

# **Update on Medicare & Lymphedema 2015**

**Networking & Educational Seminar  
For Lymphedema Therapists**

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# Objectives

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1. Identify the origins of our healthcare coverage relating to the reimbursement of lymphedema treatment services.
2. Identify 2015 changes to Medicare delivery and reimbursement and issues affecting lymphedema treatment delivery.
3. Recognize key therapy billing and coding issues, functional limitations coding problems, and therapy cap and exception information.



# From Whence Spring Our Benefits?

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- ▶ Medicare-- Title XVIII SSA
- ▶ Federal Government Employee-- FEHBA
- ▶ Self-funded Employee Health Plan-- ERISA
- ▶ Military Benefit Plans
- ▶ National Healthcare Revision-- HIPAA, BIPA, MMA, PPACA, HCERA, MCTRJCA, PSRA, ATRA, PAMA
- ▶ Medicaid-- Title XIX SSA + State Law
- ▶ Private Insurance-- State Law
- ▶ Church Employer-- State Law
- ▶ Non Self-funded Employee Health Plan-- State Law
- ▶ State Government Employee-- State Laws



# Medicare - The Model

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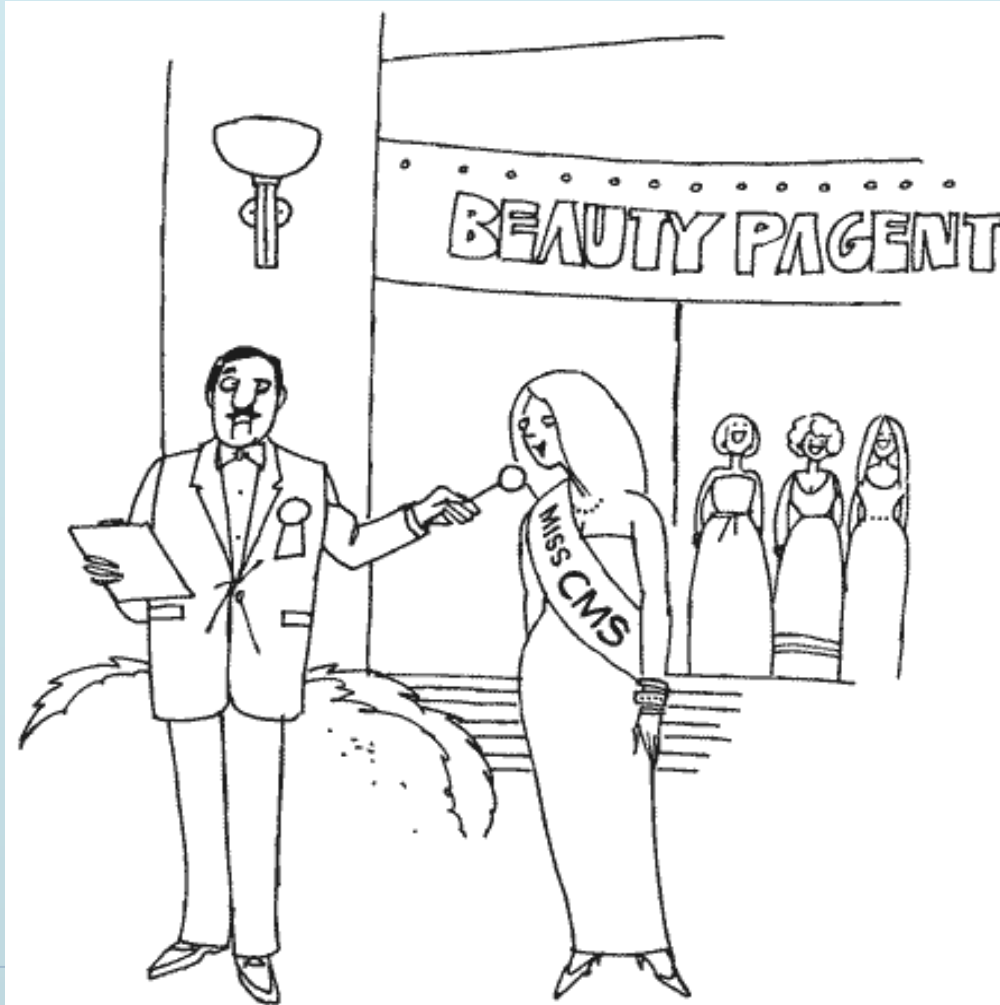
- ▶ Social Security Act Title XVIII (§1801-1899A)
  - ▶ Part A Hospital Insurance/Inpatient Care
  - ▶ Part B Outpatient Medical Services
  - ▶ Part C Managed Care/Medicare Advantage Plans
  - ▶ Part D Prescription Drug Plans
- ▶ Services provided by CMS-Affiliated Contractors
  - ▶ Part A Services provided by Fiscal Intermediaries\*
  - ▶ Part B Services provided by Carriers\*
  - ▶ Part C Services provided by HMOs
  - ▶ Part D Services provided by Sponsors

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\* Recently combined into Part A/B Medicare Administrative Contractors (MACs)



**"My special talents are moving slow and confusing people."**



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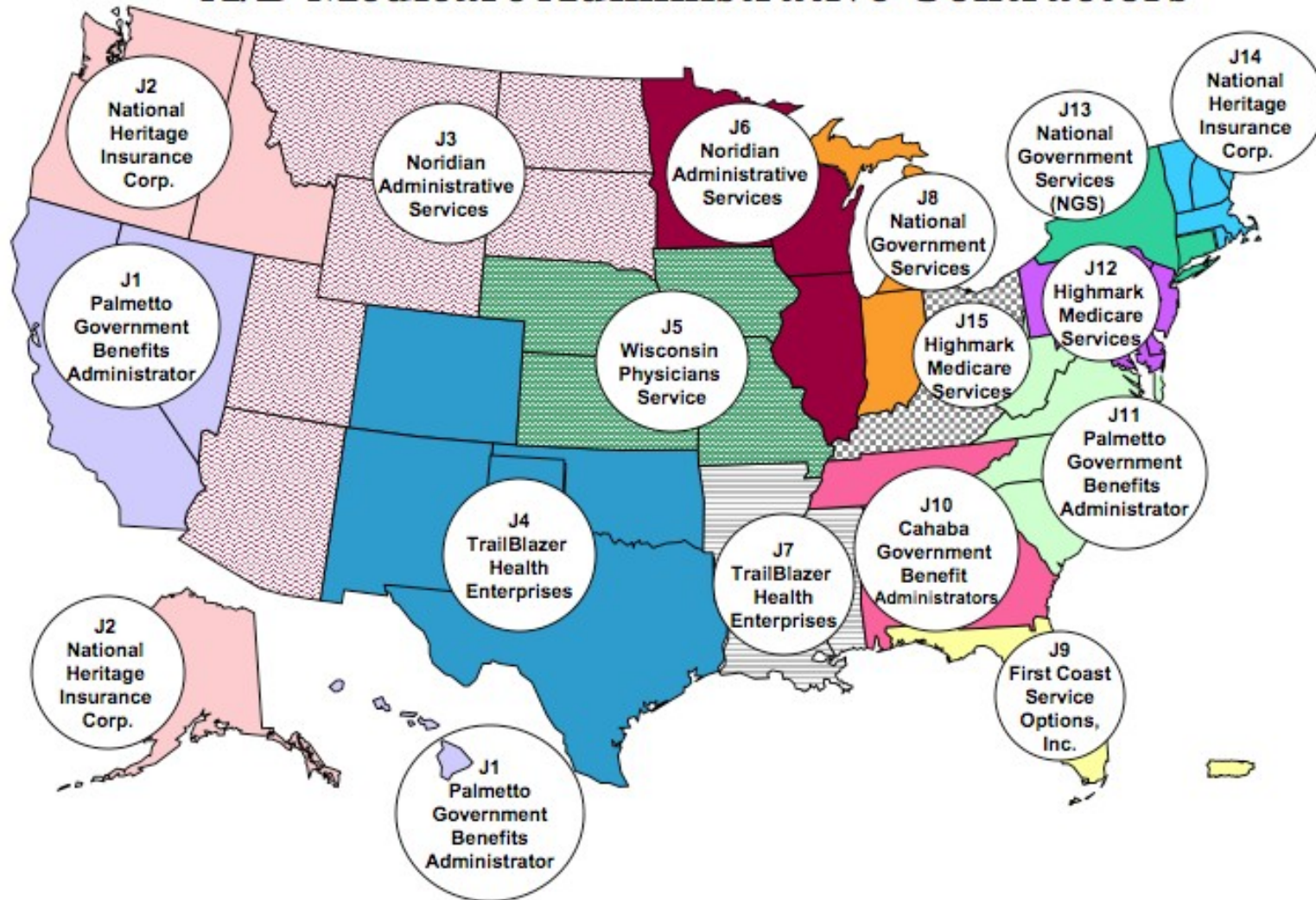
# Medicare Administrative Contractors

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- ▶ Medicare Administrative Contractors (MACs)
  - ▶ Part A/B MACs (A/B MACs)
  - ▶ DMEPOS MACs (DME MACs)
  - ▶ Home Health/Hospice MACs (HH MACs)
- ▶ Quality Improvement Contractors
  - ▶ Qualified Independent Contractors (QICs)
  - ▶ Quality Improvement Organizations (QIOs)
- ▶ Program Safeguard Contractors (PSCs)
  - ▶ Zone Program Integrity Contractors (ZPICs)
- ▶ Audit Contractors
  - ▶ Comprehensive Error Rate Testing (CERT) Contractors
  - ▶ Recovery Audit Contractors (RACs)



# A/B Medicare Administrative Contractors

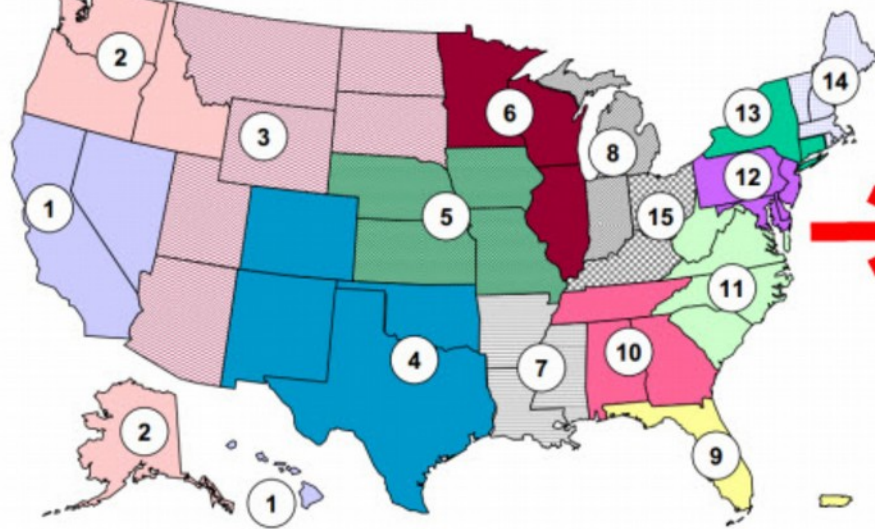




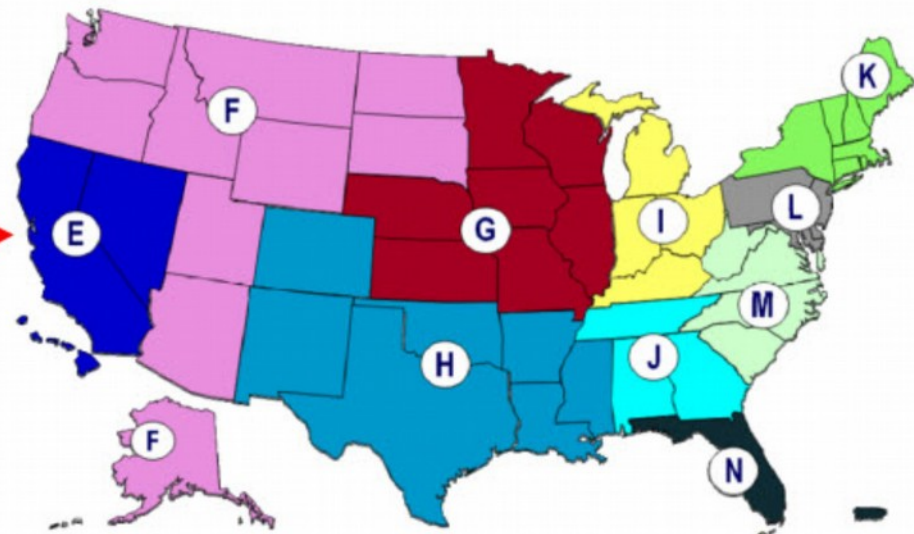
# Medicare Administrative Contractors (MACs)

## Before & After Consolidation

A/B MAC Jurisdictions

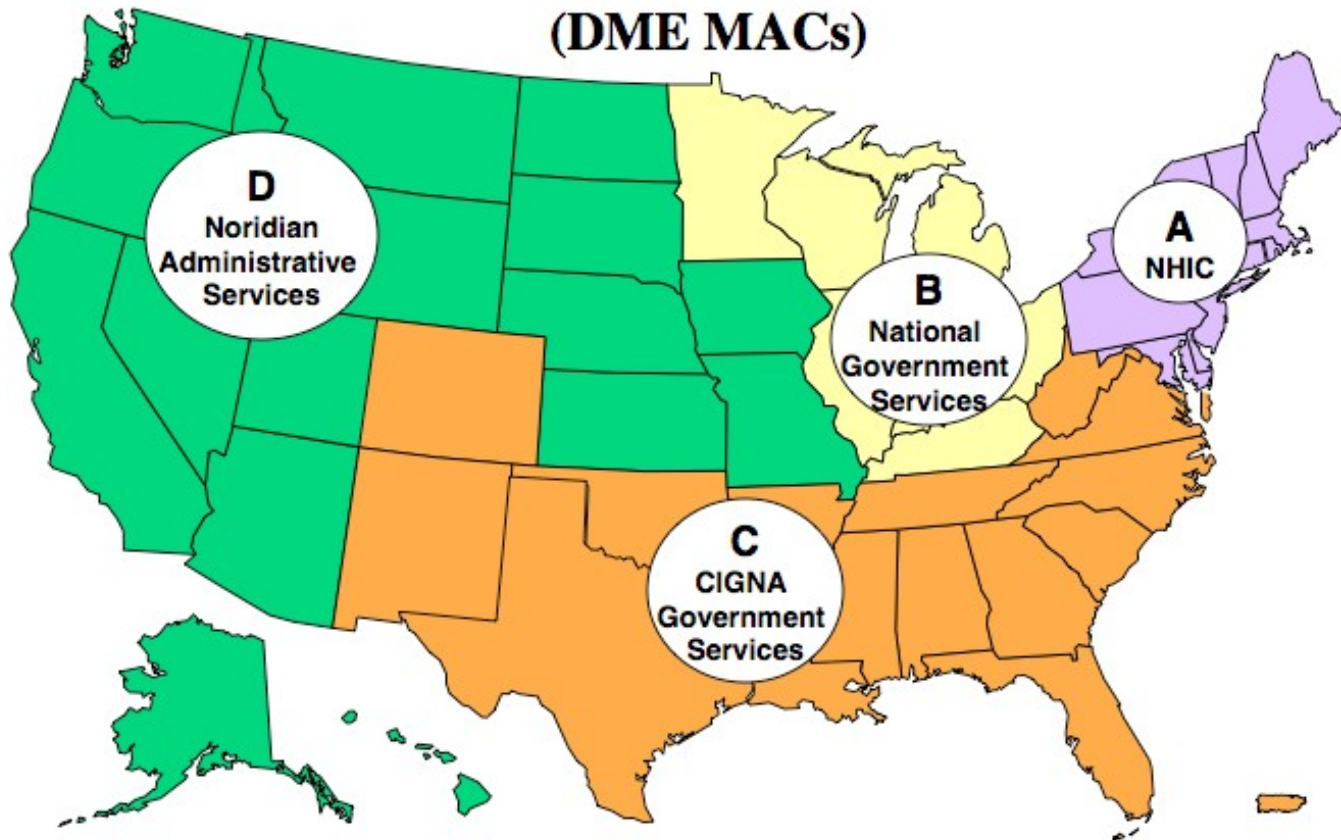


Consolidated A/B MAC Jurisdictions

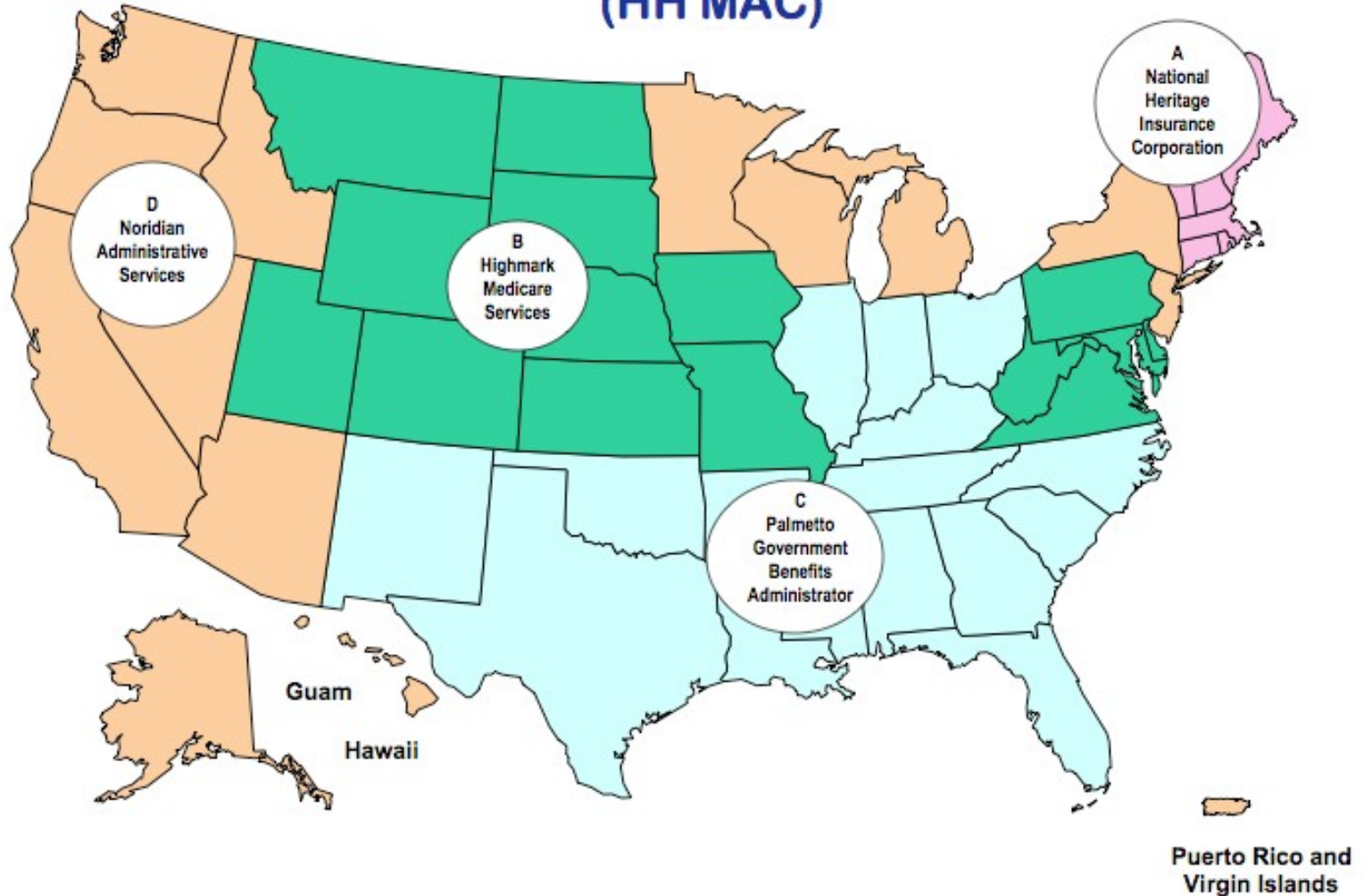




# Durable Medical Equipment Medicare Administrative Contractors (DME MACs)



# Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)



# Medicare Coverage Criteria\*

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- ▶ For any item to be covered by Medicare, it must:
  1. be eligible for a defined Medicare benefit category [§1861];
  2. be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member [§1862(a)(1)(A)] and;
  3. Meet other Medicare statutory & regulatory requirements.
- ▶ Other applicable Federal Legislation (e.g. HIPAA 1996, BIPA 2000, MMA 2003, PPACA 2010, MCTRJCA 2012, ATRA 2012, PSRA 2013, PAMA 2014, **MACRA 2015**) impose requirements.

\*"Standard Documentation Language for Local Coverage Determinations and Related Policy Articles - Revised - Joint DME MAC Publication" Revised October 30, 2014

# Flow Down of Statutory Requirements

	<b>STATUTORY DMEPOS BENEFIT CATEGORIES</b>			
<b>BENEFIT CATEGORY</b>	<b>SURGICAL DRESSINGS, SPLINTS, CASTS</b>	<b>DURABLE MEDICAL EQUIPMENT</b>	<b>PROSTHETIC DEVICES</b>	<b>PROSTHETICS AND ORTHOTICS</b>
<b>AUTHORITY</b>				
Title XVIII Social Security Act	§1832(a)(1) §1861(s)(5)	§1832(a)(1) §1861(s)(6) §1861(n)	§1832(a)(2)(I) §1861(s)(8)	§1832(a)(2)(I) §1861(s)(9)
Code of Federal Regulations 42 CFR	§410.36(a)(1)	§410.38 §414.202 DME	§410.36(a)(2) §414.202 POD(1)	§410.36(a)(3) §414.202 POD(3)
Medicare Benefit Policy Manual Pub. 100-02, Ch. 15, Covered Services	§100	§110 §110.1	§120	§130
Medicare NCD (National Coverage Determinations) Manual Pub. 100-03	§270	§280.1	§§20, 50, 80, 160, 180, 230	
Medicare Claims Processing Manual Pub. 100-04, Ch. 20 DMEPOS		§10.1.1	§10.1.2	§10.1.3
HCPCS Code Group	A-Code, S-	E-Code	L-Code, S-Code	L-Code

# Medicare Coverage of LE Treatment

Treatment Modality	Coverage*
MLD	CPT 97140
Compression Bandaging	(bundled) CPT 97140
Decongestive Exercises	CPT 97110 (instruction only)
Patient Education	(bundled) or CPT 97535
Pneumatic Compression	CPT 97016 (instruction only)
Compression Garments	Not covered**

\*CPT codes and descriptions only are copyright American Medical Association. All Rights Reserved. Applicable FARS\DFARS apply.

\*\*Should be covered as “prosthetic device benefits” according to Robert Weiss  
[http://www.lymphactivist.org/prosthetic\\_devices-insert.pdf](http://www.lymphactivist.org/prosthetic_devices-insert.pdf)

# ICD-10-CM Is (Almost) Here

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- ▶ HIPAA requires one official list of national medical code sets
  - ▶ Will cover Medicaid
- ▶ Current Procedural Terminology (CPT) codes do not change
- ▶ Planned implementation date of October 1, ~~2014~~ 2015
  - ▶ ICD-9 remains in effect until September 30, 2015
- ▶ ICD-10-CM provides greater diagnostic specificity (not utilized for lymphedema whose ICD-9 codes were just mapped into ICD-10)
- ▶ Input testing scheduled Nov 2014, Mar 2015, Jun 2015
- ▶ End-to-end testing Jan 2015, Apr 2015, Jul 2015
- ▶ Further Information is available on the CMS Website:
  - ▶ <http://www.cms.gov/Medicare/Coding/ICD10/index.html>
  - ▶ <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2014-11-05-ICD10-Presentation.pdf>
- ▶ R. Weiss' **proposed expanded lymphedema codes** on LymphActivist's Site
  - ▶ [http://www.lymphactivist.org/icd\\_10-expansion.pdf](http://www.lymphactivist.org/icd_10-expansion.pdf)





## ICD-10-CM Codes for Lymphedema

Diagnosis	ICD-10-CM	ICD-9-CM
Congenital Lymphedema/Elephantiasis, hereditary, chronic, tropholympedema, ideopathic	Q82.0	757.0
Postmastectomy Lymphedema Syndrome	I97.2	457.0
Lymphedema/Elephantiasis, nonfilarial, praecox, secondary, glandular, lymphangiectatic, lymphatic vessel, scrotum, telangiectodes, streptococcal	I89.0	457.1
Lymphedema/Elephantiasis, vulva	N90.89	624.2*/624.8
Lymphedema/Elephantiasis, eyelid	H02.851-9	374.83
Elephantiasis, acquired, surgical	I97.89	997.1*/997.99

\*CMS Crosswalk may be **incorrect**/suggested correct code (RW)

# Now is the Time to Prepare Compliance Date – October 1, 2015



# Health Care Reform

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"Today we are in the middle of a fundamental restructuring of outpatient payment away from volume based payment to one based on value. The only thing we can do about health care reform is change ourselves and the way our wound centers operate. In 2015, penalties for not reporting on quality measures begin with the loss of a percentage of Medicare payments. Now is the time for us to make a change and learn how to focus on quality of care, rather than quantity."

Caroline Fife, MD

The Woodlands, Texas (PRWEB)

October 08, 2014

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# Changes in Healthcare Policy

- Patient Protection and Affordable Care Act of 2010 (PPACA)\*
- Health Care and Education Reconciliation Act of 2010 (HCERA)\*
- Middle Class Tax Relief And Job Creation Act of 2012 (MCTRJCA)
- American Taxpayer Relief Act of 2012 (ATRA)
- Pathway for SGR Reform Act of 2013 (PSRA)
- Protecting Access to Medicare Act of 2014 (PAMA)
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

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## Fee Schedule Proposed/Final Rules

- CMS-1600-FC** CY 2014
- CMS-1611-F** CY 2015 Home Health PPS Rate Update (11/06/2014)
- CMS-1611-CN** CY2015 Correction Notice to Final Rule (12/02/2014)
- CMS-1612-FC** CY 2015 Physician Fee Schedule (11/13/ 2014)
- CMS-1612-F2** **CY 2015 Correction Notice to Final Rule (3/20/2015)**
- CMS-1613-FC** CY 2015 Hospital OPP, ASC, Quality Reporting, etc. (11/10/2014)
- CMS-1613-CN** CY 2015 Correction Notice, Final Rule (2/24.2015)

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\* Collectively referred to as the “Affordable Care Act (ACA)”

# Summary of 2015 Medicare Changes\*

- ▶ Sustainable Growth Rate (SGR) physician payment method eliminated.
- ▶ Review of potentially mis-valued CPT codes, including 97032, 97035, **97110**, 97112, 97113, 97116, **97140**, 97530 and G0283.
- ▶ The conversion factor update for providers, continues at 0.0% through 6/30/2015 (The conversion factor is \$35.8228) and raises to 0.5% thru 2019.
- ▶ Extension of existing 1.0 geographic practice cost index (GPCI) work floor.
- ▶ Extension of the **therapy cap** for CY 2015 at **\$1940/CY [-KX Modifier]**.
- ▶ Extension of the **therapy cap automatic exceptions process to 12/31/2017**.
- ▶ **Manual medical review** (MMR) process >\$3700/CY expires 03/31/2015.
- ▶ **CPT addition of** un-timed SLP evaluation codes 92521-92524 for speech fluency, speech production, language comprehension, voice quality.
- ▶ New therapy Distinct Procedural Services **-59 Modifier subsets**
- ▶ Amount in Controversy to **\$150** for ALJ hearing, **\$1460** for court appeal
- ▶ Annual Part B Deductible = **\$147**, Coinsurance = 20%

\* <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html>

# Reimbursement Changes Starting April 1\*

- ▶ Sustainable Growth Rate (SGR) 21% decrease in Medicare Physician (and Therapist) Fee Schedule payments (MPFS) **was eliminated**.
- ▶ Therapy Cap Exception Process (TCEP) **was extended**.
- ▶ Continue using the KX modifier for therapy exceeding the Cap
- ▶ Medicare held all MPFS payment claims with dates between April 1 and April 14.
- ▶ Beginning April 15 CMS will resume processing, maintaining a 10-day “rolling hold” on claims.
- ▶ The small number of claims processed at the reduced payment rate will be reprocessed with the new rate.
- ▶ Claims submitted prior to April 1 will be processed and paid under the usual time frames

\* <http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2015-04-13-eNews-SE.pdf>



# Therapy Cap Settings

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- ▶ The therapy cap applies to **all Part-B outpatient therapy settings and providers** including
  - ▶ Therapists' private practices
  - ▶ Offices of physicians and certain non-physician practitioners
  - ▶ Part-B skilled nursing facilities (Part B)
  - ▶ Home health agencies (Type of Bill 34X)
  - ▶ Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
  - ▶ Comprehensive Outpatient Rehabilitation Facilities (CORFs)
  - ▶ Critical Access Hospitals (CAHs)
  - ▶ **Hospital outpatient departments (HOPDs)**
- ▶ The therapy cap will also apply to **outpatient hospitals** as detected by:
  - ▶ Type of Bill 12X or 13X;
  - ▶ Revenue code 042X, 043X, or 044X;
  - ▶ Modifier -GN, -GO, or -GP.
  - ▶ Date of service on or after January 1, 2013
- ▶ Caps and Medical Review do not automatically apply to Medicare Part-C plans



# Extension of Therapy Cap Exception Process

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- ▶ Therapy cap raised to \$1940/year. Exceptions allowed for ***documented reasonable and medically necessary skilled therapy services***.
  - ▶ The **therapy cap exception process** extended by Protecting Access to Medicare Act of 2014 extended from Jan 1, 2014 to March 31, 2015. **MACRA further extends exception process to December 31, 2017.**
  - ▶ Requires **-KX Modifier** for all exception requests, indicating that ***services above the cap are reasonable and necessary*** and that ***justification is documented in the medical record***
  - ▶ **Mandatory review** of every claim exceeding \$1940 cap that does not have -KX Modifier
  - ▶ The Middle Class Tax Relief And Job Creation Act of 2012 requires CMS to conduct ***manual medical reviews*** of therapy services exceeding **\$3700 per calendar year**.
  - ▶ Cost of **therapy evaluations** to determine whether patient requires therapy are **exempt from cap calculations**
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# Manual Medical Review Process

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- ▶ Every provider-submitted claim for services on or after February 28, 2014 is paid, and subject to a post-payment review by a Recovery Audit Contractor (RAC).
- ▶ Steps in the review process
  - ▶ MAC flags every claim exceeding \$3700 in that year
  - ▶ MAC sends an Additional Document Request (ADR) to provider
  - ▶ Provider sends documentation justifying continuing therapy to RAC
  - ▶ RAC analyzes the data and notifies MAC of payment decision
  - ▶ MAC notifies provider of decision. If provider must pay back money received for providing “unnecessary services”, they are given option to: Pay back by check; Recoup from future payments; Apply for extended payment plan; Appeal the decision.



# Targeted Reviews: New Medical Review Process For Outpatient Services [MACRA §202(b)]

- ▶ (E)(i) In place of the manual medical review process ..., the Secretary shall implement a process for medical review ... under which the Secretary shall identify and conduct medical review for services ... furnished by a provider of services or supplier using such factors as the Secretary determines to be appropriate.
- ▶ (ii) Such factors may include the following:
  - ▶ (I) The therapy provider has had a high claims denial percentage for therapy services under this part or is less compliant with applicable requirements under this title.
  - ▶ (II) The therapy provider has a pattern of billing for therapy services under this part that is aberrant compared to peers or otherwise has questionable billing practices for such services, such as billing medically unlikely units of services in a day.
  - ▶ (III) The therapy provider is newly enrolled under this title or has not previously furnished therapy services under this part.
  - ▶ (IV) The services are furnished to treat a type of medical condition.
  - ▶ (V) The therapy provider is part of group that includes another therapy provider identified using the factors determined under this subparagraph.

# Use of the KX Modifier

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- ▶ Used only when patient's condition justifies services above cap.
- ▶ Used together with other modifiers, e.g. -GN, -GP, -GO and non-payable G-Codes for functional reporting.
- ▶ By appending the -KX modifier, the clinician is attesting that the services billed:
  - ▶ Are reasonable and necessary services that require the skills of a therapist (see MBPM Section 220.2);
  - ▶ Are justified by appropriate documentation in the medical record (see MBPM Section 220.3);
  - ▶ Qualify for an exception using the automatic process exception.
- ▶ Claims for services above cap without -KX modifier will be denied.
- ▶ Providers submit additional justification in response to any Additional Documentation Request (ADR) for claims selected for medical review.



# Therapy Modifier Changes

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- ▶ Discipline-Specific Outpatient Rehabilitation Modifiers
  - ▶ Discipline-specific modifiers -GP, -GO and -GN must match revenue codes 42x, 43x, 44x for PT, OT and SLP [MCPM Ch. 5, §20.1, Effective 07/01/14]
- ▶ Subsets of -59 “distinct procedural service” “X{EPSU} modifiers” used in lieu of -59 under circumstances defined in CPT Instructions. Effective 01/01/2015.
  - ▶ -XE Separate Encounter
  - ▶ -XS Separate Organ/Structure
  - ▶ -XP Separate Practitioner
  - ▶ -XU Unusual Non-Overlapping Service
- ▶ Use of therapy modifiers and annual cap not mandatory for Part C plans.

Reference: Transmittal 1422, Change Request 8863, Specific Modifiers For Distinct Procedural Services, Effective January 1, 2015



# Functional Data Collection/Reporting

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- ▶ **Data collection for therapy services**
  - ▶ 2015 reimbursement model same as 2013-4 with addition of PQRS incentives and penalties.
  - ▶ Continuation of the *non-payable data collection codes* for reporting functional limitations for each claim (G-Codes).
  - ▶ Future goal is new therapist reimbursement based on *improvement of function and complexity of services*.
  - ▶ **There are no quality measures in current use that would measure *lymphatic severity or lymphatic function* in the absence of functional disability.**



# Function-Related G-Codes

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- ▶ Four Basic Functional Categories
  - ▶ Mobility
  - ▶ Changing & Maintaining Body Position
  - ▶ Moving & Handling Objects
  - ▶ Self-Care
- ▶ Severity Modifiers Collected for Each Encounter
  - ▶ Seven modifiers for five ranges of impairment
- ▶ Data Collected
  - ▶ Current Status
  - ▶ Goal Status
  - ▶ Discharge Status



# “Other” PT/OT G-code Sets

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- ▶ Used to report:
  - ▶ beneficiary’s functional limitation that is not defined by one of the four categorical G-code sets;
  - ▶ beneficiary whose therapy services are not intended to treat a functional limitation; or
  - ▶ beneficiary’s functional limitation when an overall, composite or other score from a functional assessment tool is used and it does not clearly represent a functional limitation defined by one of the four code sets
- ▶ Bottom Line:
  - ▶ When **treating lymphedema in the absence of functional deficiency**, use the “Other” Code Set



# Progress on Functional Limitations Data Collection

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- ▶ Collection software and therapy clinics procedures have been generally compliant in getting G-Codes onto Medicare claims
- ▶ Outpatient therapy clinics only bill Part B. “Handover” problems with reporting transfer of cases from Part A
- ▶ Issues noted regarding therapy given to observation patients in acute-care units before determination of Part A/Part B status
  - ▶ Always do a functional evaluation and capture G-Code on initial claim whether patient was admitted as an in-patient (Part A) or for observation (Part B). This ensures that subsequent treatments can be paid even if patient’s status is subsequently changed.
  - ▶ G-Codes cannot be retroactively added to claims
  - ▶ Therapy received under Part A is counted against patient’s annual Part B annual cap calculation
- ▶ Problems with reporting patients with more than one functional limitation
- ▶ Problems with self-discharges/non-returning patients

# My Analysis of the Problem

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- ▶ Qualitative differences exist between covered Medicare services
- ▶ Lymphedema is an illness, not a body member functional deficiency
- ▶ Functional outcomes for functional deficiencies cannot be used to measure efficacy of treatment of illness

Section 1862(a)(1) Reasonable and Necessary	Section 1861(s) Covered Medical Services
Diagnosis of illness or injury	Physician's services §1861(s)(1)
Treatment of illness or injury	Services and supplies incident to physician's services §1861(s) (2)(A)
Improving function of malformed body member	Outpatient PT and OT services §1861(s)(2)(D)

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# Changes to Outpatient Therapy LCDs\* in Response to Jimmo Settlement

- ▶ Authority: CMS Transmittal No. 179, Change Request #8458 1/14/14
- ▶ “Medicare Coverage of skilled nursing and skilled therapy services ... does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the **beneficiary’s need for skilled care.**”
- ▶ Purpose of a maintenance program is to assist in maintaining progress made during therapy or to prevent or slow further deterioration due to disease or illness.
- ▶ Skilled therapy services may be necessary to improve a patient’s current condition or to prevent or slow further deterioration.
- ▶ Documentation must show that treatment by the therapist is necessary to maintain, prevent or slow further deterioration of functional status and that the service cannot be safely carried out by the beneficiary, family member, caregiver or unskilled personnel.

\*Example: 5/1/14 Revision to LCD for Outpatient Physical and Occupational Services (L26884), National Government Services, Part A/B MAC, JK



# Coverage for Therapy Maintenance Services

- ▶ **Need for Skilled Personnel**

- ▶ **Skilled therapy** services to maintain the patient's current condition or prevent or slow further deterioration are covered under the SNF, HH, and OPT benefits as long as an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary to design or establish a safe and effective maintenance program or under certain circumstances, for the actual performance of such a program.

- ▶ **Complexity of the patient or service**

- ▶ **Skilled therapy** is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.

Reference: MLN Connects National Provider Call, "*Jimmo v. Sebelius* Settlement Agreement, December 19, 2013

# Additional Documentation Guidance to Support Skilled Care Determinations\*

- ▶ Physician Documentation: orders, notes, history, exams, response
- ▶ Patient Goals: frequent assessments, goals kept current
- ▶ Duration & Quantity of Services: related to therapeutic goals
- ▶ Interdisciplinary Documentation: all members of care team
- ▶ Rationale of Skilled Services: complexity, response, prognosis
- ▶ Differentiation of Maintenance Program: efficacy of program
- ▶ Objective Measurement: physical outcomes, changed behaviors
- ▶ Specific Descriptive Documentation: avoid vagueness, subjectivity

\*Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 8, §30.2.2.1  
“Documentation to support Skilled Care Determinations”

Credit for this analysis is given to Kris Mastrangelo, Harmony Healthcare Blog  
Wednesday, Feb 26, 2014 “Updated Medicare Benefit Policy Manual”

# Change to Home Health Services Therapy Reassessment Timeframe

- ▶ Effective for episodes ending on or after Jan 1, 2015
- ▶ At least every 30 days, a qualified therapist (not an assistant) must provide needed therapy service and functionally reassess the patient
- ▶ Where more than one discipline of therapy is provided, each must comply with the above.
- ▶ Changes made to 42 C.F.R. 409.44
- ▶ Therapy reassessments must use a method that would include objective measurement in accordance with accepted clinical standards
- ▶ The measurement results and effectiveness of the therapy, or lack thereof, must be documented in the clinical record
- ▶ Policy will be found in Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 7

[CMS-1611-F] CY 2015 Home Health PPS Rate Update. ...  
<http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf>

# Advance Beneficiary Notice of Noncoverage (ABN)-Related Modifiers

- ▶ Valid ABN holds Beneficiary responsible for charges exceeding the cap.
- ▶ When Provider believes that services are not medically necessary ABN is executed and -GA Modifier is added to claim. If no ABN is on file -GZ Modifier is used and Beneficiary cannot be held liable.
- ▶ CMS prohibits issuing ABN on a prophylactic basis to all Beneficiaries exceeding the cap just in case the claim is denied.
- ▶ When Provider believes item or service is not covered because it is statutorily excluded or does not meet the definition of a covered benefit a -GY Modifier is used and an ABN is not issued since Patient is liable for charges.
- ▶ **Conundrum:** If Provider believes services above cap are medically necessary they use a -KX Modifier and submit claim. They cannot issue an ABN, and are in an unprotected position should the claim be denied on review.

<http://www.apta.org/PTinMotion/NewsNow/2013/5/3/ABN/>

<http://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/ABN-Noncoverage-FAQ.pdf>

# Local Coverage Determinations for Pneumatic Compression Device

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LCD ID ARTICLE	CONTRACTOR TYPE	CONTRACTOR NAME (AND NUMBER)	DATE INFO*
<a href="#">L11503</a> <a href="#">A37216</a>	DME MAC A	NHIC, Corp. (16003)	Rev 3: 7/01/2013 Rev 5: 11/01/2014**
<a href="#">L27028</a> <a href="#">A47127</a>	DME MAC B	National Government Services, Inc. (17003)	Rev 3: 7/01/2013 Rev 4: 11/01/2014**
<a href="#">L5017</a> <a href="#">A24141</a>	DME MAC C	CGS Administrators, LLC (18003)	Rev 3: 7/01/2013 Rev 4: 11/01/2014**
<a href="#">L11492</a> <a href="#">A37075</a>	DME MAC D	Noridian Healthcare Solutions, LLC (19003)	Rev 4: 11/01/2013 Rev 7: 11/01/2014**

\*Original effectivity 10/1/1993. Major revisions in 1995, 1998, 2002, 2003, 2006, 2007, 2011, 2013. Current Effectivity shown.

\*\*November 1, 2014 effectivity delayed indefinitely

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# Future Local Coverage Determination for Pneumatic Compression Device **WITHDRAWN**

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- ▶ Medical necessity definitions & coverage rules for use of a PCD for Tx of:
  - ▶ Edema [Non-Covered except edema caused by lymphatic dysfunction]
  - ▶ Primary & Secondary LE of the Extremity (E0650, E0651 only)
    - ▶ Diagnosis of “**chronic and severe**” lymphedema, and
    - ▶ **Documentation of at least 6 months skin breakdown**, and
    - ▶ Unresponsive to **4-week trial of “conservative” clinical treatment**
  - ▶ Extremity LE Extending into the Chest, Trunk, Abdomen (E0652)
  - ▶ Chronic Venous Insufficiency (CVI) with Venous Stasis Ulcers
    - ▶ Lower extremity edema, and
    - ▶ One or more stasis ulcers, and
    - ▶ Unresponsive to 6-month trial of conservative therapy
  - ▶ Peripheral Arterial Disease (PAD) [Non-Covered]
  - ▶ Prevention of Venous Thromboembolism [Non-Covered]



# Future Local Coverage Determination for Pneumatic Compression Device ~~WITHDRAWN~~

- ▶ Face-to-face examination by Physician or NPP and signed by Physician
  - ▶ Written order prior to delivery (WOPD) by Physician
  - ▶ Four-week trial for Lymphedema must include all of the following:
    - ▶ Compression, **MLD**, Medications A/R, Exercise, Elevation;
    - ▶ If improvement is evident, PCD not justified, repeat 4-week trial.
  - ▶ Four-week trial for extremity LE extending onto chest, trunk, abdomen
    - ▶ Four-week daily multiple-hour use of E0650 or E0651 and
    - ▶ Compression, **MLD**, Medications A/R, Exercise, Elevation, Diet, and
    - ▶ Correction (where possible) of anemia and/or hypoproteinemia.
    - ▶ If improvement is evident, E0652 PCD not justified, repeat 4-week trial.
  - ▶ An E0650 compressor with a segmented appliance/sleeve (E0671- E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667-E0669).
  - ▶ LCD does not define ICD-9 codes that support PCD
    - ▶ For CVI without venous ulcers, consider lymphedema diagnosis
- 
- ▶ LCD includes extensive documentation definition

# Face-to-Face Examinations for PCDs

- ▶ **Physician face-to-face (F2F) encounters** with patient required for certain DME referrals including *pneumatic sequential device and appliances*
- ▶ **No longer will a physician's referral for a pneumatic device be sufficient to justify medical necessity**
- ▶ Exam may be administered by NPP (PA, NP, CNS) but physician must sign off with signature and NPI number (CPT G0454)
- ▶ Conducted within 6 months prior to date of a new written order
- ▶ Documentation that beneficiary was evaluated and/or treated for the condition that supports need for PCD (ICD-9-CM diagnostic code)
- ▶ Documentation in the medical record that coverage criteria are met
- ▶ Documentation that LCD medical necessity requirements are met
- ▶ The DMEPOS supplier must have documentation of the face-to-face visit, the Certificate of Medical Necessity (CMN)\* and the completed WOPD in their file prior to the delivery of these items.
- ▶ Proof of Delivery (POD) must be obtained and retained by supplier

\*CMS-846 Pneumatic Compression Devices]



# Ordering & Referral Requirement

- ▶ For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted.
- ▶ Physicians and others eligible to order and refer items or services need to be enrolled in Medicare and be of a specialty that is eligible to order and refer.
- ▶ Requirement to use NPI affects Part B providers and suppliers of DMEPOS who submit claims to carriers, Part A/B MACs and DME MACs.
- ▶ Claims failing Ordering/Referring Requirement will deny.
- ▶ All claims for therapy services must include NPI of physician who reviews the Therapy Plan
- ▶ ACA-mandated **Written Orders Prior to Delivery (WOPDs)** must include
  - ▶ Beneficiary's name
  - ▶ Physician's name and NPI
  - ▶ Date of order and start date (if different from date of order)
  - ▶ Detailed description of the item(s) ordered
  - ▶ Physician's signature and date
- ▶ (Diagnosis of condition being treated in words or ICD-9 or ICD-10 code)

# Items Requiring PDAC Review

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- ▶ The only products which may be billed using codes E06XX are those for which a written Coding Verification Review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate Product Classification List.
- ▶ **Pneumatic Compressors (Pumps) and Non-Elastic Compression Wrap added to list of items requiring coding verification reviews by PDAC.**
- ▶ Items must meet current Local Coverage Determination (LCD) requirements and be listed in the PDAC Product Classification List.
- ▶ Searches may be made on the PDAC web site at:  
<https://www.dmepdac.com/dmecs/index.html>



# ImpediMed Inc. Announced Medicare Payment For New L-Dex®

11/3/2014 11:50:21 AM BRISBANE, Australia & SAN DIEGO--(BUSINESS WIRE)--ImpediMed (ASX:IPD) is pleased to announce today the Centers for Medicare and Medicaid Services (CMS) has published the valuation for **CPT® Category I Code 93702** for the Company's **L-Dex procedure for the assessment of lymphedema**.

- ▶ Beginning January 1, 2015, physicians and hospitals will be able to seek reimbursement for the L-Dex procedure through this new **CPT Category I code**.
- ▶ CMS has assigned CPT code 93702 to the Outpatient Ambulatory Payment Classification (APC) payment group 0097, which has a 2015 payment rate of \$112.67 when billed by a hospital outpatient facility.
- ▶ Physician payment is based on "relative value units" (RVUs). CMS has assigned 3.21 RVUs to the L-Dex CPT Code (code 93702) resulting in an average national physician payment rate of \$114.99.

# Multi-Layer Compression Systems

Year	CPT®	Protocol Description	Supply Item
2009	29540	Strapping: Ankle a/o Foot	Overlapping wraps adhesive gauze dressing
	29550	Strapping: Toes	
	29580	Strapping: Unna Boot	
2010	29581	MLCS: Below Knee	MLCS (SG093)
2012	29582	MLCS: Thigh, Leg a/o Ankle, Foot	MLCS (SG096)
	29583	MLCS: Upper Arm, Forearm	MLCS (SG096)
	29584	MLCS: UA, Forearm, Hand, Fingers	MLCS (SG096)

## ❖ Diagnoses that Support Medical Necessity

➤ Fracture, dislocation, sprain, deformities, phlebitis, varicosities, ulcers

## ❖ Generally expected to be billed not more often than once/week

References: AMA February 2012 CPT® Editorial Panel Meeting Summary of Panel Actions; LCD L29320; Establishing Interim Final Malpractice RVUs for CY 2012.

# Multi-layered High Compression Bandage System Clarifications 2012

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- ▶ Medicare A News, April 11, 2012
  - ▶ “Treatment of lymphedema with the application of high compression bandage systems continues to be non-covered by Medicare.”
  - ▶ “Three or fewer sessions ... of patient and/or caregiver education ... may be medically necessary and reimbursable ...” coded under “CPT®97535, supporting home management training.”
  - ▶ “NAS [MAC A] will cover and separately reimburse the costs of the following applications that do not meet Medicare coverage requirements:” 29581-29584. “Note: These codes should not be reported in conjunction with CPT 97140.”



# Multi-layered High Compression Bandage System Clarifications 2013-4

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- ▶ NCCI Edit Manual 2013, Chapter 2, Section F Fractures, Dislocations and Casting/Splinting/Strapping
  - ▶ “New for 2013 is the following: *Application of a multi-layer compression system (CPT codes 29581-29584) includes manual therapy in the anatomic region of a multi-layer compression system. CPT code 97140 (manual therapy techniques...) should not be reported for any type of manual therapy at the same patient encounter in the anatomic region where a multi-layer compression system is applied.*”
- ▶ NCCI Policy Manual for Medicare Services, Chapter IV Surgery: Musculoskeletal System Effective 1/1/2014 continues above wording for CPT Codes 29581-29584.
- ▶ Strapping, CPT 295xx, is not considered by Medicare to be a skilled service, and can be provided by any medical provider, specially trained or not, as long as it is within the scope of practice of the provider. It is reimbursed with one unit, and is not a timed service.



# 2015 CPT® Removes Simultaneous Multilayer Bandaging - MLD Restriction?

- ▶ On November 11, 2014 The AMA CPT Editorial Board announced in their Errata and Technical Corrections – CPT® 2015 that the exclusionary parenthetical note following CPT® 97140 referencing the multilayer compression system codes CPT® 29581-29584 was being deleted, thereby allowing the billing of the strapping and MLD codes on the same day on the same patient. This paves the way for the use of the strapping codes for bandaging after manual lymph drainage.
- ▶ **However:** NCCI Edits for 2015 have not been changed to reflect this change. Also, further CPT code descriptions must be made expanding the use of previous "strapping codes" to other than musculoskeletal and venous conditions, and CMS must now follow up and remove restrictive wording in their coding and billing instructions.

# JK Part B Prepayment Review Results

## CPT Codes 97001-97799 Jun-Aug 2014

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- ▶ Basis of review: documentation requirements as referenced in
  - ▶ LCD L26884 LCD for Outpatient PT and OT Services
  - ▶ CMS Pub. 100-02, Chap. 15, §§220-230 Outpatient Therapy Services
- ▶ The following results are based upon the completion of the review for JK Part B.
  - ▶ Jun 2014: of 1,954 services billed; 1,802 (62.0%) reduced or denied
  - ▶ Jul 2014: of 9,358 services billed; 8,772 (74.2%) reduced or denied
  - ▶ Aug 2014: of 3,500 services billed; 3,392 (98.1%) reduced or denied





# Reasons for Reduction or Denial

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- ▶ Documentation lacks *referral for therapy*
  - ▶ Documentation lacks *initial evaluation/plan of care*
  - ▶ Initial evaluation did not meet the *Documentation Requirements* outlined in LCD L26884
  - ▶ Documentation lacks *functional limitations and effects on activities of daily living* to establish baseline data necessary for assessment of rehabilitation potential
  - ▶ *Billed number of services were not supported* (i.e., the billed units exceed the allowable units for the documented time)
  - ▶ *Codes and/or units billed* did not match the modalities or times documented
  - ▶ Lacking *progress reports with CMS required elements*
  - ▶ Non-response to development letters
  - ▶ Illegible documentation
  - ▶ Missing or illegible provider *signature*
  - ▶ Incomplete or missing *beneficiary information*
- 



# New RAC Contracts On Hold

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- ▶ Next round of Recovery Audit Contractor contracts are on hold
  - ▶ CGI Federal filed protest with Government Accountability Office (GAO) over CMS plans to pay RAC contingency fee after 2nd level of appeal
  - ▶ GAO ruled against CGI, who appealed to Federal Claims Court
  - ▶ On September 2 U.S. Court of Federal Claims granted injunction barring CMS from awarding RAC contracts for the duration of the appeal
- ▶ Current RAC contracts have been extended and reviews have restarted
  - ▶ Foci of restarted reviews: spinal fusion, cosmetic surgery, **outpatient therapy** and **durable medical equipment, prosthetics and orthotics**.
  - ▶ Therapy providers should expect an onslaught of ADRs relating to patient activity exceeding the \$3700 manual medical review threshold
- ▶ Offer to hospitals to buy out pending appeals at 68% of their value

Sources: Report on Medicare Compliance, ©Atlantic Information Services, Inc. September 8, 2014; “CMS to Restart Some RAC Reviews”, Nancy Beckley, Aug 4, 2014, <http://nancybeckley.com/cms-restart-rac-reviews/>

# HHS OIG Work Plan 2015

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- ▶ Office of Inspector General of Department of Health & Human Services
- ▶ Focus in 2015 on high use of outpatient physical therapy services
- ▶ Goal is to determine whether they are in compliance with Medicare reimbursement regulations
- ▶ Prior OIG work found claims were not reasonable or not properly documented or not medically necessary
  - ▶ Social Security Act § 1862(a)(1)(A)
  - ▶ Medicare Benefit Policy Manual, CMS Pub. 100-02, Chap. 15, § 220.3
- ▶ Focus is on independent therapists who have high utilization rate for outpatient physical therapy services
- ▶ Also to be investigated are skilled care services in Home Health, Hospital and Skilled Nursing Facility settings
- ▶ Expected issue date: FY 2015.

U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) Work Plan for fiscal year (FY) 2015 <http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf>

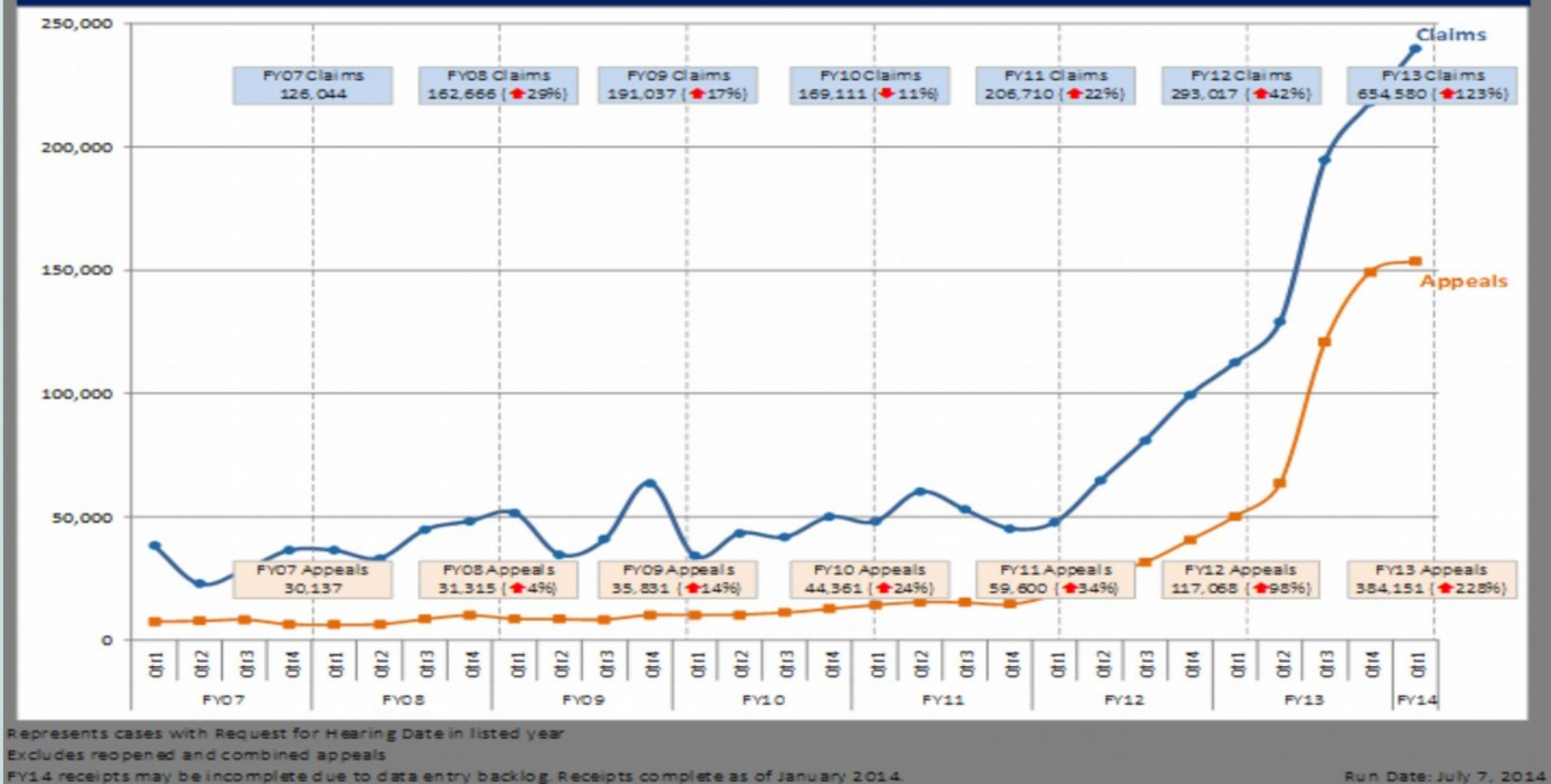
# Medicare Appeal Changes for 2014-5

- ▶ Problems
  - ▶ Two-year backlog of cases in Appellate Courts
  - ▶ Class action Suit 08/26/2014 “defective administrative review process”
  - ▶ ALJs were deciding in favor of appellants > 60% of the cases
- ▶ Changes being made to reduce backlog and reverse overturn rate
  - ▶ CMS conducting “educational classes” for ALJs
  - ▶ MACs directed to have physician be a Participant or a Party in selected ALJ Hearings starting October 27, 2014 Participation in cases involving: Policy; High value; Program integrity; Recurring issue
  - ▶ Consideration of an “appeal fee”
- ▶ Clarification of Appointment of Representative rules [IOM 100-04, Chap. 29, §270.1] and definition of “spouse” [IOM 100-04, Chap. 29, §110]

Excellent educational resource: Medicare Appeals Process Brochure, Aug 2014  
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf>

# Update on ALJ Backlog and Decisions

## Quarterly Receipts



- ▶ Average processing time of appeals decided in FY 2014 is 414.8 days
- ▶ Average processing time of appeals decided in FY 2015 is 547.1 days

# Defending Medical Review Decisions at Administrative Law Judge (ALJ) Hearings\*

- ▶ HHS Office of Inspector General Report November 2010 survey\*\*
  - ▶ Appeals filed by Providers, Beneficiaries, State = 85%, 11%, 3%
  - ▶ Decisions FF, PF, UF, Other = 56%, 6%, 24%, 14%
  - ▶ Decisions less likely to be favorable when CMS participated
- ▶ New Section 3.9 added to Medicare Program Integrity Manual
  - ▶ Directs MACs to assign a physician to defend medical review decisions at ALJ hearings in coordination with QIC
- ▶ My personal observations as to how it works
  - ▶ MAC files a brief but does not attend, no opportunity to question
  - ▶ MAC attends but presents same material as in original denial
  - ▶ MAC presents new screen shot, old data

\*Transmittal 543, Change Request 8501, Pub. 100-08 Medicare Program Integrity.

\*\* Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals, November 2012, OEI-02-10-00340.

# ALJ Decision Statistics

[http://www.hhs.gov/omha/important\\_notice\\_regarding\\_adjudication\\_timeframes.html](http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html)

Appeals	FY10	FY12	FY13	FY14	FY15 Through Nov 2014
Fully Favorable	56%	53.2%	44.3%	36.7%	42.6%
Partially Favorable	6%	6.4%	5.2%	2.8%	3.2%
Unfavorable	24%	27.9%	25.5%	30.1%	37.8%
Dismissed	14%	12.5%	25.0%	30.4%	16.4%

Includes appeals decided in the listed year. Run Date: December 16, 2014

# CMS Quality Reporting Programs

- ▶ Incentive Programs
  - ▶ Physician Quality Reporting System (PQRS)
  - ▶ Meaningful Use of Electronic Health Records (EHR) Incentive Program
    - ▶ Clinical Quality Measure (eCQM) component
  - ▶ Value-Based Payment Modifier (VM)
- ▶ Eligible Professionals (EPs)
  - ▶ PQRS: Medicare Physicians, Practitioners and **Therapists**
  - ▶ Medicare EHR Incentive Program: Physicians
  - ▶ Medicaid EHR Incentive Program: Physicians, NPPs
  - ▶ Value-Based Payment Modifier (VM): Physicians in Groups
- ▶ Methods of Reporting
  - ▶ Medicare Part B Claims submitted to CMS
  - ▶ Qualified PQRS Registry
  - ▶ Electronically using an electronic health record (EHR)
  - ▶ Electronically via CMS-certified Survey Vendor
  - ▶ Group Practice Reporting Option (GPRO)
  - ▶ Qualified Clinical Data Registry (QCDR)





# PQRS Quality Measures

- ▶ 2015 Measures posted to CMS PQRS website-  
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>
- ▶ No measure relevant to LE on 2015 list. Therapists are limited to cross-cutting quality measures associated with evaluation sessions CPT 97001-97004.
- ▶ EPs must select at least 9 measures covering a minimum of 3 NQS domains
  - ▶ >50% of Medicare patients' encounters, 01/01/15-12/31/15
  - ▶ If EP's CEHRT does not contain above, then report at least 1 measure for which there is patient data
- ▶ ACA authorizes a +0.5% PQRS incentive payment in 2014, **none in 2015**
- ▶ **For unsatisfactory measures reporting, a -1.5% adjustment is made in 2015**
- ▶ Avoiding a -2.0% PQRS negative payment adjustment (penalty) in **2017**
  1. Satisfactorily report in 2015 PQRS Program, OR
  2. Report >3 measures, >1 domain >50% via claims or qualified registry, OR
  3. Participate in qualified clinical data registry >3 measures >1 domain for >50% of applicable patients seen during participation period

# PQRS Cross-Cutting Measures Tied to Therapy CPTs\*\*

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- ▶ CPTs 97001-97004
  - ▶ Measure #128\* BMI Screening and Follow-up
  - ▶ Measure #130\* Documentation of Current Medications
  - ▶ Measure #131\* Pain Assessment & Follow-up
  - ▶ Measure #134\* Clinical Depression Screening & Follow-up (OT)
  - ▶ Measures #154,5 Falls >65 years of age: Risk Assessment, Plan of Care
  - ▶ Measure #173 Preventive Care & Screening: Alcohol Use (OT)
  - ▶ Measure #181 Elder Maltreatment Screen & Plan (OT)
  - ▶ Measure #182\* Functional Outcome Assessment
  - ▶ Measure #217-223 Functional Deficits Change: Various body sites\*\*\*
  - ▶ Measure #226\* Tobacco Use Screening/Cessation Intervention (OT)
  - ▶ Measure #236 Controlling High Blood Pressure
  - ▶ Measure #402 Tobacco Use, Help With Quitting (OT)

• Revisions to Payment Policies under The physician Fee Schedule, Rick Gawanda, 7/14/2014. \*\*2015 PQRS Measure Specifications Manual for Claims & Registry Reporting of Individual Measures, 11/10/2014; \*\*\* FOTO measures

# CY 2015 PQRS Reporting Requirements

- ▶ Eligible Professionals (EPs) who fail to complete PQRS in 2015 will be subject to a 2% adjustment (penalty) in 2017 reimbursements
- ▶ Reporting via Claims or Registry: PTs and OTs must report on 9 measures covering at least 3 National Quality Strategy (NQS) domains including at least one “cross-cutting” measure on at least 50% of Medicare FFS patients
  - ▶ If fewer apply, then report on as many as applies to provider
  - ▶ (Only 4-6 “cross-cutting” measures available to therapists)
- ▶ If number of measures reported is less than required, EP is subject to the Measures Applicability Validation (MAV) process



# Caveats

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The foregoing material is the opinion of the undersigned and may not reflect the positions of any organization or governmental agency. The statements made herein are based on personal experience and research, and the speaker's interpretation of relevant statutes. The foregoing material should not be taken as medical or legal advice, nor should it be used to guide Medicare billing.

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# Appendix A

## Documentation Tips



# Tips to Improve Therapy Documentation\*

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- ▶ Ensure the medical records submitted provide proof the service(s) was certified and rendered.
- ▶ Ensure the medical records provide justification supporting medical necessity and that skilled services were needed.
- ▶ Create a complete plan of care, making certain to include your legible signature, professional identification (e.g., PT, OTR/L) and date the plan was established.
- ▶ Document when the plan of care is modified, including how it has been modified and why the previous goals were not met or could not be met.
- ▶ Confirm the plan of care is certified (recertified when appropriate) with physician/NPP legible signature and date.
- ▶ Clearly document, in minutes, the total time spent on timed-code treatment only and the total treatment time (including timed and untimed codes) in the patient's record.

\*Task Force Scenario: Documenting Therapy and Rehabilitation Services,  
CERT A/B MAC Outreach & Education Task Force, July 15, 2014

# Contents of Plan of Care

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- ▶ **Diagnoses.**
  - ▶ **Long term treatment goals** -- Should be developed for the entire episode of care and not only for the services provided under a plan for one interval of care.
  - ▶ **Type** -- May be physical therapy, occupational therapy, or speech language pathology, or when appropriate, the type may be a description of a specific treatment or intervention. When a physician or non-physician practitioner (NPP) establishes a plan, the plan must specify the type of therapy planned.
  - ▶ **Amount** -- Refers to the number of times in a day the type of treatment will be provided. When amount is not specified, one treatment session a day is assumed.
  - ▶ **Duration** -- Number of weeks or the number of treatment sessions for the plan of care.
  - ▶ **Frequency of therapy services** -- Refers to the number of times in a week the type of treatment is provided. When frequency is not specified, one treatment is assumed.
- 



# Documentation Supporting Exception

- ▶ Documentation must indicate that the **patient requires continued skilled therapy**, i.e., therapy beyond the amount payable under the therapy cap, to achieve his or her prior functional status or maximum expected functional status within a reasonable period of time.
- ▶ Clinicians are not required to submit special documentation to support an exception to the cap.
- ▶ Clinicians are responsible for consulting guidance in **Medicare manuals and professional literature** to determine if treatment above the cap is medically necessary.
- ▶ The **condition or complexity** that caused treatment to exceed the cap must be **related to the therapy goals** and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated so that it is appropriate to exceed the cap. Documentation should indicate **how the complexity** (or combination of complexities) **directly and significantly affects treatment**.
- ▶ However, the clinician's opinion is not binding on the Medicare carrier which makes the final determination concerning whether the claim is payable.

Reference: Medicare Claims Processing Manual, Chap 5, §10.3B



# Documentation Supporting Mandatory Manual Medical Review

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- ❖ Justification;
- ❖ Evaluation or reevaluation(s) for Plan(s) of Care;
- ❖ Certification of the Plan of Care;
- ❖ Objectives and measurable goals and any other documentation requirements of the Local Coverage Determination (LCDs) (**note:** objectives and goals should also include an estimation of reasonable time frame in which the patient could be expected to achieve the stated goals);
- ❖ Progress reports;
- ❖ Treatment notes;
- ❖ Certification or recertification for therapy services;
- ❖ Any orders, if applicable, for additional therapy services; and
- ❖ Any additional information requested by MAC.



# Documentation Needed for DMEPOS

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- ▶ Medicare requires that suppliers have access to information from the patient's medical record that addresses the coverage criteria for the items prescribed
- ▶ Patient's medical record must contain sufficient information about the patient's condition to substantiate the necessity for the type and quantity of the items ordered and the frequency of use or replacement.
  - ▶ Patient's diagnosis, duration, clinical course and prognosis
  - ▶ Nature and extent of functional limitation
  - ▶ Other therapeutic interventions and results
  - ▶ Past experience with similar items
  - ▶ Completed and signed Certificates of Medical Necessity (A/R)
  - ▶ Certification of continued need for equipment
- ▶ Key Items to address
  - ▶ Why does the patient require the item(s)? Signs and symptoms?
  - ▶ Do physical exam findings support need for the item(s)?
  - ▶ Diagnoses responsible for these signs and symptoms?
  - ▶ Other diagnoses which might relate to need for item(s)

# Documentation Supporting E0650 or E0651 Pneumatic Compression Device

- ▶ A PCD coded as E0650 or E0651 is covered for both primary and secondary lymphedema in beneficiaries with “chronic and severe” lymphedema when all of the following three requirements are met:
  - ▶ 1. The beneficiary has an accurate diagnosis of lymphedema as defined above, and
  - ▶ 2. The beneficiary has documented persistence over a period of at least six months of “chronic and severe” lymphedema as identified by the documented presence of at least one of the following clinical findings over this six month period:
    - ▶ Marked hyperkeratosis with hyperplasia and hyperpigmentation,
    - ▶ Papillomatosis cutis lymphostatica,
    - ▶ Deformity of elephantiasis,
    - ▶ Persistent ulceration superimposed on chronic edema, skin breakdown with persisting lymphorrhea, and
  - ▶ 3. In addition to this at least six months of documented persistence, the lymphedema is then documented to be unresponsive to other clinical treatment over the course of a required four-week trial.

# Documentation Supporting E0652 PCD and Truncal Appliances

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- ▶ A PCD coded as E0652 is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when all of the following are met:
  - The beneficiary has lymphedema of an extremity as defined above
  - The coverage criteria for an E0650 or E0651 are met
  - The beneficiary has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial.
  
- ▶ For PCDs coded as E0652 the medical record must contain sufficient detailed and specific information to show that the applicable coverage criteria above are met.



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# **Appendix B**

## **The Affordable Care Act and LE**



# Affordable Care Act Change Summary

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- ▶ Eliminates Annual & Lifetime Limits
  - ▶ Prohibits Rescissions
  - ▶ Improves Preventive Care
  - ▶ Expands Children & Young Adult Coverage
  - ▶ Improves Patient Appeal Rights
  - ▶ Limits Medicare Advantage Excess Profits
  - ▶ Shrinks Medicare Part-D Donut Hole
  - ▶ Eliminates Denial Due To Pre-Existing Conditions
  - ▶ Covers Medical Costs During Clinical Trials
  - ▶ Establishes Individual Insurance Mandate
  - ▶ Covered California (Insurance Exchanges)
    - ▶ Bronze, Silver, Gold, Platinum Plans
  - ▶ MediCal Expansion
- 



# Application of ACA

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- ▶ Applies to most Group and Individual Plans
  - ▶ Employer-Sponsored Group Health Plans
  - ▶ Private Plans
  - ▶ Some provisions apply to Self-funded Employee Plans
- ▶ Application not yet Defined
  - ▶ TRICARE Military Plans
  - ▶ Medicare Plans
  - ▶ MediCal Plans
  - ▶ Flexible Spending Accounts
  - ▶ Health Savings Accounts
  - ▶ Indian Tribal Governments
- ▶ Exempts “Grandfathered Plans”
  - ▶ Details currently under study



# Appeal Rights Changes

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- ▶ Notification of reason for denial
- ▶ Information about rights of appeal
- ▶ Required insurer response times
  - ▶ 72 hours urgent request
  - ▶ 30 days non-urgent request
  - ▶ 60 days denial of payment already received services
  - ▶ 60 days independent external medical review
  - ▶ Internal & external review requests together if urgent
- ▶ **California has had these in place before ACA**





# Essential Benefit Categories- DoL Study

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- ▶ DOL surveyed employer health benefit plan provisions 2008-9\*
- ▶ Twelve selected medical benefits surveyed, including
  - ▶ *Physical Therapy* (covered by 70%, not mentioned by 30%)
  - ▶ *Durable Medical Equipment* (covered by 67%, not mentioned by 33%)
  - ▶ *Prosthetics* (including. orthotics) (covered by 46%, not mentioned by 54%)
- ▶ *Physical Therapy* defined as services to restore movement, relieve pain and prevent further injury
- ▶ *DME* includes rental or purchase of equipment or therapeutic supplies to treat medical conditions or improve physical mobility
- ▶ *Prosthetics* are defined as artificial limbs. *Orthotics, supplies and equipment* to support or correct the function of a limb or torso, are sometimes combined with coverage for prosthetics.

\*Selected Medical Benefits: A Report from the DOL to the DHHS 4/15/11

# ACA Essential Benefits Categories

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- ▶ *Ambulatory patient services*
- ▶ Emergency services
- ▶ Hospitalization
- ▶ Maternity and newborn care
- ▶ Mental health and substance use disorder services, including behavioral health treatment
- ▶ Prescription drugs
- ▶ *Rehabilitative and habilitative services and devices*
- ▶ Laboratory services
- ▶ *Preventive and wellness services and chronic disease management*
- ▶ Pediatric services, including oral and vision care

# Essential Health Benefits (EHBs)

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- ▶ All ten categories of services and items must be covered by insurance offered in the individual and small group markets by January 1, 2014
- ▶ As an interim policy for 2014 and 2015, the Department of Health and Human Services allowed each state to identify an existing plan as a benchmark for these EHBs.
- ▶ The result of this policy is that EHBs vary from state to state, often because of a legacy of different state-mandated benefits
- ▶ The Data Brief “Essential Health Benefits: 50-State Variations on a Theme”\* analyzes state variation in coverage and limits for these non-uniform benefits.
- ▶ Whereas all states covered outpatient rehabilitation, 11 states imposed a quantitative limit on the benefit (20-60 visits/year).
- ▶ And it is not clear yet how the *Jimmo VS Sebelius* settlement will affect the state contracts.

\*“Essential Health Benefits: 50-State Variations on a Theme” Janet Weiner & Christopher Colameco, Robert Wood Johnson Foundation, October 2014

# The Bright Side: California Includes Lymphedema Compression Items as Essential Health Benefits

- ▶ **Insurance Coverage of Lymphedema Compression Bandages and Garments Starts Jan 1, 2014 in California.**  
[http://www.lymphactivist.org/ca\\_garment\\_coverage.php](http://www.lymphactivist.org/ca_garment_coverage.php)
- ▶ Title 28 California Code of Regulations
  - ▶ Emergency Regulation 2013-4186 Essential Health Benefits became effective 07/05/2013
  - ▶ Open for public comment 10/25 - 12/09/2013
  - ▶ Section 1300.67.005 Essential Health Benefits (in addition to those services and devices required to be covered under the Knox-Keene Act)
    - ▶ (d)(9)(B)(iii) **Compression burn garments and lymphedema wraps and garments**
  - ▶ See <http://wpso.dmhc.ca.gov/regulations/#1> for details

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## ACA Nondiscrimination Section §2706

- ▶ *“A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.”*
- ▶ An excellent summary by Taylor Walsh of the progress in the implementation of this section may be found at <http://altarum.org/health-policy-blog/integrative-health-care-the-implementation-of-aca-section-2706>



## ACA § 2706 and LE Therapy Practice

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- ▶ Went into effect January 1, 2014.
  - ▶ Applies to any insurance plan and to self-insured plans (ERISA).
  - ▶ Service must be medically reasonable and necessary, covered in the insurance plan, and in scope of the provider's state license.
  - ▶ Covers any state-licensed or state-certified healthcare provider including chiropractors, MDs naturopathic physicians, acupuncturists, massage therapists, osteopaths, nurse practitioners and podiatrists.
  - ▶ E.G.: When a massage therapist treats any health condition covered in an insurance plan (e.g., back pain, neck pain, lymphedema, etc), *the massage therapist is eligible for reimbursement*, so long as that provider is licensed by his or her state to treat the condition within his or her scope of practice.
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# ACA Grace Period Puts Therapists at Risk

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- ▶ Under ACA families with income 100-400% FPL can get tax credits, in advance, to pay for their insurance premiums.
- ▶ If individual fails to pay monthly premium, insurer is required to give 3-month “grace period” before canceling coverage.
- ▶ Qualified plan required to pay provider for 30 days, and can “pend” second and third month’s claims for services.
- ▶ If patient pays the premiums before the 3 months, claims are paid.
- ▶ If patient fails to pay by the end of the 3-month grace period, insurer can deny the claims due to patient’s having no insurance coverage.
- ▶ Provider can bill the patient, but it is unlikely collecting from a patient who could not afford the insurance premiums.

Taken from “60 Days of Free Therapy & You Don’t Even Know It”  
By Rick Gawenda, September 13, 2014.