

***NHIA's Medicare Billing for Denial  
Commercial Claim Crosswalk Tool  
(Excerpts)***



# *NHIA's Medicare Billing for Denial Commercial Claim Crosswalk Tool*

## INTRODUCTION

Home infusion therapy providers, or “suppliers” in Medicare Part B terms, furnish products and services to many Medicare beneficiaries who have secondary commercial health plans, many of which cover what Medicare does not. Before many of these commercial plans pay for the items and services, they require proof of a Medicare denial via a Medicare Remittance Notice (MRN). Accordingly, in these situations, the supplier must submit a bill to one of the Medicare Durable Medical Equipment Medicare Administrative Contractors (“DME MACs”)<sup>1</sup> specifically to obtain a denial. Once the DME MAC denies payment, the supplier may submit the denial MRN along with a “secondary” claim to the commercial health plan. This is a frequent occurrence for infusion suppliers because most home infusion therapy products and services are not covered under Medicare Part B.

Use of the appropriate billing codes on claims submitted to the DME MACs for denial has been an area of great confusion and inefficiency for home infusion reimbursement professionals. To address these issues, NHIA published *NHIA's Medicare Billing for Denial Reference Tool* (“Reference Tool”) as a training and reference resource for home infusion therapy reimbursement staff and others. The Reference Tool is a comprehensive and detailed guide to coding of claims that are submitted for denial to the DME MAC. Eleven patient claim examples are included in the Reference Tool to illustrate the Medicare billing for denial requirements.

This product, *NHIA's Medicare Billing for Denial Commercial Claim Crosswalk Tool* (“Crosswalk Tool”), provides a resource for reimbursement professionals to help resolve a problem that may arise when billing for denial and subsequent secondary billing. Most commercial health plans (and some government plans) have adopted the Healthcare Common Procedure Coding System (“HCPCS”) per diem S-code coding system<sup>2</sup> for claims processing. Medicare requires the use of the product-based HCPCS code system rather than the per diem S-code system. This incompatibility requires a “crosswalk” (or translation) of the Medicare HCPCS billing codes to the simpler per diem coding system for a claim to be sent to a commercial health plan or another health plan.

The translation of Medicare’s coding to a secondary plan’s coding is complex because the charges on the claims submitted to the secondary payer may include charge lines, coding, and charges per code that do not correspond to the MRN received from Medicare. Even the total charges reported on the MRN may not match the total charges submitted to the secondary payer. In the event that the numbers and/or type of items or services charged to Medicare differ from the units charged to the secondary payer because the per diem and HCPCS systems differ, it is important to review the charges and units billed to ensure that they accurately represent the

---

<sup>1</sup> There are four DME MACs that service different portions of the country on behalf of the Medicare Part B program.

<sup>2</sup> The per diem coding system is described in the *NHIA National Coding Standard for Home Infusion Claims under HIPAA*.

products and services furnished under the appropriate coding system. If the charges and units differ, it is important to be able to explain the difference. Unexplained differences too frequently result in denial of the claims by the secondary payers, requiring the infusion supplier to pursue an appeals process. This can result in wasted reimbursement resources and significant delays in payment.

Through efforts of its Payer Relations Committee, NHIA has published this Crosswalk Tool to help reimbursement professionals address the many problems in crosswalking denied Medicare claims to secondary commercial health plans, avoid wasted resources, and lower Days Sales Outstanding (“DSO”) through faster collections.

While the objective of this publication is to provide you with a useful tool for crosswalking your Medicare billing for denial MRNs to secondary payer claims, this tool is not intended to provide a complete guide to billing Medicare for denial of home infusion claims—that is the purpose of the Reference Tool.<sup>3</sup> We also note this publication is not an educational resource on coding practices for home infusion claims using the per diem coding system. NHIA provides a resource for coding practices with its *NHIA National Coding Standard for Home Infusion Claims under HIPAA*.<sup>4</sup>

## **CHANGES AND UPDATES**

Requirements and processes for home infusion reimbursement are, of course, a moving target. Materials provided in this publication likely will require updates from time to time. Thus, NHIA may make available to purchasers of this product information on changes or replacement pages. Check for updates periodically at an internet web page that NHIA will make available to you. NHIA also may elect to publish a complete new version of this publication in lieu of posting updates. In that case, NHIA will announce availability of the new publication on that web page.

We use HCPCS codes and modifiers and Claim Adjustment Group and Reason Codes in effect as of the date of publication in 2009. If these change in the future, we may issue updates or a new version if we find updating such changes will be material to the usefulness of this publication. We look forward to learning about changes or corrections you might identify, as well as other comments you may have. Please email NHIA at [info@nhia.org](mailto:info@nhia.org), subject line: Crosswalk Tool.

---

<sup>3</sup> Obtain *NHIA’s Medicare Billing for Denial Reference Tool* from [www.nhia.org/store](http://www.nhia.org/store).

<sup>4</sup> Obtain the *NHIA National Coding Standard for Home Infusion Claims under HIPAA* at [www.nhia.org](http://www.nhia.org).

## **SCENARIOS AND BILLING STEPS**

*NHIA's Medicare Billing for Denial Commercial Claim Crosswalk Tool* (“Crosswalk Tool”) is a training and reference resource for the home infusion therapy reimbursement staff and others involved in billing and collecting from Medicare and other health plans. The Crosswalk Tool demonstrates how to translate a denial from a DME MAC into an appropriate CMS-1500 claim to be submitted to a secondary payer, despite the conflicting Medicare and commercial health plan billing and coding requirements described in the Introduction.

The Crosswalk Tool starts with a claim similar to Example B found in *NHIA's Medicare Billing for Denial Reference Tool* (“Reference Tool”), expanding it to illustrate how to translate codes and charges printed on a Medicare denial MRN for submission of a claim to a secondary health plan which uses the HCPCS per diem S-coding system. In the example, a patient is provided with an anti-infective therapy administered through a DME infusion pump for two weeks, and included are high-tech infusion nursing visits. In this particular example, the drug Zosyn<sup>®</sup> (piperacillin/tazobactam)<sup>5</sup> is not covered under Medicare coverage criteria, thus, the pump, pole, and supplies are not covered either.<sup>6</sup> The patient is not “homebound” under Medicare coverage criteria, so the nursing services cannot be covered by Medicare Part A. The home infusion supplier that also provides the home infusion nurse services is enrolled in Medicare as a DME supplier, but is not a Medicare-certified home health agency.

The Crosswalk Tool uses the patient example to demonstrate the billing techniques for three scenarios:

- Scenario One:** Charges submitted to Medicare and the secondary health plan are the provider’s usual and customary charges for the products and services provided.
- Scenario Two:** Charges submitted to Medicare are the provider’s usual and customary charges, while charges submitted to the secondary health plan are the contracted charges (per terms of agreement between provider and health plan).
- Scenario Three:** Charges submitted to Medicare and the secondary health plan are equal to charges contracted with the secondary health plan.

The fundamental techniques demonstrated in these scenarios can be applied to many different types of claims and situations.

---

<sup>5</sup> Zosyn<sup>®</sup> is a registered trademark of Wyeth Pharmaceuticals, Inc.

<sup>6</sup> See Local Coverage Determination L5044 (revision effective date January 1, 2009).