Providing DME Prior to Surgery

It's time for Medicare to institute a 5-day rule.

BY PAUL KESSELMAN, DPM

In the past few months, there have been several questions posted on PM News regarding dispensing durable medical equipment (DME) to patients prior to surgery. There are often good and bad reasons offered for doing this, ranging from a rational medical decision process to one which is strictly financial. This article will address why providing DME prior to surgery under traditional fee for service (FFS) Medicare is currently not reimbursable and offer some short and long-term solutions to this issue.

Many physicians have expressed that they would rather provide the DME services to patients prior to surgery for the following reasons:

1) The facilities they work in do not have the DME items required for the immediate post-operative setting and/or they do not have qualified staff to dispense DME;

2) It is better for patients to be properly trained in the use of the DME items prior to surgery and without the influence of the pain and narcotic analgesics, a frequent scenario in the immediate post-operative setting; and

3) Reimbursement rates that have been reduced on surgery can be offset by dispensing DME.

Reason 3, while valid from a practice management perspective, is not relevant to the patient's welfare. However, reasons 1 and 2 absolutely address medical rationales for providing the DME services prior to surgery. Unfortunately, they are not addressed under the FFS Medicare policies. FFS Medicare has many MAC Carrier Decisions (aka as LCDs in the Part B Medicare world). Some are very narrowly focused, requiring specific diagnoses to be present. Others have greater latitude and specify that only an orthopedic or neurological disorder be present in order for there to be coverage. Both, however, require that the patient's condition warrant the use of the DME device. That is, they require the prescriber to establish medical necessity for the DME device prescribed and have the patient need to use the device from the actual time it is dispensed.

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Medicare's Opinion

Medicare's opinion both in writing and at several conferences is that the medical necessity for a DME device (e.g., crutch, cane, CAM walker—pneumatic or non-pneumatic) cannot be established when it is dispensed prior

Continued on page 40

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Surgery (from page 39)

to the patient having the medical condition warranting its use. That is, they do not consider a patient undergoing an elective bunionectomy with an osteotomy as requiring surgery prior to the actual surgical procedure being performed. The LCD stipulates that the use of the CAM walker to immobilize and reduce edema cannot be established prior to the surgery. In other words, the patient does not have a medical reason to immobilize the foot until after the surgery is actually performed. The same would be true for a cane or crutch used to assist the patient in off-loading the area until after the osteotomy is performed.

These rules, while making some sense regarding medical necessity, were written prior to the advent of most surgery being performed in an out-patient setting. They also have their roots in the in-patient work-around, where most patients were admitted for their in-patient surgery prior to the actual date of their operation and stayed more than 24 hours post-operatively. While the above scenarios do not exactly parallel the current out-patient (or in-patient) setting for most podiatric elective surgical procedures, these in-patient rules are worth reviewing.

Under FFS Medicare, an in-patient may receive DME within a 48-hour window prior to discharge, even though s/he may not be exclusively using the DME device to be dispensed while still in the hospital. This allows the patient time to train in the use of the device and time to become acclimated to it. In this scenario, the patient usually receives a DME item (e.g., cane, crutch, walker, CAM boot, etc.) within 48 hours prior to discharge and is provided with physical therapy services in order to facilitate the use of the device. The patient may actually be practicing on a walker owned by the hospital and then dispensed another similar or same-type walker. The caveat is that patients have already undergone the surgical procedures when the device is dispensed. The patient may sign a written proof of delivery (WPOD) 48 hours prior to discharge, but the actual date of service (DOS) would be the date they started exclusively using the dispensed device (the date of discharge). Should the date of discharge be delayed and changed for any reason (e.g., medical complication precluding discharge), then it would be required that the device be re-dispensed, thus necessitating another WPOD.

In the above scenario, the patient's exclusive use of the device is medically necessary, but not necessarily warranted (e.g., the patient may be partially confined to bed in the immediate 48 hours prior to surgery or is using a wheelchair and transitioning to a walker to ambulate immediately post-operative). In short, the in-patient 48-hour window allows the supplier to train the patient in the use of the DME device and have a WPOD signed 48 hours prior to the DOS on the claim form.

"Catch-Up" Conditions

As with most other carrier decisions rooted years ago, Medicare has not kept up with the times. In the in-patient scenario, patients are not ready for using the device because their medical condition may not yet warrant its use, or they simply are still in the hospital and thus the place of service cannot be designated as their home. Yet in-patients may receive the device, sign for it (WPOD), and be trained to use the device, and Medicare may be billed for using the device on the date of discharge (within 48 hours). This scenario again allows the patient's other medical conditions (post-op weakness, narcotic influence, etc.) to "catch up" with the patient's use of the DME device. This is what many readers have asked Medicare to provide in an out-patient setting.

The same (catch-up) conditions do apply to the patient undergoing elective surgery in the outpatient setting (albeit in a much shorter time frame). However, FFS Medicare's rules, antiquated as they are, do not allow patients to have different dates on the WPOD and DOS on the claim form. Currently most patients are operated on either on the date of admission and discharged within 48 hours of admission or are operated on as an outpatient and never admitted to the hospital. Thus, this antiquated rule for many podiatric and orthopedic patients seems unworkable and needs to be updated.

It is certainly logical to permit patients who would be unable to follow complex instructions while still under the influence of narcotics to receive their DME prior to surgery. This would allow patients to be properly trained by the physician supplier, commercial supplier, or orthotist prior to surgery.

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Five-Day Rule?

Medicare should consider the establishment of a five-day rule whereby the WPOD could be up to five days prior to the DOS on the claim form for outpatient surgeries, whether performed in an ASU or ASC. Up to five days would allow for weekends and holidays and some flexibility prior to surgery. The inconsistency between the DOS and WPOD date could be documented by a special modifier.

As with the 48-hour in-patient rule, if the surgery were postponed for any reason, the DOS would have

Continued on page 42

Surgery *(from page 40)*

to be delayed until after it conformed with the proposed five-day time frame. A further risk for both Medicare and the supplier would be how to handle a non-custom item returned because it was not used for more than training purposes. Since the non-custom item was used by the patient, it may be hygienically improper to dispense to another patient and should now be considered a "used DME".

It could be years before Medicare adopts this type of policy, simply because a cost analysis of this additional policy could take quite some time for Medicare to perform and analyze. Medicare may also consider the need to either allow the same in-patient exception modifier for DOS and WPOD date inconsistencies to be used for the out-patient setting as is allowed with the in-patient 48 hour rule or develop a separate modifier.

Suggestions

Rather than wait for Medicare to act (if at all) for those who have suggested that rationale 1 or 2 was your reason for dispensing prior to surgery, you are both applauded and provided with the following suggestions:

1) Explain to your patients that Medicare will only cover their DME item post-operatively;

2) Discuss the fact that you don't think providing them with the device immediately post-operatively with little to no training time makes sense. This is especially true if they are having general anesthesia, sedation, etc. and will be under the influence of narcotics post-operatively.

3) Provide them with an ABN which stipulates Medicare's policy of non-coverage prior to establishment of "medical necessity" (which would only be post-operatively);

The WPOD for most DME must be consistent with the DOS on the claim form.

4) Take a refundable deposit on the cost of the device prior to surgery;

5) Refund the deposit once the medical necessity has been established (post-operatively);

6) Have the patient sign two separate WPODs on the pre-operative and post-operative dates. The first is to be used in case the patient cancels the surgery and/or postpones the surgery. This will be your proof should you wish to pursue the patient for the balance.

7) Document the training of the DME device your office provided in the pre-operative period, or copies of prescriptions and/or consulting reports from the consulting physical therapist; and

8) Always bill your DME MAC on the DOS consistent with the post-operative WPOD.

Certainly, one should inquire of the facility in which you operate as to whether they wish to provide the DME themselves. Just as physicians are facing reimbursement cuts and higher operating costs, so too are out-patient facilities (ASU and free-standing ASC). They too wish to increase their revenues and thus it is important for there to be a clear understanding of who will provide the DME item to the patient. In some scenarios, it may be best to dispense a posterior splint with a post-operative shoe and crutches (supplied by the ASU) and then dispense the CAM walker on the first post-operative visit.

In short, the WPOD for most DME must be consistent with the DOS on the claim form. The only exception is the in-patient 48 hour rule, which I propose be expanded (with some limitations) to the out-patient setting. **PM**

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