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Medicare Same or Similar Policy: How to avoid denials and how to win appeals

Summary

The Medicare Same or Similar Policy as well as the Reasonable Useful Lifetime (RUL) policy have been in place for many years. Over the past 2 years, due to a surge in fraudulent claims for DME devices submitted to Medicare, there has been increased surveillance of claims looking for violation of the Same or Similar policy. Enforcement of the Same or Similar policy has been across the board, affecting all types of extremity braces and spine braces. In short, a small group of telemedicine DME providers fraudulently billed Medicare for multiple braces for the same patient over the past 3 years resulting in significant financial loss for the government. As a result, Medicare is now reviewing claims for any beneficiary receiving more than one brace within a 5 year period.

Background

Denials for claims for AFO devices based upon Same or Similar regulations have previously been due to replacement of the same device within 5 years of the date that the original device was dispensed to the patient. Medicare has always defined that the Reasonable Useful Lifetime (RUL) is 5 years for any lower extremity brace or prosthesis. Medicare will cover ***replacement*** of the AFO brace within the 5 year limit if the device ***"has been lost, irreparably damaged or the patient's medical condition changes such that the current brace no longer meets the patient's needs."***

The term "irreparable damage", like loss or theft is considered by Medicare to be a rare, unexpected event that is an exception to the reasonable useful lifetime rule. Irreparable damage refers to a specific accident or to a natural disaster, e.g., fire, flood etc. Loss or theft of a lower extremity brace, or damage from an accident would require documentation of the exact circumstances as pre-payment audit or denial of the claim would be likely.

Irreparable damage, according to Medicare, is not the same as wear and tear from daily use. In those cases, ***repair*** but not ***replacement*** of the AFO brace would be covered by Medicare.

Repair and refurbishment

Medicare will reimburse the provider for the cost of replacing parts of the AFO brace, but not replacing the entire brace if it is still within 5 years of use. These parts include ankle joints, limb supports, soft interface padding, straps and external posting. However, the plastic cannot be re-formed to its original shape if it has been flattened or deformed. This is a common occurrence for many patients who are prescribed custom AFO devices.

Extreme biomechanical conditions and forces which mandate custom AFO treatment will often wear out the brace in less than 5 years of daily use. This wear most commonly results in flattening or distortion of shape of the plastic portion of the brace. When the shape or conformity of an AFO brace has become flattened or the plastic has lost rigidity, the brace now has become irreparably damaged. Inexplicably, Medicare does not recognize that wear and tear can cause this deterioration and failure. Herein is another flaw in the Medicare policy which can affect patient welfare.

In this case, the provider should document the fact that the current brace is no longer addressing the medical condition and is no longer meeting the patient's needs. This documentation is mandatory as the claim for a replacement, identical brace in less than 5 years of use will likely trigger a pre-payment audit or denial. Appeal with proper documentation, including photographs will be necessary to gain payment. Because the provider is aware that reimbursement for a replacement brace in less than 5 years is unlikely to come from Medicare, the patient should be informed and should sign an Advanced Beneficiary Notice (ABN).

The following modifiers should be used for repair or replacement of a brace:

Modifier RA - The RA modifier is described as replacement of a DME item, due to loss, irreparable damage, or when the item has been stolen.
Modifier RB - The RB modifier is used for replacement parts furnished in order to **repair** beneficiary-owned DMEPOS.

Providing a Different AFO Brace within 5 years

Unknown to many practitioners is the fact that providing a ***different type*** of ankle brace or AFO within 5 years of a previous brace dispensal will not always qualify for payment by Medicare. A long-standing "Same or Similar" policy has been in place with Medicare which specifies by code, all braces considered similar and which cannot be substituted for another brace previously dispensed to the patient within 5 years. The grouping of braces considered "Same or Similar" by Medicare defies logic or any valid interpretation of functionality and medical necessity of various braces

in the medical marketplace. Reviewing the many types of braces on the list reveals the fact that few, if any, are truly "Same or Similar."

In short, the "Same and Similar" classification of braces by Medicare is unfair, unjustified and truly harms the end-user: the patient. It should be noted that the illogical grouping of pre-fabricated with custom braces as "Same or Similar" by Medicare has been applied to all types of DME devices including upper extremity braces and spine braces.

What Lower Extremity Braces are Considered Same or Similar by Medicare?

Here are the lower extremity braces and codes considered same or similar by Medicare: (Common braces prescribed and dispensed by podiatrists and orthotists are in bold)

L1900, L1902**, L1904, L1906, L1907,** L1910, L1920, L1930, **L1932, L1940,** L1945, L1950, L1951, **L1960, L1970, L1971,** L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2126, L2128, L2132, L2134, L2136, L4350, **L4360, L4361, L4370, L4386, L4387, L4396, L4397, L4398, L4631**

In summary, once ANY brace on this list is dispensed to a patient and billed to Medicare, that patient is not eligible to be covered or reimbursed for any other brace on the same list for the next 5 years. Although this rule is specific for the same extremity (Right or Left) it is not limited to one single medical condition. No matter what the medical condition, whether new or identical to the previous condition, Medicare will reimburse for only one brace from this list, per extremity during a five year period.

To put this conundrum into perspective, consider that there are inexpensive, prefabricated lace up ankle braces (L 1906) on this list as well as custom hinged ankle-foot orthoses. In order to be compliant in billing for a custom AFO, Medicare requires justification from the provider why a patient would need a custom, rather than a pre-fabricated brace. One provision, stipulated by Medicare, is that the patient "could not be fitted" or could not benefit from a pre-fabricated brace. Many practitioners will attempt fitting and dispensing a pre-fab brace before considering a custom brace. Yet, if the practitioner provides a pre-fabricated brace first and bills Medicare for the device, the patient is no longer eligible for coverage for a custom brace for another 5 years.

The standard of care for most musculoskeletal conditions or injuries is implementing immediate, temporary immobilization. This may be in the form of a pre-fabricated ankle brace (L 1906) or a walking boot (L 4361). In some cases, the patient will subsequently require long term stabilization with an AFO brace, either custom (L 1970) or prefabricated (L l971). According to the Medicare "Same or Similar" policy, the standard of care in implementing immediate, less expensive

temporary immobilization will ***disqualify the patient from coverage*** for a vital long term treatment of their medical condition.

Finally, consider a patient who has the mis-fortune of suffering an acute lower extremity injury which only requires temporary immobilization with a prefabricated brace or a walking boot. What if this same patient later acquires a ***new and different*** neurologic condition which requires permanent custom bracing? According to Medicare, this patient is ineligible for coverage of the necessary treatment with a new and different brace which happens to be on the Same or Similar list as the first brace. Again, the patient is denied appropriate treatment because of this flawed policy. Clearly, the patient is entitled to advocate for appropriate standard of care and directly appeal to Medicare.

Are there any remedies or options when confronted with the Same or Similar policy?

While the Same or Similar Medicare policy appears to unjust and unfair to the patient, it is that same patient who has the best chance to get the policy reversed in their best interest. If the patient has a new medical condition and received a different brace for an old medical condition within 5 years, they should be justified in receiving and gaining coverage for a new brace. If the doctor followed standard of care an implemented immediate, less expensive immobilizing protocols in the initial treatment, the patient should not be penalized from coverage for long term treatment with a different device if medically necessary. Often times, the claims reviewer will agree with this logic as long as fraud is not suspected. Most fraudulent claims for DME products are submitted to Medicare without the knowledge of the patient beneficiary. When a patient notifies Medicare that they are well aware of their need for a new brace, a significant level of validity to the claim is provided.

Medicare will listen to the patient before listening to the prescribing doctor or provider of the DME device. If the patient calls Medicare directly ahead of time and informs them that they have a new medical condition and require a specific lower extremity brace. The patient should request that their file be updated with this new information. Then, when the new claim is submitted by the provider, often times the claim is paid without need for appeal. If a claim is denied for coverage, the patient can help in the appeal process by verifying their notification of Medicare that they had a new medical condition or that their previous brace had been lost, stolen or irreparably damaged.

The provider should anticipate a potential denial of reimbursement from Medicare under the Same or Similar policy whenever a lower extremity brace is dispensed to a eligible beneficiary. In a matter of minutes, the provider or staff can access the DME MAC provider portal for their region and obtain an accurate history of any lower extremity brace previously dispensed to a patient which may fall into the Same or Similar category of the brace which is intended to be prescribed or dispensed. If indeed the patient had received a brace on the list of Same and Similar

within the past 5 years, the patient should be asked to contact Medicare and update their file with necessary information as to why the new brace is needed. Unless the medical condition has changed, the patient should be provided and should be asked to sign an Advanced Beneficiary Notice (ABN) from the provider documenting that the patient has been informed that Medicare may not cover or reimburse for the cost of the new brace. The patient should also be re-assured that the practitioner will actively appeal any denial of the claim submitted to Medicare based upon medical necessity of the device and welfare of the patient.

GUIDELINES FOR DISPENSING AND BILLING MEDICARE FOR AFO BRACES

VERIFY

1. All Medicare patients should be informed of the Same or Similar policy and should be asked if they have ever received a lower extremity brace or walking boot within the past 5 years.
2. Regardless of whether a patient is aware of their past brace history, the provider should utilize their DME MAC provider portal to gain ***quick access*** to previous payment by Medicare for the patient covering codes for ankle braces, walking boots and AFO devices.
3. All providers should enroll in their their respective DME MAC provider portal. The websites for the 4 DME MAC regions are:
   For DME MAC JA:
   https://med.noridianmedicare.com/web/jadme/topics/nmp
   For DME MAC JD:
   https://med.noridianmedicare.com/web/jddme/topics/nmp
   For DME MAC B and C: https://mycgsportal.com/mycgs/
   Once you access the provider portal, there is a tool which allows a simple enrollment procedure.
4. Once enrolled, a provider can access the DME MAC provider portal to gain information about any specific DME product which has been previously provided to a specific patient. A code range can be entered which covers all codes between L 1900 and L 4631 which are the Same or Similar lower extremity braces. The provider will see any braces dispensed within the past 5 years to this patient in this region only. If the patient has lived in other regions over the past 5 years, then all four portals should also be accessed.
5. If no braces appear in the 5-year history, the provider and patient can proceed with the treatment plan assuming reimbursement from Medicare if the medical necessity is justified in the medical record***. There is no need to follow the next steps if no braces appear in the previous 5 year history for this patient.***

EMPOWER THE CUSTOMER/END USER

1. If one or more braces show up in the past 5 year history of the patients DME record, the patient should be informed of the possibility that Medicare will not reimburse for a new brace. The patient should now be encouraged to become an advocate for their own health by telephoning Medicare directly

and informing them that the patient will be needing a new brace and the reasons why.

2. The patient should telephone Medicare using the phone number on the back of their card. ***The process to speak with a representative, inform them of the new condition and need for a new brace should take less than 5 minutes.*** The patient should request that their file with Medicare be updated with the specific request for coverage of a new or replacement lower extremity brace based upon medical necessity. Often times, this is all that is necessary for the provider to obtain reimbursement when the claim for the new brace is submitted to the DME MAC. If not, this updated file will be helpful in the event that an appeal of the claim is necessary.
3. The patient should document the date and time of the phone call and, if possible, the name of the representative whom they spoke with at Medicare.

DOCUMENT

1. Any patient who has received a previous brace on the Same or Similar list within 5 years should be advised that a new brace may not be covered by Medicare. The practitioner can avoid financial liability by asking the patient to sign an Advance Beneficiary Notice of Non-coverage (ABN) which can be downloaded from the CMS website: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

The ABN will allow the provider to bill the patient for the DME device in the event that all efforts to gain reimbursement from Medicare fail. However, when an ABN is signed by the patient, the provider must append the claim with the GA modifier.

An ABN should not be routinely used by providers in every case where a Same or Similar denial from Medicare is anticipated. If the provider is confident that the medical condition has substantially changed, the patient is eligible for a new Same or Similar brace. According to this policy, Medicare should cover the claim even if it requires an appeal. In the case where a medical condition has changed within five years of the original Same and Similar brace, Medicare recommends that the provider need not obtain an ABN from the patient.

It is important to note that when a patient's medical condition has changed, a new and different type of brace must replace the previous brace. Medicare will not approve a claim for an identical type of brace replacing a previous brace within five years, even if the medical condition has changed. Medicare will approve a claim for a new brace with a different HCPCS code if the medical condition has changed within 5 years.

In cases other than change of medical condition where a new brace is supplied, which falls under the Same and Similar policy restriction, an ABN should be signed by the patient to provide protection of the provider from financial liability. This action would be recommended whenever a brace is being replaced for irreparable wear in less than the 5 years of reasonable useful lifetime of the brace (RUL).

There is a requirement to use the GA modifier when a patient signs an ABN. If the practitioner is confident that the device is medically necessary and is willing to appeal any denial of claim, they should use the customary KX modifier, and not ask the patient to sign an ABN.

2. The medical record should contain the following information:
- Any information received on the DME MAC provider portal regarding previous brace coverage should be saved in the medical record of the patient.
- In the event that a new brace needs to be dispensed on the same extremity within 5 years, the medical record should stipulate the necessity based upon the fact that the previous device may have been lost, stolen or irreparably damaged (due to a one time event); a different diagnosis; change in anatomy (e.g. amputation, acquired deformity, significant weight gain/loss) resulting in the previous device being unusable by the patient.
-The medical record should clearly review the previous medical condition for the original brace and the new medical condition necessitating a different brace.
3. Check out the Richie Brace website for further information about documentation in the patient medical record to be compliant with verifying the medical necessity of an AFO device:
https://www.richiebrace.com/index.php/reimbursement.html

APPEAL AND ADVOCATE
1. A claim may still be denied by Medicare based upon a Same or Similar determination. This denial can be appealed using the medical record and justification for the current brace dispensal. This appeal is initiated with a request for redetermination.
2. Providers can obtain a redetermination form from their DME MAC website provider portal. The form may be downloaded, completed and then scanned. The form can then be uploaded to the portal with all pertinent information from the patient medical record as well as a response letter from the provider outlining the rationale and medical necessity for the new brace. Standard of care and patient welfare must be emphasized in the appeal process. The patient can provide a statement and verify the date that they personally notified Medicare of the need for them to receive a new brace.

3. Once submitted, the provider portal will also enable the provider to monitor the appeals process. Comments made by the reviewer will appear on the portal. The redetermination should be completed within a 90-day period, but often is finished within 30 days.

4. Providers have reported that an appeal of a Same or Similar claim rejection has often resulted in a positive reversal of decision. If the patient and the provider can verify that a new medical condition has required a new brace, often times the Same or Similar rule is waived. A less likely reversal of claim denial is when an identical brace is dispensed to a patient within 5 years.
Unless the previous brace has been lost, stolen or irreparably damaged (due to a one time event) the only likely justification for replacement would be documentation that the patient's anatomy has changed or that the structural support of the previous brace could not be repaired.

5. If a properly executed ABN has been signed by the patient prior to dispensing the new brace, a practitioner may bill the patient for the cost of goods after all attempts for appeal have been exhausted. A fee estimate should be provided to the patient at the time they sign the ABN.

SUMMARY

Practitioners are commonly required to obtain pre-authorization from third party payors in order to assure reimbursement for services or products provided to patient beneficiaries. Compared to most insurance companies, Medicare provides an efficient on-line portal which is easily accessed by the provider to verify if a claim for a DME device might be denied due to the Same or Similar policy. This verification process as well as the patient's own action to inform Medicare of their condition takes only a matter of minutes. In the event of a denial of a claim, the appeal process with Medicare for a DME claim can be done on-line in just a few more minutes and often results in a positive reversal of decision as long as the medical necessity is properly documented.