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Routine Billing Issues Made Easy

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INTRODUCTION

INTRODUCTION

- The durable medical equipment (DME) industry, as we know it today, has been around for about 40 years. It is a young industry.
- For the first 30 years of its existence, there was little government oversight on the DME industry.
- This has changed. Over the last 10 years, it feels like the government is making up for lost time.

INTRODUCTION

- The DME industry is caught in a "perfect storm."
  - Competitive bidding
  - Reimbursement cuts
  - Stringent documentation requirements
  - Aggressive auditors
  - Proliferation of "whistleblowers"

INTRODUCTION

- Competitive bidding ("CB") has created a two-tier system.
- Those on the lower end of the socio-economic scale likely have no choice but to accept whatever it is that Medicare pays for.
- Those on the higher end of the socio-economic scale will be inclined to pay cash for "higher end" products (Cadillac vs. Cavalier).
- Some DME suppliers will implement "economies of scale" that will allow the suppliers to succeed in the Medicare fee-for-service ("FFS") arena.
- However, these suppliers will be the exception. Most DME suppliers can no longer build their business model on Medicare FFS.

INTRODUCTION

- The successful supplier needs to go outside its comfort zone and look for new sources of business.
- Said another way, the supplier needs to lessen its dependence on Medicare FFS.
- For the last four decades, suppliers have primarily provided DME on an assigned basis. Medicare paid the suppliers directly, and the patients only had to pay their copayments and deductibles.
- Until the last several years, this worked out for DME suppliers. Until the last several years, reimbursement was high enough and audits were not onerous, meaning that this "assignment model" worked well for suppliers.

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- Under this "assignment model," on the relatively rare occasion when a supplier did bill non-assigned and Medicare was asked to reimburse the patient, such reimbursement was usually made.
- All of this has changed.

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BILLING NON-ASSIGNED

INTRODUCTION

- It is becoming cost-prohibitive for many suppliers to continue with the "assignment model." The reasons are obvious:
  - Medicare reimbursement is not sustainable.
  - It is time consuming to go through the Medicare claims submission process.
  - If the DME supplier is hit with a prepayment review, then it will not get paid until it submits documentation satisfactory to the CMS contractor.
  - Even if the supplier is paid, then it is subject to a "claw back" pursuant to a post-payment audit.
- Up to now, DME suppliers have shouldered the burden of increasingly harsh Medicare policies. The suppliers have shielded their patients from the pain being inflicted by Medicare policies.

INTRODUCTION

- Financially, DME suppliers can no longer do this. For the first time in its history, the DME industry is having to shift the burden (of complying with the increasingly harsh Medicare policies) to the suppliers' patients.
- This is unpleasant but it is the "new normal."
- What we are now witnessing are
  - (i) DME suppliers are electing to be non-participating,
  - (ii) DME suppliers are "billing non-assigned," and
  - (iii) DME suppliers are aggressively moving into the retail (cash) market.
- But as is often the case, the "devil is in the details." And so let's talk about the "details."

PARTICIPATING SUPPLIER

- A DME supplier elects to become a "participating supplier" by completing the Medicare Participating Physician or Supplier Agreement (Form CMS-460).
- 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.

SPECIAL CONSIDERATIONS FOR COMPETITIVE BID ITEMS

- If a non-participating supplier without a 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 competitive bidding area ("CBA"), the item is not covered, and the patient will not be reimbursed by Medicare.
- Section 1847 of the Social Security 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 advance beneficiary notice of noncoverage ("ABN") indicating that the beneficiary was informed in writing prior to receiving the competitive 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 NON-ASSIGNED

- 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.

RENTING A CAPPED RENTAL ITEM NON-ASSIGNED

- 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.

RENTING A CAPPED RENTAL ITEM NON-ASSIGNED

- 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 meet 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 NON-ASSIGNED

- For supplies and accessories used with beneficiary-owned equipment [equipment that is owned by the beneficiary but was not paid for by the durable medical equipment Medicare administrative contractor ("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.

SUPPLIES AND ACCESSORIES NON-ASSIGNED

- 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.
- 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 NON-ASSIGNED

- 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.

ANTI-DISCRIMINATION RULE

- The Age Discrimination Act of 1975 generally prohibits age discrimination under any program receiving federal financial assistance.
- CMS has a specific anti-discrimination rule that states that CMS can terminate a DME supplier's provider transaction access number ("PTAN") for a number of reasons, including if the supplier "places restrictions on the persons it will accept for treatment and it fails either to exempt Medicare beneficiaries from those restrictions or to apply them to Medicare beneficiaries the same as to all other persons seeking care." 42 C.F.R. 489.53.

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.

COMMERCIAL INSURANCE MANDATES ASSIGNMENT

- 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

- 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 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 it 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 FOR NON-ASSIGNED CLAIMS

- 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.

CLAIM AUTHORIZATION FOR NON-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 FOR NON-ASSIGNED ITEMS

- 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.
- 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.

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 and 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.

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RETAIL SALES

WHAT DOES THE CUSTOMER REALLY WANT?

- Do not assume that the customer is only willing to purchase what is covered. In many cases, Baby Boomers will opt for the best.
- Steer conversations toward product benefits, not product features.
- The supplier should ask its payers for upgrade exceptions in supplier contracts. Payers cannot pay for hamburger and expect filet mignon to be provided.


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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.

DME SUPPLIER HAS NO PTAN

- Assume that a DME supplier without a PTAN desires to sell items for cash over the Internet.
- The supplier's web page should have the following 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:
  - 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.

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CASH PRICES THAT CAN BE CHARGED

NO PTAN

- If a DME supplier does not have a PTAN, then there are no restrictions on the prices the supplier sets for Medicare-covered and non-covered items.

HAS A PTAN

- No restrictions on the prices that the supplier sets for items not covered by Medicare.
- If the supplier is non-participating and provides a covered item on a non-assigned basis, then the supplier can, without limitation, charge more than the Medicare allowable.

HAS A 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."

HAS A PTAN PROVISION OF DISCOUNTS TO CASH CUSTOMERS

- 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).
- 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.

HAS A PTAN PROVISION OF DISCOUNTS TO CASH CUSTOMERS

- 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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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

- The ABN is used by DME suppliers to provide notice to its Medicare patients that items or services being requested are likely to be denied by Medicare. If the ABN (Form CMS R-131) is properly executed, the financial responsibility for the service or item transfer to the patient if coverage is denied.
- The purpose of the ABN is to give notice to the patient that the patient is likely to become responsible for the costs of the service or item in advance of the service or item being provided.
- ABN notice is required to be given prior to providing the patient with the service or item . This allows the patient the opportunity to make an informed decision about the item or service.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

- If an ABN is being submitted, the supplier believes the item or service will not be covered; and the supplier does not want to provide the item or service until financial responsibility is established and payment has been made or assured. A patient cannot be billed for an item or service (other than copay and deductible) if the item or service is denied unless a valid ABN is obtained.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

- There are two circumstances when ABNs are obtained
  - One is mandatory submission and
  - One is voluntary.
- A supplier is required to submit an ABN in the following situations
  - Services or equipment are not reasonable and necessary,
  - Services or equipment are for custodial care only,
  - Services or equipment are for a hospice patient who is not terminally ill,
  - Services or equipment are for a patient whose home health services requirements are not met – not confined to the home or no need for intermittent skilled nursing care, and
  - When outpatient therapy services are in excess of therapy cap amounts and don't qualify for a therapy cap exception.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

- The ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits ("NEMB") for care that is never covered.
- The voluntary ABN serves as a courtesy to the beneficiary.

VOLUNTARY USE OF ABNS

- ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification).
- However, the ABN can be issued voluntarily in place of the NEMB for care that is never covered such as:
  - Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;
  - Care that is explicitly excluded from coverage under §1862 of the Social Security Act. Examples include:
    - Services for which there is no legal obligation to pay;

VOLUNTARY USE OF ABNS

- Examples include (cont'd)
  - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
  - Services required as a result of war;
  - Personal comfort items;
  - Routine eye care;
  - Dental care; and
  - Routine foot care.

VOLUNTARY USE OF ABNS

- The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice when using the ABN for voluntary notification.

ABN SIGNATURE AND DELIVERY

- An ABN should be presented and signed in person if at all possible.
- If an ABN cannot be executed in person, it can be completed by direct telephone contact, mail, fax, or Internet email.
- HIPAA requirements always apply.
- A response from the patient is required to validate delivery. Obviously, a return email or letter confirming would be preferred; but documented proof of delivery is sufficient. Overnight delivery notification of delivery, certified mail receipt, or return email are all sufficient.

BENEFICIARY REFUSES TO COMPLETE OR SIGN THE NOTICE

- If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign or choose an option and may list witness(es) to the refusal on the notice, although this is not required.
- If a beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/service unless the consequences (health and safety of the patient or civil liability in case of harm) are such that this is not an option.
- In any case, the notifier must provide a copy of the annotated ABN to the beneficiary and keep the original version of the annotated notice in the patient's file.

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QUESTIONS?

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THANK YOU

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