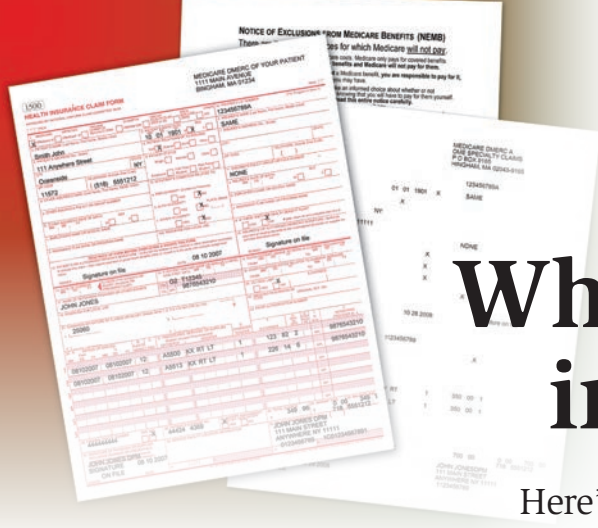

What's New in DME

Here's an annual update.

BY PAUL KESSELMAN, DPM

Welcome to the inaugural 2025 edition of DME for DPMs. It's hard to believe that it's the start of a new year and with that in mind, it's best to provide an annual update with all the hot issues facing DME and all medical providers. Post-pandemic audits are back in every medical specialty. Podiatry and DME are no exception. While many colleagues complain about DME audits, routine foot care codes still top the list for the most frequent set of codes subjected to audits for podiatrists.

2025 fee schedules for DME and physicians were not yet available in late October 2024. There will likely be a slight increase for DMEPOS for this year as it is tied to the Consumer Price Index, not the Conversion Factor and other economic factors, as is the Physician Fee Schedule.

Target Probe and Educate Audits continue. The latest data from Jurisdictions B (JB) and JC across all supplier types and product categories continue to show improved results. It appears that as of this writing (last quarter of 2024), the percentage of suppliers passing the first round is approximately 72%-75%.

Prior Authorization for L1951 (and others requiring authorization) has worked well and has a success rate of approximately 80% for all lower limb orthotics. The use of the ST modifier (for stat use) has not been abused. L1951 consists of approximately 25%-37% of all orthotic prior authorization codes. The primary reasons for rejection are: The device is not required to have prior authorization; the device was delivered prior to submitting the prior authorization, or a previous affirmative prior authorization was made for this product and for this beneficiary.

The MyCGS portal has been upgraded to version 9.0 allowing for the provider to submit more details on financial over-payments and information regarding dates for SNF/Hospital. The portal will also soon be upgraded to include webinars and *YouTube* videos, all on a wide variety of subjects.

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Those providers who typically bill JA or JD can obtain limited access to the myCGS portal for same and similar inquiries for patients whose legal address is within either the JB or JC MACs.

Prior authorization is different and must be obtained from the carrier based on the patient's legal address, not where the provider's office is located. This leaves providers who are in JA/JD MAC often unable to use a portal to obtain prior authorization for patients whose legal address is within the JB/JC jurisdiction. Recently, CGS was approached to expand portal access for prior authorization to all providers regardless of their MAC locations. CGS agreed to pose this question to CMS. However, CMS responded negatively to this request. Presently, the only acceptable way for out-of-region providers to submit prior authorization is either via mail or fax. The good news is that if you are located in JA and JD and receive prior authorization and are successfully reimbursed from JB or JC, you will be eligible to apply for full myCGS

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access for at least twelve months from the date the claim was paid.

Interactive Voice Response (IVR)

Beginning in mid-November 2024 and continuing through February 2025, IVR for all Medicare Contractors (DME and Local) will begin the process of no longer providing beneficiary eligibility information. This ostensibly is to reduce fraudulent marketing schemers from easily stealing Medicare Beneficiary's Identification (MBI). Providers should start switching to their MACs portals or utilizing commercial software or clearinghouses, which can more securely obtain such information.

Lymphedema Stockings and/or Pneumatic Compression Devices (PCD)

Each MAC website offers free continuing education webinars on lymphedema-related services. This information may be found on your DME MAC homepage. As a result of a successful beneficiary's lawsuit against CMS, the Local Carrier Decisions and Policy Articles (PA) for PCD were withdrawn in mid-November 2024. The LD and PA have since been replaced by the NCD. This can be found at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=225

All four DME MAC portals and websites contain a number of "Dear Physician" letters which provide education for any prescriber of DME. These can be very helpful in educating your MD/DO colleagues on therapeutic shoes. Short of reviewing the LCD, these letters can also provide significant insight into the reimbursement requirements for many categories of DME.

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MBI Issues

Due to fraud involving patients' Medicare accounts, all Medicare beneficiary identification has been changed to MBI. These can also be compromised. Thus, asking your patients whether there has been any change to their Medicare policy numbers at each appointment is crucial. If their account has been changed and they do not know the number, there is a tool on the DME MAC website which allows you to enter the patient's name, DOB and SS# along with some of your practice demographics, which will allow you to immediately obtain their current MBI.

Provider Enrollment Issues

Enrollment with DMEPOS continues to be problematic for all types of DME suppliers. CMS attempts to reduce fraud and abuse is applauded but the process has become arduous for the average provider to negotiate without professional help. Hiring an experienced expert familiar with the nuances of the enrollment and inspection process remains the single best method by which to successfully navigate the enrollment process.

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CMS has continued to root out fraud and abuse and part of that initiative is to make credentialing as a DMEPOS provider more difficult. As noted previously, the single most effective way to successfully negotiate your way through this laborious process is to hire an expert to review you PECOS and/or paper application. Additionally, the expert can ready your practice for the inspection. The contractors performing inspections are hired by a contractor other than the NPE contractor. Thus, the inspectors are no longer under the NPE's jurisdiction. Failing an inspection is frequently due to the following causes:

Conflicts with the PECOS or 855S and in-office documentation (hours by appointment and actual listed hours), along with contract inventory issues are by far the two most common reasons for enrollment revocation. Other common errors occur with lack of posting Supplier Standards signage (best shown in every treatment and reception room) and other NPE-required paperwork.

New DMEPOS providers often are subject to fingerprinting requirements. If so, providers will be advised of the requirements for their specific practice, such as who will require fingerprinting. This must be done at the practice's expense and a practice has thirty days to comply with those requirements.

C-HIT is the appeals contractor for those denied enrollment. They have a legal obligation to respond within thirty days but often take up to one hundred days. When C-HIT responds favorably, the NPE prioritizes that application over those the NPE is handling. The time it takes for the NPE to revalidate after receiving the approval from C-HIT varies based on the specific issues with that application.

There are a small number (1,600) of suppliers who have not submitted their Electronic Funds Transfer (EFT) information through PECOS to their

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NPE, not their DME MAC. These providers risk dis-enrollment or have already been dis-enrolled. If you have been dis-enrolled you will need to go through the difficult process of appealing your enrollment. Please check your EFT status in PECOS to be sure you are up-to-date. There are also changes coming soon to EFT verification prior to allowing changes. This is for both DME and non-DME and is being put in place to prevent changes to providers' records without authorization.

It is important to provide up-to-date office premises liability insurance and a state license to the NPE (either via PECOS or mail). Be sure your office liability policy lists the correct NPE as the certificate holder.

Participation Status

You should by now have received the annual postcard which outlines your option to switch your participating/non-participating status. It is important to note that if your tax ID is the same for DME and Med/Surgery, your participating/non-participating status must be the same. If you choose different participating status, that creates potential self-referral stark violation issues. You would be wise to speak with your healthcare attorney about those implications. If you choose to maintain your status, no action is required.

Summary

All things considered, it is very much still worth maintaining your status as a DMEPOS provider and having to deal with the headaches of potential audits, documentation, and site revalidation issues. Profitability on Cam Boots can be almost $200 and on custom AFOs easily eclipsing $700, therapeutic shoes easily over $200. Equally important is continuing in the DMEPOS program, which allows you to treat to the limits of your knowledge/license and provide patients with the necessary care they may immediately require.

Annual Deductible

As of this writing, the annual deductible for 2025 is projected to increase by $17 to $257. Please see either your DME MAC or PDAC homepage for the 2025 DME fee schedule, which should now be available. **PM**

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Council for the DME MACs' NSC and provider portal subcommittees. He is a noted expert on durable medical equipment (DME) and an expert for Codingline.com and many third-party payers. Dr. Kesselman is also a medical advisor and consultant to many medical manufacturers and compliance organizations.