Chapter 1 Contents

Welcome

Welcome to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction C Supplier Manual. This manual is provided for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who serve beneficiaries in Jurisdiction C. This manual contains an overview of important and useful information for DMEPOS suppliers regarding the Medicare program. It is the first resource that you should use for Medicare billing questions.

The *Supplier Manual* is updated on a quarterly basis and is available on our website at https://www.cgsmedicare.com.

In every quarterly *Supplier Manual* revision, all text that has been added or revised from the previous quarter's version of the manual is shown in red text. All unchanged text is shown in black text. Please note that additions/revisions do not necessarily denote a change in policy. Some additions/revisions are added solely to provide greater clarity and understanding.

To stay up to date on the most recent Medicare news, subscribe to our electronic mailing list (formerly known as the ListServ). This email newsletter gives you immediate access to the latest Medicare information, including publications, important updates, educational workshops, and medical review information. Sign up today at https://www.cgsmedicare.com/email.html.

Internet-only Manual (IOM) References

Most of the information in this manual is derived from the Centers for Medicare and Medicaid Services' (CMS) Internet-only Manuals (IOMs). The IOMs are a replica of the CMS official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations, and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

In order to give you an easy way to cross-reference the information in the IOM with the information in the *DME MAC Jurisdiction C Supplier Manual*, you will find references to the applicable IOM

sections throughout each chapter of the *Supplier Manual*. The references are listed beneath title headings in the following format:

CMS Manual System, Publication Number, *Publication Name*, Chapter, §Section

You can access the IOMs at the following website: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (refer to Chapter 15 in this manual for more information about the CMS Manual System).

1. CGS's Role as a DME MAC

The Centers for Medicare & Medicaid Services (CMS), the government agency which oversees the Medicare program, selected four companies to process DMEPOS claims for the Medicare program. These companies function as DME MACs. Each DME MAC is responsible for processing DMEPOS claims for beneficiaries residing in their specific jurisdiction.

CGS is the DME MAC for Jurisdiction C. Jurisdiction C includes Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia.

Our role is strictly that of processing and paying Medicare claims in accordance to the Social Security Act, Medicare Modernization Act, health insurance regulations and laws, and the Centers for Medicare & Medicaid Services rulings.

For the administration of the DME MAC Jurisdiction C contract, our offices are located in Nashville, Tennessee.

2. What Is Medicare?

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 1, §§10-10.1 & 10.3

The Medicare program is a federal health insurance program for:

- People age 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare is run by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services (DHHS).

Medicare is divided into several different parts which pay for certain types of services or situations. Hospital insurance (Medicare Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. Medical insurance (Medicare Part B) helps pay for medically necessary services by a physician, outpatient hospital services, home health care, and a number of other medical services and supplies that are not covered by Part A, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for home use.

Prescription Drug Coverage (Medicare Part D) pays for prescription drugs for Medicare-eligible beneficiaries who are enrolled in a Medicare prescription drug plan. Medicare prescription drug plans are available in every part of the country and all plans cover both brand name and generic drugs.

All topics covered in this manual refer to Medicare Part B DMEPOS.

3. What Is DME?

CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, §110.1

Durable medical equipment is equipment which:

- Can withstand repeated use,
- Is primarily and customarily used to serve a medical purpose,
- Generally is not useful to a person in the absence of an illness or injury, and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

4. Deductible and Coinsurance

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, §§20.1-2

Medicare beneficiaries must meet a deductible each calendar year before payment can be made by Medicare Part B. The beneficiary may be billed for any amount applied to the deductible on both assigned and nonassigned claims. The deductible is applied to approved charges only (the deductible is not applied to any non-covered charge). The Medicare Part B deductible for 2024 is $240. The deductible is subject to change every calendar year.

In order for Medicare Part B to reimburse for covered medical services, a beneficiary must satisfy the annual deductible regardless of when during the calendar year he or she became eligible.

NOTE: Expenses are allocated to the deductible in the order in which claims are received and processed by Medicare, not necessarily in order of date of service.

Our Interactive Voice Response (IVR) Unit (which can be reached at 1.866.238.9650) is available to determine current deductible status for a beneficiary. Please see Chapter 13 of this manual for more information about the IVR.

After the Medicare Part B deductible has been satisfied for the calendar year, Medicare reimburses 80 percent of the amount allowed by Medicare for an item/service. The remaining 20 percent of the allowed amount is the responsibility of the beneficiary. This amount is referred to as the coinsurance.

5. Eligibility

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2

Medicare eligibility is determined by the Social Security Administration (SSA). An individual may become entitled through Social Security based on his or her own earnings or that of a spouse, parent, or child. Anyone who becomes entitled to premium-free hospital insurance (Medicare Part A) is automatically enrolled in medical insurance (Medicare Part B), except in Puerto Rico. Medicare Part B is a voluntary program for which the insured must pay a monthly premium; therefore, individuals who do not want coverage may refuse Medicare Part B enrollment. The effective date of Medicare Part B coverage depends on the month in which enrollment takes place. An individual's Medicare Part B coverage ends when the individual requests disenrollment, does not pay premiums, dies, or, for individuals less than 65 years of age, when hospital insurance entitlement ends. Beneficiaries who have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) are also eligible for Medicare Part D (Prescription Drug Coverage).

You may contact the DME MAC Jurisdiction C IVR at 1.866.238.9650 to determine eligibility. Please see Chapter 13 of this manual for more information about the IVR.

Aged Insureds (65 years of age)

An aged insured is a person 65 years of age or older who is eligible for monthly Social Security or Railroad Retirement cash benefits or equivalent federal government benefits. Premium-free hospital insurance becomes effective on the first of the month in which the individual reaches age 65 if he or she applies for the benefit within six months of his/her birth month. Age 65 is considered to be reached on the day before the 65th birthday. For instance, an individual born on August 1st reaches age 65 on July 31st, and thus hospital insurance would be effective July 1st.

Some aged individuals do not qualify for premium-free hospital insurance due to insufficient Social Security Quarters of Coverage but may purchase Medicare Part A coverage. The individual must be a United States resident and either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously for five years or more. This person must also enroll (or already be enrolled) in Supplementary Medical Insurance (SMI). This type of enrollee must pay a monthly premium for both Medicare Part A and Medicare Part B coverage. If the premium is not paid within a specified period, then coverage is terminated.

Under Age 65 with Permanent Kidney Failure (End Stage Renal Disease)

Eligibility for coverage of a permanent kidney failure patient begins the third month after the month in which a course of renal dialysis begins, unless the individual receives a kidney transplant on or before the third month. In that case, eligibility begins the month the individual is admitted as an inpatient to a hospital for procedures in preparation for, or in anticipation of, a kidney transplant, provided that the transplant surgery takes place within the following two months. When the transplant is delayed more than two months after the preparatory hospitalization, eligibility begins with the second month prior to the month of transplant.

Also, Medicare entitlement can begin in the first month of a course of dialysis if the individual participates in a self-dialysis training program in a Medicare-approved facility prior to the third month after the course of dialysis. The individual is expected to complete the training and self-dialyze thereafter. If a beneficiary is entitled to Medicare only because of permanent kidney failure, Medicare protection will end 12 months after dialysis ends or 36 months after the month of a kidney transplant. If the transplant fails during or after that 36-month period and the beneficiary again resumes maintenance dialysis or receives another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Under Age 65 and Permanently Disabled

Medicare entitlement for the disabled begins with the 25th month after an individual has been eligible for Social Security Disability benefits. Subsequently, if the beneficiary is no longer entitled to Social Security disability payments, then his or her Medicare coverage will generally continue for one more calendar month after he/she is sent notice of the termination of the disability payments.

6. Medicare ID— Health Insurance Claim Number (HICN) and Medicare Beneficiary Identifier (MBI)

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2, §§50.2-50.4.2

The Health Insurance Claim Number (HICN) has served as the traditional beneficiary identification number for Medicare entitlement. The HICN is shown on old versions of the beneficiary's Medicare card. Beginning April 1, 2018, CMS is replacing the traditional HICN with the new Medicare Beneficiary Identifier (MBI) on Medicare cards.

Whereas the general format of the HICN was based on a Social Security Number (SSN), the new MBI is a completely new alpha-numeric ID that does not contain any link to a beneficiary's SSN. Removing SSNs from Medicare cards will help to prevent fraud, fight identity theft, and keep taxpayer dollars safe.

During the MBI transition period, which began April 1, 2018, and ended December 31, 2019, either the HICN or MBI could be used in all data transactions with Medicare contractors, including claim submission, web portal transactions, and any other type of data transaction. Beginning January 1, 2020, Medicare claims must be submitted using MBIs (with a few exceptions).

The Medicare ID (HICN or MBI) is probably the most important piece of information you can have about your Medicare patient. Claims cannot be paid if the HICN/MBI is missing or incorrect.

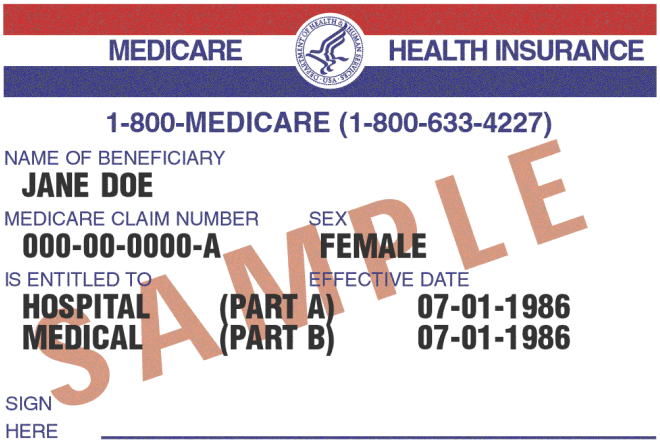
For additional information about the new Medicare Card and MBI, visit https://www.cms.gov/medicare/new-medicare-card/index.html.

7. The Medicare Card

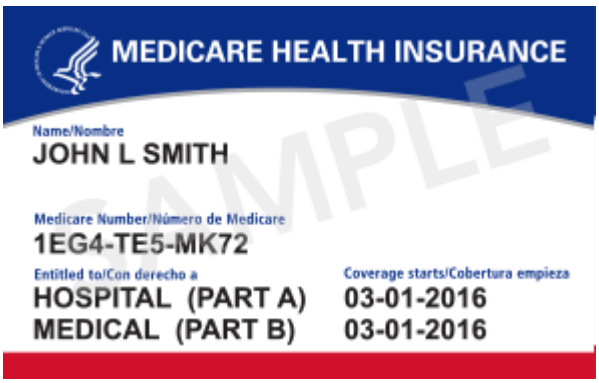
A Medicare card is issued to every person who is entitled to Medicare benefits. This card identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the Social Security records)
- HICN (for cards issued prior to April 1, 2018) or MBI (for cards issued April 1, 2018, and after)
- Beginning date of Medicare entitlement for hospital (Part A) and/or medical (Part B) insurance

The following is an example of an HICN-based Medicare card:



The following is an example of an MBI-based Medicare card:



We recommend that you obtain a copy of the Medicare card and incorporate it in the beneficiary's file for accuracy of claim submissions.

For additional information about the new MBI-based Medicare cards, visit https://www.cms.gov/medicare/new-medicare-card/nmc-home.html.

8. Termination of Enrollment

There are times when a beneficiary's enrollment in Medicare may terminate for various reasons. This may not be reflected on the Medicare card. If you receive a denial from Medicare indicating no entitlement for the dates of service on the claim, there are several items you can check:

1. Did you copy the correct and complete Medicare ID from the Medicare card?
2. Is this the correct date of service? Be sure to check the year.
3. Has the beneficiary's enrollment been terminated? Check with the beneficiary to verify this possibility. The DME MAC generally does not have any details regarding the reason of termination of a beneficiary's enrollment.

9. Medicare Advantage Plans

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2, §60

As an alternative to the traditional fee-for-service Medicare plan, beneficiaries have the option of enrolling in a Medicare Advantage Plan. Medicare Advantage Plans include Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Medicare Special Needs Plans, and Medicare Private Fee-for-Service Plans. Claims for these plans must be filed with the contractor administering that particular plan. **Do not** file claims for Medicare Advantage Plans to CGS.

10. Other Government Insurance Plans

Railroad Retirement Board (RRB*)*

Claims for DMEPOS items for beneficiaries eligible for Railroad Retirement Board (RRB) benefits are also processed by CGS for beneficiaries in Jurisdiction C.

United Mine Workers Association (UMWA)

In the event a claim is filed to our office for the United Mine Workers Association (UMWA), the claim will be returned to you to resubmit to the UMWA for processing. A statement to that effect will be printed on your Medicare Remittance Advice. A statement will also be printed on the beneficiary's Medicare Summary Notice (MSN). These notices will let you and the beneficiary know that future claims should be filed with the appropriate office. Contact Information for the UMWA can be found in Chapter 15 of this Supplier Manual.

11. Privacy Act of 1974 and HIPAA Privacy Rules

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 6, §§10 & 190

The purpose of the Privacy Act and HIPAA Privacy Rules is to provide safeguards for individuals against an invasion of privacy. Federal agencies are required to permit individuals to:

1. Determine what records pertaining to him/her are collected, used, or disseminated by such agencies.
2. Prevent records pertaining to him/her from being used for another purpose without their consent.
3. Gain access to information pertaining to him/her in federal agency records, and to correct such records when appropriate.

Disclosure of information about a beneficiary to any party other than the beneficiary (or his/her legal guardian) him/herself is prohibited without the beneficiary's (or legal guardian's) explicit written authorization. This authorization may be in any form, but it must:

- Include the beneficiary's name and Medicare ID;
- Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;

- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed;
- A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as “at the request of the individual”);
- Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary’s enrollment in the health plan);
- Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative’s authority to act for the individual must also be provided;
- A statement describing the individual’s right to revoke the authorization along with a description of the process to revoke the authorization;
- A statement describing the inability to condition treatment, payment, enrollment, or eligibility for benefits on whether or not the beneficiary signs the authorization;
- A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.

Blanket consents to disclose all of the beneficiary's records to unspecified individuals or organizations will not be honored. The consent must specify the item/service for which the disclosure is requested and should only include those items/services prescribed by the beneficiary’s physician.

12. Freedom of Information Act (FOIA)

The Freedom of Information Act (FOIA) requires that most records in custody of CMS (and its contractors) be made available to the general public when requested. The FOIA does not apply to materials specifically prepared for public distribution or sale, e.g., press releases, speeches, fact sheets, listings (names and business addresses) of Medicaid and/or Medicare providers, information brochures, and any publication which has been assigned a CMS, Health and Human Services, Government Printing Office, or National Technical Information Service (NTIS) publication number, etc.

The FOIA covers records (paper or electronic/tape) only. It does not cover information which may be requested and imparted orally or in writing. For example, requests for dates, addresses, figures such as the Medicare enrollment for a state, which need not be responded to with the production of a document are not FOIA requests. Such requests should be directed to the proper public inquiries office.

FOIA examples:

- Existing records (handwritten, printed, or electronic)
- Excerpts from the Medicare manuals, Code of Federal Regulations, supplier manuals, and newsletters

- Supplier name lists
- Fee schedules
- Coding reports and letters
- Claim data reports

Non-FOIA examples:

- Requests for dates
- Addresses
- Figures (i.e., Medicare enrollment for a state)
- General questions about coverage or policy interpretation
- HCPCS coding information

All FOIA requests are subject to fees for search, review, and copy/duplication. Before submitting your request, you may want to see if the information can be obtained from our website, https://www.cgsmedicare.com. FOIA requests must be submitted in writing and should provide details that will help us identify and find the records being requested. If there is insufficient information, we will ask you for more. Include your name and telephone number(s) to help us reach you if we have questions.

Please send FOIA requests to the following address:

CGS
Attn: DME MAC Freedom of Information Coordinator
Suite ST610
26 Century Blvd
Nashville, TN 37214