Problems Plague HCFA's New Regional Carrier Transition

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By Herbert P. Weiss, N.H.A.

With the publishing of its proposed rule in the November, 1991 *Federal Register*, the Health Care Financing Administration (HCFA) moved to implement sweeping reforms to change the way durable medical equipment, prosthetics, orthotics, and supplies are covered under Medicare Part B and how supplier claims are submitted, processed and reimbursed.

The federal agency claimed that its efforts would lower costs, result in increased administrative simplicity, reduce paper work, and help eliminate fraud and abuse. But even with these good intentions, the agency's efforts to modify Medicare claims processing by consolidating 34 carriers to a streamlined four-carrier regional system (known as DMERC for "Durable Medical Equipment Regional Carrier") has been plagued with problems, snags, and snafus.

A Bumpy Road to Consolidation

"HCFA's very ambitious nine-month timetable (from January 1 to October 1, 1993) for bringing 54 states, territories, and the District of Columbia into the new DMERC system was unrealistic and virtually impossible to accomplish on schedule," said Ann E. Berriman, Esq., an attorney with the Washington, D.C. law firm of Gardner, Carton & Douglas. "Implementation problems occurred because of the large number of details that just weren't worked out properly," she said.

HCFA revised its state-by-state transition schedule four times because of glitches in phasing in the new DMERC system, Berriman told *O & P Business News*. Berriman highlighted some of the problems that occurred in creating four regional Medicare Part B carriers.

New coverage policies are restrictive. Suppliers, trade groups, and clinicians submitted over two thousand comments citing flaws, mistakes, and clinical errors in the first draft of the DMERC's medical policies, coverage rules, and medical necessity criteria. But the short timetable to develop the final version, to be printed and released in the Supplier Manual, forced HCFA to act quickly to revise the policies without further outside input. The negative backlash against this action forced the agency to release all of its policies with the exception of six product categories (including lower limb prostheses, which are still under development).

The DMERC's final policy covering orthotic products is restrictive and generally requires more extensive supporting documentation when submitting a claim. Claims for lower limb prostheses must still be submitted to the DMERCs after the transition date, however, they will be processed using the previous claims processing and medical necessity rules, until a final coverage policy is developed by the DMERCs.

Improperly filled out CMNs slows payment. Although the DMERCs have sponsored seminars about newly standardized Certificate of Medical Necessity (CMN) forms, the burden of educating physicians about CMN requirements has fallen to suppliers. The new CMN forms are more detailed and time consuming to fill out. This, combined with the fact that physicians have not been educated about how to correctly fill them out, could cause delayed payment or denials.

For the first time, carriers are now sending CMNs directly to physicians for claim development which might cause delays in claim payment if they don't resubmit the CMN and requested supporting documentation on a timely basis.

HCFA fails to meet its own deadline. The transition schedule was temporarily halted because HCFA was late in releasing its Request for Proposal inviting carriers to bid on becoming one of the four regional DMERCs and then awarding the DMERC contracts to: Travelers Insurance Company, Wilkes-Barre, PA (Region A); AdminaStar Federal, Indianapolis, IN (Region B); Palmetto Government Benefits, Columbia, SC (Region C); and CIGNA, Nashville, TN (Region D). This action caused the target transition schedule to be pushed back from July, 1992 to October, 1992.

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PROBLEMS PLAGUE REGIONAL CARRIER TRANSITION

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"It has been difficult for DMERCs to set up the EMC process to allow suppliers to electronically file claims on a timely basis."

Problems in enrolling and receiving a supplier number from Medicare's National Supplier Clearing House also occurred because of missed deadlines. The agency struggled to develop its new supplier application (HCFA Form 192), resulting in applications being mailed out late to 170,000 Medicare Part B physicians and suppliers. Many of these suppliers failed to return the form promptly because of the difficulty of filling it out correctly.

Finally, intense controversies over new medical policies by DMERC Medical Directors and a delay in publishing of a Supplier Manual 45 days before the start of the transfer to the regional carriers also held up the transition process.

Filing claims by computer is confusing suppliers. HCFA has made it extremely clear to suppliers that it prefers claims for Medicare Part B supplies to be submitted by Electronic Media Claims (EMC). However, the agency had significant delays in developing the National Standard Format (NSF), which was to provide a uniform system for the electronic processing of all Part B claims and eliminate incompatible formats. The NSF was not available in completed form to suppliers and their software vendors until the Fall of 1993.

It has been difficult for DMERCs to set up the EMC process to allow suppliers to electronically file claims on a timely basis. First, DMERCs have experienced technical problems in developing their own PC-modem software packages for submitting claims under the new processing system. Software packages are just now reaching suppliers weeks after their state has been brought into the new system. Second, few software vendors have received the DMERC's "seal of approval" for their software packages, reducing the variety and availability of packages on the market. As a result, many suppliers wanting to submit claims by EMC to the DMERCs have not yet been tested and must either file claims

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by paper or hold their claims until they get EMC capability. Those suppliers lucky enough to have been tested describe the process as very confusing and time consuming.

Advanced payment mechanism not triggered. Under some circumstances, suppliers may be eligible to receive advanced payments (about 50% of their documented Medicare accounts receivable) if a long delay in the claims processing occurs during the transition period as a result of a system-wide problem. But if claims can't be put into the system because the supplier hasn't been tested or a supplier's claims have been rejected, the advanced payment mechanism can't be triggered.

As the regional carrier system phase-in continues, monitoring the transition and becoming more knowledgeable about the newly evolving system and how it could affect their practice will help suppliers to financially survive.

Herbert P. Weiss, a licensed nursing home administrator, is a Providence, Rhode Island-based free-lance writer covering health care and aging issues.

NEXT: Easy Tips on Making it Through Carrier Consolidation

SIX REASONS For Pending, Denied and Further Developed Claims

Although there are current systemic problems that result in a pending, denied, or a further developed claim, suppliers can watch out for and minimize these six common mistakes that happen when claims are filled out:

1. No referring physician number on claim.
2. Putting a claim in for noncovered items.
3. Invalid supplier numbers.
4. Incomplete CMNs.
5. Diagnosis not shown on claim.
6. Date of birth on claim doesn't match date of birth shown for the patient.

Source: Tim Redmon, NARD's Director of Home Health Care, Regulatory Affairs, and LTC Pharmacy Services, 205 Daingerfield Road, Alexandria, VA 22314, (703) 683-3619.

FIELD FACTS

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Report from California

Vogue Prosthetic Orthotic Center, Inc. and Reseda Prosthetics are located near the epicenter of the recent California earthquake (Northridge).

Karen Friedlander of Vogue Prosthetic Orthotic Center told *O & P Business News* that although they suffered no structural damage, they see tremendous damage to many buildings as they look out the front window. One company employee has had to move from home because of earthquake damage.

At Reseda Prosthetics, a block wall behind the company's building fell, according to Marlene Collins. However, there was no structural damage to their building. There was quite a cleanup job and some damage to equipment and supplies inside, but no employees were injured in the quake.

Otto Bock Closing Winnipeg Facility

Otto Bock Orthopedic Industry recently announced plans to close their Winnipeg, Manitoba manufacturing facility in 1994. Manufacturing operations will be moved back to Germany in an effort to reduce overhead and also to consolidate research and development, engineering, and production.

This last summer, wholesale distribution operations were transferred from Winnipeg to Oakville, Ontario (a suburb of Toronto). These changes will allow Otto Bock in North America to restructure and to focus exclusively on its sales and distribution operation as well as its efforts to address the educational and support needs of its customers. &p

Nine Survival Tips on Coping with DMERCs

By Herbert P. Weiss, N.H.A.

This is the last in a two-part series on surviving regional carrier consolidation.

Quickly adapting to new medical policies, documentation and billing procedures under a new, more streamlined Medicare Part B four carrier regional system will allow orthotic and prosthetic suppliers to continue in business and prosper. Unfortunately, snags in the phase-in of the regional carriers (known as DMERC for "Durable Medical Equipment Regional Carrier") have put some suppliers at a disadvantage and have forced others into serious financial difficulties, says Medicare legal expert Ann E. Berriman, a health care attorney with the Washington, D.C. office of the law firm of Gardner, Carton & Douglas. The financial stakes are high if you don't develop a realistic response to the continually evolving changes, she notes.

Berriman offers the following nine suggestions to help orthotic and prosthetic suppliers weather the regional carrier transition.

1.

Electronic billing will help ensure faster payment. The DMERCs are pushing hard to get as many suppliers as possible to submit Medicare Part B claims electronically by offering them low-priced, even free, software packages. Additional advantages include electronic transmission of Explanation of Medical Benefits (EOMBs), electronic transfer of reimbursement directly into a suppliers' bank account, as well as on-line inquiries and status reports of claims. Also, claims submitted by electronic media (EMC) can increase a supplier's cash flow since payment can be made after a 13-day waiting period versus the mandatory 26-day floor for paper claims. The regional carriers also save money in personnel and other costs — in fact, cutting their processing costs in EMC claims as much as 50% over the cost of a paper claim.

Filing claims electronically can also minimize detailed and time-consuming up-front medical review of a claim before it is processed with EMC. The presumption favors the supplier — more claims are paid first and only a sample audited later to assure quality control in processing.

It must be remembered, however, that along with these benefits come responsibilities. All EMC suppliers must sign an EMC Agreement that requires that **all** source documents be kept on site and be virtually immediately accessible to DMERC review. Source documents include, but are not limited to:

- Original authorizations of benefits;
- Certificates of Medical Necessity (CMNs);
- Prescriptions;
- Physician Orders; and
- Other medical documentation used to support claims.

2.

Keep current on national standards format (NSF) and all EMC and claims filing requirements. This can be extremely crucial to maintaining good cash flow for your facility. Right now, and for the next year or so at least, there are changes being made to the system and the software daily. Watch your DMERC bulletins and keep up to date with the O & P profession to keep with all the changes. Currently, most of the DMERCs are providing bulletins and updates to suppliers at least every four to six weeks, if not more frequently. Review the bulletins for billing tips and save them all for future reference.

3.

Carefully read the DMERC Supplier Manual issued to you. If you are providing services in more than one region, make certain to compare and contrast the two manuals you received. The manuals are similar, but not identical. Unlike the old days when a supplier could often legitimately assert that the Part B claims processing rules were vague and varied from carrier to carrier, now all suppliers will be held to a standard of **knowing,** inside and out, all the information contained in the 300-plus page Supplier Manual.

4.

When in doubt, contact your DMERC and SADMERC (Statistical Analysis DMERC). Be careful, however, when doing this. The DMERC staffs are well-intentioned, but often times they are hastily and poorly trained. Use common sense when working with your DMERC. Check and recheck the information you receive and always try to keep good documentation of your calls. Whenever possible, try to get any advice you receive from the DMERC or SADMERC confirmed in writing. If they won't put their answer in writing, you might try confirming their over-the-telephone response in a short letter to them. Always make it clear that you are relying on your understanding of the advice they give you and, if it is flawed in any way, they must contact you to correct your understanding.

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NINE SURVIVAL TIPS ON COPING WITH DMERCS

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5.

Learn the new medical policies and coverage guidelines for your DMERC(s). While there have been more dramatic changes in these coverage policies for durable medical equipment and supplies, there have also been significant, if subtle, variations in orthotic and prosthetic medical policies. Don't assume just because you understood the way your previous local carrier viewed the products you furnish that your DMERC has adopted those views or will be judging your claims in the same fashion. Unfortunately, O & P facilities are at a disadvantage in this instance, since the final medical policies on lower limb prosthetics are not yet finalized or available to suppliers. In the interim, you will have to try to read between the lines on the available policies and use common sense (or a crystal ball, if you have one). Always keep in mind that HCFA has reserved the right to review these claims on a post-payment audit basis to determine whether the paper products have been supplied and reimbursed.

6.

Educate all referral sources about new DMERC medical policies and documentation requirements. It is crucial for suppliers to educate all referral sources about the new Medicare Part B rules, especially prescribing physicians. Teach physicians about the new coverage requirements that affect their patients and your reimbursement. You can save yourself both time and money if the physicians that prescribe the items you fabricate write complete orders and/or fill out Certificates of Medical Necessity properly. Failure to anticipate the information and documentation your DMERC expects is likely to cause delays and possibly outright denial of your claims. At that point, you will have to go back and get the documentation and appeal your claim to get reimbursed.

7.

Consider your status in the Medicare program. If you are a participating supplier under the old system, you automatically become participating with the DMERCs unless you opted out **in writing** at the end of calendar year 1993. If you are participating, it means you must accept assignment for all Medicare covered items for every Medicare patient you service. Not even a claim for a replacement stump sock or mastectomy bra may be done on the basis of a private retail transaction.

If you are participating, be mindful of your rights and responsibilities. While you **must** accept assignment on all Medicare claims and therefore cannot charge either the patient or another party anything over the Medicare allowable, you can have the DMERC automatically file your coinsurance claim for you electronically with any official Medigap insurance program. And don't forget, you are listed in the participating supplier (MEDPARD) directory and you get a decal for your office door declaring your status as a participating supplier.

8.

Don't forget that, regardless of your participation status, all suppliers must file claims (but need not accept assignment) for Medicare beneficiaries. If you are nonparticipating and choose not to accept assignment, the Medicare fee schedule amount will go straight to the beneficiary. You do have up to a year to file these claims, however.

9.

Develop company policies regarding when you will accept assignment (assuming you are nonparticipating) and when you feel you need the protection of an advance notice to the beneficiary. You should consider advance notice to the beneficiary when you are unsure whether the item(s) you are supplying to a patient will be considered "medically necessary" by the DMERC. If you have doubts, you should use the Advance Notice procedures explained in your Supplier Manual. Remember, notice of possible denial by Medicare must be furnished in writing, in advance, and include the beneficiary's promise to pay if Medicare does not. It also must specifically list the items being supplied, as well as a reason Medicare is not likely to consider the product medically necessary. Failure to follow this procedure exactly may result in increased bad debt for your Medicare receivables.

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