Medicare A,B,C,D: Basic Training

Presented by:
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Ft. Lauderdale, Florida

This program is approved by NCPA for 0.15 CEUs (1.5 contact hours) of continuing education credit. NCPA is approved by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Medicare A, B, C, D: Basic Training

**Learning Objectives:**

1. Explain the process to acquire a Part B supplier number from the national supplier clearing house (NSC).

2. Describe how to fill out billing form CMS 1500 and where to find teaching resources for your staff.

3. Understand basic Medicare terminology.

4. Outline methods to remain profitable in response to the upcoming CMS competitive bid program.
Medicare A, B, C, D's: Basic Training
Lori Wolfe, Reimbursement Specialist
Continuing Education Course

Statement of Need:
The goal of this educational program is to assist the pharmacist, pharmacy techs, and billing staff in the appropriate billing practices and procedures for Medicare Part B reimbursement.

Target Audience
Pharmacists, Pharmacy Technicians, and Billing Staff

Objectives
• Explain the Medicare program as it relates to pharmacy
• Explain the process to acquire a Part B supplier number
• Describe how to fill out the CMS-1500 claim form
• Understand basic Medicare terminology
• Discuss methods to remain profitable in response to the upcoming CMS competitive bidding program
Medicare Eligibility

Who is eligible for Medicare?

- Persons 65 years old or older
- Persons under 65 with permanent kidney failure
- Persons under 65 who are permanently disabled (24 consecutive months) and entitled to Social Security Administration (SSA) benefits

Medicare Part A

- 100% coverage, $876 annual deductible
- Hospital insurance
- In-patient (skilled)
- Home health nursing
- Hospice
- Premium-free coverage

Medicare Part B

- 80% coverage, $110 deductible
- Medical insurance
  - Durable/Home medical equipment (HME)
  - Doctor’s visits
  - Out-patient services
  - Enrollment required
  - Premium deducted monthly
Why Get Involved in Billing Medicare?

1. **Competitive Edge**
   - Set Yourself Apart

2. **Customer Retention and Recruitment**
   - Specialized Service

3. **Opportunity to Increase Business**
   - Home Healthcare Volume
   - Rx Volume
   - OTC Sales
   - Ancillary products

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To Bill the Medicare Program, You Must Have a Provider Number…

**How do you obtain a Medicare provider number?**

- Write or call the National Supplier Clearinghouse (NSC) at:
  
  National Supplier Clearinghouse  
  P.O. Box 100142  
  Columbia, SC 29202-3142  
  866-238-9652  
  [www.palmettogba.com](http://www.palmettogba.com) (other partners)

*Select the CMS-855S application form for those that are using the internet

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Once you have a Medicare Part B provider number you are required to bill for:

- Every Medicare covered item, for every Medicare Part B beneficiary
- **OR**
- Turn the patient away!
Assignment of Benefits

- Assignment
  - Agree to accept what Medicare allows as payment in full
  - Do not bill patient more than 20% of allowable and $110 deductible
  - Medicare pays provider directly
    - 80% of approved amount

So Why Take Assignment?

- Pros
  - Helps generate additional business
  - If Medicare pays well, why not?
  - Patient will not have to pay entire amount up front

- Cons
  - You don’t have your money up front
  - Wait and see period before Medicare pays
  - Sometimes the Medicare allowable doesn’t cover costs

- If you are NOT a PAR provider, you may pick and choose assignment based upon product (except for drugs which must be billed under assignment)

Assignment Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail/Submitted fee</td>
<td>$25.00</td>
</tr>
<tr>
<td>Approved charge (paid at 80% assuming that the $110 deductible has been met)</td>
<td>$20.00</td>
</tr>
<tr>
<td>Allowable charge reduction which cannot be collected from any source (submitted fee minus approved charge)</td>
<td>$5.00</td>
</tr>
<tr>
<td>Payment at 80% of the approved charge</td>
<td>$16.00</td>
</tr>
<tr>
<td>Coinsurance (20% of approved charge)</td>
<td>$4.00</td>
</tr>
</tbody>
</table>
Non-Assigned Example

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail/Submitted fee</td>
<td>$25.00</td>
</tr>
<tr>
<td>Customer/Patient pays pharmacist</td>
<td>$25.00</td>
</tr>
<tr>
<td>Allowable/Approved charge</td>
<td>$20.00</td>
</tr>
<tr>
<td>Medicare reimburses customer (80% of allow.)</td>
<td>$16.00</td>
</tr>
</tbody>
</table>

Assignment Violators

- Suppliers who repeatedly violate the assignment agreement could be charged and found guilty of a misdemeanor.
  - **Punishment:** maximum fine of $2,000, up to six months imprisonment, or both.

Participating Provider

- Agrees to accept assignment for a calendar year beginning January 1 for all Medicare covered items
  - Written notice required to rescind (send in Nov/Dec.)
  - Send notice Federal Express or certified mail/receipt requested
- Non-participating provider may accept assignment on a claim by claim basis (exception: mandatory assignment on drugs billable to Medicare Part B)
Check your Provider Status

- Call the National Supplier Clearinghouse
  - 866-238-9652 (toll free 8a.m.-4 p.m. EST)
- Changes to provider information must be submitted within 30 days
- Re-enrollment required every 3 years
- If you relocate, notify Medicare immediately
  - Payments subject to “Do Not Forward” provision
- Medicare is constantly looking to change the enrollment process to rid of fraudulent providers

Mandatory Assignment for Drugs

- Effective February 1, 2001, assignment MUST be accepted for any drug covered under Medicare Part B
- Pharmacists who dispense and bill for drugs are obligated to take assignment

Mandatory Claim Submission

- When you do not accept assignment…
  - If the item is Medicare covered and the patient is Medicare eligible, you must file a non-assigned claim
  - Medical documentation is the beneficiary or provider’s responsibility
  - Statute of limitations is one year
    • (10% reduction thereafter)
Documentation:
What is needed in a patient’s file?

Administrative Documents
• Communication Log
• Intake Form
• Insurance verification form (if applicable)
• Advanced Beneficiary Notice (if applicable)
• Assignment of Benefits
• Medical release information
• Supplier Standards
• Dr.’s written order (Rx)
• Copy of diabetic log every 6 months (if applicable)

Financial Documents
• Delivery Ticket(s) (for every delivery made)
• Patient profile (print screen)
• Medicare Summary Notice (EOB)

Filling Out the CMS-1500 Claim Form

1 = Indicate insurance type (Medicare, Medicaid, CHAMPUS, etc…)
1a = Health Insurance Claim Number (HICN)
2 = Patient’s name (last, first, middle initial)
3 = Patient’s date of birth & sex
4 = Insured’s name (LEAVE BLANK IF MEDICARE IS PRIMARY. IF PATIENT IS THE HOLDER OF THE INSURANCE, ENTER THE WORD “SAME”)
5 = Patient’s address (no punctuation)
6 = Patient’s relationship to the insured (only when #4 is completed)

7 = Insured’s Address (Only complete if blocks 4, 6, & 11 were completed)
8 = Patient Status (Check the appropriate box for marital, employment, student status)
9 = Other Insured’s Date of Birth (Only for PAR Providers and only when beneficiary has Medigap policy)
10a-c = Is Patient’s Condition Related to:
– Employment, Auto Accident, Other Accident
Filling out the CMS-1500 Claim Form (Con’t)

- 10d = This block is used ONLY for Medicaid info. (enter the Medicaid # preceded by MCD)
- 11 = Insured’s Policy Group or FECA # (This block MUST be completed. Enter the word “NONE” here if Medicare is the primary payer.)
- 11a = Enter the insured date of birth and sex if different than box 3
- 11b = Enter the employer’s name, if applicable. (If insured is retired, enter “RETIRED”)
- 11c = Enter the name of the insurance plan

Filling out the CMS-1500 Claim Form (Con’t)

- 11d = Write the word “none”
- 12 = Have the patient or patient’s representative sign here. For patient’s who assign benefits and sign the AOB you may use “SIGNATURE ON FILE”.
- 13 = Have the patient or patient’s representative sign here. For patient’s who assign benefits you may use “SIGNATURE ON FILE”.
- 14 = Enter date of current illness or injury
- 15 = Leave blank
- 16 = Complete if worker’s comp (Leave blank if Medicare/Medicaid)

Filling out the CMS-1500 Claim Form (Con’t)

- 17 = If the service is covered by Medicare, enter the referring provider’s info.
- 17a = Enter the CMS assigned NPI provider number (new), if one is not available use the UPIN
- 18 = Only complete this section if services are related to a hospitalization
- 19 = Leave blank (for OT or MD’s providing foot care)
- 20 = For diagnostic testing only
Completing the CMS-1500 Claim Form (Con’t)

- 21 = Enter ICD-9 (Dx code) to the highest level of specificity
- 22 = Leave blank (use only for Medicaid)
- 23 = Enter prior authorization # (if applicable, if not leave blank)
- 24a = Enter dates of service (use spanned dates when applicable)
- 24b = Enter the “place of service” (12 is the most common code used for HME)
- 24c = Not applicable to Medicare Providers
- 24d = Enter the HCPCS code and modifier
- 24e = Diagnosis code – enter the diagnosis code reference number as shown in block 21
- 24f = Retail charge
- 24g = Billing units
- 25 = Federal Tax ID # or Social Security #
- 26 = Patient’s ID # (established by the provider)
- 27 = Accept Assignment (check yes or no)
- 28 = Total charge for service(s)
- 29 = Total paid
- 30 = Balance due (leave blank)
- 31 = Provider’s signature

Filling Out the CMS-1500 Claim Form (Con’t)

- 32 = Name/Address of facility where services rendered (if name/address are the same as biller’s name/address, enter “same”)
- 33 = Provider’s billing name, address, zip, phone and Provider Identification Number (PIN issued by NSC)
Charge Amounts

- Is business for retail or Medicare customer?
- May vary based upon product
- What you bill Medicare is what you bill general public
- Medicare stores data at charge amount
  - Most bill higher than the allowable
- Medicare pays 80% of the lower of your charge or their allowable

Reimbursable vs Nonreimbursable Items

Medicare Covered Items
- Durable goods
  - Hospital beds, nebulizers, seat lift mechanisms
  - Ambulation aides
  - Supplies
  - Wound care, diabetic, etc.
  - Oxygen

Medicare Non-Covered Items
- Bath safety items
  - Shower bench, raised toilet seat, grab bars
- Not medically necessary items
  - Overbed table
- Preventative items
- TED hose/support stockings
- Contraindicated items
  - Seat lift chair and wheelchair

Advance Beneficiary Notice (ABN)

- To be used when a supplier knows that the beneficiary does not meet the Medicare requirements, however still wants the product
- Allows supplier to bill beneficiary if the product is denied for the reason stated by the supplier. (necessary or reasonable)
- Use on both assigned & non-assigned claims!
ABNs (continued)

- Applies to:
  - Medical necessity denials
  - Medically unnecessary upgrades
  - Prohibited, unsolicited telephone contacts
  - No supplier number
  - Denial of ADMC (Advance Determination of Medicare Coverage) request

ABNs (continued)

- Must use Medicare’s form (CMS-R-131-G)
- Must be done in advance – before dispensing product/supply
- Append claim with “GA” modifier
  - Do not send form to Medicare
- Should be specific to an item
  - Describe the item
  - Give reason why you think it’ll be denied

2005 MMA Changes

- Infusion drugs remain frozen at 95 percent of the AWP – dispensing fee added
- Inhalation drug reimbursement change to average sales price (ASP) + 6% + $57 dispensing fee (or $80 fee for 3 months)
Medicare Reform Act: 2005

- New “G” codes for dispensing fees, effective 1/1/05:
  - G0369 - Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant - $50
  - G0370 - Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s) - $24
  - G0371 - Pharmacy dispensing fee for inhalation drug(s); per 30-days - $57
  - G0374 - Pharmacy dispensing fee for inhalation drug(s); per 90-days - $80

2005 Impact

- Some nebulizer patients may have more limited access to certain drugs
- Oxygen 8-12% cut in reimbursement
  - Finally released cuts in April, 2005
  - Impact? Just beginning to be felt
- Some small providers begin feeling overall woes of reductions
  - Less strategic buying power
  - Fewer resources
    - Medicare contractor (RTI) meets with small providers to learn about their issues
    - Mail-order concerns included in discussion

Planning for Additional Cuts

- 2005 what to do?
  - Stay abreast of changes as they are available
    - Sign up for list-serve wherever possible
  - Will access to care be restricted?
    - Will patients go without or will they receive inferior quality of product and/or service?
  - Simultaneously look for changes in pricing and/or create alternate products
  - Look to diversify product offering and payer mix
  - Streamline and automate as much as possible
MMA – Competitive Bidding

- **2007** – Competitive bidding to begin in 10 of the nation’s top 10 metropolitan statistical areas (MSAs) for 6 or fewer items
- Selection process not yet defined
  - Demonstration used RFP approach
  - From RFP, determined composite bid price
  - Evaluated providers on individual quality standards
- Will a provider be awarded contract for one product category but not all?
  - Demonstration allowed providers to participate with one product
- **2009** - Top 80 MSAs subject to competitive bidding

MMA and the Pharmacist

- What will happen to drugs billable to Medicare Part B?
- Current covered drugs to stay Part B and newly covered drugs to go to Part D?
- Will drugs be included in competitive bidding?
  - If so, which ones?
  - Nebulizer medications were included in San Antonio, Texas
  - Mail order issues
  - Small provider matters

MMA and Quality Standards

- Accreditation
- New quality standards to be established
  - Expect more than existing 21 standards
- One or more “recognized independent accreditation organizations”
  - ACHC, JCAHO, CHAP
- Standards should be established before 2007
  - Latest, by implementation of competitive bidding
Medicare Reform Act – CB Impact

- Competitive Bidding impact
  - Potential access to care
    - Product limitations
    - Service restrictions (even with enhanced quality standards)
  - Fewer providers
    - Possible subsequent reduction in allowables for all providers
  - Smaller, independent providers
    - Vendor consolidation
      - Work with Cardinal to utilize vendor contracts
    - Superior service may need redefining
  - What about networking?

Remember Competitive Bidding Demonstration

- GENERAL OUTCOMES
- BBA ‘97 directed CMS to conduct competitive bidding demonstrations
- CMS chose 3 demonstrations
  - 2 in Polk County, Florida
  - 1 in San Antonio, Texas
- Overall experience seen as successful
  - Independent evaluation by RTI
    - Favorable results were found
  - Patients were generally satisfied
  - CMS recognized for successful project
    - Received awards

How Should You Prepare?
Take A Step Back

- Remove yourself from setting
- Determine your strategic direction
- Focus on staff, software, office systems
- Decide on best, most viable option for your future
- What role do you want to play?

Preparing for Reductions

- How to plan?
  - Evaluate each process in work flow
    - Look for excess time spent on tasks
    - Look for duplication of effort
    - Look for manual processes
    - Ensure that you have the right people in the right positions
    - Do you collect maximum A/R (accounts receivable)?
      - Evaluate your AR collection process

Summary

- When profitable and worth the investment—take assignment
- Know which items are reimbursable and which are noncovered to ensure payment
- Know how ABNs work and use them generously
- Follow Medicare changes – What will Medicare Reform do next?
- Study competitive bidding demonstration results – where/how would you fit in?
Q & A Session
# Health Insurance Claim Form

**Recipieent Information**
- Name: Jane Doe
- Address: 10 Cherry Lane, Anywhere, OH 33333
- Phone: (614) 777-7777
- SSN: 123-45-6789
- Date of Birth: 02 02 1930
- Policy Group/FEIN: 102 02 1930
- Insured’s ID Number: 123-45-6789 A
- INSURED’S NAME (Last Name, First Name, Middle Initial): Jane Doe
- CITY: Anywhere
- STATE: OH
- Zip Code: 33333

**Insured Information**
- Insured’s Name: Jane Doe
- Address: 10 Cherry Lane, Anywhere, OH 33333
- Phone: (614) 777-7777
- Policy Group/FEIN: 102 02 1930
- Insured’s ID Number: 123-45-6789 A
- INSURED’S NAME (Last Name, First Name, Middle Initial): Jane Doe
- CITY: Anywhere
- STATE: OH
- Zip Code: 33333

**Physician Information**
- Name: Marcus Welby, M.D.
- NPI: A12345
- Service Code: E0135

**Pharmacy Information**
- Name: ABC Pharmacy
- Address: 300 Main Street, Youngstown, OH 33333
- Phone: (614) 662-2222
- NPI: 95-4325333

**Insured’s Policy Group or FEIN Number**
- None

**Other Insured’s Name (Last Name, First Name, Middle Initial)**
- None

**Signature on File**
- Signature on File

**Physician/Supplier Information**
- Signature on File

**Claim Details**
- Place of Service: 716 97

**Medical Procedure Code**
- Procedure: E0135
- Diagnosis: NU
- Charge: 25 00
- Unit: 1

**Other Information**
- Signature: Marcus Welby, M.D.
- Date: [Date]

**Additional Notes**
- Please print or type.
Medicare A, B, C, D: Basic Training

**Learning Assessment Questions:**

1. Enrollment is required for:
   a. Medicare Part A
   b. Medicare Part B
   c. Medicare Part D
   d. A & C
   e. B & C

2. It is acceptable to select Medicare beneficiaries that your business will bill for under certain circumstances.
   a. True
   b. False

3. Providers must re-enroll:
   a. Never
   b. every three years
   c. every year
   d. every five years

4. What the supplier bills to Medicare patients must match what is billed to all other patients.
   a. True
   b. False

5. Participating providers agree to accept assignment for a period of:
   a. 6 months
   b. 5 years
   c. 3 years
   d. 1 year
Learning Assessment Answers:

1. Enrollment is required for:
   a. Medicare Part A
   b. Medicare Part B
   c. Medicare Part D
   d. A & C
   e. B & C

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