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Common Questions on Billing Claims to Medicare Non-Assigned

1. What are the documentation requirements for the supplier when submitting a non-assigned claim?
    a. Is there a form or notice that is signed upon initiation of service?
    b. Is there alternate language or guidelines for changing assignment on an active service or rental that has previously billed assigned?

The documentation and coverage criteria requirements are the same as they are for assigned claims.

There is no specific form or notice to inform the beneficiary of billing a claim non-assigned.

Each claim billed to Medicare is considered a new individual claim. Suppliers can choose to take assignment or not on a claim-by-claim basis.

2. Please provide education on what the supplier can and should charge the customer when billing non-assigned.

If suppliers don't accept assignment, there's no limit on the amount they can charge you.
https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html

3. There is a lot of confusion related to the following statement from CMS: "The provider may bill the beneficiary no more than the "limiting charge" for covered services. Should the provider bill more than the limiting charge for a covered service, the provider will have violated the non-participating agreement and may be subject to fines or penalties. When a provider does not accept assignment on a Medicare claim, he/she is not required to file a claim to the beneficiary's secondary insurance. NOTE: The "limiting charge" applies only to certain Medicare-covered services and *doesn't apply to some supplies and durable medical equipment.*"
    a. Please explain this last sentence and provide which (if any) supplies that the "limiting charge" applies to under the DME MAC Jurisdiction.

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The limiting charge only applies to non-participating physicians. The limiting charge is 115 percent of the physician fee schedule amount.

4. What are the exceptions for non-participating suppliers regarding submission of non-assigned claims? Please itemize when a non-participating supplier must accept assignment (as in the case of covered medications)?

For DME, an exception to the non-participating agreement is that non-participating providers are required by law to accept assignment when the beneficiary has both Medicare and Medicaid.

5. Please educate on the differences between a Participating Provider and Non-Participating Provider along with when suppliers have the option to become a Par Provider or can opt out of being a Par Provider.

Participating in the Medicare program simply means that you agree to accept assignment for all services furnished to Medicare patients. By accepting assignment you agree to accept the amount approved by Medicare as total payment for covered services.

Non-participating providers in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis.

Suppliers can only change their participating status toward the end of each calendar year. Generally from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program as participating can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.

6. Participating provider: when signing up to be a Participating Provider, is it by NPI or tax id for the company?
    a. If it is by NPI, does that mean that each NPI under the tax id of the company, can choose to have some locations be participating and others non-participating?

Participation status is associated with an entity's tax ID number and not a location. A business entity with multiple locations under the same tax ID number cannot choose to have different participation statuses for each location. All locations will automatically be assigned the same status (participating or non-participating) depending what the entity has chosen.

If a supplier is considered "Par", is there ever an opportunity to bill a non-assigned claim?

b. For example, a Par provider provides a walker to a customer who does not qualify for the walker and an ABN has been signed, how would the Par supplier do this?

No. Participating providers cannot bill non-assigned claims to Medicare. Suppliers may choose to use Option 2 on the ABN to avoid filing a claim.

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.

c. **If, as a Par supplier, we asked that customer to pay us up front the full amount, would that amount be our retail price or the Medicare allowed amount?**

If a supplier does not file a claim with Medicare, there's no limit on the amount they can charge you.

d. If a customer pays a participating provider up front, how do we make sure the customer is the one to receive payment from Medicare, if this is possible?

Participating providers cannot bill non-assigned claims to Medicare.

7. Are there any requirements for suppliers (par or non-par) to submit claims for a product that a manufacturer has classified as non-coded?
    a. Is the education different for items with mandatory product classification (like power mobility or wheelchair seating) versus when product classification is voluntary (as in the case of standard walkers)?

For items and services that are covered, at least under certain circumstances, the beneficiary is entitled to coverage under the program and the supplier has to comply with respect to medical necessity criteria and other coverage rules as a result of working with that beneficiary. Thus, if an item or service provided to a Medicare beneficiary is determined to not be medically necessary, the provider is responsible for knowing that and for having provided the item or service anyway.

For items and services that are never covered under Medicare, the beneficiary and supplier are essentially acting outside of the Medicare program, and the program's rules therefore do not apply.