HME Reimbursement: A NEW Frontier

HME REIMBURSEMENT:
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Learning Objectives

1. **Draw** an educated conclusion of when you can accept a payer's rates with the current documentation requirements
2. **Discover** viable options when you determine you can't accept the patient's insurance rates
3. **Judge** if you are meeting your company's financial objective to run a business
4. **Chart** a course to get to the desired destination (customer care / financial sustainability)

And that's NOT all folks....

The Mobility *Frontier*

Documentation
- Venture into Physician and Therapist Education (How to convince them to allow you to help them which will help you)
- Documentation requirements Path of Least Resistance for Mobility Assistive Equipment (Get What you NEED the FIRST TIME with NO MORE Addendums!)
- Are You Really Asking for More Than Your Competitor (well are you?)
- Executing a valid ABN when necessary (denial, upgrade and retail)

Claim Submission
- Don't get Snared by the Prior Authorization and ADMC TRAP (it's NOT a guarantee**...learn why**)
- Prepping the Claim for Success
- Explore Modifier Logic (yes I said logic, partner)
- Why Claims get "Stuck"? And what YOU can do about it!

Denials
- Uncover the most common denials and learn how to avoid them
- Learn to "Speak their language" when appealing a denial

YEE HAW!

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The DME industry is caught in a "Perfect Storm."

- Competitive bidding
- Reimbursement cuts (all payers)
- **Stringent documentation requirements**
- Aggressive auditors
- Proliferation of "whistleblowers"

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Documentation - Physician and Therapist Education

- Everyone has productivity requirements (**EVERYONE**)
- Understanding what is required improves productivity by avoiding redoing work (addendnums)
- Patient receives the necessary items in a timely manner with least amount of financial responsibility
- Help educate them with lunch sessions, cheat sheets, being available to answer questions

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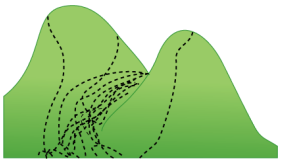
Documentation – Path of Least Resistance



Physician

- Perform a face to face exam in a detailed narrative note in the chart
- Identify mobility limitation, symptoms and progression
- List item being ordered and perform a routine physical exam

Therapist

- Rule out ALL least costly alternatives to the item being recommended for the patient
- Tried and failed **OR** considered and ruled out with reason why (narrative AND objective measurements – manual muscle test, ROM, SAT, pain scale, deformity, etc)
- Make it **EASY to find** within the documents (when difficult to find it is reducing **THEIR** productivity)

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Documentation – Are you asking for MORE than your competitors?

- Probably NOT but they may not be getting what is required
- Why so not to alienate (aka **** ***) the clinicians, family, patient
- BUT remember the AUDIT
- If it seems like they are getting away with it they aren't or won't for too long

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There's a new "Sheriff in Town" and it's, YOU, NOT the payers!

- 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 it partner.
- For the first time in its history, the DME industry is 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."

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Executing a VALID ABN – Advance Beneficiary Notice

- 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
- HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GA modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. **(Note: The codes must be billed in this specific order on the claim.)**

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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.** _____ 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
Power wheelchair and accessories	The manual chair and scooter were not ruled out due to weakness as stated with a manual muscle test of 5/5 BUE	$4500.00

Acceptable ABN

- **Be on the approved form CMS-R-131 (Exp. 03/2020)**
- **New form implemented March 28th, enforced June 21th**
- 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 noncovered item and/or service
- Be signed and dated by beneficiary or representative
- Once signed by beneficiary or representative may not be modified or revised

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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.**

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 last Fall)

  - WANTS: K0802 NUGA (Patient requested upgrade and valid ABN on file)
  - NEEDS: K0800 NUGKKX (Reasonable & necessary item associated with GA)

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Upgrades – No Charge (when practical)

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 high strength lightweight (K0004) in stock for low inventory
- Doctor orders standard (K0001) and patient meets criteria for standard
- Bill K0001 RRKHKXGL
- Chose to delivery a medically unnecessary upgrade to patient at no charge (K0004)
- Add note in narrative on claim what patient actually received using HCPCS, make/model and reason for upgrade

  (Pt rec'd K0004 high strength lightweight manual chair, only keep this type for inventory purposes)

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

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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 want is medically needed
- Fragmented Billing – cannot have assigned & non-assigned items on same delivery ticket on same DOS

Non-Assigned

- The allowable for the E0986 is $5685.96 after 13 months of rental.
- If you can't accept that amount 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 $541.42 plus the amount you need over the total allowable.
- If you need $6000 for this item then you can collect $855.46 from the patient in the first month then bill $855.46 non assigned.
- Make sure you let the patient know in writing that they will only receive 80% of the Medicare allowed amount of $433.14 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.

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Servicing Your Customers

Many providers are asking the question, "What can we do when the payer's rate is not adequate to operate my business?" "I'm losing MY shirt on these products and services!"
When you identify payer's rate is not sustainable for a product / service,

Don't Lose YOUR Shirt!

Take Action!

1. Try to accept assignment
2. If payment rates are not adequate offer a non assigned option
3. If non assigned is not an option (payer doesn't allow or Medicare Medicaid bene)
4. Retail Transaction ABN option 2 (waive payer benefit if allowed)
5. If waiving benefit is not allowed assist patient make **their voices heard** as to why they can't obtain the items prescribed – TAKE ACTION

Take ACTION

1. Notify the payer that these rates are unsustainable and you can't continue to provide products / services for that rate. If no resolution proceed to step 2.

2. If a Medicare plan or Medicaid plan contact local, state and federal congressional representatives to voice your concern that these rates or practice are not sustainable. If it's a private insurance don't agree to the terms of the contract. If no resolution proceed to step 3.

Advocate for these patients with the payers and congressional representatives AND assist them in advocating for themselves with help from ***People for Quality Care at VGM****.*

3. Inform the patient that you can only provide these service / product on a non assigned basis due to the reimbursement rate from their health insurance. If the payer prohibits non assigned claims proceed to step 4.

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Take ACTION

4. Inform the patient that you can only provide the services / products if they waive their health insurance benefit (for Medicare ABN option 2) and no claim will be filed (100% out of pocket with no money from the payer). If the payer prohibits the patient from waiving their health insurance benefit or if the patient can't afford the product / service proceed to step 5.

5. Inform the patient that you can't provide these service / product due to the reimbursement rate from their health insurance AND assist them on how to advocate for themselves.

A payer can't force you to Lose YOUR Shirt when you provide a product / service, unless you agreed to it in a contract or you just accept it. You can say NO but this is easier said than done because patient care comes first. However, if the payer's rates are not adequate and you accept them, they'll believe their rates ARE adequate and YOU will continue to Lose YOUR Shirt!

Payers need to hear from their customers!

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MEMBER SERVICE ORGANIZATION

Why am I being charged more for my medical equipment and repairs?

In 2016, Medicare expanded competitive bid rates across the country which significantly reduced your Medicare benefit by reducing the rates they pay for medical equipment by an average of 50%. You may have not noticed this as we wanted to continue to meet our customers' needs without increasing your out of pocket expenses. Unfortunately this has put us in a position of not being able to accept assignment (the Medicare rate) for many products and service that we once did.

Due to these significant reduction in the Medicare rate, we have no choice but to reluctantly request that our customers' pay up front for medical equipment and repairs. We will still file a claim to Medicare on your behalf (non-assigned) and if approved you will receive 80% of the allowed amount from Medicare.

We are NOT responsible for these significant reductions to your Medicare benefits and would rather not have to charge you more for these products and repairs, but if we don't, we won't survive as a company and won't be here to service your future needs.

We have strongly voiced our concern about these rate reductions with Medicare officials and Congressional Representatives in Washington D.C. However, Medicare has proceeded with these reductions that have forced us into increasing your out of pocket cost. Medicare believes that their rates are adequate as providers have continued to accept them until recently as they are no longer sustainable. They've heard from us and now they need to hear from you!

WHAT CAN YOU DO?

If you are unhappy with how these significant reduction in the Medicare rate has affected your out of pocket cost thus negatively impacting your life or restricting your access to the equipment you need, PLEASE let your congressional representative know that you are not happy with these changes that are DIRECTLY DUE to the COMPETITIVE BIDDING PROGRAM.

HOW CAN YOU MAKE YOUR VOICE HEARD?

Contact your Representative and Senators to let them know how these changes are impacting your life. The People for Quality Care has made this simple. Visit "PeopleForQualityCare.com/TakeAction" to let them know how these cuts are impacting your life! Don't have Internet access but still want to voice your concerns? Call People for Quality Care at 800-260-7913 to share your concerns TODAY!

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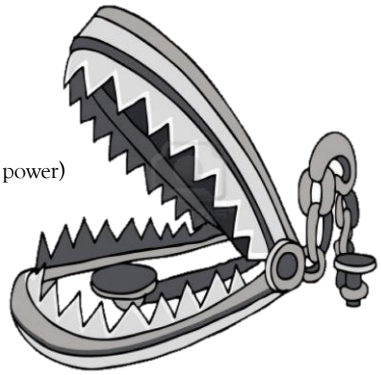
Claim Submission – Prior Authorization / ADMC

- Don't get **Snared** by the Prior Authorization / ADMC **TRAP**
- It's NOT a guarantee
- Medical Necessity AND Same Similar
- PAR – Base and Accessories Contingent on the BASE Code (single power / multiple power) ONLY
- ADMC – Base AND ALL Accessories
- Still NOT a guarantee as they make ERRORS too
- Rep Payee on File?
- Traps are inhumane and so is this (financially)



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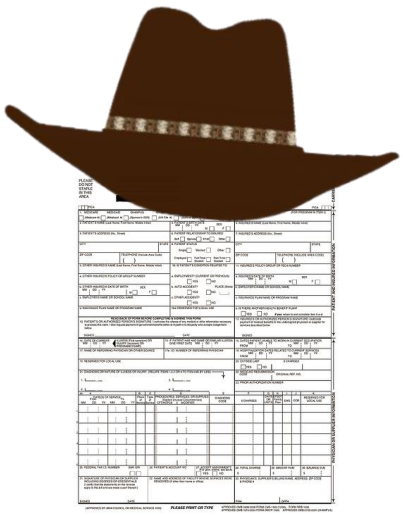
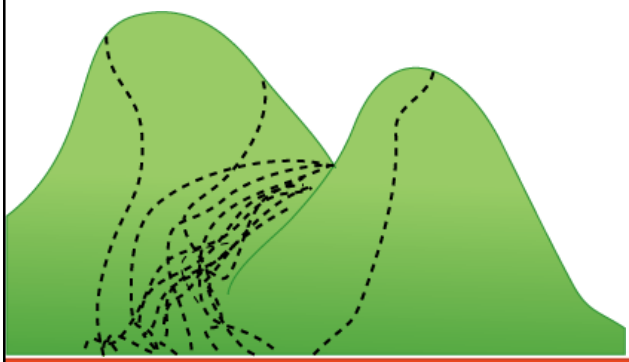
Prepping the Claim for Success





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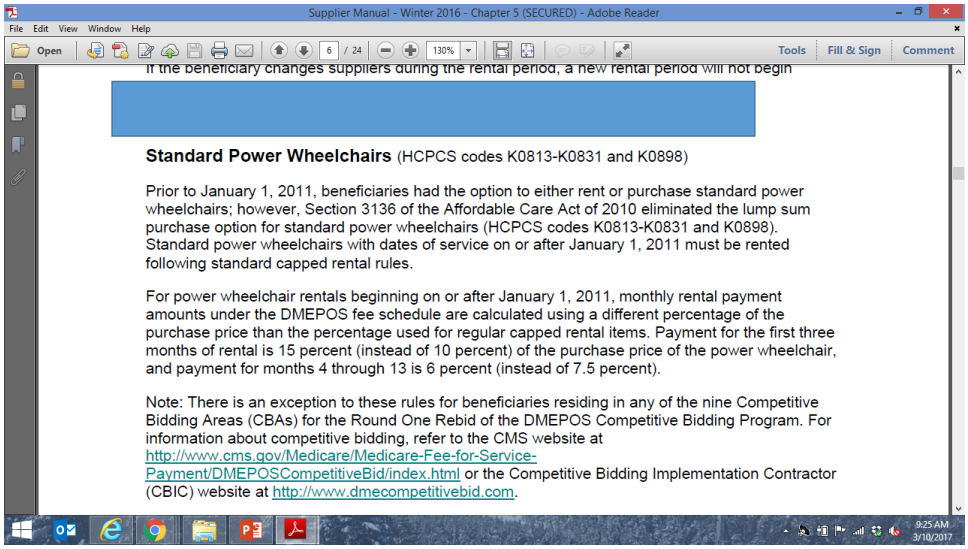

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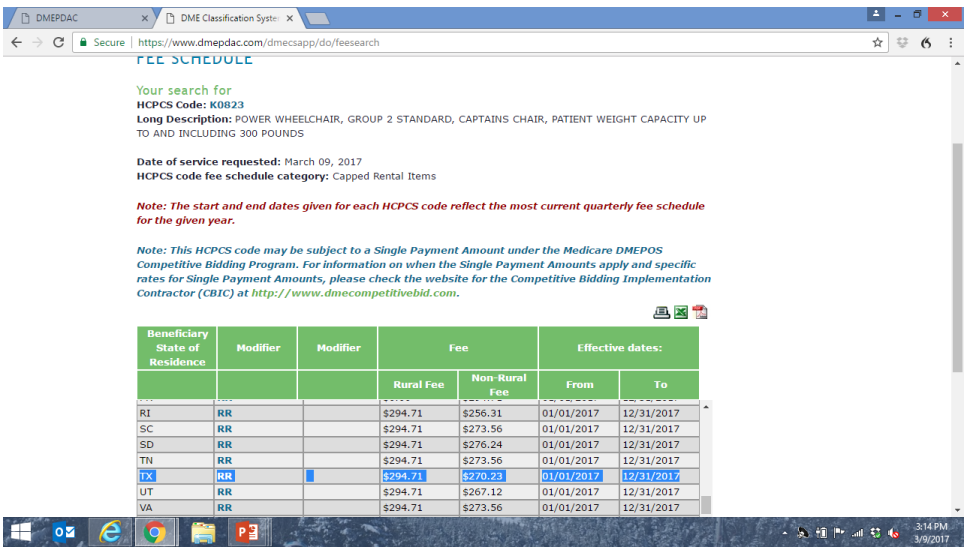

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Calculating Allowed Amount (Capped Rental Power Wheelchairs with NO First Month Purchase Option – RENTAL ONLY Allowable AFTER 13 Months)

Power Wheelchair Bases (K0812-K0831) – RR Allowable divided by .15 = Purchase Allowable

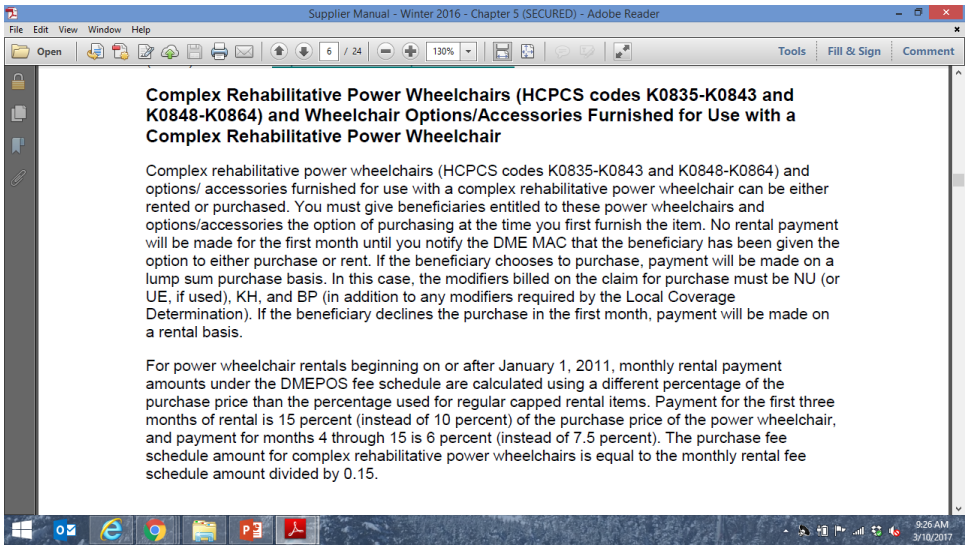
15% of the Purchase Allowable each Month for Months 1-3 (45% total)
6% of the Purchase Allowable each Month for Months 4-13 (60% total)

Total Allowed Amount AFTER 13 Months – 105% of the Purchase Allowable

K0823 (group 2 standard captain seat power base) allowable in the fee schedule for TX (rural) = $294.71

Purchase Allowable = $1964.73 (RR divided by .15)
Months 1-3 = $294.71 each month = $884.13 (45% of purchase allowable)
Months 4-13 = $117.88 each month = $1178.84 (60% of purchase allowable)

Total Allowed Amount AFTER 13 Months = $2062.97 (RR divided by .15 times 1.05)



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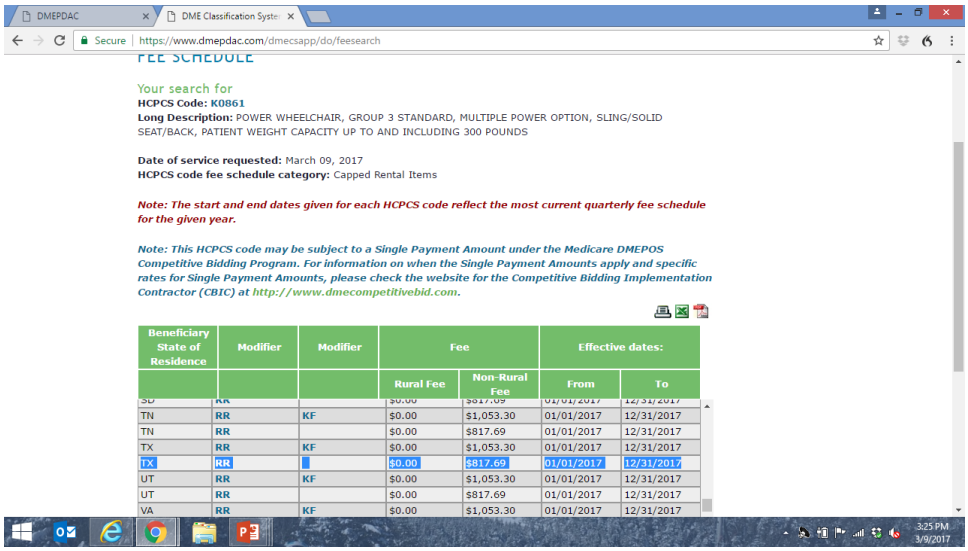

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Calculating Allowed Amount (Capped Rental <u>with Purchase Option</u>)

Power Wheelchair Bases (K0835-K0864) – RR Allowable divided by .15 = Purchase Allowable

15% of the Purchase Allowable each Month for Months 1-3 (45% total)
6% of the Purchase Allowable each Month for Months 4-13 (60% total)

Total Allowed Amount AFTER 13 Months – 105% of the Purchase Allowable

K0861 (group 3 multiple power base) allowable in the fee schedule for TX (rural) = $817.69

Purchase Allowable = $5451.27 (RR divided by .15)

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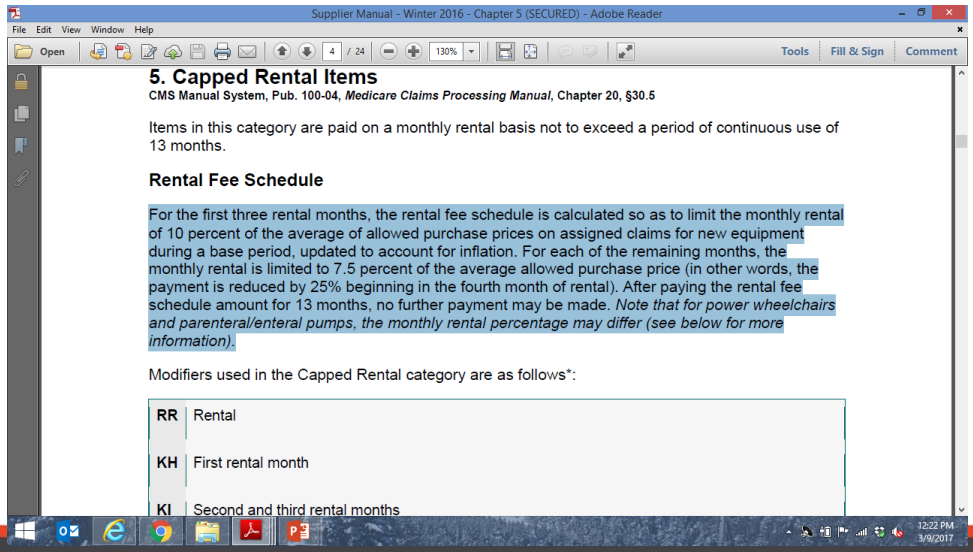
Calculating Allowables for OTHER Capped Rental Items



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Billing Scenario Examples - Capped Rental Accessory

- Capped rental **accessory** (E1002) provided on a **group 3 complex rehab power base** regardless of where the beneficiary resides
  - E1002 NUKHBP**KU**KX
  - Allowable in TX - $388.89 (with KU)
  - Purchase Allowed Amount - $3888.90 (RR x 10)
- Capped rental **accessory** (E1002) provided on a **group 2 complex rehab power base** regardless of where the beneficiary resides
  - E1002 NUKHBPKX
  - Allowable in TX - $346.16
  - Purchase Allowed Amount - $3461.60 (RR x 10)

Additional Allowed Amount with KU (group 3 accessories) = **$427.30**

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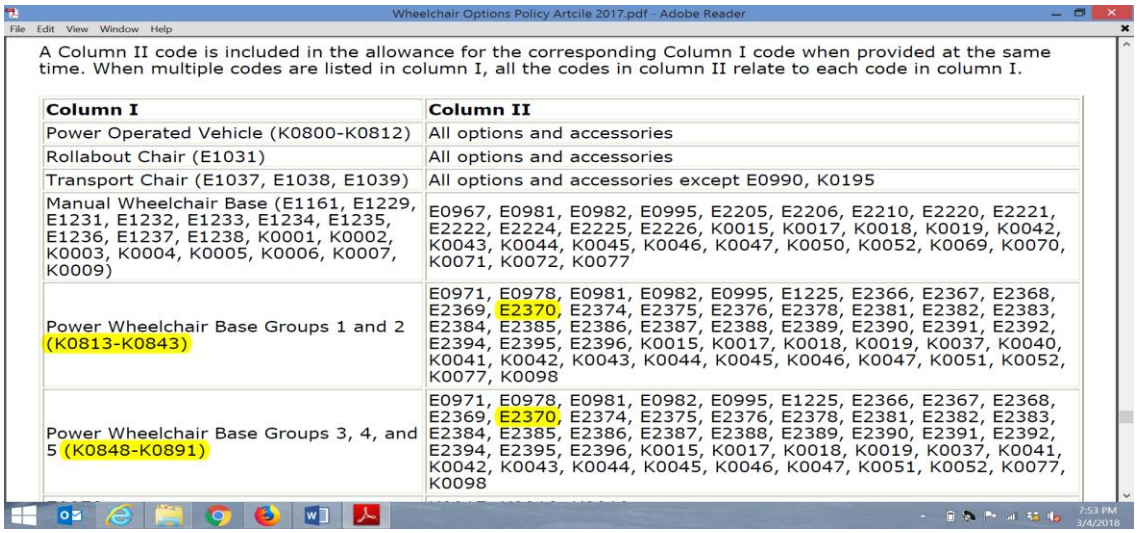
Can I Bill Medicare for that Wheelchair Option / Accessory?

When providing a wheelchair option / accessory many providers question if the item is separately reimbursable by Medicare. This is a common question and the answer depends on several factors. To determine if you can bill Medicare separately for a wheelchair option / accessory you must considered the following.

Is the item included in the allowable for another item (the base code)?

Many items are included in the allowed amount for the base code and if so they are not separately reimbursable with the initial claim. An example of this are the motors (E2370) on a power wheelchair as they are included in the basic equipment package for ALL power wheelchair bases. This can be determined by looking at the Wheelchair Options Policy Article on page 14. All codes in column II are included in the allowable for the column I code. See example below and note that the E2370 in column II is included in the allowable for the column I codes from K0813 - K0891.



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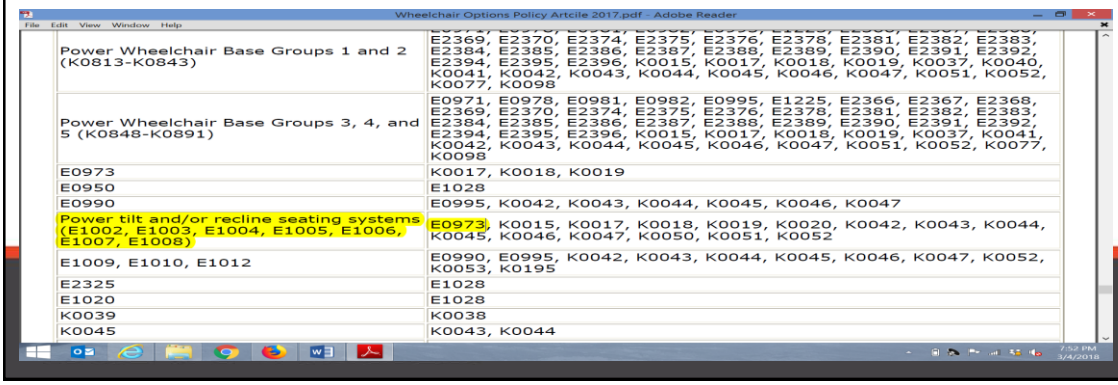
Can I Bill Medicare for that Wheelchair Option / Accessory?

Another example is detachable height adjustable armrests (E0973) as these are NOT included in the allowable for the power wheelchair base codes, therefore they can be billed separately if (2) and (3) are met. However, E0973 is included in the allowable for the power positioning seating (E1002-E1008). Therefore E0973 can't be billed separately when providing codes E1002-E1008 on a power wheelchair base.



	E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0040, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
Power Wheelchair Base Groups 1 and 2 (K0813-K0843)	
Power Wheelchair Base Groups 3, 4, and 5 (K0848-K0891)	E0971, E0978, E0981, E0982, E0995, E1225, E2366, E2367, E2368, E2369, E2370, E2374, E2375, E2376, E2378, E2381, E2382, E2383, E2384, E2385, E2386, E2387, E2388, E2389, E2390, E2391, E2392, E2394, E2395, E2396, K0015, K0017, K0018, K0019, K0037, K0041, K0042, K0043, K0044, K0045, K0046, K0047, K0051, K0052, K0077, K0098
E0973	K0017, K0018, K0019
E0950	E1028
E0990	E0995, K0042, K0043, K0044, K0045, K0046, K0047
Power tilt and/or recline seating systems (E1002, E1003, E1004, E1005, E1006, E1007, E1008)	E0973, K0015, K0017, K0018, K0019, K0020, K0042, K0043, K0044, K0045, K0046, K0047, K0050, K0051, K0052
E1009, E1010, E1012	E0990, E0995, K0042, K0043, K0044, K0045, K0046, K0047, K0052, K0053, K0195
E2325	E1028
E1020	E1028
K0039	K0038
K0045	K0043, K0044

Can I Bill Medicare for that Wheelchair Option / Accessory?

If the option / accessory is NOT in column II for an item you are already billing for then it may be separately reimbursable if (2) and (3) are met. Note: Even if a manufacturer charges you for an item that is in column II when provided with a column I base code you can't bill it separately.

Is the item medically necessary per policy?

Just because detachable height adjustable armrests (E0973) are not included in the allowable for power wheelchair base codes (let's say for a K0823) they can only be billed separately for reimbursement IF there is medical documentation from a clinician, with no financial relationship to the equipment supplier, to support the medical necessity. Don't fall into the trap of having packages for all Medicare beneficiaries for separately reimbursable items unless you have the documentation to support the need for those items in the patient file.

Can I Bill Medicare for that Wheelchair Option / Accessory?

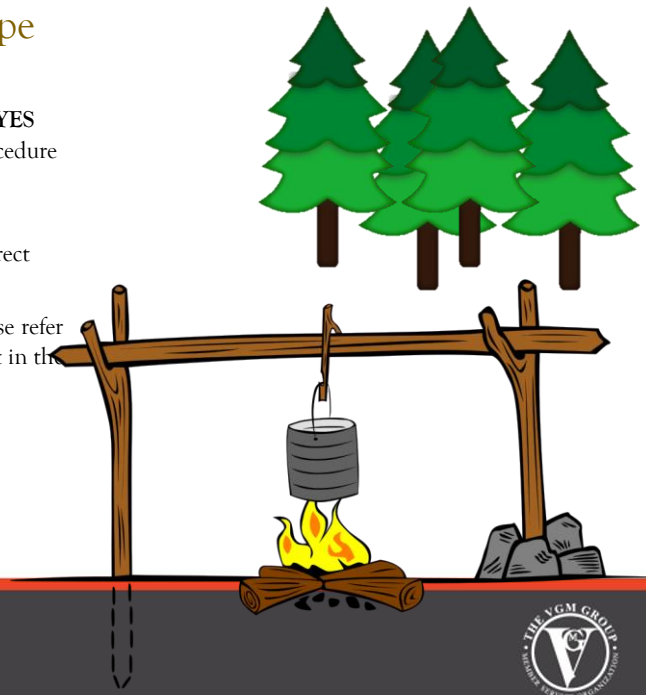
Did the manufacturer separately charge you for the item? No cost items may not be billed to Medicare for reimbursement!

If the manufacturer bundles the separately reimbursable item (not listed in column II) in a base code and there is no charge $0 on the invoice for the item then it is considered "free" and it may not be separately billed to Medicare for reimbursement. This holds true even if medical necessity has been supported by a clinician (number 2).

Please ensure you billing for separately reimbursable items when ALL three requirements have been met and that you are not billing separately for options / accessories when all three requirements have not been met.

Modifiers – What's the Right Recipe

- You are afraid to look but you reluctantly do and you see, **YES the CO-4 denial** (the modifier is inconsistent with the procedure code).
- Modifiers can be frightening! Some wonder why they are necessary and some wonder if anyone really knows the correct answer / order.
- You call Medicare to ask and are told "I can't tell you, please refer to the LCD". Why can't they tell you and the answer is not in the LCD!



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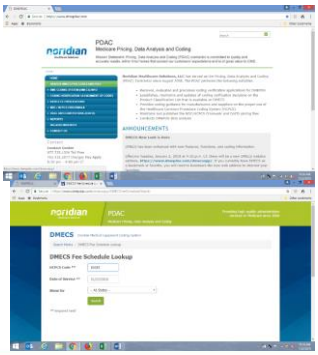
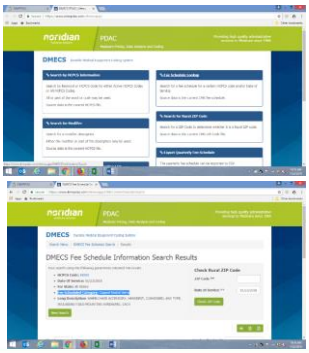
Modifiers – What's the Right Recipe

Let's face your fears and first determine if the item is in the capped rental or inexpensive or routinely purchased (IRP) fee schedule category.
www.dmepdac.com





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Modifiers – What's the Right Recipe

Once you determine the fee schedule category you now know the modifiers.

- All capped rental items will always have a KH in the second position even for repairs.
- The first position will either be NU (new first month purchase), UE (used first month purchase) or RR (rental only).
- ONLY complex rehab power bases have the first month purchase option and all capped rental accessories provided with those bases also have the first month purchase option.
- IRP items will NEVER have a KH modifier.

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Modifiers – What's the Right Recipe

Capped Rental Power Chair Bases K0835-K0864 and capped rental accessories used on those bases with beneficiary signed purchase option letter would be:

NU - New product

KH - First month of a capped rental

BP – Beneficiary elected to purchase (in writing via purchase option letter)

KX – Coverage criteria met per policy and is on file

KU – Affected accessories on a group 3 power base (reimburses at the unadjusted fee schedule higher reimbursement)

LT / RT – If each one unit on a specific side of the chair (E0955 headrest would not require the RT / LT)

Modifiers – What's the Right Recipe

Capped Rental Power Chair Bases K0813 – K0831 and capped rental accessories used on those bases would be:

RR – Rental ONLY
KH – First month of a capped rental, KI 2nd and 3rd months and KJ 4th – 13th months **(Oct 1, 2018 the KH is NO longer needed on capped rental purchases)**
KX – Medical necessity on file
LT / RT – If each one unit on a specific side of the chair (E0955 headrest would not require the RT / LT)

Miscellaneous Modifiers

KY – Competitive bid (CB) item on a non bid base (E1161, K0005, K08350-K0864) when beneficiary resides in a CB area (initial claim ONLY NOT to be used on repairs with RB mod)
RB – Replacement as part of a repair
99 – When you have more than 4 mods use 99 in 4th position to indicate overflow place remaining mods in extra narrative field

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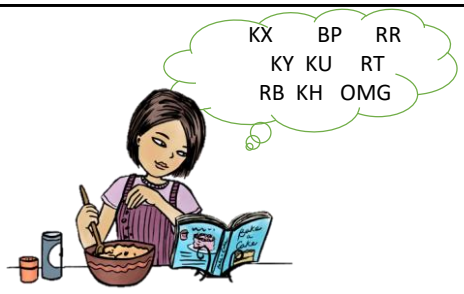
Modifiers – What's the Right Recipe



Common Examples Initial Claims

Group 3 Multiple Power Base (K0861)

K0861 NUKHBPKX
E1007 NUKHKX99 extra narrative BPKU
E2311 NUKHKX99 extra narrative BPKU
E1012 NUKHKX99 extra narrative BPKU
E2313 NUKHBPKX (NO KU even if on group 3 base as the code E2313 is not affected)
E2363 NUKUKX
E2603 NUKUKX
E2607 NUKUKX
E2609 NUKX (NEVER KU as it a manually priced item)
E1028 (one unit per line unless as a pair on a K0835-K0864 base) NUKHKX99 extra narrative BP,KU, RT or LT (KU if on a group 3 base)
K0108 NUKX

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Modifiers – What's the Right Recipe

Group 2 Standard Captains Seat Base (K0823)

K0823 RR**KH**KX (KH – First month of a capped rental, KI 2nd and 3rd months and KJ 4th – 13th months)
E0973 NURTLTKX (use appropriate RT LT when applicable)
E2361 NUKX

Common Examples Repairs

E2370 (2 units) NUKHRBKX (and KU if on a group 3 base)
E2374 NUKHRBKX (and KU if on a group 3 base)
E0973 (2 units) NUKX (and RB if replacing on a tilt, recline or tilt and recline and NO RB if replacing on any other seating (captains seat, solid seat with NO power positioning)
E2363 NURBKX (and KU if on a group 3 base)
K0739 (NO Modifiers required)
K0462 (NO Modifiers required)

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The **KE modifier is BACK** temporarily!

The DME MACs published the following article on May 31, 2018 regarding the KE modifier. If you provide manual wheelchairs to Medicare beneficiaries that reside in a rural area, then please continue reading.

If you provide an **affected accessory** on a manual wheelchair base (K0001-K0009 and E1161) to a Medicare beneficiary who resides in a rural area (based on zip code) and the date of service is from June 1, 2018 – Dec 31, 2019, then you should append the **KE modifier** on those accessories. The purpose of the **KE modifier** is to receive the highest reimbursement possible for those accessories.

Example in rural Washington

E0973 (detachable height adjustable armrests)
E0973 with **KE** modifier $81.52 each = $163.04 per pair
E0973 without the KE modifier $75.45 each = $150.90 per pair
E2603 (skin protection cushion)
E2603 with the **KE** modifier = $133.23
E2603 without the KE modifier = $127.32

IFR Rural Allowables Comparison

K0823 in Rural WA

Jan 1, 2018 – May 31, 2018 – 294.71 (total allowed after 13 months = $2062.97

June 1, 2018 – Dec 31, 2019 - Rural WA $440.11 (total allowed after 13 months = $3080.76

Additional $1017.79

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Repairs

- Medicare pays for parts **and** labor not covered by a manufacturer / supplier warranty for patient owned equipment
- Patient owned is either purchase items (scooters, ultra lightweight manual chair) or capped rental items with the purchase option (complex power chairs) or capped rentals that have paid 13 months (standard power chairs, manual chairs, hospital beds, CPAP)
- While equipment is under rental (up to 13 months) the supplier is responsible for all repairs and can't charge the patient OR Medicare
- Suppliers are only required to repairs items they are renting
- Suppliers are NOT required by Medicare to repairs items that are patient owned

Repairs

- Suppliers are NOT required to accept assignment on repairs and may charge above the allowable if the supplier is NON-PARTICIPATING
- Medicare will NOT automatically pay for a new item (power chair) after 5 years (supplier tech must document what parts need to be replaced and the cost (allowables)
- Medicare will pay for temporary replacement equipment "loaner" (one unit which is one month in amount of item being repaired) while patient owned equipment is being repaired (item being repaired must be inoperable or not safely operable and repair will take longer than 24 hours)
- Even if the part IS covered under warranty!

Repairs

- Labor (K0739) CAN be billed without a part being billed
- If part is covered under warranty but labor is NOT covered then it can be billed
- Documentation in narrative – part replaced was covered under manufacturer warranty labor is not covered by warranty

Temporary Replacement Equipment (TRE)

Turn Repairs into a Profit rather than a Loss

If you provide a service / product you should be reimbursed for that service or product. When you repair patient owned DME that is not covered by a manufacturer or supplier warranty and you provide equipment for the patient to use while their equipment is being repaired, you are entitled to reimbursement for that temporary replacement equipment (**TRE**) at the first month rental rate for the item being repaired.

Conditions for Temporary Replacement Equipment (TRE)

The code is K0462 (NO modifiers required) and you are entitled to one unit (1), which is one month of reimbursement (rental span) for a repair which takes longer than one day (24 hours)

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Temporary Replacement Equipment (TRE)

- Meaning if the patient owned DME is inoperable OR not safely operable AND the repair will take longer than one day (24 hours) you can submit one unit of K0462 along with the part(s) and labor
- Item being repaired MUST be patient owned, not covered by manufacturer or supplier warranty, originally paid by Medicare, is NOT safely operable **AND** the repair will take longer than 24 hours. (*A torn arm pad that does not affect the safety of the power wheelchair would not be justify a K0462 but if the motors are not working properly (safely) would be).*

Temporary Replacement Equipment (TRE)

- **Billing Documentation** requirements for code **K0462**
  - A narrative description of the equipment being used as a temporary replacement, including the manufacturer, brand name, model name or number of the temporary replacement item
  - A detailed statement of why the replacement is needed **AND** why it is taking longer than 24 hours to repair
  - Claims must include the HCPCS code and manufacturer name, brand name, and model name or number of the beneficiary-owned piece of equipment and the date of purchase of the equipment
  - Delivery ticket signed and dated for the TRE

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Temporary Replacement Equipment (TRE)

Calculating the Allowable for the TRE (K0462)

- The allowable for the TRE (K0462) is based on the rental allowable for the item being repaired
- Repairing the motors on a K0861 would allow $826.68 for K0462 in 2018 (allowable for the K0861 as TRE)
- Repairing motors on a K0823 would allow $270.23 for the K0462 in 2018 (non rural in TX for K0823 as TRE)
- Repairing a joystick E2374 on any group 3 power chair by just replacing the joystick with a rental until the patient's new joystick arrives would allow $51.82 for the K0462 in 2018 (with KU modifier in TX)

Temporary Replacement Equipment (TRE)

Back Billing K0462

If you provided the TRE that meets all the requirements as noted AND you already billed for the parts and labor but did NOT bill for the TRE (K0462) you can still bill for reimbursement **up to a year from the date of service!!!**

Note you **MUST** include all the documentation requirements noted AND indicate in the extra narrative field the date of service when the parts and labor were billed that relates to this TRE.

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Yee HAW we made IT !

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Be sure to sign up for reimbursement updates sent directly to your phone! Text "EZNGS81432" to the number 797979

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