Solutions for the HME Supplier Options and Opportunities

BUSINESS FORUM
Rally for Success

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)** ****Being considered for CB next round**

BUSINESS FORUM
Rally for Success

CB Product Categories - Any Willing Supplier In Good Standing

Changes will occur with current Contracts, No Contract, and Subcontracts

- 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

Steps For Consideration – Preparation 2019

1. What does 855S application(or PECOS) look like?
   https://pecos.cms.hhs.gov/pecos/login.do#headingLv1 electronic version
   https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf paper application
2. Is Accreditation P&P current?
3. Have appropriate supplier license, staff license, etc?
   https://www.palmettogba.com/licensure/licdirec.nsf/NSCLicensureMap_N
4. Check (change) Enrollment Status
5. REMEMBER reimbursement rates are based off of Beneficiary's permanent address (zip) on file with SSA
6. Good time to review Supplier Standards (are you in compliance)
7. Staff education on medical policies (LCD) and related articles
   www.noridianmedicare.com
   www.cgsmedicare.com

Page 10 of 855S

https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
electronic version

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

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

CMS-855S (05/16) 10

BUSINESS FORUM Rally for Success

SECTION 1: BASIC INFORMATION *(Continued)*

C. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections as indicated.

☐ You are a **new enrollee** in Medicare or are enrolling a new business location with a tax identification number not previously enrolled with the NSC MAC.	**Complete all sections**
☐ You are **adding a new business location** using a tax identification number currently enrolled with the NSC MAC.	**Complete sections 1–7, 9 (for managing employee only), 11 (optional), 12, and either 14 or 15**
☐ You are **reactivating** your Medicare supplier billing number.	**Complete all sections**
☐ You are **revalidating** your Medicare enrollment.	**Complete all sections**
☐ You are **voluntarily terminating your Medicare enrollment.** Effective date of termination:	**Complete sections 1, 2a, 4b, 4D, 11 (optional), and either 14 or 15**
☒ You are **changing your Medicare enrollment information** other than your tax identification number.	**Go to Section 1D**
☐ You are **changing your Tax Identification Number.**	**Complete all sections**

BUSINESS FORUM Rally for Success

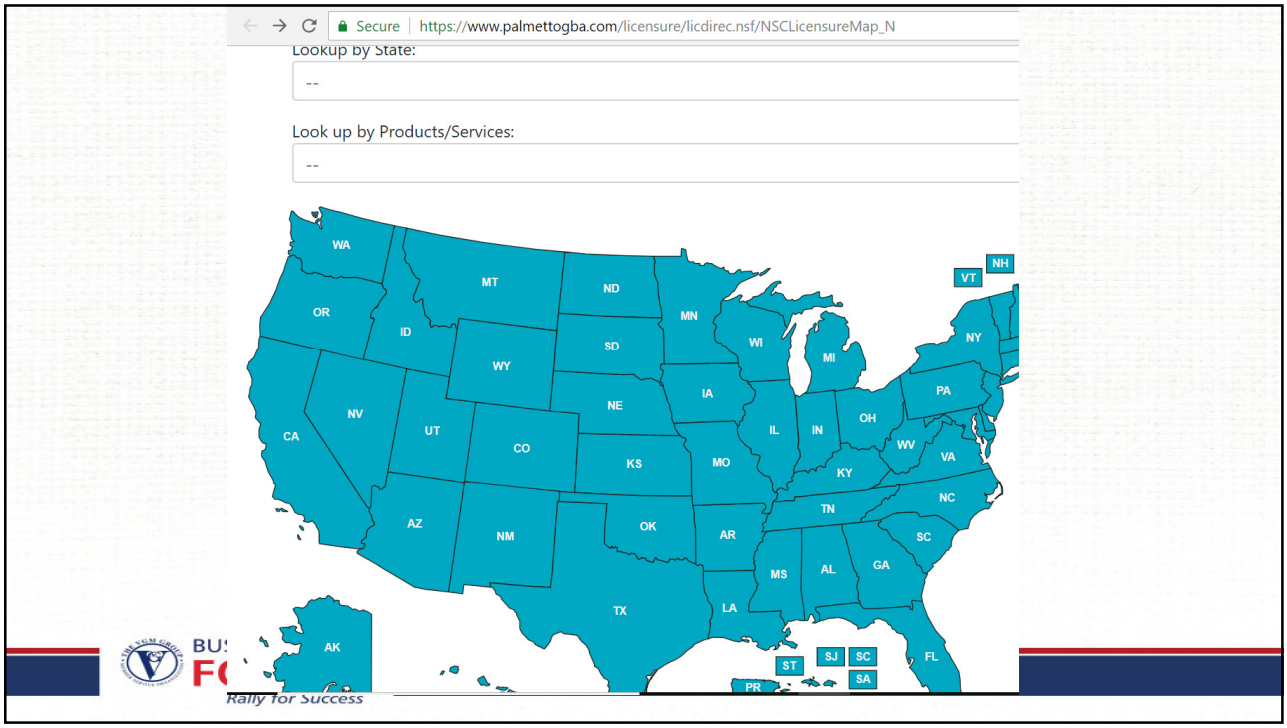
D. WHAT INFORMATION IS CHANGING?

Check all that apply and complete the required sections.

PLEASE NOTE: When reporting ANY information, sections 1B, 7 and either 14 or 15 **MUST** always be Completed in addition to completing the information that is changing within the required section.

CHECK ALL THAT APPLY	REQUIRED SECTIONS
☐ Current Business Location	**1, 2, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Supplier Type *(submit licensure if applicable)* ☒ Products and Services *(submit accreditation if applicable)*	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Accreditation Information	**1, 3, 7, 11 (optional), 12 (if applicable), and either 14 or 15**
☐ Address Information ☐ 1099 Mailing Address ☐ Correspondence Mailing Address ☐ Revalidation Mailing Address ☐ Remittance/Special Payment Mailing Address ☐ Record Storage Address	**1, 4 as applicable for the address that is being changed, 7, 11 (optional), 12 (if applicable), and either 14 or 15.**
☐ Comprehensive Liability Insurance Information	**1, 5, 7, 11 (optional), 12, and either 14 or 15**
☐ Surety Bond Information	**1, 6, 7, 11 (optional), 12, and either 14 or 15**
☐ Final Adverse Legal Actions	**1, 7, 11 (optional), 12, and either 14 or 15**
☐ Ownership and/or Managing Control Information (Organizations and/or Individuals)	**1, 7, 8 and/or 9, 11 (optional), 12 (if applicable), and either 14 or 15**

BUSINESS FORUM
Rally for Success



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

BUSINESS FORUM Rally for Success

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 **(changes January 2019)**
  - **Can still be enrolled as non-participating**
- **DME suppliers get a higher reimbursement for accepting assignment - MYTH**

BUSINESS FORUM Rally for Success

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

BUSINESS FORUM Rally for Success

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 what is medically needed
- Fragmented Billing – cannot have assigned & non-assigned items on same delivery same DOS for same service
  - Performed at the same place and on the same occasion
  - Medicare Claims Processing Manual, Chapter 1, 30.2

BUSINESS FORUM Rally for Success

What to change your status to Non-Participating?

- ✓ Change in PECOS system (electronic), **OR**
- ✓ Mail a letter to the NSC - Authorized Official (AO) or Delegating Official (DO) must sign

  Use company letterhead

  State in the letter that XYZ Supplier is changing enrollment status to non-participating for DOS starting January 1, 2019

  Include PTAN, NPI, TIN, and contact information

  Mailing Address - NSC:

  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

Then ready for January 1, 2019– ***will*** ***not*** receive confirmation from NSC

This does not mean processes have to change right away –change when ready

BUSINESS FORUM Rally for Success

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

BUSINESS FORUM Rally for Success

Non-Assigned Example For Consideration- Inexpensive & Routinely Purchase

- The allowable for the **A7034** **{**NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP)**}**
  Allowable as Purchase (NU) =$60.12 (pre IFR for rural)
- If you can't accept that allowable and need to collect more to meet margins, the only way is go non assigned – allowable not acceptable so charging more.
- If you need $80.00 for this item then you can collect full amount from the patient and submitted as non assigned.
- Make sure you let the patient know (in writing) that they will only receive 80% of the Medicare allowed amount of $48.10 (if approved).

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

BUSINESS FORUM Rally for Success

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 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.

BUSINESS FORUM Rally for Success

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.
  - Can negotiate non-assigned with the contract – it works!

BUSINESS FORUM Rally for Success

Frequently Asked Question

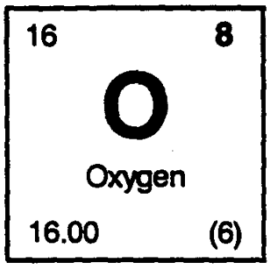
- **Can an oxygen supplier switch assignment anytime during the five-year period?**
  - **Response:** Nonparticipating suppliers may accept assignment on a claim by claim basis. 42 CFR Section 414.226 (g)(3) requires that "before furnishing oxygen equipment, the supplier must disclose to the beneficiary 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.

BUSINESS FORUM Rally for Success

Oxygen Contents Issues

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



BUSINESS FORUM
Rally for Success

DO NOT Let Referrals and Payers Dictate Your Business!

- 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 and reimbursement cuts.
- Financially, DME suppliers can no longer do this and we've witnessed.
- DME suppliers are having to make difficult choices when the reimbursement rates are not adequate to run a business
- This is unpleasant … but it is the "new normal."
- YOU RUN YOUR BUSINESS – it's a business!

BUSINESS FORUM
Rally for Success

Know Your Payers

- KNOW YOUR CONTRACTS
- MUST have a copy ON FILE including the allowable (fee schedule)
- Know and understand their policies, DO NOT ASSUME
- Find out what there rules are, where they is located (website or send in email)
- Do not have a phone conversation with their CSR and assume that is the rule – Why??
- Negotiate their rates – Do Not Accept unreasonable rates
- And find out if they accept non-assigned. Will be in contract or need to negotiate, they will NOT tell you.
  - BCBS in NY –does allow non-assigned

BUSINESS FORUM Rally for Success

CB Modifiers – During Gap Period

- KT modifier (traveling patient) no longer effective starting Jan. 1, 2019 through gap period
- All other modifiers still applicable: KE, KU, KY (mobility related):
  - KY – Item used on Complex Wheelchair Base (processing to allow a CB item on a non CB base non contract provider)
  - KU – W/C accessory and seat and back cushions used with Group 3 Complex Rehab w/c base (K0848 – K0864) (only for DOS January 1, 2016 - Present), to override the adjusted fee schedule for CB
  - KE - Must be used to identify accessory code that can be dually billed with either a CB or NCBA base item & not subject to fee schedule reduction under MIPAA (only used for DOS prior to July 1, 2016)

  New Dates of Service are June 1, 2018 – Dec. 31, 2018 – 2019 (IFR) – and continues through gap period (until Dec. 31, 2020)

BUSINESS FORUM Rally for Success

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

BUSINESS FORUM
Rally for Success

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**

BUSINESS FORUM
Rally for Success

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.

BUSINESS FORUM Rally for Success

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.** Item 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.** Item below.

D. Item	E. Reason Medicare May Not Pay:	F. Estimated Cost
Oxygen stationary concentrator	Oxygen test results are 95% on room air at rest. Patient does not meet Medicare's coverage criteria for home oxygen, when testing on room air at rest, the test results need to be at 88% or lower.	$130.00 per month

BUSINESS FORUM Rally for Success

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.** Item 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.** Item below.

D. Item	E. Reason Medicare May Not Pay:	F. Estimated Cost
Folding Walker	Patient had same/similar item within the 5 year reasonable useful lifetime. Patient got a walker under Medicare around August 2016	$80.00

BUSINESS FORUM Rally for Success

Other Examples for Section E

Valid

- "The beneficiary does not have the required diagnosis to qualify for this item per the Medicare policy."
- "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)."

Invalid

- "Beneficiary might have similar equipment on file."
- "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."

BUSINESS FORUM Rally for Success

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.**

BUSINESS FORUM Rally for Success

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)

BUSINESS FORUM Rally for Success

Are upgrades allowed on CPAP supplies when a beneficiary elects to have a more extensive mask than what would be allowed by Medicare?

No. Medicare covers the mask but does not consider it an upgrade if it is simply a more expensive type of mask. Medicare suppliers who enrolled as "non-participating" have the option of not accepting assignment on a claim-by-claim basis which would allow additional reimbursement options. A difference in price alone does not warrant an upgrade. The beneficiary needs a mask to use with their PAP device. If the quantities of masks that they wanted were above what Medicare allowed, which is one every three months, then that could potentially be an upgrade regarding the quantity of masks.

- **Think about orders – getting brand specific – need to be generic such as full face mask**
- **Think about non-assigned. Let bene know which item insurance covers (assigned) and what is out of pocket with small reimbursement (non-assigned)**

BUSINESS FORUM Rally for Success

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)

BUSINESS FORUM Rally for Success

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.**

BUSINESS FORUM Rally for Success

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.

BUSINESS FORUM Rally for Success

Continued Need vs Continued Use

- **Continued Need**
  - For ongoing supplies and rented DME items, in addition to information justifying the initial need of the items and/or supplies, there must be information in the medical record to support that the item continues to remain reasonable and necessary
  - A recent order by the treating physician for refills (within the past 12 months)
  - A recent change in prescription
  - A properly completed CMN with an appropriate length of need specified
  - Timely documentation in the beneficiary's medical record showing usage of the item (within the past 12 months)

Continued Need vs Continued Use

- **Continued Use**
  - The ongoing utilization of supplies or a rented item by a beneficiary
  - Suppliers are responsible for monitoring utilization of rental items and supplies
  - Monitoring of purchased items or capped rental items that have converted to a purchase is not required
  - Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary
  - Timely documentation in the medical record showing usage of the item, related option/accessories, and supplies
  - Refill request
  - Supplier records documenting beneficiary confirmation of continued use of a rental item

What does KX Mean

- When you add a KX modifier on a line item you are telling Medicare that you "KNOW" this patient meets criteria for the item you are billing.
- Documentation has to be in progress notes
- Supporting Documentation –

Can USE in ADDITION to Physician notes:

  - PT/OT evaluations,
  - Prosthetist/Orthotist,
  - Nursing notes
  - Home health notes
  - Hospital discharge notes
  - SNF notes
  - Any other clinical notes, lab tests, dietician

BUSINESS FORUM Rally for Success

LCDs With a KX Modifier Requirement

Ankle-Foot/Knee-Foot Orthosis
Automatic External Defibrillators
Cervical Traction Devices
Commodes
External Infusion Pumps
Glucose Monitors
High Frequency Chest Wall Oscillation Devices
Hospital Beds
Immunosuppressive Drugs
Knee Orthoses
Manual Wheelchair Bases
Nebulizers
Negative Pressure Wound Therapy Devices
Oral Antiemetic Drugs
Oral Appliances for OSA

Oxygen Equipment – starting 8-1-2018
Orthopedic Footwear
Patient Lifts
Pneumatic Compression Devices
Positive Airway Pressure Devices
Power Mobility Products
Pressure Reducing Support Surfaces
Refractive Lenses
Respiratory Assist Devices
Speech Generating Devices
Therapeutic Shoes for Persons with Diabetes
Transcutaneous Electrical Nerve Stimulators
Urological Supplies
Walkers
Wheelchair Options and Accessories
Wheelchair Seating

BUSINESS FORUM Rally for Success

Switching from Advantage Plan to Medicare FFS

A beneficiary who was previously enrolled in a Medicare Advantage Plan, returning to traditional Medicare FFS, is subject to the same benefits, rules, requirements, and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare.
Therefore, if a beneficiary received any items or services from their Medicare Advantage Plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a capped rental item (e.g., hospital bed) through a Medicare Advantage Plan must, under traditional FFS Medicare, obtain a Certificate of Medical Necessity (CMN), if applicable, and meet FFS Medicare criteria for the item before a new capped rental period would begin.

A partial exception to this rule involves home oxygen claims. If a beneficiary begins taking oxygen while under a Medicare Advantage Plan, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins. In this situation, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN, but the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in Local Coverage Determination.

It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS.

From Supplier Manual

BUSINESS FORUM
Rally for Success

Delivery via Shipping or Delivery Service Directly to a Beneficiary

POD documentation must be a complete record tracking the item(s) from you to the beneficiary.

An example of acceptable proof of delivery would include both your detailed shipping invoice and the delivery service's tracking information. Your record must be linked to the delivery service record by some clear method like the delivery service's package identification number or your invoice number for the package sent to the beneficiary.

Store this in YOUR Files – DO NOT RELY on the shipping services to store – IT WILL BE GONE and SOON

BUSINESS FORUM
Rally for Success

Delivery via Shipping or Delivery Service Directly to a Beneficiary

The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, your invoice number, or alternative method that links your delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description). The long description of the HCPCS code, may be used as a means to provide a detailed description of the item being delivered.
- Quantity delivered
- Date delivered
- Evidence of delivery

If you utilize a shipping service or mail order, you must use the shipping date as the DOS on the claim.

The shipping date may be defined as the date the delivery/shipping service label is created or the date the item is retrieved for delivery. However, such dates should not demonstrate significant variation.

Or, Can use the date of delivery as the DOS on the claim

Updated: Winter Supplier Manual Chapter (01-02-18)

BUSINESS FORUM Rally for Success

C2C Update – Demonstration Project at Reconsideration

- Demonstration started January 2016 with oxygen equipment and glucose testing supplies
- Expanded to all other product categories winter (1st Quarter) of 2017
- Started Only in Jurisdictions C and D (Jur. A & B considered control groups)
- 2 Phases: Formal Telephone Discussion (new claims) and Reopening (existing claims) at ALJ
- Formal Telephone Discussions:
  - Scheduling letters mailed versus discussions that occurred:
  - Over 33,000 mailed for 2016 held approximately 19,000 discussions = participation rate 57%
  - Over 66,000 mailed for 2017 held approximately 58,000 discussions = participation rate 84%
  - Over 36,000 mailed for Jan-Jun of 2018 held approximately 32,000 discussions = participation rate 86%

Reopenings - Either reopened or withdrawn from the ALJ

- Approximately 22,000 in 2016
  - **C2C's withdrawal process was approved at the beginning of April 2017
- Approximately 81,000 in 2017
- Approximately 122,181 for Jan-Jun of 2018

- August 28, 2017 - Myself along w/ suppliers & other VGM staff testified at SBA Hearing on this project and CB

BUSINESS FORUM Rally for Success

October 23, 2018 – News Article Released – EXPANDED into both Jurisdictions A and B starting November 1, 2018!

For ALL product categories except diabetic testing supplies and any other projects involved in CMS initiative such as the Prior Authorization for PMDs.

BUSINESS FORUM Rally for Success

C2C Update – Demonstration Project

Formal Telephone Discussion

- Suppliers submits initial appeal request (new claims)
- C2C will determine if appeal meets telephone discussion
- Supplier will get notification mailed that will include scheduled discussion date and time
- Telephone discussion will be recorded and placed in administrative case file
- If additional documentation is required, supplier will be notified in writing and have 30 days from formal telephone discussion to submit additional documentation
- **Can write on C2C form if "requesting a formal telephone discussion"**
- **Remember to follow normal appeals process – redetermination is 1st**

BUSINESS FORUM Rally for Success

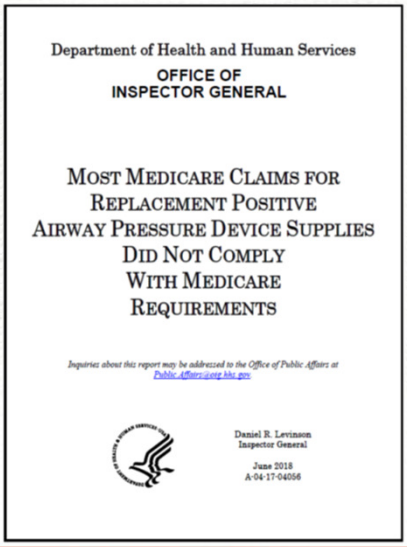
C2C Update – Demonstration Project – 2nd Phase

Reopening at ALJ Level

- Prior to reopening claim, C2C will notify suppliers in writing regarding of cases included in reopening process along with missing or insufficient documentation required to allow payment
- Upon receipt of requested documentation, C2C shall confirm the documents to support a favorable decision
- Notify ALJ of claims that can now be resolved favorably via a C2C reopening, request cases to be remanded (applicable only to appeals pending at ALJ)
- C2C will reopen claims closed but not yet appealed to ALJ level of appeal (as long as it's within 60 days from QIC denial date) and will work with suppliers to reopen related claims currently pending at ALJ level
- Reopening will ONLY occur upon receipt of missing or otherwise relevant documentation that would yield favorable decision
- Benefits to participate in reopening: receive payment sooner than at ALJ, ability to submit documents on cases pending at ALJ, and telephone discussion on reopening case as necessary
- And don't worry - Claim will remain in line at ALJ if C2C cannot overturn for favorable decision

BUSINESS FORUM
Rally for Success

OIG Report - CPAP Supplies



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MOST MEDICARE CLAIMS FOR REPLACEMENT POSITIVE AIRWAY PRESSURE DEVICE SUPPLIES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

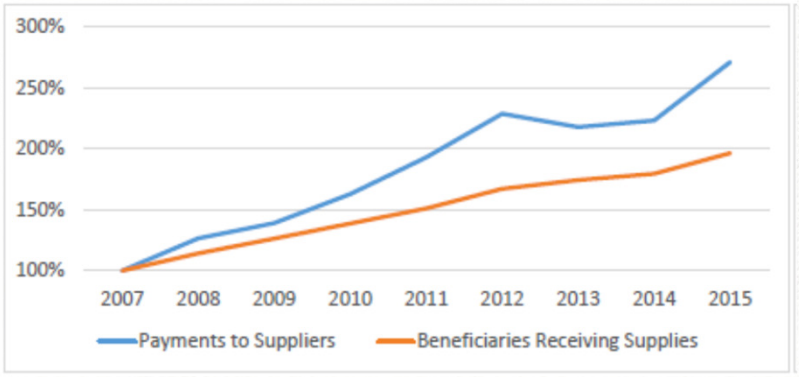
Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Daniel R. Levinson
Inspector General

June 2018
A-04-17-04056

BUSINESS FORUM
Rally for Success

Payments & Beneficiaries Receiving Supplies



Medicare payments for PAP supplies increased 271% from approximately $194 million in 2007 to $526 million in 2015.
The number of beneficiaries receiving supplies increased 196% from 774,000 in 2007 to 1.52 million in 2015.

BUSINESS FORUM
Rally for Success

The Sample

- Sample time frame: 1/1/2014 – 12/31/2015
- Sample of 110 claims out of a universe of 7,279,625 claims
- Total amount paid in the sample was $16,872 vs the universe of $847,462,971

BUSINESS FORUM
Rally for Success

Findings

- Out of 110 claims in the sample, 86 claims did not meet Medicare requirements
- Total overpayment in the sample: $13,414
- Extrapolated overpayment: $631.3 million
- "These overpayments occurred because CMS oversight of replacement PAP supplies were not sufficient to ensure that suppliers complied with Medicare requirements or to prevent payment of claims that did not meet those requirements."

Denial Reasons

Description of Error	Number of Errors[5]
Physicians' orders were not in accordance with LCDs	53
Replacement supplies were not reasonable or necessary	
Supplier did not have a proper request for replacement supplies	50
Supplier did not document continued need for PAP device therapy and supplies	22
Supplier dispensed more supplies than allowed	1
Supplier had no proof of delivery	36
Supplier did not respond to our requests for documentation	3

[5] The total exceeds 86 because 57 sample items contained more than 1 error.

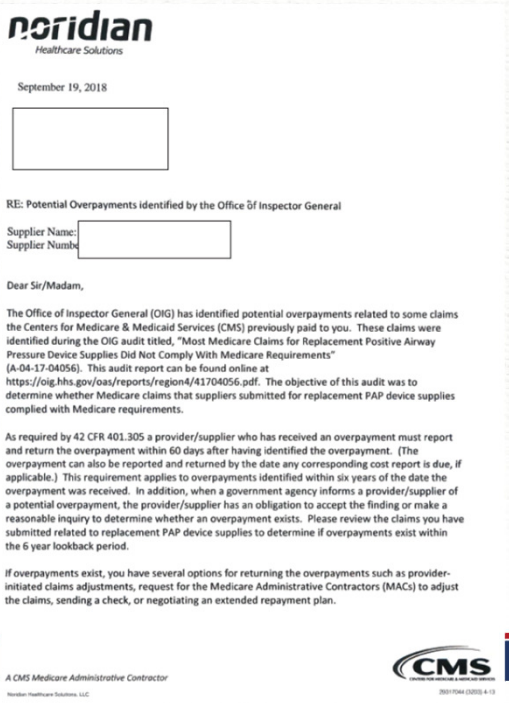
Recommendations

- Instruct Medicare contractors to recover the portion of the overpayments of $13,414 associated with the 86 sample claims that are within the 4 year reopening period.
- Work with Medicare contactors to establish periodic reviews of claims for PAP supplies
- Take remedial action for suppliers that contractors find consistently bill claims that do not meet requirements

Recommendations

- Instruct the Medicare contractors to notify the 82 suppliers associated with the 86 denied claims to "exercise reasonable due diligence to investigate and return any identified overpayments, in accordance with the 60 day rule, and to identify and track any returned overpayments as having been made in accordance with this recommendation."
- Look back period is 6 years…..

Now what?



noridian
Healthcare Solutions

September 19, 2018

RE: Potential Overpayments identified by the Office of Inspector General

Supplier Name:
Supplier Numbe

Dear Sir/Madam,

The Office of Inspector General (OIG) has identified potential overpayments related to some claims the Centers for Medicare & Medicaid Services (CMS) previously paid to you. These claims were identified during the OIG audit titled, "Most Medicare Claims for Replacement Positive Airway Pressure Device Supplies Did Not Comply With Medicare Requirements" (A-04-17-04056). This audit report can be found online at https://oig.hhs.gov/oas/reports/region4/41704056.pdf. The objective of this audit was to determine whether Medicare claims that suppliers submitted for replacement PAP device supplies complied with Medicare requirements.

As required by 42 CFR 401.305 a provider/supplier who has received an overpayment must report and return the overpayment within 60 days after having identified the overpayment. (The overpayment can also be reported and returned by the date any corresponding cost report is due, if applicable.) This requirement applies to overpayments identified within six years of the date the overpayment was received. In addition, when a government agency informs a provider/supplier of a potential overpayment, the provider/supplier has an obligation to accept the finding or make a reasonable inquiry to determine whether an overpayment exists. Please review the claims you have submitted related to replacement PAP device supplies to determine if overpayments exist within the 6 year lookback period.

If overpayments exist, you have several options for returning the overpayments such as provider-initiated claims adjustments, request for the Medicare Administrative Contractors (MACs) to adjust the claims, sending a check, or negotiating an extended repayment plan.

A CMS Medicare Administrative Contractor

Noridian Healthcare Solutions, LLC

CMS

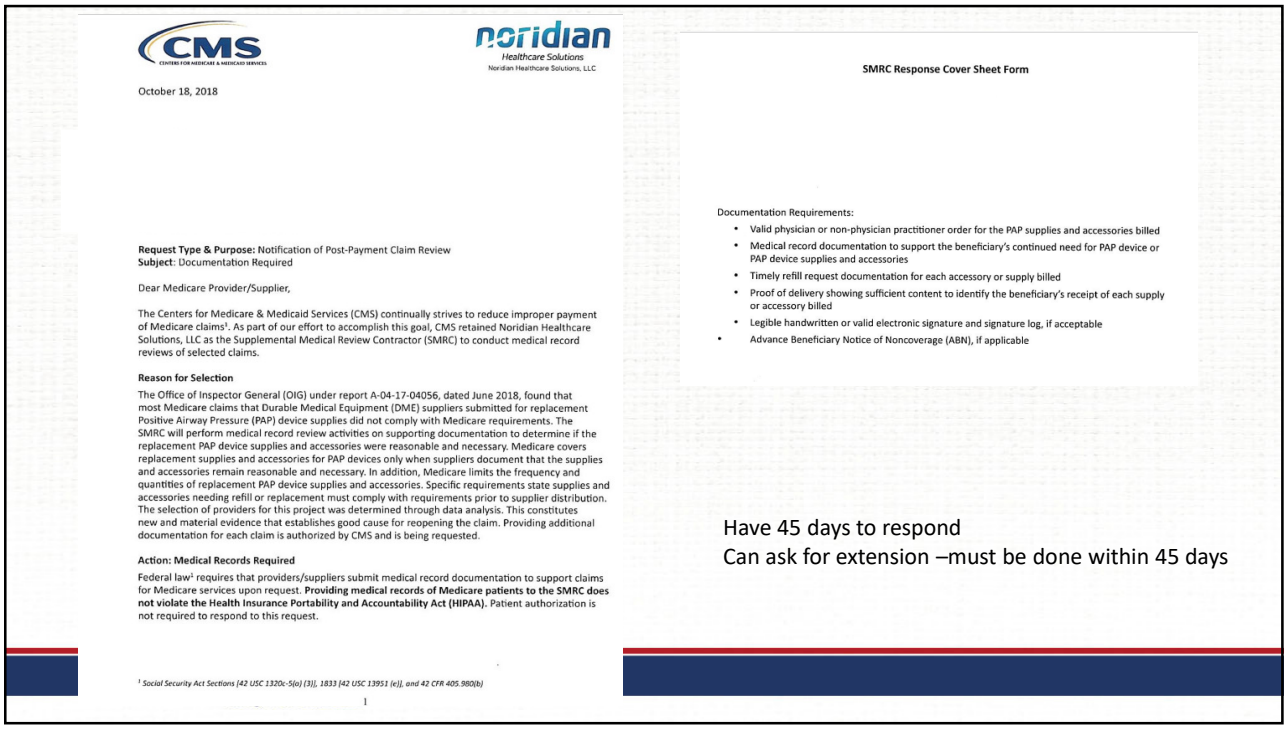
BUSINESS FORUM
Rally for Success

Important notes

Please provide your MAC with written confirmation that you performed a self-assessment of the claims and determined that either no claims were submitted in error, or you have identified and returned, or are working to return, applicable overpayment(s) to the MAC. Please include documentation of any identified overpaid claims and amounts with your confirmation.

With regards to the documentation, please provide a written description of: A) how each self-assessment was conducted; B) the universe, sample size and service dates of the claims identified and reviewed in the self-assessments; C) the statistically valid sampling and extrapolation methodology used to identify the universe and sample; and D) if extrapolation/sampling was not used, details of how you completed the self-assessment, including a statement that you individually reviewed the entire universe of those claims it identified for review, if applicable.

BUSINESS FORUM
Rally for Success



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

noridian
Healthcare Solutions
Noridian Healthcare Solutions, LLC

October 18, 2018

Request Type & Purpose: Notification of Post-Payment Claim Review
Subject: Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce improper payment of Medicare claims[1]. As part of our effort to accomplish this goal, CMS retained Noridian Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC) to conduct medical record reviews of selected claims.

Reason for Selection

The Office of Inspector General (OIG) under report A-04-17-04056, dated June 2018, found that most Medicare claims that Durable Medical Equipment (DME) suppliers submitted for replacement Positive Airway Pressure (PAP) device supplies did not comply with Medicare requirements. The SMRC will perform medical record review activities on supporting documentation to determine if the replacement PAP device supplies and accessories were reasonable and necessary. Medicare covers replacement supplies and accessories for PAP devices only when suppliers document that the supplies and accessories remain reasonable and necessary. In addition, Medicare limits the frequency and quantities of replacement PAP device supplies and accessories. Specific requirements state supplies and accessories needing refill or replacement must comply with requirements prior to supplier distribution. The selection of providers for this project was determined through data analysis. This constitutes new and material evidence that establishes good cause for reopening the claim. Providing additional documentation for each claim is authorized by CMS and is being requested.

Action: Medical Records Required

Federal law[1] requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. **Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request.

[1] *Social Security Act Sections [42 USC 1320c-5(a) (3)], 1833 [42 USC 13951 (e)], and 42 CFR 405.980(b)*

1

SMRC Response Cover Sheet Form

Documentation Requirements:

- Valid physician or non-physician practitioner order for the PAP supplies and accessories billed
- Medical record documentation to support the beneficiary's continued need for PAP device or PAP device supplies and accessories
- Timely refill request documentation for each accessory or supply billed
- Proof of delivery showing sufficient content to identify the beneficiary's receipt of each supply or accessory billed
- Legible handwritten or valid electronic signature and signature log, if acceptable
- Advance Beneficiary Notice of Noncoverage (ABN), if applicable

Have 45 days to respond
Can ask for extension –must be done within 45 days

Don't assume the answer is "no"

- The first question should not be what is your insurance
  - *Show the options available – let them decide!*
- Use knowledge and access to information to add value
- Provide good outcomes
- Don't think of it as upselling, but improvement in quality of life
- Share your services

BUSINESS FORUM
Rally for Success

What Is The Secret Sauce?

- Customer Service and Education are key for all involved in patient care
- Treat the referral as more consultative
- Educate customer service reps (all staff)
- Educate RT, PT, OT, nurses (hospital, HHA, SNF)
- Remind referrals you are local
- Patient's want to be loyal

BUSINESS FORUM
Rally for Success

Implement a Protocol for Successful Reimbursement

- Ensure everyone involved understands the requirements and are acting in the best interested of the company
- Assign someone within as the final decision (give them the authority to make these decisions without question)
- Set rules --- identify the grey areas and set company policies
- Don't allow delivery until all requirements are met
- Making sure all understand policies
- PROACTIVELY ADDRESS COMPETING FORCES WITHIN
- Changing corporate culture starts with leadership – celebrate successes and learn from errors
- And stop saying, "we've always done it that way" – time to adapt to change

BUSINESS FORUM
Rally for Success

Any Willing Supplier in 2019

Are you sure your referrals are committed to you?

Thank You For Your Support!

Ronda Buhrmester
ronda.buhrmester@vgm.com
217-493-5440

www.vgm.com/reimbursement

Sign Up For My Emails @ www.vgm.com
Under members only
Choose VGM News & Gov/Leg Updates

BUSINESS FORUM
Rally for Success