

MEMORANDUM....

DATE: August 3, 2000
TO: All NPPV Customers
FROM: Jacki McClure, BS, RRT, Respironics Government Relations
RE: DMERC “Pre-payment Letters”

Recently, several HME providers advised Respironics that select DMERCs are now requesting specific documentation to support the medical need for Respiratory Assist Devices on a frequent basis. To help prepare all Respironics customers for this situation, the Respironics Reimbursement Support Line contacted each DMERC to inquire about this practice. The following provides detailed information specific to our findings.

As stated in Medicare’s Compliance Program Guidelines, claims submitted to the DMERCs for items and services are eligible for payment only if the item is (1) ordered, (2) provided, (3) covered and (4) considered reasonable and necessary for a Medicare beneficiary, given his or her medical condition. Upon the DMERC’s request, a provider must have available and be prepared to submit documentation supporting the medical need for the item or service provided. Requested documentation may include:

- the physician’s orders
- proof of delivery
- written confirmation of verbal orders, and
- any other documentation to support the medical need of the item or service that the DMEPOS supplier provided.¹

Additionally, each DMERC confirmed by phone that all have systems in place to generate standard follow-up letters to providers. Although the content of each letter may vary, in many cases the letters request supporting medical necessity documentation (e.g. copies of specific test results, copies of specific sections of a patient’s medical record) to ensure that the item or service is medically necessary for the beneficiary. These letters are triggered by different components, including a predetermined HCPCS code or a select provider filing the claim.

As claims will not be processed for payment until the information has been received, adding this extra step to the current claims filing process may delay payment. Therefore, to assist you in preparing for these “pre-payment requests”, we are providing *the attached copy of a sample letter from DMERC Region A*. We encourage you to keep this requested information available in the beneficiary’s medical record to ensure quick processing of your claims.

If you have any questions regarding the above information, please contact your local DMERC or your Respironics sales representative. For complex reimbursement issues, please contact the Respironics Reimbursement Support Line at 877-606-2255.

¹ *Compliance Program Guidance for the Durable Medical Equipment, Prosthetics, Orthotics and Supply Industry, Federal Register Notice, July 6, 1999*

From: Adminastarfederal

April 19, 2000

Dear Supplier:

The Region B DMERC has been requesting additional information on claims for Respiratory Assist Devices (RADs) (HCPCS codes K0532 and K0533) which were initially provided on or after October 1, 1999. One of the questions on the development letter asks for a "copy of the test reports documenting that the coverage criteria specified in the medical policy have been met". In most cases, we have not been receiving the documentation that we requested. We need copies of the actual test reports generated by the laboratory, hospital, physician office, other testing facility, etc. Summaries, abstracted values, and/or supplier-created forms are not sufficient. Failure to submit the requested documentation will result in the denial of the claim in question and subsequent claims until documentation is received verifying that coverage criteria have been met.

Depending on the patient's diagnosis-Group I (Restrictive Thoracic Disorders), Group II (COPD), Group III (Central Sleep Apnea), or Group IV (Obstructive Sleep Apnea) - one or more of the following test reports must be submitted. The minimum data elements that the reports must include are also listed. Refer to the policy for information on which tests are required to document medical necessity of a RAD for specific diagnoses.

An additional reminder. For devices initially provided on or after 10/1/99, a ZX modifier may be added to the claims for the first through third months only if all of the coverage criteria for the applicable Group (I-IV) have been met. Use of the modifier when the criteria are not met would generally be considered fraudulent billing.

Arterial blood gas

- Name of the entity performing the test
- Test date
- Whether the test was performed on room air or on oxygen (and if on oxygen, what was the liter flow)
- PO₂, PCO₂, pH

Sleep oximetry

- Name of the entity performing the test
- Test date
- Whether the test was performed on room air or on oxygen (and if on oxygen, what was the liter flow)
- Whether the test was performed with the patient on a RAD, if applicable (and if so, the type of device and the pressure settings)
- Duration of individual episodes of continuous desaturation to $\leq 88\%$ or the duration of the longest episode of continuous desaturation to $\leq 88\%$ (A value for the total duration of the episodes of desaturation to $\leq 88\%$ is not sufficient.)

Polysomnogram

- Name of the entity performing the test
- Test date
- Whether the test was performed on room air or on oxygen (and if on oxygen, what was the liter flow)
- Whether the test was performed with the patient on a RAD or CPAP (E0601), if applicable (and if so, the type of device and the pressure settings)
- Duration of recorded sleep
- Number and type (e.g., central, obstructive, etc.) of recorded episodes of apnea
- Statement of physician interpretation (e.g., OSA, CSA, other diagnosis)
- For CSA - the duration of individual episodes of continuous desaturation to $\leq 88\%$ or the total duration of the longest episode of continuous desaturation to $\leq 88\%$ (A value for the total duration of episodes of desaturation to $\leq 88\%$ is not sufficient.)
- For OSA - the results of testing on CPAP (E0601)

Maximum inspiratory pressure or Forced vital capacity

- Name of the entity performing the test
- Test date
- Test result