

Medicare Supplier Standards

MEDICARE SUPPLIER STANDARDS

Medicare has strict guidelines and standards that suppliers (providers) must meet in order to continue to be a provider for Medicare beneficiaries. All of these standards are published on the **Medicare Supplier Number Application (CMS-855S)**. Any supplier found in non-compliance with the following supplier standards is subject to revocation of their NSC (National Supplier Clearinghouse) issued supplier number. In order to be a supplier in good standing with Medicare, a supplier must meet the following Medicare Supplier Standards:

Note: This list is an abbreviated version of the application certification standards that every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. pt. 424, sec 424.57(c) and were effective on December 11, 2000.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare-covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, or cell phone is prohibited.

10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in revocation of the supplier's billing privileges retroactive to the date the insurance lapsed.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from calling beneficiaries in order to solicit new business.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare-covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e. the supplier may not sell or allow another entity to use its Medicare Supplier Billing Number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation

26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date- May 4, 2009

The home infusion company will distribute a copy of these supplier standards in the initial packet that goes out with the first delivery to all Medicare beneficiaries. These standards were put in place to protect Medicare and its beneficiaries from poor quality of products or services, and patients have the right to know what the standards are. These standards should be commonplace practice for any reputable infusion company.

MEDICARE JURISDICTION AND BILLING

Medicare billing is somewhat more simplified than most private insurance companies. Medicare states up front what it requires to reimburse a supplier. Medicare reimbursement is divided into four national jurisdictions across the country: Regions A, B, C, and D. Each Jurisdiction publishes a DMERC Manual with periodic updates, distributed to every provider who subscribes through their Provider Number. DMERC stands for Durable Medical Equipment Regional Carrier. **The four DMERC claims processing centers for claims submissions are:**

- Jurisdiction A – NHIC, Corp
- Jurisdiction B – National Government Services (NGS)
- Jurisdiction C – Connecticut General Life Insurance Co. (CIGNA)
- Jurisdiction D – Noridian Administrative Services

In each jurisdiction DMERC Manual there is a section on jurisdiction that lists each HCPCS code and the carrier to which it must be submitted. For Medicare, there are two types of carriers: DMERC and the Local Medicare carrier. Any item that is not typically covered by Medicare (DMERC) may be submitted to the local carrier for payment. Submission of a claim does *not* imply that the item is covered, nor is it a guarantee of payment. In addition to the jurisdiction of HCPCS codes and items, the DMERC Manual will also provide information on which regional DME carrier (DMERC) has jurisdiction over which states. All healthcare billers and collectors who may bill for Medicare are encouraged to read the DMERC Manual for the applicable regional DME carrier in their state.

If Medicare coverage is not indicated, or it is known that the patient does not meet the medical necessity requirements, it would be appropriate to first see if the local carrier has jurisdiction prior to billing Medicare for denial.

There are **two ways to bill Medicare as a primary insurance:**

1. Medicare for Payment - Claim submitted at full list (retail) price with medical necessity documentation for HCPCS codes/items believed to be covered.

2. Medicare for Denial - Claim submitted at full list (retail) price with or without medical necessity documentation for HCPCS codes / items known not to be covered. The denial or EOMB that is subsequently received will be forwarded with the claim to the patient's secondary insurance for payment.

Both Medicare and Medicare for Denial claims must be submitted at full list or retail prices. The full list or published retail price is usually higher than the allowable amount that will be paid by any payer, including Medicare.

Any claim for any payer can be submitted (billed) in two ways:

1. At List Price
2. At Allowable Prices (Contracted Rates or Allowable Fees)

Medicare and some, but not all, private insurance carriers require that all claims be submitted to them at the supplier's list price. Even though the allowable amount that will be paid is sometimes considerably lower, the payer can show the cost savings from list to allowable to their stockholders (as in private insurance corporations). The pricing submitted on the CMS 1500 is part of the billing format, in addition to whether the format is in a Per Diem, line item, or kit billing format. As previously discussed, Medicare requires a kit billing format.

MEDICARE COVERAGE CRITERIA

Medicare has established criteria that cover particular items or therapies. Some criteria require certain diagnoses, or the use of certain drugs or certain equipment. These criteria must be met in order for a therapy to be considered covered and reimbursable. It is always important to check your current DMERC Manual and periodic updates that DMERC distributes in order to have the most accurate and up-to-date information. As of the publication of this course, the following information represents the current coverage criteria for Medicare DMERC guidelines. It is not within the scope of this manual to duplicate or fully explain any DMERC Manual.

DME items which automatically conflict: use of an IV pole with an ambulatory pump. Medicare will only pay for an IV Pole with a stationary pump. IV poles are billed as capped rental items like other DME, which rent until the purchase price is met. All Medicare beneficiaries must be given the option (in the 10th month of rental) to decide whether they wish to keep renting the piece of equipment or to purchase it. The Provider sends out a **Rent-To-Purchase Option** letter during the 10th month. (See your DMERC manual for full guidelines for capped rentals.) Prior to service, an **Advanced Beneficiary Notice** must be signed by the patient for any treatment potentially not covered by Medicare.

Below is an approved list of chemotherapy drugs for the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable or where the patient refuses surgical excision of the tumor.

- Bleomycin Sulfate (Blenoxane)
- Cladribine
- Cytarabine (Cytosar-U)
- Doxorubicin HCL (Adriamycin PFS or RDF, Rubex)
- Fluorouracil (5FU, Adrucil)
- Floxuridine (FUDR)
- Vinblastine Sulfate (Velban, Velsar, Alkaban-AQ)
- Vincristine Sulfate (Oncovin, Vincasar PFS)

The only approved claim form for Medicare is the CMS 1500 form. Claims must be submitted at the supplier's (provider's) retail list price with appropriate kit billing. The appropriate DMERC Information Form (DIF) must be submitted with the claim to the regional DMERC; otherwise a denial for not medically necessary will result. Field #1 on the CMS 1500 must be marked as a Medicare claim. Claims are billed using standard HCPCS codes.

MEDICARE FRAUD & ABUSE

The following are the key points to understand when it comes to Fraud & Abuse. Fraud and Abuse are punishable by law and can result in fine or imprisonment or both.

- Advanced Beneficiary Notice (ABN) - If Medicare would normally cover a service but the patient does not meet the medical criteria, then the supplier must notify the patient in writing prior to start of care. This written notice must advise the patient that he or she doesn't meet the medical criteria set forth by Medicare. Only then can the supplier bill a patient for services that Medicare denies as not medically necessary. Without the ABN, the supplier cannot bill the patient under these circumstances.
- Co-Payments/Deductibles - A supplier cannot routinely waive or write-off 20% co-payments or deductibles, or offer home medical equipment at no charge. If this happens, home infusion companies will have forms (demonstrating financial hardship) that must be filled out and signed by the patient before the charges can be waived. Suppliers must show proof that co-payments and deductibles were routinely billed.
- A supplier cannot provide more expensive equipment than is medically necessary.
- A supplier cannot provide lower-cost equipment while billing Medicare for higher-cost equipment, or provide used equipment while billing for new equipment.
- A supplier cannot bill Medicare for items that were not provided or delivered.

- A supplier cannot charge the patient for more than the 20% applicable, or bill for items or services without documentation in the patient's chart.

REVIEW OF CONCEPTS

- **Medicare Supplier Number Application (CMS-855S)** – Publication that states Medicare’s strict guidelines and standards that suppliers (providers) must meet in order to continue to be a provider for Medicare beneficiaries.
- **4 DMERC Claims Processing Centers for Claim Submissions:**
- **2 Ways to Bill Medicare as a Primary Insurance:**
- **Any Claim for Any Payer can be Submitted in 2 Ways:**
- **Rent-to-Purchase Option** – A letter sent to the patient during the 10th month of rental to determine if the patient wishes to keep renting the piece of equipment or purchase it.
- **Advanced Beneficiary Notice (ABN)** – A form that establishes any treatment potentially not covered by Medicare that a Medicare patient must sign prior to beginning service.

WORKS CITED

USA. Department of Health & Human Services. Centers for Medicare & Medicaid Services. *Medicare Enrollment Application*. CMS, July 2009. Web. 7 Apr. 2010.
<<http://www.cms.gov/cmsforms/downloads/cms855s.pdf>>.

QUESTIONS

1. What does NSC stand for?
 - a. National Standard Company
 - b. New Supply Company
 - c. National Supplier Clearinghouse**
 - d. New Supply Clearinghouse
2. Why did Medicare issue the NSC standards?
 - a. To set the pricing a provider bills
 - b. Protect beneficiaries from substandard or poor quality products**
 - c. Establish a coding system used by all providers
 - d. All of the Above
3. What are the two types of Medicare Jurisdiction?
 - I. Jurisdiction over ICD-9 Codes
 - II. Jurisdiction over DMERC
 - III. Jurisdiction over HCPC Codes
 - IV. Jurisdiction over CPT-4 Codes
 - a. I + II
 - b. I + III
 - c. I + IV
 - d. II + III**
4. When would you bill Medicare as the primary payer?
 - I. Medicare is the only insurance for direct payment.
 - II. Following submission to a supplemental plan.
 - III. There is a non-covered service and the denial must be billed for.
 - a. I + II
 - b. I + III**
 - c. II + III
 - d. None of the Above
5. What type of pricing structure must be billed on Medicare claims forms?
 - a. Allowable Pricing
 - b. AWP – Average Wholesale Pricing
 - c. Discounted Pricing
 - d. Retail/List Pricing**
6. What Medicare CMN form must be used to bill Parenteral Nutrition?
 - a. DIF 10.02A
 - b. DIF 10.03**
 - c. DIF 09.02
 - d. None of the Above
7. What Medicare CMN form must be used to bill Parenteral Nutrition?
 - a. DIF 09.02
 - b. DIF 10.03**

- c. DIF 10.02B
 - d. DIF 10.3B
8. What CMN is used to bill other Infusion therapies?
- a. **DIF 09.03**
 - b. DIF 10.02A
 - c. DIF 09.02B
 - d. DIF 10.3A
9. What is the name of the form that a patient is required to sign when it is anticipated that the service to be provided will not be covered by Medicare?
- a. Assignment of Benefits
 - b. Prior Authorization Form
 - c. Certificate of Medical necessity
 - d. **Advanced Beneficiary Notice**
10. Medicare generally covers what percentage of the allowable charge?
- a. 100%
 - b. **80%**
 - c. 50%
 - d. 20%