1

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2

The CMS considered comments from stakeholders expressing concern about possible negative impacts the adjustments might have on quality and access to items and services, especially in rural areas of the country. In light of these concerns, the adjustments to the fee schedule amounts for DME and enteral nutrition were phased in during the first six months of 2016, for claims with dates of service January 1, 2016 through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. In addition, in no case can the adjusted fee for a rural area (any area outside a Metropolitan Statistical Area) be lower than the national ceiling amount described above.

The CMS has been closely monitoring claims and health outcomes data to verify that beneficiary access to quality items and services in Non-Competitive Bidding (NCB) areas continues during and after the six month transition. A valuable indicator of whether payment amounts are sufficient is the percentage of claims that suppliers have submitted as assigned, accepting the fee schedule amount as payment in full. Suppliers in NCB areas are not required to accept assignment of Medicare claims for items subject to competitive bidding (CB items). This means that if an adjusted fee schedule amount is not sufficient to cover the costs of furnishing the item to a particular beneficiary in the supplier's service area because of where the beneficiary lives or for other reasons, the supplier can decide not to accept assignment of the claim and collect the extra money needed to cover their costs directly from the beneficiary.

Assignment rate at 99%

3

Participating VS Non-Participating

- An assignment agreement is between a supplier and a Medicare beneficiary
- The option of accepting assignment belongs solely to the supplier
- Suppliers have a choice to become a participating or non-participating Medicare supplier
- Suppliers can change their participation status annually. Participation status is part of the enrollment process through the National Supplier Clearinghouse (NSC)
- **~ Open enrollment occurs every November 15- December 31**
- If status is being changed, it MUST be post marked by Dec. 31 to change status for Jan. 1
- Enrollment status follows Tax ID, i.e. hospital based DMEs may be under same tax ID as hospital
- Unsure of your status – NSC contact #866-238-9652 – will tell you enrollment status, or www.medicare.gov

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Participating Status

- Participation means the supplier **always agrees to accept assignment** for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year
- By agreeing, the supplier **always** accepts the **Medicare allowed amount as payment in full** and doesn't collect more than the deductible and coinsurance from the beneficiary
- By accepting assignment, the payment is sent to the supplier
- If want to change from non-participating to participating, **complete form CMS-460**
- Suppliers awarded a CB contract must accept assignment on CB items **-Can be enrolled as non-participating**
- **MTYH - DME suppliers get a higher reimbursement for accepting assignment**

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Non-Participating Status

- DME suppliers can be enrolled as a non-participating supplier
- 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
- The Charge to the beneficiary is the suppliers usual and customary, **no** limiting charge
- Non-assigned claims: 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

6

Let's Discuss the Non–Assigned Claim

- Beneficiary authorization (AOB) 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 prior to and get authorization
- Fragmented Billing – cannot have assigned & non-assigned items on same delivery ticket on same DOS
  - ➢ CPAP machine (assigned) and CPAP supplies (non-assigned) NOT okay
  - ➢ Unless its for different services – wound dressings (non-assigned) and wheelchair (assigned) are OKAY

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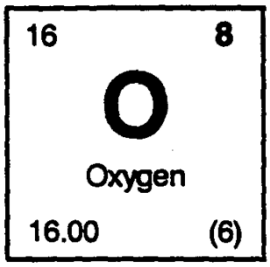
Frequently Asked Question

- **Can an oxygen supplier switch assignment anytime during the five-year period?**
  - **Response:** Nonparticipating suppliers may accept assignment on a claim by claim basis. 42 CFR Section 414.226 (g)(3) requires that "before furnishing oxygen equipment, the supplier must disclose to the beneficiary it's intentions as to whether it will or will not accept assignment of all monthly rental claims for the duration of the rental period."



- A non-participating supplier <u>can</u> bill oxygen contents non-assigned after the 36 month rental period.

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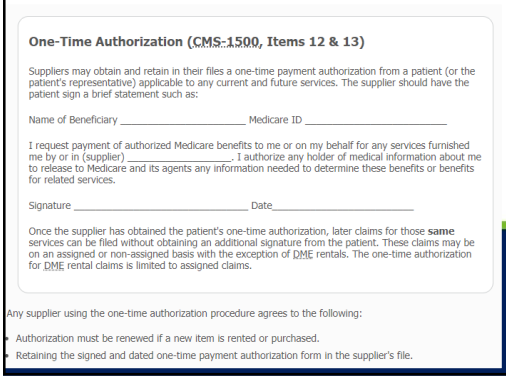
CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1

You may only receive Medicare payment if the beneficiary assigns his or her Medicare benefits to you. Regulations authorize Medicare to pay for claims submitted by a supplier only if the beneficiary or the person authorized to request payment on the beneficiary's behalf assigns the claims to the supplier and the supplier accepts assignment. For all claims submitted on or after January 1, 2005, payment shall be made to physicians and suppliers even without a beneficiary-signed assignment of benefits (AOB) form when the service can only be paid on an assignment related basis. This includes any mandatory assignment situations and participating physician or supplier situations. When you accept assignment, you must accept Medicare's determination of the approved amount as the full fee for the service(s) rendered. For more information about beneficiary authorization, see the Chapter 6 of this manual.



One-Time Authorization (CMS-1500, Items 12 & 13)

Suppliers may obtain and retain in their files a one-time payment authorization from a patient (or the patient's representative) applicable to any current and future services. The supplier should have the patient sign a brief statement such as:

Name of Beneficiary _____ Medicare ID _____

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (supplier) _____. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature _____ Date_____

Once the supplier has obtained the patient's one-time authorization, later claims for those **same** services can be filed without obtaining an additional signature from the patient. These claims may be on an assigned or non-assigned basis with the exception of DME rentals. The one-time authorization for DME rental claims is limited to assigned claims.

Any supplier using the one-time authorization procedure agrees to the following:

- Authorization must be renewed if a new item is rented or purchased.
- Retaining the signed and dated one-time payment authorization form in the supplier's file.

https://www.cms.gov/Regulations-and-Guidance/Guidancea/Manuals/Downloads/clm104c01.pdf

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Switching to Medicare Advantage

- Many Medicare beneficiaries are switching from Medicare fee-for-service ("FFS") to Medicare Advantage plans.
- The key question is: "Do Medicare Advantage plans allow the DME supplier to bill non-assigned or do Medicare Advantage plans require the supplier to take assignment?"
  - Suppliers will need to look to the specific Medicare Advantage plan to see if the specific plan requires the supplier to take assignment or allows the supplier to bill non-assigned.
  - If the answer it that the specific Medicare Advantage plan requires assignment, then the supplier can follow the advice set out above and only make the item available to the patient if the insurance reimbursement meets the threshold dollar amount.

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Commercial Insurance

- Under the anti-discrimination provision, the supplier can adopt a policy in which
  - (A) it bills non-assigned for Products A, B, and C, **and/or**
  - (B) it bills non-assigned for all products in which third party reimbursement is $100 or less
- **This policy does not discriminate against Medicare patients because this policy applies across the board ... that is, it applies equally to Medicare patients and commercial insurance patients.**
- The supplier can always make that item available to a Medicare patient on a non-assigned basis.
- If the commercial insurance does not allow non-assigned claims, the item is only available to the patient if the insurance reimbursement meets the threshold dollar amount.

As a supplement (Medigap)

- Plans F and Plan G cover Medicare Part B excess charges
- Excess charges are the difference in cost between what a non-participating doctor or health-care provider charges for a medical service and the Medicare-approved amount.

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Anti-Discrimination

Example 1:

Supplier is non-participating, offers products A, B, C, D, E, and F.

Accepts assignment from all payors and Medicare on all items.

Supplier opts to no longer accept Medicare assignment on products A, B, and C but will continue to accept assignment from all non-Medicare payors for these items

Will continue to accept assignment on products D, E, and F from all payors and Medicare.

Problem:

Bad approach because this is considered discrimination against Medicare beneficiaries.

Solution:

Supplier needs to create a policy that bases the acceptance of assignment decision on the expected amount of reimbursement for that particular item, not who the payer is.

Accepting assignment on product A requires a minimum reimbursement of $100, otherwise the product will be treated as a cash pay item regardless of payer.

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Anti-Discrimination

Example 2:

Supplier can reduce range of items it offers regardless of payer

Supplier will no longer offer items A, B, and C to any patient, but will continue with items D, E, and F and accept assignment as usual.

Solution: Good

This example doesn't treat Medicare beneficiaries any different than non-Medicare beneficiaries

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Anti-Discrimination

Example 3:

Supplier continues to offer same products currently being offered, but would only accept assignment on specific items regardless of payer.

Items A, B, and C would be assigned items regardless of payer, and remaining items D, E, and F would be cash pay items regardless of payer.

Solution: Good

Treats Medicare and Non-Medicare beneficiaries the same and does not pose any risk of discrimination against Medicare beneficiaries.

Would still submit claims for those items that are non-assigned items for all payors.

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SECTION 3: PRODUCTS/ACCREDITATION INFORMATION *(Continued)*

D. PRODUCTS AND SERVICES FURNISHED BY THIS SUPPLIER **Page 10 of 855S**

Check all that apply and submit all applicable licenses and/or certifications.

If you are unsure of the licensure and/or certification and/or accreditation requirements for your product(s) or services(s), check with your state. The NSC MAC website at **http://www.palmettogba.com/nsc** may offer guidance. Failure to attach applicable licensure and/or certification could result in denial or revocation of your Medicare billing privileges and/or overpayment collection.

- ☐ Automatic External Defibrillators (AEDs) and/or Supplies
- ☐ Blood Glucose Monitors and/or Supplies (mail order)
- ☐ Blood Glucose Monitors and/or Supplies (non-mail order)
- ☐ Breast Prostheses and/or Accessories
- ☐ Canes and/or Crutches
- ☐ Cochlear Implants
- ☐ Commodes/Urinals/Bedpans
- ☐ Continuous Passive Motion (CPM) Devices
- ☐ Continuous Positive Airway Pressure (CPAP) Devices and/or Supplies
- ☐ Contracture Treatment Devices: Dynamic Splint
- ☐ Diabetic Shoes/Inserts
- ☐ Diabetic Shoes/Inserts—Custom
- ☐ Enteral Nutrients
- ☐ Enteral Equipment and/or Supplies
- ☐ External Infusion Pumps
- ☐ External Infusion Pump Supplies
- ☐ Facial Prostheses
- ☐ Gastric Suction Pumps
- ☐ Heat & Cold Applications
- ☐ High Frequency Chest Wall Oscillation (HFCWO) Devices and/or Supplies
- ☐ Hospital Beds—Electric
- ☐ Hospital Beds—Manual
- ☐ Implanted Infusion Pumps and/or Supplies
- ☐ Infrared Heating Pad Systems and/or Supplies
- ☐ Insulin Infusion Pumps
- ☐ Insulin Infusion Pump Supplies
- ☐ Intermittent Positive Pressure Breathing (IPPB) Devices
- ☐ Intrapulmonary Percussive Ventilation Devices
- ☐ Limb Prostheses
- ☐ Mechanical In-Exsufflation Devices
- ☐ Nebulizer Equipment and/or Supplies
- ☐ Negative Pressure Wound Therapy Pumps and/or Supplies
- ☐ Neuromuscular Electrical Stimulators (NMES) and/or Supplies
- ☐ Neurostimulators and/or Supplies
- ☐ Ocular Prostheses
- ☐ Orthoses: Custom Fabricated
- ☐ Orthoses: Prefabricated (custom fitted)
- ☐ Orthoses: Off-the-Shelf
- ☐ Osteogenesis Stimulators
- ☐ Ostomy Supplies
- ☐ Oxygen Equipment and/or Supplies
- ☐ Parenteral Nutrients
- ☐ Parenteral Equipment and/or Supplies
- ☐ Patient Lifts
- ☐ Penile Pumps
- ☐ Pneumatic Compression Devices and/or Supplies
- ☐ Power Operated Vehicles (Scooters)
- ☐ Prosthetic Lenses: Conventional Contact Lenses
- ☐ Prosthetic Lenses: Conventional Eyeglasses
- ☐ Prosthetic Lenses: Prosthetic Cataract Lenses
- ☐ Respiratory Assist Devices
- ☐ Respiratory Suction Pumps
- ☐ Seat Lift Mechanisms
- ☐ Somatic Prostheses
- ☐ Speech Generating Devices
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – New
- ☐ Support Surfaces: Pressure Reducing Beds/ Mattresses/Overlays/Pads – Used
- ☐ Surgical Dressings
- ☐ Tracheostomy Supplies
- ☐ Traction Equipment
- ☐ Transcutaneous Electrical Nerve Stimulators (TENS) and/or Supplies
- ☐ Ultraviolet Light Devices and/or Supplies
- ☐ Urological Supplies
- ☐ Ventilators: All Types-Not CPAP or RAD
- ☐ Voice Prosthetics
- ☐ Walkers
- ☐ Wheelchair Seating/Cushions
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Manual Wheelchair Related Accessories
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchairs
- ☐ Wheelchairs—Complex Rehabilitative Power Wheelchair Related Accessories
- ☐ Wheelchairs—Standard Manual
- ☐ Wheelchairs—Standard Manual Related Accessories and Repairs
- ☐ Wheelchairs—Standard Power
- ☐ Wheelchairs—Standard Power Related Accessories and Repairs

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855s.pdf

Or change within PECOS system

You can remove items from this list and charge as retail only item!

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Ready to change enrollment to Non-Participating Status?

- Can - Mail a letter to the NSC
  - Should use company letterhead
  - State you are changing to non-participating starting in January 2019
  - Include PTAN, NPI, TIN, and contact information
- Or, Change in PECOS
- Good to go on January 1, 2022 – normally you do not receive confirmation from NSC
- **This does not mean anything has to change right away –change when ready**
- Mailing Address:

  National Supplier Clearinghouse
  Palmetto GBA, AG-495
  PO Box 100142
  Columbia, SC 29202-3142

https://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/National%20Supplier%20Clearinghouse

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Can a supplier upgrade within the same HCPCS code and use the ABN?

No -- A supplier CANNOT upgrade within the same HCPCS Code

- Removed Fall 2016
- Offer as non-assigned, or
- Find a product that fits within the reimbursement schedule

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Are upgrades allowed on CPAP supplies when a beneficiary elects to have a more extensive mask than what would be allowed by Medicare?

No. Medicare covers the mask but does not consider it an upgrade if it is simply a more expensive type of mask. Medicare suppliers who enrolled as "non-participating" have the option of not accepting assignment on a claim-by-claim basis which would allow additional reimbursement options. A difference in price alone does not warrant an upgrade. The beneficiary needs a mask to use with their PAP device. If the quantities of masks that they wanted were above what Medicare allowed, which is one every three months, then that could potentially be an upgrade regarding the quantity of masks.

- **Think about orders – getting brand specific – need to be generic such as full face mask**
- **Think about non-assigned. Let bene know which item insurance covers (assigned) and what is out of pocket due to low reimbursement (non-assigned)**

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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
- Can upgrade from standard walker to rolling walker
- Cannot upgrade from a walker to wheelchair
- **Cannot upgrade within the same HCPCS Code** (removed Fall 2016)

Hospital Bed
WANTS: E0265RRKHGA (Patient requested upgrade and valid ABN on file)
NEEDS: E0250RRKHKXGK (Reasonable & necessary item associated with GA)

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Can a reason to use an ABN be that it's a non-assigned claim?

Need a valid reason to use an ABN

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Dissecting the Fee Schedule

www.cms.gov

File Name	Description	Year
DME21-B	April 2021 DMEPOS Fee Schedule Information	2021
DME-21AR	Revised January 2021 DMEPOS Fee Schedule	2021
DME21-D	October 2021 DMEPOS Fee Schedule Update	2021
DME21-A	January 2021 DME Fee Schedule	2021
DME20-CARES	Interim Final Rule with Comment Period (CMS-5531-IFC) Durable Medical Equipment Fee Schedule. This file update contains the changes required under section 3712 of the CARES Act.	2020
DME20-D	October 2020 DMEPOS Fee Schedule Update	2020
DME20-B	April 2020 DMEPOS Fee Schedule	2020
DME20-C	July 2020 DMEPOS Fee Schedule Update	2020

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PDAC | Topics | Forms | Search for...

www.dmepdac.com

PDAC-Medicare Contractor for Pricing, Data Analysis and Coding of HCPCS Level II DMEPOS Codes

Palmetto GBA received the Centers for Medicare & Medicaid Services (CMS) national contract beginning in 1993 and developed many of the current PDAC functions. Additional enhancements are anticipated in the future. Palmetto GBA creates value by continuously transforming ideas into solutions that improve service, quality and cost. Our vision is to empower our customers to reach new heights of performance, ultimately improving the quality of life for our customers, our employees, and our communities.


DMECS


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Top News

Effective October 1, 2021

UPDATE: The PDAC has recently revised its Code Verification Review Application and related forms to be more user friendly and to better assist submitters with communicating required information. Effective October 1, 2021, PDAC will only accept Forms found on the PDAC website. After this date, any submission received on an improper form may be rejected.

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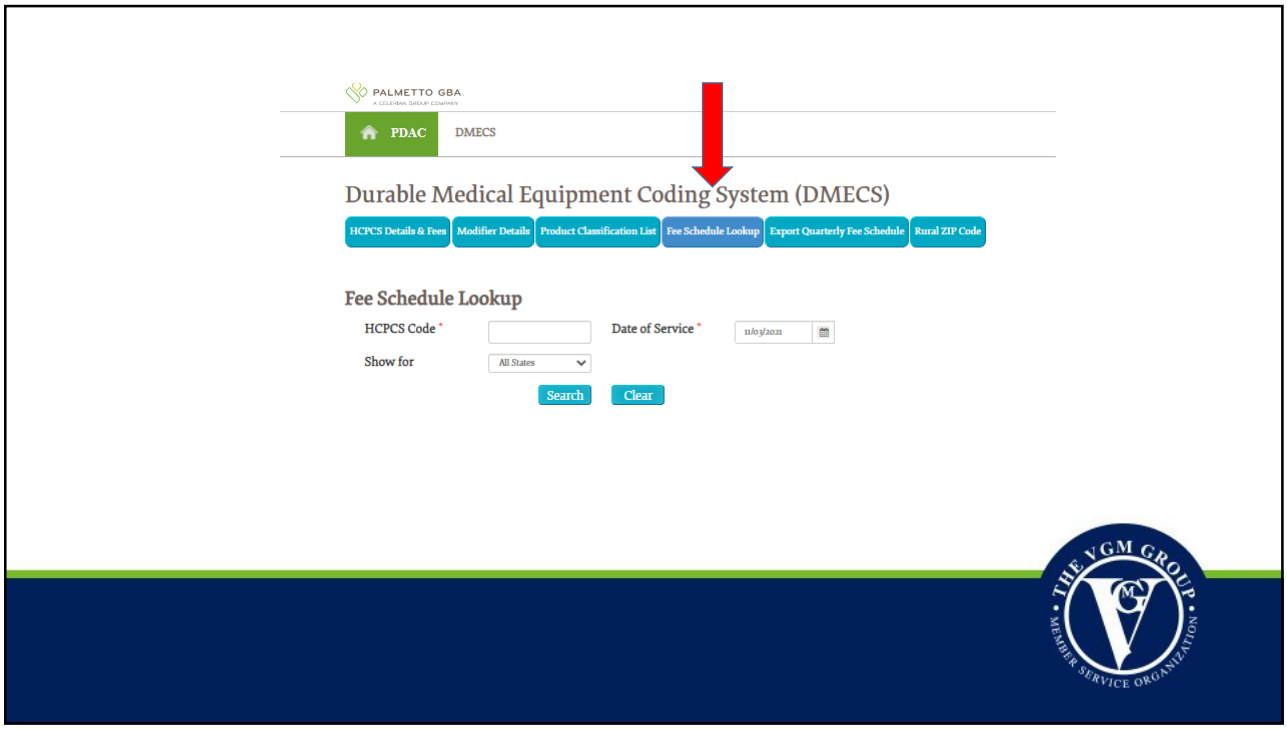
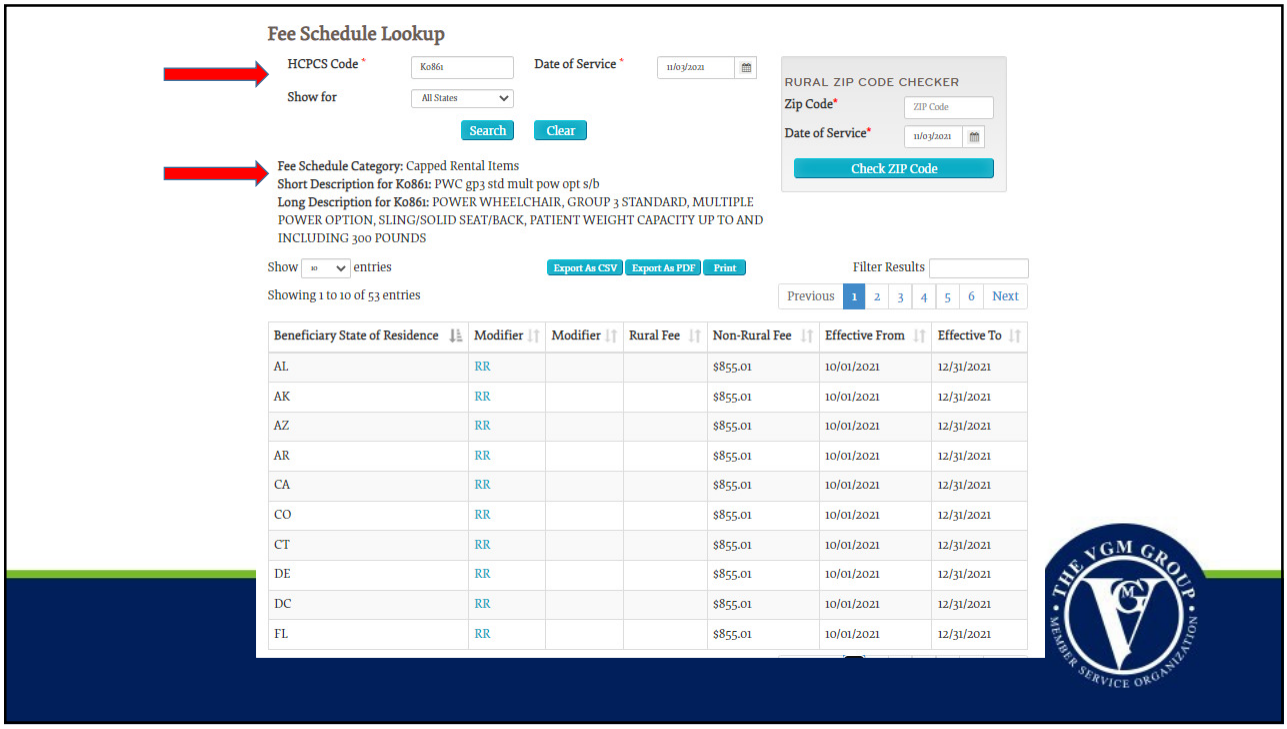

PALMETTO GBA
PDAC
DMECS
Durable Medical Equipment Coding System (DMECS)
HCPCS Details & Fees
Modifier Details
Product Classification List
Fee Schedule Lookup
Export Quarterly Fee Schedule
Rural ZIP Code
Fee Schedule Lookup
HCPCS Code *
Date of Service *
11/03/2021
Show for
All States
Search
Clear

23


Fee Schedule Lookup
HCPCS Code *
K0861
Date of Service *
11/03/2021
Show for
All States
Search
Clear
RURAL ZIP CODE CHECKER
Zip Code*
ZIP Code
Date of Service*
11/03/2021
Check ZIP Code
Fee Schedule Category: Capped Rental Items
Short Description for K0861: PWC gp3 std mult pow opt s/b
Long Description for K0861: POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Show 10 entries
Export As CSV
Export As PDF
Print
Filter Results
Showing 1 to 10 of 53 entries
Previous 1 2 3 4 5 6 Next
Beneficiary State of Residence
Modifier
Modifier
Rural Fee
Non-Rural Fee
Effective From
Effective To
AL RR $855.01 10/01/2021 12/31/2021
AK RR $855.01 10/01/2021 12/31/2021
AZ RR $855.01 10/01/2021 12/31/2021
AR RR $855.01 10/01/2021 12/31/2021
CA RR $855.01 10/01/2021 12/31/2021
CO RR $855.01 10/01/2021 12/31/2021
CT RR $855.01 10/01/2021 12/31/2021
DE RR $855.01 10/01/2021 12/31/2021
DC RR $855.01 10/01/2021 12/31/2021
FL RR $855.01 10/01/2021 12/31/2021

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DMEPOS Fee Schedule Categories

Chapter 5 Contents

CGS Supplier Manual

Introduction

1. Inexpensive or Other Routinely Purchased DME (IRP)
2. Items Requiring Frequent and Substantial Servicing
3. Certain Customized Items
4. Other Prosthetic and Orthotic Devices
5. Capped Rental Items
6. Oxygen and Oxygen Equipment
7. Medicare Advantage Plan Beneficiaries Transferring to Fee-For-Service Medicare
8. Supplies and Accessories Used with Beneficiary-Owned Equipment
9. Repairs, Maintenance, and Replacement
10. DMEPOS Competitive Bidding Program

Noridian Supplier Manual

Chapter 5 - DMEPOS

- Capped Rental Items
- Customized Items
- DMEPOS and Inpatient Stays
- Inexpensive or Other Routinely Purchased DME
- Items Requiring Frequent and Substantial Servicing
- Other Prosthetic and Orthotic Devices
- Oxygen and Oxygen Equipment
- Parenteral/Enteral Nutrition Therapy
- Payment Categories
- Repairs, Maintenance and Replacement

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5. Capped Rental Items

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5

Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

Rental Fee Schedule

For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10 percent of the average of allowed purchase prices on assigned claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5 percent of the average allowed purchase price (in other words, the payment is reduced by 25% beginning in the fourth month of rental). After paying the rental fee schedule amount for 13 months, no further payment may be made. *Note that for power wheelchairs and parenteral/enteral pumps, the monthly rental percentage may differ (see below for more information).*

Modifiers used in the Capped Rental category are as follows*:

RR	Rental
KH	First rental month
KI	Second and third rental months

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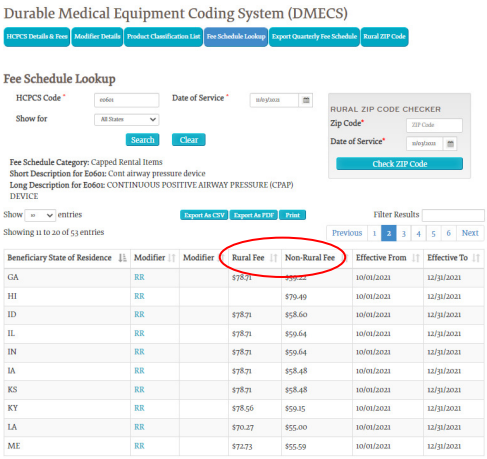
CPAP E0601



S.P.A. in CB Territories

HCPC	Mod	Mod	Mod	CAT	Aiken County, SC	Akron, OH	Albany, NY	Albuquerque, NM	Allentown, PA	Arlington, VA
E0562	UE			IN	104.88	99.07	105.09	106.58	104.43	108.10
E0565	RR			CR	41.55	44.27	42.56	43.82	42.42	41.13
E0570	RR			CR	4.62	6.56	5.05	7.78	5.02	6.11
E0572	RR			CR	25.75	38.35	21.60	33.66	12.97	35.95
E0585	RR			CR	21.36	34.93	25.01	32.55	20.55	33.86
E0601	RR			CR	40.68	43.52	43.22	44.37	39.94	41.51

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Calculating Allowed Amount (Capped Rental – RENTAL ONLY Allowable AFTER 13 Months)

CPAP (E0601) – RR Allowable x 10 = Purchase Allowable

10% of the Purchase Allowable each Month for Months 1-3 (30% total)
7.5% of the Purchase Allowable each Month for Months 4-13 (75% total)

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

~~$43.95 x 13= $ 571.35~~

Example: E0601 (CPAP) allowable in the fee schedule = $43.95

Purchase Allowable = $439.50 (RR x 10)
Months 1-3 - $43.95 each month
Months 4-13 - $32.96 each month

Total Allowed Amount AFTER 13 Months = $461.45 (Purchase Allowable x1.05)

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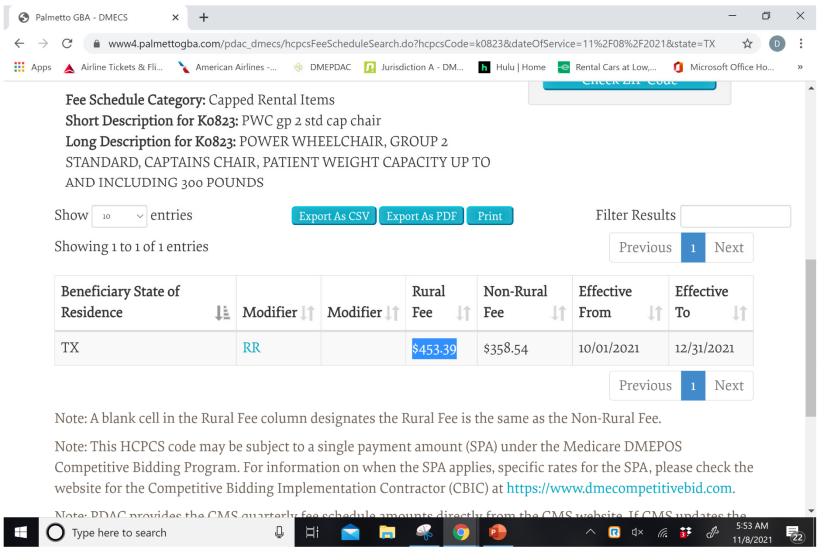
Group 2 Power Chair K0823



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Calculating Allowed Amount (Capped Rental – 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) = $453.39

Purchase Allowable = $3022.60 (RR divided by .15)
Months 1-3 = $453.39 each month = $1360.17 (45% of purchase allowable)
Months 4-13 = $181.35 each month = $1813.56 (60% of purchase allowable)

Total Allowed Amount AFTER 13 Months = $3173.73 (RR divided by .15 times 1.05)

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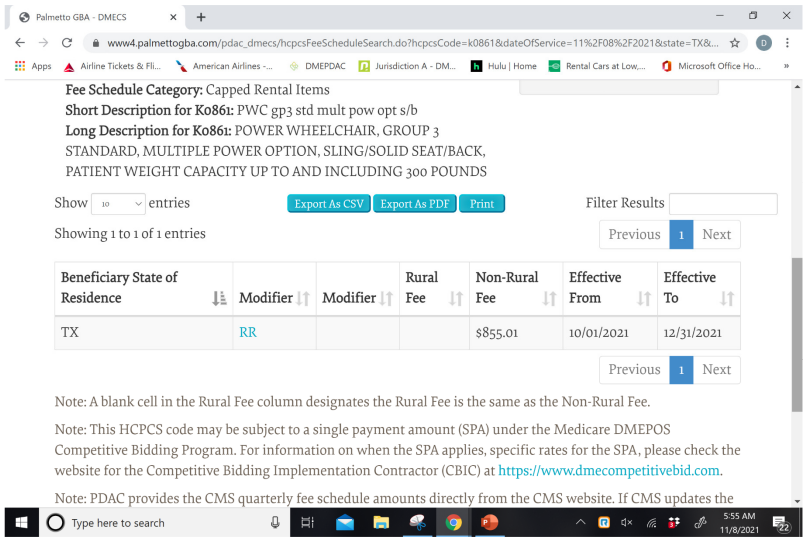
Group 3 Power Chair K0861



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Calculating Allowed Amount (Capped Rental with Purchase Option)

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) = $855.01

Purchase Allowable = $5700.07 (RR divided by .15)

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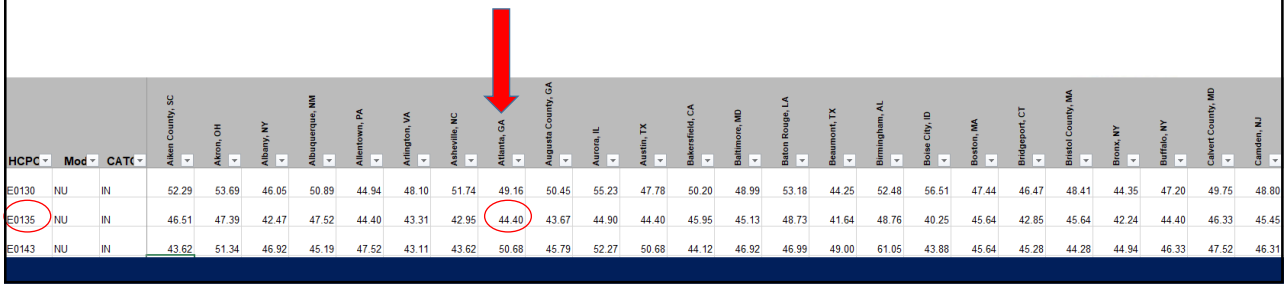
Non-Assigned Example For Consideration- Inexpensive & Routinely Purchase

- The allowable for the **E0135** (WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT)
  Allowable as Purchase (NU) =$44.40
- If you can't accept that allowable and need to collect more to meet margins, the only way is go non assigned – allowable not acceptable so charging more.
- If you need $100 for a WALKER then you can collect full amount from the patient and submitted as non assigned.
- Make sure you let the patient know they will only receive 80% of the Medicare allowed amount of **$35.52** (if approved).

Make sure the patient knows the reason and the process of the entire transactions.



HCPC	Mod	CAT	Aiken County, SC	Akron, OH	Albany, NY	Albuquerque, NM	Allentown, PA	Arlington, VA	Asheville, NC	Atlanta, GA	Augusta County, GA	Aurora, IL	Austin, TX	Bakersfield, CA	Baltimore, MD	Baton Rouge, LA	Beaumont, TX	Birmingham, AL	Boise City, ID	Boston, MA	Bridgeport, CT	Bristol County, MA	Bronx, NY	Buffalo, NY	Calvert County, MD	Camden, NJ
E0130	NU	IN	52.29	53.69	46.05	50.89	44.94	48.10	51.74	49.16	50.45	55.23	47.78	50.20	48.99	53.18	44.25	52.48	56.51	47.44	46.47	48.41	44.35	47.20	49.75	48.80
E0135	NU	IN	46.51	47.39	42.47	47.52	44.40	43.31	42.95	44.40	43.67	44.90	44.40	45.95	45.13	48.73	41.64	48.76	40.25	45.64	42.85	45.64	42.24	44.40	46.33	45.45
E0143	NU	IN	43.62	51.34	46.92	45.19	47.52	43.11	43.62	50.68	45.79	52.27	50.68	44.12	46.92	46.99	49.00	61.05	43.88	45.64	45.28	44.28	44.94	46.33	47.52	46.31

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Non-Assigned Example Consideration

- 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.

Apply this to any capped rental equipment

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Non-Assigned Example For Consideration –Capped Rental

- The allowable for the **E0260** (HOSPITAL BED, SEMI-ELECTRIC (HEAD/FOOT ADJUSTMENT), WITH ANY TYPE SIDE RAILS & MATTRESS)
- **Allowable as Capped Rental =$65.40/month with Purchase Allowable= $686.70 after 13 months**
- The allowable isn't acceptable and need to collect more to meet margins, the way to go is non-assigned in the first month collecting the first month rental fee $65.40 plus the amount needed over the total allowable.
- If you need $850 for this item then you can collect $222.16 from the patient in the first month then bill $222.16 non assigned.
- Make sure you let the patient know **in writing** that they will only receive 80% of the Medicare allowed amount of $52.32 (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.

Apply this to any capped rental equipment

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Non-Assigned Example For Consideration

- The allowable for the **E0601** is $461.45 after 13 months of rental.
- If you can't accept that allowable 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 $43.95 plus the amount you need over the total allowable.
- If you need $650 for this item then you can collect $228.08 from the patient in the first month then bill non assigned.
- Make sure you let the patient know in writing that they will only receive 80% of the Medicare allowed amount of $35.16 (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.

Apply this to any capped rental equipment

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Questions???

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