DME 2024 Update

Presented by Paul Kesselman DPM DABFAS DABMSP
APMA DME Workgroup Coordinator
DME Consultant to PICA
Member DME MAC Council
The GURU of DME

Disclosures

Paul Kesselman DPM

Is Owner of Park DPM Consulting, LLC and Partner in Pare Coding and Compliance Services

Is a member of the Advisory Board for: Ethnocare, VHT, ReevCare and other O/P DME MFG

Disclosure will be made when a product is discussed for an unapproved use.

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Learning Objectives

1. Identify DME Issues for the Podiatry Practice
2. Demonstrate How Policy Effectuates Ability to Prescribe/Dispense
3. Analyze appropriate use of tools provided by DME MAC

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- Dr. Kesselman is CEO of PARK DPM and Partner in Pare Coding &Coding and Compliance Services
- Dr. Kesselman serves as a paid consultant and is on the speaker's bureau for many medical manufacturers. None of their products will be discussed during this presentation.

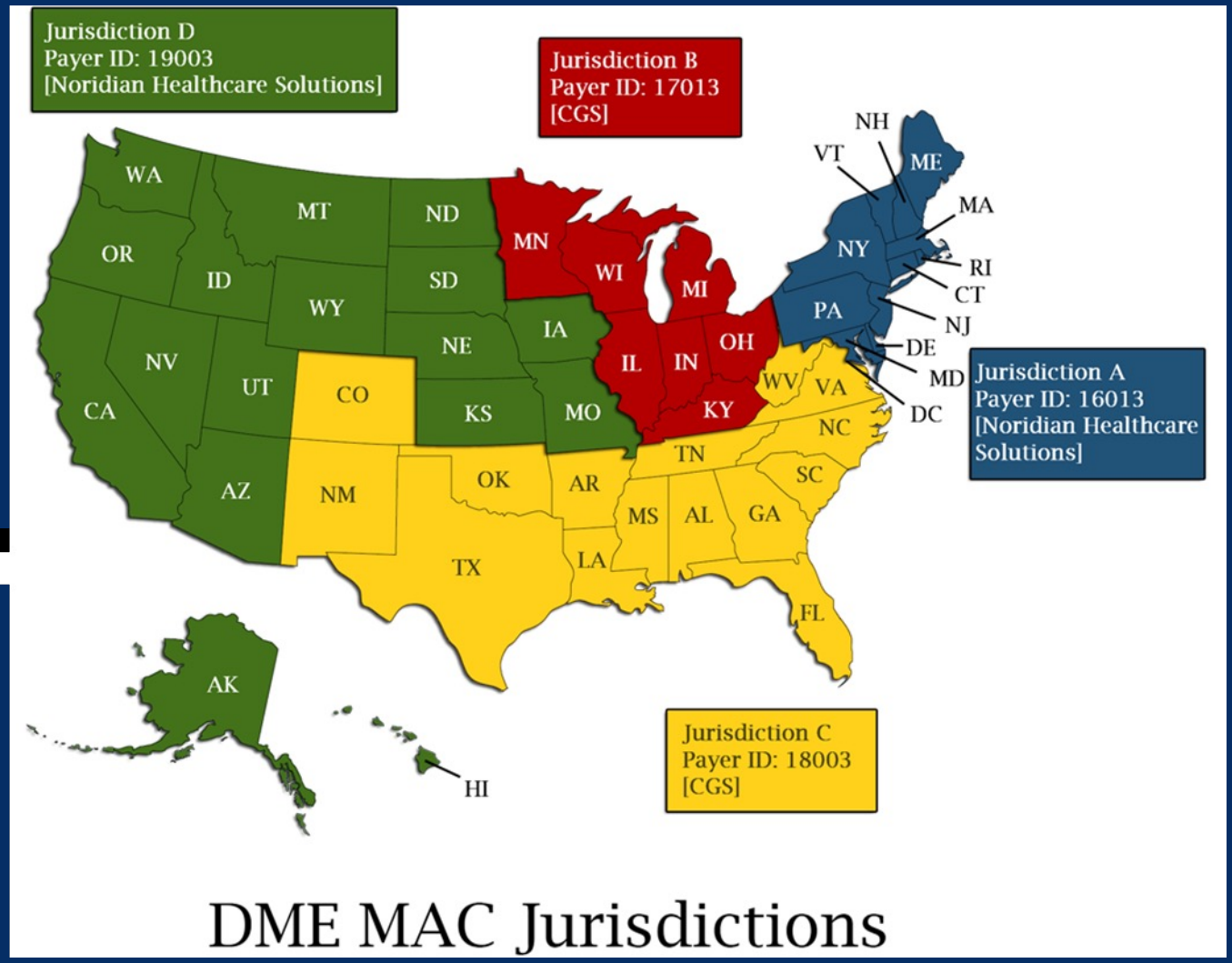
Groucho on Medicare

- Groucho on Medicare
  Groucho said if he had to do it all again, he'd been a doctor but that was before Medicare. I wouldn't do it now. In those days (meaning before Medicare) the doctor could keep all the money he made.
  Now doctors only get to keep 20% of what they are paid"

DME Fee Schedule

- 2023 Increased ~ 3% - Deflationary Factors
- Net Increase: ~2.6%
- Not Tied to MPFS
- Tied to CPI & other Complex Formulations
- Rural vs Suburban for Competitive Bidding
- Competitive Bidding on Hiatus. What's Next?
- Fee is Based on Patient's Legal Home Address in CWF
- Fees Vary By State

Where do the Medicare DMEPOS Claims Go?



DME MAC Jurisdictions

Popular Key HCPCS Fee Schedule Updates

- A5500: $86.77
- A5512: $35.39
- A5513: $52.81
- A5514: $52.81
- Ca:
- L4361: $355.42
- L4387: $182.06
- L4397: $189.47
- L5000: $704.70

Other DME Fees of Interest

Labor rates for orthotic or prosthetic repair/per 15 minutes

L4205: Repair of Orthotic covered by Medicare $46.48

L7520: Repair of Prosthetic: $54.18

L4210 (Repair or replacement of minor parts orthotic device) or L7510 (Repair of replacement minor parts of prosthetic).

This is billed by part invoice.

Ongoing OIG Issues and DMEPOS

- Multiple OIG Investigations into DME Marketing Scandals
- Telemarketing executives defraud MCR & VA for DME &Gen. Testing
- Payments for DMEPOS Under Hospice Care
- Payments for DMEPOS While In Patient Hospital or SNF
- DPMs & Compound Pharmacy Kickbacks

CERT Audit

- Comprehensive Error Rate=CERT
- Appeal any CERT Errors
- Providers Randomly Selected Based on HCPCS/CPT
- CERT is Actually Judging the Carrier for Claims They Should or Should Not Have Paid
- Review and Appeal to Your Carrier
- Local or DME MAC Desires Lower Scores

CERT ERROR RATES for DME 2022-2020

	2022	2021	2020
Lower Limb Orth.	57.5%	50.6%	65.7%
Surgical Dressings	41.8%	69.7%	67.3%
Diabetic Shoes	51.4%	67.9%	68.2%

Table I2: Improper Payment Rates and Amounts by Provider Type: DMEPOS

	2023		2022		2021		2020		2019	
Supplier Type Billing to DMEPOS	**Projected Improper Payments**	**Improper Payment Rate**	**Projected Improper Payments**	**Improper Payment Rate**	**Projected Improper Payments**	**Improper Payment Rate**	**Projected Improper Payments**	**Improper Payment Rate**	**Projected Improper Payments**	**Improper Payment Rate**
Medical supply company not included in 51, 52, or 53	$1,147,505,612	25.6%	$1,166,293,439	27.5%	$1,219,989,222	32.0%	$1,559,907,357	35.4%	$ 1,115,477,711	31.5%
Pharmacy	$460,540,965	18.5%	$53,894,448	20.5%	$552,495,612	20.4%	$408,989,118	18.8%	$ 501,703,228	21.6%
Medical Supply Company with Respiratory Therapist	$132,041,846	17.8%	$187,970,603	23.6%	$211,100,578	29.3%	$213,884,066	30.4%	$ 235,480,594	37.9%
All Provider Types With Less Than 30 Claims	$67,381,864	40.5%	$62,239,872	39.6%	$79,901,172	36.5%	$147,246,669	65.6%	$ 97,460,983	44.0%
Individual orthotic personnel certified by an accrediting organization	$18,302,378	10.6%	$40,462,711	29.2%	$42,637,513	31.5%	$65,077,260	33.5%	$ 162,204,490	41.3%
Podiatry	$29,934,209	47.5%	$43,976,606	55.1%	$60,892,064	62.6%	$65,074,507	68.4%	$ 68,247,132	67.1%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	$11,387,146	11.4%	$27,530,789	23.6%	$35,872,853	32.9%	$60,085,086	34.9%	$ 50,669,898	26.3%
Individual prosthetic personnel certified by an accrediting organization	$8,182,383	5.5%	$35,094,759	25.5%	$78,294,106	27.6%	$57,845,903	17.6%	$ 36,687,392	19.6%
Medical supply company with orthotic personnel certified by an accrediting organization	$19,233,143	17.4%	$14,185,719	6.7%			$57,091,889	45.1%	$ 38,488,617	25.4%
Orthopedic Surgery	$31,492,946	41.1%	$27,247,416	35.3%	$40,974,635	41.4%	$48,160,951	51.0%	$ 69,828,372	67.4%
General Practice	$6,447,663	18.8%	$26,676,054	45.5%	$15,274,876	45.7%	$27,146,419	64.8%	$ 23,856,232	60.8%
Multispecialty Clinic or Group Practice	$5,520,691	39.2%	$5,212,823	36.7%			$8,007,185	40.9%	$ 17,202,228	69.5%
Supplier of oxygen and/or oxygen related equipment	$9,526,265	14.7%	$17,274,869	28.5%	$13,159,866	26.1%	$15,651,438	39.7%	$ 11,614,356	31.1%
Optometry					$19,875,651	89.5%	$15,326,311	83.5%	$ 15,316,044	74.2%
Individual prosthetic/orthotic personnel certified by an accrediting organization	$8,182,383	5.5%	$12,056,796	36.5%			$14,898,945	30.2%		
Opthamology							$6,154,816	68.8%		
Medical supply company with prosthetic personnel certified by accrediting organization					$12,203,961	41.9%				
Overall	$1,947,497,111	22.5%	**$2,190,116,903**	**25.2%**	**$2,383,672,110**	**28.6%**	**$2,770,547,921**	**31.8%**	$ 2,444,237,277	30.7%

Part B Error Rate for DPM: 6.6%

Summary Statement on CERT From Council Member

- ARTICLE ON CERT IMPROPER PAYMENT REPORT 2023

- CMS recently published the 2023 improper payment report. The DMEPOS improper payment rate continued to decline from the all time high of 74% in 2010 to 22.5% in 2023. While this shows significant improvement, it is still the highest improper payment rate when compared to all Medicare Parts A and B. Overall CMS reported an improper payment rate of 7.38% for all segments of healthcare.
- While CERT audits are random with only 8,248 claims reviewed for DMEPOS, this is the only published error rate and as such is often viewed by policy makers and legislators as a benchmark.
- AA Homecare reviews the report in detail each year to help educate the supplier community and the DME MACs on specific policy groups and supplier types that have higher improper payment rates.
- This year's reports continue to show supplier types podiatry, orthopedic surgery and multispecialty clinic or group practice to have much higher error rates than traditional DMEPOS suppliers. On review of the product categories with the highest improper payment rates, lower limb orthoses, surgical dressings, LSO, diabetic shoes, manual wheelchairs and pneumatic compression devices topped the list.

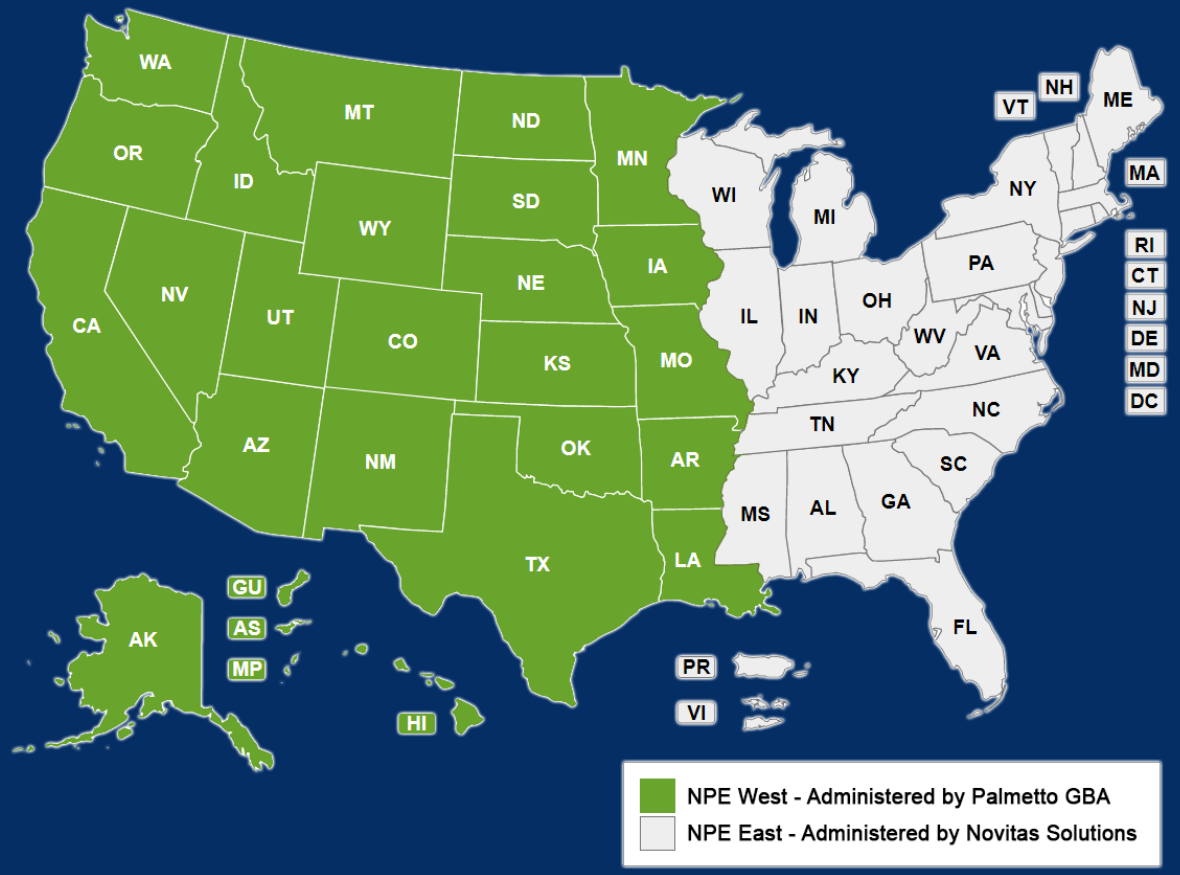
DMEPOS Enrollment

DMEPOS Enrollment

- Getting More Complicated By The Day
- 855S Currently Undergoing an Update
- Use PECOS
- Updated PECOS Due Summer 2024 (Promised Since Summer 2023)

Enrollment and Re Enrollment Issues

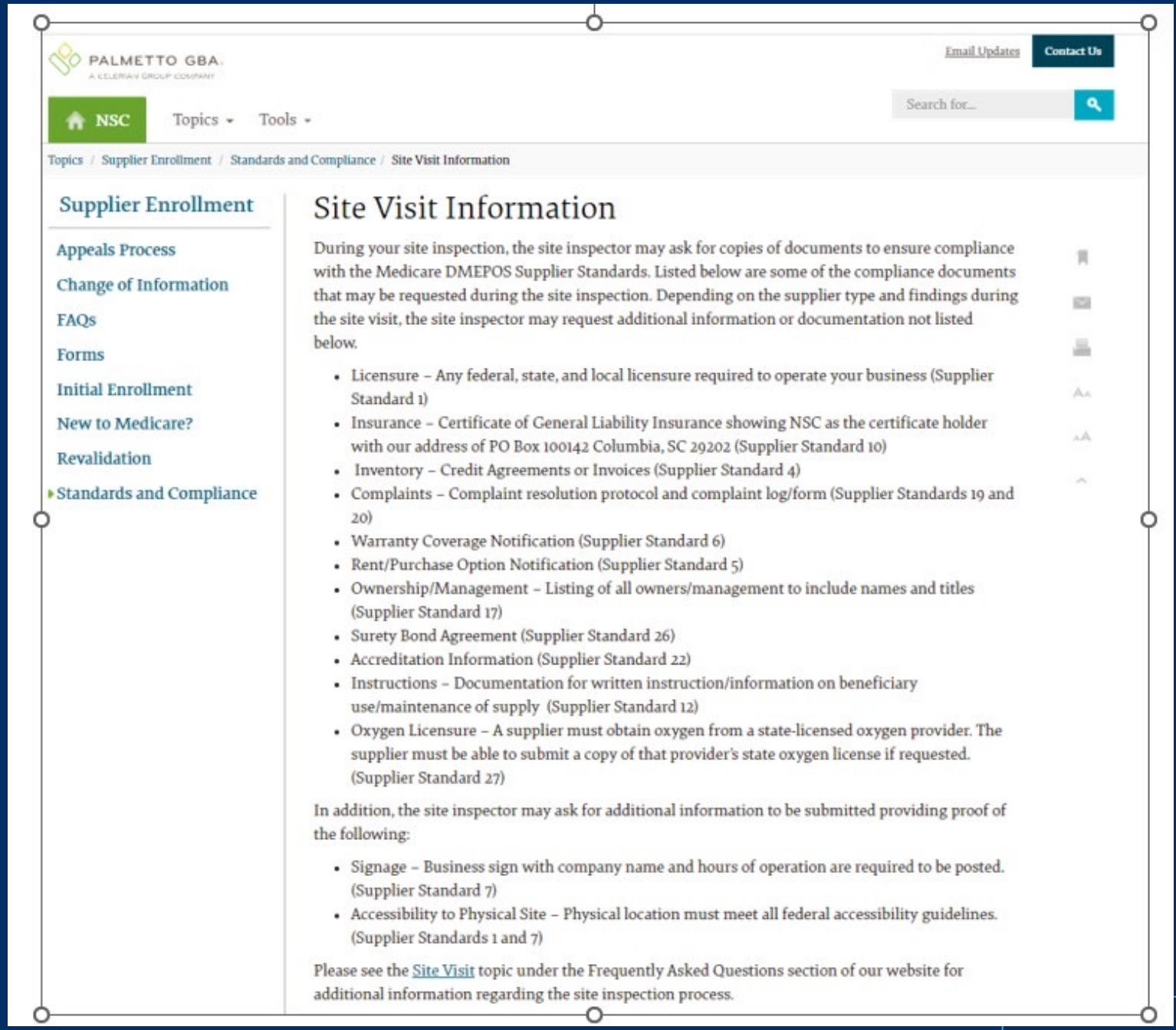
- Said Goodbye to NSC as of 11/7/22
- NPE West:
  - Palmetto GBA, AG-495 P O Box 100142 Columbia SC 29202-3142 . c 866-238-9652 (Same as NSC)
- NPE East
  - 2020 Technology Parkway, Suite 100 Mechanicsburg, PA 17050-9411
  - 866-520-5193
  - All web tools, FAQs, articles and other information on the current NSC website will be adjusted to reflect the new NPE West.
- Novitas is new to DME but not to enrollment
- NSC is now renamed Palmetto Same Staff



Medicare Provider Enrollment

2022: $631
2023: $688
2024: $709

Fee is Per location!!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Supplier Enrollment
Appeals Process
Change of Information
FAQs
Forms
Initial Enrollment
New to Medicare?
Revalidation
Standards and Compliance
Site Visit Information
During your site inspection, the site inspector may ask for copies of documents to ensure compliance with the Medicare DMEPOS Supplier Standards. Listed below are some of the compliance documents that may be requested during the site inspection. Depending on the supplier type and findings during the site visit, the site inspector may request additional information or documentation not listed below.
Licensure – Any federal, state, and local licensure required to operate your business (Supplier Standard 1)
Insurance – Certificate of General Liability Insurance showing NSC as the certificate holder with our address of PO Box 100142 Columbia, SC 29202 (Supplier Standard 10)
Inventory – Credit Agreements or Invoices (Supplier Standard 4)
Complaints – Complaint resolution protocol and complaint log/form (Supplier Standards 19 and 20)
Warranty Coverage Notification (Supplier Standard 6)
Rent/Purchase Option Notification (Supplier Standard 5)
Ownership/Management – Listing of all owners/management to include names and titles (Supplier Standard 17)
Surety Bond Agreement (Supplier Standard 26)
Accreditation Information (Supplier Standard 22)
Instructions – Documentation for written instruction/information on beneficiary use/maintenance of supply (Supplier Standard 12)
Oxygen Licensure – A supplier must obtain oxygen from a state-licensed oxygen provider. The supplier must be able to submit a copy of that provider's state oxygen license if requested. (Supplier Standard 27)
In addition, the site inspector may ask for additional information to be submitted providing proof of the following:
Signage – Business sign with company name and hours of operation are required to be posted. (Supplier Standard 7)
Accessibility to Physical Site – Physical location must meet all federal accessibility guidelines. (Supplier Standards 1 and 7)
Please see the Site Visit topic under the Frequently Asked Questions section of our website for additional information regarding the site inspection process.

Supplier Enrollment

- Appeals Process
- Change of Information
- FAQs
- Forms
- Initial Enrollment
- New to Medicare?
- Revalidation
- Standards and Compliance

Change of Information Guide

Supplier Standard 2 requires suppliers to notify the NSC of any change to the information provided on the CMS 855S or as reported in Internet-based PECOS within 30 days of the change. Therefore, if you have added or stopped providing a specialty, product or service; moved to a new location; or made changes to your ownership, you must notify the NSC. Failure to do so may result in the revocation of your billing privileges and/or overpayments.

Change in Products or Services

If a supplier is adding products or services that will be provided to a Medicare beneficiary state required licenses should be submitted along with the CMS 855S. This indicates compliance with state and federal regulations with regard to the new specialty, product or service (Supplier Standard 1).

Information as to what licenses are required is available under Licensure Information. The licensure information should only be used as a guide. Federal and state agencies have the final authority to determine what licenses are required. Suppliers are responsible for ensuring they have all the licenses required to operate their business.

Listed below are the common sections for making changes to a supplier file.

Common Sections for all Changes of Information (CMS-855S Version 05/16)

Section 1B (Business Identification)

- List the supplier's legal business name (LBN)
- List the NPI
- List the Tax Identification Number (TIN)
- List the Supplier Billing Number (PTAN)

Section 1C (Reason for Submitting This Application)

Section 1D (What Information Is Changing?)

- As instructed, check all that apply

Section 7 (Adverse Legal Actions/Convictions)

Review the information in this section and check the appropriate box. Do not leave this section blank. If the section does not apply, check 'No'. If you need to report any actions, check 'Yes' and provide the required information.

Section 11 (Contact Person)

CMS Awards $87M in Site Verification Support Task Orders to Deloitte, Palmetto GBA

JANE EDWARDS AUGUST 21, 2020 CONTRACT AWARDS, NEWS

Deloitte Consulting and Palmetto GBA have won task orders worth $86.7M combined from the Centers for Medicare and Medicaid Services for site verification support services.

The task orders were awarded under the $2B Provider Enrollment and Oversight multiple-award, indefinite-delivery/indefinite-quantity contract, which seeks to provide enrollment and screening support to help CMS detect and prevent fraud, abuse and waste in Medicare and Medicaid programs.

Deloitte will carry out site verifications for providers and suppliers in the Western region under a potential $43 task order, while Palmetto will provide services in the Eastern region under a $43.7M task order.

Inspection services under the task orders include visits to provider locations, internal site visits and documentation of findings, according to the statement of work.


PALMETTO GBA
A CELERIAN GROUP COMPANY
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Supplier Enrollment
Appeals Process
Change of Information
FAQs
Forms
Initial Enrollment
New to Medicare?
Revalidation
Standards and Compliance
How can I be sure the individual present to conduct the site visit is authorized to do so?
Answer:
Site inspections are now conducted by two separate CMS contractors and are no longer conducted by the NSC. One contractor handles all states east of the Mississippi River and another all states to the west of the Mississippi River. Each contractor may use subcontractors to perform inspections. Regardless, an authorized site inspector will have a photo identification and a signed letter on CMS letterhead authorizing the individual to conduct the visit. Please note, the inspector will have a camera to take various pictures of the facility, sign, inventory, etc. The inspector will also have a questionnaire to complete based on the supplier standards.
The inspector may ask to review business records (e.g. licenses, insurance) and/or beneficiary files to determine compliance with certain requirements of the supplier standards. However, the site inspector should never take, copy, or photograph beneficiary files. Please notify the NSC immediately if the site inspector requests to take or copy beneficiary files.
For other questions about site inspections contact the NSC at 866-238-9652.

Common Enrollment Errors/Issues

- List Exact Actual Office Hours to Meet 30 Hour Requirement
- Lack of Comprehensive List of DMEPOS (Don’t Check Orthotics)
- If PC or LLC Provide Individual NPI not Group NPI
- Flawed Certificate of Insurance
- Failure to enroll each location can be costly beyond DMEPOS!
- New Product Category Lymphedema Compression Issues
- EFT to DME MAC Is NO MORE!!!! Must go with PECOS (855s)
- State Licensure is out of date

New Enrollment Requirement

- If you provide supplies in more than one category, you may be asked to provide proof of inventory agreement from your vendors
- This is more than a simple vendor agreement

New Appeals Contractor

- If NPE Application is Rejected Cannot Appeal to Your NPE
- Appeals to New Contractor:

Chags Health Information Technology LLC

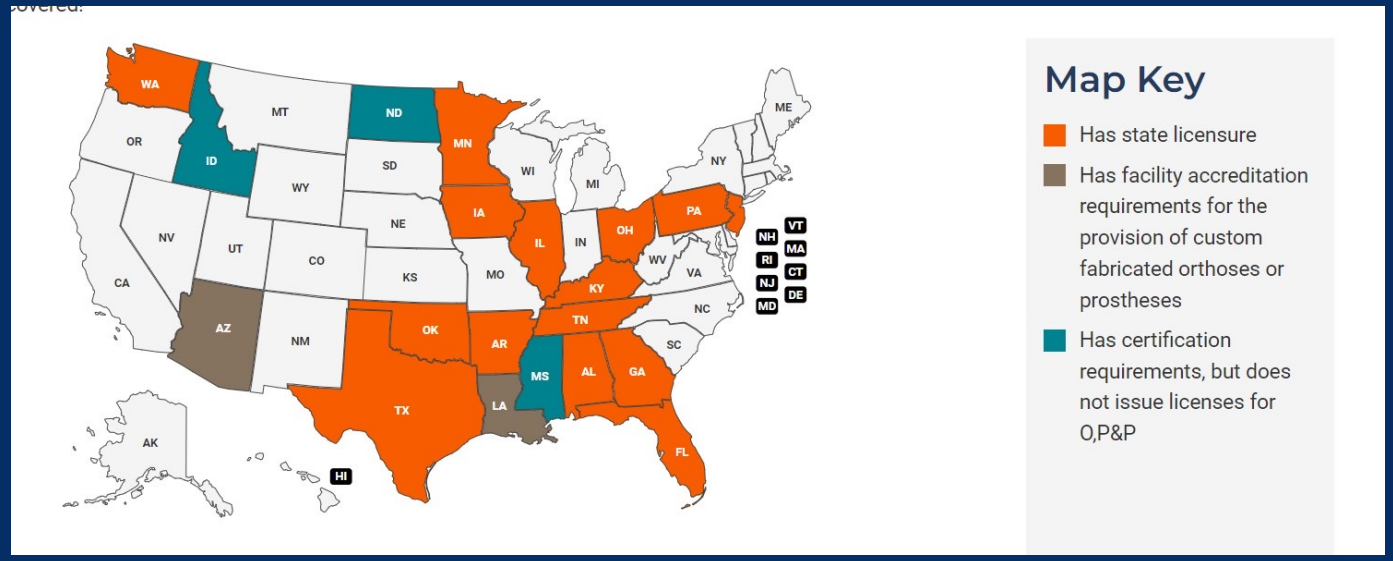
- Fax: 866-410-7404
- Phone: 800-245-9206
- Email: PEARC@c-hit.com
- Mailing Address: P.O. BOX 45266, Jacksonville, FL 32232

State Licensure Requirements

- Hire an Expert for DME and Local Enrollments
- These are not the applications of the 1980’s
- Significant Provider Implications/Penalties if not filed correctly/timely

State Licensure Requirements

- CMS/NSC to Enforce State Licensure Regulations
- Podiatrists Should Check off Any & All Classes of DMEPOS Plan to Dispense
- Some state databases are incorrect!!!



Where Can I Check My State Data Base?

- Https://palmettogba.com/palmetto/npewest.nsf/DID/P4LF7PNQM8?Open&emb=CA

What Do You Do if Your Banking Info is Compromised/Changed?

- Change in PECOS
- Contact the NPE (No longer DME MAC)

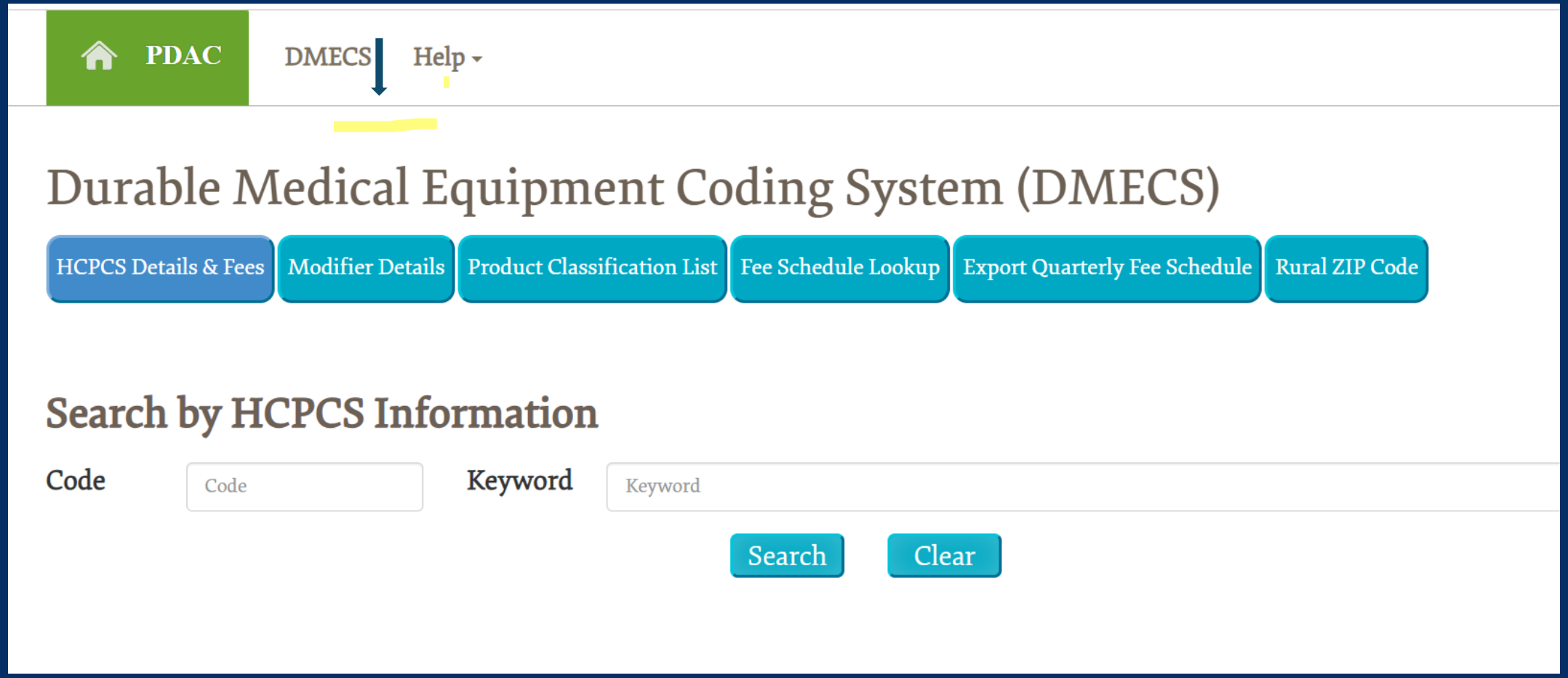
PDAC Issues

- www.dmepdac.com

HCPCS Requiring PDAC Validation

- L1906, A5512-A5514 not mfg. by supplier
- A6021-A6024 Collagen Dressings

DMECS TO Look Up Mandated Validated Codes



PDAC Product Categories

- 01=Custom Fabricated
- 02=Custom Fitted
- 03=OTS

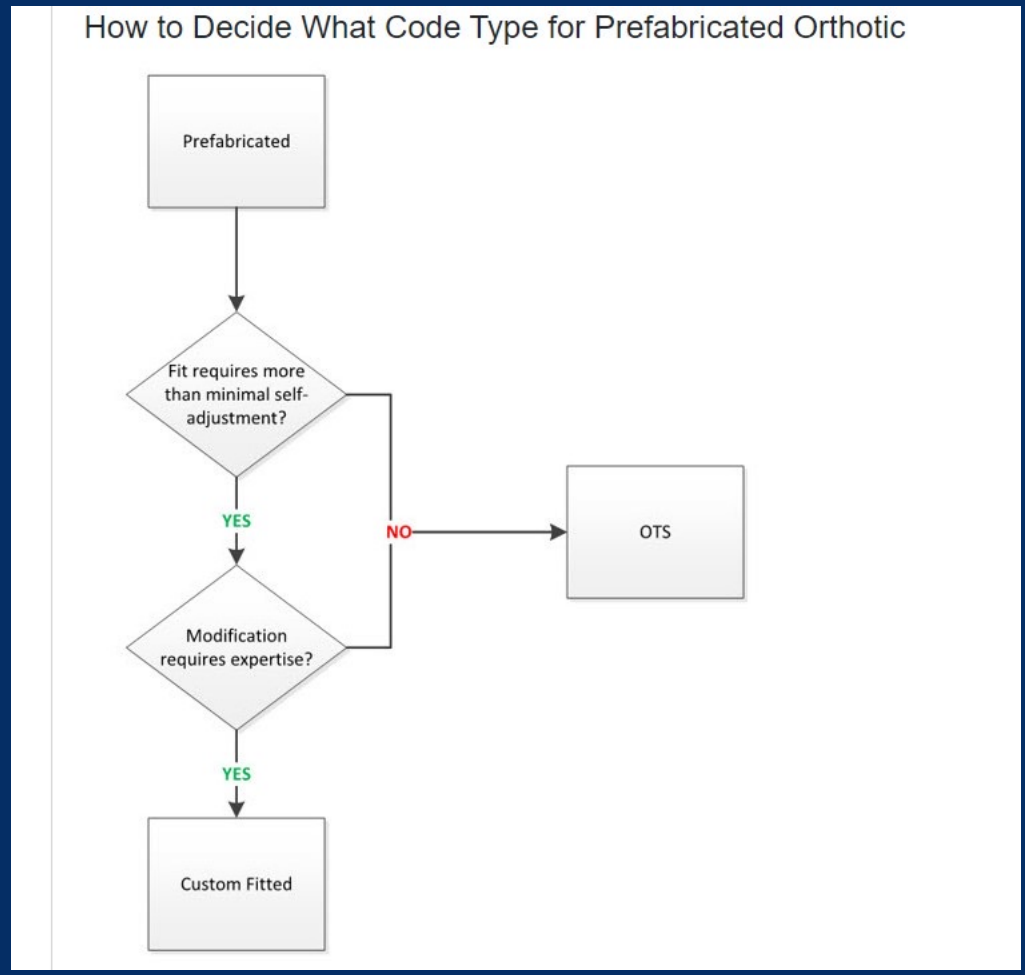
- Custom Fit and OTS are considered Complete by Parent Code
- Only Custom Fabricated (01) are allowed add on coding

- Warning about Billing OTS or Custom Fit w/Add On Codes

Custom fitted vs. OTS?

•Off-the-shelf (OTS) - Prefabricated item that requires minimal self-adjustment e.g., being trimmed, bent, molded, assembled, or otherwise adjusted to fit the beneficiary. Minimal self-adjustment does not require the expertise of a certified orthotist or an individual with specialized training in the provision of orthotics.

•Custom fitted - Prefabricated item that requires more than minimal self-adjustments e.g., has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by a certified orthotist or an individual with specialized training in the provision of orthotics



3-D Printed Orthotic Devices - Correct Coding Joint DME MAC and PDAC Publication Posted February 1, 2024

- The Pricing, Data Analysis and Coding (PDAC) Contractor and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) would like to address recent inquiries and concerns regarding additive manufacturing (i.e., 3D printing) of orthotic devices. This advanced technology constructs three-dimensional items modeled and designed from Computer-Aided Design (CAD) software and/or from digital scanning. The Centers for Medicare & Medicaid Services (CMS) has provided guidance to the DME MACs and PDAC that additive manufacturing is an acceptable custom fabrication technique as long as it adheres to the CMS DMEPOS Quality Standards, Appendix C.

Jurisdictional Council Issues

- **NASC: Committee**
- **Contractor & Portal Issues**
- Portal Advisory Board Connections
- Strengthened Relationships with AOPA, PFA & Others
- Improved Relationships with DME Contractors and CMDs

JB JC Portal

- Annual Re-Registration Tied to ANY DME MAC PTAN, NPI, PMT
- Same and Similar Available to JA JD Suppliers
- Provides Annual Therapeutic Shoe & Diabetic Supplies
- Goes Back 8 Years for AFO, Surgical Dressings, etc.
- Same/Similar Search: ICD10, DOS, Name/Ph# of Supplier
- Podcast on APMA Completed

Same and Similar (Not Much Updated Since 2020)

- Meetings with Other Stakeholders 12/04/20, May 2021
- APTA, AOTA, AOPA, PFA, APMA
- Continued Correspondence With Joel Kaiser at CMS
- May Need to Transition Meetings with CMS Technology Dept
- Stuck on RUL 5 Year Rule (Except for Inceptions)
- AOTA &APTA APMA and Others Meetings With CMS Multiple Times
- Planned Meeting with AOPA on new strategy shortly

DME Minimum Useful Lifetime

- To Qualify as DME, Most DME Must Meet 3 year MUL
- PDAC Has Updated its Validation Requirements to Match MUL
- There are exceptions
- Will this result in Rescinding of Validation?

Reasonable Useful Lifetime

- Most MACs are Using RUL Not Med. Necessity (Payment criteria)
- Most DME Assigned a 5 Year Reasonable Useful Lifetime
- Exceptions:
- Knee Orthosis-1 Yr: OTS, 2 Yr: Custom Fit 3 Yr. Custom Fab
- Surgical Dressings: Frequency Dependent on Product Type
- Therapeutic Shoes: Not Technically DME But Yearly Benefit
- Lower Limb Prosthetics (L5000+) Replacement is based on medical necessity
- Canes, crutches, walkers: 5 Years (All in same category)

AOPA's Initiatives Backed by APMA

- Separate DME (Walkers, Beds, PCD, etc.) from Orthotics & Prosthetics
- Carriers have split POE Meetings into two groups O/P and DME
- Will separation of DME from O/P into two separate categories result in MUL being used as basis for S/S?

Supported by APMA

AOPA Applauds Introduction of the Medicare Orthotics and Prosthetics Patient-Centered Care Act in the Senate

This important legislation has four provisions:

- The first would create separate statutory requirements for the provision of orthoses and prostheses to reflect the clinical, service-oriented nature of orthotics and prosthetics care.
- The second would restore Congress' intended meaning of the term "minimal self-adjustment," to more clearly define off-the-shelf orthoses that are subject to the Centers for Medicare & Medicaid Services' competitive bidding program.
- Third, it would prohibit the practice of "drop shipping" custom orthoses and prostheses to Medicare beneficiaries. This provision would reduce ongoing Medicare waste, fraud, and abuse in the orthotic and prosthetic benefit; a need recently highlighted when the Department of Justice uncovered $1.2 billion in fraud through last year's "Operation Brace Yourself," and during the pandemic, several owners of medical equipment companies were charged with submitting false and fraudulent claims to Medicare for orthotic braces that were medically unnecessary, ineligible for Medicare reimbursement, or not provided as represented.
- Finally, the Act ensures that patients have access to the full range of orthotic care from one orthotic/prosthetic practitioner rather than requiring patients to visit multiple providers in the case where the treating orthotist or prosthetist does not have a competitive bidding contract. This provision helps ensure efficient and convenient patient care and is similar to the treatment afforded to physicians and therapists under the competitive bidding program.

Same or Similar

- ? Need for Center for Clinical Standards and Quality at CMS
- To Change RUL Need to Provide Clinical Evidence-
- Mfgs., Clinical Experience, Studies
- There Continues to be a debate from CMS on how the RUL was determined, if it is an LCD issue, CMS, NCD (for UE Devices)
- Where did the 5 Year RUL Come from Commercial Devices (e.g.
- A/C, Refrigerators)
- Answer: It came from RUL NOT MUL

Same or Similar Denials for Orthoses and the Appeals Process

Joint DME MAC (Durable Medical Equipment Medicare Administrative Contractor) Article
Posted August 27, 2020

Items that are identical or similar to items previously paid for by Medicare may be provided when the item is lost, stolen, irreparably damaged, or there has been a change in the beneficiary's medical/physiological condition. The delivery of an orthosis that is the same or similar to an item, previously provided and paid by Medicare, and is within the Reasonable Useful Lifetime (RUL), may be denied on the basis of the RUL (Reasonable Useful Lifetime). Orthotic devices have a minimum 5-year reasonable useful lifetime (RUL) per the Medicare Benefit Policy Manual (Internet-Only Manual 100-02), Chapter 15, Section 110.2, with the exception of certain knee orthoses which have HCPCS (Healthcare Common Procedure Coding System) code specific RUL (Reasonable Useful Lifetime) instructions of 1, 2, or 3 years depending upon the HCPCS (Healthcare Common Procedure Coding System) code. These specific RUL (Reasonable Useful Lifetime)s are listed in the Knee Orthoses Policy Article (A52465).

An orthosis that is denied as same or similar may be submitted for a redetermination. The DME MAC (Durable Medical Equipment Medicare Administrative Contractor)s will review documentation to determine if the previous item was lost, stolen, irreparably damaged by a specific incident, or if there was a change in the beneficiary's medical/physiological condition.

Change In Medical Condition

If a claim for an orthosis is denied as same or similar, the supplier may submit a redetermination. If the replacement orthosis is provided due to a change in medical condition, the supplier should submit the following at a minimum (with the redetermination form):

1. Standard written order (SWO);
2. Proof of delivery; and
3. Medical record documentation to substantiate a change of medical/physiological condition.

The medical records should demonstrate the beneficiary's change in medical/physiological condition necessitating the need for the new orthosis. A focused history and examination of the impacted body part is critical to establishing medical necessity. The medical record should include (but is not limited to):

- the beneficiary's diagnosis
- prognosis
- duration of condition
- functional limitations
- clinical course
- past experience with related items
- reasons why previous orthotic devices are not functional nor appropriate for the current condition.

The orthotist (supplier) records are a part of the medical record, and are considered in the context of documentation made by the treating practitioner and other healthcare practitioners, to provide additional details to demonstrate the item is reasonable and necessary. The orthotist's notes are expected to corroborate and provide details consistent with the practitioner's records. Medical necessity and subsequent payment will not be provided solely based on the orthotist's documentation. Supplier prepared statements and practitioner attestations, by themselves, do not provide sufficient documentation of medical necessity; even if signed by the ordering practitioner. These documents are not considered part of the medical record.

Lost, Stolen, or Irreparably Damaged

When providing a replacement orthosis which is lost, stolen or irreparably damaged (irreparable damage refers to a specific incident or to a natural disaster (e.g., fire, flood)), and the claim is denied due to same or similar equipment on file, a redetermination may be submitted, and must include documentation of the loss or irreparable damage, as well as a SWO (Standard Written Order) to reaffirm the medical necessity of the item. These redetermination instructions are the same as noted for a change in medical/physiological condition.

Coverage

Certain types of orthoses have specific coverage requirements and these coverage requirements must be met to receive payment. These coverage details are available in the Ankle-Foot/Knee-Ankle-Foot Orthosis, Knee Orthoses, and Spinal Orthoses: TLSO (Thoracic-Lumbar-Sacral Orthosis) and LSO (Lumbar Sacral Orthosis) Local Coverage Determinations and related Policy Articles found on the Medicare Coverage Database (L33686, A52457, L33318, A52465, and L33790, A52500, respectively); additional documentation requirements are addressed in the Standard Documentation Requirements article A55426.

Information regarding the appeal process including timeframes, addresses, fax numbers, submission forms, and checklists is located on each DME MAC (Durable Medical Equipment Medicare Administrative Contractor)'s website

Jurisdiction A: https://med.noridianmedicare.com/web/jadme/claims-appeals
Jurisdiction B: https://www.cgsmedicare.com/jb/claims/appeals/index.html
Jurisdiction C: https://www.cgsmedicare.com/jc/claims/appeals/index.html
Jurisdiction D: https://med.noridianmedicare.com/web/jddme/claims-appeals

Publication History

Same or Similar Appeals

- Still Problematic if Not Using Portal
- Fax Frequent Interruption
- Frequent Denials—
- Lack of Proper Review By Auditors
- Despite Progression or Regression
- Change in Condition or Diagnosis are often ignored
- RAC is most egregious in not following DME MAC Joint Publication

Same or Similar Bottom Line

- Obtain & SAVE Patient to the patient's EMR
- What was previously dispensed?
- Obtain the ICD10 (MyCGS 7.3)
- Any changes in Dx/Condition?
- Photos to illustrate poor fit
- Expect Denials
- Appeal Using Portal

DME Recovery Audit Contractors (RAC) Performant

- Based on TIN
- 10% of all paid claims by policy group/8 periods/year(45 days)
- Each Product Category (surgical dressings, therapeutic shoes, AFO) are considered separate
- Can review charts 3 Years Back
- RAC Gets Paid a % of What They Collect
- You fight and Win They Don’t Get Paid!

RAC Product Categories Subject to CMS Approval

- 1/3 of RAC Issues are DME Related
- AFO: Same and Similar
- *Bioengineered Skin Substitutes: Excessive/Insufficient Quantity**
- Canes/Crutches: 3 Year Look Back
- Surgical Dressings Subject to Home Health Consolidated Billing
- Surgical Dressings: Is the dressing consistent with patient's condition?
- DME Billed During Hospice
- Therapeutic Shoes: Does Patient Meet All Parameters of the Policy?
- * Non DME RAC

Recent Study on RAC 2022

- Study of 25,000 DMEPOS claims RAC Reviewed
- Only 10% were appealed to ALJ
- Of the claims appealed: >50% are favorable to provider

- Conclusion: Appeal your claims

Provider Portal Issues

- Register/Use All Four Contractor Portals
- Registration Difficulties Resolved
- Noridian/CGS Sharing Still Problematic
- CGS 7.3 Allows One Search for B/C
- JA/JD Must Be Checked Individually But Only 1 Log In
- Once a year registration
- Password Issues (Password Hints on the fly)

Portal Advisory Group

- Draft Versions of MyCGS 7.3 In Development:
- B/C Simultaneous Searches
- HCPCS/ICD10 Linkage
- Search by Policy or Range or Individual HCPCS
- Search by One NPI or Several NPI
- Print/Download Button to Save Results to your portal library
- Still seeking 1 stop S/S Search Noridian/CGS

Appeals Using Portal vs Fax/Mail

- Instant Feedback on Receipt with Log ID
- Follow course of Appeal on Portal
- Allows for Communication with Nurse Reviewer
- Lost Faxes and Cannot Confirm Receipt
- Your receipt is receipt of transmission not their receipt
- Hard Copy Snail Mail(Pony Express)
- ESMD is expensive but as good as portal.

DME Audits

- TPE Was Suspended 03/20 Now Reinstated 08/21
- Post Payment Audits for DOS Prior to March 2020 + Now
- DME MAC, CERT, RAC, SMRC
- **High Failure Rate on Submission W/O Expert Assistance**
- Sx. Dressings, AFO, T Shoes For DPM’s
- Knee/Spinal Orthosis and other DMEPOS also very high

Targeted Probe and Educate (TPE)

The MAC will review 20-40 of your claims and supporting medical records

If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC)

If compliant, you will not be reviewed again for at least **1 year** on the selected topic

You will be given at least a **45-day** period to make changes and improve

If some claims are denied, you will be invited to a one-on-one education session

4th Quarter 2023 Noridian Medical Review Results JD

TPE Pre-Payment Reviews

Review Criteria	Current Error Rate	Current Review Results
Ankle-Foot Orthosis (AFO) TPE Reviews	4%	View Current Review Results
Diabetic Supplies TPE Reviews	35%	View Current Review Results
Enteral Nutrition TPE Reviews	15%	View Current Review Results
Knee Orthosis TPE Reviews	54%	View Current Review Results
Manual Wheelchairs TPE Reviews	21%	View Current Review Results
Ostomy Supplies TPE Reviews	23%	View Current Review Results
Parenteral Nutrition TPE Reviews	19%	View Current Review Results
Pneumatic Compression Devices TPE Reviews	24%	View Current Review Results
Positive Airway Pressure (PAP) Devices TPE Reviews	17%	View Current Review Results
Spinal Orthosis TPE Reviews	18%	View Current Review Results
Surgical Dressing Supplies TPE Reviews	76%	View Current Review Results
Therapeutic Shoes for Persons with Diabetes TPE Reviews	51%	View Current Review Results
Urological Supplies TPE Reviews	10%	View Current Review Results

Post Payment Review Current Error Rate

• **L1940:** ANKLE FOOT ORTHOSIS, PLASTIC OR OTHER MATERIAL, CUSTOM-FABRICATED	49%	View Notification	View Quarterly Review Results	View Final Review Results
• **L1970**: ANKLE FOOT ORTHOSIS, PLASTIC WITH ANKLE JOINT, CUSTOM-FABRICATED	52%	View Notification	View Quarterly Review Results	View Final Review Results
• **L4361**: WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, OFF-THE-SHELF	37%	View Notification	View Quarterly Review Results	View Final Review Results
• **A4407:** OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	27%	View Notification	View Quarterly Review Results	View Final Review Results
• **A4409:** OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH	38%	View Notification	View Quarterly Review Results	View Final Review Results
• **A4352:** INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH	58%	View Notification	View Quarterly Review Results	View Final Review Results
• **A4353:** INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES	44%	View Notification	View Quarterly Review Results	View Final Review Results
• **A6010**: COLLAGEN BASED WOUND FILLER, DRY FORM, STERILE, PER GRAM OF COLLAGEN	86%	View Notification	View Quarterly Review Results	View Final Review Results
• **A6196**: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	82%	View Notification	View Quarterly Review Results	View Final Review Results
• **A6197**: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL	100%	View Notification	View Quarterly	View Final

JD AFO TPE 4rd Q 2023

Ankle-Foot Orthosis (HCPCS L1940, L1970 & L4361) Final Edit Effectiveness Results of Service Specific Post-Payment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a post-payment service specific review of HCPCS codes L1940, L1970 and L4361. The final edit effectiveness results from September 2021 through November 2021 are as follows.

Based on dollars, the overall claim potential improper payment rate is 49% for HCPCS L1940.

Based on dollars, the overall claim potential improper payment rate is 52% for HCPCS L1970.

Based on dollars, the overall claim potential improper payment rate is 37% for HCPCS L4361.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Post-Payment Notification Letter.
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.

Surgical Dressings Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS codes A6010, A6021, A6023, A6196, A6197, A6209, A6212, A6222, A6252, A6253 and A6446. The quarterly edit effectiveness results from October 2023 - December 2023 are as follows:

Based on dollars, the overall claim potential improper payment rate is **76%**.

Top Medical Necessity Denial Reasons

- Medical record documentation does not contain current clinical information which supports the reasonableness and necessity of the type and quantity of surgical dressings provided.
- Medical record documentation does not support the use of foam dressings when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudate.
- Medical record documentation does not support the use of alginate or other fiber gelling dressing covers for moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers).

Top Technical Denial Reasons

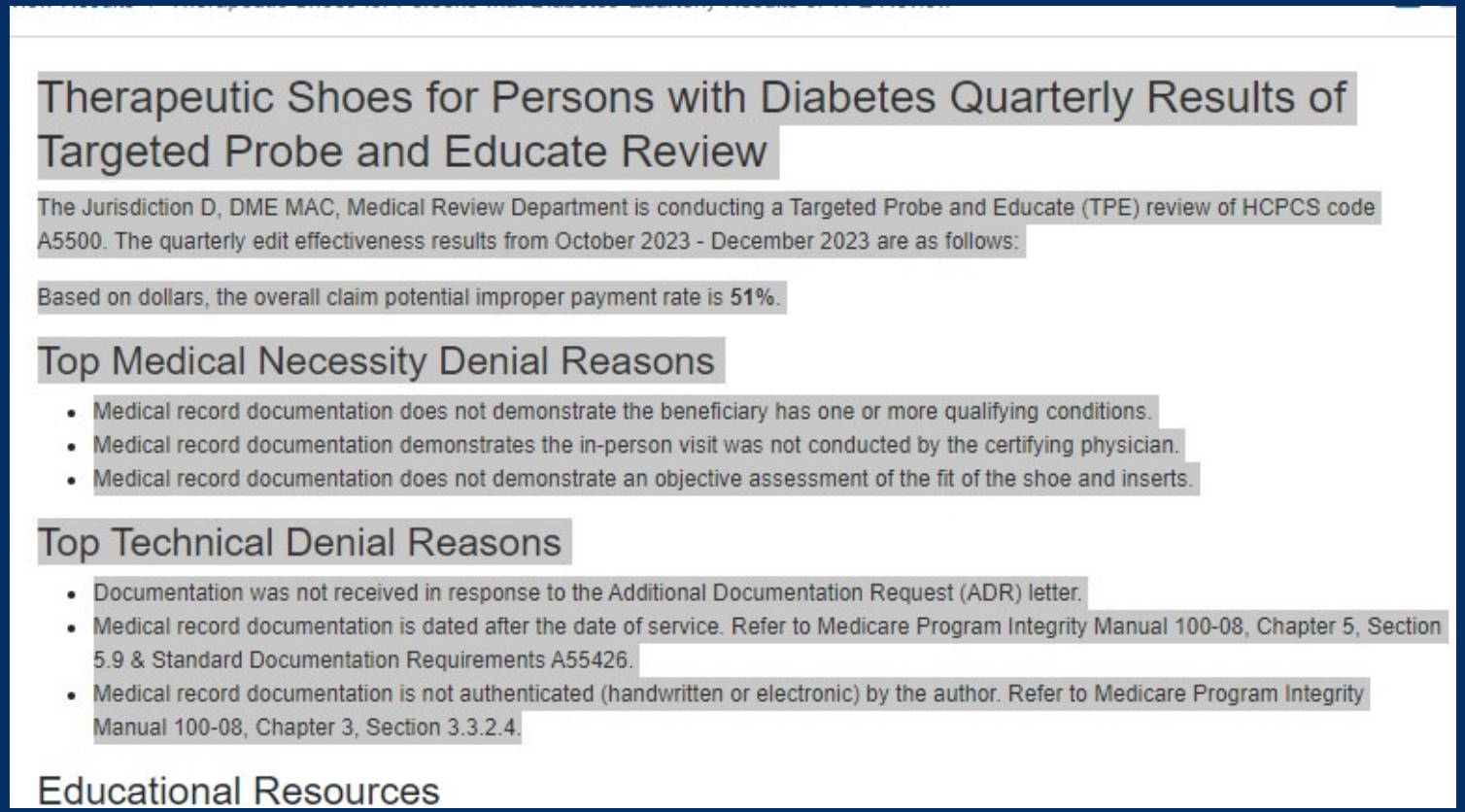
- Claim includes items which are not billable to the DME MAC.
- Standard written order (SWO) is missing the treating practitioner's signature. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
- Documentation does not include a standard written order (SWO). Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.1 & Standard Documentation Requirements A55426.

Educational Resources

Surgical Dressing Audit Failures

- Lack of Appropriate Measurements (L x W x D)
- Drainage (Heavy, Moderate, Mild, None)
- Primary Dressing Incompatible With Drainage Requirements
- Statement of Dressing Capacity Being Met After X Days)
- Date of Last & Type of Debridement
- Incompatibility for Secondary or Need for Secondary Dressing
- Frequency and/or Units Incompatible With LCD
- Dressing Size Incompatible with Wound Size

Therapeutic Shoes Quarterly Results of Targeted Probe and Educate Review



Therapeutic Shoes for Persons with Diabetes Quarterly Results of Targeted Probe and Educate Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code A5500. The quarterly edit effectiveness results from October 2023 - December 2023 are as follows:

Based on dollars, the overall claim potential improper payment rate is **51%**.

Top Medical Necessity Denial Reasons

- Medical record documentation does not demonstrate the beneficiary has one or more qualifying conditions.
- Medical record documentation demonstrates the in-person visit was not conducted by the certifying physician.
- Medical record documentation does not demonstrate an objective assessment of the fit of the shoe and inserts.

Top Technical Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical record documentation is dated after the date of service. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.9 & Standard Documentation Requirements A55426.
- Medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.

Educational Resources

Audit Expectations

- Higher Number of Failures Without Expert Advice
- Correctable Errors Should Be Dealt immediately with reopening
- Appeals as you go up are more difficult
- ALJ is more favorable to provider than the carrier
- 5 Year Wait is now only a few months.
- Submit Claim Right First Time
- Ask help

L30XX Issues

- The major issue with private payers has now shifted
- Durometer of Device/Heel Cup Incorporated into Policy
- Laterality Issue Due to ICD10 and Failed With HCPCS

L3000 HCPCS Issues for Carriers

- More Pre-Payment Prior Authorizations
- 6 Month and Other Failed Tx Written into Policy
- Date of Delivery
- Labs Being Called in by Investigators: Good or Bad?

L3000 in NJ and Ca.

- NJ: Audits Halted Based on Heel Cup Depth
- Focused on Rigidity/Laterality
- Frequency
- No Future Audits Planned for L3000 or S0395 for DPM's (Ca)

Other HCPCS Common Work Group Issues

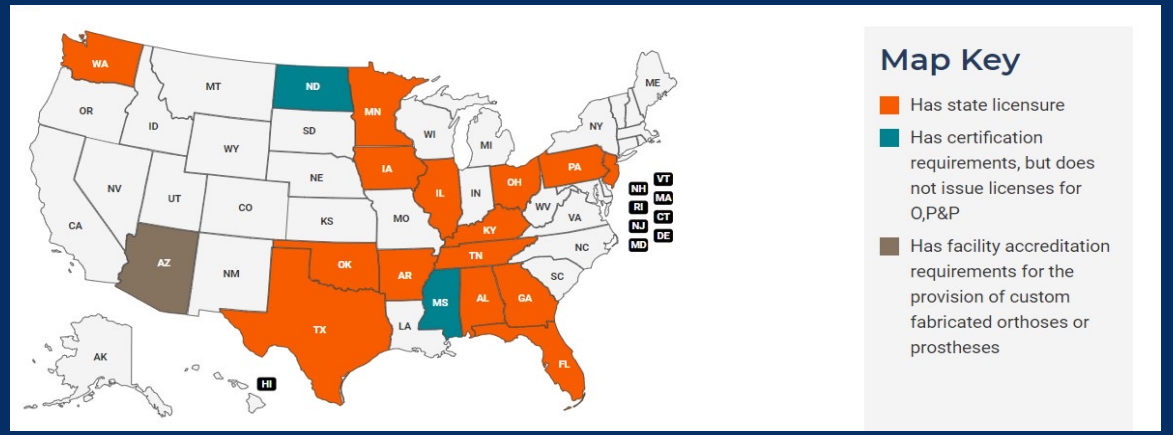
- S0395…. Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic
- Still Needs to be Modified:
- Impression Bio Foam, casting, or scanning of a foot performed by a practitioner other than the manufacturer of the orthotic

Other Third-Party Payer Issues

- Lack of adherence with CMS Requirements: WPOD
- Policies May Require P/A or Carve Out for Certain DMEPOS
- Lack of Proper Adherence of P/A and Benefit-
- Member Obtained P/A & Claim Rejected

Staff Dispensing of DME

- Licensing Issues for 19 States with licensure requirements
- All States Potential Liability Issues for Physicians Having non licensed, non-trained personnel dispensing to high-risk patients
- Proper Documentation of the DMEPOS needs to be done by the DPM in accordance with the LCD



Dispensing Pre-Operative

- Patient Must Have Medical Necessity Prior to Dispensing DMEPOS

- Pre-Operative Need:
- Patient having elective HAV Sx: No
- Patient having ORIF for Fx: Yes ?

COVID and PHE

- CR Modifier + Narratives = Advise inability to follow LCD
- All DME MAC Have Instructions for Use
- CR can only be used for DOS Prior to End of PHE

Summary

- Stop Taking Shortcuts on Documentation
- Pay Attention to the LCD
- Use Language In the LCD and Looked For By the Auditors
- Advocate First for Your Patient ---Advocate for You!

Questions???

- Thanks to the APMA BOT and APMA HPP and Workgroup
- Thanks for listening!
- drkesselman@parkdpm.com; paul@parecomplianceservices.com

- 516 632-9944 or 516-457-6959