Medicare: Reasonable and Useful Lifetime

WHAT IS

S THAT!

Ken Berley and Jan Palmer

In writing this article, I have partnered with my dear friend, Jan Palmer. Hopefully, together, we can shed some light on the complex subject of Medicare "same or similar" regulations, which have recently resulted in the routine denial of Medicare OAT claims. Federal regulations on the Reasonable and Useful Lifetime (RUL) of a piece of Durable Medical Equipment is a complex matter and readers are, hereby, forewarned that this is the most complicated article that I have attempted on the subject of Medicare Billing.

WARNING, this will be boring! With that said, I cannot thank Jan enough for keeping me straight and for her tireless efforts to advance the field Dental Sleep Medicine and Medical Billing.

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History of Medicare Durable Medical Equipment (DME) for Oral Appliance Therapy

Dental Sleep Medicine (DSM) took a giant leap forward in 2011, when the Centers for Medicare and Medicaid Services (CMS) opened the door for dentists to participate in Medicare, by offering Oral Appliance Therapy (OAT) for the treatment of Obstructive Sleep Apnea (OSA). At the urging of the American Academy of Sleep Medicine (AASM), OAT was classified as DME, which is a subcategory of Medicare Part B. As a result, when dentists provide OAT for Medicare patients, they are functioning as a medical equipment supplier. While we do not issue canes or wheelchairs, dentists, providing OAT, are not view by Medicare as a healthcare provider. The decision to place OAT within DME ensured that Sleep Physicians would maintain oversight of Oral Appliance therapy and remain in control of patient care. This is due to the fact that all DME requires a physician's prescription before the equipment can be dispensed. Therefore, no dentist can legally fabricate an oral appliance for the treatment of OSA, without a prescription from a supervising prescribing physician. As a consolation prize for dentists, Medicare did included verbiage which limited the fabrication of an oral appliance (OA) to a licensed dentist. Therefore, any physicians that are fabricating oral appliances for Medicare patients are in direct violation of the currents CMS regulations. Therefore, for a beneficiary to qualify for OAT benefits, a sleep physician, must diagnose the patient's OSA, and the supervising physician must write a prescription for OAT which must then be filled (provided) by a licensed dentist. The diagnosing sleep physician's notes must reflect the OSA diagnosis. Dentists get their authority to treat an OSA patients from the diagnosing and prescribing physicians and must rely on the notes of these practitioners to document the appropriateness and medical necessity of OAT for reimbursement.

Regulations Outlined

The local coverage determination (LCD) L33611 and related policy article A52512 outlines what is necessary for OAT to be a covered service. Some of the more commonly misunderstood criteria are:

a) The beneficiary must have a face-to-face examination with a physician prior to the diagnostic PSG/HSAT, a copy of this summary should be readily available should Medicare request the notes (good practice to obtain prior to treatment), and

b) The detailed written order must be issued (signed and dated) by the prescribing physician and the MAD must be delivered, within the 6-month period from the date of the pre-diagnostic face to face examination visit to appliance delivery, and

c) The diagnosis of any SDB must be made by a sleep physician and any diagnostic testing for SDB must ordered by a physician. The LCD specifies a dentist may not order the diagnostic test, it is the responsibility of the supervising physician to determine the appropriate treatment based on the severity of the beneficiary's SDB, and

d) It is acceptable if the physician that ordered the diagnostic test is not the physician that signs the detailed written order (DWO) for OAT. An example of this would be: Beneficiary sees primary care physician, discussed sleep related issues, PCP orders a PSG/HSAT which is interpreted by a board-certified sleep MD. The beneficiary may see the PCP or other physician qualified to treat SDB after an OSA diagnosis who then determines the appropriate therapy for the treatment of the patient's OSA. It should be noted that a post diagnosis appointment with a physician is not mandatory under the LCD.

The OA must be issued (provided) by a licensed dentist, as a medical supplier, this makes it possible for dental offices to enroll as DME suppliers. (Physicians cannot legally provide OAT and bill Medicare). OAT is a covered Medicare benefit if appropriate for the patient and medically necessary. Once an OSA diagnosis is made by a physician, the treating dentist is provided a signed DWO (prescription) for OAT. The supplier/dentist is then required to provide a Medicare approved appliance that has been fabricated by a Medicare approved lab. The information on which labs and appliances are Medicare approved, can be found on the Pricing, Data Analysis and Coding (PDAC) website www.dmepdac.com.

Readers should refer to Local Coverage Determination (LCD) L33611 and the related oral appliance policy articles (A52512 and A55426) for documentation requirements for OAT for treatment of OSA. A thorough understanding of the LCD and related articles is mandatory for any dentist filing Medicare. Therefore, keep these articles available as a reference!

Reasonable and Useful Lifetime for DME

Under Federal regulations at 42 CFR 414.210(f), the Reasonable Useful Lifetime (RUL) of DME, states that the RUL of any piece of DME is to be not less than five (5) years. Under the RUL, Medicare will not benefit multiple pieces of DME that are utilized to treat the same condition. For example, Medicare would likely refuse benefits for a motorized battery powered wheelchair and a standard wheel chair. The same or similar provision is an attempt to prevent the payment of duplicate therapy (i.e. you only get one wheelchair). Therefore, if Medicare has paid for a piece of DME for the treatment of OSA, any new claim that you submit within 5 years for the treatment of OSA will be denied. A beneficiary cannot have two pieces of DME that have been determined to be the "Same or Similar" to treat OSA.

Sadly, CMS has determined that CPAP and OAT are "similar" pieces of DME use to treat OSA. Medicare will pay for the replacement of a piece of DME during the first five years of use if the item is lost (due to extenuating circumstances such as flood, hurricane and natural disasters), irreparably damaged or the beneficiary's medical condition changes such that the current equipment no longer meets the beneficiary's needs. Replacement due to irreparable wear during the period of reasonable useful lifetime is not covered. Since CPAP and OAT have been classified by CMS as same or similar devices, under the RUL guidelines, Medicare will only pay for one of these therapies every 5 years for the treatment of OSA.

March 2018: Medicare Same or Similar Denials

For the last seven years, dentists have been filing Medicare for OAT without any significant problems. Then in March 2018, CMS updated their system in response to the increased payments for OAT. The "Same or Similar" system update was in response to some patients utilizing both CPAP and OAT, which violates CMS regulations. Medicare's system is now fully updated and programed to automatically deny any claim for OAT if Medicare has paid for CPAP within the last 5 years. The enforcement of the CMS "same and similar/ RUL" policy has significantly affected many DSM practices. Since the March update, the OAT Code is linked to the CPAP Code as same or similar devices for the treatment of OSA. Therefore, as of March 2018, if a Medicare beneficiary has had a CPAP for more than 90 days within the last 5 years, any claim submitted for OAT will be denied.

Why is 90 days the magic number? During the initial 90 days of PAP rental, the treating physician is expected to evaluate whether CPAP is the best therapy to treat the beneficiaries OSA. Once satisfied with compliance and efficacy of CPAP therapy, the treating physician signs a Medicare CPAP Certification. Certification is appropriate whenever the beneficiary utilized CPAP for 4 hours or more per night for a minimum of 21 out of any 30-day period within the first 90 days of CPAP usage. If a Medicare patient has had a CPAP for more than 90 days, you can be sure that Medicare has funded the PAP therapy. Once the certification is signed and Medicare pays for the PAP therapy, any oral appliance submitted will deny due to RUL.

CMS position on Same or Similar for OAT

Repeated letters to the Medical Directors at CMS, have finally resulted in some concessions. It is now the position of CMS, that if a dental practitioner can provide documentation showing that CPAP usage has been discontinued by the treating physician, that all Medicare regulations were followed to the letter, and all payments for PAP therapy have ceased, then, and only then, Medicare may will benefit OAT.

Documentation Needed for Appeals?

What if the patient fails PAP after 91 days of use?

If the beneficiary "fails" PAP therapy after day 91, the probability of overturning a denial significantly decreases. The claim will be denied due to the RUL regulations. Treatment timeline must be well documented, and the ordering physician must now enter an order to "discontinue (DC) PAP therapy" and order OAT. If the ordering physician's notes do not show that CPAP was discontinued, Medicare will not benefit OAT. As a side note, these requirements are problematic from a legal standpoint, as no reasonable Sleep Medicine Professional should DC any therapy without an alternative therapy in place. In other words, if PAP has been prescribed by a physician, it might be a breach of the standard of care to DC this therapy before a MAD has been delivered.

Additionally, the beneficiary's DME PAP supplier must discontinue billing Medicare for PAP expenses and the supplier's notes must reflect that PAP was discontinued. The PAP supplier's notes should be included in any denial reconsideration and show that all PAP expenses have ceased. The ordering physician's treatment notes must document why the Medicare beneficiary failed PAP and show that a valid attempt was made to comply with therapy. The treating dentist cannot provide this documentation, it MUST come from the ordering physician.

What if the patient fails CPAP before Certification?

If the ordering sleep physician determines that the beneficiary has not met the requirements for PAP certification, it is extremely important that the sleep physician's notes document that the PAP was discontinued and why it was ineffective. A MAD fabricated and delivered prior to the certification of PAP will be paid with no denial. Therefore, it is ideal if the diagnosing physician can determine the most appropriate treatment for the beneficiaries' SDB as soon as possible to give DSM practitioners adequate time to deliver a MAD within the first 90 days of treatment. Unfortunately, DSM providers will likely have a difficult time delivering a MAD within the first 90 days of OSA therapy if PAP is dispensed initially due to scheduling and fabrication time. Therefore, most Medicare beneficiary's that are referred for OAT will likely have a claims history which will include a payment for PAP within the last 5 years and OAT denial is likely.

You received your first denial, now what?

Appeal:

The first level of the appeals process requires that you submit a "redetermination". The Medicare redetermination request form is available at https://www.cms.gov/ or on your DME jurisdictions website. When filing a redetermination, include as much documentation as you have to support overturning the denial of your claim, such as the physicians written order, (which must be dated within 6 months of the original face to face office visit pre-diagnosis), the diagnosing physician's office notes for the face-to-face examination, a copy of the sleep test (PSG or HSAT), PAP prescription, DWO, physician's office notes regarding PAP failure, PAP discontinuance order, the treating dentist's clinical intake examination and delivery appointment notes and a copy of the denial. The redetermination must include any and all supporting documentation necessary to prove medical necessity for OAT after DC of PAP. Include the PAP supplier notes if available, to show that PAP expenses are no longer being billed to Medicare. This will show that the beneficiary is not utilizing combination therapy, which would be a violation of Medicare regulations. Include the physician's notes to explain any lapse in the continuation of care. For example: (PAP returned 12 months ago and there has been a lapse in treatment). Your dental intake examination and the order sleep physician's notes should document how the beneficiary's symptoms have worsened making OAT "medically necessary".

The more medical justification you provide, the better the chance of overturning the denial. The more time that the rental of PAP is over day 91, the less chance you have of a successfully outcome.

What if the redetermination is denied?

A Level II appeal is your next course of action which is known as a "reconsideration" of the claim. Again, the appeal must be requested in writing and the necessary form can be obtained at https://www.cms.gov/. It is essential to include all supporting documents that you have available. Explain why the denial of your redetermination was inappropriate. The reconsideration request will be reviewed by the qualified independent contractor (QIC) for your jurisdiction. This is the last level of the appeals process which allows you to submit supporting documentation, therefore, it is imperative to include all the information you have that can support overturning the case.

Advanced Beneficiary Notification (ABN)

Given, the system update and restrictions associated with the "Same or Similar" policy, it is vitally important to determine whether the Medicare same or similar restrictions will apply for any Medicare beneficiary. If you determine that a patient's Medicare claim for OAT will be denied under RUL, it may be advisable to have that patient execute an Advanced Beneficiary Notification (ABN) to inform the patient that their Medicare claim will likely be denied. The ABN places the beneficiary on notice that if the Medicare claim is denied, then they will be personally responsible for the charges for OAT. If you fail to obtain a signed ABN from the patient prior to rendering the service, your practice will not be able to collect any amount due from the patient when Medicare denies your claim. Without a properly executed ABN, the providing dentist cannot charge the beneficiary for the OAT. Therefore, a signed ABN may be

useful when a RUL denial is expected. A denial should be expected when a Medicare beneficiary is referred for OAT and there has been more than 91 days since the beneficiary was placed on PAP. Participating and non-participating Medicare suppliers should execute an ABN prior to impressions when a Medicare denial is anticipated. When presented with the probability of a denied Medicare claim, the beneficiary can make an informed decision.

Unfortunately, if an ABN is signed, the appropriate modifier must be used when filing to inform Medicare that an ABN has been executed. This act ensures that your Medicare claim will be denied and makes a reversal of this denial more difficult. When submitted with the appropriate ABN modifier, Medicare is placed on notice that "the supplier feels the item will not be a covered service and the beneficiary has been informed of this fact and understands why the item will not be a covered by Medicare." Refer to the LCD for more information regarding correct coding for oral appliances that do not meet Medicare guidelines.

If an ABN is on file and the office is instructed to submit to Medicare, when the claim is submitted correctly the resulting denial will indicate that the beneficiary is responsibility for the charges. Providers should be aware that they are then required to collect the fee that was submitted. (i.e. if you file for $6500.00, you are required to collect that amount).

If the beneficiary is willing to forego filing the claim to Medicare, a cash discount may be possible. The patient becomes a cash patient when an ABN is executed, and option B is selected on the ABN document. If option B is selected, the patient must understand why no Medicare coverage is expected and that you will not file a claim with Medicare for the OAT. Under that scenario the patient becomes a cash pay patient and could be offered an appropriate cash discount.

Extra Tip:

Most offices are unaware that some medical insurance companies, may refuse to allow you to collect from a patient, on denied claims if you are in-network. Therefore, prudent practitioners may want to start utilizing an advanced patient notice for services that a private payer might not cover. Some payers will accept the Medicare ABN, but some have their own form. If you are in-network with one or more medical insurance companies, you should check with those payers and see if they have an ABN-type notices for your use.

What if a physician orders OAT as the first line of treatment and it is not effective?

If OAT is the first line of treatment, the ordering physician is responsible for evaluating and documenting the effectiveness of the therapy. Once the sleep physician determines that OAT is inadequate, PAP may be ordered if the beneficiary qualifies under LCD L33718. Again, a claim for PAP will automatically be denied as not reasonable and necessary when submitted. The PAP will be classified as "same or similar treatment within the 5-year RUL". Timing is of the essence, however, if PAP is initiated immediately after failing OAT, the denial would have the possibility of being overturned at first level appeal. PAP will always receive preferential treatment.

Why wasn't the dental sleep medicine community Notified?

Medicare jurisdictions are continually updating their systems, since there was no policy change, no notification was required. Same or similar/RUL has been in place since 2001. This is not a new policy; the system was just updated to apply to CPAP and OAT.

Conclusion:

Once diagnosed with OSA, the treating physician has the option of choosing what therapy is best for that beneficiary. Commonly, sleep physicians prescribe PAP as first line therapy. Once PAP is dispensed, there is a 90-day certification period where the beneficiary must document usage of 4 hours per night for 21 nights in any 30-day period during the first 90 days of treatment. If the beneficiary satisfies these requirements, the sleep physician will certify that the beneficiary has been successful, and Medicare will pay for the PAP. If the beneficiary does not qualify for PAP during the 90-day certification period, Medicare will not reimburse for the PAP and the beneficiary is eligible for benefits for an OA. If your patient has utilized PAP therapy more than 90 days, your Medicare claim for OAT will be denied. However, on appeal, you have a reasonable chance of receiving payment, if and only if, you have followed Medicare rules to the letter and you provide the necessary documentation on appeal to prove that ALL the rules have been followed AND there is no way for the patient to wear CPAP. The problem is that the time and effort required to secure the documentation and file the appeals puts an amazing amount of work on your billing staff. In my office, we are currently too busy to appeal each Medicare claim. So, we have each Medicare patient sign an ABN. The more difficult question is whether you require an ABN to be executed before you treat a Medicare patient. We live in an affluent area where the majority of Medicare patients can proceed with treatment when required to pay cash. However, if you initiate this policy, a significant portion of your Medicare patients may be unable to finance treatment. Additionally, if the patient signs an ABN, CMS regulations require that you must use the appropriate modifier to designate that you have an ABN of file and any appeal of the resultant denials are almost always unsuccessful.

It is equally important to inform your referring physicians of the consequences of this update and how it will affect their patients. It is possible that DSM may have received an unexpected benefit because of the March update, in that, it may be easier to document that OAT is ineffective, than document the ineffectiveness of PAP. Only time will tell, however under RUL, OAT may be the best choice as first line therapy for mild to moderate cases. A discussion with your referring physicians could prove beneficial to your DSM practice.

About The Authors

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Dr. Ken Berley has practiced dentistry in Arkansas for over 35 years and practiced law for over 22 years and is licensed in Arkansas and Texas. He is Diplomate of the American Board of Dental Sleep Medicine and a Fellow of the American College of Legal Medicine. For the past 10 years he has focused on the practice of sleep disordered breathing and has developed many of the forms and consents routinely used in sleep medicine. Dr. Berley and his wife Patty, own Berley Consulting, providing mentoring, training and forms for those practitioners wishing to take their DSM practice to the next level.

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