



EDUCATIONAL RESOURCES

# SUCCESSFULLY MOVING INTO THE RETAIL MARKET

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# INTRODUCTION

# INTRODUCTION

- Medicare came into existence in 1965. The first generation it took care of was “The Greatest Generation”—the World War II folks.
- The DME industry came into existence in the mid to late 70s.
- Understandably, the 23 million of the Greatest Generation believed that Medicare should pay for all or most of their health care needs, including DME.
- “Back in the day,” the DME supplier’s business model was relatively simple:
  - The supplier would receive a physician’s order and would hand the product to the Medicare beneficiary.
  - The biggest challenge for the supplier was to learn how to properly bill Medicare.
- Reimbursement was high, audits were practically nonexistent, and competitive bidding was not even a concept.
- Well, that was then, and this is now.

# INTRODUCTION

- The customers have changed and the DME suppliers have changed.
- Customers - The Greatest Generation is pretty much gone. It has been replaced by 78 million Baby Boomers who are retiring at the rate of 10,000 per day.
  - Unlike earlier generations, Boomers are going to live well into their 80s.
  - Unlike earlier generations, Boomers understand that they have to pay cash for at least some of their medical care.
  - Boomers want to live active lives until the very end.
  - Many Boomers are willing to pay cash for the Cadillac product as opposed to having Medicare pay for the Cavalier product.

# INTRODUCTION

- DME Suppliers - Unlike in past decades, today's DME suppliers are facing (i) reduced reimbursement, (ii) stringent documentation requirements, (iii) aggressive audits, and (iv) competitive bidding.
  - Suppliers can no longer rely on the old business model. Said another way, suppliers cannot base their success on receiving physician orders and knowing how to bill Medicare.
  - Suppliers must be innovative in their marketing. They must market to referral sources and to patients themselves (and their caregivers).
  - Suppliers must lessen their dependence on Medicare fee-for-service ("FFS"). An important way to do this is to focus on selling products for cash.





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# CASH SALES: OPERATIONAL ISSUES

# WHY CASH SALES?

## Decreasing

- ↓ Hospital Stays
- ↓ Government Reimbursement
- ↓ HMO Coverage
- ↓ Extended Family Care
- ↓ Seniors as Customers
- ↓ Demand for basic “Good” Products

## Increasing

- ↑ Aging Population
- ↑ “Quicker & Sicker” Patient Discharges
- ↑ Health & Wellness
- ↑ Self-Care
- ↑ Baby Boomers as Customers
- ↑ Demand for “Better/ Best” Products

# RETAIL SHOWROOM

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- Retail Location:
  - Visible – Easy to find
  - Accessible – Easy to drive into and park
  - Convenient – Located near other retail shopping
  - Co-Located – Close to chain pharmacy
- Average Showroom Size:
  - Stand-alone DME - 1,000 – 1,500 sq. ft.
  - DME/Pharmacy - 400 – 800 sq. ft.



# INTAKE VS. CASH SALES

## Traditional Intake

“What insurance do you have?”

Show reimbursable product

Process insurance

Eligibility

Intake

Dr’s order

Authorization

*= 1 hr.*

*= 1 product/patient*

## Cash Sales

“Who is the end-user?”

“What is his medical condition and need?”

Display all available products that meet his needs

Cross-sell and up-sell

*= 20 min.*

*= 2 products/customer*

# “CAN RETAILERS HALT SHOWROOMING?”

- Brick and Mortar vs. Internet Only
- Best Buy vs. Amazon
  - Customers shop in retail store for brand and complete product selection
  - Customers buy online for price (and free shipping)
    - 50% of consumers who buy products online have already shopped for them in a traditional retail store
    - Chains are offering free shipping – and matching competitor’s online pricing – for their best customers

# SUCCESSFULLY SELLING AGAINST THE CHAINS

## Boutique Business Basics

Specialty/Niche Retailer

More knowledgeable salespeople

Deeper selection, higher margins

Experiential store environment

“Our Customer Care Program”

(or Pledge or Guarantee)

## Sell the Package (or Brand!)

Medical grade product = Brand = 30% added value

Consumer education

Product demonstration

Delivery

Customer service follow-up

24/7 support

Recall notification

Warranty support

Repair service w/o shipping cost or wait period

# BEST PRACTICES

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- Display to Sell
  - Display products out-of-the-box and on the floor for customers to touch, try and then buy.
- Complete Retail Selection
  - Good/Better/Best product options for core products within each category generate higher sales-per-customer.
- Multiple Products Per Customer
  - Displaying “better” and “best” product options generate higher profits by adding-on the related cash products in addition to basic “good” items.

# TOUCH, TRY, AND BUY





# ROOM DISPLAYS



◀ Before

After ▼



Display, don't store -- Offer product mix -- Use retail packaging -- Use branded product -- Use category signs

# MERCHANDISING

- ✓ Avoid Clutter
- ✓ Use Retail Packaging
- ✓ Choose Category Captain
- ✓ Use Distribution
- ✓ Offer Basic + Upgrade Product Options



# BEST PRACTICES

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- The primary referral sources for cash sales are
  - Chain pharmacists
  - Assisted living facilities
  - Independent living facilities
  - Urgent care offices



# DOES YOUR HOSPITAL BED LOOK LIKE THIS?





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# SEPARATE LEGAL ENTITY FOR RETAIL BUSINESS



# REASONS FOR A SEPARATE LEGAL ENTITY

- There are 4 fundamental reasons behind setting up ABC Retail as a separate legal entity:
  - Exposure to Audits – ABC Medical is at risk for recoupment liability in the event of an aggressive audit. If ABC Retail is only a “division” or “DBA” of ABC Medical, and if ABC Medical does get hit with a large recoupment, then it will also adversely affect the financial condition of the retail “division.” On the other hand, if ABC Retail is a separate legal entity, then generally speaking, any recoupment liability imposed against ABC Medical will not spill over to ABC Retail.
  - Future Sale of Retail Business – If ABC Retail is a “division” of ABC Medical, and if John Smith desires in the future to sell his retail business, but retain his Part B Business, then Smith has no choice but to have ABC Medical enter into an asset sale of its retail business. Smith will not have the option of selling his stock in ABC Medical. On the other hand, if ABC Retail is a separate legal entity, and if Smith decides in the future to sell the retail business, then he has the option of engaging in either an asset sale or a stock sale. Additionally, if ABC Retail is a separate legal entity, then it can bring in additional investors.

# REASONS FOR A SEPARATE LEGAL ENTITY

- Bringing in Investors – If the retail business is successful and needs to bring in additional investment capital in order to expand, then it can do so if the retail business is in a separate legal entity.
- Effect on Usual and Customary Pricing

# NEW LEGAL ENTITY

- Notice to Medicare Beneficiaries. Medicare will pay for medical equipment and supplies only if a supplier has a Medicare supplier number. We do not have a Medicare supplier number. Medicare will not pay for any medical equipment and supplies we sell or rent to you. You will be personally and fully responsible for payment.
- Assume that ABC Medical Equipment, Inc. has a PTAN and is located on Main Street. Assume that John Smith is the sole stockholder of ABC. Although it is not legally required, it makes good business sense for Smith to set up a new corporation with its own Tax ID #, called "ABC Retail Sales, Inc."
- ABC Retail will not have a PTAN
- ABC Retail will be located on Elm Street. Or it can be located on Main Street next to ABC Medical, with ABC Medical being in Suite A and ABC Retail being in Suite B. The bottom line is that ABC Medical and ABC Retail will be physically separated from each other.
- Each corporation will have its own employees, own bank account, etc. In short, each corporation will be operated as a distinct entity.

# NEW LEGAL ENTITY

- When a customer wants the Cadillac product and services, then he can pay cash for the product at ABC Retail. If a customer wants Medicare to pay for the product, then he can obtain the product from ABC Medical.
- ABC Retail will stock only "Cadillac" products. ABC Medical will stock a variety of products, including "Cavalier" products.
- It will be important for ABC Medical and ABC Retail to truly operate as separate legal entities (e.g., no commingling of money). This way, someone suing one of the companies will not be able to "pierce the corporate veil" and sue the other company as well.
- ABC Retail needs to be aware of 42 U.S.C. 1395m(j)(4)(A), which states that if a supplier furnishes DME to a Medicare beneficiary, for which no payment may be made because the supplier does not have a Medicare supplier number, then any expenses incurred for the DME will be the responsibility of the supplier.

# NEW LEGAL ENTITY

- This means that the ABC Retail customer will have no financial responsibility for the product, and ABC Retail will be required to refund the customer, unless before the product was furnished,
  - (i) the customer was informed that Medicare would not reimburse the customer for the product and
  - (ii) the customer agreed to pay cash knowing that he would not be reimbursed.
- In order to meet this requirement, when a customer walks into ABC Retail and if the employee suspects that the customer is covered by Medicare, then the employee may want the customer to sign an ABN.
- Alternatively, ABC Retail may want to make the calculated decision that having suspected Medicare customers sign an ABN will have a “chilling” effect on the retail experience for the customer. Therefore, ABC Retail might decide not to require a suspected Medicare customer to sign an ABN; and then in those few instances when a Medicare customer subsequently complains that he was unaware that Medicare would not reimburse him, ABC Retail will reimburse the customer.



# NEW LEGAL ENTITY

- ABC Retail should also post signs that are conspicuous to the public, that say that ABC Retail is not a Medicare supplier.
- ABC Retail sells items for cash over the internet. ABC Retail's web page should have a disclaimer in large bold type appear as soon as the customer clicks on a link to view DME, as well as immediately prior to check-out.
- If a customer walks into ABC Retail and says that he wants Medicare to pay for the product, then ABC Retail can refer the customer to ABC Medical. Conversely, if a customer walks into ABC Medical, does not like the product selection, and is willing to pay cash for a higher-end product, then ABC Medical can refer the customer to ABC Retail.
- Even though the two companies will have the same owner (John Smith), the companies are nevertheless separate legal entities (each with its own Tax ID #). And, so the relationship between the two companies needs to be the same as if they were not owned by the same person. Therefore, there can be no money going back and forth between the two companies that is tied to referrals.



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# DME SUPPLIER HAS NO PTAN

# DME SUPPLIER HAS NO PTAN

- Certain disclaimers must be made when a supplier sells, without a PTAN, DME to a Medicare beneficiary. 42 U.S.C. §1395m(j)(4)(A) states that if a supplier furnishes DME to a Medicare beneficiary, for which no payment may be made because the supplier does not have a Medicare supplier number, then any expenses incurred for the DME will be the responsibility of the supplier.
- The beneficiary will have no financial responsibility for the expenses, and the supplier will refund any amounts collected from the beneficiary, unless before the DME was furnished, the beneficiary was informed that Medicare would not pay for the DME and the beneficiary agreed to pay for the item.
- Assume that a DME supplier, without a PTAN, desires to sell items for cash over the internet.
- The supplier's web page should have a disclaimer appear in bold type appear as soon as the customer clicks on a link to view DME as well as immediately prior to check-out.

# DME SUPPLIER HAS NO PTAN

- Notice to Medicare Beneficiaries. Medicare will pay for medical equipment and supplies only if a supplier has a Medicare supplier number. We do not have a Medicare supplier number. Medicare will not pay for any medical equipment and supplies we sell or rent to you. You will be personally and fully responsible for payment.
- No restrictions on the prices that the supplier sets for items not covered by Medicare.



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# CASH PRICES THAT CAN BE CHARGED



# HAS PTAN – PROVISION OF DISCOUNTS TO CASH CUSTOMERS

- Assume that the supplier is non-participating, provides a covered item on a non-assigned basis, and desires to charge less than the Medicare allowable.
- There is a federal statute that says that a DME supplier is prohibited from charging Medicare substantially in excess of the company's usual charges, unless there is good cause.
- The current regulations do not give any guidance on what constitutes "substantially in excess," "usual charges," or "good cause."
- The clearest guidance comes from a 2003 proposed rule that was not subsequently implemented. This proposed rule contemplates the "usual charge" to be either the average or median of the supplier's charges to payors other than Medicare (and some others).
- Under the proposed rule, a DME supplier's usual charge should not be less than 83% of the Medicare fee schedule amount (i.e., up to a 17% discount from the Medicare fee schedule).

# HAS PTAN – PROVISION OF DISCOUNTS TO CASH CUSTOMERS

- There would be an exception for good cause, which would allow a supplier's usual charges to be less than 83% of the Medicare fee schedule, if the supplier can prove unusual circumstances requiring additional time, effort or expense, or increased costs of serving Medicare beneficiaries.
- The proposed rule would include charges of affiliate companies into the calculation of a supplier's usual charges.
- An affiliated company is any entity that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the DME supplier.
- The proposed rule explicitly excludes fees set by Medicare, State health care programs, and other Federal health care programs (except TRICARE). By implication, charges not specifically excluded will be included.



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# CHARGING CASH CUSTOMERS LESS THAN WHAT IS BILLED TO STATE MEDICAID

# CHARGING CASH CUSTOMERS LESS THAN WHAT IS BILLED TO STATE MEDICAID

- Billing and collecting from state Medicaid programs is more expensive and time consuming for a DME supplier than collecting from a cash-paying customer. It is logical for suppliers to desire to charge a cash-paying customer less than what the supplier bills Medicaid. The question thus arises: Is it permissible for the supplier to do so?
- Most state Medicaid programs require the supplier to bill the Medicaid program its usual price.



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# UPGRADES



# UPGRADES

- When a supplier furnishes an upgraded item of DMEPOS and the supplier expects Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, the supplier must obtain an ABN from the beneficiary.
- General Instructions for the Use of ABNs for Upgrading DMEPOS Items
  - An upgrade may be from one item to another within a single Health Insurance Common Procedure Coding System (HCPCS) code or may be from one HCPCS code to another.
    - When an upgrade is within a single code the upgraded item must include features that exceed the official code descriptor for that item.
    - The upgrade must be within the range of items or services that are medically appropriate for the beneficiary's medical condition and the purpose of the physician's order.
    - ABNs may not be used to substitute a different item or service that is not medically appropriate for the beneficiary's medical condition for the original item or service.
  - The upgraded item must still meet the intended medical purpose of the item the physician ordered.



# UPGRADES

- Use of an ABN to furnish an upgraded item or service, with the beneficiary being personally responsible for the difference between the costs of the standard and upgraded item or service, does not change coverage or payment rules, statutory provisions, or manual instructions for the particular benefit involved.
- In cases where the DME MACs would make payment for the item the physician ordered on a rental basis, the supplier must furnish the upgrade on a rental basis.
- A supplier furnishing an upgrade and using an ABN must submit a claim and include information on the claim that identifies the upgrade features.
- Suppliers must submit a claim for upgraded items and services using the GA modifier on the upgraded line item to indicate that the beneficiary signed an ABN.
- Suppliers must list upgrade features using the ASC X12 837 professional claim format or on the paper Form CMS-1500 in Item 19 or as an attachment to the claim for paper claims.
- Denials should be based on medical necessity.

# UPGRADES

- Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain circumstances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price they would charge for a nonupgraded item.
  - The reason for this may be that a supplier prefers to carry only higher-level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products.
  - A supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines.
  - The supplier may also be accommodating a physician order for an upgrade.
- Suppliers are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary that they would charge for a non-upgraded item. This policy allows suppliers to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds what the non-upgraded item that Medicare considers to be medically necessary.

# UPGRADES

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- No Charge Upgrades
  - Even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed amount for a nonupgraded item that does not include features that exceed the beneficiary's medical needs.

# UPGRADES

- Billing Instructions
  - When a supplier decides to furnish an upgraded DMEPOS item but to charge Medicare and the beneficiary for the non-upgraded item
    - The supplier must bill for the nonupgraded item rather than the item the supplier actually furnished.
    - The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the GL modifier which means
      - Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN
  - Suppliers must show the upgrade using the ASC X12 837 professional claim format, or in Item 19 of a paper Form CMS-1500 claim, or as an attachment.
    - The supplier must specify the make and model of the item actually furnished, that is, the upgraded item, and describe why this item is an upgrade DME MACs are to pay based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage and payment requirements.
  - A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the nonupgraded item but not for the upgraded item.



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# PARTICIPATING VS. NON-PARTICIPATING

# PARTICIPATING SUPPLIER

- A DME supplier elects to become a “participating supplier” by completing the Medicare Participating Physician or Supplier Agreement (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms460.pdf>).
- When a DME supplier elects to become a participating supplier, the supplier agrees to accept assignment on all claims for Medicare products and services and agrees to be paid the Medicare-allowed amount as full payment, less any unmet deductible and coinsurance.
- As such, the supplier is “precluded from charging the enrollee more than the deductible or coinsurance based upon the approved payment amount determination.”



# NON-PARTICIPATING SUPPLIER

- When a DME supplier is a “non-participating supplier,” the supplier “may accept assignment on a claim-by-claim basis.”
- If a non-participating supplier accepts assignment on a claim, it agrees to be paid the Medicare-allowed amount as full payment for that particular Part B claim, except for any unmet deductible and coinsurance.
- If a non-participating supplier does not accept assignment, the supplier can collect directly from the patient for Medicare covered products and services and charge more than the Medicare allowable in such cases.
- In this instance, the supplier is required to file the claim with Medicare on a non-assigned basis on behalf of the patient, and any Medicare reimbursement is sent directly to the patient.

# SWITCHING FROM PARTICIPATING SUPPLIER TO NON-PARTICIPATING SUPPLIER

- If a participating supplier elects to become a non-participating supplier, the supplier must terminate its existing Medicare participating supplier agreement.
- To terminate an existing Medicare participating supplier agreement and become non-participating, the supplier “must notify the National Supplier Clearinghouse (NSC) in writing during the [Medicare participating supplier agreement] enrollment period.”
- The annual participation enrollment period begins on November 15 and concludes on December 31 of each year.
- Must complete CMS Form 460
  - <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS460.pdf>



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# BILLING NON-ASSIGNED

# COMPETITIVE BID ITEMS

- If a non-participating supplier without a competitive bid (“CB”) contract sells or rents an item (that falls within a product category covered by CB) on a non-assigned basis to a patient residing in a CBA, the item is not covered and the patient will not be reimbursed by Medicare.
- The Act excludes from coverage instances “where the expenses are for an item or service furnished in a competitive acquisition area by an entity other than an entity with which the Secretary has entered into a contract ...”
- Additionally, the noncontract supplier is required to notify the beneficiary that it is not a contract supplier for the competitive bidding item in the CBA, and the supplier must obtain a signed ABN indicating that the beneficiary was informed in writing prior to receiving the competitively bid item or service that there would be no payment by Medicare due to the supplier’s noncontract status. 42 CFR § 414.408 (e)(3)(ii)

# RENTING A CAPPED RENTAL ITEM

- Assume that an item is reimbursable by Medicare as a “capped rental item.”
- Assume that the non-participating, noncontract supplier rents the item, on a non-assigned basis, to a patient not residing in a CBA.
- In this situation, the supplier can collect a rental amount from the patient that is higher than the Medicare fee schedule, and Medicare will pay 80% of the Medicare fee schedule rental payment to the patient on a monthly basis.



# TERM OF ABN

- Assume that an item is reimbursable by Medicare as a “capped rental item.”
- Assume that the supplier rents the item, on a non-assigned basis, to a patient not residing in the CBA. Assume that the supplier concludes that an ABN is appropriate.
- The question is this: “Is it sufficient for the supplier to issue one ABN at the beginning of the rental term, or must the supplier issue an ABN every month of the rental term?”
- A single ABN is good for one year.
- A new ABN would be required if the rental extends beyond one year, or if the reason for expected Medicare denial changes.
- For example, assume an initial ABN is issued because the patient has not met the “face to face” visit requirement. Subsequently, the patient has a physician visit and meets that requirement, but still fails to medical coverage criteria. A new ABN would need to be obtained with the new reason for expected Medicare denial of coverage.
- Note: Although a single ABN is good for one year, the supplier must still have the beneficiary complete a signature authorization for the claim form every month for items rented on a non-assigned basis.

# SUPPLIES AND ACCESSORIES

- For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), Medicare will pay for them, however all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:
  - HCPCS code of base equipment
  - A notation that this equipment is beneficiary-owned
  - Date the patient obtained the equipment
- Claims for supplies and accessories must include all three pieces of information listed above.
- Claims lacking any one of the above elements will be denied for missing information.
- Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met.

# SUPPLIES AND ACCESSORIES

- In the event of a documentation request from the DME MAC or a redetermination request, the supplier must provide information justifying the medical necessity for the base item and the supplies and/or accessories.
- Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation, and coding requirements.
- Note: drugs and biologicals are mandatory assignment items so the supplier is required to accept assignment for those items and cannot bill nebulizer drugs on a non-assigned basis.

# REPAIRS

- Repairs to equipment that a beneficiary owns are covered when necessary to make the equipment serviceable.
- If the expense for repairs exceeds the estimated expense of purchasing (or renting another item of equipment for the remaining period of medical need), no payment can be made for the amount of the excess.
- When billing for repairs, include the HCPCS code and date of purchase of the item being repaired (if the HCPCS code is not available, include the manufacturer's name, product name, and model number of the equipment), the manufacturer's name, product name, model number, and MSRP of the repair item provided, and the justification for the repair.

# COMMERCIAL INSURANCE MANDATES ASSIGNMENT

- Under the anti-discrimination provision, the supplier can adopt a policy in which (A) it bills non-assigned for Products A, B, and C and/or (B) it bills non-assigned for all products in which third party reimbursement is \$100 or less.  
This policy does not discriminate against Medicare patients because this policy applies across the board; that is, it applies equally to Medicare patients and commercial insurance patients.
- The following question arises: If the insurance company requires the supplier to bill on an assigned basis for all products, including "Product A," then does the supplier have the right (under the anti-discrimination provision) to sell/rent "Product A" to the Medicare patient on a non-assigned basis?
- The answer is "yes." The supplier has the right to choose whether to accept Medicare assignment on a claim-by-claim basis. Rather than saying it will only take assignment on claims based on a certain dollar figure, the supplier should adopt a policy that a particular item will be available to a patient if the reimbursement received meets a certain dollar threshold.



# COMMERCIAL INSURANCE MANDATES ASSIGNMENT

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- The supplier can always make that item available to a Medicare patient on a non-assigned basis.
- If the commercial insurance does not allow non-assigned claims, the item is only available to the patient if the insurance reimbursement meets the threshold dollar amount.

# SWITCHING TO MEDICARE ADVANTAGE

- Many Medicare beneficiaries are switching from Medicare fee-for-service ("FFS") to Medicare Advantage plans.
- The key question is: "Do Medicare Advantage plans allow the DME supplier to bill non-assigned or do Medicare Advantage plans require the supplier to take assignment?"
- Suppliers will need to look to the specific Medicare Advantage plan to see if the specific plan requires the supplier to take assignment or allows the supplier to bill non-assigned. If the answer is that the specific Medicare Advantage plan requires assignment, then the supplier can follow the advice set out above and only make the item available to the patient if the insurance reimbursement meets the threshold dollar amount.

# CLAIM AUTHORIZATION

- A request for payment signed by the beneficiary must be filed on or with each claim for charge basis reimbursement.
- Generally, suppliers may obtain and retain in their files a one-time payment authorization from a beneficiary (or the beneficiary's representative) applicable to any current and future services.
- The one-time payment authorization does not apply to non-assigned rental claims.
- Once the supplier has obtained the beneficiary's one-time authorization, later claims can be filed without obtaining an additional signature from the beneficiary.
- These claims may be on an assigned or non-assigned basis with the exception of DME rentals. The one-time authorization for DME rental claims is limited to assigned claims.
- The supplier will have to get a beneficiary signature authorization each month for items rented on a non-assigned basis.

# WHAT THE SUPPLIER CAN CHARGE

- The supplier can charge the patient an amount higher than the Medicare fee schedule. While the supplier can charge the patient an amount lower than the Medicare fee schedule, the supplier needs to be aware of the federal statute that says that a supplier is prohibited from charging Medicare substantially in excess of the supplier's usual and customary charges, unless there is good cause shown. See the section, below, entitled "Discounts to Cash Customers."
- In addition, the supplier needs to also be aware of (i) Medicaid statutes that say that the supplier must bill Medicaid its "usual and customary," and (ii) provisions in commercial insurance contracts that state that the supplier must give its "best price" to the insurer.

# LIMITING CHARGE

- According to CMS: “The provider may bill the beneficiary no more than the “limiting charge” for covered services.
- Should the provider bill more than the limiting charge for a covered service, the provider will have violated the non-participating agreement and may be subject to fines or penalties.
- NOTE: The “limiting charge” applies only to certain Medicare-covered services and *doesn't apply to some supplies and durable medical equipment.*

# LIMITING CHARGE

- The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them, if the services/supplies are covered by the Medicare program and are provided:
  - Physicians' services;
  - Services and supplies furnished incident to a physician's services that are commonly furnished in a physician's office;
  - Outpatient physical therapy services furnished by an independently practicing physical therapist;
  - Outpatient occupational therapy services furnished by an independently practicing occupational therapist;
  - Diagnostic tests; and
  - Radiation therapy services (including x-ray, radium, and radioactive isotope therapy, and materials and services of technicians)
- Therefore, items provided by a DME supplier are not subject to the "limiting charge" provisions.



# SELLING CAPPED RENTAL ITEMS

- Since Medicare will not pay anything for the sale of a capped rental item, an approach may be to allow the beneficiary to rent on a non-assigned basis so that the supplier receives higher reimbursement, but the beneficiary still receives paid 80% of the Medicare allowable.

# BILLING FOR ITEMS ON SAME DAY

- A supplier cannot submit some items assigned and others non-assigned on the same claim.
- It is unclear if a supplier can have two separate claims, one assigned and one non-assigned, with the same date of service, or if different dates of service are required.
- Examples:
  - Billing nutrition assigned, billing supply kits non-assigned.
  - Over the quantity of items and there is no support of medical necessity for the increase in quantity.

# CHANGING FROM ASSIGNED TO NON-ASSIGNED

- If the supplier is non-participating, then it can change to non-assigned during the rental period.
- The supplier should give the patient at least 30 days advance notice, so the patient can look for another supplier that will accept assignment if it wants to.
- Also, if the supplier changes to non-assigned for rental equipment, the supplier will have to obtain a beneficiary claim authorization signature for each month's rental.
- In a recent webinar, the DME MACs stated that a supplier cannot change from assigned to non-assigned during the course of the 36-month oxygen rental.
- B&F disagrees. Language from the Federal Register makes it clear that the supplier's notice regarding acceptance of assignment is not binding.
- CMS has said it will issue a FAQ that addresses this issue but as of yet no additional guidance has been issued.



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# PROMOTIONAL ITEMS TO CUSTOMERS AND POTENTIAL CUSTOMERS

# PROMOTIONAL ITEMS TO CUSTOMERS AND POTENTIAL CUSTOMERS

- The DME supplier can offer a non-cash/non-cash equivalent item of nominal value (i.e., retail value of not more than \$15) to customers/prospective customers covered by a government health care program.
- Over a 12-month period, the DME supplier may not give items to any one customer that have a combined retail value greater than \$75.
- If the customer is not covered by a government health care program, then the DME supplier must nevertheless determine if there are any applicable state statutes that address gifts to customers/prospective customers.





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# HEALTH FAIRS, LUNCHEONS, KIOSKS, AND OPEN HOUSES



# HEALTH FAIRS, LUNCHEONS, KIOSKS, AND OPEN HOUSES

- The DME supplier can participate in local health fairs. Similarly, the supplier can put on a short program during lunch at a senior citizens' center, at which time the supplier can distribute promotional literature.
- The DME supplier can place a kiosk in a mall that promotes the supplier's products and services. On a periodic basis, the DME supplier can hold an open house.



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# RETAIL TAKEAWAYS

# RETAIL TAKEAWAYS

- Be a resource, going above and beyond to maximize the customer experience.
- Advertising has become more dynamic and resembles traditional *retail*, not traditional *DME*. Use web-based, video-educational, and community-outreach marketing.
- Find ways to get people into your physical and/or virtual showroom. This is where you can educate customers and referral sources on products that they don't know about but may need.
- Remerchandise your store monthly/quarterly.
- Leverage your competitive advantage: being local. Customers want to touch/feel products and have local service they can count on.
- Understand the importance of the internet; the winning formula is a sharp local presence with a robust e-commerce capacity.



EDUCATIONAL RESOURCES

# QUESTIONS?

Email us at [customerservice@achcu.com](mailto:customerservice@achcu.com)





EDUCATIONAL RESOURCES

# THANK YOU

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