DMERC
MEDICARE ADVISORY

Durable Medical Equipment Regional Carrier PO Box 100141 Columbia SC 29202-3141

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Meet Your DMERC at Medtrade Spring in Las Vegas

Are you going to Medtrade Spring in Las Vegas? If so, please stop by booth number 1705 to meet representatives from the four DMERCs, EDI and NSC. Please plan to join us on Wednesday, April 24 from 9:45 to 10:45 a.m. at the Meet Your DMERC session where you will receive the latest DMERC information.

In This Issue:

18 New LMRPs

ZX Replaced with Kx

Comments and suggestions are welcome. Please direct them to Communications Specialists in the Professional Relations Department at the address listed above.
In the accompanying Region C DMERC DMPEPOS Supplier Manual update, the following policies have been revised. A brief summary of the changes in each policy is described; however, suppliers are advised to review each policy for complete details:

**Ankle-Foot/Knee-Ankle-Foot Orthoses**
(Effective for DOS on or after April 1, 2002)
- New HCPCS Codes descriptors adding "prefabricated"
- New descriptor for HCPCS code L4396
- Deleted splint codes now under local carrier jurisdiction - HCPCS codes L2102, L2104, L2122, L2124
- Per June 2000 bulletin article, definition of custom-fabricated added
- Added RT and LT modifiers
- Added new GY modifier

**Commodes**
(Effective for DOS on or after July 1, 2002)
- New HCPCS E code replacing K code for extra wide, heavy-duty commodes
- New HCPCS code for commode with seat lift mechanism and coverage criteria allowing for its reimbursement
- A new KX modifier to be used with a commode with seat lift mechanism if coverage and payment rules have been fulfilled

**Continuous Positive Airway Pressure Devices**
(Effective for DOS on or after July 1, 2002)
- Updates Coverage and Payment Rules to reflect National Coverage Decision to cover CPAP based on apnea-hypopnea index
- Eliminate CMN
- KX modifier used to indicate coverage criteria met
- Revised verbiage of HCPCS code K0184
- Allow coverage of either heated or non-heated humidifier with a covered CPAP device

**Dialysis Supplies**
(Effective for DOS on or after July 1, 2002)
- All HCPCS codes for "kits" have been eliminated and replaced by new codes for individual supply items;
- Addition of a KX modifier to be used only when the supplier has a written agreement with the backup dialysis facility and all other coverage and payment rules have been fulfilled;
- Re-emphasis on using the EM modifier for emergency supplies only once in the lifetime of a beneficiary.

**Enteral Nutrition**
(Effective for DOS on or after April 1, 2002)
- HCPCS code B4086 replaces HCPCS codes B4084 and B4085
- ZY modifier deleted from policy; enteral nutrients not administered through feeding tube now coded HCPCS code A9270
- Expected range of calories/kg/day eliminated

**External Infusion Pump**
(Effective for DOS on or after July 1, 2002)
- C-peptide level minimum raised to ≤ 110% of lower limit of normal of laboratory's measurement method
- HCPCS code K0548 added for insulin lispro
- Expanded allowable dosage range for dopamine (≤ 5 mcg/kg/min)
- Replace ZX with KX, effective July 1, 2002

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
### Home Blood Glucose Monitors
(Effective for DOS on or after July 1, 2002)
- New HCPCS codes E0620, E2100, E2101 and A4257
- Definition of HCPCS code E0620 (skin piercing device for collection of capillary blood, laser, each) added to definition section
- Deletion of HCPCS code E0609 and crosswalk to HCPCS codes E2100, E2101
- Coverage and Payment rules addition for HCPCS code E2101
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Replace ZX with KX, effective July 1, 2002
- Changed timeframe for new prescription from every 6 months to every 12 months
- Application of Least Costly Alternative authority to HCPCS codes E0620 and A4257

### Hospital Beds
(Effective for DOS on or after April 1, 2002)
- HCPCS code E0316 to policy
- Deletes requirement to list ICD-9 diagnosis codes for bed cradles (E0280)

### Immunosuppressive Drugs
(Effective for DOS on or after April 1, 2002)
- Added new HCPCS code J7511
- Added HCPCS code J7511 to Coverage and Payment Rules

### Lower Limb Prostheses
(Effective for DOS on or after April 1, 2002)
- Included HCPCS code changes that have been made since the policy was last published - HCPCS codes L5301-L5341, L5671, L5704-L5707, L5847, L5968, L5975, L5979, L5988-L5990, L8420, L8430, L8470, L8480
- Added statements concerning provision of prostheses to patients prior to discharge for a hospital or SNF which have been previously published in bulletins
- Revised section on replacement of prostheses
- Added coding guidelines on suspension locking mechanisms
- Clarified documentation needed to support the use of a K modifier on a claim

### Nebulizers
(Effective for DOS on or after April 1, 2002)
- Expansion of coverage for large volume nebulizers with saline or water for use with tracheobronchial stents (519.1);
- Expansion of indications for use of pentamidine with added ICD-9 codes;
- Expansion of indications for use of pentamidine with added ICD-9 codes;
- New HCPCS E codes replace K codes;
- New HCPCS codes for inhaled corticosteroids;
- Revision of HCPCS code for albuterol to include levalbuterol and its proper billing unit.

### Pneumatic Compression Devices used in Treatment of Lymphedema
(Effective for DOS on or after January 14, 2002)
- Based on a CMS (Centers for Medicare and Medicaid Services - formerly HCFA) national coverage decision, the distinction
between lymphedema and chronic venous insufficiency and the respective coverage and payment rules for use of these devices for either condition is further clarified.

**Respiratory Assist Devices**
(Effective for DOS on or after July 1, 2002)
- New criteria for Obstructive Sleep Apnea, involving an Apnea/Hypopnea Index
- Liberalization of documentation requirements for the beneficiary and physician compliance statements (see related article in DMERC Medicare Advisory bulletin)
- Liberalization extending coverage and separate payment for heat-ed humidifiers (HCPCS code K0531) when prescribed for use with a covered RAD without backup rate (HCPCS code K0532)
- RAD with backup rate used with invasive interface (HCPCS code K0534) added to explain when to bill this code
- ZX modifier replaced by KX modifier on or after July 1, 2002

**Spinal Orthoses**
(Effective for DOS on or after July 1, 2002)
- Included HCPCS code changes that have been made since the policy was last published - HCPCS codes L0315, L0317, L0321, L0331, L0391, L0515, L0561, L0986
- Eliminated HCPCS codes K0112 and K0113
- Added or revised definitions for several terms used in HCPCS code descriptors
- Added statements concerning coverage of orthoses relating to inpatient hospital or SNF stays which have been previously published in bulletins
- Added noncoverage statement of HCPCS code L0984 which was previously published in a bulletin

**Surgical Dressings**
(Effective for DOS on or after April 1, 2002)
- Included HCPCS code changes that have been made since the policy was last published - HCPCS A6010-A6024, A6196-A6202, A6222-A6224, A6231-A6233
- Current HCPCS code for tape, HCPCS code A6265, made invalid for DMERC and two new HCPCS codes for tape, K0572 and K0573, established
- Substituted GY modifier for ZY modifier
- Added coverage and coding guidelines for compression bandage systems used for the treatment of venous stasis ulcers
- Added statement about coverage of compression dressings
- Revised coverage statements concerning secondary dressings to allow for multi-layer compression bandage systems
- Revised statements regarding kits to clarify coverage of medically necessary components of kits
- Impregnated roll gauze dressings designed for the treatment of venous stasis ulcers (e.g., Unna Boot) are coded using HCPCS code A6266.
- Removed specific mention of Nurse Practitioners, Physician Assistants, and other non-physician practitioners in statements about documentation requirements. This is to be consistent with wording in other policies. The general statements about the acceptance of orders from non-physician practitioners which are found in the Supplier Manual continue to apply to this policy.
Suction Pumps
(Effective for DOS on or after April 1, 2002)
- New HCPCS code for gastrointestinal suction pumps as distinguished from tracheal suction pumps
- New HCPCS A codes replacing K codes for canisters and tubing
- Definitional distinction between tracheal and oral suction catheters
- Allowance of an additional ICD-9 diagnosis code for coverage of tracheal suction equipment and supplies

Therapeutic Shoes for Diabetics
(Effective for DOS on or after July 1, 2002)
- Crosswalk HCPCS code A5502 to A5509, A5510 and A5511.
- Non-coverage statement for HCPCS code A5510
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Added RT and LT modifiers
- Replace ZX with KX, effective July 1, 2002
- Clarified that HCPCS code A5507 can be used for repairs to diabetic shoes
- Clarified that the certifying physician may not be a podiatrist

Urological Supplies
(Effective for DOS on or after July 1, 2002)
- Adds to policy HCPCS codes A4319, A4324, A4325, A4331-3, A4348, A4360, K0572, K0573
- Deleted from policy HCPCS codes A4329, A4359, A4554, A5149, A6265, K0280, K0281, K0407-9, K0411
- Adds use of GY modifier for non-covered conditions
- Replace ZX with KX, effective July 1, 2002

Several ostomy HCPCS codes have been made not valid for submission to the DMERC, while many new HCPCS codes become effective with dates of service on or after April 1, 2002. As explained below, some of these new HCPCS codes represent add-on features which may be billed separately.

HCPCS codes not valid for submission to the DMERC on or after 4/1/02:

A4368 Ostomy filter, any type, each
A4370 Ostomy skin barrier, paste, per oz.
A4374 Ostomy skin barrier, with flange (solid, flexible, or accordion) extended wear, with built-in convexity, any size, each
A4386 Ostomy skin barrier, with flange (solid, flexible or accordion) extended wear, without built-in convexity, any size, each
A5061 Pouch, drainable; with barrier attached (1 piece)
A5123 Skin barrier; with flange (solid, flexible or accordion), any size, each
A6265 Tape, all types, per 18 square inches
NEW OSTOMY
HCPCS CODES
AS OF APRIL 1, 2002

cont.

New HCPCS Codes:

K0561 Ostomy skin barrier, non-pectin based, paste, per ounce
K0562 Ostomy skin barrier, pectin-based, paste, per ounce
K0563 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built in convexity, 4 x 4 inches or smaller, each
K0564 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
K0565 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
K0566 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
K0567 Ostomy pouch, drainable, with karaya based barrier attached, without built-in convexity, (1 piece), each
K0568 Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity, (1 piece), each
K0569 Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), each
K0570 Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 inches or smaller, each
K0571 Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each
K0572 Tape, non-waterproof, per 18 square inches
K0573 Tape, waterproof, per 18 square inches
K0574 Addition to ostomy pouch, filter, integral or added separately to pouch, each
K0575 Addition to ostomy pouch, rustle-free material, per pouch
K0576 Addition to ostomy pouch, friction and irritant-reducing, absorbent, interface layer (comfort panel), per pouch
K0577 Addition to ostomy pouch, odor barrier, incorporated into pouch laminate, per pouch
K0578 Addition to ostomy pouch, faucet-type tap with valve for draining urinary pouch, each
K0579 Addition to ostomy pouch, absorbent material (sheet/pad/crystal packet) to thicken liquid stomal output, for use in pouch, each
K0580 Addition to ostomy pouch, flange locking mechanism, each

Definitions of New HCPCS Codes: The following are revisions or additions to definitions found in the LMRP for Ostomy Supplies in the Supplier Manual, referring to the new HCPCS codes.

Barriers:

A solid barrier (wafer) is an interface between the patient's skin and the pouching system, has measurable thickness and has an adhesive property. Barriers may be integrated into a "1 piece" pouch, they may be manufactured with a flange and be part of a "2 piece" pouch system (skin barrier with flange, e.g., HCPCS code K0570), or they may be used independently (e.g., HCPCS code A4362), usually with a pouch that does not have its own integral skin barrier. When barriers are used as part of a "1 piece" drainable pouch, they may be either pectin-
NEW OSTOMY
HCPCS CODES
AS OF APRIL 1, 2002

cont.

based (e.g., HCPCS code K0568) or karaya-based (e.g., HCPCS code K0567). An extended wear barrier (e.g., HCPCS code K0565) is a pectin-based barrier with special additives which achieve a stronger adhesive seal, resist breakdown by urine or bowel effluent, permit longer wear times between changes, and normal wear times for those who cannot achieve them with standard barriers. There are distinct HCPCS codes for extended wear compared to standard wear barriers.

A barrier with built in convexity (e.g., HCPCS code K0563) is one in which an outward curve is usually achieved with plastic embedded in the barrier, allowing better protrusion of the stoma and adherence to the skin. There are distinct HCPCS codes for barriers with built-in convexity compared to flat barriers.

Ostomy skin barriers greater than 4 x 4 inches (HCPCS codes K0564, K0566, K0571) refer to the size of the skin barriers themselves, and not to the area of any surrounding tape.

Pouches:

A "high output" pouch (HCPCS code K0569) has a capacity of greater than or equal to 0.75 liters, an anti-reflux valve, a large bore solid spout with cap or plug and is part of a 2 piece system.

Add on Features to Pouches:

Filters (HCPCS code K0574) allow venting of gas trapped in the ostomy pouch. They may also include materials such as charcoal to deodorize the vented gas. Filters may be incorporated in the pouch, inserted into a venting ring on the pouch, or attached to the pouch exterior.

Rustle-free material (HCPCS code K0575) reduces the crackling noise produced by pouch materials with bodily movement.

Friction and irritant - reducing, absorbent interface layer (comfort panel) (HCPCS code K0576) is a soft material layer on the body side of the pouch that reduces skin irritation, sticking and sweating that would otherwise result from direct contact of the pouch with the skin.

An odor barrier (HCPCS code K0577) is a film layer (e.g., polyvinyl dichloride) incorporated into the pouch, which serves to retain odor within the pouch. It is separate from any odor absorbing material contained in a pouch filter (HCPCS code K0574).

A faucet-type tap (HCPCS code K0578) with a valve for draining urinary pouches (HCPCS codes A4391, A4392, A4393, A5071, A5072, A5073) is distinguished from plugs, caps, fold up or clip type drainage closures.

Absorbent material (HCPCS code K0579) may come as sheets, pads or crystals, that is added to the ostomy pouch.

HCPCS code K0580 describes a lever type flange locking mechanism. It differs from simple push on pouch securing mechanisms. The mechanism may be incorporated either in the pouch flange or skin barrier flange.
NEW OSTOMY CODES AS OF APRIL 1, 2002

cont.

Pastes:

A paste is used as a protective layer and sealant beneath ostomy appliances, and is applied directly on the skin. It may be primarily pectin based (HCPCS code K0562), or non-pectin based, e.g., karaya (HCPCS code K0561).

Additional Allowances for Certain Codes:

When supplied with a covered ostomy pouch, HCPCS codes K0574 - K0580 are paid separately and in addition to the ostomy pouch HCPCS codes for which these K codes represent add-on features. They should be billed on separate claim lines, in addition to the pouch HCPCS code, when they represent additional features of that pouch.

For HCPCS codes K0575, K0576, K0577, K0578, K0580, only one unit of each HCPCS code per pouch may be billed.

Usual Maximum Quantities of New Codes: Only those new HCPCS codes that are direct analogues of eliminated HCPCS codes, for which maximum quantities had been listed in the table in the Ostomy Supplies LMRP, are listed below:

HCPCS codes K0567 and K0568 replace HCPCS code A5061; the usual maximum allowable quantity remains 20 units per month.

HCPCS codes K0570 and K0571 replace HCPCS code A5123; the usual maximum allowable quantity remains 20 units per month.

HCPCS codes K0572 and K0573 replace HCPCS code A6265; the usual maximum allowable quantity remains 40 units per month.

HCPCS codes K0561 and K0562 replace HCPCS code A4370; the usual maximum allowable quantity remains 4 units per month.

An order from the treating physician must specify the quantity of ostomy supplies required by a beneficiary, and if greater than the usual maximum quantity of supplies per month stated in the LMRP are needed, this should be specified on the order and the reasons for the increased need documented in the patient's medical record. The add-on HCPCS codes (K0574-K0580) do not need to be specifically listed on the physician's order.

Under the standard grace period, the invalid HCPCS codes will continue to be accepted on claims for dates of service on or after April 1, 2002, that are received by June 30, 2002. However, use of the invalid HCPCS codes for dates of service on or after April 1, 2002, received on claims on or after July 1, 2002, will be denied as incorrect coding.
**POLICY REVISION - CPAP**

The accompanying Region C DMERC DMEPOS Supplier Manual update contains a revision of the Continuous Positive Airway Pressure (CPAP) device local medical review policy (LMRP). The revised policy updates the Coverage and Payment rules to reflect the National Coverage Decision (NCD) allowing use of an apnea-hypopnea index (AHI) for the diagnosis of obstructive sleep apnea. In addition, the revised policy provides instructions for continued coverage of the device beyond the first three months, clarifies that accessories used with CPAP are separately reimbursable, and provides coverage for heated humidifiers used with a CPAP device.

A major change in the revised policy is the elimination of the CPAP Certificate of Medical Necessity (CMN). In lieu of a CMN, the supplier must use a KX modifier to indicate that the Coverage and Payment Rules have been met. KX modifier use applies to both the HCPCS code E0601 and accessories. Suppliers should note that the LMRP revision is effective for dates of service on or after July 1, 2002. However, the change in the national policy (Coverage Issues Manual § 60-17) to cover CPAP based on the AHI is effective for dates of service on or after April 1, 2002. Therefore, the following instructions must be followed by suppliers submitting claims for HCPCS code E0601 and related accessories:

**DOS prior to 4/1/02**
HCFA-1500 Form and CPAP CMN - LMRP and CIM § 60-17 in effect for these dates of service apply

**DOS on or after 4/1/02 but prior to 7/1/02**
HCFA-1500 Form with HCPCS code E0601 and accessories - No modifier; No CMN; No LMRP; Revised CIM § 60-17 in effect

**DOS on or after 7/1/02**
HCFA-1500 Form with HCPCS code E0601 and accessories - No CMN; KX modifier on HCPCS code E0601 and accessories if revised LMRP policy requirements met; Revised CIM § 60-17 in effect

There is no LMRP in effect for dates of service between April 2002 and July 2002; however, claims for CPAP and accessories are still bound by the requirements in the revised national policy CIM § 60-17. National policy requires that initial claims for CPAP devices must be supported by documentation in the medical record indicating that the patient meets Medicare's stated coverage criteria. This information must be available to the DMERC upon request.

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**RESPIRATORY ASSIST DEVICE POLICY:**

**Update on Timing of Beneficiary/Physician Statement Completion**

The Respiratory Assist Device (RAD) Local Medical Review Policy (LMRP) has certain timing requirements that will be revised in the next policy update. However, claims are being adjudicated based upon these changes.

**What has not changed and remains a requirement:**
- The beneficiary and physician may not complete nor sign their respective statements attesting to the beneficiary's compliant use of the device anytime prior to the 61st day after date of issue.
**Respiratory Assist Device Policy:**

**Update on Timing of Beneficiary/Physician Statement Completion**

**cont.**

What has changed:

- The beneficiary no longer has to see the physician within the same month that the Beneficiary Statement is completed.
- An office visit is not required for statement completion if the physician is able to otherwise ascertain the facts needed to do so, and those facts are accurately reflected in the progress notes of the patient's medical chart.
- Neither the beneficiary nor the physician needs to complete and sign the statement by the 90th day. However, the supplier may not submit a claim(s) for the 4th or succeeding months' services using the ZX modifier (KX on or after July 1, 2002), until or unless both statements have been completed, signed, and indicate that all other LMRP coverage criteria referenced in the statements (see the RAD LMRP in the Region C DMERC DMEPOS Supplier Manual) have been fulfilled.
- Only after both statements have been returned as described, even if either one is signed after the 90th day, the supplier may submit claims with a ZX (KX) modifier for those months (on or after the 61st day) during which the statements were lacking. (If a beneficiary and physician are attesting to continued compliant use and benefit even later than the 90th day, it only serves as stronger evidence of the beneficiary's commitment to continued use of the equipment and justification for Medicare's continued reimbursement for it.)

As an example, if use of a RAD is begun on 7/1 and if a qualifying physician statement is not obtained until 10/15 and a qualifying beneficiary statement is not obtained until 11/20, then if the claims for 10/1 and 11/1 (i.e., the fourth and fifth months' claims) are not submitted until on or after 11/20 (i.e., after both statements have been obtained), the ZX (KX) modifier may be added to the appropriate claim lines. However, if the 10/1 and 11/1 claims are submitted before 11/20, the ZX (KX) modifier may not be added.

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**New Permanent Modifier - KX**

Effective for dates of service on or after July 1, 2002, a new Level II national modifier has been created:

**KX - Specific Required Documentation on File**

The KX modifier will replace the local modifier ZX currently used in local medical review policies (LMRPs). The new modifier is required when a LMRP directs the use of a modifier to indicate "specific required documentation on file." The following LMRPs are affected by this change:

- Erythropoetin
- External Infusion Pumps
- Home Blood Glucose Monitors
- Group 1 Support Surfaces
- Group 2 Support Surfaces
- Negative Pressure Wound Therapy
- Orthopedic Footwear
- Osteogenesis Stimulators
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Urological Supplies
- Walkers
- Therapeutic Shoes for Diabetics

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

cont.

RIB BELTS AND ABDOMINAL BINDERS NOW COVERED

In the Spring/Summer, 1998 DMERC MEDICARE Advisory, a determination on rib belts was published excluding them from coverage because they were not considered to be included in the benefit category of braces. CMS has issued a determination that elastic rib belts (HCPCS codes A4572, L0210, L0220) and abdominal binders (HCPCS code A4462) may be covered as braces when they are used in the following fashion:

1. The brace serves a medical purpose and it is only associated with treating an illness, injury, or malformed body member;
2. It provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace;
3. It is not a device used to supply compression therapy (for example, to reduce the size, volume, or swelling of a body member or to help circulation);
4. It is not a device used for convenience or appearance;
5. It is not a device used for cosmetic purposes.

Coverage will apply to claims for dates of service on or after August 1, 2001.

TAPE-HCPCS CODE CHANGES

Two new HCPCS codes have been established for tape.

K0572 Tape, non-waterproof, per 18 square inches
K0573 Tape, waterproof, per 18 square inches

These HCPCS codes are effective for dates of service on or after 4/1/02. The current HCPCS code for tape, A6265 (tape, all types, per 18 square inches), has been made invalid for claim submission to the DMERC for dates of service on or after 4/1/02. Under the standard grace period, HCPCS code A6265 will continue to be accepted on claims with dates of service on or after 4/1/02 that are received by 6/30/02. Claim lines with HCPCS code A6265 with dates of service on or after 4/1/02 that are received on or after 7/1/02 will be rejected as invalid coding. HCPCS code A6265 will continue to be valid for claims with dates of service on or before March 31, 2002, regardless of the date that the claim is received.

This HCPCS code change applies to use of the tape code in all situations including the LMRPs: Facial Prostheses, Ostomy Supplies, Surgical Dressings, and Urological Supplies.
WHEN REGION C DEVELOPS CLAIMS FOR EXTRA DOCUMENTATION

by Paul D. Metzger, M.D.
Medical Director
Region C DMERC

The Medical Review department of Region C DMERC may find it necessary to request additional documentation from a supplier after a claim has been submitted. This is called claim development, and the supplier will receive a letter requesting, among other things, copies of the treating physician's progress notes, along with a copy of an order for the billed item (if a CMN was not required), as well as a description of the product by manufacturer, model name or number (since only a HCPCS code may have been submitted on the claim). The purpose of this article is to give some insight to suppliers, as to what the Medical Review department is looking to receive in response to such requests.

References to the "physician's order," mean the treating physician, or nurse practitioner, clinical nurse specialist, or physician assistant (the last, for claims with dates of service on or after July 1, 2001) directly involved in the care of the beneficiary for whom durable medical equipment, prostheses, orthoses or supplies (DMEPOS) is ordered. The order must be sufficiently detailed according to the Region C DMERC DMEPOS Supplier Manual for orders.

The physician's progress notes (actual physician entries into the patient's medical record) must include entries relevant to the disease and treatment plan that corroborate medical necessity for the billed item, according to coverage criteria in the published DMERC local medical review policy (LMRP), where one exists. If no policy exists for the item, there still must be entries in the medical record indicating the presence of a disease state and treatment plan that would indicate some relevance to the DMEPOS which the physician has ordered. Other helpful documents from the medical chart might include hospital discharge summaries, operative, laboratory and pathology reports, and entries from ancillary health care professionals such as physical therapists, nutritionists/dietitians, home health nurses, etc., so long as these represent entries by clinicians directly involved in the care of the patient.

Although physician letters will certainly be considered, they are not a substitute for the physician's contemporaneous progress notes, which represent the universally acknowledged legal documentation of the treating physician's complete interaction with the patient. From their earliest years of training, physicians are taught that if a disease or a treatment is not documented in the patient's chart, "it never happened."

Check sheets, pre-formatted summary statements relevant to the billed DMEPOS, and even policy-required supplier obtained statements (for example, for therapeutic shoes or support surfaces) are necessary, but they will not be sufficient in the absence of the requested physician progress notes.

The DMERC is charged with the responsibility of safeguarding the confidentiality of received medical records, and Palmetto GBA has in place strict compliance standards to ensure the beneficiary's confidentiality is not violated.

Medicare contractors, such as the DMERCs, have authority to request documents from physicians, as well as suppliers, to ascertain that Medicare only reimburses for items that are medically reasonable and necessary.
What follows are examples of items for which suppliers might receive development letters and elements that should be documented in the treating physician's progress notes found in the medical chart. The mentioned elements are examples only, and are not meant to be all inclusive:

**DMEPOS examples for which LMRP exists:**

**Surgical Dressings:** Progress notes must indicate the presence, number, stage, location, size and exudate amount of the wound(s) being treated, as well as which dressings are being applied to which wounds, if more than one wound and dressing type is involved, and whether as primary or secondary dressing. Sequential entries should indicate the progress of wound healing. Attention to other aspects of patient care for wound therapy should be apparent, such as efforts at debridement, nutritional status, incontinence treatment, positioning and turning, support surfaces, if being used.

**Urological Supplies:** Progress notes must indicate the presence of permanent incontinence; the type of supplies (catheter type), and if a specialty type of catheter, the reasons why; the drainage technique (indwelling, intermittent), and if intermittent, the number of times per day; the presence or history of urinary tract infections (their diagnosis and treatment).

**Wheelchairs and Power Wheelchairs:** Progress notes must indicate the ambulatory status of a patient and the medical conditions causing its impairment, which should give some indication of where the vehicle will be used (within the home?); if a power vehicle, why the patient is unable to propel a manual, or even lightweight manual wheelchair.

**Nebulizer Medications:** Progress notes must indicate the respiratory disease being treated along with treatment plans mentioning the particular medications being billed, as well as dosing information about the amount and frequency of administration.

**Respiratory Assist Devices:** Progress notes must indicate the physician's involvement in the diagnosis of the respiratory disorder as well as symptoms being addressed by the device. In addition to the beneficiary and physician compliance statements, there must be laboratory and polysomnogram (if applicable) results that justify the level of equipment being ordered. If invasive interface devices are ordered, indication of the presence of a tracheostomy should be present.

**Therapeutic Shoes for Diabetics:** in addition to the completed and signed statement from the certifying physician (either an M.D. or an D.O., not a podiatrist), progress notes from the certifying physician must indicate the presence and treatment of diabetes mellitus, as well as the nature of the foot disorder if the certifying physician is also ordering the shoes. There also must be progress notes from the ordering physician, if different from the certifying physician (who may be a podiatrist), indicating the nature of the foot disorder that warrants the need for the shoes.

**Lower Limb Prostheses:** Progress notes must indicate the occurrence of a lower limb amputation, along with some indication of the ambu-
latory ability of the patient that corroborates the ambulatory status K modifier (K0-K4) submitted on the claim.

Support Surfaces: Progress notes must indicate the disease and debility of the patient, description of wounds and wound care, and what other support surfaces have been used (if applicable).

Spinal Orthoses: Progress notes must indicate the presence and nature of the patient’s back injury, disease or surgery, including location in the spine, which should correlate with the spinal orthosis being billed.

**DMEPOS examples for which LMRP does not exist:**

Orthoses for which there is not an LMRP: Progress notes must fully describe the disease, injury or surgery that correlates with the level of the orthosis being billed, including some indication of the rehabilitative potential and modalities being ordered as well, where appropriate.

Ventilators: Progress notes must indicate the presence of a respiratory condition that might warrant the ventilatory support being prescribed.

Neuromuscular Electrical Stimulator: Progress notes must indicate a condition that would lead to limb immobilization, that is not due to central or peripheral neurological involvement, and which is not being used as a physical therapy modality for a limb no longer immobilized.

Ultraviolet Light Cabinets: Progress notes must indicate the presence, severity and other attempts at treatment of the psoriatic condition, as well as the geographic conditions or disability precluding travel to an outpatient facility for the UV treatments.

Letters, free-standing statements, and even detailed physician orders do not replace the necessity for the DMERC to see the physician's progress note entries in the patient's medical chart corroborating the medical necessity of the DMEPOS items being billed.

**Correction—Joint Contracture Devices**

E1820

The last paragraph in this article, printed in the Winter 2001 DMERC Medicare Advisory, contained an incorrect code. The paragraph should have read:

HCPSC code E1820 (replacement soft interface material, dynamic adjustable extension/flexion 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.
In an effort to provide efficient and effective use of Medicare operational and program resources, the following is a list of preferred DMERC claims filing procedures:

1. **Frequency of claims** - Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims should be submitted on a monthly basis. Claims should be filed no more or less frequently than monthly for a month's worth of DMEPOS unless medical policy allows filing at a different frequency (e.g. diabetic test strips).

2. **Submit Claims in Sequence** - In the case of continuous periods of service, submit claims in sequence. When there is a break in service (<60 days), continue sequential billing when the service(s) resume(s).

3. **Automatic Mailing/Delivery of DMEPOS** - To assure need of the DMEPOS item(s), suppliers may not automatically deliver additional supplies/equipment unless specifically requested by the beneficiary, physician, or designated representative. The beneficiary or caregiver must request refills of repetitive services and/or supplies before dispensing. Suppliers may not initiate a refill of an order. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

Effective April 1, 2002, suppliers must file claims for glucose supplies and test strips on behalf of the beneficiary for dates of services on or after October 1, 2001. Medicare will no longer accept claims filed by the beneficiary. In addition to mandatory submission of claims, suppliers must indicate the “from” and “to” dates when filing claims for diabetic supplies (e.g., 01/01/02 to 03/31/02).

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.
COMPLIMENTARY/SUPPLEMENTAL POLICIES UPDATE

Non-Medigap Medicare supplemental policies are Medicare supplemental policies that do not meet the definition of Medigap policies. Often these policies are referred to as complementary coverage policies.

Do not list these Non-Medigap Medicare supplemental policies on the HCFA-1500 (12-90) claim form. If we have an agreement with a Non-Medigap Medicare supplemental insurer, Palmetto GBA will automatically forward the Medicare claim information to that insurer and indicate that we did so on your Medicare remittance.

The most current list of these insurers as of January 1, 2002, is shown below:

- AARP Health Care Options
- Acordia Senior of the Southeast
- Aetna Life Insurance Company
- Alabama Medicaid
- American Family Life Assurance Co. (AFLAC)
- American Insurance Administration Group, Inc.
- American Postal Workers Union Health Plan
- American Republican Insurance Company
- Anthem Insurance Companies, Inc.
- Arkansas Medicaid
- BCBS Of Alabama
- BCBS Of Arkansas
- BCBS Of Colorado
- BCBS Of Colorado (FEP)
- BCBS Of Florida
- BCBS Of Louisiana
- BCBS Of Michigan
- BCBS Of Minnesota
- BCBS Of New Hampshire
- BCBS Of New Mexico
- BCBS Of New Mexico (FEP)
- BCBS Of North Carolina
- BCBS Of Oklahoma
- BCBS Of South Carolina (FEP)
- BCBS Of South Carolina (Over 65 Plan)
- BCBS Of Texas
- BCBS Of Wisconsin
- Benefit Planners, Ltd.
- Carefirst
- Central States Health and Life Co. Of Omaha
- Claims Administration Corp.
- Companion Life
- Continental Life Insurance
- Dallas General Life Insurance Co.
- Empire Blue Cross Blue Shield Florida Medicaid
- Georgia Medicaid
- Government Employee Hospital Assoc.
- Group Health Incorporated (GHI)
- Health Data Management
- Health Plan Services
- Horizon BCBS of New Jersey
- Kentucky Medicaid
- Louisiana Medicaid
- Mississippi Medicaid
- Monumental Life Insurance Company
- Mutual Of Omaha
- NALC-National Association of Letter Carriers
- New Mexico Medicaid
- North Carolina Medicaid
- Oklahoma Health Care Authority (Medicaid)
- Olympic Health Management Systems
- Peoples Benefit Insurance Company
- Physicians Mutual Insurance Company
- Pioneer Life
- Seabury & Smith, Inc.
- South Carolina Medicaid
- Standard Life and Accident Ins. Co.
- Tennessee Medicaid
- Texas Medicaid
- TRICARE For Life
- Triple-S, Inc.
- Unicare
- Union Fidelity Life Insurance Company
- United American Insurance Company
- United Healthcare
- United Teachers
- USAA Life Insurance Company
- Worldnet Services Corp.
**Deceased Physician’s UPINs**

Effective April 1, 2002, the Common Working File will reject claims containing a deceased physician’s UPIN. If there is a change in physician, a revised CMN is required and the new UPIN should be indicated on the HCFA-1500 (12-90) claim form.

**Denial Code Change for DME Furnished in a Skilled Nursing Facility (SNF)**

Effective October 1, 2001, the denial code used in connection with denials of DME furnished to a SNF resident during a stay that the Part A Prospective Payment System does not cover was changed to reflect patient responsibility. Section 1861(n) of the Social Security Act limits the Part B DME benefit to coverage of items that are furnished for use in a beneficiary’s home, and specifically excludes SNFs from the definition of a “home” for this purpose. Therefore, DME provided in the SNF setting is a noncovered service under Part B and it is permissible to charge the beneficiary for types of services that Medicare does not cover.

**Skilled Nursing Facility (SNF) Consolidated Billing (CB) Coding Information on the Web**

As of January 1, 2002, coding information for SNF CB may be found on the CMS Web site at [www.hcfa.gov/medlearn/refsnf.htm](http://www.hcfa.gov/medlearn/refsnf.htm) under the topic "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers." This information may be used by carriers and providers to determine by code whether services rendered to beneficiaries in Part A covered SNF stays or non-Part A covered SNF stays, (Part A benefits exhausted), are included or excluded from CB. You will reimburse services that are excluded from CB. Services that are included in CB, must be billed to the SNF for payment. These files are for services rendered in calendar year 2002. Carriers and providers will be notified of any subsequent coding changes.

Four code files will be found on the Web site:

- Codes for physician professional services (other than the interpretation of diagnostic tests) that when rendered to beneficiaries in a Part A covered stay are not included in CB and must be submitted to the carrier or DMERC for payment.

- Codes for the physician interpretation of diagnostic tests that when rendered to beneficiaries in a Part A covered stay and submitted with a 26-professional component modifier are not included in CB. These services must be submitted to the carrier for payment.

- Codes for ambulance services that will always be included in CB when submitted with an NN modifier and must not be submitted to the carrier for payment. These services must be submitted to the SNF for payment. There are additional situations in
which ambulance services are consolidated. Refer to Program Memorandum AB-01-159 to identify these situations.

- Codes for physical, occupational, and speech therapy services that, when rendered to a beneficiary in a non-Part A covered stay, (i.e., Part A benefits exhausted), are included in CB and may not be submitted to the carrier for payment. They must be submitted to the SNF for payment.

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**SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) CODING INFORMATION ON THE WEB**

**Clinical Trial Claims**

This article is reprinted from the Winter 2001 DMERC Medicare Advisory and includes some information inadvertently omitted.

On June 7, 2000, the President of the United States issued an executive memorandum directing the Centers for Medicare & Medicaid Services (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. CMS has developed a National Coverage Determination (NCD) which can be accessed and downloaded from the CMS webpage at: [www.cms.hhs.gov/quality/8d.htm](http://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., physicians’ 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 inter-
CLINICAL TRIAL CLAIMS

Cont.

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

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

◆ Deemed Trials - Some trials are considered 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 Drugs 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 time the principal investigators of 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
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.

This national coverage policy is based upon the authority found in §1862(a)(1)(E) of the Social Security Act. It is binding on all Medicare carriers, intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, Health Care Prepayment Plans, and Medicare+Choice organizations (§1852(a)(1)(A) of the Act).

Effective for dates of service on or after September 19, 2000, when submitting claims for services or items that meet the requirements as outlined in the final National Coverage Decision you must identify these services with the “QV” procedure code modifier.

"QV" - "Item or service provided as routine care in an approved clinical trial" (The full coverage policy regarding clinical trials may be accessed at www.cms.hhs.gov/quality/8d.htm.)

The modifier is line item specific and must be used to identify items and services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary’s participation in a Medicare-covered clinical trial. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the clinical management of the patient are not covered and may not be billed using the QV modifier. Items and services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category also may not be billed using the QV modifier. Finally, items and services customarily provided by the research sponsor free of charge for any enrollee in the trial may not be billed.

In addition to the QV modifier, providers must also report diagnosis code V70.5 (Health Examination of Defined Subpopulations) as a secondary diagnosis for patients participating in Medicare-covered clinical trials.
CLINICAL TRIAL CLAIMS
cont.

The QV modifier and V70.5 diagnosis code will serve as your attestation that the service meets the Medicare coverage criteria (i.e., was furnished to a beneficiary who is participating in a Medicare qualifying clinical trial and represents routine patient care, including complications associated with qualifying trial participation).

Submit separate line items for clinical trial services when billing other covered services not directly related to a Medicare qualifying clinical trial on the same claim.

When submitting claims with the QV procedure code modifier and V70.5 diagnosis code, the billing provider must include in the beneficiary's medical record the following information: trial name, sponsor, and sponsor-assigned protocol number. This information should not be submitted with the claim but must be provided if requested for medical review. A copy of the signed informed consent document must also be made readily available if requested for medical review.

Payment for these qualifying clinical trial services furnished on or after September 19, 2000, will be made based on the payment methodology applicable for the service that was furnished (e.g., physician fee schedule, lab fee schedule, DME fee schedule, reasonable charge). All applicable deductible and coinsurance rules apply to these services with one exception. Managed care enrollees will not be responsible for the Part A and Part B deductibles for covered clinical trial services billed as fee for service.

If you have a claim for a Medicare qualifying clinical trial service that has been denied for a date of service on or after September 19, 2000, the action you take to get the claim paid will depend on whether the service was initially submitted with the QV modifier and ICD-9 code.

Initial Claim Did Not Include the QV Modifier and ICD-9 Code V70.5--If clinical trial routine care services on a claim are denied and were not identified as clinical trial services (i.e., the clinical trial modifier and ICD-9 code was not included), resubmit the services on a new claim with the QV modifier and ICD-9 code V70.5 for the care or medical complications arising from a Medicare-qualifying clinical trial.

Denied Service Included the QV Modifier and ICD-9 Code--If a service Medicare covers is billed with the QV modifier and ICD-9 code and initially denied (e.g., for medical necessity or utilization) contact us (866-238-9650) and request an adjustment to the claim. If appropriate, we will adjust and pay the claim.

Payment Of Clinical Trial Services For Managed Care Enrollees--Until Medicare capitation rates are adjusted to account for clinical trials, payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans will be made on a fee for service basis by the Medicare contractors that process fee-for-service claims. Providers will need to submit fee for service bills for Medicare covered clinical trial services furnished to managed care enrollees. The payment amounts will be based on the applicable Medicare fee schedules for such services. In addition, the Part A and Part B deductibles are assumed to be met for covered clinical trial services billed as fee for service for managed care enrollees.
**Oxygen Contents**

The CMS Regional Office recently advised Palmetto GBA of the appropriate claims processing guidelines regarding oxygen contents, which is payment for one (1) unit of contents per month. The 2002 fee schedule amounts for stationary and portable systems are available on the Palmetto GBA Web site.

**Important HIPAA Changes to Medicare Billing**

The following information was mailed to all EDI submitters on November 30, 2001. Included in this mailing was a copy of the GPNet Communications Manual, HIPAA/GPNet Testing Procedures and Supplemental Guide for ANSI ASC X12N 837 version 4010 Implementation Guide. Please note that these documents are subject to change as we receive additional information regarding the transition to HIPAA-ready electronic formats. We will post updated versions of these documents to our Web site. Please visit us often at www.PalmettoGBA.com. Click on the HIPAA button on the bottom of our home page to check for updates to the enclosed documentation.

During the past year, our Medicare Advisories and Web site have been providing you with information regarding upcoming changes to Medicare Electronic Data Interchange (EDI) effected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The provisions of the Administrative Simplification Act, a portion of HIPAA, mandates new standard formats for electronically submitted health care transactions. Among the affected transactions is the health insurance claim format, the ANSI ASC X12N 837 version 4010, which will replace the National Standard Format (NSF) currently used by all durable medical equipment, prosthetic and orthotic suppliers (DMEPOS) for billing their Medicare claims to the Durable Medical Equipment Regional Carrier (DMERC).

To accommodate these claim format changes, Palmetto GBA is implementing a new EDI Gateway, called GPNet, to replace our existing Bulletin Board System (BBS), CONNECT:Mailbox, and magnetic tape processes. All electronic submitters of Medicare claims to Palmetto GBA will be required to change both their formats and their telecommunications methods. The law requires that all HIPAA provisions be fully implemented by October 16, 2002. Copies of HIPAA Implementation Guides can be obtained through the Washington Publishing Company Web site at: www.wpc-edi.com/HIPAA.

The purpose of this article is to provide you with the details of the format and telecommunications changes. Our goal is to make this transition of your electronic claims submissions as simple as possible, with minimal disruption to your billing processes. Please take the time to read this information carefully to gain an understanding of the steps necessary to effect a smooth transition.

**Summary of HIPAA Migration Schedule for ANSI 837 Claims**

Palmetto GBA will be ready to receive your claim files in the ANSI 837 v4010 format via GPNet effective January 2, 2002. Submitters may migrate their claim submission at any time during the period of
IMPORTANT HIPAA CHANGES TO MEDICARE BILLING

cont.

January 2, 2002 and October 16, 2002; however, you must migrate your format and connectivity to GPNet at the same time. We encourage you to migrate as early during this period as possible to avoid issues sometimes associated with "last minute" transitions.

GPNet will replace our existing Bulletin Board System (BBS), CONNECT:Mailbox, and magnetic tape processes. It will support asynchronous, File Transfer Protocol (FTP) and Network Data Mover (NDM) telecommunications only. The GPNet Communications Manual, which includes detailed telecommunications specifications, is included in this package.

The ANSI 837 v4010 replaces the NSF batch file format and earlier versions of the ANSI 837. Detailed information on how to obtain the ANSI 837 v4010 specifications, as well as a supplemental guide for using the ANSI 837, are included in the Supplemental Manual to the ANSI ASC X12N 837 version 4010 Implementation Guide.

Testing and Production Procedures
Testing procedures have been established to ensure ANSI 837 v4010 data integrity and connectivity with GPNet prior to submitting your claim files in a production mode. Because of the volume of providers to be migrated, testing has been streamlined for submitters who have received HIPAA compliance certification or use certified vendor software. The HIPAA/GPNet Testing Procedures document includes detailed testing procedures for both connectivity and data integrity.

Once the testing requirements have been met, you may begin submitting in a production mode. Minor changes from the testing mode will be necessary. Details of these changes are also included in the HIPAA/GPNet Testing Procedures document.

Edits and Acknowledgements
Telecommunication and format changes necessitate changes to some of the edit reports and claim file acknowledgements you currently receive. With the use of the HIPAA-ready format, there will also be a new acknowledgement, the ANSI 997. The GPNet Communications Manual includes details regarding changes to edit reports, acknowledgements and the ANSI 997.

Low-cost Software
PACES, the free software product currently used by Palmetto GBA DMERC suppliers, prepares and submits claims files in the National Standard Format. Palmetto GBA will provide a new, Windows-based, free software product that facilitates submission of ANSI 837 v4010 claim files for all Medicare lines of business. The new software product is called PC-ACE Pro32.

We will begin distributing this new product on February 1, 2002. This will allow submitters sufficient time to migrate from the old software product and become HIPAA-ready. Users of the Pro32 software will not be required to submit test claims prior to submitting production claims. It is important to remember that migration to the new software must be accomplished simultaneously with migration to GPNet.

ANSI-835 Electronic Remittance Update
Palmetto GBA will begin exclusive use of the ANSI 835 v4010
Electronic Remittance transaction on October 16, 2002. We will cease issuance of non-version 4010 and NSF remittance transactions on this date. Additionally, ERNPrint software will not be upgraded to support printing of ANSI 835 v4010 for DMERC remittances. Each submitter that has elected to receive remittances electronically must accept v4010 or contract with a clearinghouse to translate data from the ANSI ASC X12N 835 v4010 standard on their behalf by October 16, 2002. A submitter that elects to use a clearinghouse for translation services is liable for those costs.

The ANSI ASC X12N 835 v4010 Implementation Guide and X12N Data Dictionary are available for download without charge from www.wpc-edi.com/HIPAA. Submitters must either request system compatibility testing for use of the ANSI 835 v4010 prior to October 16, 2002, or be confident that they have completed system changes to accept and use v4010 transactions by October 16, 2002. Any trading partner desiring to conduct testing prior to receiving production remittance data must schedule testing after January 2, 2002, and ensure testing is completed before October 16, 2002. As a result of the large number of providers, agents, clearinghouses and trading partners to be tested and the number of HIPAA standard transactions, it will not be feasible to test each entity during the last quarter of the transition process.

Palmetto GBA will begin testing the ANSI ASC X12N 835 v4010 transaction with submitters as of January 2, 2002. Additional information on ANSI 835 v4010 and the migration schedule will be sent to all recipients of electronic remittances during the first quarter of 2002.

Update on Other Transactions

Two other transactions will be impacted by the HIPAA requirements. We will send information on the ANSI 276/277 Claim Status Request and Response and the ANSI 270/271 Eligibility Inquiry and Response transactions as soon as information is finalized and available.

Because of the magnitude of these changes, we encourage you to migrate your formats and telecommunications early and we encourage your questions. If you have any questions regarding this information or other HIPAA requirements, please contact our Technology Support Center toll-free at (866) 749-4301. For updated HIPAA information, visit www.PalmettoGBA.com and click on the HIPAA button on the bottom of our home page for updated information. While at our Web site, update your registration to receive future HIPAA notifications.

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**DMERC Online CSI and ERN Enrollment Form**

Palmetto GBA Medicare Electronic Data Interchange is pleased to offer online enrollment for DMERC Claim Status Inquiry (CSI) and Electronic Remittance Notices (ERN). CSI allows you to electronically check the status of production claims after they have passed the front-end edits and received claim control numbers (CCN). ERNs are electronically downloaded notices that duplicate the information con-
**DMERC Online CSI and ERN Enrollment Form**

cont.

Please visit www.PalmettoGBA.com to access the DMERC Online CSI and ERN Enrollment Form. From the home page, select Providers/Electronic Data Interchange (EDI)/EDI Enrollment/DMERC/DMERC Online CSI and ERN Enrollment Form. Follow the online instructions for completing the enrollment form.

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**Have You Moved?**

Stay updated with EDI and HIPAA-related mailings! If you are an electronic submitter and have recently changed your mailing address please contact the Technology Support Center at (866) 749-4301 to update your information.

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**Billing Requirements**

**Miscellaneous HCPCS Codes**

When billing miscellaneous HCPCS codes, suppliers should include a description of the item being supplied, its brand name, manufacturer, catalog picture or description, catalog retail and wholesale price or manufacturer invoice. For surgical dressings, the size and volume of the dressing should be included. Without this information, the claim may be inappropriately paid or denied. Following is a list of miscellaneous codes that require the documentation described above:

| Not Otherwise Classified Codes                                                                 |
| (Should only be used in the absence of a HCPCS code assigned to define the item provided)    |
| A4335 | B9999 | L0999 | L8499 | J3490* |
| A4421 | E1399 | L2999 | L8699 | J7599* |
| A4913 | E1699 | L3649 | Q0181 | J7699* |
| A5149 | K0108 | L3999 | V2199 | J7799* |
| A6261 | K0415 | L5999 | V2299 | J8499* |
| A6262 | K0416 | L7499 | V2399 | J8999* |
| B9998 | K0448 | L8039 | V2799 | J9999* |

*Claims billed with drugs under Not Otherwise Classified (NOC) HCPCS codes should include the drug name, strength, unit dosage and NDC.

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<tr>
<th>Individually Considered HCPCS Codes</th>
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<tr>
<td>A6020</td>
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<td>A6198</td>
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<td>A6205</td>
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<td>A6206</td>
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*Report the HCPCS code in which the item billed is an accessory, and/or service component of that code.

Note: If you are unsure of correct coding, please contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMCRC) coding helpline. This helpline is designed to answer coding inquiries as well as fee schedule amounts for HCPCS codes by state.
**BILLING REQUIREMENTS**

**Miscellaneous HCPCS Codes**

The SADMERC helpline representatives will not be able to assist with pricing questions for not otherwise classified and individually considered codes, items priced by reasonable charge, or items with no established fee schedule allowance.

The helpline number is (877) 735-1326, Monday through Friday 9 a.m. to 12 p.m. and 1 p.m. to 4 p.m. Eastern Standard Time.

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**KEEP UP TO DATE WITH THE LATEST MEDICARE NEWS**

Are you keeping up to date on the latest Medicare publications and information? By registering on the Palmetto GBA Web site 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 to use many extra features. 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
- Update your E-mail profile at any time

Here are some helpful tips before you register:

- Make note of your User name and Password, as these items are case and character sensitive. Be sure to remember how you entered this information when registering. Hint: When registering, key in your user name and password in either all upper or lowercase. This is easier to remember.

- 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.

After you register the first time, you only need to login when you want to update your profile.

---

**OVERPAYMENT REMINDER**

When refunding overpayments to Medicare, please include a copy of the overpayment letter along with the check. This will expedite the process of having your check applied, and help to avoid offsets of benefits.

Suppliers may also refund overpayments to Medicare, which have not been requested by Medicare by using the DMERC Region C Overpayment Refund Form on the next page. Return your check made payable to Palmetto GBA-DMERC, along with a completed copy of the Refund Form and a copy of the Remittance Notice to the following address:

Medicare DMERC Overpayment Department, AG-342
Palmetto GBA
PO. Box 100183
Columbia, S.C. 29202-3183

If you have any questions, please call (803) 788-0222, extension 42907.
Use this form when sending Palmetto GBA unsolicited/voluntary refund checks:

### To Be Completed by Palmetto GBA

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date of Deposit:</td>
</tr>
<tr>
<td>Contractor Deposit Control Number:</td>
<td></td>
</tr>
<tr>
<td>Contractor Contact Name:</td>
<td></td>
</tr>
<tr>
<td>Contractor Address:</td>
<td></td>
</tr>
<tr>
<td>Contractor Fax Number:</td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name:</td>
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<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Provider Number:</td>
<td>Check Number:</td>
</tr>
<tr>
<td>Contact Person:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>Amount of Check:</td>
<td>Check Date:</td>
</tr>
</tbody>
</table>

### Refund Information

For each claim provide the following:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Medicare Claim Number:</td>
<td>HIC Number:</td>
</tr>
<tr>
<td>Date(s) of Service:</td>
<td>Claim Amount Refunded: $</td>
</tr>
</tbody>
</table>

Reason for Code Claim Adjustment: (Select reason from list below. Use one reason per claim.)

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

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

### For Institutional Facilities Only:

Cost Report Year(s):

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

### For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? (circle one) Yes No

### Reason Codes:

**Billing/Clerical Error**
- 01 – Corrected Date of Service
- 02 – Duplicate
- 03 – Corrected CPT Code
- 04 – Not Our Patient(s)
- 05 – Modifier Added/Removed
- 06 – Billed in Error

**MSP/Other Payer Involvement**
- 07 – Corrected CPT Code
- 08 – MSP Group Health Plan Insurance
- 09 – MSP No Fault Insurance
- 10 – MSP Liability Insurance
- 11 – MSP, Workers Comp. (Including Black Lung)
- 12 – Veterans Administration

**Miscellaneous**
- 13 – Insufficient Documentation
- 14 – Patient Enrolled in an HMO
- 15 – Services Not Rendered
- 16 – Medical Necessity
- 17 – Other (Please Specify)
- 18 – Did not accept assignment

Mail this form with your check to:
Medicare DMERC Overpayment Department,
AK-250 Palmetto GBA
PO Box 100183
Columbia, SC 29202-3183
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, which can be accessed by:

- Calling the customer service lines at (866) 238-9652 and requesting the CMS-855S form.
- 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 "CMS-855S Application Form."

Please refer to page five 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.

Electronic Medicare Provider Enrollment Forms

Medicare Provider Enrollment forms can be accessed at http://www.hcfa.gov/medicare/enrollment/forms/ on the CMS Web site. These forms include the CMS 855A, CMS 855B, CMS 855I, CMS 855R and CMS 855S. A comprehensive User Guide is also available on the Web site that provides detailed instructions on how to download these applications for individual use. The forms can then be completed online, saved, and printed for final signature and submission. At this time, these forms cannot be submitted electronically.

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 August 2002:

- March 12, 2002: DMERC Hospital Beds and Support Surfaces
- March 26, 2002: DMERC Infusion Therapy
- April 11, 2002: DMERC Parenteral and Enteral Nutrition
- April 23, 2002: DMERC Basic Billing, Part 1
- April 24, 2002: DMERC Basic Billing, Part 2
- May 21, 2002: DMERC Diabetic Coverage
- June 4, 2002: DMERC Oxygen Coverage
- June 18, 2002: DMERC Basic Billing, Part 1
- June 19, 2002: DMERC Basic Billing, Part 2
- July 9, 2002: DMERC CPAP and RAD
- July 23, 2002: DMERC Vision
Review Request Reminder

The time limit for requesting a review is six (6) months from the date of issuance of the remittance notice. This time limit applies to both written and telephone reviews. The DMERC review staff will determine if the request was filed timely or if good cause was established for a request not filed timely.

Hearing and Administrative Law Judge (ALJ) Appeal Request

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 aggregated. If your request does not specifically state or list the designated claims that are being aggregated, each claim will be treated as an individual request and those not meeting the amount in controversy will be dismissed.

Requests for Transfer of In-Person Hearings

Transfer of an in-person hearing is intended to accommodate beneficiary appeal requests for in-person hearing. A transfer may be used to accommodate either (1) beneficiaries who live in one part of the country part of the year, but spend an extended period of time in another part of the country for part of the year; or, (2) beneficiaries who are being represented by a son/daughter/relative where the representative lives in one part of the country, and the beneficiary lives in another. There may be other similar situations that would warrant approval of a beneficiary's transfer request. The overriding consideration is to provide access for a beneficiary to an in-person hearing.

Transfer of an in-person hearing has very limited application for physicians or other suppliers. Physicians or other suppliers with appeal rights are expected to pursue their appeals through the carrier that processes their claims. For transfer requests from physicians or other suppliers, there must be extenuating circumstances present for granting a request for transfer.
Requests for Transfer of In-Person Hearings

NOTE: Extenuating circumstances does not include the desire by a physician or other supplier to have a particular representative from another state or area of the country represent them. There is a strong presumption that there are competent/suitable representatives available to a physician or other supplier in the contractor’s service area (MCM, Part 3, Section 12016.3).

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 Region C DMERC DMEPOS Supplier Manual and send it with your check to the address indicated on the form.

Sanctions and Reinstatements

Due to security and privacy reasons, CMS no longer publishes the printed copy of the sanction report, also known as Publication 69. The printed version was discontinued in September 2001. The electronic version was 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 [http://www.dhhs.gov/oig/cum-san/index.htm](http://www.dhhs.gov/oig/cum-san/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 if 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. CMS recommends using this site to access the type of information previously obtained through Publication 69.
FIRST QUARTER ORAL ANTI-CANCER DRUG FEES

The following drug allowables are effective January 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>01/01/2002 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.
DRUG PRICING

First quarter 2002

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

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, 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, the brand product with the lowest AWP is used to calculate the allowance.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Region C</th>
<th>HCPCS Code</th>
<th>Region C</th>
<th>HCPCS Code</th>
<th>Region C</th>
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<td>J7680</td>
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<td>IC</td>
<td>J7669KO</td>
<td>$ 1.09</td>
<td>Q9920      to Q9940</td>
<td>$ 10.00</td>
</tr>
</tbody>
</table>
**Publications on the Internet**

Palmetto GBA is exploring the use of technology available on our Web site (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>Company Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

**NSC Supplier Number(s)** If you need more space, please send your list of supplier numbers on an additional sheet. Please include your company name, contact person, and telephone number on any additional pages.

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
Team Tips is a section created by your dedicated teams to assist you with claims, filing, appeals and inquiries. These helpful tips will be provided by each team based on trends identified in their daily interaction with you, their customer.

**Team A:** Make sure that each paper claim form and CMN is legible before submission to the DMERC. This will cut down on errors and claim rejections.

**Team B:** If a claim is denied with a medical necessity denial, the claim cannot be refiled. The next step is an Informal Review request. An example of a medical necessity denial is a denial for using the wrong diagnosis code. Do not submit the claim again with the correct diagnosis. Correct the original claim through the appeals process.

**Team D:** For frequently called numbers such as NSC or EDI, refer to Chapter 71 of the Region C DMERC DMEPOS Supplier Manual, or the Region C Directory on page 37 of this Advisory.

**Team E:** Please have all beneficiary records accessible when calling the DMERC Customer Service Center so that the team may handle all calls efficiently.

**Team F:** CMS’s claims processing standard is 30 days. In addition, please remember that interest will be paid only to “clean” claims not processed within 30 calendar days. Refer to page 10.3 in the Region C DMERC DMEPOS Supplier Manual for additional information on interest payments and the definition of a clean claim.

A duplicate denial indicates that Palmetto GBA has already paid the claim or that the claim was previously denied for a medical necessity denial reason.

**Team J:** The status of a non-assigned claim can be discussed only with a beneficiary. Also, payment of non-assigned claims will be made to the beneficiary.

Item 29 on the HCFA-1500 (12-90) form is used to indicate the total amount the patient paid for covered services only. It should not be used to indicate primary insurance payment. Entering a number in Item 29 may cause Medicare payments to be sent to the beneficiary instead of the provider on assigned claims.

If you do not receive an FCN number and an offset amount on a remit the money has not been offset. The remit is showing the adjustment that was made on the claim.

**Team L:** When calling your dedicated team, please have the following items ready to expedite your call: 1. Supplier number, 2. Provider telephone number and extension, 3. Medicare number (HICN), 4. Date of service in question, 5. HCPCS code in question.

**Team S:** Only one lifetime oxygen recertification is necessary. There is no need to send in the same CMN repeatedly once it is on file with Medicare.

**Team Y (MSP):** When attaching the primary insurance remittance advice to your claim, please make sure that a copy of the insurance processing explanation(s) is included. Many times when an item is denied by the primary insurer the denial reason(s) related to that item may be either on the back of the remittance advice or on another page of the remittance advice. If the primary denial reason is not available at the time the claim is processed, the item will be denied for missing information.
Medicare Secondary Payer is not within hearings jurisdiction. If a CCN receives an MSP denial, even if it has had a review, all correspondence for these types of denials must go to the MSP Unit for resolution.

**Data Entry:** The number one reason paper claims are returned to suppliers is an incomplete or missing supplier number. This is not your Federal Tax ID. If you do not know your supplier number you should contact the NSC at (866) 238-9652.

The second reason for most returns is a missing or invalid patient Medicare number. Please confirm the beneficiary’s number by reviewing his/her Medicare card.

**Appeals:** When requesting a hearing, please specify the type of hearing desired: on-the-record, telephone or in-person.

CMS standards state that 90% of final determinations must be issued within 120 days of the date of receipt of the request for hearing officer hearing.

Please remember to fill out a Review Request form. Use the narrative field to explain the items you want Palmetto GBA to review.
OMBUDDSMEN 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
Jane Crosby
IN THE INTERIM CONTACT
P.O. Box 10141, 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
P.O. Box 40996
Raleigh, NC 27629-0996
(919) 212-9881

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., PMB 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.

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

Please retain this list as your new DMERC telephone directory.

### Palmetto GBA contacts

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

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

### National numbers

<table>
<thead>
<tr>
<th><strong>Mailing Address</strong></th>
<th><strong>Telephone Number</strong></th>
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</table>
| **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)**  
Palmetto GBA  
17 Technology Circle  
Columbia, SC  29203 | (877) 735-1326 |

Bulletins issued after October 1, 1999 are available at no cost from our Web site at [www.PalmettoGBA.com](http://www.PalmettoGBA.com).