Medicare 101 for the Clinician Prescribing Seating and Mobility Products

International Seating Symposium 2011

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Medicare - What Is It?

- Federally managed medical insurance plan
  - Part A - automatic
    - Covers in-patient care and some home health
  - Part B - voluntary
    - Deductibles, premiums and co-pays
    - Covers outpatient medical, physician and lab services, DMEPOS, oxygen, incontinence supplies, surgical dressings, vision products, parenteral and enteral nutrition, home dialysis and some home health, PT and OT services

Who is Eligible?

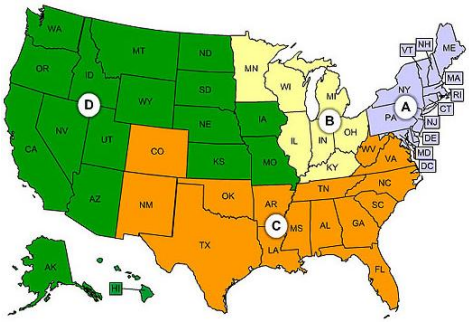
- Over 65 and:
  - Eligible for or receiving SS
  - Eligible for SS based on spouse's (≥ 62) work
  - Specific time at local, state or federal job
- Under 65 and:
  - Permanently disabled on SSDI for 24 months
  - End-stage renal disease
  - ALS and receiving SSDI
  - Specific time at local, state or federal job and qualify for SSDI

Ordering DME

- Who can order DME?
  - Physician
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Physician's Assistant (PA)
- Who cannot order DME?
  - Chiropractor
  - Christian Science practitioner
  - Naturopath
  - Podiatrist – anything below the ankle
    - Cannot order power operated vehicle (POV)

Who Administers the Program?

- Country divided into 4 jurisdictions



Who Administers the Program?

- DME Medicare Administrative Contractors (DME MACs)
  - Claims processing
  - Medical review
  - Local coverage determinations (LCDs)
  - ADMCs
  - Supplier education
- Program Safeguard Contractors (PSCs)
  - Medical policy development
  - Fraud investigations
  - Prepay and post-pay medical review of claims
  - Data analysis

Jurisdictions A, B, C and D

- 4 DME MACs
  - A - National Heritage Insurance Co (NHIC)
  - B - National Government Services (NGS)
  - C - CIGNA Government Services.
  - D - Noridian Administrative Services (NAS)
- 3 PSCs
  - A and B – Tricenturion
  - C - TrustSolutions
  - D - SafeGuard Services

What Is the HCPCS

- Healthcare Common Procedure Coding System
- Code-set that identifies products or services provided under Medicare
  - Level I (CPT codes)
    - Medical procedures and services
    - Maintained by the AMA
  - Level II (HCPCS codes)
    - Products and services not included in CPTs
    - Maintained by CMS, America's Health Insurance Plans and BC/BS

How Do HCPCS Codes Work?

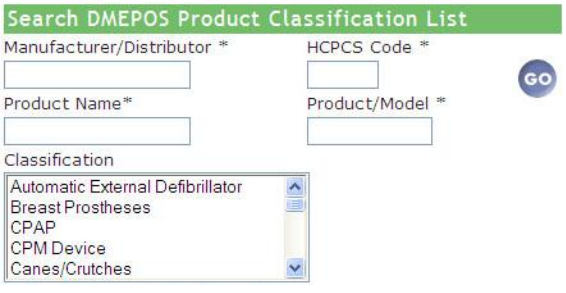
- Used for billing
- Describe a type of product or accessory
  - General or specific definition
  - Wide or narrow range of products
- Assigned specific reimbursement amount
- Administered by PDAC
  - Pricing, Data Analysis and Coding Contractor
- Why does Medicare have codes for products they do not cover?

HCPCS Codes

- How do you know which code to use?
  - Manufacturer submits for code voluntarily or because code verification is required
  - Supplier's best judgment
  - Miscellaneous code
- Check DMEC System
  - https://www.dmepdac.com
  - Scroll to "Top PDAC links"
  - Click on "DMEC Coding"

DMECs System

- Search for products and codes



DMECs System

- Search codes, modifiers or fees

What is the Fee Schedule?

- Reimbursement amount specified for each HCPCS code
  - The "allowable"
  - Set by CMS
  - Amount for any product billed with that code

- May be different state to state
  - Ceiling and floor amounts
- http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp#TopOfPage

Coverage Policies

- National Coverage Determinations
  - National medical policies
  - Basic coverage criteria and information
  - Developed by CMS and apply nationally
- Local Coverage Determinations and Policy Articles
  - Developed by DME MAC Medical Directors
  - Identical across all 4 Jurisdictions

Coverage Policies

- Local Coverage Determination (LCD)
  - Further defines NCD
  - Specific coverage criteria,
  - Lists of applicable HCPC and ICD-9 codes
  - Documentation requirements
- Policy Article
  - Statutory coverage and payment policies
  - Definitions of specific products and accessories
  - Coding guidelines

Coverage Policies

- Why should you be familiar with these?:
  - Ensure complete documentation
  - Use appropriate terminology /diagnosis codes
  - Be aware of coverage “black holes”
  - Avoid denials and down-coding
  - Help educate physicians and other practitioners
  - Be informed to fight for change

Where Are the LCDs?

- Region A
  - www.medicarenhic.com/dme/medical_review/mr_index.shtml
- Region B
  - www.adminastar.com/Providers/DMERC/MedicalPolicy/MedicalPolicy.cfm
- Region C
  - www.cignagovernmentservices.com/jc/coverage/LCDinfo.html
- Region D
  - www.noridianmedicare.com/p-medb/coverage/

In Home Restriction

- Must be medically necessary in the home
  - An unintended interpretation of the law?
- Can prevent appropriate product provision
- What can you do?
  - Recommend the most appropriate product to meet your client’s needs
  - Know how to document
  - Empower your clients with knowledge
  - Encourage legislators to change the law

Payment Categories

- Inexpensive / routinely purchased
  - Paid in one lump sum after claim approved
  - Seating/mobility items include:
    - Manual wheelchairs K0005, E1161, K0009
    - Pediatric manual wheelchairs E1231 – E1238
    - Scooters
    - Push-rim power assists
    - Seat cushions and backs

Payment Categories

- Capped rental
  - Allowable paid in monthly increments over maximum of 13 months of continuous use
  - Seating/mobility items include:
    - Manual chairs K0001 – K0004, K0006, K0007
    - All power wheelchairs
    - Most support surfaces

Capped Rental Items

- Monthly allowable is 10% of average allowed purchase price
  - Months 1 – 3: Medicare pays 80% of monthly allowable, secondary insurance/client pays 20%
  - Months 4 -13 - payment reduced by 25%
- Who owns the product?
  - Month 1 -13 supplier retains ownership
  - After month 13, client assumes ownership
  - Exception – first month purchase option for power wheelchairs

First Month Purchase Option

- Until Jan 2011, client could choose to own power chair upon delivery
  - Supplier paid full reimbursement in one lump sum in month 1
  - 95% of clients chose purchase option due to long term need
- Health Care Reform Bill
  - Eliminates purchase option for Group 1 and 2 power wheelchairs
- What does this mean for your clients?

First Month Purchase Option Elimination

- Cash flow problems for suppliers
  - Bad economy - hard to get loans
  - Forced to purchase less expensive product
- Burden of upfront costs
  - Very low cost, potentially low quality equipment with minimum features
- Potential to get used equipment vs new
  - Rental fleets established
- Suppliers getting out of consumer power
  - Decreased access to appropriate equipment

First Month Purchase Option Elimination

- Problems with temporary hospitalizations or nursing home stays > 60 days
  - Must be re-evaluated with appropriate documentation from physician
  - Could receive different chair after discharge
- Problems with relocations
- Access problem for bariatric patients

How Are Suppliers Paid?

- Supplier bills for base item and all separately billed accessories on the claim
  - Separate line item for each HCPCs code
- Supplier is paid fee schedules for those codes regardless of specific model provided
  - Less expensive product with few options
  - Higher quality product with many options

How Are Suppliers Paid?

- No prior approval
- Order and deliver product
- Submit claim
- Cross fingers
  - Approved ☺
  - Denied ☹☹
  - No more down-coding to least costly alternative

What Are Suppliers Paid?

- Approved claims
  - Paid 80% of allowable for what was provided ☺
- Denied claims
  - Paid nothing unless: ☹☹
    - Signed Advanced Beneficiary Notice
    - Unassigned claim
    - Decision is reversed in appeals process

Claim Form Submission

- What can get a claim denied up front?
  - Wrong or inappropriate ICD-9 codes
  - Wrong HCPCs codes
  - Wrong patient Medicare number
  - Wrong or missing NPI
  - Inappropriate POS
  - Wrong or missing modifiers
  - Modifiers in wrong order

Claims

- Remember…claims are processed electronically
- An approval doesn't eliminate the risk of

- Must produce all supporting documentation

Current Types of Audits

- DME MAC
  - Pre-pay and post pay audits
- Recovery Audit Contractors (RACs)
  - Post-pay audits
  - RACs are compensated for recouping money
- Zone Program Integrity Contractors (ZPICs)
  - Pre and post pay audits
  - Looking for fraud and abuse
- Comprehensive Error Rate Contractors (CERT)
  - Post pay audits
  - Claims processing errors

What is Not Separately Reimbursed?

- Fee schedule "includes" costs for:
  - Evaluation and product simulation
  - Provision of demo equipment
  - Product assembly and set-up
  - Final fitting and adjustments
  - Delivery and education
  - Backup or loaner equipment except 1 month rental of power chair
  - Anything included in "basic packages"

Basic Packages

- Manual wheelchairs*
  - Any S/A or removable armrests (except ht adj)
  - Any S/A or removable legrests (except ELRs)
  - Any seat width and depth 15 - 19"
  - Any handrim
  - Any tire for wheels, casters (except airless)
  - Any wheel rim or hub
  - Any wheel locks

* Includes but not limited to

Basic Packages

- Power wheelchairs
  - Any pelvic belt (except shoulder harness/straps)
  - Battery charger
  - Any type tires and casters
  - Any S/A or removable legrests (except ELRs)
  - Any S/A or removable footrests/platform*
  - Any S/A or removable armrests (except ht adj)
  - Any seat width/depth or back width*
  - Non-expandable controller, standard joystick (except expandable controller and alternative input)

Exceptions

Advanced Determination of Medical Coverage (ADMC)

- Submit documentation to DME MAC prior to delivery / claims submission
  - DME MAC reviews and indicates if client meets coverage criteria for product/options
  - Negative determination due to:
    - Equipment not medically necessary
    - Insufficient documentation
    - Equipment statutorily non-covered
  - Determination cannot be appealed
  - Can re-submit once within 6 months

ADMC

- Pros
  - Get indication if DME MAC considers product reasonable and necessary before submission
- Potential cons:
  - Must submit all required documentation
  - Claim could still be denied for:
    - Change in medical condition
    - Client does not meet other Medicare eligibility
    - Same or similar equipment
  - Does not indicate or ensure payment amount

ADMC

- Wheelchairs eligible for ADMC:
  - Ultra lightweight manual wheelchairs (K0005)
  - Adult manual tilt in space (E1161)
  - Pediatric manual wheelchairs
  - Otherwise not coded manual chair (K0009)
  - Group 2, 3, 4 or 5 single power option or multiple power option power chairs
  - Group 3 or 4 no power option chairs provided with alternative drive control

Advanced Beneficiary Notice (ABN)

- Signed by client prior to receiving product
  - Acknowledges risk of Medicare denial
- Client chooses to receive product and assume responsibility for cost
  - Pays “out of pocket”
  - Covered by other insurance
- Supplier is guaranteed payment
- Not required if product is statutorily non-covered

ABN

- Use for base product or option/accessory
- Use for upgrade
  - Cannot be part of basic package
- Reasons for use
  - MD orders, but client does not meet criteria
  - Client requests, but does not meet criteria
  - Supplier providing free upgrade
  - Client has same or similar paid by Medicare
  - Negative ADMC determination
  - Non-assigned claim

Delivery Before Discharge

- Equipment can be delivered to hospital or SNF up to 2 days prior to D/C
  - Must be for purposes of fitting or training
  - Must be for subsequent use in the home
  - Supplier makes sure client takes item home *or*
  - Picks up item and delivers to client after D/C
- Cannot bill for:
  - Usage in facility prior to D/C
  - Days at client’s home prior to D/C

When is Equipment Replaced?

- Beyond repair and has been in continuous use for reasonable useful lifetime
  - 5 years unless otherwise specified
  - Must need to be replaced
  - Cost to repair outweighs cost of new
  - Document age, manufacturer, model, reason
  - Include cost analysis
- Change in medical condition
  - Document reason
- Loss due to accident, fire, flood, theft
  - Include insurance report, police report

Competitive Bidding (NCB)

- Required by Medicare Prescription Drug, Improvement and Modernization Act 2003
- Delayed by Congressional Act July 2008
- CMS did not make any significant improvements as mandated
- Round 1 went into effect on Jan 1, 2011

Round 1 MSA's

- Charlotte, NC
- Cincinnati, OH
- Cleveland, OH
- Dallas-Fort Worth, TX
- Kansas City, KS
- Miami, FL
- Orlando, FL
- Pittsburgh, PA
- Riverside, CA

Product Categories Under NCB

- Product categories
  - Consumer power and accessories
  - Walkers
  - Hospital beds and accessories
  - O2 equipment
  - Respiratory assist devices and CPAPs
  - Diabetic supplies
  - Enteral nutrition and supplies
  - Group 2 and 3 support surfaces (Miami)
- Carved out from original list
  - Negative pressure wound therapy
  - Complex power and accessories

How Does It Work

- Suppliers submit bids for each product with % of MSA that they can service
- "Winning" payment amount calculated
- Suppliers who submitted bids at or below this amount are offered contracts starting with supplier who bid lowest
- Contract suppliers must accept winning payment amount
- Patients can only use contract suppliers

Issues We Predicted

- Issues we predicted:
  - Severely restricted access
  - Less service, cheaper products
  - Less knowledgeable suppliers?
  - Suppliers going out of business
  - Potential for manual mobility to be included?

The Results of NCB

- Some suppliers awarded contracts are:
  - Bankrupt or filing for bankruptcy
  - Not licensed to provide items or services
  - Have credit problems
  - Have no store in that area
- ~ 87% of existing providers in mail-order diabetic supplies lost contracts
  - 21 of 32 winners have no prior experience
- Bids lower than all bids submitted?

The Results of NCB

- Incorrect information from CMS:
  - Who contract winners are
  - Which beneficiaries need to change providers
  - Who can or must do repairs
  - CMS sending patients to non-contract winners or to retail outlets

The Results of NCB

- Patients confused about switching suppliers
- Difficulty finding contract suppliers
  - Delayed discharges / hospital admissions
  - Problems coordinating delivery of items
  - Case managers “cherry picking” suppliers
- Lack of knowledge among referrals
  - Hospitals unaware of the program
  - No list of winners
  - No plan to deal with the changes
  - Physicians unaware of need for new orders
- Companies laying off employees

How Can You Help?

- Keep up with the issues
  - www.nrrts.org
  - www.aahomecare.org
  - www.ncart.us
  - www.vgm.com
  - www.peopleforqualitycare.org
- Contact your legislators
  - www.vgmdclink.com
- Report issues
  - www.competitivebiddingconcerns.com
  - www.aahomecare.org/displaycommon.cfm?an=1&subarticlenbr=495

U.S. REHAB

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