BILLING NONASSIGNED

PREPARED FOR
AAHOMECARE'S
RETAIL WORK
GROUP

RETAIL WORK GROUP

AAHomecare recognizes that billing Medicare on an assignment basis has become very challenging for many DME suppliers. AAHomecare also understands that many DME suppliers see an opportunity in implementing an innovative retail business in which customers pay cash. For these reasons, AAHomecare has formed a Retail Work Group comprised of stakeholders in the DME industry. The Retail Work Group is developing tools for suppliers to utilize as they move into the retail market. These tools include educational "white papers" such as this paper entitled "Billing Nonassigned."

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BILLING NONASSIGNED

By: Jeffrey S. Baird, Esq.

Introduction

The 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 of the DME industry. This has changed. The industry is now caught in a "perfect storm" of:

- Competitive bidding;
- Reimbursement cuts;
- Stringent documentation requirements; and
- Aggressive audits.

Some DME suppliers will implement "economies of scale" that will allow them to succeed in the Medicare fee-for-service ("FFS") arena. On the other hand, many suppliers can no longer base their business model on Medicare FFS. Out of necessity, these suppliers are taking steps to lessen their dependence on Medicare FFS.

For the last four decades, suppliers have primarily provided DME on an assignment basis. Medicare paid the suppliers directly and the patients only had to pay their copayments and deductibles. Until the last several years, reimbursement was high enough and audits were not onerous … meaning that this "assignment model" worked well for suppliers. It is now becoming cost-prohibitive for many suppliers to continue with the "assignment model."

Up to now, DME suppliers have shouldered the burden of increasingly burdensome Medicare policies and lower reimbursement. Financially, it is difficult for many DME suppliers to continue to do this. Many suppliers are now shifting some of the burden to their patients.

We are now witnessing many DME suppliers (i) electing to be non-participating and (ii) "billing nonassigned." If a non-participating supplier provides a product on a nonassigned basis, this means that the supplier (i) is not agreeing to accept the Medicare allowable as payment in full, (ii) can collect directly from the patient, and (iii) can charge more than the Medicare allowable. The supplier must file the claim with Medicare on behalf of the patient and any Medicare reimbursement will go directly to the patient. But as is often the case, the "devil is in the details." The balance of this white paper discusses the "details."

Participating vs. Non-Participating

Participating. 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 accept the Medicare-allowed amount as

full payment. The supplier will collect any unmet deductible and 20% coinsurance from the beneficiary and will be paid the balance of the Medicare fee schedule amount from the DME MAC.

Non-Participating. 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. If a non-participating supplier does not accept assignment, the supplier can charge more than the Medicare allowable and will collect directly from the patient for Medicare covered products and services in such cases. In this instance, the supplier is required to file the claim with Medicare on a nonassigned 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 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.

Avoiding Discrimination

The Age Discrimination Act of 1975 generally prohibits age discrimination under any program receiving federal financial assistance. CMS has a specific rule stating that CMS can terminate a DME supplier's 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.

Billing Nonassigned

Statutorily Non-Covered. If a non-participating supplier without a Competitive Bidding ("CB") contract sells or rents an item that falls within a product category covered by CB on a nonassigned basis to a patient residing in a Competitive Bidding Area ("CBA"), the item is statutorily non-covered, and Medicare will not reimburse the patient. The noncontract supplier is responsible for notifying the beneficiary that it is not a contract supplier for the item in the CBA, and the supplier must obtain a signed ABN indicating that the beneficiary was informed in writing prior to receiving the competitively bid item or service that there would be no payment by Medicare due to the supplier's noncontract status.

Price That the Supplier Can Charge. Assume that a supplier sells an item, on a nonassigned basis, to a patient for cash. Assume that Medicare reimburses the item as a "sale item," not as a "capped rental item." The supplier can sell the item to the patient for an amount in excess of the Medicare fee schedule, and Medicare will pay the patient 80% of the fee schedule amount (less the patient's deductible).

Renting/Selling a Capped Rental Item. Assume that an item is reimbursable by Medicare as a "capped rental item." Assume that the supplier rents the item, on a nonassigned basis, to a patient. 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. Assume that, instead of renting the item, the supplier wants to sell the item on a nonassigned basis, to a patient for cash. In this situation, Medicare will not make any payment to the patient for the item. This is because Medicare will only pay for rental of capped items and does not pay for the purchase of such items. Because the supplier should expect Medicare not to make payment in this situation, it must obtain an ABN signed by the patient informing the patient that Medicare will pay for the rental, but not the purchase, of the item. The better approach may be to allow the patient to rent on a nonassigned basis so that the supplier receives higher reimbursement, but the patient still gets paid 80% of the Medicare allowable.

Term of ABN. An ABN is required for assigned or nonassigned claims when the supplier reasonably expects that Medicare will not pay for the item or service, which is otherwise usually covered by Medicare. A single ABN is good for one year. A new ABN would be required if the rental extends beyond one year, or if the reason for expected Medicare denial changes.

Beneficiary Claim Authorization. If the supplier is billing for an item on a nonassigned basis, it must still have the Medicare beneficiary sign a claim authorization. This authorization can be a one-time authorization specifying the item, UNLESS the item is being rented on a nonassigned basis, in which case the supplier must have the beneficiary sign a separate authorization for each month the item is rented on a nonassigned basis.

Supplies and Accessories. For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), Medicare will pay for them, however all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment;
- A notation that this equipment is beneficiary-owned; and
- Date the patient obtained the equipment.

Medicare will only cover supplies and accessories for equipment that meets the existing coverage criteria for the base item. 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. The DME supplier can bill for supplies and accessories on a nonassigned basis. In so doing, the supplier can charge higher than the allowable.

Repairs. Repairs to equipment that a beneficiary owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing (or renting another item of equipment for the remaining period of medical need), no payment can

be made for the amount of the excess. When billing for repairs, include the HCPCS code and date of purchase of the item being repaired (if the HCPCS code is not available, include the manufacturer's name, product name, and model number of the equipment), the manufacturer's name, product name, model number, and MSRP of the repair item provided, and the justification of the repair. The DME supplier can bill for the repairs on a nonassigned basis. If the bill exceeds the allowable for a replacement device, then that information should be disclosed to the beneficiary, via an ABN, as a potential reason for denial.

Commercial Insurance Mandating Assignment

If the commercial insurer requires the DME supplier to bill on an assigned basis for all products, then does the supplier have the right (under the anti-discrimination provision) to sell/rent a particular product to a Medicare patient on a nonassigned basis? The answer is "yes." The supplier has the right to choose whether to accept Medicare assignment on a claim by claim basis. 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. The supplier can always make that item available to a Medicare patient on a nonassigned basis. If the commercial insurance does not allow nonassigned claims, the item is only available to the patient if the insurance reimbursement meets the threshold dollar amount.

Medicare Advantage

Suppliers will need to look at the Medicare Advantage plan to see if the plan requires the supplier to take assignment or allows the supplier to bill nonassigned. If the answer is that the plan requires assignment, then the supplier can adopt a policy where an item is only available to a patient if the reimbursement received meets a threshold dollar amount.

What the Supplier Can Charge

A non-participating supplier can charge the patient an amount higher than the Medicare fee schedule. If the supplier desires to charge the patient less than the Medicare fee schedule, then it 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 charge, unless there is good cause shown. The supplier needs to also be aware of (i) Medicaid statutes that specify the supplier's charge that must be billed to the Medicaid program and (ii) provisions in commercial insurance contracts that may require that the supplier must give its "best price" to the insurer.

Limiting Charge

According to CMS requirements, some providers are prohibited from billing the beneficiary in excess of the "limiting charge" for covered services. Should the provider bill more

than the limiting charge for a covered service, the provider may be subject to fines or penalties. This "limiting charge" restriction does not apply to DME suppliers.

Billing for Items on Same Day

A supplier cannot submit some items assigned and others nonassigned on the same claim. It is unclear if a supplier can have two separate claims, one assigned and one nonassigned, with the same date of service, or if different dates of service are required.

Changing from Assigned to Nonassigned

If the supplier is non-participating, then it can change from assigned to nonassigned 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. In a webinar, the DME MACs stated that a supplier cannot change an oxygen patient from assigned to nonassigned during the course of the 36 month rental period. Brown & Fortunato disagrees. Language from the Federal Register makes it clear that the supplier's notice to the patient of its original intention regarding acceptance of assignment is not binding. We expect that CMS will issue an FAQ that addresses this issue.

Oxygen Contents

A non-participating supplier can bill oxygen contents nonassigned after the 36 month rental period.

Stationary and Portable

If an oxygen patient has both a stationary unit and a portable unit that are being billed on two different anniversary dates, one claim can be assigned and the other claim can be nonassigned. It is unclear as to whether the claims can have the same date of service, or if different dates of service will be required.

Dropping Accreditation

If a supplier drops its accreditation on a product category (resulting in the supplier no longer being able to bill Medicare for that product category), this does not allow the supplier to collect cash up front. The supplier must be accredited for the products it provides because accreditation certifies that the supplier meets the specific standards for the products provided. Otherwise, the supplier may be in violation of the supplier standards and the requirements of the supplier's accreditation agency. This is true for both Medicare and commercial insurance patients.

Post-Payment Audits

Because relatively few DME claims have historically been billed nonassigned, there is no significant track record of CMS pursuing recoupments of nonassigned claims. Having said this, nonassigned claims are equally as vulnerable to audits as assigned claims. If a nonassigned claim

is audited, the supplier is not insulated from being assessed an overpayment unless (i) the item is a non-covered item under Medicare or (ii) the supplier has obtained an ABN.

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