Reimbursement Issues with Custom Milled Inserts (K0903)

This seemingly never-ending saga continues.

BY PAUL KESSELMAN, DPM

A recent DME for DPMs' column presented what was hoped to be some final thoughts on the implementation of K0903 (custom milled diabetic inserts). Since its publication, another set of issues regarding the use of K0903 has emerged from some non-traditional Medicare carriers. This month's column will review some issues associated when submitting HCPCS K0903 to Medicare Advantage and Medicare Supplemental plans.

Medicare Advantage (Part C) Plans:

Several weeks ago, a colleague contacted me regarding a Medicare Advantage Plan's payment for custom milled inserts (K0903), claiming the payment rate was approximately one-third the amount he regularly had been receiving for custom molded (A5513) inserts. Corroboration was received from the billing service that three pairs of inserts were billed and paid for.

The complaints (including the fee received) sounded very familiar:

1) The custom milled insert they provided and custom molded inserts they had been receiving from their vendor were indistinguishable from one another;

2) The vendor charged them the same for both types of inserts;

3) The profit on the custom milled inserts was either non-existent or negligible.

These exact points were brought up during many discussions last year to the various CMS agencies involved in developing the Medicare fee schedule for K0903. The long-term goal now is to contact all the Medicare Advantage Plans and resolve any fee schedule discrepancies regarding K0903. There are numerous Medicare Part C plans currently on the market. Many are very reluctant to have fee schedule discussions with their providers (directly or indirectly). CMS has no legal jurisdiction over the fee schedules set by Medicare Part C plans. There is a long precedent of CMS not participating in such discussions. Thus, any resolution to obtain a respectable fee schedule is going to take a considerable amount of effort and some time. The lesson learned here is that one should never take for granted any carryover effect from one insurance carrier (in this case Medicare) to a privately run Medicare Advantage Plan.

The Medicare reimbursement schedule for all DMEPOS has always been more reflective of the work provided than those schedules offered from Medicare Advantage Plans. Thus a Medicare Advantage fee schedule not being reflective of a custom product and your costs is not at all surprising. Without an immediate short-term resolution in sight, there are several action points to consider:

1) Obtain a written pre-determination of benefits from each Medicare Advantage plan on all DME services. Ask the customer service representatives for the web link for the policy (if it exists). Ask about any frequency or diagnosis limitations, any utilization issues (can you as a DPM provide or is it carved out?) and most importantly, ask for the fee schedule. If they will not provide you with any of the key components, or the parameters provided are uncomfortably difficult to navigate or non-profitable, consider referring the patient back to the carrier for further advice. Your contract likely does not compel you to provide every service to every patient;

Continued on page 88

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K0903 *(from page 87)*

2) Contact your APMA CAC and PIAC representatives;
3) Contact APMA Health Policy and Practice Committee;
4) Use any connections you have with Federal and/or State legislatures.

Since April 2018, several colleagues are having no issues with respect to receiving payment from their DME Medicare carrier for K0903. However, the secondary payer is denying payment either because they don't recognize the HCPCS code or they refuse to "pay this type of provider for this HCPCS code (K0903)".

At this time, one should appeal these denials. Provide them with the updated code listing from the Medicare Therapeutic Shoe Policy. In the past, when new HCPCS codes are added, private insurance companies lag behind in adding new codes to their computer programs and reimbursement schedules.

In other cases, a new code has been incorrectly linked to a payment edit which restricts payment to specific types of providers. In this case, K0903 has an incorrect coding edit, precluding a podiatrist from being paid for K0903.

If history serves a valuable lesson, it is likely that the new code will be added and any incorrect coding edits shortly will be removed. This requires some noise from you, the provider! Successful appeals of these types of claim denials is one way to communicate the need for them to update their software, and quickly. Successful appeals cost carriers more than the money they pay you. It is to their advantage to resolve these matters quickly. The steps outlined for resolving the problem associated with the Medicare Advantage plans will also be beneficial in resolving these issues for your practice.

It is inevitable that when a new code is introduced, or an existing one modified, there will be some significant "glitches" downstream. The glitches seen with K0903 were inevitable. The main efforts by leadership over the last year were discussions with various CMS agencies. These include the four DME MAC, PDAC, and the HCPCS Common Workgroup. The Medicare issues with respect to K0903 for now have been resolved. The repercussions of using this new temporary code with many other (local and nationally-known) insurance carriers is now reverberating.

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This is a time when you as a provider will benefit most by communicating any issues regarding payment for K0903 to local and national leadership. Please do not remain silent on these issues. APMA and your state component association needs your help in resolving these problems with the Medicare Advantage and supplemental insurance carriers. Ask your lab if they still produce custom molded (A5513) devices validated by the PDAC.

Avoid reverting back to A5512 as a solution. Using pre-fabricated heat-molded inserts on your highest risk patients may guarantee you more headaches then you bargained for!

Hopefully the issues outlined above will be resolved by 2019. We then look forward to the reappearance of some new ones, as K0903 (a temporary code) is replaced by a permanent A code next year. **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). 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.