

DME Policy Changes 2009

Here's a summary of the top issues affecting DME reimbursement for podiatry

By Paul Kesselman, DPM

Disclaimer: Dr. Kesselman serves on the advisory board for and holds stock in Visual Footcare Technologies. The "CDFE" products discussed in this article have not been specifically approved by any U.S. medical or health insurance organization for reimbursement. Advice provided about reimbursement is not a guarantee of coverage. The reader is advised to check with their various third-party payers to inquire about their reimbursement criteria.

This month's installment of DME for DPM's will provide a summary of the top issues affecting DME reimbursement for DPM's. Detailed information for many of these topics is available in previous installments of DME for DPM's, or has been posted on both the Codingline and APMA websites or in APMA News.

KX Modifier Requirement on All Ankle Foot Orthotics

As of this year, the KX modifier is required on all claims for any type of ankle foot orthotic. This includes both the parent and add-on HCPCS codes for all custom and off-the-shelf devices, including CAM Boots, ankle braces and all types of custom AFO's. All lines of the claim must include the KX modifier. The definition of the KX modifier stipulates that the supplier has the required medical necessity documentation for any product for which they are requesting reimbursement.

Re-Opening Discontinued for Claims Without KX Modifiers

As of August 1, 2009, DME MAC's will no longer accept re-openings for claims missing a KX modifier. Due to a large error submission ratio from a lack of a KX modifier, the re-opening line of all the DME MAC's has been overwhelmed. Presently, any claim rejections resulting from the lack of a KX modifier must be re-submitted to the DME MAC.

Orthopedic Shoes (Not Therapeutic Shoes for Diabetics)

Beginning October 1, 2009 claims for L coded orthopedic shoes and orthotics (not covered under Medicare's Therapeutic Shoe Program for Patients with Diabetes) must include either the KX or GY modifiers. If the shoes meet the coverage criteria then one may use the KX modifier (e.g., the shoe is attached to a brace). If an item does not meet the coverage criteria (e.g., shoe is not attached to a brace) or is a non-covered item, the claim line(s) must include the GY modifier. Claims with a GY modifier will be denied due to statutory limitations. Each shoe, insert or modification must include either the KX or the GY modifier. If a claim line doesn't include a modifier, then that line will be rejected and you will have to resubmit that claim line with the appropriate modifier. Without an appropriate modifier the claim will not be properly processed by Medicare. This will result in non-payment (for KX claims) and/or refusal by the

Medigap, secondary or Flexible Savings or Health Savings Accounts to process (depending on their secondary coverage guidelines). Remember that use of the KX modifier under false pretenses may be seen as fraudulent activity by Medicare and other third party payers.

Price Data Analysis Contractor (PDAC)

The PDAC has issued several policy advisories since the end of last year affecting podiatric suppliers. The frequencies of claims for multiple coded braces, CAM Boots and surgical dressings have significantly increased. This has resulted in the PDAC instituting several policy changes regarding these devices.

Arizona AFO's

A policy statement was issued in December 2008 withdrawing the use of the following codes for all Arizona AFO models:

L1960 Ankle foot Orthosis, posterior solid ankle, plastic, custom fabricated

L2275 Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined

L2280 Addition to lower extremity, molded inner boot

Instead, the PDAC policy states that reimbursement is only allowed for the following codes for all Arizona Type AFO models:

L1940 Ankle foot Orthosis, plastic

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or other material, custom fabricated

L2330 Addition to lower extremity, lacer molded to patient model, for custom fabricated orthoses only

L2820 Addition to lower extremity orthoses, soft interface for molded plastic below knee section

The policy also stated that suppliers using codes other than those stated in the policy should voluntarily refund money to the DME MAC's.

This policy change was made without any input from Arizona Custom Footwear, the manufacturer owning the Arizona AFO trademark. These changes were also based on review of "copy cat" devices, not necessarily manufactured to the same standards recommended by Arizona Custom Foot Wear. The changes also were implemented to all Arizona type models despite their significant specification and application variations.

Shortly after the initial posting, officials of Arizona Custom Foot Wear met with PDAC. In June 2009, the policy was partially rescinded to allow for L1960 (this was posted on the American Orthotic and Prosthetic Associations website). PDAC did not notify Arizona Custom Foot Wear when a correction would be posted on the PDAC website. As of this writing, no official retraction has been posted on the PDAC website with respect to the L1960 coding, codes L2280 or L2275 or any concerning the voluntary refund.

Crow Boots

On August 18 2009, the PDAC posted a policy correction limiting the codes for Crow Boots to the following:

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED

L2232 ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE FOOT ORTHOSIS, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L2275 ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL

L2820 ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTER-

FACE FOR MOLDED PLASTIC, BELOW KNEE SECTION

L3010 FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH

Several objections to this policy include:

1) CROW Boots may incorporate a pre-tibial shell and patella bearing shelf to allow this device to function as a patella bearing orthotic;

2) The use of the L3010 device is inappropriate as the depth of the foot orthotic component is more accurately described by L3000 (UCB type device). Since the CROW boot functions as a shoe, the L3000 (or L3010) would be reimbursable by Medicare. However, there is no fee schedule for either L3000 or L3010. Suppliers and patients alike are unaware of their financial responsibilities for weeks, until the conclusion of a pre-payment review and payment by the DME MAC.

3) The very definition of the KX modifier deems the supplier responsible for documenting medical necessity, making such drastic policy limitations unnecessary.

4) The Arizona AFO and the CROW Boot both require far more maintenance than their plastic AFO counterparts. The labor and repairs, not separately reimbursable under the 5 year global period for these devices, adds to their costs and further reduces the profitability of providing these devices.

Custom devices such as the Arizona AFO and CROW Boot should not be subjected to the same coding restrictions as off-the shelf devices by the PDAC or any other governmental agency. The verbiage in these new policies makes it almost impossible for anyone to provide appropriate custom devices, with all the required modifications for any reasonable profit.

For all these reasons, the PDAC should reconsider instituting such drastic limitations on custom orthotic devices.

CAM Boots Used to Off-Load Ulcerations

On July 22, 2009, the PDAC issued a policy stating that walking boots used for treatment of non-orthopedic conditions, used solely for

the prevention or treatment of a lower extremity ulcer, edema reduction, or ulcer prevention must be coded as A9283. This policy seems to be inapt for many reasons:

1) The CMS agency entrusted with the responsibility of defining HCPCS codes (HCPCS Common Work Group) held no hearings on changing the definition of A9283 to include CAM Boots; nor have they posted any change in the HCPCS code definition of A9283 to include CAM Boot.

2) No lay person or medical professional could possibly confuse an off-loading device (e.g. Orthowedge or surgical shoe) as identical to that of a CAM Boot.

3) A diagnosis (ulcer vs. orthopedic) is the only determining factor in using a different HCPCS code for exactly the same product. The primary use of these devices is identical as both are indicated for ambulatory use. A parallel between pre-fabricated solid AFO's used as a non-ambulatory device (e.g. plantar fasciitis) and those used for ambulatory purposes does not apply to this scenario.

4) Use of the A9283 code to describe both Orthowedge shoes and CAM Boots will confuse private third party carriers. Many do allow reimbursement for either L4386 and/or L4360 to off-load an ulcer or for edema reduction or ulcer prevention. Because many third party payers either pay less or deny coverage for A9283, this new policy may deny non-Medicare patients (or those with secondary coverage) reimbursement for these medically necessary devices.

5) The use of the KX modifier for the L4360 or L4386 HCPCS codes stipulates the supplier can provide documentation of medical necessity and conformity with the AFO LCD. This makes this new policy unnecessary.

6) CMS' policy to deny coverage for the use of CAM Boots (L4386 and L4360) continues to be incorrect. It ignores overwhelming evidence by many well-researched articles highlighting the benefits of these devices for patients with any type of neuropathic foot ulcers. The use of Orthowedge and other surgical shoes is inadequate, contrary to the best interests of many elderly or neurologically impaired patients and may contribute to further injuries.

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Surgical Dressing Sterility Requirements

All surgical dressings must now be labeled sterile in order to qualify for reimbursement. This was not a previous requirement for reimbursement, nor did the FDA require this requirement when approving many surgical dressings. Many popular surgical dressings (Hydrogels) currently do not comply with this regulation. Manufacturers, rather than bearing the expenses of changing this ruling, are marketing new products to comply with these regulations. One should check with your Hydrogel manufacturer to be sure that they comply with this new regulation.

Pre-Payment Probe of Surgical Dressings

DME MAC B is conducting a pre-payment probe for all claims for foam surgical dressings (A6209—A6214). This probe is being conducted after an initial widespread probe review showed that a large number of suppliers are submitting claims for surgical foam dressings when the wound does not qualify for this type of dressing and/or frequency of dressing changes.

A pre-payment review will increase your chances of claim rejection without proper documentation. Your profitability will also be reduced due to the costs of responding to the carrier. However, you should provide your patients with those medically necessary items and carefully document the need for foam dressings as outlined in the DME MAC Surgical Dressing policy. This can be found at on the DME MAC website under LCD or on the following link: http://www.ngsmedicare.com/NGSMedicare/dme_lcd/l27222_active_lcd.htm.

Accreditation and Surety Bond

CMS Program Integrity Department has continued to provide me with assurances that podiatrists providing DME to their own patients do not require Accreditation or a Surety Bond. Many DME MAC's continues to post erroneous messages on their website concerning this policy, which may have re-

sulted in third party vendors increasing their advertising barrage on many podiatric offices. Anyone who receives "hard sale" tactics by these vendors or is confused by the DME MAC C posting would be best served by researching the APMA, Codingline and NSC websites for updates.

Closet Arrangements

Medicare will shortly require that third party vendors leasing DME closets in physicians' offices "sell" these products to the physician prior to the item being dispensed. This policy will effectively terminate the ability for the third party supplier to bill for DME under their supplier number. All responsibility is transferred to the physician, who must now obtain his/her own DME supplier number. This policy will effectively end the closet leasing arrangement for physicians supplying Medicare patients.

Provider Enrollment and Control of Ownership System (PECOS) and Its Effect on DME

In 2003, Medicare instituted a system whereby the provider data from your CMS 855 application is entered into a data base called PECOS. This allows all of Medicare's computer systems nationwide to insure that provider NPI matches h/her licensure/specialty profile. This is something the NPI system does not do as anyone can obtain an NPI number using any tax identifier and taxonomy specialty code.

Beginning January 2010, if the referring/prescribing physicians profile is not entered into the PECOS system, the DME MAC's will deny payment on your DME claims. Informational letters will accompany DME claims processed starting in October 2009, if the referring/prescribing physician does not have h/her data entered into the PECOS system. Essentially anyone whose provider status has not changed since 2003 will be required to enroll with the PECOS system. This may be done either via a paper application or electronically.

The means by which suppliers will have to check this information prior to providing beneficiaries with DME are still being worked out. Additional questions regarding

this matter remain unanswered, such as the legality of enforcing this system, problems with getting MD/DO's who are not suppliers to comply with these regulations, payment disruptions to your local Medicare claims if you submit a PECOS application (paper or on-line), etc. CMS is planning educational on-line forums to further explain this new regulation. By the time of publication more information will be available on the APMA and CMS websites and from your vendor.

One can check his/her own PECOS status on the PECOS website by using his/her NPI screen name and password at: <https://pecos.cms.hhs.gov/pecos/login.do>

Further information may be found at: http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp

Therapeutic Shoe Probe

DME MAC Region B's post payment audit revealed significant problems with suppliers dispensing therapeutic shoes. The most egregious reason for audit failure was the lack of secondary foot findings documented by the supervising physician. Because the supervisory statement is physician (MD/DO)-to-supplier correspondence, the DME MAC's do not consider this sufficient documentation. The podiatrist should send the supervisory physician a copy of the patient's "Comprehensive Diabetic Foot Examination" (CDFE) documenting the patient's foot pathologies. This would both satisfy the DME MAC's requirements for MD/DO documentation of secondary foot findings and make the DPM eligible for PQRI bonuses (see Oct. 09 issue). The CDFE would be considered physician-to-physician correspondence and the DME MAC's could consider this documentation of a secondary foot diagnosis by the MD/DO.

A better approach would be to provide a separate form (or a line at the bottom of the CDFE) for the MD/DO to sign. This would stipulate that h/she has read your CDFE and h/she agrees with these findings. You would instruct the MD/DO to return copies of all of

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these forms. Other than the supervisory physician statement, this would be considered physician-to-physician correspondence. This would satisfy the DME MAC's requirements for supervising physicians to have a secondary foot finding in their charts. Placing a statement of agreement with the DPM's secondary foot findings on the supervisory form would be considered physician-to-supplier correspondence. This would not satisfy the DME MAC's requirements. (Figure 1)

Medicare Competitive Bidding

Medicare's long awaited competitive bidding program is set to roll out early next year, with bidding deadlines during the fall of 2009. Currently physicians are exempt from this program. It will be interesting to see whether or not Medicare expands this program to include physician suppliers and/or products dispensed by DPM's. If Medicare can project a potential for significant savings (even with the potential for patient harm) one could expect some further expansion of this program.

"As Medicare Goes, So Goes The Third Party Payers"

Expect many TPA to come out with competitive bidding programs especially if the "Medicare Competitive Bidding Initiative" succeeds.

Private Insurance Plans Seeing More DME Claims

Private carriers are seeing an increased number of claims for DME. As with Medicare, this is a result of a significant increase in the number of major orthopedic injuries requiring O&P products amongst aging baby boomers. The epidemic of diabetes and private payers implementing preventative treatment strategies (e.g. Therapeutic Shoes for Diabetics) has resulted in increased financial expen-

ditures for these products by Third Party Administrators (T.P.A.). Diabetes, cardiac and pulmonary disease has also seen an explosion in fiscal expenditures for glucose test strips, glucometers and expensive respiratory equipment (stationary and portable oxygen and CPAP units).

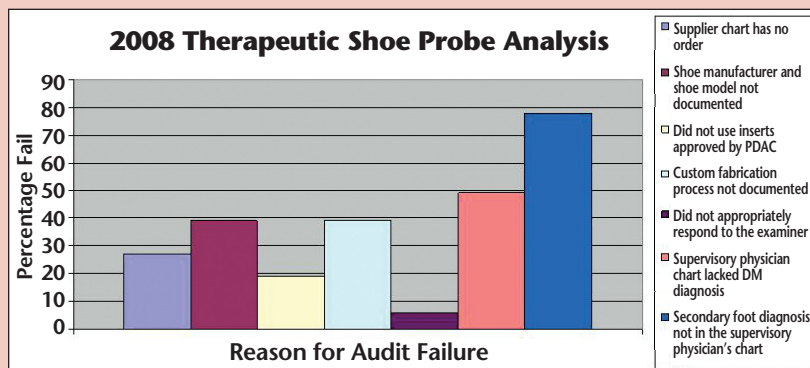
This has not gone unnoticed by TPA and there certainly will be at-

ers. These suppliers are contracted for DME devices at a fraction of the usual reimbursement to private physicians. The large DME suppliers can afford to participate at these low rates because they buy in bulk directly from the manufacturers. They can purchase items such as CAM Boots at a fraction of the cost incurred by private physicians who

usually buy such items from distributors at higher costs.

These off-the-shelf items may be a loss leader to the DME suppliers who consider this as part of the cost of participating in TPA. The upside potential for the DME supplier is the TPA will provide a large referral base of patients requiring higher reimbursing custom and prosthetic items.

FIGURE 1



tempts at curtailing the resultant financial drain. Price roll backs, increased pre and post-payment audits and tighter reimbursement guidelines are likely to follow.

Podiatrists may be most vulnerable when dispensing CAM Boots instead of less expensive surgical shoes. A surgical shoe is often a non-covered item or would reimburse at (\$5 to \$25). This is at a fraction of the reimbursement of CAM Boots (\$100-\$250). Most TPA do not have policies stipulating reimbursement guidelines for surgical shoes vs. CAM Boots. However if the significant increase in utilization of CAM Boots continues, expect some response from many TPA. In the interim, it would be wise for the DPM to carefully document the medical necessity of either type of CAM Boot (L4386 or L4360) vs. that of a surgical shoe (L3260 or A9283).

If CMS continues to insist on non-coverage for CAM Boots to off-load diabetic foot ulcers, similar policies may be enacted by third party payers.

Carve Outs by Private Carriers and DME

Many third party payers have already implemented significant DME cost reduction strategies by "carve outs" to large DME suppli-

Summary

This past year has seen many changes in DME policies. Many more are likely well beyond 2010. Continued vigilance by all DME suppliers is suggested. Subscriptions of the CMS, APMA, Codingline, PM News and TPA websites as well as regular reading of this column are highly recommended. ■

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certified by the American Board of Multiple Specialties in Podiatry with certification in prevention and treatment of diabetic foot wounds. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MAC's (DMERC's). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.