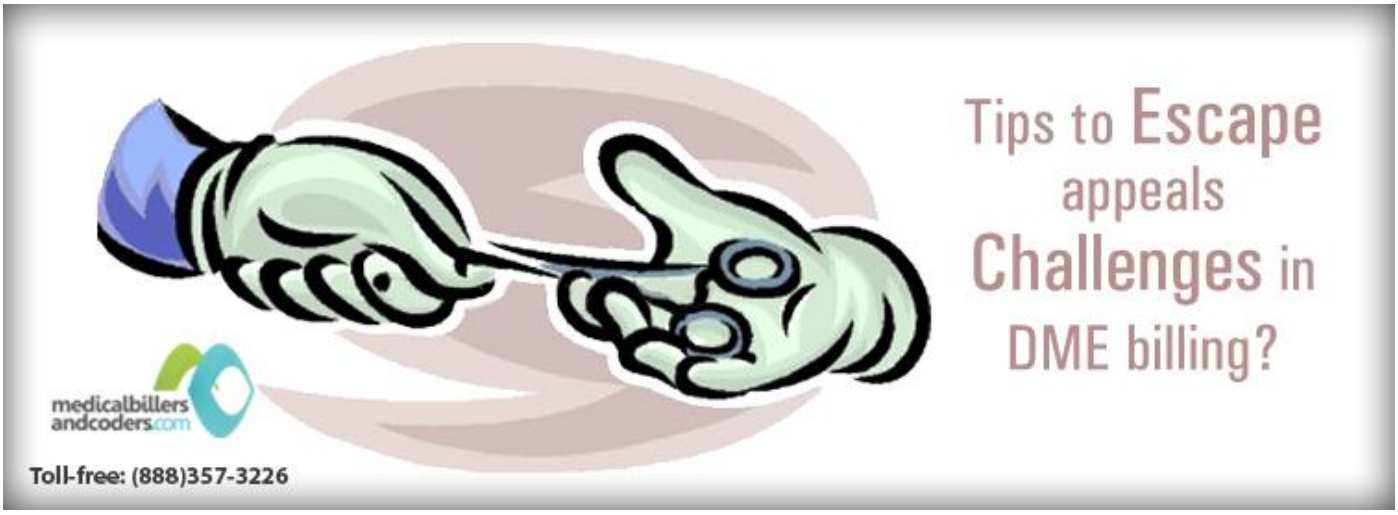

Tips to escape appeals challenges in DME billing?

DME billing sees a high denial rate and given the various problems faced by the service. Know how to deal with them.

There exist many reasons for denial of medical claims. Given the new regulations by Centres for Medicare/Medicaid, DME claim denials are stated to be very high. It is well known that DME services are but ancillary to the primary clinical purpose, and hence DME services have often been underpaid or even denied payments because of the various challenges physicians face when submitting their claims. It has been reported that CMS has seen dramatic drops in utilization rates in bid areas for critical medical equipment such as oxygen therapy, power wheelchairs, and hospital beds. To add to this, thousands of Medicare beneficiaries are reporting problems accessing equipment prescribed by their physicians, as well as delays in receiving it. Although physicians have a right to recommend DMEs, yet without showing medical necessity, they may lose out on reimbursements. Further, the appeal processes can be resource intensive in terms of both time and human resource, ie clinical staff. Evidence indicates that the number of DME businesses continues to decline, and many others struggle financially, given the delays in reimbursement which is costing the industry to suffer and thereby the patients. The laws are only going to get tougher, and in such an environment following certain simple but efficient ways to keep reimbursements flowing in is to decrease denials.

By following certain simple processes one can bring down the denial claims and thereby the need to appeal

- **Verification** of patients insurance coverage supports DME services is very essential initially
- Documentation of the patient's health is extremely crucial, especially when DME billing is brought into the picture. In case of an appeal, the physician will need to prove that a face-to-face examination of the

beneficiary had taken place for the purpose of determining the medical necessity, especially when it pertains to a power mobility device (pmd), as part of the overall treatment. Hence keep a **well-documented file on the patient's medical history** if vital importance.

- A **prescription for the DME must** be issued and furnished to the supplier within 45 days after the examination along with documentation which includes pertinent portion of the patient's medical records that **support the medical necessity**
- It is very necessary to **demonstrate the medical necessity of DME** such as power wheelchairs, scooters which are provided to the beneficiaries, in order to receive reimbursements against that. The medical records should include the patient's diagnosis and other pertinent information, including duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related item
- Keep **updated about Medicare Regulations** given the continuous changes that have been set in motion since 2011
- **Competitive bidding of DMEs** – Since Medicare/ Medicaid Centres have put a ceiling on DMEs reimbursements, physicians should take cognizance of what DMEs can be employed by their patients given their insurance eligibility
- Lastly, having **a trained staff**, who is well aware of the regulations and changes and patient's insurance eligibility is very essential to bring down the denial claims and thereby decrease the appeals

To maintain focus on patients health, the areas that require regulatory updates constantly and knowledge in Coding systems and use of modifiers, may be outsourced to experts. This will help to improve reimbursements given that the required expertise will be able to do just what needs to be done even before submission.