

Medicare Region B DMERC/Region B Council Frequently Asked Questions

Home Medical Equipment

1. Question: Oxygen client has Private insurance and Medicare secondary. The private insurance stops paying on the rental of oxygen equipment because it considers the purchase price to have been met. Question: Does the supplier have to convert the equipment to customer owned, or can the supplier bill the primary for denial (purchase price met) and bill Medicare secondary for payment since Medicare does not cap out oxygen equipment?

The supplier should bill the primary insurance carrier for denial and continue to bill Medicare as secondary.

2. Question: When replacing a capped rental item such as a semi-electric hospital bed that has been a capped rental for longer than five years and the equipment is no longer working well, medical policy states that this equipment can be replaced and a new rental period begun. What modifiers are required to inform the Durable Medical Equipment Regional Carrier (DMERC) that this is the case so they do not deny as a duplicate claim? Is there any other documentation/justification required to start the new rental period?

Please refer to the September 2003 *Region B DMERC Supplier Bulletin*, page five. The article entitled “CMNs and Orders for Repair or Replacement of DME” addresses this issue in detail. It would also be helpful to provide an explanation of the reason for replacement in the narrative filed of the claim.

3. Question: Many times when we (the supplier) supply a patient with a wheeled walker and ask the question, “Have you ever had a walker in the past?” the patient says emphatically “no.” Then we receive a rejection maximum benefit met or patient has same/similar equipment. We have not gotten an Advance Beneficiary Notice (ABN) because there was no reason to expect that it would be rejected. I have been told by the customer service representatives (CSRs) that our only option is to get our equipment back. Why can we not bill the patient if they want to keep the equipment? What documentation would we have to get, at that point, when we know that Medicare will not pay for it but the patient wants to keep the equipment? We really do not want the equipment back, we want to service our patient, but it comes down to the fact that we need to be paid.

Per the Centers for Medicare & Medicaid Services (CMS) Transmittal AB-02-168, Change Request 2415, if a supplier fails to obtain an ABN for items denied by Medicare the supplier must refund any monies collected for the item and the supplier has the right to collect the equipment.

It is recommended that suppliers determine the patient’s history during the intake process to determine if same or similar equipment was previously obtained.

However, if a claim denies because the patient has previously received same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary or exercise his/her appeal rights and request a review.

If the supplier does not request redetermination of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the supplier receives the remittance advice.

If the supplier requests a redetermination within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the supplier receives the notice of the contractor’s determination of the supplier’s appeal.

4. Question: On many occasions, we are requested to send documents and claims to the Region B DMERC to correct or change information in the common working file (CWF). However, we never receive an acknowledgement that it has been received or how the situation has been resolved. We wait for payment or rejection to try to figure out how it has

been processed and often times we do not receive anything. Could break in service (similar to reviews and fair hearings) send an acknowledgement of receipt and then just another notification of how the issue has been resolved?

There are no plans at this time to issue acknowledgement letters for break in service inquiries. Once the information received has been processed, the supplier will receive notification of the decision on the remittance advice.

5. Question: What is the Medicare policy for dealing with beneficiary requests to purchase products that are in the fee schedule as capped rentals? This question was posed in the last frequently asked questions (FAQ #17) but the response was to request examples from the provider submitting the question. As many providers experience these requests from Medicare beneficiaries, we all need a response to this question. If we comply with the beneficiary request and have them sign an ABN, the claim is still denied as a “CO” and the provider is required to refund the beneficiary.

Per the December 2004 *Region B DMERC Supplier Bulletin* the following information can be found in Chapter 8, Claim Submission, Page four of the *Region B DMERC Supplier Manual*, which states: OBRA 89 requires a Medicare provider to submit a completed claim within one year when furnishing covered items to a Medicare beneficiary. The provider is relieved of this obligation, and may perform a cash transaction when furnishing (statutorily) noncovered items, unless the beneficiary requests Medicare payment/determination. If the beneficiary chooses to waive Medicare determination/payment on Medicare covered items, the supplier is relieved of the responsibility to file claims for covered Medicare items. Should the beneficiary change his/her mind in the future, the requirement to file the claim would again be in force. If the patient chooses to waive the right to have Medicare billed, it would be advisable, not required, for the supplier to have written documentation of this in their records.

Enteral/Parenteral/IV Therapy

1. Question: When creating a new enteral Certificate of Medical Necessity (CMN) due to a formula code change for a grandfathered patient, is it acceptable to date the physician signature as January 1, 2005 even though the hard copy CMN signature is from 2003?

Yes.

2. Question: Please confirm that in the circumstance that a patient was on a B4150 formula that was changed to a B4154 and the provider has no documentation to support a specialty formula, the formula is payable without the documentation for as long as the patient requires this specific formula, and the article dated January 14, 2005 will be sufficient documentation to ensure continued payment.

Yes, that is true if the patient was receiving the formula prior to January 1, 2005, met all the coverage criteria for B4150 at that time, and continued on that same formula after January 1, 2005.

3. Question: When a grandfathered patient was on Resource Diabetic (B4150), effective January 1, 2005, what documentation is recommended to be on file in the patient’s record?

A CMN with a certification date prior to January 1, 2005 that specifies resource diabetic and a copy of the list serve/bulletin article.

4. Question: For new patients after January 1, 2005, what documentation will you require a supplier to have on file in the patient’s record for Resource Diabetic or Glytrol since no previous documentation was required? Manufacturers do not have any specific recommendations other than a diagnosis of diabetes mellitus, glucose intolerance, or hyperglycemia. There is no indication that there needs to be any documentation of uncontrolled blood sugars, hemoglobin A1C levels, insulin dependence, or other diabetes related complications.

There must be information in the patient’s medical record to justify the need for the formula that is ordered. No specific criteria are defined in the policy.

5. Question: With the new HCPCS description, will the codes B4150-B4155 be billed in the same category as before?

For patients who initiated use on those products on or after January 1, 2005, there must be information in the medical record to justify the need for the formula for that patient—just as for other products categorized as B4154, special metabolic need. For patients who were on the formula prior to January 1, 2005 and covered by Medicare, only the general coverage criteria for enteral nutrition need to be met.

Respiratory Care Equipment/Oxygen Therapy

1. Question: We set up a new patient on oxygen, obtain an initial Certificate of Medical Necessity (CMN) and submit the CMN with the claims to Medicare. Several months later, we start getting denials, after receiving payments, stating we need to obtain a recertification. At this time, we find the patient has had equipment with another company and Medicare has been paying because that CMN from the other company was being used. We have been instructed several times by Medicare customer service representatives (CSRs) to send our CMN to review and request it to be loaded as a new initial CMN, wait, and then call to see if that CMN has been loaded, then resubmit claims. Is this appropriate?

These steps are appropriate. The supplier should complete and submit through written redeterminations a Redetermination form and indicate that they are requesting that the CMN be corrected with an explanation of why the correction is needed. In addition, the supplier should submit any additional documentation that will help support the CMN correction. The supplier should then contact Customer Service to check the status of the CMN correction and resubmit the claims.

2. Question: The *Region B DMERC Supplier Manual*, Chapter 17 – Medical Policy Oxygen, Revision 38, March 2004 states that “Emergency or stand-by oxygen systems will be denied as not medically necessary since they are precautionary and not therapeutic in nature.” What does this apply to? Does this mean back-up equipment for use during a power failure or could you please clarify.

That statement refers to situations in which the patient is not receiving oxygen on an ongoing basis, but has the oxygen to use as needed. If a patient is receiving oxygen on an ongoing basis and the supplier elects to provide back-up equipment for use in a power failure, that equipment would be included in the monthly allowance for the primary equipment. There should be no separate billing for the back-up equipment.

3. Question: Is two liters PRN a valid order or does it need to be more specific? And if so, where is this stated in the manual?

A valid order must specify the situations in which the oxygen is to be used—i.e., either continuously, or only during sleep, or with exercise. An order which only says “as needed” is not sufficient. This falls under the general requirement that all written order must be sufficiently detailed.

4. Question: Is oxygen therapy covered with qualifying test results and a diagnosis of pneumonia? If it is covered, how many months should it be paid for since pneumonia is not a chronic lung disease?

Yes, it would be covered in that situation. There is no specific duration of coverage. It is expected that the physician will re-test the patient when he/she determines that the patient is at the chronic baseline condition. Of course, if the initial test result fell within the Group two range, a retest would be required during the third month of coverage.

5. Question: Is oxygen therapy covered with qualifying test results and a diagnosis of hypoxemia?

Though an ICD-9 code for hypoxemia would be sufficient for claim submission, there should be documentation in the patient’s medical record identifying the cause of the hypoxemia.

6. Question: Doctor ordered a BiPAP ST for a patient who suffers from end stage Chronic Obstructive Pulmonary Disease (COPD). (CO2s are in the high 70’s) If the patient was not tried for two months prior on BiPAP, will Medicare just deny the first two months of BiPAP ST rental and start paying in the third month? Or will all consecutive month be denied?

If a patient was not tried on a BiPAP for at least two months, the BiPAP ST would not be covered at all.

7. Question: Would it not be more cost efficient for Medicare to purchase nebulizers?

That is not an issue that has been addressed by the durable medical equipment regional carriers (DMERCs). The determination of the payment category for a particular item of durable medical equipment (DME) is determined by the CMS based on guidelines defined in the statute.

8. Question: When the physician is completing the 484 form for a group I patient, is it necessary that he answer questions 8, 9, and 10? When transmitting electronically, would it be appropriate for the supplier to enter "D", for does not apply, if the physician leaves the questions blank?

According to the instructions on the CMN form, questions 8 through 10 only need to be completed if the patient's PO2 is 56 to 59% or their saturation is 89% or higher. When submitting the CMN electronically, if questions 8 through 10 are required to be answered, "D" can be entered if the physician leaves the questions blank.

9. Question: In the Respiratory Assist Device (RAD) policy for OSA it states "...If E0470 is billed and these criteria are not met...payment will be based on the allowance for the least costly medically appropriate alternative, E0601." If we bill with the modifier KX we are stating that we have the medical documentation to qualify the customer for a BiPAP. If we bill without the modifier KX will the claim be denied? Please clarify the proper way to submit this claim.

There are four categories of coverage for E0470 respiratory assist devices: Restrictive Thoracic Diseases, COPD, Central Sleep Apnea, and Obstructive Sleep Apnea (OSA). In three of the categories, the policy states that if coverage criteria are not met, then the E0470 will be denied. Only in the OSA category does it say that if criteria for an E0470 are not met but CPAP criteria are met, then AdminaStar Federal will downcode. Because of the way that the system edits are set, if a claim for E0470 is billed without a modifier KX (as would be appropriate if it was used for an OSA patient who did not meet criteria) the claim will deny as not medically necessary. The adjustment to pay comparable to a continuous positive airway pressure (CPAP) device would have to be made through the appeals process.

10. Question: What are the documentation guidelines to obtain reimbursement on CPAP/BiPAP machines? What information would a claims processor find useful in evaluating repair claims. What information is required to be submitted with a repair claim?

Documentation requirement for a CPAP and BiPAP are defined in the CPAP and RAD LCDs. Because they are capped rental items, repairs for CPAP and E0470 BiPAP machines are only eligible for payment if Medicare has covered 13 months of rental and the patient has selected the purchase option. In those situations, there must be information describing what is being repaired and the reason for the repair.

11. Question: Client was covered by private insurance when they obtained their CPAP and now are on Medicare. Some sleep labs are slow in getting reports back to suppliers and the reports are all different in the way things are reported. Studies done some time ago did not always indicate the recording time prior to trial of CPAP. It is difficult for suppliers to know if beneficiaries meet current guidelines for coverage.

For a CPAP device to be covered and for a supplier to be able to use a modifier KX, there must be a sleep study report that documents that current coverage criteria are met.

12. Question: We have submitted claims for CPAP supplies that the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) has coded as A9999. Examples of supplies: Headgear Clip and Swivel Adaptors. These parts are being replaced, but the headgear or mask is not being replaced. Medicare has denied the claims even when we bill with the RP modifier. We have gone to review for the headgear clip and the review decision came back unfavorable stating, "Medicare did not allow the headgear clip (A9999) because it is considered in the payment for the headgear." We did state in review that it was a replacement part and that it was more cost effective to replace the part than to buy new headgear. Why doesn't Medicare pay for replacement parts since it would be much more cost effective than replacing the entire headgear or mask?

For components of DME accessories, Medicare takes into account the useful lifetime for the item accessory itself. For example, CPAP headgear (A7035) has a replacement frequency of one every six months. It is expected that individual components will last that long, so if a replacement headgear clip is billed within six months following provision of the headgear itself, it will likely be denied. For items that require special replacement consideration,

manufacturers or suppliers may seek a unique Healthcare Common Procedure Coding System (HCPCS) code through the HCPCS Alpha-Numeric Workgroup at the CMS. For example, this year a new code, A7045, was established for the replacement of an “exhalation port with or without swivel.”

13. Question: For heated humidifiers, how often are the chambers (A7046) able to be replaced?

There is no specific guideline stated in the policy. Our understanding is that the typical replacement frequency would be once every three to six months.

14. Question: Medicare beneficiary owns a BiPAP ST but does not qualify for Medicare coverage. The beneficiary qualifies for a BiPAP S but not the ST. How are supplies for patient owned equipment billed? Should the provider use the modifier KX when billing the replacement supplies because the beneficiary qualifies for RAD coverage, or not use the modifier KX because the client does not qualify for the specific type of RAD ordered by the physician? The BiPAP ST was purchased by the state Medicaid program.

In the situation described, the modifier KX may be used with the accessories.

15. Question: E0571 continues to be denied as not medically necessary instead of being downcoded. Refer to previous question #15 in the December 2004 frequently asked questions (FAQ). The response to last quarter’s question did not address the fact that these claims are being denied after previous rentals for the same beneficiary were downcoded and paid. In other words, claims for the first through fifth rental months were downcoded to E0570 and paid. Suddenly with the sixth rental month, the claim for the same beneficiary is being denied as not medically necessary. There has been no published change in the policy, so why the change in claims processing?

Additional research will need to be conducted once the requested examples are received from the supplier.

16. Question: If an oxygen patient is on greater than four liters per minute (LPM), however there is not a test on four liters or the test does not qualify the patient for 1½ reimbursement how can this be submitted electronically to receive the lesser allowance? This was addressed in the December 2003 FAQ’s (#1 and #27) but still seems to be an issue.

Currently, the claims cannot be submitted electronically as the claim and the CMN would reject with error code 40047—Measurements Invalid. The edit explanation states “the oxygen saturation/arterial blood gas test results segment (question seven on the oxygen certification form) is missing or invalid. It has been indicated that greater than four LPM is prescribed and the test results were not provided.” See box below.

40047	Measurements	2400. MEA	The oxygen saturation /arterial blood gas test results segment (question seven on the oxygen certification form) is missing or invalid. It has been indicated that greater than four LPM is prescribed and the test results were not provided.
	Invalid		

As of April 4, 2005 (our April release date), the claims can be submitted and accepted on the front end electronically. Edit code 40047 will be removed. Therefore, a claim and CMN that indicates higher than four LPM in question six when question seven is left blank will be accepted into the Medicare processing system. The Medicare processing system will process the claim based on the lesser allowance.

Prosthetics/Orthotics

No Questions Submitted.

Rehab Equipment

1. Question: We deal with many complex disabled clients who rely on a custom power chair for their mobility. Will Medicare pay for a new power chair, most likely the same Healthcare Common Procedure Coding System (HCPCS) code, based on the fact alone that the chair is over five years old and is no longer reliable. Or in the case that their living environment is better suited to a mid-wheel drive chair? Most of the time repairs can be done. However, like a car, it is the motors today, the control box next week, and the joystick next month. Not only is this a waste of money, but due to

the complex seating and adaptive switch use, a loaner chair is not an option while their chair is down for several weeks or longer.

If the patient's current wheelchair is more than five years old and if coverage criteria are currently met, a new wheelchair would be covered.

Ostomy/Urological/Medical Supplies

No Questions Submitted.

Diabetic Monitoring and Supplies

No Questions Submitted.

Documentation/Regulatory/Miscellaneous

1. Question: We have just recently received Medicare denials on heated Continuous positive airway pressure (CPAP) humidifiers (E0562) stating same or similar if patient received a cool humidifier (E0561) in the past. Why would this suddenly be occurring since they had been paid for in the past? Is there any additional documentation that could be submitted to have this paid and if not, can we bill the patient privately with a waiver?

AdminaStar Federal is currently researching this issue. If the research proves AdminaStar Federal paid for two humidifiers, recovery efforts will be pursued to retrieve payments made in error. The policy clearly states "Either a nonheated (E0561) or heated (E0562) humidifier is covered and paid separately when ordered by the treating physician for use with a covered E0470 respiratory assist device."

Currently, if a supplier initially billed and was paid for a cool humidifier and then billed a heated humidifier, AdminaStar Federal's system is set up to deny for same or similar and the supplier could request an appeal with documentation from the patient's medical records stating why heated humidity is medically necessary. Otherwise, the provider can get an advanced beneficiary notice (ABN) signed. The policy clearly states Medicare will pay for one or the other. Paying for both will only be considered on an individual consideration basis with documentation.

2. Question: A Medicare beneficiary needs repairs on their power wheelchair or scooter that was purchased by a private insurance. What steps need to occur in order to have the repair covered by Medicare? What steps would need to be taken if the chair was purchased by Medicare?

An article on page six of the September 2004 Region B Supplier Bulletin specifically addresses the documentation required for repairs of wheelchairs not purchased by Medicare. For wheelchairs purchased by Medicare, the claim should include information on what needs to be repaired and the reason for the repair.

3. Question: DMERC B has communicated there is a backlog in the overpayment department. When is DMERC B expected to be caught up with the voluntary refund backlog? It currently takes over six months for voluntary refunds to be reflected in corrected EOMBs. Such drastic delays impact suppliers' obligations to the secondary payors such as State Medicaid and private parties. This is hard to explain to customers who have returned items and are waiting for co-insurance refunds.

The Region B DMERC Payment Correction Unit (PCU) is forecasting the Recovery backlog to be completed by July, 2005. Currently the inventory is approximately 32,000 cases. An analysis program has been implemented to identify incorrect billing trends and/or system problems. Ten associates have been added to the PCU unit to help assist in reducing the backlog. An additional ten associates are in-process to be hired.

4. Question: What is the minimum weight requirement for a patient who has a medical need for an E0181, Heavy duty Alternating Pressure Pad? What if any criteria are required for payment of this code compared to the standard APP E0180?

The patient should weigh more than 250 pounds. The coverage criteria for E0180 and E0181 are the same.

5. Question: Please consider these two situations (which are very similar) and how the DMERC CSR response differs. Suppliers are wondering if they are receiving the correct response from the DMERC CSR staff.

Situation #1: A new wheelchair rental claim denies for XYZ supplier because the customer received a same or similar item from ABC supplier in the past that has already billed and been paid for 15 monthly rentals.

Situation #2: A new wheelchair claim is down coded from KH to KJ for XYZ supplier because ABC supplier had billed for seven months. The customer returned the wheelchair to ABC supplier and obtained a wheelchair from the XYZ supplier.

In situation #1 if XYZ calls customer service the CSR will tell XYZ the name of the other supplier, initial rental date, and HCPCS of the item they billed. However, if we call about Situation #2, some CSRs say they cannot give us that same information. Are they mistaken? If not, please explain why two sets of rules apply. The only difference is the number of rental months paid to the other provider.

AdminaStar Federal customer service representatives should provide suppliers the name of the other supplier if the information changes the way the claim pays, or if the information causes a claim denial. In both situations the customer service representatives would be able to give the name of the other supplier, initial rental date, and HCPCS of the item billed. Refresher training regarding this issue will be given to the customer service representatives.

6. Question: Since early December, we have been getting refund requests for claims paid in error while the beneficiary was in a skilled nursing facility. (They started with dates of service in late 2003 and seem to be working their way through 2004). When does Medicare expect to be caught up with these adjustments? Are the appropriate edits in place now so that claims will deny right away (when appropriate)? It is difficult to get discharge information 12 months after the fact. Also, the supplier community had the understanding that as long as the “from” date was not during an episode of skilled care or hospital care then the rental month should be able to be paid for the entire month. If the beneficiary was in a skilled care or hosp for the entire month, rental payment was not possible. Is this still the understanding?

The Region B DMERC Payment Correction Unit (PCU) will be issuing approximately 500 recovery requests each week beginning in mid-March and expects the Recovery backlog effort to take approximately 32 weeks to complete. These recovery requests are based on overpayments identified and reported to the Region B DMERC Payment Correction Unit by CWF. Region B DMERC has appropriate edits in the system for skilled nursing facility (SNF) claims. When a beneficiary is in a SNF, claims should be submitted to Part A for processing. Claims submitted to the DMERC that should be paid by Part A, may result in a refund request once CWF updates and indicates the beneficiary was in a SNF during the dates of service billed. For rental payment situations where the “from” date was not during a skilled care episode or inpatient hospital stay, the entire month would be considered for coverage. If the beneficiary was in a skilled nursing care or inpatient hospital stay for the entire month the rental payment would not be payable for that month.

7. Question: Does DMERC B take a negative view of companies who do not respond to refund request letters but rather elect to wait for the off-set? When a company responds to a refund request letter by submitting payment and the amount is also offset by the DMERC, what recourse does the supplier have to collect the second refunded amount? Please be advised this is happening frequently and is administratively burdensome and unnecessary.

No, the Region B DMERC does not take a negative view of companies who do not respond to refund request letters and elect to wait for the offset. However, it does add a delay in the closing out of the open receivable and may result in interest accruing. Providers may request “voluntary offset” via letter or fax prior to the offset date if they do not wish to send payment. Interest will not be applied to the “voluntary offset” if claims payments covering the offset amount are applied within the 30-day payment window.

When a company submits payment in response to a refund request letter after the receivable goes into offset, the credit balance resulting from the payment will be applied to any other open receivables they currently have in offset status. If no other open “offset” receivable exists, the remaining credit balance may be refunded.

8. Question: In order to correctly attach a modifier KX to a basic commode claim the supplier must have sufficient documentation on file to show the patient is unable to make it to a toilet because the patient is confined to a room without a toilet, the patient does not have a toilet on the same floor where they live or the patient's residence does not have a toilet. Would a statement that is included on the physician order and signed by the physician suffice as proper documentation to verify this living arrangement or would the supplier need some other type of documentation in its files? If other documentation is needed can you describe what is acceptable?

A statement written on the order by the physician would be sufficient.

Other

1. Question: Medicare electronic data interchange (EDI)—Why is a total batch rejected when there is only an error on one claim? Why isn't just that claim rejected? Is this something that is being reviewed and possibly changed?

This procedure has been in effect since the inception of the Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets. HIPAA uses the American National Standards Institute (ANSI) American Standards Committee (ASC) X12N 4010A1 for Medicare claims transactions as the standard mode for EDI. The implementation guide (IG) is maintained by the ANSI X12N Insurance Subcommittee and it contains the specifications for formatting the 837 inbound claims transaction. The IG is what the software vendors use to format the HIPAA electronic claim transaction.

Medicare will reject an entire batch if a segment or element (one claim) within the batch violates the Implementation Guide (IG). An error that violates the IG makes the file technically non-HIPAA compliant.

Item six in the Trading Partner Agreement for Inbound Claim Submission states:

Implementation Guide (IG) edits have been developed to return the entire ST (Transaction Set Header)/SE (Transaction Set Trailer) if the 837 Implementation Guide is not followed. AdminaStar Federal will return an Electronic Media Claim (EMC) Receipt Report identifying any implementation guide edits received. Multiple inbound claims can be submitted within an ST/SE; however, there are Implementation Guide edits that will reject all claims within a ST/SE even if only one claim receives an error. AdminaStar Federal will accept transmissions with one claim per ST/SE.

AdminaStar Federal's Trading Partner Agreement can be found on the Web site at www.adminastar.com. Select DMERC, Electronic Data Interchange (EDI), HIPAA Claims (837), 837.TPA.PDF

This process currently follows the ASC X12N 837 IG and will not be changed at this time.

2. Question: The December 2004 *DMERC Region B Supplier Bulletin* states that "...If the durable medical equipment regional carrier (DMERC) determines that a drug is not medically (necessary) for the stated indication or if it determines that the pump is not necessary to administer the drug even though the drug itself may be medically necessary, the pump, the drug and related infusion supplies are all denied as not medically necessary. There is no way for the supplier to obtain a 'coverage' denial in these situations."

The Ohio Medicaid billing instructions state "... Claims for Medicare-covered services that have been denied as 'not medically necessary' by Medicare are not eligible for payment by Medicaid. Providers should appeal such denials to Medicare." With these conflicting policies, how can suppliers be paid for these Medicare/Medicaid cases?

BIN 1100.6 Claims Completely Denied or Line Item Services Denied by Medicare—Claims and/or line item services that have been denied by Medicare may be eligible for payment by Medicaid if:

1. The service(s) are not covered by Medicare ('not covered' means that Medicare never covers the service under any circumstances) and Medicaid does cover the service. For example, dental services, optometry services, and pharmacy services.
2. Medicare covers a service only under certain circumstances and Medicaid coverage is available for those circumstances when Medicare coverage is not available.

Note: Claims for Medicare-covered services that have been denied as “not medically necessary” by Medicare are not eligible for payment by Medicaid. Providers should appeal such denials to Medicare.

If the provider is submitting a claim that has been completely denied by Medicare and the service meets the criteria specified in (1) or (2) above, DO NOT follow the Medicare/Medicaid crossover instructions. Prepare an appropriate CMS-1500 or JFS 06780 claim form following the regular billing instructions, attaching the denial from Medicare Summary Notice of Medicare Benefits, attach the JFS-06653 Medicaid Claim Problem Form and mail to the address listed below. The JFS 06653 (in section 5. “Explanation”) should include a complete description of why the Medicare-denied service is eligible for payment by the Medicaid Program.

For line item denials or denied services, if there are a number of services for the same recipient, and only one is not covered by Medicare, fill out a separate claim form for the noncovered services. Remember, when billing for a service denied by Medicare, each claim form must be accompanied by a Summary Notice of Medicare benefits. This is important because the computer program that pays the claim will reject a mixed claim form.

CMS has instructed the DMERCs that if a pump is denied as not medically necessary then the drug must be denied as not medically necessary. The fact that another insurer decides not to provide secondary coverage based on a Medicare medical necessity denial is not an issue that the DMERC can resolve.

3. Question: When obtaining an order for supplies—i.e., diabetic, ostomy, urological, the quantity indicated, should it be per month, per day, per year; what time frame should be used?

The order should specify the quantity used per day or per month.

4. Question: Do you take a negative view of companies who do not respond to refund request letters but wait for the off-set? When a company responds to a refund request letter by submitting payment and the amount is also off-set, what recourse does the company have?

The Payment Correction Unit (PCU) offsets do not start unless a full refund has not been received within 30 days of the initial refund demand letter. In addition, interest penalties begin to accrue on the 31st day after the refund request letter has been sent. If a supplier chooses to let AdminaStar Federal take the offset instead of sending a refund check, this action does not give a negative view of the company. The only time allowing an offset to take place could be a problem, is if the supplier opts for an offset and subsequently stops submitting claims to the Medicare program. AdminaStar Federal would then have no way of recouping the money in house, because there would no payments scheduled to go out to the supplier. In addition, if a supplier is going to opt for an offset on any overpayments identified, that request also should be submitted in writing, with appropriate signatures. This action can be implemented anytime an overpayment is subsequently identified for that particular supplier. When a company submits payment in response to a refund request letter after the receivable goes into offset, the credit balance resulting from the payment will be applied to any other open receivables they currently have in offset status. If no other open “offset” receivable exists, the remaining credit balance may be refunded.

5. Question: Advanced Beneficiary Notice (ABN)—is an ABN necessary when billing another insurance for an item that is noncovered by Medicare?

In any case where a national coverage decision provides that a particular service is never covered, under any circumstances, as not reasonable and necessary under Section 1862(a) (1) of the Social Security Act (the Act) (e.g., at present, hearing aids are denied as not reasonable and necessary), an ABN that states in the “Because:” box that: “Medicare never pays for this item/service” may be routinely given to beneficiaries, and no claim need be submitted to Medicare. Providing an ABN for items that are statutorily noncovered by Medicare to the beneficiary, will allow the beneficiary to make an informed decision regarding the possibility of additional financial obligations for the item or service being provided. If the beneficiary demands that a claim be submitted to Medicare, submit the claim as a demand bill in accordance with Section 1.3.G., which states:

G. Demand Bills—A demand bill is a complete, processable claim which must be submitted promptly to Medicare by the physician or supplier at the timely request of the beneficiary, the beneficiary’s representative, or, in the case of a beneficiary dually entitled to Medicare and Medicaid, a state as the beneficiary’s subrogee. A demand bill is requested usually, but not necessarily, pursuant to notification of the

beneficiary (or representative or subrogee) of the fact that the physician or supplier expects Medicare to deny payment of claim. When the beneficiary (or representative or subrogee) selects an option on an ABN that includes a request that a claim be submitted to Medicare, no further demand is necessary; a demand bill must be submitted. When a beneficiary chooses Option 1 on an ABN-G or an ABN-L and receives the item or service, claims submission is mandatory. The physician or supplier must submit a claim, billing as covered, for an initial determination. On such a claim, a modifier GA must appear on the CMS-1500 in item 24D. The GA modifier indicates that an ABN was furnished by the physician or supplier and is on file in their office and it also documents the physician's or supplier's expectation that Medicare will not pay the claim. (The modifier GA is mandatory; it must be used anytime an ABN was obtained). The use of the modifier GZ is optional. A modifier GZ may be included on the CMS-1500 in item 24D if the physician or supplier wishes to indicate that denial for medical necessity is expected but an ABN was not obtained. The provision of an ABN and/or the inclusion of a modifier GA or modifier GZ by the physician or supplier only represent the physician's or supplier's assessment that Medicare will deny payment.

6. Question: If a patient does not qualify for portable oxygen, due to the fact that the answer to question three on the 484 specifies use only during sleep, is an ABN necessary to collect for portable oxygen from the patient?

Yes.

7. Question: We have been told that Medicare is behind in processing refunds. Currently we receive a request from Medicare for a refund and are given 30 days to process these, or Medicare does a take back for the refund. We are processing refunds within the 30 days, however, since Medicare's refund department is behind in processing refunds (both voluntary and demanded) the take back department waits the 30 days and does a take back. This means that we refund the money AND Medicare is doing a take back on the same money. Medicare has told us that the only way we can get our refund back to balance this out is to send the claim/claims in question to review. We have also learned that Medicare review is four to six months behind which is further adding to the time consumed by this process. Is there anything else that can be done?

The backlog does not affect a check coming in as a response to a demand letter. The Payment Corrections Unit (PCU) is not backlogged in applying checks to receivables. That process is completed within three to five days of receiving the check. The backlog applies only to voluntary refunds and those overpayments that have not been validated, therefore; no receivable is set up. If a supplier refunds Medicare due to a demand letter received from the PCU and Medicare still takes this money back, the supplier should contact the PCU in writing at the following address:

Payment Correction Unit
PCU—DMERC—Indiana
Lockbox # 660078
Indianapolis, Indiana 46266-0078

Refund checks and refund correspondence related to Medicare as a Secondary Payer (MSP) should be directed to the following address:

Medicare MSP DMERC
Lockbox #660065
Indianapolis, Indiana 46266-0065

If a supplier disagrees with the refund request the supplier should refund the money to Medicare and then file an appeal. When appealing an overpayment, the supplier should submit the request to the Fair Hearings Department. The amount in controversy must be at least \$100. The refund request letter will contain specific instructions for filing an appeal. The following is the address for the DMERC Fair Hearings Department:

Medicare DMERC Hearings
PO Box 50462
Indianapolis, Indiana 46250-0462

8. Question: We are currently getting B17 denials for no CMN/SMN attached to the claims we send. We can track the claims/CMNs leaving our system and being received by EDI but Medicare is stating that they are not receiving them. Is this a system issue with Medicare? Should we be doing something else?

The B17 denial can mean that Medicare does not have a Certificate of Medical Necessity (CMN) on file at all, but the B17 denial can also mean that the CMN is incomplete or the initial, recertification or revised CMN is not on file. Please reference the AdminaStar Federal Web site located at www.adminastar.com and click on the following links for helpful tips on how to prevent B17 denials: DMERC/Electronic Data Interchange (EDI)/Manuals/B17DENIALS.PDF. The DMERC is not aware of any current issues where the Certificate of Medical Necessity (CMN) is accepted on the electronic front end, but is not being put into the processing system. Please contact the EDI Helpdesk at (877) ASF-4EDI with specific examples for research.