Durable Medical Equipment

DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies)

GLOBAL PROVISIONS: Supplies utilized in performing billable procedures in your office are not separately billable (they are included in the global allowance)

e.g., you cannot bill separately for sutures and a dressing pack when performing a hammertoe correction in the office

This is true for all payers
Strictest Rules Apply to Medicare

- Noridian is the MDE MAC for Jurisdiction D, which includes:
  - Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, N Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

- Noridian is based in Fargo, North Dakota
- CMD for Noridian DME MAC is Dick Whitten, MD
DMEPOS are billed via HCPCS Codes

- Examples:
  - A5500  For diabetics only, Off the shelf Depth Shoe
  - A5501  For diabetic only, Custom Depth Shoe
  - L1970  Ankle Foot Orthosis, Plastic with ankle joint, custom-fabricated
  - L1971  AFO, Plastic or other material with ankle joint, Prefabricated

- REFERENCE:
  - https://www.noridianmedicare.com/dme/
Medicare DMEPOS Fee Schedule

- Published each year
- Available online:
  - https://www.noridianmedicare.com/dme/fees/dmepos.html
PDAC

• Formerly called SADMERC
  • Means “Pricing, Data Analysis and Coding”
  • PDAC is clearly a better and more descriptive term than SADMERC

• Evaluates items of DMEPOS, and assigns them to applicable HCPCS codes

• Not true for ALL items of DMEPOS, but ones for which there could be confusion (e.g., AFOs) (more on this later…)

• https://www.dmepdac.com/
Medicare Rules

- To be a DME supplier under Medicare:
  - Must be fully and successfully registered in the National Plan and Provider Enumeration System (NPPES) (PECOS)
  - Medicare will only pay for DME if it meets their criteria and conditions, and if both the Prescribing Provider AND the Supplier are registered in NPPES (effective Jan 2014)
    - Prior to Jan 2014, that notice was “informational”
    - The edit has now been activated— the claims will reject
- “Revalidation”
  - Keep your NPPES/PECOS information current
  - Must officially report any changes within 30 days
  - What does that mean?
Medicare DME Rules

- All items of DME require a “face-to-face” visit with the prescribing/certifying physician within 6 months of the service (based upon date of delivery)
- Medicare does use their computers to scan billings from the primary physician over the previous 6 months (e.g., as for management of diabetes)
- The place of Service for all DME is “Home” (because that is where it is used)
Medicare Supplier Standards

• Listed in the Noridian Healthcare Solutions Jurisdiction D Durable Medical Equipment Supplier Manual
• (available on Noridian web site)
• (also available in 42 CFR Section 424.57C)

• Skim the Supplier Manual, but pay very close attention to the “Supplier Standards”
• Have any of you ever had a DME Supplier “Inspection”?
DME MAC Local Coverage Determinations (LCDs)

- Payer-specific coverage criteria and coding guidelines for certain types of DME:
  - Therapeutic Shoes for Persons with Diabetes (L157)
  - Ankle-Foot/Knee-Ankle-Foot Orthoses (L142)
  - Orthopedic Footwear (L11456)
  - Pneumatic Compression Devices (L11492)

- [https://www.noridianmedicare.com/dme/](https://www.noridianmedicare.com/dme/)
- READ (and outline?) the applicable LCDs, paying close attention to qualifying criteria (and verbiage), and diagnosis coding. THIS IS IMPORTANT!
So, What’s the Problem?

- The Prescribing and/or Certifying medical community (MDs, DOs, DPMs) and the Suppliers (some are stand-alone; some are Physician-Suppliers) have a VERY different opinion on what constitutes appropriate documentation than the Medicare auditors.

- On pre-payment and post-payment audit by Medicare, the “error rate” for Diabetic Shoes and AFOs is 95-100%!

- They then take the money back and, in most cases, you cannot bill the patient for the item(s). As the supplier, you must then absorb the loss.
DME

- DME MACs are taking a very narrow strict literal reading of the guidelines. If your documentation does not meet that literal and strict standard of review, the claim is denied.

- Most Common Reasons for Denial:
  - No response to request for additional documentation
  - Treating physician’s records did not sufficiently document the qualifying condition (therefore “Not Medically Necessary”)
  - (“Adequate”) Proof of Delivery not provided
  - Submitted medical records are not authenticated as “complete and accurate” (via electronic signature, etc.)
The Burden is on the Supplier

- In some instances, that may be a physician-supplier
- Must meet (and continue to meet ALL the Supplier Standards)
  - Must prepare and maintain complete records that support all required aspects of the care and DME
  - Detailed Written Order
  - Detailed Dispensing Order
  - General Medical Record Information meeting coverage criteria on LCD
  - Estimated improvement in functional “K” level
  - Proof why required custom, rather than prefabricated
  - (Adequate) Proof of Delivery
“Proof of Delivery”

- It is NOT a mere note in your record that the item was dispensed and instructions were provided
- “…to determine from delivery information that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement, and that the item(s) are intended for, and received by, a specific Medicare beneficiary”
- No stamped signatures
- Must be real signatures, and dated, or electronically signed
- And all documents must reflect the same date of delivery
Examples of Terminology

- Medical record stated “Charcot Deformity”
- LCD states “fixed tri-plane deformity”
- To us, they are the same; to Medicare reviewers, they are not
- They seem to want the EXACT terms and descriptions
Face to Face Requirement

• Prior to writing a prescription/order for any item of DME, the prescribing/ordering provider MUST have a face-to-face visit with the patient within the previous 6 months.
• That visit must be fully and appropriately documented, including:
  • Description of the condition/deformity, specifically meeting criteria for medical necessity (as per applicable LCD).
  • Continued use/need.
  • Items of DME can not be replaced or re-prescribed merely because time has lapsed. There must be some documented indication of need (worn out, changing deformity, new problem, etc.).
AFOs (LCD L142)

- Ambulatory patients (Rules are DIFFERENT for non-ambulatory patients)
  - Weakness or deformity of the foot and ankle
  - Require stabilization for medical reasons
  - Have the potential to benefit functionally (based upon K level?)
  - If the patient is using crutches, are they “non-ambulatory”?

- For CUSTOM AFOs, also require ONE of the following:
  - Could not be fitted with a prefabricated AFO
  - Condition expected to be permanent, or long standing (> 6 months)
  - Need to control in more than one plane
  - Patient has documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury
  - Patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions
AFO Definition

• In 2012, DME MACs unilaterally redefined criteria for an AFO, raising the height limit essentially to (or above) the knee
• Physician and supplier community objected
• On review, of the 2 references cited by the CMDs, one was 12 years old and refers to a solid plastic AFO, and the other is a portion of a handout for a review course for novices preparing for a board exam
• In Jan 2013, the CMDs reversed that opinion, but they still don’t like the idea of a Richie Brace or equivalent as being classified as an AFO
AFO Definition

• One manufacturer’s device was submitted to PDAC in expectation of being designated an AFO (with applicable HCPCS code)

• To the manufacturer’s dismay, the HCPCS code assigned was L2999- non-specific [therefore non-covered] device

• Although the manufacturer has the formal L2999 designation, they are withholding that fact from Physicians (as knowing it would be a non-covered device, the physicians won’t dispense or prescribe it)

• APMA is drafting a news item to explain the differences to providers
AFO Definition (and redefinition) 2014

• “Prefabricated, Off the Shelf”
• L4361 Walking boot, pneumatic and/or vacuum
• L4387 Walking boot, non-pneumatic
• L4397 Static or dynamic AFO
• “Prefabricated item that has been trimmed, bent, molded, assembled or otherwise customized to fit a specific patient by an individual with expertise”
• L4360 Walking boot, pneumatic and/or vacuum
• L4386 Walking boot, non-pneumatic
• L4396 Static or dynamic AFO
• FOR NOW, BOTH PAY THE SAME..that will change..
• And how will they define “an individual with expertise”? 
AFO Re-Definition 2014

- Do NOT confuse “Prefabricated devices which have been modified” with “Custom Made”
- Payers are really primed for this type of misrepresentation (i.e., fraud), and are aggressively pursuing/prosecuting
- They have published (very) specific Coding Guidelines to this specific point
- ..and they have no sense of humor
HCPCS DME Modifiers

• EY- No physician or other license health care provider order for this item or service (could be patient responsibility-ABN)
• GY- Item or service statutorily excluded, or does not meet definition of any Medicare benefit (patient responsibility)
• KX- Requirements all met, records available for review
• LT- Left side
• RT- Right side

• To get DME paid, need BOTH the KX modifier, AND LT or RT
HCPCS DME Modifiers

- GA- Claim might be denied as not medically necessary (for any reason), signed ABN on file
- GY- Claim might be denied as not medically necessary (for any reason), NO ABN on file
Orthopedic Footwear (11456)

• Other than under the terms of Diabetic Therapeutic Shoes, shoes and inserts/orthoses (L3000-L3060) are ONLY covered if they are an integral part of a shoe which is an integral part of a brace.

• That is RARE- but possible. But it also must be dispensed with the brace (so it will be dispensed and billed by an orthotist).

• To bill Medicare in expectation of prompt denial and statement of patient responsibility:
  • L3000-GY-LT & L3000-GY-RT (for custom functional orthoses)
  • L3060-GY-LT & L3060-GY-RT (for prefab functional orthoses)

• The inserts in a diabetic shoe are billed with applicable HCPCS A codes- NOT L codes. Do NOT confuse (or misrepresent) the two.
AFO- Arizona Brace

• L1940 Ankle foot orthosis, plastic or other material, custom fabricated
• L2330 Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
• L2820 Addition to lower extremity orthosis, soft interface for molded plastic below knee section
• L2330 is used whether the closure is lacer or velcro. L2820 is used only if a soft interface, either leather or other material, is provided
• Following codes should not be used with these braces:
• L2275 Addition to lower extremity, varus/valgus correction
• L2280 Addition to lower extremity, molded inner boot
Requirements for Lower Limb Orthoses and Prostheses

• When the beneficiary:
  • Will reach or maintain a defined functional state (K level) within a reasonable period of time; AND
  • Is motivated to ambulate
Functional K Levels

- Define
Therapeutic Shoes for Persons with Diabetes (L157)

- There are three entities:
  - Prescribing Provider (DPM, MD, DO, NP, RN) (within 6 months)
  - Certifying Physician (MD or DO ONLY) (within 3 months)
  - Supplier
- Each must remember which “hat” they are wearing, and their respective responsibility—esp. in documentation
- It is the Supplier who is responsible for making sure all the documentation is complete and sufficient, and maintain all the applicable records
- The Supplier (who may be you if you are a physician-supplier) will really appreciate your assistance in making sure everyone does their part correctly
So, Why the Huge Problem with Diabetic Shoes?

• 95-100% error rate on audit
• Remember, Medicare then takes the money back, and you can then usually not charge the patient
• THE ISSUE: CONTENT OF MEDICAL RECORDS AND STATEMENTS BY THE CERTIFYING PHYSICIAN
• ANOTHER ISSUE: INADEQUATE PROOF OF DELIVERY
• The general physicians are frustrated, exhausted, overworked, and really hate being told (by someone else- esp. the government) the specific content they have to have in their medical records
So, What does Medicare Expect of the Certifying Physician?

- Specific content within their own medical record for the patient within 6 months prior to dispensing of the DME that reflects ongoing treatment of the patient’s diabetes.
- In addition, within 3 months of delivery of the shoes, there must be an additional statement in the patient’s medical record that:
  - The patient in fact has diabetes, and he/she is the physician managing that
  - The patient is under a comprehensive plan of care (there is NO requirement of how “successful” that care has been)
- The patient has any ONE of the following:
  - Previous amputation of all or a portion of either foot
  - History of ulceration on either foot
  - History of “preulcerous callous” on either foot
  - Peripheral neuropathy with evidence of callous formation on either foot
  - Deformity of either foot (not further defined), OR
  - Poor Circulation in either foot (not further defined)

Must ALSO state that the patient correspondingly needs diabetic shoes
What?

• Here’s a scenario

• Patient XYZ had a face-to-face visit with his/her personal physician, in which they discussed management of the diabetes. That visit occurred 5 months prior to the dispensing of the diabetic shoes and inserts

• The Certifying Physician has now been advised that his/her patient XYZ is now being fitted with diabetic shoes and inserts. It has been 5 months since they last saw the patient face-to-face. They do NOT have to call the patient back in.

• But, within 3 months of the dispensing, the Certifying Physician must generate applicable and appropriate documentation (the “Certifying Statement”) that reflects their agreement with the qualifying conditions. That statement must be signed and dated by the MD/DO (cannot be NP or PA)
Therapeutic Shoe Documentation

• In the past, Medicare has insisted upon independent content within the Certifying Physician’s medical record that contain ALL these points- and clearly and specifically state all these points
• As you might imagine, there have been horrible problems
• And the folks getting hurt are the patients- and the suppliers
• To this end, APMA has proposed to the DME MACS that the Prescribing Physician be permitted to submit an “Attestation Form” to the Certifying Physician indicating all the criteria, and that, by signing and dating that Attestation (indicating that they agree with all statements), might meet all applicable requirements
ALJ Appeals

- On appeals to the ALJ, the physician supplier usually WINS

But that ruling only applies to those patients on the appeal - no "standing ruling"
So need to appeal each time
It is our understanding that there is a major backlog (delay) in ALJ appeals
APMA DME Subcommittee

• APMA has organized DME subcommittees at BOTH the national and local/state level
• Noridian Medicare is the single largest block of states with the same DME MAC
• I am a member of the national committee, and the Chairman of the Washington State committee
• We would welcome participation by interested individuals
• We particularly hope to have a Noridian DME subcommittee, with representatives from each state for which Noridian is the DME MAC
DME

- Questions
- Thank you