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Wisconsin Society of Orthotists, Prosthetists & Pedorthists

WSOPP

Message From President

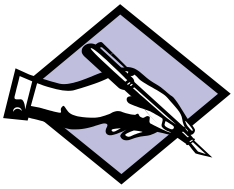
Moving forward, one step at a time

How do we, as a profession, stay current and viable when it seems like everything around us is changing? As a field that is as steeped in tradition and legacy as it is in new frontiers on technology, turning the page on our future seem like a insurmountable climb. We find ourselves today spending more time processing the paperwork in a clients chart then we do directly with our patients helping them achieve their functional goals. For many of us, this represents a monumental cultural shift in the way we do business on a day to day basis. A cultural shift that at first impression seems to take direct aim at our foundation. I have heard over the last several weeks many different viewpoints and impressions of the recent changes in documentation requirements and payment timelines; each seems to strike an emotional chord, and rightfully so. I have taken the opinion that the very visceral response that is rising is because the practitioners, technicians, administrative staff and vendors that we work with on a daily basis are as equally passionate about serving our patients as we are. There are few other professional trades that I feel have such a high level of compassion to their clients on all fronts as we do; we need to commend ourselves on this!

We also need to let this same passion drive us forward in a productive manner. One can spend countless hours resisting change and find that one is only further behind. Or, one can also spend the same hours improving themselves, their business practices and finding new ways to succeed. It is with this idea that we have changed the format of this particular newsletter. You will find the contents inside to be helpful in understanding some of the most recent changes to coding and policy as it pertains particularly to Medicare billings. WSOPP has not abandoned Licensure or Parity bills. However the Board of Directors as supported by the recent membership survey feels that much more research into the effects of either of these bills needs to be ascertained before any successful attempts can be made to pass ether bill.

Our next membership meeting will focus on some of the potential pitfalls that may come from these bills. This is an avenue that we have not before presented to the membership. I urge you join us for the discussion. We also have a representative from National Government Services CERT/ POE coordinator for our region joining us to discuss the audit process, changes in policy and documentation requirements. Due to this valuable information we are inviting all administrative staff to join us for the day as well. I hope that you will learn valuable information at this meeting.

Don't loose focus on serving our patients. The culture is changing, but the core of profession is not. Let our core be the foundation we need to improve our business practices and move forward.



Respectfully,
Andrea Pavlik, CO, CFm

Semi-Annual Membership Meeting

April 12, 2013

8:00 to 5:00

Kalahari Resort

Wisconsin Dells, WI

- *National Government Services*
- *Forensic O&P Consulting*

CEU'S applied for from ABC

To receive up-to-date information about Medicare and/or changes within the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC), National Government Services, Inc. encourages suppliers to sign up for the Jurisdiction B DME MAC electronic mailing list.

To subscribe to the Jurisdiction B DME MAC E-mail Updates, go to the National Government Services Web site:

- Locate **DME** as your Medicare contract/business type and select the **DME** home link
- Select the **Accept** button when presented with the Attestation page
- Once on the **Durable Medical Equipment Home** page, select **E-mail Updates** under the **Publications** tab located on the side navigation

Minutes: April 27, 2012 Membership Meeting

October 5, 2012 Meeting Location: Rock Gardens, Green Bay, WI

The business meeting was called to order by Andrea Pavlik at 1:05 PM.

1. Andrea introduced James Kaiser, CP as our afternoon speaker to discuss licensure and parity in O&P. Because of this the licensure and parity reports were tabled until after his presentation.
2. Andrea announced to those in attendance that Jack Schultz had recently passed away, and moment of silence was observed.
3. Andrea said thank you to the vendors that were present, and to Allard for the morning program.
4. The minutes from the spring meeting were then reviewed by the membership. Brian Kelsey made a motion to accept, seconded by David Castellanos. The motion carried and the minutes were approved.
5. The WSOPT bylaws were discussed. As there were two open director positions, it was asked whether or not we should amend the bylaws to change the number of director positions on the board to be narrowed from 3 to 1, leaving 5 board members. Andrea asked the membership to nominate peers for the director positions,
6. Committee report for communications:
    a. Andrea stated that she was looking for a new webhost for the WSOPP website, as our current host is MIA.
    b. Andrea advised the membership to save the date for 4.12.13 for the spring meeting, which will be at the Kalahari resort in the WI Dells. She asked for help with ideas and topics for that meeting
7. Committee report on Medicaid: One issue that Pam Hoffmann wanted clarification on processes and definitions in regards to preparatory prostheses. Chuck Schultz and Ken Uebele had helped format a response to Pam that included some definitions and an article dealing with residual volume.
8. Committee report from Treasury: Brian Kelsey told the membership that we have $48, 851 currently in our account. Our account is being audited by an accountant per the bylaws.
9. Jim Kaiser presented on parity and licensure in O&P. Brian Kelsey reviewed the course of our parity battle to this date. An open discussion ensued about the role of a parity bill with the State, plus general concerns on the Affordable Care Act and how it will affect our trades, and the consensus was that since a bill was introduced on the national level, it was wiser to focus legislative and financial means towards a licensure bill. The Board agreed to investigate and move forward to determine costs and potential sponsors for a licensure bill.
10. The meeting was adjourned at 3:30 pm.

Minutes reported by David Castellanos, CPed

Communication Committee

Do you have a
question or concern regarding
O&P issues
within the state?

www.wsopp.org

offers some information and has an option to contact us easily!

Treasury Report

Treasury
maintained by:
Brian Kelsey, CPO
Balance as of newsletter printing:
$45,302.36

All accounts are in good standing. Books have been officially transferred and accounts updated with new Board personnel names.

Mastectomy Bra Billing Issues

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC), has received several questions regarding mastectomy bras and upgrading. The long narrative description for Healthcare Common Procedure Coding System (HCPCS) L8000–L8002 indicates that the bra may be constructed of any material (e.g., cotton, polyester or other materials), with any type or location of closure, any size, with or without integrated structural support (e.g., underwire). L8015 describes a camisole-type undergarment with polyester fill used post mastectomy.

Upgrade billing is not permitted for mastectomy bras (L8000–L8002, L8015), despite any characteristics, features, or prices involved. Suppliers who bill claims for mastectomy bras as an upgrade will have claims returned as unprocessable with American National Standard Institute (ANSI) 4 due to incorrect modifier. Claims returned as unprocessable will need to be corrected by the supplier and resubmitted.

Suppliers who have chosen to be nonparticipating suppliers may bill the claim as nonassigned in order for the beneficiary to cover the difference in price.

Please refer to the external breast prostheses local coverage determination and policy article located on the National Government Services Web site.

Printed from the Jurisdiction B Connections December 2012 Update (page 43)

"Change is the law of life.
And those who look only to the past or present are certain to miss the future.
- John F. Kennedy

HCPCS Code L0430—Invalid

Effective for dates of service on or after November 17, 2012, Healthcare Common Procedure Coding System (HCPCS) code (L0430—Spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted [dewall posture protector only]) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Products previously coded L0430 by the Pricing, Data Analysis, and Coding (PDAC) contractor and posted to the Durable Medical Equipment Coding System (DMECS) will be end dated on November 17, 2012. For more information on the DMECS, visit the DME Coding System (DMECS) Info Web page.

Manufacturers, distributors, or suppliers previously billing for L0430 should submit a Coding Verification Review Application to the PDAC to determine the correct billing code.

The PDAC coding verification review application required for these products is the orthotics application. This application is located on the PDAC Web site.

If you have questions, please contact the PDAC Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. central time, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact form located on the PDAC Web site.

Refer to the Spinal Orthosis: TLSO and LSO local coverage determination and policy article for additional coverage, coding, and documentation requirements.

Do you have these sites bookmarked?

Www.dmepdac.com - sign up for coding updates. Site contains information on coding, fees, product coding

www.ngsmedicare.com– Site contains all LCD's, Policy articles, updates.

Documentation for K Levels for Prosthetics

National Government Services, the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) has received several inquiries in regards to what documentation must appear in the medical record to support the K level for prosthetics.

Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

1. The beneficiary's past history (including prior prosthetic use if applicable); and

2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and

3. The beneficiary's desire to ambulate.

This information must be documented by the **treating physician and the prosthetist**.

The medical record should reflect that a comprehensive medical assessment has occurred. The medical record should include, but is not limited to, past history, current functional capabilities and the beneficiary's expected functional potential, including an explanation for the difference, if that is the case. The medical record should establish the severity of the beneficiary's condition and the immediate and long term need for the prosthetic and the therapeutic benefits the beneficiary is expected to realize from its use. An entry in the medical record of therapeutic effectiveness or benefit based on speculation or theory alone cannot be accepted. When restoration of function is cited as a reason for use of the prosthetic, the exact nature of the deformity or medical problem should be clear from the medical evidence submitted. Also, the manner in which the prosthetic will restore or improve the bodily function should be explained by the treating physician. The K-level selected must be consistent with the overall health status of the beneficiary.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of prosthetic.

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"Never doubt that a small group of thoughtful, committed people can change the world. Indeed it is the only thing that ever has. - Margaret Mead

Note: Suppliers are reminded per the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, *Medicare Program Integrity Manual*, Chapter 5, Section 5.7–5.9, supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes

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Billing for Cancelled orders for Custom devices

National Government Services, the Jurisdiction B Durable Medical Equipment Administrative Contractor (DME MAC) has received several questions regarding the billing of expenses for custom-made items that have been canceled or not picked up by the patient. The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 20.3 states the following:

"If a custom made-item was ordered but not furnished to a beneficiary because the individual died or because the order was canceled by the beneficiary or because the beneficiary's condition changed and the item was no longer reasonable and necessary or appropriate, payment can be made based on the suppliers' expenses."

• What should the date of service on the claim be?

In such cases, the expense is considered incurred on the date the beneficiary died or the date the supplier learned of the cancellation or that the item was no longer reasonable and necessary or appropriate for the beneficiary's condition.

• What Healthcare Common Procedure Coding System (HCPCS) code should be used?

Suppliers should only bill for the components to the custom orthotic/prosthetic that could not be placed back on the shelf for resale or otherwise used by another patient. If the component has an assigned HCPCS code the component should be billed under that code. If the component does not have an assigned HCPCS code, a not otherwise classified HCPCS code should be billed. Suppliers should refer to the applicable local coverage determination (LCD) and policy article (PA) to determine the appropriate HCPCS codes that should be billed.

• Does the claim have to be filed as assigned?

No, if the beneficiary died or the beneficiary's condition changed and the item was no longer reasonable and necessary or appropriate for the beneficiary's condition, payment can be made on either an assigned or nonassigned basis. However, if the beneficiary, for any other reason, canceled the order, payment can be made to the supplier only.

• How much will the supplier be paid?

The allowed amount is determined, based upon the services furnished and materials used. Suppliers should only bill for incurred expenses up to the date they learned of the beneficiary's death or of the cancellation of the order or that the item was no longer reasonable and necessary or appropriate. The DME MAC, determines the services performed and the allowable amount appropriate in the particular situation. It takes into account any salvage value of the device to the supplier.

If a supplier breaches an agreement to make a prosthesis, brace, or other custom-made device for a Medicare beneficiary (e.g., an unexcused failure to provide the item within the time specified in the contract), payment may not be made for any work or material expended on the item. Whether a particular supplier has lived up to its agreement, of course, depends on the facts in the individual case. Therefore, it is recommended that suppliers provide the beneficiary with a contract which specifically outlines the item that will be made and provided and the amount of time expected to deliver the item.

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"People who work together will win, whether it be against complex football defenses, or the problems of modern society."- Vince Lombardi

WSOPP

Wisconsin Society of Orthotists, Prosthetists & Pedorthists

WSOPP– Communications
ATTN: Andrea Pavlik, CO
1344 North Taylor Drive
Sheboygan, WI 53083

Phone: 920-803-9610
Fax: 920-803-9611

We're On the Web!!!
Www.WSOPP.ORG