DME 2026 Update

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Disclosures

Paul Kesselman DPM has no relevant financial interests to disclose.

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

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Commercial support was not received for this activity.

Learning Objectives

- Discover what is new since last year and what is coming down the pike
- Discuss what is going on with the T Shoe Program
- Explore changes with Same or Similar

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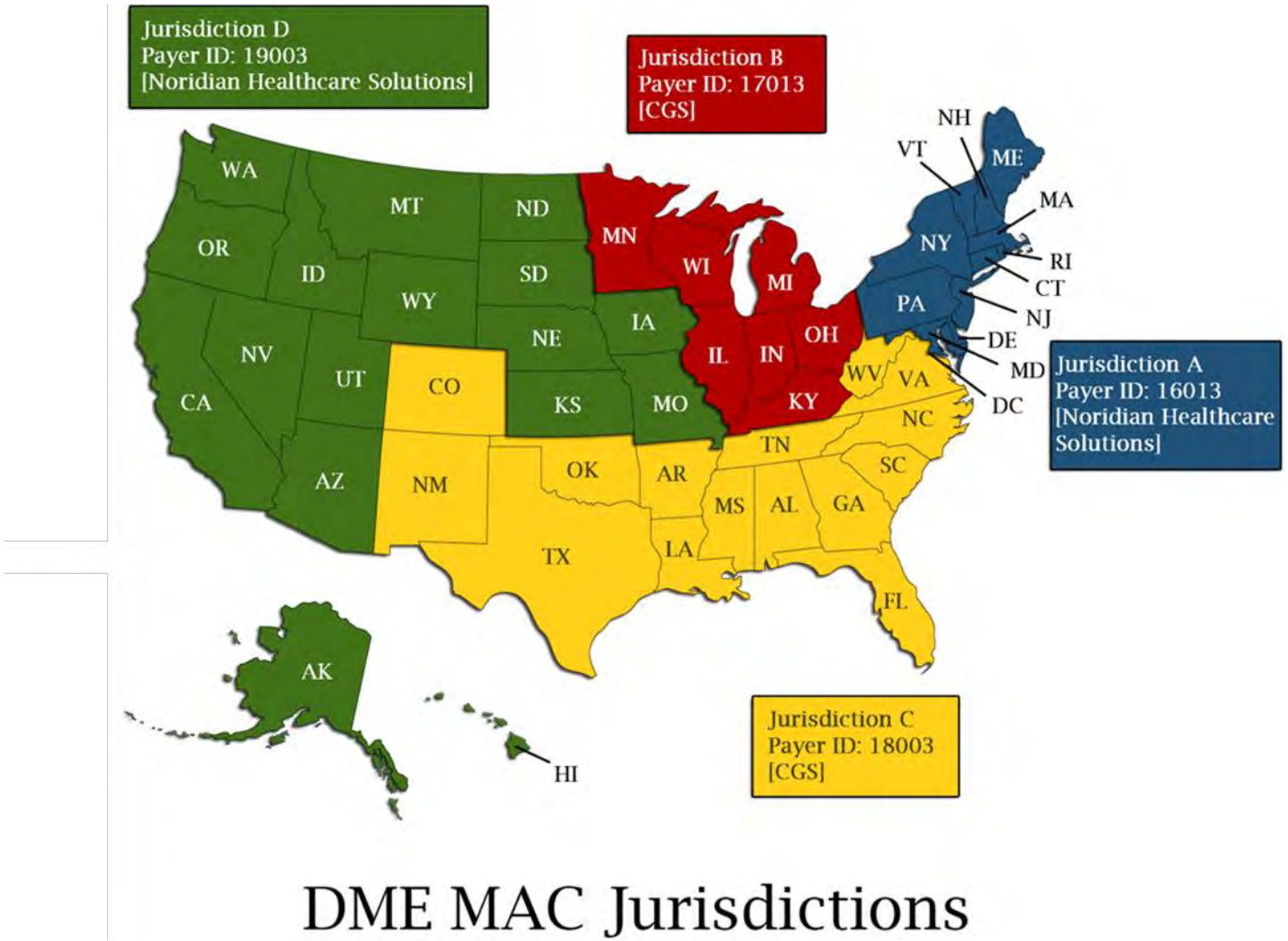
- Dr. Kesselman is CEO of PARK DPM and Partner in Pare Coding &Coding and Compliance Services
- Dr. Kesselman serves as a paid consultant and is on the speaker's bureau for many medical manufacturers. None of their products will be discussed during this presentation.

DME Fee Schedule

- 2026 Changes from 2025 Negative 0.7% productivity adjustment
- 2% sequestration
- Net Increase: ~2.0% vs. 2.4% for 2025
- Not Tied to MPFS
- Tied to CPI & other Complex Formulations
- Rural vs Suburban for Competitive Bidding
- Competitive Bidding Still on Hiatus. Next round
- 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

Why It’s Important To Use Carrier Portals

- Both DME Carriers Noridian JA/JD +CGS JB/JC Have Provider Portals
- Free and Easier than contacting CSR or Navigation IVR
- Beneficiary Eligibility, Deductible, 2◦ Insurance & MBI Look Up Tool
- Claim Status, Claims EOB Printing
- ADR Viewing and Responding
- Redetermination/Reopening Submission and Status
- DDMC and Prior Authorization Status
- And a whole lot more that IVR and CSR Will No Longer Provide

Popular Key HCPCS Fee Schedule Updates

HCPCS	Ca: 2025	Ca: 2026
A5500:	$88.85	$90.63
A5512:	$36.24	$36.96
A5513:	$54.08	$55.16
A5514:	$54.08	$55.16
L1970:	$870.62	$888.03
L4361:	$363.95	$371.23
L4387:	$186.43	$190.16
L4397:	$194.02	$197.90
L5000	$721.31	$735.74

Other DME Fees of Interest

Labor rates for orthotic or prosthetic repair/per 15 minutes

L4205: Repair of Orthotic covered by Medicare

Ca: 2025: $47.87 2026: $49.16

L4210 (Repair or replacement of minor parts orthotic device) or L7510 (Repair of replacement minor parts of prosthetic). This is billed by part invoice. This is based on the cost of the part.

L7520: Repair of Prosthetic:

Ca: 2025 $55.81 2026: 57.32

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Ongoing OIG Issues and DMEPOS

- Multiple OIG Investigations into DME Marketing Scandals
- Telemarketing executives defraud MCR & VA for DME &
- Genetic Testing
- Payments for DMEPOS Under Hospice Care
- DMEPOS Payments for In-Patient, SNF or Home Health
- Physicians & 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
- Carriers Want Lower Scores

CERT ERROR RATES for DME 2020-2024

	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%

2024
35.2%
57.6%
47.1%

Current overall rate was 7.66 % in 2023 2024:8.44%
DME overall =24.12% $2.2B

Table 9: Top Root Causes for Surgical Dressings

Root Cause Description	Error Category	Sample Claim Count
Wound management documentation - Inadequate	Insufficient Documentation	95
No response	No Documentation	29
Wound management documentation - Missing	Insufficient Documentation	23
Proof of delivery - Missing	Insufficient Documentation	19
Order - Missing	Insufficient Documentation	18
Submitted order not written by provider listed on the claim as ordering/referring provider	Other	15
Units of service (UOS) ordered does not support the units of service (UOS) provided and billed*	Insufficient Documentation	15
Proof of delivery - Inadequate	Insufficient Documentation	14
The date of service billed was not supported by the submitted documentation	Other	12
Order - Inadequate	Insufficient Documentation	10

Note: Root causes frequently associated with partial improper payments are identified with an asterisk.

All Provider Types	**1,026**	**$853,651,814**	**5.3%**	**4.1% - 6.6%**	**100.0%**

Table H4: Improper Payment Rates for Urological Supplies by Referring Provider

Urological Supplies	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
Family Practice	141	$832,363,352	96.3%	91.6% - 101.1%	94.0%
Nurse Practitioner	43	$38,106,658	44.1%	(12.7%) - 100.9%	4.3%
Urology	187	$7,906,901	4.5%	1.6% - 7.4%	0.9%
Internal Medicine	53	$795,310	2.9%	(0.6%) - 6.4%	0.1%
All Referring Providers	**490**	**$885,848,191**	**74.1%**	**53.9% - 94.3%**	**100.0%**

Table H5: Improper Payment Rates for Surgical Dressings by Referring Provider

Surgical Dressings	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Type of Service Improper Payments
General Surgery	107	$102,256,547	75.9%	65.8% - 86.1%	50.2%
Family Practice	123	$32,300,909	27.5%	6.8% - 48.3%	15.9%
Internal Medicine	132	$21,992,368	34.4%	21.1% - 47.6%	10.8%
Nurse Practitioner	98	$9,718,617	26.1%	6.3% - 46.0%	4.8%
Podiatry	42	$4,472,017	27.9%	7.0% - 48.8%	2.2%
Physician Assistant	32	$4,122,317	29.1%	7.4% - 50.7%	2.0%
All Referring Providers	**598**	**$203,604,968**	**47.1%**	**36.9% - 57.4%**	**100.0%**

Table H6: Improper Payment Rates for Glucose Monitor by Referring Provider

		Projected	Improper		Percent of Type of

Table I1: Improper Payment Rates and Amounts by Provider Type: Part B

Providers Billing to Part B	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Clinical Laboratory (Billing Independently)	1,638	$1,421,143,632	26.7%	19.2% - 34.2%	4.8%
Internal Medicine	866	$773,434,434	9.8%	7.5% - 12.1%	2.6%
Physical Therapist in Private Practice	510	$731,760,479	19.9%	14.6% - 25.2%	2.5%
All Provider Types With Less Than 30 Claims	664	$695,663,017	10.8%	6.3% - 15.3%	2.3%
Nurse Practitioner	835	$476,720,264	7.2%	5.3% - 9.2%	1.6%
Ambulance Service Supplier (e.g., private ambulance companies)	342	$452,598,022	10.4%	5.6% - 15.3%	1.5%
Family Practice	509	$416,972,278	7.6%	4.3% - 11.0%	1.4%
Cardiology	379	$321,213,865	8.7%	5.8% - 11.5%	1.1%
Emergency Medicine	165	$278,578,295	14.8%	10.7% - 18.9%	0.9%
Diagnostic Radiology	564	$260,830,181	5.8%	3.3% - 8.3%	0.9%
Ophthalmology	507	$253,124,779	3.2%	0.2% - 6.3%	0.9%
Ambulatory Surgical Center	331	$241,912,063	3.7%	1.7% - 5.7%	0.8%
Radiation Oncology	173	$226,228,587	15.8%	9.0% - 22.6%	0.8%
Nephrology	140	$212,471,664	16.6%	10.0% - 23.2%	0.7%
IDTF	253	$200,118,305	21.5%	0.9% - 42.0%	0.7%
Orthopedic Surgery	147	$188,626,782	6.3%	0.9% - 11.8%	0.6%
Pulmonary Disease	107	$178,790,919	14.4%	8.2% - 20.6%	0.6%
Gastroenterology	133	$178,420,590	14.6%	0.9% - 28.3%	0.6%
Physician Assistant	304	$168,069,844	3.2%	0.8% - 5.5%	0.6%
Podiatry	170	$147,685,729	5.1%	0.6% - 9.7%	0.5%
Anesthesiology	202	$147,680,721	10.8%	2.0% - 19.6%	0.5%
Chiropractic	100	$144,031,007	30.4%	18.7% - 42.2%	0.5%
Hospitalist	166	$141,000,892	13.1%	5.5% - 20.8%	0.5%
Physical Medicine and Rehabilitation	136	$120,990,931	12.4%	6.3% - 18.6%	0.4%
Hematology/Oncology	292	$113,720,869	1.7%	0.2% - 3.2%	0.4%
Dermatology	202	$103,438,232	3.4%	0.9% - 5.8%	0.3%
Neurology	130	$99,438,247	7.8%	3.4% - 12.1%	0.3%
Psychiatry	60	$97,257,705	13.3%	5.2% - 21.5%	0.3%
Urology	85	$88,264,058	8.4%	2.3% - 14.6%	0.3%
Pathology	94	$79,860,881	8.9%	2.6% - 15.2%	0.3%
General Surgery	93	$74,238,495	3.6%	0.5% - 6.7%	0.2%
Unknown Provider Type	102	$68,179,750	13.4%	4.9% - 21.9%	0.2%

Table J2: Improper Payment Rates by Provider Type and Type of Error: DMEPOS

Provider Types Billing to DMEPOS	Improper Payment Rate	Claims Reviewed	Percentage of Provider Type Improper Payments by Type of Error				
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other
Medical supply company with orthotic personnel certified by an accrediting organization	72.5%	185	84.0%	11.5%	1.5%	0.0%	2.9%
Podiatry	54.3%	75	0.4%	81.9%	0.6%	0.0%	17.2%
Orthopedic Surgery	48.2%	179	0.0%	83.6%	1.4%	0.0%	15.0%
Optometry	46.4%	35	0.0%	42.4%	40.3%	0.0%	17.3%
All Provider Types With Less Than 30 Claims	44.8%	217	28.8%	49.3%	2.3%	0.0%	19.7%
Medical supply company not included in 51, 52, or 53	29.9%	4,035	63.1%	25.3%	2.5%	0.2%	9.0%
Individual orthotic personnel certified by an accrediting organization	19.1%	133	0.0%	58.5%	2.7%	0.0%	38.7%
General Practice	18.6%	79	2.1%	56.3%	13.7%	3.3%	24.6%
Multispecialty Clinic or Group Practice	17.7%	49	0.0%	90.3%	9.7%	0.0%	0.0%
Medical Supply Company with Respiratory Therapist	17.0%	791	12.0%	55.6%	18.4%	0.1%	13.9%
Supplier of oxygen and/or oxygen related equipment	11.7%	42	0.0%	25.9%	21.3%	0.0%	52.8%
Pharmacy	11.1%	2,654	10.4%	53.7%	11.1%	1.0%	23.8%
Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization	5.1%	75	16.4%	37.4%	0.0%	0.0%	46.1%
Individual prosthetic personnel certified by an accrediting organization	3.7%	101	0.0%	82.7%	10.7%	1.3%	5.3%
All Provider Types	**24.1%**	**8,650**	**50.5%**	**32.8%**	**4.6%**	**0.2%**	**11.9%**

Table L2: Top 20 Service-Specific Overpayment Rates: DMEPOS

DMEPOS (HCPCS)	Claims Reviewed	Lines Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
Intermittent urinary cath (A4353)	44	140	$54,634	$58,352	$851,491,178	96.0%	89.3% - 102.7%
All Codes With Less Than 30 Claims	2,852	5,756	$299,811	$3,333,059	$338,136,474	15.7%	12.1% - 19.2%
Non-adju cgm supply allow (A4239)	260	277	$15,565	$91,128	$178,457,559	16.6%	9.6% - 23.6%
Collagen dressing >48 sq in (A6023)	68	88	$291,211	$414,165	$87,163,818	65.0%	40.9% - 89.0%
Oxygen concentrator (E1390)	247	247	$3,441	$26,985	$61,647,459	12.3%	7.7% - 17.0%
Ko double upright prefab ots (L1852)	79	112	$47,781	$61,870	$53,988,737	84.1%	74.1% - 94.2%
Home vent non-invasive inter (E0466)	337	349	$45,514	$382,921	$49,296,838	11.6%	8.0% - 15.1%
Collagen based wound filler (A6010)	58	64	$86,702	$136,056	$35,790,653	44.8%	30.3% - 59.3%
Collagen dressing <=16 sq in (A6021)	215	242	$97,993	$206,732	$31,987,264	47.8%	37.6% - 58.0%
Replacement nasal cushion (A7032)	75	75	$1,771	$9,084	$23,909,777	20.3%	6.6% - 33.9%
Who nontorsion jnts pre ots (L3916)	48	82	$23,906	$37,121	$23,378,915	62.9%	47.5% - 78.3%
Straight tip urine catheter (A4351)	41	58	$3,049	$13,267	$19,505,543	18.9%	(1.2%) - 39.1%
Replacement facemask interfa (A7031)	184	187	$2,845	$19,317	$19,289,084	11.5%	6.1% - 16.9%
CPAP full face mask (A7030)	114	114	$1,443	$13,150	$18,025,008	10.5%	4.6% - 16.4%
Nasal application device (A7034)	83	83	$750	$5,954	$17,433,071	13.6%	4.8% - 22.4%
LSO sc r ant/pos pnl pre cst (L0637)	47	47	$31,573	$58,197	$16,257,131	56.0%	40.9% - 71.1%
Diab shoe for density insert (A5500)	42	83	$3,218	$6,598	$15,798,850	51.9%	35.8% - 68.1%
Parenteral sol 74-100 gm pro (B4197)	145	184	$33,578	$250,056	$15,244,664	16.8%	4.7% - 28.9%
Blood glucose/reagent strips (A4253)	45	45	$269	$843	$13,912,392	30.4%	15.6% - 45.2%
Parenteral sol 52-73 gm prot (B4193)	46	63	$21,626	$70,221	$13,377,519	30.6%	14.5% - 46.7%
All Other Codes	6,339	11,051	$871,919	$5,356,112	$382,655,443	12.5%	11.2% - 13.8%
Total (DMEPOS)	**8,650**	**19,347**	**$1,938,599**	**$10,551,188**	**$2,266,747,377**	**24.1%**	**16.6% - 31.5%**

Table B10: Medicare FFS Projected Improper Payments by State – DMEPOS Only (Dollars in Millions) (Unadjusted for Impact of A/B Rebilling)

State	Claims Reviewed	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
VA	261	$542.8	73.2%	37.0% - 109.3%	1.8%
FL	582	$236.6	31.6%	22.5% - 40.7%	0.8%
CA	808	$171.1	18.8%	13.5% - 24.0%	0.6%
TX	518	$155.4	30.5%	14.7% - 46.3%	0.5%
MD	210	$128.6	46.1%	38.6% - 53.7%	0.4%
IL	413	$121.8	29.0%	7.2% - 50.8%	0.4%
NY	490	$81.8	20.0%	11.2% - 28.8%	0.3%
KY	182	$61.4	31.3%	2.2% - 60.3%	0.2%
MI	237	$52.2	21.0%	3.0% - 38.9%	0.2%
NJ	246	$52.1	21.3%	0.1% - 42.5%	0.2%
OH	287	$48.0	20.6%	10.1% - 31.0%	0.2%
PA	388	$47.3	13.0%	7.7% - 18.2%	0.2%
MA	234	$36.8	14.4%	6.8% - 22.0%	0.1%

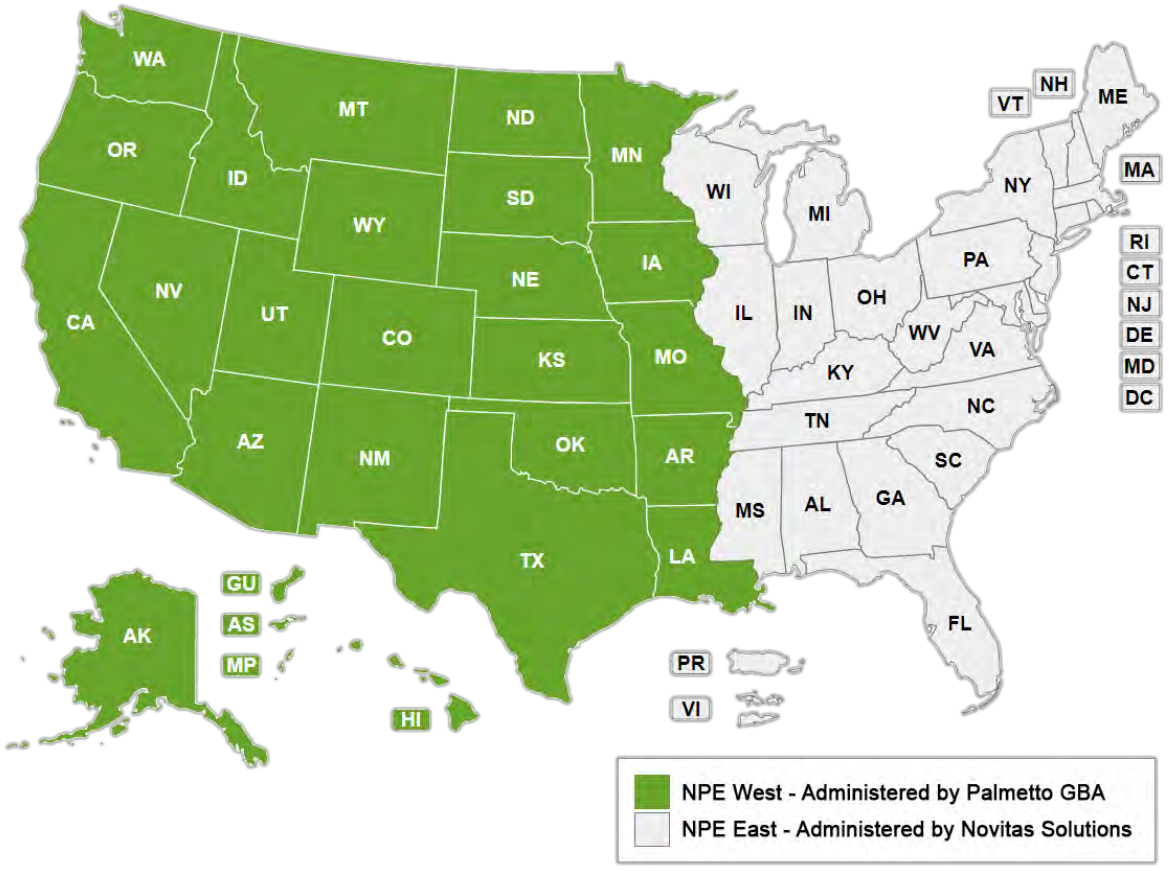
DMEPOS Enrollment

DMEPOS Enrollment

- Getting More Complicated By The Day
- 855S Currently Undergoing an Update
- Use PECOS
- Updated PECOS Program Currently Scrapped
- Moratorium on new supplier enrollment proposed 02/25/26
- What does this mean for physician enrollment in DME?

Enrollment and Re Enrollment Issues

- NPE West:
  - Palmetto GBA, AG-495 P O Box 100142 Columbia SC 29202-3142 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
2025: $735
2026: $750

Fee is Per location!!

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

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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.

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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.

Site Inspectors

- Recently assigned to new contractors
- The site inspectors are not under contract with NPE
- Appeals due to site inspection failure must go to the site inspection contractor

Common Enrollment Errors/Issues

- List Exact Actual Office Hours to Meet 30 Hour Requirement
- Lack of Comprehensive List of DMEPOS (Check all types you may dispense)
- 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
- Listing multiple states is a red flag!

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

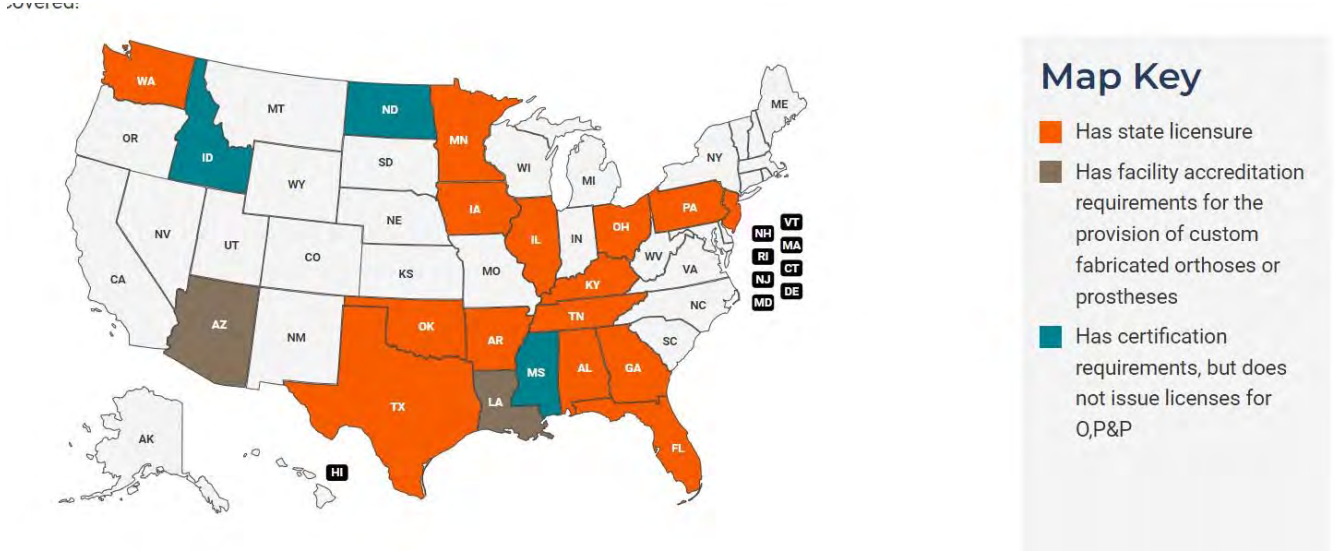
- Fax: 866-410-7404
- Phone: 800-245-9206
- Email: PEARC@c-hit.com
- Mailing Address: P.O. BOX 45266, Jacksonville, FL 32232

Suggestions for Enrollment Applications

- 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)

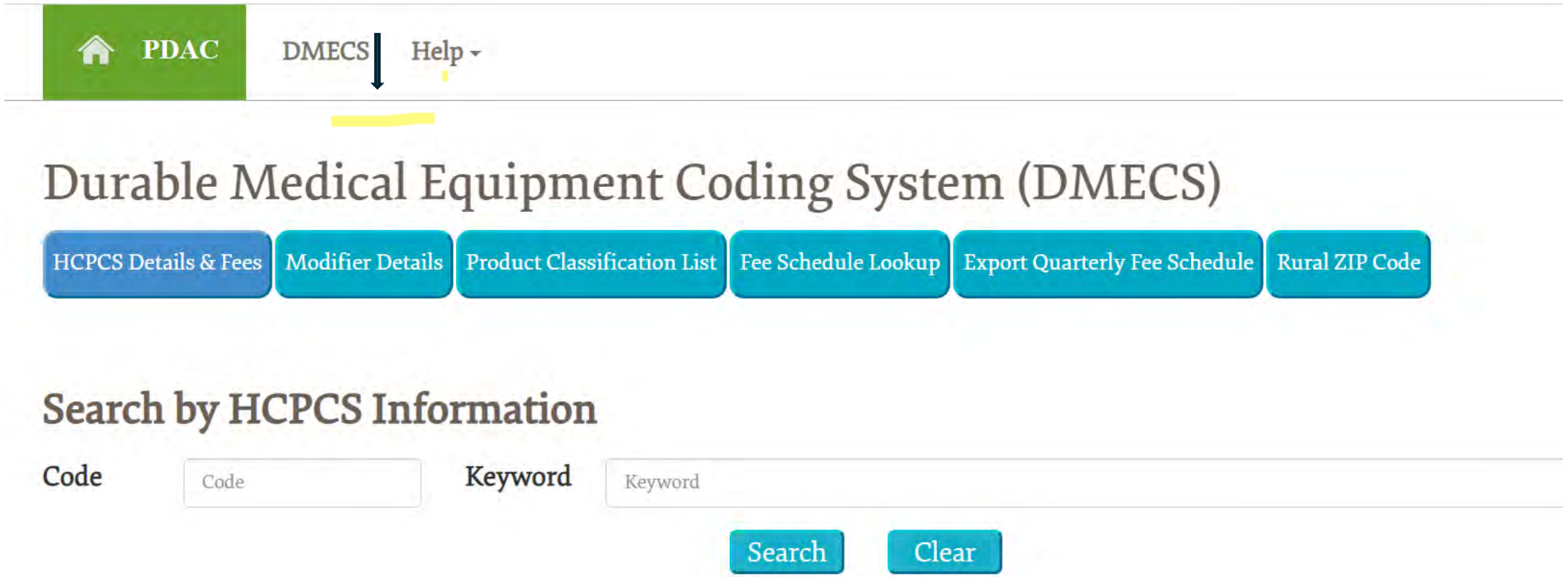
PDAC Issues

- www.dmepdac.com

HCPCS Requiring PDAC Validation

- L1906, A5512-A5514 not mfg. by supplier
- A6021-A6024 Collagen Dressings
- L1932: ANKLE FOOT ORTHOSIS, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
- L1933: ANKLE FOOT ORTHOSIS, RIGID ANTERIOR TIBIAL SECTION, TOTAL CARBON FIBER OR EQUAL MATERIAL, PREFABRICATED ITEM , Off the Shelf
- L1951: ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTIS
- L1952: ANKLE FOOT ORTHOSIS, SPIRAL, (INSTITUTE OF REHABILITATIVE MEDICINE TYPE), PLASTIC OR OTHER MATERIAL, PREFABRICATED, OFF-THE-SHELF

DMECS TO Look Up Mandated Validated Codes



PDAC Product Categories

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

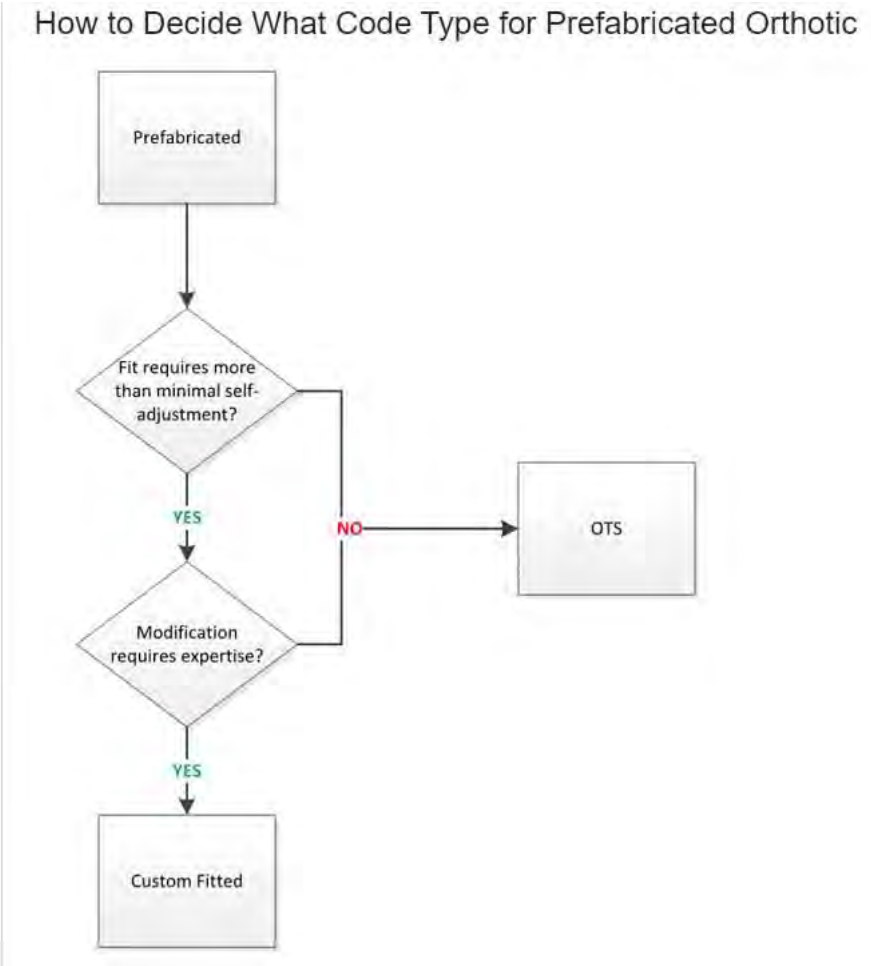
- Custom Fit and OTS are considered Complete by Parent Code
- Only Custom Fabricated (01) are allowed add on coding

- 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.

DME Requiring Prior Auth by DME MAC

- L1951: Ankle foot orthosis (AFO), spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment Eff 8/12/24
- L1932: Ankle foot orthosis, rigid anterior tibial section, total carbon fiber or equal material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise Eff 4/13/26

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 Exceptions)
- 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 Yrs: 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 Appeals

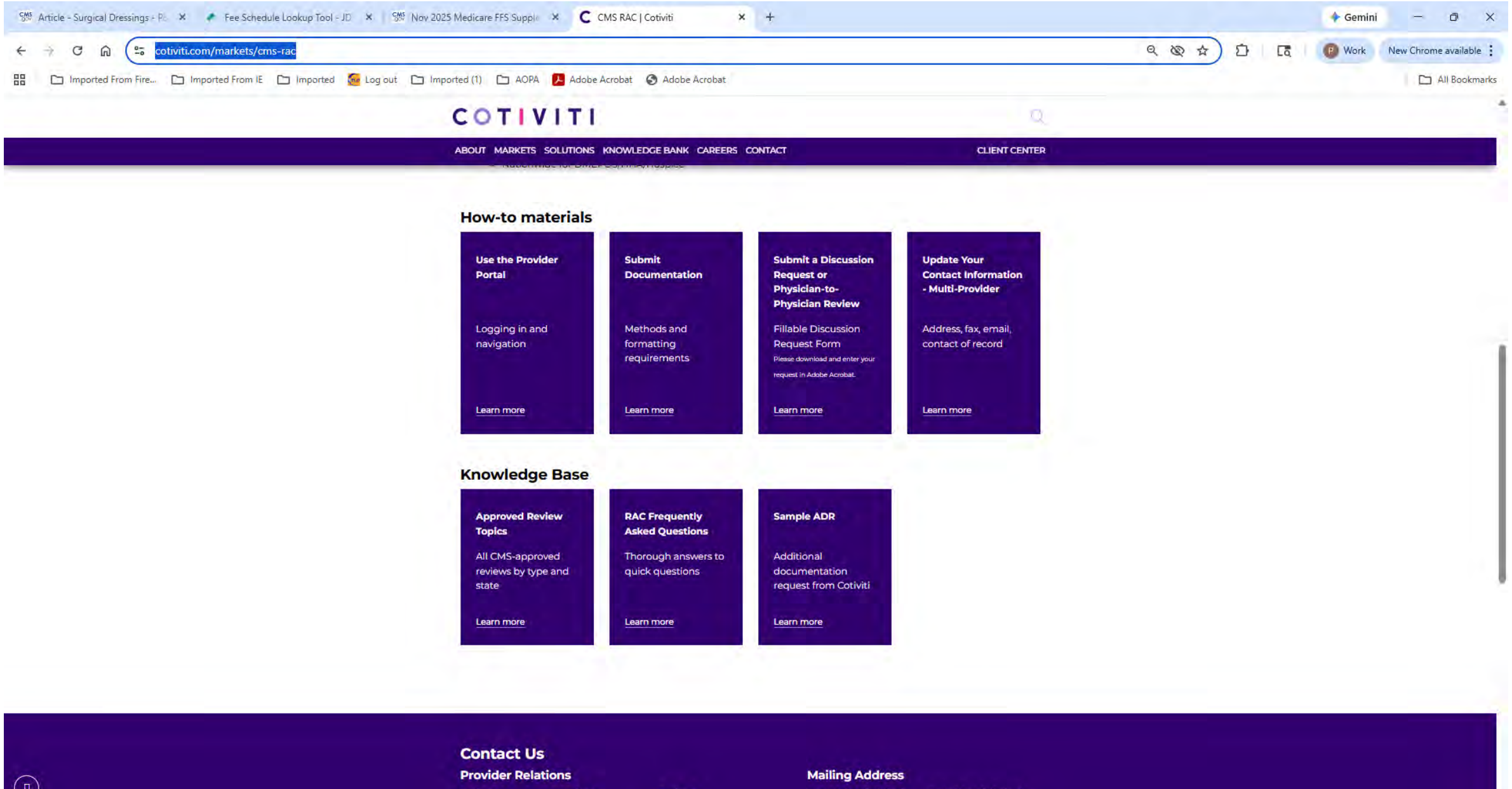
- Still Problematic if Not Using Portal
- Fax Frequent Interruption
- Frequent Denials—
- Lack of Proper Review By Auditors
- Despite Progression or Regression
- Change in Condition or Diagnosis are often ignored
- RAC is most egregious in not following DME MAC Joint Publication

DME Recovery Audit Contractors (RAC)
Cotivity as of Mid 2025:

- 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!

- https://www.cotiviti.com/markets/cms-rac

Cotivity Website



Triggers of a RAC DME Audit

- Upcoding or coding errors: Billing with codes that yield higher payment than supported (upcoding) or

RAC Product Categories Subject to CMS Approval

- 1/3 of RAC Issues are DME Related
- AFO: Same and Similar
- *CTP: Excessive/Insufficient Quantity** ***and MORE!!!***
- 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

- Only 10% were appealed to ALJ
- Of the claims appealed: >66% are favorable to provider

- Conclusion: Appeal your claims

August 27, 2020

Same or Similar Denials for Orthoses and the Appeals Process

Joint DME MAC Article

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. 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 code specific RUL instructions of 1, 2, or 3 years depending upon the HCPCS code. These specific RULs 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 MACs 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):

- Standard written order (SWO);
- Proof of delivery; and,
- 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 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 and LSO Local Coverage Determinations and related Policy Articles found on the Medicare Coverage Database (L33686 EXT, A52457 EXT, L33315 EXT, A52465 EXT, and L33750 EXT, A52500 EXT, respectively); additional documentation requirements are addressed in the Standard Documentation Requirements article A55426 EXT.

Information regarding the appeal process including timeframes, addresses, fax numbers, submission forms, and checklists is located on each DME MAC's website.

- Jurisdiction A EXT
- Jurisdiction B
- Jurisdiction C
- Jurisdiction D EXT

Publication History

August 27, 2020 Originally Published

Same or Similar Bottom Line

- 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
- Import Results to the patient’s EMR

Provider Portal Issues

- Register/Use All Four Contractor Portals
- Registration Difficulties Resolved
- Noridian/CGS Sharing Still Problematic
- CGS 9.3 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)

CGS Portal Advisory Group Has Attained These

- Same or Similar Lookup for JA and JD Suppliers
- B/C Simultaneous Searches
- HCPCS/ICD10 Linkage
- Who Provided Previous Device?
- 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

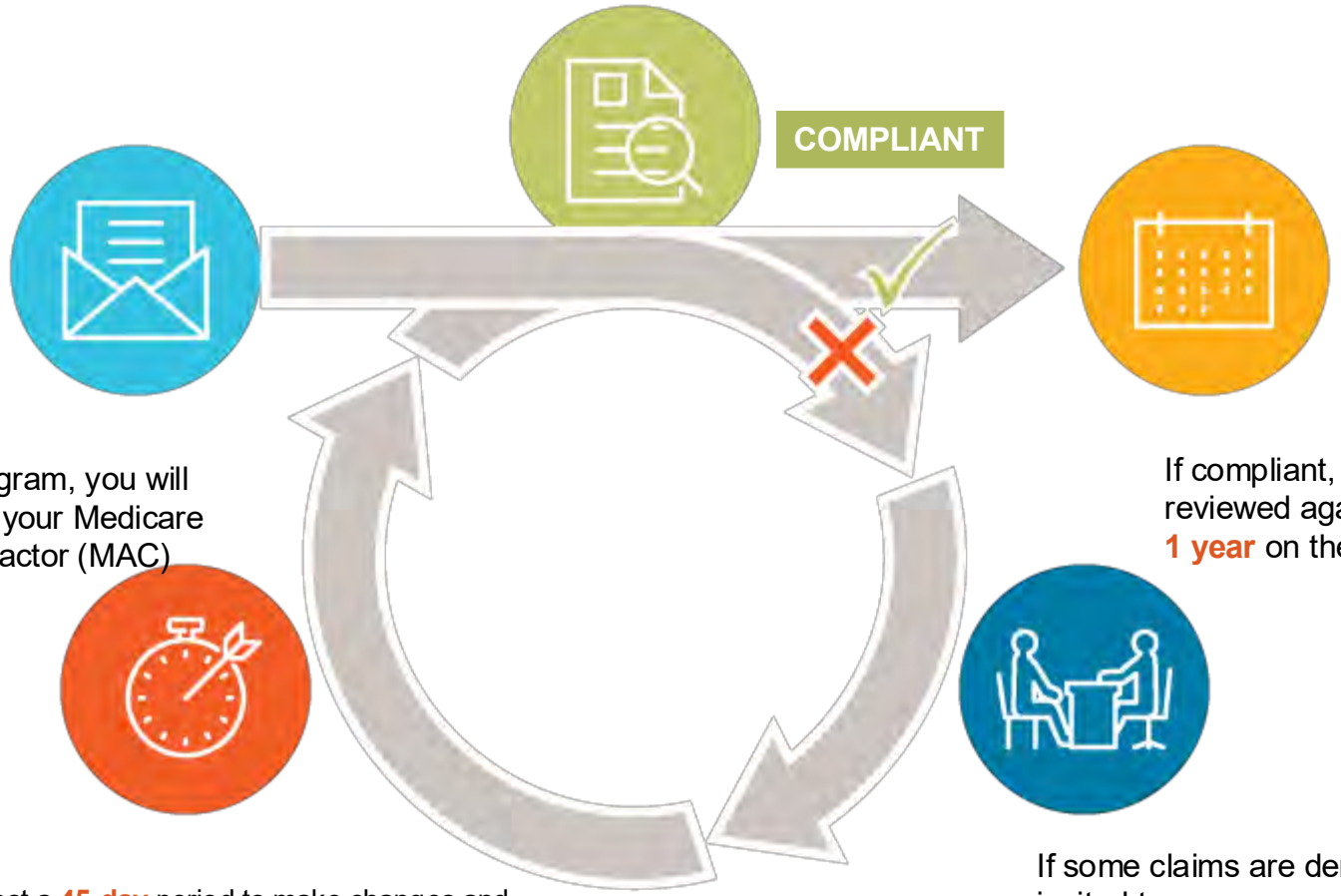
- Instant Feedback on Receipt with Log ID
- Follow Course of Appeal on Portal
- Allows for Communication with Nurse Reviewer
- Faxes are interrupted/lost and cannot confirm receipt
- Your receipt is receipt of transmission not their receipt
- Hard Copy Snail Mail(Pony Express)
- ESMD is expensive; Not any better than the free portal.

DME Audits JD

- TPE Are Different Each Quarter and For Each Carrier
- 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

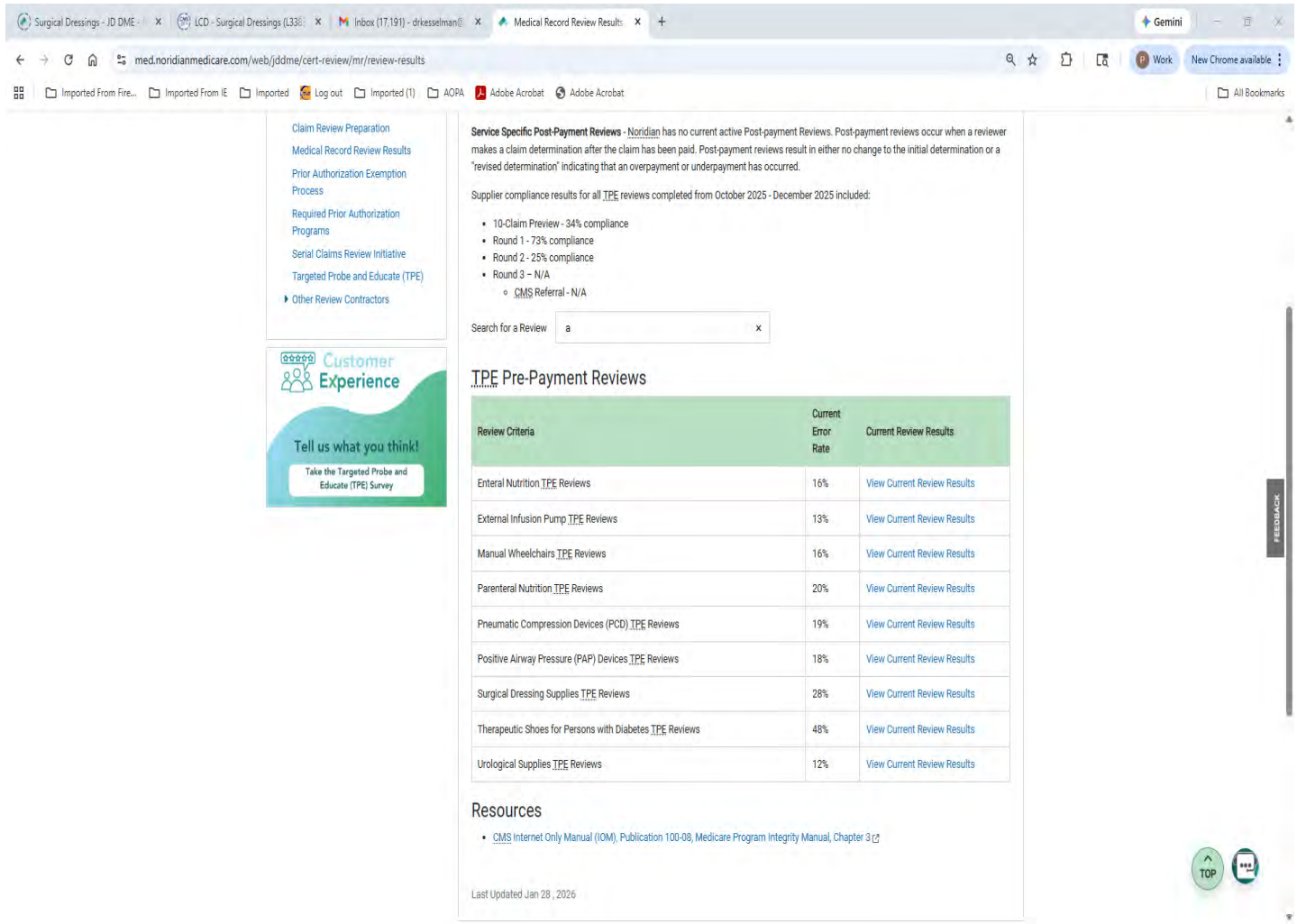
You will be given at least a **45-day** period to make changes and improve

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

Compliance Rates for Fourth QTR 2025 JD

- 10 Round Preview: 34%
- Round 1: 73%
- Round 2: 25%
- Round 3: N/A

4th Quarter 2024 Noridian Medical Review Results JD



- **Therapeutic Shoe Top Denials(48%)**

- **Cert MD/DO has not initialed, dated and indicated agreement with info from the records of the in person visit from the rx entity prior to signing the cert. statement**
- **Records do not indicate patient has qualifying condition**
- **Lack of record of in-person visit addressing diabetes management**

Sx Dressing Top Medical Necessity Denial Reasons (28%)

Insufficient medical documentation to support type and quantity of sx dressing
Medical record does not support collagen dressings are being used for full thickness wounds with light to moderate exudate or stalled wounds or have not progressed toward a healing goal.

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

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 Nationwide

- 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)
- NJ: Allows for 4 units/year if patient is >21 y/o
- Issue with privates is now:
- Confusing/Conflicting Language over coverage (e.g. Aetna)
- Profit Margins are either negligible, or costs are higher than fees

Future of L3000

- In House 3-D Printing Initial Higher Up-Front Costs
- Eventual per device costs are negligible
- Repairs vs discard and re-order?
- What can you achieve with 3-D Printing?

Other HCPCS Common Work Group Issues

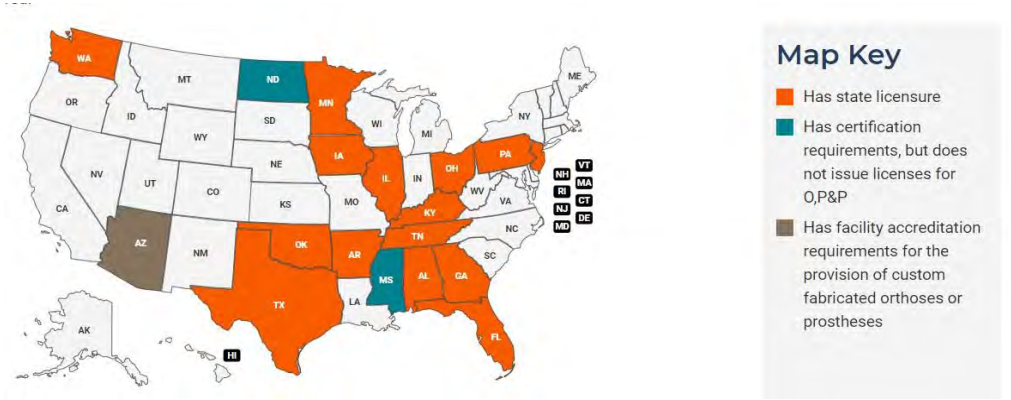
- S0395…. Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic
- Still Needs to be Modified:
- Impression Bio Foam, casting, or scanning of a foot performed by a practitioner other than the manufacturer of the orthotic

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 ?

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 for listening!
- drkesselman@parkdpm.com;

- 516 632-9944 or 516-457-6959