DME Medicare News

DMERC Region A Service Office v P. O. Box 6800 v Wilkes-Barre, PA 18773-6800

No. 29 METRAHEALTH June, 1996

Contents

Contacts

DME Region A Service Office The MetraHealth Insurance Co. FAX	(717) 735-9400 (717) 735-9402
Beneficiary Toll-Free Number	(800) 842-2052
Bulletin Board Participating Suppliers Non-Participating Suppliers	 (800) 842-5713 (717) 735-9515
E-Mail186433@ibmmail.com	
EMC FAX	(717) 735-9510
National Supplier Clearinghouse	(803) 754-3951
SADMERC	(803) 736-6809
Supplier Help Line Number	(717) 735-9445

The Region A "DME Medicare News" is published by MetraHealth Government Operations DMERC Professional Relations Unit for DMEPOS suppliers in Region A. For further information on this publication, please contact:

METRAHEALTH
A United HealthCare company

Region A DMERC
Professional Relations - Outreach
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

Michelle Zawatsky, Editor (717) 735-9412

DMERC Organizational Changes

Over the past few months, the Region A DMERC has made organizational changes. We are pleased to announce the following changes within our organization.

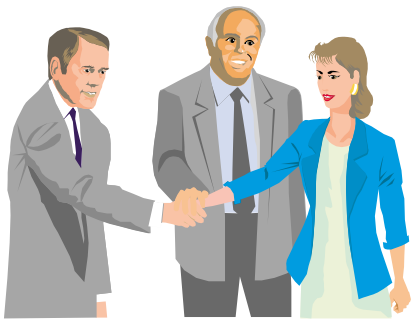
Victoria Menichillo and Andrea Vasil have been appointed as Operations Managers at the DMERC. This position entails a broad range of responsibilities over various departments within the DMERC. Victoria and Andrea bring with them to this position a broad understanding of DMERC operations and vast experience in Health Care Management.

In addition, Steve Crittenden will manage the administrative functions of the DMERC.

Dan Fedor, formerly an Ombudsman for New York, has been appointed Manager of Professional Relations. In addition to being an Ombudsman, Dan's experience encompases both the Claim Entry and EMC Units. Dan can be reached at 717-735-9410.

Laura Viot has been named as Ombudsman for the following area codes of New York state: 315, 518, 607, 716, 914. Laura can be reached at 717-735-9527. In addition, Tom O'Connor will be the Ombudsman for New York City and Long Island suppliers with the following area codes: 212, 516, 718, 917. Tom's new phone number is 717-735-9414.

Please join us in congratulating Victoria, Andrea, Steve, Dan, Laura, and Tom in their new roles at the DMERC.



Claim Entry

Reason Codes and Medicare-Specific Remark Codes and Messages

Medicare REF Remarks Codes

Code Value	Description
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases are limited to the first or the thirteenth month of medical necessity.
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the beneficiary's zip code.
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M15	Separately billed services have been bundled under a single procedure code as they are considered components of that same procedure. Separate payment is not allowed.
M16	Please see the letter or bulletin of (date) for further information.
M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.
M19	Oxygen certification/recertification (HCFA-484) is incomplete.
M20	HCPCS needed.
M21	Claim for services/items provided in a home must indicate the place of residence.
M22	Claim lacks the number of miles traveled.
M23	Invoice needed for the cost of the material or contrast agent.

Code Value	Description
M24	Claim must indicate the number of doses per vial.
M25	Payment has been (denied for the / made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he / she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request review, we will, upon application from the patient, reimburse him / her for the amount you have collected from him / her (for the / in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the / made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient / any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he / she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him / her. It also instructs the patient to contact your office if he / she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408 . The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and / or exclusion from the program. Please contact this office if you have any questions about this notice.

Code Value	Description
M27	The beneficiary has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the beneficiary's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the beneficiary does not exercise his / her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his / her representative has stated in writing that he / she does not intend to request a reconsideration, or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Claim lacks the operative report.
M30	Claim lacks the pathology report.
M31	Claim lacks the radiology report.
M32	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.

Code Value	Description
M33	Claim lacks the UPIN of the ordering / referring or performing physician, or the UPIN is invalid.
M34	Claim lacks the CLIA certification number.
M35	Claim lacks pre-operative photos or visual field results.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the beneficiary has been given the option of changing the rental to a purchase.
M37	Service not covered when the beneficiary is under age 35.
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that Medicare would not pay for it, and the patient agreed to pay.
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.
M43	Reserved for future use.
M44	Incomplete / invalid condition code.
M45	Incomplete / invalid occurrence codes and dates.
M46	Incomplete / invalid occurrence span code and dates.
M47	Incomplete / invalid internal or document control number.
M48	Reserved for future use.
M49	Incomplete / invalid value code(s) and / or amount(s).
M50	Incomplete / invalid revenue code(s).

Code Value	Description
M51	Incomplete/invalid procedure code(s) and/or rates. Refer to the HCFA Common Procedure Coding System. (Add to message for carriers only: If an appropriate procedure code does not exist, refer to Item 19 on the HCFA-1500 instructions.)
M52	Incomplete/invalid date(s) of service.
M53	Did not complete or enter the appropriate number of days or units(s) of service.
M54	Did not complete or enter the correct total charges for services rendered.
M55	Reserved for future use.
M56	Incomplete/invalid payer identification.
M57	Incomplete/invalid provider number.
M58-61	Reserved for future use.
M62	Incomplete/invalid treatment authorization code.
M63	Reserved for future use.
M64	Incomplete/invalid other diagnosis code.
M65-66	Reserved for future use.
M67	Incomplete/invalid procedure code(s) and/or date(s).
M68	Incomplete/invalid attending or referring physician identification.
M69-75	Reserved for future use.
M76	Incomplete/invalid patient's diagnosis and condition.
M77	Incomplete/invalid place of service(s). Refer to Section 2010.3 in the HCFA-1500 instructions.
M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79	Did not complete or enter the appropriate charge for each listed service.
M80	We cannot pay for this when performed during the same session as a previously processed service for the beneficiary.
M81 and following	Reserved for future use.

Medicare MIA/MOA Remarks Codes

Code Value	Description
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under 1879 of the Social Security Act, and the patient chooses not to appeal.)
MA03	If you do not agree with the Medicare approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been reviewed/reconsidered. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

Code Value	Description
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
MA05	Incorrect admission date, patient status or type of bill entry on claim. (NOTE: See MA30, MA40 and MA43.)
MA06	Incorrect beginning and/or ending date(s) on claim.
MA07	The claim information has also been forwarded to Medicaid for review.
MA08	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
MA10	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA13	You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR (patient responsibility) group code.

Code Value	Description
MA14	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
MA15	Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.
MA22	Payment of less than $1.00 suppressed.
MA23	Demand bill approved as result of medical review.
MA24	Christian Science Sanitorium/SNF bill in the same benefit period.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.

Code Value	Description
MA26	Our records indicate that you were previously informed of this rule.
MA27	Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.
MA28	Receipt of this notice by a physician who did not accept assignment is for information only and does not make the physician a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA29	Incomplete/invalid provider name, city, state, and zip code.
MA30	Incomplete/invalid type of bill.
MA31	Incomplete/invalid beginning and ending dates of the period billed.
MA32	Incomplete/invalid number of covered days during the billing period.
MA33	Incomplete/invalid number of noncovered days during the billing period.
MA34	Incomplete/invalid number of coinsurance days during the billing period.
MA35	Incomplete/invalid number of lifetime reserve days.
MA36	Incomplete/invalid patient's name.
MA37	Incomplete/invalid patient's address.
MA38	Incomplete/invalid patient's birth date.
MA39	Incomplete/invalid patient's sex.
MA40	Incomplete/invalid admission date.
MA41	Incomplete/invalid type of admission.
MA42	Incomplete/invalid source of admission.
MA43	Incomplete/invalid patient status.
MA44-MA47	Reserved for future use.

Code Value	Description
MA48	Incomplete/invalid name and/or address of responsible party or primary payer.
MA49-MA57	Reserved for future use.
MA58	Incomplete release of information indicator.
MA59	The beneficiary overpaid you for these services. You must issue the beneficiary a refund for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60	Incomplete/invalid patient's relationship to insured.
MA61	Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62	Telephone review decision.
MA63	Incomplete/invalid principal diagnosis code.
MA64	Reserved for future use.
MA65	Incomplete/invalid admitting diagnosis.
MA66	Incomplete/invalid principal procedure code and/or date.
MA67-68	Reserved for future use.
MA69	Incomplete/invalid remarks.
MA70	Incomplete provider representative signature.
MA71	Incomplete/invalid provider representative signature date.
MA71-74	Reserved for future use.
MA75	Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, please resubmit.
MA76-80	Reserved for future use.

Code Value	Description
MA81	Our records indicate neither a physician or supplier signature is on the claim or on file.
MA82	Did not complete or enter the correct physician / supplier's Medicare number or billing name, address, city, state, zip code, and phone number.
MA83	Did not indicate whether Medicare is the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
MA84	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the employer's name and / or retirement date.
MA85	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insurance plan or group / program name.
MA86	Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the group number of the primary insurer.
MA87	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's correct name.
MA88	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter accurately the insured's address and / or telephone number.
MA89	Our records indicate that a primary payer exists (other than Medicare); however, you did not complete or enter the appropriate patient's relationship to the insured.
MA90	Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employment status code of the primary insurer.
MA91	Our records indicate that there is insurance primary to Medicare; however, you either did not complete or enter accurately the employer location of the primary insurer.
MA92	Our records indicate that there is insurance primary to Medicare; however, you did not complete or enter accurately the required information. (Refer to the HCFA-1500 instructions on how to complete MSP information.)
MA93	Our records indicate that there is insurance primary to Medicare and is indicated properly on the claim; however, paper submissions require a copy of the primary payers EOB to be attached to the claim.
MA94-98	Reserved for future use.
MA99	Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.
MA100	Did not complete or enter accurately the date of current illness, injury or pregnancy.
MA101	Reserved for future use.
MA102	Did not complete or enter accurately the referring / ordering / supervising physician's name and / or their UPIN (or surrogate).
MA103	Reserved for future use.
MA104	Did not complete or enter accurately the date the patient was last seen and / or the UPIN of their attending physician.
MA105-109	Reserved for future use.
MA110	Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if "no purchased tests are included on the claim."
MA111	Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and / or the performing laboratory's name and address.

Code Value	Description
MA112	Our records indicate that the performing physician / supplier is a member of a group practice; however, you did not complete or enter accurately their carrier assigned PIN.
MA113	Reserved for future use.
MA114	Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished.
MA115	Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location where the service(s) were rendered.
MA116	Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
MA117-120	Reserved for future use.
MA121	Did not complete or enter accurately the date the X-Ray was performed.
MA122	Did not complete or enter accurately the initial date "actual" treatment occurred.
MA123-127	Reserved for future use.
MA128	Did not complete or enter accurately the six digit FDA approved certification number.
MA129	Reserved for future use.
MA130	Your claim contains incomplete and / or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate fiscal intermediary or carrier.
MA131 and higher	Reserved for future use.

Beneficiary Change of Address

Effective July 1, 1996, the beneficiary address in all Medicare Part B carrier files (including Durable Medical Equipment Regional Carriers) may be changed only upon receipt of an address received from the Common Working File (CWF). Under no circumstances is a beneficiary's address to be changed as a result of a change noted on the HCFA-1500 form.

As our files are updated, the address received from the CWF will be used to establish jurisdiction for submission of the claim to the appropriate DMERC.

If the beneficiary only resides temporarily within the Region A DMERC, their claims will no longer be processed by this office. They must now be directed to the DMERC that has jurisdiction based on the beneficiary's permanent residence.

Change of address information will be forwarded to the CWF by the Social Security Administration (SSA). We are requesting providers to reinforce, with their patients, the importance of notifying the SSA (at 1-800-772-1213) of a change in address.

Vision Claims

Medicare pays for refractive lenses (glasses or contact lenses) which restore vision by the crystalline lens of the eye because of surgical removal or congenital absence. Payment can be made after cataract surgery or intraocular lens (IOL) implant. Coverage is limited to no more than one pair of eyeglasses after each cataract surgery or IOL implant. Replacement glasses are not covered.

Under the vision guidelines, payment can be made for the following items when medically necessary: frames, spectacles / lenses, contact lenses, low vision aids, and miscellaneous items such as lens balancing, standard or UV tint, and scratch-resistant coating.

Claims submitted must **completely and accurately reflect all services and discounts provided to a beneficiary**. When billing deluxe frames, use Code V2020 for the standard frames, and a second line item using Code V2025 for the difference between the charges for the deluxe frames and the standard frames. When billing claims for progressive lenses, use the appropriate code for the standard bifocal (V2200 through V2299) or trifocal (V2300 through V2399) lens, and a second line item using Code V2781 for the difference between the charge for the progressive lens and the standard item.

When a provider chooses the assignment method of payment on a Medicare claim, the provider agrees to accept the carrier's determination of the allowable charges for the service as **full charge** for that service. Payment should not be demanded or accepted from the beneficiary in assignment cases for the difference between the

allowable charge and the actual charge, if a reduction of the actual charge has been made by the Medicare carrier. You may bill the beneficiary for any portion of the allowable charge which is applied to the deductible, the 20% coinsurance, and any charge for services **not-covered** by Medicare.

Unprocessable Claims

The December 1995 issue of "DME Medicare News" (page 19) contained information regarding claims which are considered unprocessable due to incomplete/invalid data. **This process applies to all assigned claims and is effective for claims received on or after April 1, 1996.**

If the claim is submitted electronically, in most cases, these claims will not pass the National Standard Format edits and will reject front end. Providers who submit their claims on paper will be notified via the Provider Remittance Notice if the claim cannot be processed.

There will be **no appeal rights** for claims which are rejected because of incomplete/invalid information. **Necessary corrections must be made by the provider and the claim must be resubmitted**.

Please review this important information published in the December 1995 newsletter. If there are any questions, please contact our Provider Services Unit, Monday through Friday, 8:00 a.m. to 4:00 p.m. at 717-735-9445.

Billing Reminder for Group II Oxygen Claims

Coverage is available for patients whose arterial PO2 is 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89 percent if any of the following are documented:

- ❑ Dependent edema suggesting congestive heart failure,
- ❑ Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave greater than 3 mm in Standard Leads II, III, or AVF), or
- ❑ Erythrocythemia with a hematocrit greater than 56 percent.

Chronic Obstructive Pulmonary Disease (COPD) alone is not a qualifying diagnosis for coverage of Group II oxygen claims.

Please refer to Policy 13.31, Oxygen and Oxygen Equipment, in your Supplier Manual for complete details on filing oxygen claims.

Reminder to Oxygen Providers

Box 3C of the HCFA 484 OMB Form is a required field. This box requires the name and address of the physician/provider performing the test(s). Missing or incomplete information can result in claim denials and/or delays.

Maxillofacial Prosthesis - Jurisdiction Transfer

Effective for claims received on or after July 1, 1996, the DMERCs will process claims for maxillofacial prosthesis which have been provided by nonphysicians. Claims by nonphysicians may be submitted to the DMERC using HCPCS code L8499 (unlisted procedure for miscellaneous prosthetic services), with sufficient narrative that explains the procedure, time and material involved in the creation of the prosthesis. Be sure to include the UPIN of the referring physician.

If the claim is for a replacement of a previous prosthesis, the claim must include, in addition to the above, information which specifies:

1. When the last prosthesis was provided,
2. The reason for replacement,
3. Whether the replacement was produced from the previous master model or required a new impression, and
4. If a new impression was required, an explanation why.

Claims from nonphysicians with dates of service prior to July 1, 1996 may be submitted to the DMERC if they have never been submitted to the local carrier of if they had been submitted to the local carrier and denied with the explanation that the claim was not local carrier jurisdiction. Claims that have been submitted to the local carrier and denied with other reasons may not be submitted to the DMERC.

Claims from physicians will continue to be processed by the local carrier.

Waiver Action Codes/EOMB Messages

Below is a list of the waiver Action Codes / EOMB Messages where the GA modifier would apply. Action Code 221 / EOMB Message CO-B5 will be added to the waiver list effective for claims received at the DMERC on or after August 18, 1996.

Action Code	EOMB Message
242	C0-114
245	C0-114
258	C0-B22 or PR-B22
259	C0-57 or PR-57
367	C0-57 or PR-57
382	CO-114
384	CO-114
393	CO-50
399	CO-57 M25 or CO-57
487	CO-114
510	CO-57
511	CO-50
512	CO-57
513	CO-50 or PR-50
514	CO-57 or PR-57
515	CO-56
517	CO-57 or PR-57
518	CO-57
519	CO-B14
520	CO-57
521	CO-57
523	CO-57
524	CO-57
525	CO-57
531	CO-50
540	CO-57
541	CO-50
741	CO-48
751	CO-114
755	CO-57
756	CO-54
757	CO-50
758	CO-B22
789	CO-54
796	CO-57
797	CO-57
902	CO-57

Medical Policy

Vancomycin

Effective for courses of therapy beginning on or after September 1, 1996, Vancomycin will not be covered when it is administered using an infusion pump. If Vancomycin administration using an infusion pump is begun before September 1, 1996, coverage will continue for the duration of that course of therapy.

All claims for Vancomycin received by the DMERC on or after September 1, 1996 should include a statement indicating the start date for the current course of Vancomycin therapy. This information should be entered in the HA0 record of an electronic claim or attached to a hard copy claim.

Miscellaneous

New PO Box for Accounting Department

The Accounting Department has a new Post Office Box number for refunds. All questions and checks for overpayment refunds should be sent to:

Medicare - Region A DMERC
Attn: Accounting Dept.
P.O. Box 6900
Wilkes-Barre, PA 18773-6900

Pricing

1996 Prevailing Charge Information

The following table represents Prevailing Charge information only;
it may not represent actual allowance for the item.

Procedure Code	Mod 1	Mod 2	Prev. Chg. 75th	Cust. Chg. 50th	National IIC	Prevailing LCL
B4034			7.50	6.72	5.77	6.16
B4035			13.87	12.80	10.99	11.75
B4036			9.68	8.41	7.53	8.00
B4081			24.50	24.50	20.37	20.00
B4082			19.00	18.40	15.17	16.43
B4083			2.93	2.70	2.32	2.50
B4084			21.30	19.82	17.02	18.17
B4085			47.95	45.00	38.60	43.10
B4150			0.85	0.75	0.63	0.70
B4151			1.90	1.75	1.47	1.57
B4152			0.76	0.64	0.53	0.59
B4153			2.61	2.09	1.79	1.91
B4156			2.09	1.50	1.28	1.24
B4164			26.39	23.00	15.53	18.46
B4168			22.62	22.62	22.62	0.00
B4176			70.00	62.74	52.57	36.41
B4178			116.23	116.23	0.00	51.04
B4180			33.00	27.01	22.26	27.01
B4184			106.50	98.00	72.99	75.00
B4186			186.40	144.98	97.31	100.00
B4189			277.11	257.46	162.39	197.00
B4193			422.10	310.00	209.84	262.50
B4197			494.64	382.07	255.46	248.00
B4199			465.73	499.00	291.92	276.00
B4216			32.74	21.18	7.06	6.85
B4220			18.46	15.00	7.31	9.43
B4222			21.27	13.33	10.72	7.50
B4224			53.81	32.84	22.86	27.74
B5000			13.35	12.50	10.86	10.54
B5100			6.20	5.00	4.24	0.00
B5200			5.85	0.00	0.00	0.00
B9000	NU		1155.63	1155.63	1155.63	1155.63
B9000	RR		150.00	126.00	106.19	112.50
B9000	UE		866.71	866.71	866.71	866.71
B9000	MS		53.10	53.10	53.10	53.10
B9002	NU		1200.00	1200.00	1155.63	1346.36
B9002	RR		140.43	130.00	111.92	120.00
B9002	UE		866.71	866.71	866.71	866.71
B9002	MS		55.96	55.96	55.96	55.96
B9004	NU		2305.15	2305.15	2305.15	2305.15
B9004	RR		600.00	490.00	364.93	442.88
B9004	UE		1728.87	1728.87	1728.87	1728.87
B9004	MS		182.46	182.46	182.46	182.46

Procedure Code	Mod 1	Mod 2	Prev. Chg. 75th	Cust. Chg. 50th	National IIC	Prevailing LCL
B9006	NU		2305.15	2305.15	2305.15	2305.15
B9006	RR		500.00	480.00	364.93	440.00
B9006	UE		1728.87	1728.87	1728.87	1728.87
B9006	MS		182.46	182.46	182.46	182.46
E0776	NU	XA	142.00	102.63	96.10	125.00
E0776	RR	XA	33.00	30.00	24.33	25.00
XX030			2.49	2.07	2.05	1.66
XX031			0.00	0.00	1.65	0.00
XX032			1.36	1.33	0.00	1.15
XX033			1.46	1.31	1.12	1.25
XX034			6.41	6.41	5.31	0.00
XX035			4.95	4.94	4.07	4.74
XX036			5.67	5.06	4.17	4.86
XX037			0.00	0.00	3.05	0.00
XX038			1.60	1.60	1.37	1.60
XX039			1.21	0.99	0.81	0.89
XX040			1.37	1.31	1.08	1.20
XX041			1.50	1.34	1.15	1.26
XX042			5.34	5.34	4.78	4.63
XX043			1.07	1.00	0.79	0.89
XX044			4.50	4.00	3.36	3.59
XX045			1.51	1.45	1.25	1.35
XX047			1.71	1.37	1.17	1.25
XX048			0.00	0.00	1.41	0.63
XX049			0.88	0.76	0.65	0.72
XX050			3.86	3.50	3.18	3.25
XX051			0.77	0.64	0.54	0.60
XX052			0.00	0.00	2.41	0.00
XX053			1.01	0.94	0.71	0.78
XX054			0.00	0.00	2.27	0.00
XX055			0.00	0.00	4.37	0.00
XX056			0.00	0.00	1.13	0.00
XX057			2.26	2.17	1.86	2.17
XX058			3.55	2.50	2.05	2.18
XX059			0.00	0.00	2.80	0.00
XX060			0.42	0.42	0.42	0.00
XX061			0.00	0.00	10.30	0.00
XX062			0.00	0.00	0.44	0.00
XX063			0.00	0.00	0.54	0.00
XX064			0.00	0.00	1.30	0.00
XX065			0.00	0.00	0.53	0.00
XX066			0.00	0.00	0.44	0.00
XX068			1.35	0.69	0.00	0.52
XX069			1.08	1.00	0.89	0.95
XX070			0.00	0.00	2.53	0.00
XX071			1.71	1.71	1.60	1.71
XX072			0.00	0.00	0.28	0.00
XX074			0.00	0.00	0.00	1.95
XX075			1.71	1.64	1.41	1.52
XX076			1.73	1.70	1.46	1.56
XX077			3.54	3.54	3.54	4.26

Pneumatic Compressors/ Lymphedema Pumps - Updated March 1, 1996

Editor's Note: Bolded text indicates additions/changes to the previously published list.

Manufacturer/Brand Name	*Model Name/#*	*HCPCS Code*
Advantage	2100	E0652
Bio Compressions Systems/Sequential Circulator	2000	E0651
	3000	E0652
	3001	E0652
	3004	E0652
Chattanooga	PreSsion	E0651
	PreSsion 4328 CGS	E0651
	PreSsion 4330 VGS	E0652
	4320	E0650
	4322	E0650
Huntleigh	Flowplus (AC330)	E0650
	Flowpress (AC300)	E0651
	Flowtron	E0650
	Lymphatron	E0651
	Lymphatron (AC340)	E0651
	Lymphatron Trio (AC350)	E0652
Jobst/Extremity Pump	Clinical Model	E0650
	System 7000	E0650
	System 7500 (II)	E0651
Kendall	Home Rx (5550)	E0651
Lympha Press	103A	E0651
	103M	E0652
	201A-Mini	E0651
	201-M	E0652
MedComp	**MC 5 Gradient Sequential**	**E0652**
Talley/Hemaflow 2 Pump	Intermittent	E0650
	Sequential	E0651
Talley/Multicom	100	E0650
	200	E0650
	300	E0651
	300G	E0652
	500 ('93 & '94 model)	E0652 *
Talley/Multipulse	1000	E0652
Ther-Con	**Thera-Flow****	E0652
	651 SERIES	E0651
Wright Linear Pump	II	E0652
	IV	E0652

*Talley/Multicom model '92 or before = E0651
**Formerly listed at Sequential

1996 Final Fees for K0413, K0414 and K0417

Code	Mod	CT	ME	MA	NH	RI	VT	NY	NJ	PA	DE
K0413	RR	410.17	410.17	410.17	410.17	348.64	410.17	399.91	386.99	395.23	402.55
K0414	RR	497.71	497.71	497.71	497.71	423.05	497.71	485.25	469.57	479.58	488.48
K0417	NU	9.62	9.62	9.62	9.62	9.62	9.62	9.62	9.62	9.62	9.62

K Codes - Revised 1996 Fee Schedule

The revised 1996 fees for the codes K0011 and K0012 are listed below. These fees are effective for claims received at the DMERC on or after April 2, 1996.

Code	CT	ME	MA	NH	RI	VT	NY	NJ	PA	DE
K0011	4,888.00	4,888.00	4,888.00	4,888.00	4,154.80	4,888.00	4,765.70	4,611.60	4,709.80	4,797.00
K0012	2,998.30	2,998.30	2,998.30	2,998.30	2,548.60	2.998.30	2,923.10	2,828.80	2,889.00	2,942.80

Overpayments

At a recent DMERC Educational Seminar, a supplier asked how to refund an overpayment discovered by their billing department. You do not need to wait for Medicare to send a letter requesting the refund. A supplier can make a "voluntary" overpayment refund whenever the payment is made in error. The following instructions show how to submit a voluntary refund to Medicare:

- ❑ Do not return the entire Medicare Remittance Notice unless it was all paid in error. Please keep the portion of the check paid to you correctly. You should refund only the amount paid incorrectly. Pay by check or money order, payable to: Medicare - Region A DMERC.
- ❑ To assist us in identifying the incorrect payment, copy the portion of the Explanation of Medicare Benefits (EOMB) that shows the incorrect payment and write a brief description of the error. In addition, please include your ten-digit National Supplier Clearinghouse supplier number, beneficiary's name, beneficiary's health insurance number (HIC #) and the control number for proper identification. The copy of the EOMB provides this information.

If Medicare has requested this overpayment, please attach a copy of the overpayment letter with your refund.

Offset Information

Q. If a supplier agrees with a refund request determination, is there a way for the supplier to have the initial amount offset? Time constraints are sometimes a problem - by the time a request is received, reviewed, processed and sent, it becomes past due. How can a provider handle this?

A. A supplier can request immediate offset, via fax, to the accounting department (717-735-9594); or by calling (717-735-9445) and advising a Provider Services Representative. If a supplier is an electronic biller, they may send a notice via the Bulletin Board.

Please remember that assigned claims totalling the overpayment amount must be recouped prior to the date referenced in the request for refund letter, or interest will be assessed on the remaining balance.

Payment Floor

The following information is provided to you in an effort to clarify processing time requirements for electronically submitted claims.

The required performance level for payment of an electronically submitted claim, which does not require investigation, is to complete at least 95% of claims between the 14th and 30th calendar day following the date of receipt. This time frame has been established by HCFA and is contained in the **Medicare Carriers Manual Part 2, Program Administration, Section 5240. Therefore, the possibility exists that an electronic claim may pend up to 30 calendar days after it is received and not be considered beyond the required time frame.** Claims which do not require investigation and are not processed within this time frame will accrue interest beginning with the 31st day.

Thus far in fiscal year 1996, the Region A DMERC has completed 96.4% of non-investigated EMC claims within 14 to 30 days.

One of the major advantages of billing electronically is faster payment of your claims. Even though the adjudication window spans 14 to 30 days, the majority of claims are adjudicated early in this time frame. As an example, in February 1996, **80%** of all EMC claims were adjudicated within 14 days of receipt.

Should you have any questions regarding this notice, please contact our Provider Services Unit, Monday through Friday, 8:00 a.m. to 4:00 p.m., at 717-735-9445.

Support Surfaces - Maintenance and Servicing

In the March 1996 issue of "DME Medicare News," use of the ZX modifier for Group 2 Support Surfaces was clarified. Use of the ZX modifier also applies to maintenance and servicing (MS). Namely, when the initial claim for a Group 2 Support Surface is received on or after January 1, 1996, the ZX modifier may be added to the code with an MS modifier only if the ulcer has not healed. Once the ulcer has healed, the ZX modifier may not be added to the MS code. However, if the initial claim for a Group 2 Support Surface was received prior to January 1, 1996 and was approved, the ZX modifier may be added to the MS code if a stage II, III or IV ulcer on the trunk or pelvis was present on January 1, 1996.

Similar instructions would also apply to MS claims for those Group 1 Support Surfaces which are in the capped rental payment category and when the beneficiary chooses the rental option. Namely, when the initial claim is received on or after January 1, 1996, the ZX modifier may be added to the code with the MS modifier only if the criteria specified in situation (a) or (b) in the Coverage and Payment Rules section of the policy have been met. However, if the initial claim for one of the Group 1 Support Surfaces was received prior to January 1, 1996 and was approved, the ZX modifier may be added to the MS code on subsequent claims.

Resolution of CO-50 Denial

Code/Message:

522	Information pertaining to your case does not support the need for this equipment
CO	Contractual Obligations
50	Non-covered services since not deemed a medical necessity by the payer

Description of the Problem

This denial is a medical necessity denial which indicates that the information on the claim does not support the need for this equipment. In some cases, the answers to the question sets on the CMN do not indicate medical necessity as established in the medical policy.

Steps to Take

- ❑ Resubmit - N / A
- ❑ Adjust - N / A
- ❑ Review - This is the only recourse for resolution of this denial. Please follow the instructions provided below.

  A copy of the following information is required:

  1. For an EMC claim where either the provider or their billing service incorrectly keyed the CMN information on the original claim transmission.

  2. For a paper claim where the provider feels that the information on the CMN was correct and the denial is due to a keying error by the DMERC processor.

Information required:

- Provider Remittance Notice showing the CO-50 denial
- A copy of the original CMN
- A letter detailing your request for review/reconsideration

The purpose of the CMN is for the physician to provide information to aid the DMERC in making medical necessity decisions. The provider **may not** assume that answers to questions on the CMN, which do not support medical necessity, have been answered in error by the physician.

If the provider received information from the physician initially which supported medical necessity, it is possible that the physician may have answered the questions incorrectly. In that case, the provider may request that the physician complete a new CMN. The original CMN with alterations/corrections will not be considered acceptable.

If the CO-50 denial results due to an incorrect or incomplete CMN, the provider may request a review by including all of the following information:

- ❑ A copy of the Provider Remittance Notice,
- ❑ A copy of the newly completed CMN,
- ❑ A statement from the physician explaining the reason why the original CMN was incomplete or incorrect (i.e., the patient's condition changed, simply omitted question, inadvertently provided an incorrect answer).

Failure to comply by providing all the needed documentation as listed above will be cause for the original denial to be affirmed.

Clarification of Overpayment Determinations and Repayment

In accordance with Section 1842(a)(1)(c) of the Social Security Act, carriers under contract to the Health Care Financing Administration are authorized to complete reviews on providers of services to ensure that proper payments are made. The DMERC is responsible for conducting such reviews to ensure that Medicare claims have been submitted and adjudicated for payment appropriately.

These reviews may result from data analysis, comprehensive and focused reviews, or inquiries regarding possible improper billing practices. If an overpayment is identified, the DMERC will send a letter to the provider explaining the reason for the overpayment and requesting a refund.

We are aware of some misunderstandings regarding how to refund Medicare and what actions should be taken if you disagree with the overpayment determination. To clarify these issues, we have listed several points to consider when you receive an overpayment notice:

- ❑ The overpaid amount is due in full within 30 days from the date of the initial refund request letter.
- ❑ If the overpayment is not refunded in full within the 30 days, interest begins on the 31st day from the date of the original refund request letter.
- ❑ Refunds should be sent, with a copy of the overpayment letter, to the following address:

  Medicare - Region A DMERC
  Attn: Accounting Unit
  P. O. Box 6900
  Wilkes-Barre, PA 18773-6900

- ❑ If we do not receive the refund check within the required time, the overpayment amount, plus interest, will be collected through offset of future Medicare payments.
- ❑ If you believe the offset should not be implemented, you must notify the Accounting Unit, in writing, by mail or fax (717-735-9594). The notification must state the specific reason(s) why you believe the offset should not occur. It must be received within 15 days from the date of the original refund request letter.
- ❑ If the overpayment is $1,000.00 or more and repayment creates financial hardship, you may contact the Accounting Unit in writing, by mail or fax, to request repayment in installments. The Accounting Unit will contact you regarding specific information required to evaluate the financial hardship. They will then notify you of the determination of reimbursement through installments.
- ❑ The DMERC will automatically initiate the offset process 40 days from the date of the original refund request letter unless the DMERC:
  - Receives a refund check for the full amount
  - Notified you that the offset would not take place

- Has made an agreement regarding installment payments

❑ If you disagree with the overpayment determination, you may request a hearing within six months from the date of the initial request for refund letter. Requests for hearings should be sent, in writing, to any Social Security Office or to the Hearing Coordinator at the following address:

Medicare - Region A DMERC
Attn: Hearing Coordinator
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

If the hearing is decided in your favor, a repayment will be issued immediately following the decision.

Please Note:

❑ The overpayment is due within the 30 day period despite the request for a hearing

❑ Agreement of repayment installments does not automatically bring your issues to a hearing; each must be a separate request

If you do not understand the overpayment request, or have additional questions, please contact the Medicare representative whose signature appears on the letter. An address and phone number are provided. You may also contact the Accounting Unit for assistance at the fax number or address as referenced on page 17.

New HCPCS Code for Oral Cyclosporine

A new temporary Level II HCPCS code for oral Cyclosporine has been established, effective for dates of service on or after July 1, 1996:

K0418 Cyclosporine, Oral, per 100mg. The price per unit for K0418 (100 mg) is $5.45.

Code K0121, Cyclosporine, oral, 25 mg, is still valid for submission to the DMERC.

Billing Procedure - Wheelchair Accessories

Recently, the Reconsiderations Unit has seen an increase in the number of review requests for wheelchair accessories. The following list contains codes which are commonly billed incorrectly:

K0015	K0040	K0052	K0069	K0083	K0095
K0016	K0041	K0053	K0070	K0084	K0096
K0017	K0042	K0059	K0071	K0085	K0097
K0018	K0043	K0060	K0072	K0086	K0098
K0019	K0044	K0061	K0073	K0087	K0099
K0021	K0045	K0062	K0074	K0088	K0106
K0034	K0046	K0063	K0075	K0089	
K0035	K0047	K0064	K0076	K0090	
K0036	K0048	K0065	K0077	K0091	
K0037	K0049	K0066	K0078	K0092	
K0038	K0050	K0067	K0081	K0093	
K0039	K0051	K0068	K0082	K0094	

When billing the above codes, the modifiers LT (left) and RT (right) must be used to indicate the appropriate side placement of the accessory. You must also specify the number of units being billed.

When any of these items are supplied bilaterally, please report both units on the same claim line with both the LT and RT modifiers. This applies to rentals and purchases. Please refer to the examples below:

K0021 RR LT RT (2) Units
K0021 NU LT RT (2) Units

Not adhering to this procedure will result in a duplicate denial for the code which you are billing.

If only one unit is supplied, use either the LT or RT modifier accordingly.

Additional Documentation Reminder

If a DMERC medical policy requires a CMN, it must be submitted with the claim, electronically for EMC billers or hard copy for paper claims.

CMNs are not considered additional documentation, as specified in Supplier Notice 96-18 on additional documentation procedures, unless specifically requested by the DMERC. They should not be routinely submitted using this procedure.

Billing Procedure - E1350

When billing E1350 for repair of equipment that the beneficiary owns, the following documentation is required:

1. A description of the nature and medical necessity of the repair (i.e.; reason) see narrative example below,*
2. An itemization of labor time (hours and / or minutes) involved for each individual item or part,
3. The supplier must document the date the individual equipment / item was purchased,
4. The HCPCS code or description of the equipment / item being billed.

**Safety belt worn and torn, solid seat insert cracked beyond repair, cover torn and soiled, and brakes required tightening for safe functioning.*

For EMC claims, the documentation should be entered in the HA0 record or submitted 48 hours prior to submission of the claim (please refer to Provider Notice 96-18 or page 30 of the March 1996 edition of "DME Medicare News" for more information on submitting additional documentation).

Please Note: If the information is not submitted on or with the claim, the claim may be denied. If the expense for repairs exceeds the estimated expense of purchasing another piece of equipment, no payment may be made for the excess amount.

Effective for dates of services on or after August 1, 1996.

Examples:

	Number of Services	Amount Billed
1. K0031 - Safety belt/pelvic strap 1/2 hour (install)	1	$35.00
2. K0030 - Solid seat insert, planar seat, single density foam, 1 hour (install)	1	40.00
3. K0108 - Cushion cover, name brand, model number, 30 minutes (remove old, torn, cover, install new one)	1	45.00
4. 30 minutes (brake adjustment)		
5. E1350 - 2 hours 30 minutes	5	120.00

Please Note: Providers must also supply the following information on the claim: beneficiary-owned name brand, model name / number, and HCPCS Code of the purchased wheelchair and date wheelchair was purchased.

Professional Relations

Provider Notices

The Professional Relations Unit has been receiving several inquiries from providers about receiving Provider Notices. Provider Notices are not mailed individually to the 45,000 providers on our mailing list. Notices are distributed to the four State Supplier Associations in our Region (JAMES, NEMED, NYMEP, and PAMS). Notices are also on the ARU system, which is updated every 3 days, and the Bulletin Board System for electronic claim submitters (another advantage of billing electronically).

If a provider does not receive this information from any of the methods listed above, the same information contained in a Provider Notice appears as an article in the next issue of "DME Medicare News."

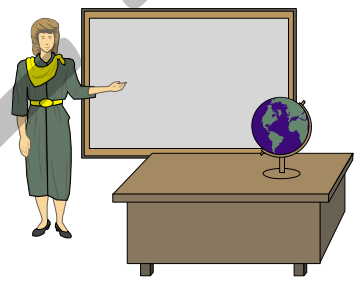
Continuing Education Workshops

The Region A DMERC is providing a series of Continuing Education workshops for the Provider Community. In addition to a one-day general session, these seminars feature a whole day dedicated to specialty workshops, highlighting certain DMEPOS items. During these "round table" sessions, providers will have the opportunity to receive focused information and instruction on each topic. Note: It is possible for each person attending Day 2 to participate in two of the four specialized sessions.

Workshop Dates and Locations

Date	City/State	Location	Phone
8/12 & 8/13	Bangor, ME	Ramada Inn, 357 Odlin Rd.	207-947-6961
8/15 & 8/16	Concord, NH	Holiday Inn, 172 N. Main St.	603-224-9534
8/19 & 8/20	Burlington, VT	Radisson Hotel, 60 Battery St.	802-963-7818
8/22 & 8/23	Framingham, MA	Sheraton Tara, 1657 Worchester Rd.	508-879-7200
8/26 & 8/27	Rocky Hill, CT	Marriott Hotel, 100 Capital Blvd.	203-257-6000
9/5 & 9/6	Buffalo, NY	Marriott Hotel, 1340 Millersport Hgwy 1422	716-689-6900
9/9 & 9/10	Utica, NY	Holiday Inn, 1777 Burnstone Rd.	315-797-2131
9/12 & 9/13	New York City, NY	Sheraton La Guardia East, 135-20 39th Ave.	718-460-6666
9/16 & 9/17	Pittsburgh, PA	Sheraton North, 910 Sheraton Dr.	412-776-6900
9/19 & 9/20	King of Prussia, PA	Holiday Inn, 260 Mall Blvd.	610-265-7500
9/24 & 9/25	Somerset, NJ	Holiday Inn, 195 Davidson Ave.	908-356-1700
9/26 & 9/27	White Haven, PA	Mountain Laurel Resort, I-80 at PA Turnpike	717-443-8411

Workshop Agenda



Workshop Day 1

8:30 a.m.	Registration
9:00 - 12:00 p.m.	Overview of the New Supplier Manual*
	Completion of the HCFA-1500 Form
	The latest revisions to the Certificates of Medical Necessity and instructions for completion
	Fraud and Abuse in the Medicare Program
12:00 - 1:00 p.m.	Lunch (provided)
1:00 - 4:00 p.m.	Electronic Billing Overview & Update General DMERC Update Medical Policy Update Questions and Answers

Workshop Day 2

8:30 a.m.	Registration
9:00 - 12:00 p.m.	Specialty Workshops
12:00 - 1:00 p.m.	Lunch (provided)
1:00 - 4:00 p.m.	Specialty Workshops

Specialty Workshops will be two three-hour sessions on the following topics:

EMC - Submitting claims electronically using the DMERC's free Accelerate software and the Bulletin Board System

Wheelchairs

PEN

Orthotics & Prosthetics

The new Supplier Manual is pending release in July 1996. If received prior to the workshop, please bring the manual with you. Manuals will not be distributed the day of the workshop.

To Register

Please complete and mail the registration form below, along with your registration fee (check only - made payable to **MetraHealth Insurance Company**) to:

Region A DMERC
Attn: Seminar Registration
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

The **non-refundable** registration fee is as follows:

Attending Day 1 ONLY (General Session)	$30.00/person
Attending Day 2 ONLY (2 Specialty Workshops)	$30.00/person
Attending BOTH Day 1 and Day 2	$50.00/person

Your registration form and payment must be received two weeks prior to the workshop you wish to attend. Confirmations will be received via mail and are mandatory for admittance to the workshops. It is not necessary to call to verify your registration. Due to limited space, registration is required and will not be accepted at the door the day of the workshop. All available space is on a first-come, first-served basis. In the event that a particular specialty seminar is filled to capacity, you will be notified by telephone and given the opportunity to make another selection. In the event that you are unable to attend, please send a replacement or, by notifying us, it may be possible to apply your registration to another location, but registrations will not be transferable to the next round of workshops. Workshop materials and a deli lunch will be provided both days.

Please note: The DMERC reserves the right to cancel any workshop. If this occurs, your registration fee will be refunded.

Continuing Education Workshops Registration Form

(Note: Please use a separate Registration Form for each person attending)

Company Name:______________________________________

Provider/Submitter No.:______________________________________

Address: ______________________________________

____

Phone Number:____________________ Fax Number: ____________________

State & City of workshop you wish to attend:______________________________

Name of Person Attending: ______________________________

Attending: ❑ Day 1 Only ❑ Day 2 Only* ❑ Both Days*

*If attending Day 2, please check Specialty Workshops and times you wish to attend:

❑ EMC** ❑ 9 a.m. ❑ 1 p.m.

❑ PEN ❑ 9 a.m. ❑ 1 p.m.

❑ O&P ❑ 9 a.m. ❑ 1 p.m.

❑ Wheelchairs ❑ 9 a.m. ❑ 1 p.m.

**Please Note: The EMC Specialty Workshops for the morning sessions in New York City and White Haven will be forvendors ONLY. Providers interested in these workshop locations MUST register for the afternoon session.

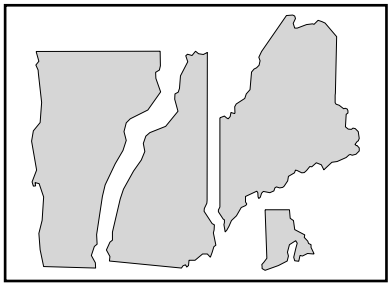
Amount Enclosed:______________

Professional Relations Ombudsmen

Please refer inquiries to the appropriate team

Team New England

PR Representative
Robert Wright

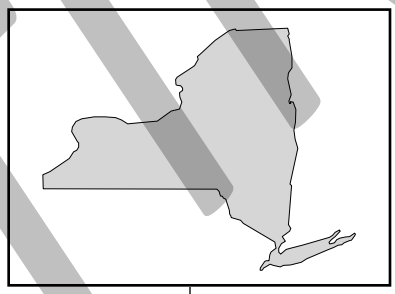


ME, NH, VT, RI
Area Codes:
207, 401, 603, 802
Michele Healey
Ombudsman
717-735-9415

MA, CT
Area Codes:
203, 413, 508, 617, 860
Doris Spencer
Ombudsman
717-735-9413
203-639-3150

Team New York

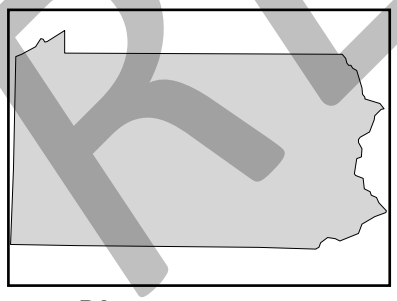
PR Representative
Erin Groblewski



NY State
Area Codes:
315, 518, 607, 716, 914
Laura Viot
Ombudsman
717-735-9527

NY City and Long Island
Area Codes:
212, 516, 718, 917
Tom O'Connor
Ombudsman
717-735-9414

Team Pennsylvania

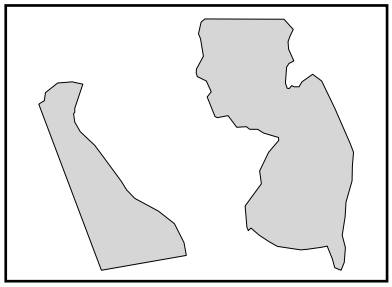


PA
Area Codes:
215, 412, 610
Amy Capece
Ombudsman
717-735-9409

PA
Area Codes:
717, 814
Tracy Gusditis
Ombudsman
717-735-9411

Team New Jersey/Delaware

PR Representative
Derek Zemanek



NJ, DE
Area Codes:
201, 302, 609, 908
Brian Thomas
Ombudsman
717-735-9407

Medicare Secondary Payer

Limiting Charge and Medicare Secondary Payer

This is to further clarify issues regarding a new policy decision based on the Social Security Act Amendments of 1994 (SSAA '94). A provision of these amendments extends the limiting charge provision to nonparticipating physicians and nonparticipating suppliers when they do not take Medicare assignment on a claim for which Medicare is the **secondary** insurer. The statute now prohibits nonparticipating physicians and nonparticipating suppliers who do not accept assignment from billing or collecting amounts above the applicable limiting charge, regardless of whether Medicare is primary or secondary.

Regardless of whether Medicare is primary or secondary, if a beneficiary is enrolled in Part B of Medicare, a nonparticipating physician or nonparticipating supplier who does not accept assignment must bill at or below the Medicare limiting charge. **This requirement is effective for Medicare covered physicians' services furnished after December 31, 1994, the effective date of this provision in SSAA '94.**

The limiting charge applies only when a nonparticipating physician, or nonparticipating supplier does not take assignment on a Medicare claim. If the physician or supplier takes assignment of the Medicare claim (either as a result of a participation agreement to always take assignment, or an assignment for a specific claim), then the limiting charge does not apply. The regulations at 42 CFR 411.31, which permit physicians and suppliers to bill and collect their full charges for services continue to apply with regard to physicians and suppliers that take Medicare assignment for the Medicare claim. The 1994 Social Security Amendments restricted the charges only for services for which the nonparticipating physician or nonparticipating supplier does not take assignment for the Medicare claim. They did not impose the limiting charge on assigned claims, nor did they impose the obligations of Medicare assignment on physician or supplier claims to primary payers other then Medicare.

Electronic Media Claims

How to Get Started Electronic Billing

Interested in a cost effective and accurate method of submitting DMEPOS claims? Electronic billing can supply the solution. The Region A DMERC offers a free software program called "Accelerate," which uses a claim entry screen that resembles the HCFA -1500 form. The EMC Team will assist with software installation and provide the support needed to run this program. By following the steps below, the EMC Team can start today to help you with electronic billing, even with a vendor or billing service.

Accelerate

1. Contact the EMC Team by phone, mail, or fax.
2. A signature agreement will be mailed to you.
3. Upon receipt of the signature agreement, the EMC Department will issue a submitter number and send the Accelerate software to you.
4. Our EMC Team will be glad to assist you in setting up your DMEPOS claims through a vendor / billing service.

Vendor/Billing Service

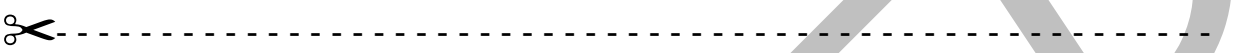
1. Contact the EMC Team by phone, mail, or fax.

2. A signature agreement will be mailed to you.

3. Upon return of the signature agreement, the EMC Department will issue a submitter number. Contact your vendor / billing service to arrange for testing of at least 20-30 claims. Once these tests are passed, you are ready to transmit DMEPOS Claims.

4. Our EMC Team will then help you install and transmit your DMEPOS claims.

EMC is available to both participating and non-participating suppliers. Assigned and non-assigned claims are accepted. Complete the form below for more information, and return it to the EMC Department by mail (DMERC Region A , Attn: EMC Department P.O. Box 6800, Wilkes-Barre, PA 18773) or fax (717-735-9510). If you have specific questions, please call 717-735-9532, 9528.



Accelerate Software Information Request

Please check all that apply:

I am interested and would like the **FREE** software package.

I would like more information regarding EMC submission _____ mailed to me.

I have a computer system which is supported by _____ (indicate name of vendor / billing service). Please have an EMC Representative call me.

Office Name _____

National Supplier Clearinghouse Number _____

Street _____

City _____ State _____ Zip _____

Contact Person _____ Telephone ( ) _____

Volume of Medicare DMEPOS claims per month _____

Return this form to the EMC Department:

Mail to:

The MetraHealth Insurance Company
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: EMC Department

or

Fax to:

The MetraHealth Insurance Company
Region A DMERC
Attn: EMC Department
Fax Number: 717-735-9510

If you have specific questions, please call 717-735-9532 or 717-735-9528.

Important EMC Numbers

Bulletin Board

Non-Participating Suppliers: 717-735-9515

Participating Suppliers: 800-842-5713

EMC Help Desk

717-735-9517 717-735-9532
717-735-9518 717-735-9528
717-735-9519 717-735-9530
717-735-9521

ERNs

As of April 1, 1996, the Region A DMERC is only returning Versions 01.04 and 02.00 of Electronic Remittance Notices. If you would like to receive ERNs in one of these versions, please contact the EMC Unit. Please note that Accelerate users can receive ERNs; however, a program is needed to interpret this information.

Zipped EMC Files

The DMERC EMC Unit can accept production files which are submitted in a "zipped" (i.e., compressed) format. This allows for multiple files to be sent at once and cuts down on transmission time. If you are interested in this option, you must contact the EMC Unit at 717-735-9521 or 717-735-9530 to be set up. Once you are set up for sending compressed files, you can only send compressed files.

New Acknowledgment Reports

The EMC Unit is now returning acknowledgment reports in a new layout. The acknowledgment reports are now ending with an AKS extension. Genacks2 is MetraHealth's free print program. If you are using MetraHealth's Accelerate software Version 02.00, you should have installed this program from your disks. Genacks2 is also located on the Bulletin Board. You may download the program if you do not have a copy. If you are using a vendor's software, you should contact your vendor for information on how to download and print your acknowledgment reports. If you are a programmer and need a copy of the file layout for the new acknowledgments, please call our office at 717-735-9532.

The BBS Supplier Questionnaire System

An electronic inquiry system has been implemented on the EMC Bulletin Board System. This system allows suppliers to direct questions and inquiries to various departments of the DMERC and to receive a response in a timely manner. Currently, there are question forms for MSP / Accounting and the Professional Relations Departments. This list will be expanding to include other departments. The questionnaires can be found under menu pick "Ask the DMERC." If you have a question for a department that is not currently listed, you may use the BBS General Mail Messages to forward your question. The alternative message system may be found under menu pick option A, "Ask the E-Team."

Messages left on the Bulletin Board will be responded to within 48 hours (2 working days). Please feel free to use the questionnaires as an alternative form of correspondence with the DMERC, and use them as often as needed.

Any questions you may have regarding "Ask the DMERC " option may be directed to us via the BBS mail system or by calling the EMC Unit.

EMC Reminder

If submitting your claims electronically where there is no insurance primary to Medicare, **DO NO**T send a DA2 record. A DA1 record should be sent when you are a participating provider and have a Medigap policy. The DA2 record is **only** used for MSP claims. Using these records incorrectly may slow down the adjudication process of your claims.

If you have any questions on the correct usage of these fields and are using MetraHealth's Accelerate software, please contact the EMC Unit at 717-735-9528 or 717-735-9532. If you are using a vendor's software, please contact your vendor with any questions.

National Standard Format 2.0

All providers who submit their claims electronically must be upgraded to version 2.0 of the National Standard Format by August 1, 1996. If you have not passed testing with the new format by that date, your claims will be rejected front end.