeal. Refiling claims may cost you your appeal rights.

PHYSICIAN RESPONSIBILITY IN COMPLETING CMNs

Palmetto GBA asks suppliers to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity. It is the physician's responsibility to determine both the medical need for, and the utilization of, all health care services. The physician should ensure that information relating to the beneficiary's condition is correct. Suppliers may include language in their cover letters to remind physicians of their responsibilities.
**TEMPORARY REPLACEMENT OF PATIENT-OWNED EQUIPMENT**

This article is reprinted from the Summer 1998 Supplement of the DMERC Medicare Advisory.

Effective for claims with dates of service on or after July 1, 1998, a new HCPCS code has been established for the temporary replacement of beneficiary-owned equipment which is being repaired. The new HCPCS code is:

K0462-Temporary Replacement for Patient-Owned Equipment Being Repaired, any type.

The monthly allowance of the beneficiary-owned item is payable for one month only, while it is being repaired. This HCPCS code should not be billed and will not be reimbursed for equipment which has not been purchased by the beneficiary.

A claim for HCPCS code K0462 must include a narrative description of the equipment being used as a temporary replacement, the manufacturer, brand name, model name or number of the temporary replacement item, and a statement of why the replacement is needed. Claims without this information will be denied as not medically necessary.

Reimbursement will be based on the allowable for the KJ modifier for the item provided (e.g., K0011RRKJ).

---

**BACKUP EQUIPMENT**

This article is reprinted from the Winter 1997 DMERC Medicare Advisory.

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for the patient but provided for precautionary reasons to deal with an emergency in which the primary piece of equipment malfunctions. Medicare does not pay separately or make an additional payment for backup equipment.

When a determination is made that the breakdown or malfunction of a particular piece of equipment will result in immediate life threatening consequences for the patient, Medicare will place that item in the frequent and substantial servicing payment category. For items in this payment category, the supplier receives monthly rental payments for as long as the equipment is medically necessary. However, the supplier is responsible for ensuring there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment. The expectation is that an acceptable plan would involve input from the patient and the treating physician, and would take into account the severity of the patient's condition and time restraints in providing emergency support. This means that the supplier is responsible for ensuring that the patient's medical needs for the use of this equipment will be met on a continuous and ongoing basis, and that there is a plan to deal with any interruptions in the use of the equipment that would be life threatening to the patient. The plan may be as simple as the supplier furnishing backup equipment. However, Medicare will not pay separately and/or make any addition-
Backup Equipment cont.

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.

Backup equipment must be distinguished from multiple medically necessary items which are defined as identical or similar devices, each of which meets a different medical need for the patient. Though Medicare does not pay separately for backup equipment, Medicare may make separate payment for a second piece of equipment if it is required to serve a different purpose as determined by the patient’s medical needs. Examples (not all-inclusive) of situations in which multiple equipment may be covered are:

1) A patient requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure ventilator with a nasal mask) during the rest of the day.

2) A patient who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment the patient may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

3) A patient requires one type of infusion pump for a particular drug (e.g., a pump with patient control features for parenteral morphine) and needs a different type of pump for another drug (e.g., continuous infusion chemotherapy).

Examples (not all-inclusive) of situations in which a second or other multiple piece of equipment would be considered a backup and, therefore, would not be covered are:

1) A ventilator-dependent patient is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.

2) The drug epoprostenol (Flolan) is administered using an ambulatory infusion pump and a second infusion pump is provided as a precaution in case of malfunction of the primary pump. (Because interruption of a continuous infusion of this drug results in immediate life threatening consequences, a unique code will be established for an infusion pump used to administer this drug and the code will be placed in the frequent and substantial servicing payment category.)
The Centers for Medicare & Medicaid Services (CMS) has issued updated guidelines for security-related requirements in regards to Network Services as follows:

- Amendments to the instructions for security-related requirements
- Notification requirements by providers for provider/vendor contract changes
- Completion of new Network Service Agreements required

Security-Related Requirements:

Eligibility verification vendors are responsible for the privacy and security of the providers that contract with them for eligibility information, and must be able to associate all inquiries with providers.

For specific information on how this affects you and your provider/vendor relationship, please see our Web site at www.PalmettoGBA.com and select Other Partners, Electronic Data Interchange (EDI), and General Information, and select the document “Security Requirements between Providers and Vendors.”

Notification Requirements By Providers of Provider/Vendor Contract Changes:

Palmetto GBA must maintain current eligibility access information. Providers must provide Palmetto GBA written notice of any changes to their vendor contracts, including network services, within 30 days of the effective date for the changes. Contractual changes include, but are not limited to:

- Change in vendors;
- Vendor ceases operations;
- Vendor is purchased by, or merged/aligned with another vendor or organization;
- Change in services provided by a vendor; and
- Discontinued use of vendor service by a provider.

When a new provider/vendor contract is initiated, or an existing contract changes for any of the above reasons or another reason, written notification must be submitted to Palmetto GBA within 30 days of the effective date of the changes.

Notification must include vendor name and address identification and vendor tax identification number.

Notification may consist of the following:

- A new contract with termination notification for prior contract;
- Addenda to existing contracts; and
- Contract termination.

Palmetto GBA must be notified when providers, submitters, and suppliers change from one network service vendor to another, cease arrangements with a network service vendor, or leave the Medicare program. Adjustments must be made to the Palmetto GBA system to reflect these changes.
Network Services Agreement:

The Network Services Agreement has been amended and must be signed by all current and new network service vendors. Network service vendors who have not signed the new agreement will not be permitted to continue serving providers for eligibility access. Palmetto GBA will be sending new Network Service Agreements to each vendor currently on file. If you are a new vendor and need an agreement, please call the Palmetto GBA EDI Technology Support Center toll-free at 1 (866) 749-4301.

Appeal Reminders

You will save time, money and frustration by remembering two types of Medicare claims with no appeal rights. They are:

1. Returned/rejected claims: These are claims that were not processed due to incomplete or invalid information. Medicare must have certain required data before making a determination to pay or deny a claim. Some examples of this information are the patient's name, the physician's UPIN, and date of service. How do you know if your claim was not accepted for processing? Here are some important reminders, and you can find more information in Chapter 10 of the Region C DMERC DMEPOS Supplier Manual.

   - Electronic claims: Your claim was rejected if there is no Claim Control Number (CCN) beside a patient's Medicare number on your electronic receipt report and if there is an "R" under the Status column for that same beneficiary. By checking your electronic Error Report, you can identify the problem, correct it, and resubmit the claim.

   - Paper claims: If your paper claim has a CO-16 denial code, it had incomplete or invalid information. The remittance explanation will state, "Claim/service lacks information which is needed for adjudication." If you can't identify the problem, please call your Dedicated Work Team (866) 238-9650 for assistance. After you correct the problem, simply resubmit the claim. DO NOT write "corrected claim" on the new claim and DO NOT attach a copy of the remittance to it. Doing so will delay processing by sending it to the wrong department.

2. Duplicate claims. Medicare appeal rights are afforded to initial determinations, not to duplicate or previously denied claims. Suppliers may request a review within six months of the date on the remittance notice of the initial claim determination. Duplicate claim denials are not considered initial determinations and do not have appeal rights.
Effective October 1, 2002, checks will not be the only mail sent to the supplier's "Pay To" address in a "Return Service Requested" envelope. All remittance notices will be sent in these envelopes. This includes suppliers paid via electronic funds transfer (EFT).

Supplier Standard 2 states that suppliers must notify the NSC of any change to their supplier file within 30 days of the change. If you have moved and haven't yet sent in change of information form, be sure to get your new address in to the NSC immediately. Failure to do so will result in your Medicare payments being held by the DMERCs.

Currently, Medicare payments are sent to the supplier's "Pay To" address in an envelope marked "Return Service Requested." This means "Do Not Forward." The US Postal Service returns it to the applicable DMERC if the supplier is no longer at that location. On October 1st, this will also happen for remittance notices. Here is the DNF process:

Upon receiving a "Return Service Requested" envelope — the DMERC places a DNF code on the file, suspends payments, and notifies the NSC that the "Pay To" address is not correct for that supplier number.

The NSC places a DNF code in its system, transmits the code to all DMERCs so that payments are suspended for that supplier number, and attempts to contact the supplier.

The supplier must verify its address in writing. This means sending in a CMS-855S form to verify its address if there was no change and the mail was returned to the DMERC in error, or to update its supplier file with the new address. For step-by-step instructions on using the CMS-855S form as a "Change of Information" form, please access the following web address: www.palmettogba.com. Select /Other Partners/ National Supplier Clearinghouse/FAQs.

Upon receiving the Change of Information form — the NSC processes the change, removes the DNF code, and transmits the code removal to all DMERCs so that payments resume.

If the supplier cannot be reached or fails to send in the CMS-855S form within 35 days of the postmark date on the envelope, the supplier number will be inactivated. The supplier will then have to go through the "reactivation" process, which may take up to 60 days.

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, which can be accessed by:

- Calling the customer service lines at (866) 238-9652 and request the CMS-855S form.
NSC Quick Tip cont.

- Visiting the Web site at www.PalmettoGBA.com and downloading a copy of the CMS-855S form (dated 11/01). Select: Other Medicare Partners/ NSC/ Forms, and then "Electronic CMS-855S Application Form."

Please refer to page five (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.

Online Workshop Schedule

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

- September 10  DMERC Wheelchair Coverage
- September 24  DMERC Diabetic Coverage
- October 8    DMERC Basic Billing Part 1
- October 9    DMERC Basic Billing Part 2
- October 22   DMERC CPAP and RAD Coverage
- November 12  DMERC PEN Coverage
- November 19  DMERC Prosthetics and Orthotics Coverage
- December 3  DMERC Basic Billing Part 1
- December 4  DMERC Basic Billing Part 2
- December 17 DMERC Hospital Beds and Support Surfaces Coverage

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.

Register on the Palmetto GBA Web Site

Are you keeping up to date on the latest Medicare publications and information? By registering on the Palmetto GBA Web site (www.PalmettoGBA.com) and completing a user profile, you can be notified by e-mail when new or important information is added to our Web site. You only need to register once. It is quick and easy. You do NOT have to register to use our Web site, but registering lets you:

- Receive weekly e-mail notification of Medicare news and updates.
- Know when the next online workshop will be offered.
- Update your e-mail profile at any time.
REGISTER ON THE PALMETTO GBA WEB SITE

To register, access the DMERC section of the Palmetto GBA Web site. From the Web site homepage, select Providers/DMERC. From the top of the screen, select the login option.

Follow the on-screen instructions. Here are some helpful tips:

1. Make note of your User name and Password, as these items are case-sensitive.
2. Check the topics of your interest and check the Every Week notification frequency box. Otherwise you will not be notified, although your profile will be noted in the system.
3. Be sure to fill out all required fields.
4. After you register the first time, you only need to login when you want to update your profile.

If you have questions about this process, please use the contact us button (located at the top of your screen) to send an e-mail to Palmetto GBA via our Web site. Once on the contact us page, select DMERC (Region C), then "E-mail Palmetto GBA" for technical assistance (at the bottom). At the bottom of the page you will provide your name, e-mail address and nature of your concern.

NEW ONLINE TUTORIALS COMING SOON

Beginning in October, the DMERC Professional Relations department will offer suppliers additional online training on local medical review policies. DMERC ombudsmen are developing several policy-specific Web-based training courses for topics that have not been covered in online workshops. Tutorials planned include surgical dressings, home dialysis, nebulizers, and many more. Suppliers will be able to access these courses from their office or home computers at any time.

MEDICARE SUMMARY NOTICES ARE AVAILABLE TO YOUR MEDICARE PATIENTS ONLINE

Palmetto GBA is pleased to announce that your Medicare patients will soon be able to view and print their benefit statements, Medicare Summary Notices (MSN), online 24 hours a day, 7 days a week. They can register for this service on Palmetto GBA's Web site, www.PalmettoGBA.com. If your Medicare patients wish to find out more about this feature, they will need to contact the Medicare contractor that processes their claims.

We are asking for your help in distributing this exciting news. Please post the flyer located on the next page in your office waiting room.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Get Your Medicare Benefit Statements Online!

Palmetto GBA is pleased to announce that you will soon be able to receive a duplicate copy of your benefit statement, i.e., Medicare Summary Notice (MSN) from the Internet. With a click of your mouse, you will be able to view and print your benefit statements 24 hours a day, 7 days a week. To take advantage of this opportunity, please register on Palmetto GBA’s Web site, www.PalmettoGBA.com. Click on “Beneficiary” then “e-MSN.” Even if you register for this service, paper copies of your statements will continue to be mailed to you as they normally are.

To find out more about this new feature, contact your Medicare contractor. The names of the contractors and the date this will become available to you are:

<table>
<thead>
<tr>
<th>Contractor/Intermediary</th>
<th>e-MSN Implementation</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Customer Service Center</td>
<td>September 3, 2002</td>
<td>(800) 583-2236</td>
</tr>
<tr>
<td>• South Carolina Medicare Part A, Home Health and Hospice</td>
<td></td>
<td></td>
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<tr>
<td>• South Carolina Medicare Part B</td>
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</tr>
<tr>
<td>• Durable Medical Equipment Regional Carrier, Region C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina Medicare Part A</td>
<td>October 1, 2002</td>
<td>(800) 685-1512</td>
</tr>
<tr>
<td>Ohio Medicare Part B</td>
<td>October 1, 2002</td>
<td>(800) 282-0530</td>
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<tr>
<td>West Virginia Medicare Part B</td>
<td>October 1, 2002</td>
<td>(800) 848-0106</td>
</tr>
</tbody>
</table>

Don’t delay, register today to receive your MSNs online!

Palmetto GBA
A CMS Contracted Intermediary and Carrier
September 2002
The following drug allowables are effective July 1, 2002, 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.

The fees are as follows:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>STRENGTH</th>
<th>07/01/2002 PER TABLET FEE</th>
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</thead>
<tbody>
<tr>
<td>Busulfan</td>
<td>2 mg</td>
<td>$1.99</td>
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<tr>
<td>Capecitabine</td>
<td>150 mg</td>
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<tr>
<td>Capecitabine</td>
<td>500 mg</td>
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<tr>
<td>Cyclophosphamide</td>
<td>25 mg</td>
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<td>Cyclophosphamide</td>
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</tr>
<tr>
<td>Etoposide</td>
<td>50 mg</td>
<td>$45.26</td>
</tr>
<tr>
<td>Melphalan</td>
<td>2 mg</td>
<td>$2.38</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>2.5 mg</td>
<td>$2.91</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>5 mg</td>
<td>$7.25</td>
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<td>Methotrexate</td>
<td>7.5 mg</td>
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</tr>
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<td>Methotrexate</td>
<td>10 mg</td>
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</tr>
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<td>Methotrexate</td>
<td>15 mg</td>
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<td>Temozolomide</td>
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<td>Temozolomide</td>
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<tr>
<td>Temozolomide</td>
<td>250 mg</td>
<td>$327.28</td>
</tr>
</tbody>
</table>

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

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

The unit of measure for the fee amounts noted corresponds to the unit of measure noted in the code descriptions published in the 2002 HCPCS coding manual. Please be sure to report the same unit of measure in the Days/Unit field (Item 24g) of the CMS-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...
2002 Third Quarter Drug Fee Update

cont.

one unit on the claim form. If you administered 100 mg., you would list two units on the claim form.

The following drug allowables are effective July 1, 2002 and are subject to change on a quarterly basis:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Region C</th>
<th>HCPCS Code</th>
<th>Region C</th>
<th>HCPCS Code</th>
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</tr>
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</table>

IC denotes individually considered HCPCS codes.

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

Bulletins issued after October 1, 1999 are available at no cost from our Web site at www.PalmettoGBA.com.
**REGION C DIRECTORY**

Please retain this list as your new DMERC telephone directory.

### Palmetto GBA contacts

<table>
<thead>
<tr>
<th>MAILING ADDRESS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>
| **Benefit Integrity Unit**  
Palmetto GBA, Medicare Region C DMERC  
PO. Box 100236  
Columbia, SC  29202-3236 | (877) 867-4852 |
| **Dedicated Work Teams/DMERC General Information**  
Technology Support Center (Formerly EDI Help Desk)  
Palmetto GBA, Medicare Region C DMERC  
PO. Box 100145  
Columbia, SC  29202-3145 | (866) 238-9650 |
| **Hearings Department***  
Palmetto GBA, Medicare Region C DMERC  
PO. Box 100249  
Columbia, SC  29202 | (866) 238-9650 |
| **ADMC Department***  
Palmetto GBA, Medicare Region C DMERC  
PO. Box 100235  
Columbia, SC  29202-3235 | FAX: (803) 424-2622 |
| **Professional Relations Department**  
Palmetto GBA, Medicare Region C DMERC  
PO. Box 100141  
Columbia, SC  29202-3141 | (803) 763-5744 |

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

### National numbers

<table>
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<tr>
<th>MAILING ADDRESS</th>
<th>TELEPHONE NUMBER</th>
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| **National Supplier Clearinghouse (NSC)**  
P.O. Box 100142  
Columbia, SC  29202-3142 | (866) 238-9652 |
| **Region A DMERC** | (866) 419-9458 |
| **Region B DMERC** | (877) 299-7900 |
| **Region D DMERC** | (877) 320-0390 |
| **Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)**  
Mail code: AG-370  
2300 Springdale Drive, Bldg. One  
Camden, S.C. 29020 | (877) 735-1326 |
Ombudsmen addresses and their territories

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Littleton, CO 80161-2027
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Louisiana/Mississippi
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Out of Region C
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Missouri City, TX 77459
(281) 416-9688

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