

NHIA's Medicare Billing for Denial Reference Tool

INTRODUCTION

The home infusion therapy provider, or “supplier” as known by DMERC* Medicare Part B, services many Medicare beneficiaries that have secondary coverage plans. While NHIA does not endorse the practice, many of these plans require proof of a denial via an Explanation of Medicare Benefit (EOMB) before they will pay. And if a beneficiary or a dual eligible’s state Medicaid program requires it, according to Centers for Medicare & Medicare Services (CMS) documents, the supplier must promptly submit a billing for denial (also called a “demand bill”) to Medicare. For these reasons, infusion providers frequently submit billings for denial to DMERC Medicare Part B for services they provide since most home infusion therapy is not covered under DMERC criteria. In the future, these billings will be submitted to a DME MAC as that transition is put in place (see later).

Coding of claims submitted for denial to the DMERCs has been an area of great confusion, frustration, and inefficiency to home infusion reimbursement professionals. This has led to incorrect coding of claims submitted to the DMERCs, which in turn leads to EOMBs that do not deny the claims with correct denial codes, or worse, claims that are paid by the DMERC that should not be. Such occurrences mean these claims must be resubmitted and appealed. In addition, some believe the DMERC claims processors make mistakes in this area. Providers’ attempts to get the DMERCs to process correctly are even more difficult since there are few clear and detailed instructions from the DMERCs on how to correctly code billing for denial claims.

Realizing the extent and costliness of these issues, NHIA’s Payer Relations Committee began work over one year ago to review CMS and DMERC publications and develop this NHIA educational and reference tool to assist infusion providers in submitting billings for denial. The committee’s hard work has resulted in this publication that will provide, for the first time, a comprehensive and detailed claiming guide on how to code billings for denial to the DMERC and receive expected results on a denial EOMB.

NHIA’s Medicare Billing for Denial Reference Tool is a resource of training and reference for the home infusion therapy reimbursement staff and others involved. It provides eleven billing for denial examples that represent the most typical billing for denial situations for reimbursement professionals to submit to the DMERC:

- Infusion drug therapy via gravity – Example A
- Infusion drug therapy via DME pump for non-covered drug or coverage criteria not met – Example B
- IVIG infusion (four examples with different coverage scenarios) – Examples C, D, E & F
- Total Parenteral Nutrition (two examples) – Examples G & H
- Enteral therapies (three examples) – Examples I, J & K

* Durable Medical Equipment Regional Carrier
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Through these illustrative examples, you are provided with:

- Indication of when an Advanced Beneficiary Notice (ABN) and/or Certificate of Medical Necessity (CMN) are required for situations where there will not be Medicare DMERC coverage
- Coding examples for use of the modifiers needed along with claim notes for submitting a billing for denial
- Expected denial codes that the DMERC should return: Claim Adjustment Group Codes and Reason Codes
- Exceptions where DMERCs have different expectations (see comments with examples)

The examples are valuable references for “how to do it” and the decision tree serves as a quick reference. It is always best to have expertise within your reimbursement organization on the conceptual and specific regulatory or Medicare contractor publications. For this purpose, key materials published by CMS and the DMERCs are provided in the Appendices with useful explanations, and we encourage you to review especially Appendices C and D. Other particularly useful Appendices we would like to point out are Appendix A which contains descriptions of important billing for denial codes, Appendix B which provides guidance for when you provide non-Medicare-covered home infusion nursing, and Appendix G which gives you a useful NHIA letter to secondary payers.

This publication provides examples that you will be able to apply to your business in order to get the “good” denial you need to submit to the secondary payer. By “good”, we mean that you successfully get back from the DMERC an EOMB that contains the coding they are supposed to provide per their procedures. Your success in achieving these results is important toward reducing rework and delays that hurt your speed of collections and increase your Days Sales Outstanding (DSO). This is perhaps one-half of the battle and NHIA recognizes there are other issues still to be resolved. This publication is a by-product of NHIA’s advocacy to CMS and the DMERCs in this area of Medicare billing for denial, and our advocacy is continuing.

While the objective of this publication is to provide you with a useful tool in determining critical elements of billing Medicare for denial, you should understand there isn’t intent to provide a complete billing guide for Medicare or other payers. NHIA offers educational and reference products for reimbursement professionals through publications and presentations at its annual conferences and audio conferences in the NHIA Store at www.nhianet.org.

CHANGES AND UPDATES

Requirements and processes for home infusion reimbursement are, of course, a moving target. You can expect that materials provided in this tool may need to be updated with changes and any needed corrections that might become apparent. For this purpose, on a web update page NHIA will make available information to purchasers of this product notations on small changes or replacement pages that may be needed in between republication of a new version of this tool.

Some pending changes already apparent are:

- CMS is transitioning its DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) contractors from DMERCs to DME MACs*. At time of publication, we do not predict that the examples will require changing for the DME MACs. Where you read DMERC in this tool, we think you will be able to assume that also means DME MAC.
- Beginning for a three month transition on October 1, 2006, DME MAC Information Forms (DIFs) will replace CMNs for home infusion therapies covered under DMEPOS, i.e. for external DME infusion pump administered therapies, TPN and enteral nutrition. Here again we do not predict that the examples will require changing, except that where you read “CMN Obtained” we think you will be able to assume it means “DIF Obtained”.

We use HCPCS codes and modifiers, and Claim Adjustment Group and Reason Codes, in effect as of the date of publication in 2006. These could change in the future. CMS, DMERCs and DME MACs could change their written or unwritten requirements or claim processes. There may be further improvements in billing for denial as a result from NHIA’s continuing advocacy.

For these types of changes that may require updates to this tool, NHIA will inform you on the update web page or through publication of a new version of this tool. We look forward to learning about any changes or corrections you might identify, as well as other comments you may have about this publication. Please email NHIA at info@nhianet.org, subject line: MDB Tool.

USE OF THIS TOOL

To develop this tool, through its Payer Relations Committee NHIA convened a task force of individuals with substantial experience in home infusion therapy reimbursement operations who have prepared the materials in this publication. Every possible effort has been made to verify that the material in NHIA’s Medicare Billing for Denial Reference Tool and updates to it conform to law, regulation and other requirements and that the materials are free of errors. Due to the breadth and depth of the expertise of the task force and the development process for this publication, NHIA believes that NHIA’s Medicare Billing for Denial Reference Tool and any updates reflect billing requirements as of the published dates. However, a user of this tool should always consult professional advisors concerning applicable federal and state laws and regulations. The materials about no warranties and using this tool at your own risk on the publisher’s page near the beginning of this publication are important for you to understand.

* Durable Medical Equipment Medicare Administrative Contractor
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