Any Willing Supplier Preparation for January 2019

CB Product Categories

- Enteral Nutrients, Equipment and Supplies
- General Home Equipment and Related Supplies and Accessories
  - includes hospital beds and related accessories, group 1 and 2 support surfaces, commode chairs, patient lifts, and seat lifts
- Nebulizers and Related Supplies
- Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories
- Respiratory Equipment and Related Supplies and Accessories
  - includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices and respiratory assist devices (RADs) and related supplies and accessories
- Standard Mobility Equipment and Related Accessories
  - includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies

Non-CB Products - Opportunities

- Urological supplies
- Tracheostomy care and supplies
- Suction equipment
- Ostomy supplies
- Surgical/Wound dressings
- Complex rehab
- Mastectomy products
- Pneumatic Compression Devices
- External Infusion Pumps
- Orthotic and Prosthetic
- High Frequency Chest Wall (vests)
- Mechanical In-exsufflation devices (cough assist)
- Therapeutic Shoes for Diabetes
- Ventilators (invasive and non-invasive)

Steps For Consideration

1. What does 855S look like?
   https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf
2. Is Accreditation P&P current?
3. Have appropriate licenses, staff certification, etc?
   https://www.palmettogba.com/licensure/licdirec.nsf/NSCLicensureMap_N
4. Staff educated on medical policies (LCD)
   www.noridianmedicare.com
   www.cgsmedicare.com

SECTION 3: PRODUCTS/ACCREDITATION INFORMATION *(Continued)*

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER

Check all that apply and submit all applicable licenses and/or certifications.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your state. The NSC MAC website at http://www.palmettogba.com/nsc may offer guidance. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

- ☐ Automatic External Defibrillators (AEDs) and/or Supplies
- ☐ Blood Glucose Monitors and/or Supplies (mail order)
- ☐ Blood Glucose Monitors and/or Supplies (non-mail order)
- ☐ Breast Prostheses and/or Accessories
- ☐ Canes and/or Crutches
- ☐ Cochlear Implants
- ☐ Commodes/Urinals/Bedpans
- ☐ Continuous Passive Motion (CPM) Devices
- ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies
- ☐ Contracture Treatment Devices: Dynamic Splint
- ☐ Diabetic Shoes/Inserts
- ☐ Diabetic Shoes/Inserts—Custom
- ☐ Enteral Nutrients
- ☐ Enteral Equipment and/or Supplies
- ☐ External Infusion Pumps
- ☐ External Infusion Pump Supplies
- ☐ Facial Prostheses
- ☐ Gastric Suction Pumps
- ☐ Heat & Cold Applications
- ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies
- ☐ Hospital Beds—Electric
- ☐ Hospital Beds—Manual
- ☐ Implanted Infusion Pumps and/or Supplies
- ☐ Infrared Heating Pad Systems and/or Supplies
- ☐ Insulin Infusion Pumps
- ☐ Insulin Infusion Pump Supplies
- ☐ Intermittent Positive Pressure Breathing (IPPB) Devices
- ☐ Intrapulmonary Percussive Ventilation Devices
- ☐ Limb Prostheses
- ☐ Mechanical In-Exsufflation Devices
- ☐ Nebulizer Equipment and/or Supplies
- ☐ Negative Pressure Wound Therapy Pumps and/or Supplies
- ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies
- ☐ Neurostimulators and/or Supplies
- ☐ Ocular Prostheses
- ☐ Orthoses: Custom Fabricated
- ☐ Orthoses: Prefabricated (custom fitted)
- ☐ Orthoses: Off-the-Shelf
- ☐ Osteogenesis Stimulators
- ☐ Ostomy Supplies
- ☐ Oxygen Equipment and/or Supplies
- ☐ Parenteral Nutrients
- ☐ Parenteral Equipment and/or Supplies
- ☐ Patient Lifts
- ☐ Penile Pumps
- ☐ Pneumatic Compression Devices and/or Supplies
- ☐ Power Operated Vehicles (Scooters)
- ☐ Prosthetic Lenses: Conventional Contact Lenses
- ☐ Prosthetic Lenses: Conventional Eyeglasses
- ☐ Prosthetic Lenses: Prosthetic Cataract Lenses
- ☐ Respiratory Assist Devices
- ☐ Respiratory Suction Pumps
- ☐ Seat Lift Mechanisms
- ☐ Somatic Prostheses
- ☐ Speech Generating Devices
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – New
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – Used
- ☐ Surgical Dressings
- ☐ Tracheostomy Supplies
- ☐ Traction Equipment
- ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies
- ☐ Ultraviolet Light Devices and/or Supplies
- ☐ Urological Supplies
- ☐ Ventilators: All Types–Not CPAP or RAD
- ☐ Voice Prosthetics
- ☐ Walkers
- ☐ Wheelchair Seating/Cushions
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories
- ☐ Wheelchairs—Standard Manual
- ☐ Wheelchairs—Standard Manual Related Accessories and Repairs
- ☐ Wheelchairs—Standard Power
- ☐ Wheelchairs—Standard Power Related Accessories and Repairs

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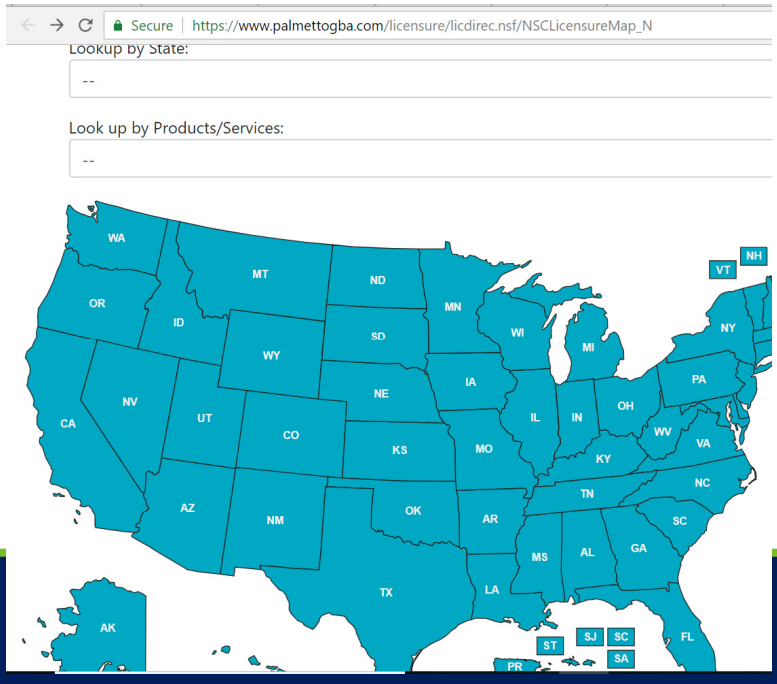
https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf



Enrollment Status – Participating / Non Participating

- Suppliers have a choice to become a participating or non-participating Medicare supplier
- The option of participating or non participating belongs **solely to the supplier**
- Suppliers can change their participation status annually. Participation status is part of the enrollment process through the National Supplier Clearinghouse (NSC)

  ~ Open enrollment occurs every **November 15- December 31**
- Must be post marked by Dec. 31 to change status for Jan. 1
- Enrollment status follows Tax ID, i.e. hospital based DMEs may be under same tax ID as hospital
- NSC contact #866-238-9652 – will tell you enrollment status or www.medicare.gov

Participating

- Participation means the supplier **always agrees to accept assignment** for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year
- By agreeing, the supplier **always** accepts the **Medicare allowed amount as payment in full** and doesn't collect more than the deductible and coinsurance from the beneficiary
- By accepting assignment, the payment is sent to the supplier
- If want to change from non-participating to participating, **complete form CMS-460**
- Suppliers awarded a CB contract must accept assignment on CB items **(Let's chat about 2019)**
  - **Can still be enrolled as non-participating**
- **DME suppliers get a higher reimbursement for accepting assignment - HOGWASH**

Non-Participating

- Suppliers who choose not to sign the participation contract are referred to as **non-participating suppliers**
- The non-participating supplier can choose on a claim by claim basis whether or not to accept assignment, except where CMS regulations require mandatory assignment
- Non participating suppliers are not required to file a claim to secondary insurance
- Suppliers are able to collect the **payment upfront** from the beneficiary Charge is –usual and customary, **no limiting charge**
- Non-assigned claims, the Medicare payment (80% of allowed amount) is sent to the beneficiary (if approved)
- Non-participating suppliers are required to accept assignment when beneficiary has both Medicare and Medicaid

What Else With Non-assigned?

- Beneficiary authorization is required each month prior to billing non-assigned claim for rental items
- If switching from assigned to non-assigned on a claim (rental), need to notify beneficiary in advance for authorization
- Either give beneficiary option of choosing item that supplier does accept assignment
  - Or, beneficiary can find a supplier that accepts assignment for that item
  - Insurance doesn't pay for the Cadillac – they pay for want is medically needed
- Fragmented Billing – cannot have assigned & non-assigned items on same delivery ticket on same DOS

What to change your status to Non-Participating?

- Mail a letter to the NSC
- Should use company letterhead
- State in the letter that your company is changing enrollment status to non-participating starting in January 2019
- Include PTAN, NPI, TIN, and contact information
- Good to go on January 1, 2019– will not receive confirmation from NSC
- This does not mean processes have to change right away –change when ready
- Mailing Address:

  National Supplier Clearinghouse

  Palmetto GBA, AG-495

  PO Box 100142

  Columbia, SC 29202-3142

https://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/National%20Supplier%20Clearinghouse

Non-Assigned Example For Consideration

- The allowable for the E0986 is $5685.96 after 13 months of rental.
- If you can't accept that amount and need to collect more from the patient the only way is go non assigned in the first month collecting the first month rental fee $541.42 plus the amount you need over the total allowable.
- If you need $6000 for this item then you can collect $855.46 from the patient in the first month then bill $855.46 non assigned.
- Make sure you let the patient know in writing that they will only receive 80% of the Medicare allowed amount of $433.14 if approved.
- Then in months 2-13 switch back to assigned.

Make sure the patient knows the reason and the process of the entire transactions.

Apply this to any capped rental equipment

Non-Assigned Example Consideration

- The allowable for the **E0601** is $415.70 after 13 months of rental.
- If you can't accept that allowable and need to collect more from the patient the only way is go non assigned in the first month collecting the first month rental fee $39.59 plus the amount you need over the total allowable.
- If you need $650 for this item then you can collect $273.89 from the patient in the first month then bill $273.89 non assigned.
- Make sure you let the patient know in writing that they will only receive 80% of the Medicare allowed amount of $31.67 (if approved).
- Then in months 2-13 switch back to assigned.

Make sure the patient knows the reason and the process of the entire transactions.

Apply this to any capped rental equipment

Other Payers

- 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.

Switching to Medicare Advantage

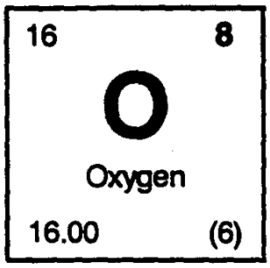
- Many Medicare beneficiaries are switching from Medicare fee-for-service ("FFS") to Medicare Advantage plans.
- The key question is: "Do Medicare Advantage plans allow the DME supplier to bill non-assigned or do Medicare Advantage plans require the supplier to take assignment?"
  - Suppliers will need 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 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.

Frequently Asked Question

- **Can an oxygen supplier switch assignment anytime during the five-year period?**
  - **Response:** Nonparticipating suppliers may accept assignment on a claim by claim basis. 42 CFR Section 414.226 (g)(3) requires that "before furnishing oxygen equipment, the supplier must disclose to the beneficiary it's intentions as to whether it will or will not accept assignment of all monthly rental claims for the duration of the rental period."
- In a 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.
- B&F understands that CMS will issue a FAQ that addresses this issue.

Oxygen Contents Issues

- A non-participating supplier <u>can</u> bill oxygen contents non-assigned after the 36 month rental period.



Relatively New ABN Form

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

ABN – Advance Beneficiary Notice (Of DENIAL)

- An Advance Beneficiary Notice (ABN) is a written notice that suppliers may give to a Medicare beneficiary before providing items and/or services that Medicare otherwise might NOT pay for
  - Lack of medical necessity
  - Same / similar denial
  - Upgrade
  - Quantities exceed allowed amount
- The ABN allows the beneficiary to make an informed consumer decision as to whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance
- SPEAKS to the beneficiary

Acceptable ABN

- Be on the approved form CMS-R-131 (Exp. 03/2020)
- Clearly identity supplier name, address, and telephone number (A)
- Clearly identify the beneficiary (B)
- Identification Number (C) Field is optional and can include identifier such as medical record number or date of birth
  - Medicare numbers, HICNs, or social security numbers MUST NOT appear on the ABN
- Clearly identify the item and/or service
- State that supplier believes Medicare is likely (or certain) to deny payment for particular item and/or service
- Give reason for belief Medicare is likely (or certain)to deny payment for the item and/or service
- Give a reasonable estimated cost of non-covered item and/or service
- Be signed and dated by beneficiary or representative
- Once signed by beneficiary or representative may not be modified or revised

IF ABN signed at time of delivery, recommended to note time on ABN and delivery ticket – to prove prior to delivery.

In box D you must enter the items that are expected to deny and in box E the reason Medicare may not pay

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Power wheelchair and accessories	The manual chair and scooter were not ruled out due to weakness as stated with a manual muscle test of 5/5 BUE	$4500.00

In box D you must enter the items that are expected to deny and in box E the reason Medicare may not pay

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** CPAP device below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** CPAP device below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
CPAP device	Failed trial period for CPAP. Does not meet compliance, patient only at 50% and has not been back to doctor for re-evaluation.	$75.00 per month

Other Examples for Section E

Valid	Invalid
"The beneficiary does not have the required diagnosis to qualify for this item per the Medicare policy."	"Beneficiary might have similar equipment on file."
"The beneficiary currently has a standard wheelchair (K0002) paid for by Medicare on 12/2/2009 which is same or similar to this power wheelchair (K0823)."	"Medicare may not pay for this item."
	"Beneficiary may not be eligible for Medicare Part B at this time."
	"Not enough supporting documentation in the medical record."

If the beneficiary wants the item but does NOT want you to bill Medicare the beneficiary must check

Option 2 **(required for retail transactions)**

You may **NOT** choose a box for the beneficiary

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☑ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Upgrades – Patient Wants

- Can shift liability to patient when they CHOOSE to upgrade
- **Want versus need**
- Charge patient difference between –using your usual and customary charge
- Must be within the same range of services for that medical condition
- **Cannot upgrade within the same HCPCS Code** (removed Fall 2016)
- Can upgrade from standard walker to rolling walker
- Cannot upgrade from a walker to wheelchair
- **The codes must be billed in this specific order on the claim: want vs need**

  Hospital Bed Example

  - WANTS: E0260RRKHGA (Patient requested upgrade and valid ABN on file)
  - NEEDS: E0250RRKHKXGK (Reasonable & necessary item associated with GA)

Upgrades – No Charge

The supplier CHOOSES to provide patient with upgrade and no additional charge for upgrade

Does not need to sign an ABN—because not charging more than normal deductible and co-insurance

One Example:

- Supplier chooses to keep semi-electric beds (E0260) in stock for low inventory
- Doctor orders fixed height (E0250) and patient meets criteria for fixed height
- Bill E0250RRKHKXGL
- Chose to delivery a medically unnecessary upgrade to patient at no charge (E0260)
- Add note in narrative on claim what patient actually received using HCPCS, make/model and reason for upgrade

  (Pt rec'd E0260 Invacare semi-electric HB, MODEL, only keep this type for inventory purposes)

If ABN Needed For Non-Assigned Claim

Box G:

- Single line strike through (No Black Out)
- Sentence must be stricken – may not be entirely deleted or concealed
- No requirement for initial or date annotated
- If changes to Section G, Option 1 must be completed before issuing ABN to the bene

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

If ABN Needed For Non-Assigned Claim

Instructions for Box H:

- Statement can be included on the ABN for non-assigned items
- May be handwritten or typed (printed)
- ABNs with the sentence stricken out in Option 1 MUST contain the CMS-approved non-assigned statement in box H
  - ✓ If it does not, then it is not considered a valid notice
  - ✓ If Blank H consists of the CMS-approved statement, then the last sentence in Option 1 must be stricken

H. Additional Information:

This supplier does not accept payment from Medicare for the item (s) listed in the table above. If I check Option 1 above, I am responsible for paying the supplier's charge for the item (s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare approved amount for the item (s), and this payment to me may be less than the supplier's charge.

- Team of expert consultants providing…
  - Prescreen Reviews
  - Forms and Documentation Reviews
  - Proactive Claim Audits
  - On-going compliance support packages
  - "Any willing provider" prep kit (1 hr product-specific webinar for staff and 1 hr documentation/form review = $399 for VGM Members)
  - TPE/RAC/UPIC Audit support and appeal preparation

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