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Recorded Webinar: External Breast Prostheses

Contract	DME MAC Jurisdictions B & C
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Date Recorded:	07.25.2023

Today's webinar will provide an overview of the external breast prosthesis policy. It is designed to familiarize you with the basic coverage criteria and documentation needed. As a supplier, be sure to review the supplier manual, the LCD and policy article, as well as the standard documentation requirements for all claims submitted to the DME MACs just so that you get the full understanding of what is needed.

I have just a couple of things from the disclaimer. Now the information was current at the time of the webinar, so make sure to check the website and electronic email messages for updates. And the last thing I want to remind attendees is that you may not record this presentation for any reason. However, CGS may record webinars for educational purposes.

Today we will discuss coverage criteria for external breast prostheses including the accessories and the HCPCS codes that fall within that category. Then we'll talk about the appropriate modifiers, with a brief look at the documentation requirements as they apply to this particular policy. I'll go over a few frequently asked questions. We'll talk a little bit about the comprehensive error rate testing program or CERT. Then we'll review the resources that are available to assist you with this policy.

Now this slide has information on where to find complete details on the specifics for coverage for external breast prostheses. A mastectomy is a required element for coverage. The applicable diagnosis codes are found in the policy article. Now each claim must have the appropriate diagnosis code included. The diagnosis code alone is not sufficient documentation for coverage. Medicare will be looking for documentation in the medical records to support the diagnosis appended to the claim. There must be documentation in the medical record, for example from the office notes or hospital notes. Now the original surgery documentation is not necessary.

Here I have the HCPCS codes for the actual breast prosthesis. The L8020 is the mastectomy form and that would include those made of fabric, foam, or fiber filled. The L8030 is for the silicone or equal without adhesive and the L8039 is for a breast prosthesis that is not otherwise specified. So, if you're billing for the L8039, you must include a narrative because this is considered a miscellaneous code. You would include with the claim, the product name and or model number, the manufacturer's name and suggested price. The documentation of medical necessity for the item is also needed.

Now the L8015 is an external prosthesis garment. Basically, it is a camisole, which includes a mastectomy form. Now Medicare pays for these post-operatively before a permanent prosthesis is selected or when a beneficiary chooses to wear a camisole indefinitely as an alternative to a mastectomy bra and breast prosthesis.

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So, here are the types of bras that Medicare will cover for a beneficiary who has a covered mastectomy form or silicone or equal prostheses. Now, the pocket of the bra is used to hold the form or prostheses adjacent to the chest wall and that would be either the L8020 or the L8030. Now the L8000 is just the bra with pocket. It does not include the integrated prostheses. Now this bra may be made of any material such as cotton, polyester, or other materials. It could be any size, with or without integrated structural support, like underwear. Now the L8000 bra is integrated with the prosthesis, and it is unilateral. The L8002 is the bilateral bra integrated with the prosthesis. These also can be made of any material just like the L8000, with any type or location of closure, any size and with or without integrated structural support. The treating practitioner determines frequency and the number of refills for the bras.

Now there are several items related to mastectomies that will be denied because they are not considered reasonable and necessary by Medicare. So, let's take a closer look at each. So, the L8010 is the mastectomy sleeve, and it will be denied because it is not a prosthesis, nor does it improve the functioning of a malformed body member. The L8030 which is one with an integrated adhesive is not considered reasonable and necessary. There is no clinical evidence that a built-in adhesive has any advantages over a prosthesis without it. And lastly, a custom breast prosthesis, the L8035. It is not shown to have any medical necessity over and above a prefabricated prosthesis and so it is not considered reasonable.

Whether unilateral or bilateral, the coverage is for one prosthesis per side. So more than one per side will be denied as not reasonable and necessary. Now different types of prostheses have a different reasonable useful lifetime or RULs. So, the reasonable use for lifetime is based on how long the item can be reasonably expected to function properly when you take into account the normal wear and tear. So, the RUL for a silicone breast prosthesis is 2 years. While a fabric, foam or fiber filled prosthesis is 6 months. Now the nipple prosthesis has a reasonable useful lifetime of 3 months. Now keep in mind that Medicare does not cover replacements of an item before its reasonable useful lifetime due to ordinary wear and tear.

So, when and why can a prosthesis be replaced? Now there are 3 times when replacement is covered. Now the first is the end of the RUL, that's the reasonable use for lifetime. It's that when the item is simply worn out. Now the second is when the prosthesis is lost or damaged beyond repair. For example, a lost prosthesis would be if the item was in luggage that was lost or stolen. Now, an example of irreparable damage would be damage sustained in maybe a fire or flood. And the third reason for replacement is a change in the beneficiary's medical condition. This could be because the beneficiary had additional surgeries, they lost or gained weight. So those are situations where the replacements would be because of the medical condition. Now in the first 2 situations, the item is replaced by the same type of item. The third, the prosthesis is replaced by a different item as necessitated by the change in the beneficiary's condition. This difference between the same type or a different type determines what kind of modifier you will need.

So, when do you need a new order? Whenever an item is replaced or whatever reason, that is when you're gonna have to have a new order. For the RA modifier, if an item is being replaced because of damage or loss, the RA modifier must be used. Now the reason for the replacement should be explained in Item 19 of a paper claim or in the NTE 2400 segment of an electronic claim. However, if the replacement comes after the RUL has expired, you do not need to use the RA modifier. Now keep in mind that if an item is being replaced by a different item because of the beneficiary's condition or that the beneficiary's condition has changed, you do not need to use the RA modifier. And that's because the item is not actually a replacement of the original item, but a new order for a different item with a different HCPCS code.

And that leads us into the topic of modifiers, the RT and LT when billing bilateral prostheses. You would bill each item on a separate claim line using the RT and LT modifiers and one unit of service on each claim line. Bras and the camisole codes do not require the RT or LT modifiers.

Now, certain modifiers are required for use with Advance Beneficiary Notices of Non coverage or ABNs. So, in April, CMS announced that the form CMS-R-131 had been renewed with a new expiration date of January 31, 2026. You can continue to use this form with expiration dates of June 2023 until June 30th, but the new form becomes mandatory on June 30th. After that, any other version is invalid. So, this is for any new date of service that you will need to have the new form. Now the purpose of the ABN is to provide the beneficiary with a written notice that advises them that the item will likely be denied. Now the ABN should be issued prior to dispensing an item or service that is expected to be disallowed. This allows the Medicare beneficiary to make an informed decision about the item or service they may have to pay out of pocket for. Section F of the ABN form must be completely and accurately filled out and clearly explain the reason you believe Medicare will deny the claim. Make sure that the beneficiary understands how much money they will be expected to pay out of pocket. As for the information at the bottom of the slide,

make sure that you use the correct modifier depending on whether or not you have an ABN. So, the GA, if you have a valid ABN and the GZ, if you do not.

Now an upgrade is an item with features that go beyond what is medically necessary. Now modifiers you would use with an upgrade are the GK and GL. So, on the claim form, the GK goes with the item that is actually covered. On the claim line for the upgrade, you'd use either the GA for a valid ABN or GZ for no ABN. Now if an upgrade is provided at no charge to the beneficiary, then an ABN is not necessary. In these situations, you would use the GL modifier indicating a free upgrade. Now mastectomy bras cannot be upgraded. Bras are covered by 3 HCPCS codes, the L8000, the L8001 and the L8002. Now for this policy, you cannot provide an upgrade within the same HCPCS code. No matter which bra is provided and billed, Medicare will only pay the amount associated with that HCPCS code. Now I do have an example of how to build an upgrade on the next slide.

So, here's an example of upgrade billing where the supplier bills and collects an additional charge. So, the breast prosthesis with adhesive and a breast prosthesis without. So, what you would do, you would bill 2-line items. On the first one, you're going to build the upgrade item with the GA modifier indicating you have a valid ABN on file. Now on the second line will be for the standard item or the item that is reasonable and necessary with the GK modifier. So, this is how it would look on your claim. So, on Line 1, you would have the L8031 and in this example, we have the RT for the right side with the GA modifier and this is the silicone prosthesis with adhesive, upgrade with a valid ABN. This 2nd line would read L8030 with the RT modifier and GK, the silicon prostheses without adhesive. This is the standard item that is reasonable and necessary.

Now, when the supplier provides a free upgrade, you would bill only one line item with the reasonable and necessary item or the standard non upgraded item, no additional charge and no ABN. Now the line would appear on the claim as, in this example, the L8030, which is the silicone prosthesis without adhesive with the right-side modifier and the GL indicating medically unnecessary upgraded item. Next, you would need to specify the make and model of the item actually furnished or the upgraded item in the narrative section and describe why this item is an upgrade. So, for an example, these may be the only ones that you carry, or you didn't have the standard prosthesis and provided this one as a free upgrade to the beneficiary.

So, on this slide, I have the documentation that is needed in the beneficiary's file. Now, I do have several items listed here, but you may not need each one. It really is going to depend on the policy and the items that you are providing. So, for the most part, you don't need to submit your documentation with your claim unless specifically noted in the policy. So, remember, there are certain pieces of documentation that is needed prior to billing. When it comes to the medical records, you don't have to have them in your possession, but make sure you have access to them in case of an audit. That is why it is important to establish a relationship with your referral source so when you need medical records, they can provide them to you quickly. So, the documentation requirements are the standard written order, the beneficiary's authorization, proof of delivery, the ABN when applicable. Information required for use of a specific modifier and clinical documentation to support medical need and continued use of the item. Now when it comes to clinical documentation to support medical need and continued use of the item, if you're in an audit situation, it is for continued use because continued need is established with a mastectomy.

So, when it comes to who can order DMEPOS items, Chapter 3 of the Supplier Manual explains who, what, and when. So, who are the ordering practitioners? So, it's a physician and their designation is either an MD or a DO, and they may write or prescribe any type of equipment or supply.

Next, you have the nurse practitioners, the clinical nurse specialists, and physician assistants. These practitioners can also write and sign the standard written order. Now I'm not going to read through the criteria for the NP, CNS or for the PAs. This information is here on the slide for you to reference, but please be sure to review them so that you are familiar with the requirements for each of these practitioners.

So, let's look closer at the standard written order. Now the standard written order is needed for all services billed to Medicare and must be obtained by the supplier prior to submitting a claim and must include the elements that's listed here. So, on your standard written order, you would have the beneficiary's name or the Medicare beneficiary identifier or MBI, an order date, a general description of the item. The description can be either general or HCPCS code, the HCPCS code narrative or a brand name and or model number. For equipment, in addition to the base item, the standard written order may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgrade. For supplies, in addition to the description of the base, the DMEPOS order or prescription may include all concurrently ordered supplies

that are separately billed. So, remember, if any item is billed on the claim, it must be listed on the order. You'll need the quantity to be dispensed when applicable. The treating practitioner's name or their NPI and the treating practitioner's signature. Now just a few additional notes regarding the standard written order, a signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements that's outlined in the Program Integrity Manual at 3.3.2.4.

So, when do you need to get a new order? So, there are 5 occasions that require a new order. For all claims for purchases or initial rentals. If there is a change in the order or prescription. For example, the quantity or something new is added, you'll need a new prescription. On a regular basis even if there's no change in the order or prescription. Now this is only when the particular medical policy states that it is required. So, if the policy states that a new order is needed in 6 months or your individual state requires a new order at 12 months, then that is what you would need to provide. You'll also need a new order when the item is replaced. You'll need a new order when there is a change in the supplier. And if the new supplier is unable to obtain a copy of a valid order or prescription for the item from the transferring or outgoing supplier. So, if you're taking on a beneficiary and you cannot get a copy of their prescription from the outgoing supplier, then you would need to get a new prescription. One other thing that you may want to keep in mind, if you are accepting a prescription or the order from the outgoing, you want to do make sure that you've reviewed that order to ensure that it meets the requirements because once you accept that, then you are taking on that order as it is written.

Now, mastectomy garments like bras are considered non-consumable supplies. So, for example, they are more durable than things like surgical dressings or diabetic supplies, which are used up, but bras still require periodic replacement. You have to determine whether the item is still functional. If it is still functioning, it cannot be replaced. When it is no longer in a functional state, the reason for replacement must be documented with the description of the condition of the item. Some examples include the elastic is stretched or the straps are frayed. Maybe the closure clasp is torn or missing. So, you have to provide that reason why the item is no longer functioning in order for the replacement to take place or occur.

Next, we'll look at proof of delivery. Now proof of delivery is a supplier standard. Medicare uses the proof of delivery to ensure that the item delivered is the item ordered by the treating practitioner. It is the item that you billed, and it is the same item that the beneficiary received. It is also used to determine whether the claim was coded and billed correctly. So here we have direct delivery or Method 1 and what that proof of delivery must contain. So, the proof of delivery must include the beneficiary's name, a delivery address, the quantity that's being delivered, a description of the item or items and the date delivered and the beneficiary's signature. So how much detail is needed for the description? Well, Medicare would be looking for one that clearly identifies the item has been correctly coded and billed. You can use the brand name model or serial number the long narrative description of the HCPCS code or the HCPCS code itself. Either description is acceptable. Now your delivery date must be the date that when the beneficiary or their designated representative received the item and that is the date of service. Now the beneficiary's signature requirement was waived during the PHE and the CR modifier and COVID-19 in the narrative was needed. Now please note that the public health emergency or the PHE for COVID-19 ended on May 11th of this year. As suppliers, you need to discontinue using the CR modifier, COVID-19 narrative and obtain a beneficiary or designated representative's signature for claims with dates or service on or after May 12 of this year.

Now when you're using a delivery service such as the postal service, UPS, or FedEx, you want to have your shipping invoice and the delivery services tracking slip, you want to make sure that those items are clearly linked together. So, generally this is done with the delivery services identification number on your invoice and the tracking number that matches up. We just need to have that clear paper trail of when it left you, when they picked it up so that helps Medicare to connect those items together. So, you can use a return postage pay delivery invoice from the beneficiary as the proof of delivery, but it must contain all of the information that's shown here.

Now when using method 2, a shipping service, a signature is not needed, only evidence of delivery. Now evidence of delivery would be if the delivery service indicated, left at the front door left and the side of the house left, in the garage etc. Now in method 2, the date of service is the shipping date. Now Medicare adjusted the definition of what you can use as the shipping date and Method 2 of delivery. So, let's look at those on the next slide.

So, two options for the date of service to use on your claim. So, suppliers may use the shipping date as the date of service. Now the shipping date is defined as either the date that the delivery or the shipping service label is created or it's the date that the item is retrieved by the shipping service for delivery. Now please note such dates should not demonstrate significant variation. Suppliers may use the date of delivery as the data service on the claim. Again, suppliers may

also utilize a return postage paid delivery invoice from the beneficiary or the designee as proof of delivery. This type of proof of delivery document must contain all of the information specified on the previous slide.

Now, when the beneficiary is in a skilled nursing facility, whether you deliver it yourself or use a delivery service, you must have the information on this screen - proof that the items were delivered and documentation showing the items were accepted by the nursing facility expressly for the usage of that beneficiary. And the last item, the quantities delivered and used must justify the quantity billed.

So, on the next several slides, I will review some frequently asked questions that we received regarding the external breast prostheses.

So, if the beneficiary requires a new prosthesis due to weight gain or loss, will Medicare allow reimbursement?

And the answer is yes.

- The external breast prosthesis of a different type can be covered at any time if there is a change in the physiological condition that necessitates a different type of item.
- If the medical condition changes, this should be documented in the beneficiary's medical record. The ordering practitioner would also be required to submit a new order, which explains the need for a different type of prosthesis.
- The order must be kept in the suppliers file but need not be submitted with the claim unless requested.

How many bras may a beneficiary receive per year?

The policy does not specify a specific quantity.

- The treating practitioner determines what is reasonable and necessary for the individual beneficiary.
- Medical records should reflect and support what is dispensed to the beneficiary. So, we had the medical directors to kind of weigh in on this question because we had some confusion on how many. So, suppliers have indicated that they were just in the habit you know delivering 6 bras at a time and that is because maybe the idea of 6 being allowed or a limit, comes from the MUEs stating that 6 is the maximum unit of services that will be reported for a HCPCS code for the vast majority of appropriately reported claims. Now you can find more information on the MUEs at the link that's listed here on your slide. But again, the how many that the beneficiary receives, that will be determined by the treating practitioner based on the individual beneficiary and what is reasonable and necessary.

Is a prosthesis covered for a lumpectomy?

The answer is no.

- Lumpectomies are not covered under the external breast prostheses LCD.
- However, if there is significant tissue removal supported by the medical record, a prosthesis may be covered for a partial mastectomy.

So, what modifier would be used when billing a replacement item?

So, remember from earlier, you would use the RA modifier only when the item is being replaced for loss, theft, or irreparable damage. You would include the reason for replacement in Item 19 of your paper claim or in 2400 segment of electronic claims.

- You did not use the RA modifier when the item is being replaced. After reasonably useful lifetime. Due to a change in the beneficiary's medical condition because the item is not a replacement of the original but a new item. A new order for an item of a different HCPCS code. Okay. So again, the RA is only used for replacements due to irreparable damage, theft or loss, you do not use the RA for RUL or changes in conditions.
- You would also use all other applicable modifiers that are required to be submitted on your claim.

If a beneficiary had one breast removed for a covered diagnosis and the other removed for prevention, is a prosthesis covered for the second?

- Per the external breast prosthesis LCD, a breast prosthesis is covered for any beneficiary who has had a mastectomy, regardless of the reason. You also want to see the policy article for the applicable covered diagnoses.

Can HCPCS codes L8015, which is the external breast prosthesis garment, be issued prior to surgery?

- And the answer is no. It is only covered when the prosthesis becomes medically necessary, which is after the surgical procedure.

If a prosthesis costs more than what the fee schedule allows, can it be billed as an upgrade?

- And the answer is no. Nonparticipating suppliers may collect the difference between the fee schedule and the supplier charge on non-assigned claims.
- Participating suppliers must accept assignment on all claims and may not charge the difference between the fee schedule and the supplier's charge.

If a beneficiary chooses to wear a camisole, which is the L8015 as an alternative to a breast prosthesis and bra, will it be covered even years after the mastectomy surgery?

And the answer is yes.

- In the policy LCD, it indicates that the HCPCS code L8015 is covered when a beneficiary uses this garment during the post- operative period prior to being fitted with a permanent breast prosthesis or wears the garment as an alternative to a mastectomy bra and breast prosthesis.

Will prosthesis and mastectomy bras be covered for a mastectomy beneficiary that has had reconstructive surgery?

And the answer is yes.

- CMS would cover the prosthesis and bras since the beneficiary had a mastectomy, which is the covered condition even though they've had reconstruction, it was not adequate, or it fails. So again, if they had reconstruction, Medicare will still cover the bras and prosthesis.

Now, we're going to move on and talk a bit about the Comprehensive Error Rate Testing program or CERT. Now, CERT, it was developed by CMS, back in 1996 to measure Medicare Fee-for-service improper Payment Rate and this was for the purpose of reducing costs that are associated with improperly completed and improperly paid Medicare claims. Now the CERT contractor randomly requests and audits claims from both Jurisdictions B and C. Now at that time, they also receive the suppliers address listed in the system so that they can request the records for review. Now, CERT, will send up to 4 letters to the supplier requesting these records and that's usually about one every 20 days or so. Now failure to respond to CERT request for documentation may result in an error. This is why suppliers should keep their information up to date with the National Provider Enrollment Contractors NPE East or NPE West, which used to be the NSC, because the address on file is where the additional documentation requests will be sent.

Now the information on this slide gives you just a snippet of the improper payment rate for 2022. Now this report was published in December of 2022. You can access the full report on CMS's website using the link shown on the slide. So, the overall DMEPOS error rate is 25.2%. And the projected improper payment amount is 2.2 billion dollars. The improper rate for the external breast prostheses was at 34.4% for 2022.

So, here I have some tips to help you when you receive requests from CERT.

- Suppliers should implement a thorough intake process. Now we do have a suggested intake form and documentation checklist on our website and those things will help you with that process. You should also,
- Respond to requests for documentation just to avoid receiving an overpayment demand letter.
- Use the bar code sheet that is included with the request as the cover letter with your documentation. And for additional help with CERT, visit the dedicated webpages on CGS's website. You should also go to the CERT website to review what can be expected and when it comes to requests for additional documentation and how to respond.

So, NGS was the CERT contractor but has now changed their name. All that really means to you is that their email address has changed. Here's their updated contact information. So, it is Empower AI, Inc. you have information for customer service, their fax number, their email address, and links to their website.

So here are the ways to respond to a request from CERT. Now the information on this slide is used for submitting medical record responses. The options are fax, mail, esMD, encrypted CDs, and encrypted email. For more detail on timelines, sample letters, FAQs, visit the dedicated CERT page on the CGS website using the links at the bottom of your slide.

So, if you disagree with the CERT decision, you can file a redetermination request to the appropriate DME MAC and not the CERT contractor.

- Make sure all of the records are legible. Now over time, faxing and copying records can distort the image. You want to send your appeals to the appropriate jurisdiction based on jurisdiction that I have listed on the slide.
- If you receive an overpayment demand letter and wish to appeal, you would use the overpayment appeals information.

So, the next several slides we'll cover resources.

Now this slide contains links to resources covered in the presentation. Additional information can be found using these references.

- We have links to the LCD in policy.
- Publications in the supplier manual.
- The online education courses or OECs.
- The Physicians! Are you ordering External Breast Prostheses and Supplies Articles. We have links to both JB and JC websites.

So here are some additional tools and references to help you with your billing.

- The Advanced Modifier Engine or AME is available for modifier usage.
- The Claim Denial Resolution Tool provides suppliers with the denial reason, things to look for and your next possible steps to resolve your issue.
- Use the CGS Wizard for finding process claim information without having to log into the myCGS web portal. You only need the CCN for access. And lastly, we do have a link to the myCGS web portal.

So here are the most commonly used Jurisdiction B resources. We include this in all our presentations so that you will have this information at your fingertips. Not gonna read through that, but here's that information for you.

We have the same information for Jurisdiction C. Just want to remind suppliers that the phone number and addresses are different than that of jurisdiction B so it's important that you use the correct contact based on the jurisdiction that you're billing.

So here are a few other contractors that you need to be aware of.

- If you have questions about coding, maybe you have an item that you don't know the HCPCS code for or you have a new item that you want to verify if you're using the correct code, you would contact the Pricing, Data Analysis, and Coding department, which is PDAC.
- You will contact the CEDI, the Common Electronic Data Interchange department, if you need help with front-end rejections or if you want free low-cost billing electronic software, they can help you with that information.
- And of course, we have the National Provider Enrollment. If you are located east of the Mississippi River, then you will reach out to Novitas Solutions for enrollment questions or changes. If you're located west of the Mississippi, then you will reach out to Palmetto GBA.

The electronic mailing list that is going to be the best way for you to stay up to date on DME news for jurisdictions B and C. You can sign up to receive these electronic mailing messages on the CGS medicare.com website or by clicking on the link here on the slide or copying it and pasting it into your web browser. You would just need to enter your first and last name and email address, phone number, complete address and company information and what specialty or Medicare contract email that you're interested in receiving. You must select at least one or more of the options. You click sign up and you're done.

This slide advertises our free myCGS web portal. It has all the information that is available on the interactive voice response and more. You can also submit redeterminations and reopenings through the myCGS web portal. Using my CGS will save you time, money, and resources. For

registration information, access the mycGS Registration Guide and for detailed information on using myCGS, you can access the myCGS User Manual.

So, this brings us to the end of the presentation portion of the webinar.