



When Does One Bill for L3000 and When for L3020?

It's time to shelve some antiquated HCPCS definitions.

BY PAUL KESSELMAN, DPM

A large podiatry group recently asked for a random review of their DME charts. After completion of the audit, the practice manager and compliance officer had several questions concerning custom foot orthotic coding. Their questions can be summarized into the following simple question: “When does one bill for L3000 and when for L3020?”

This question came as no surprise despite this being discussed many times over the past few years in a variety of print and online forums. This includes a consensus opinion in the form of a “white paper” readily available for members of APMA, American Orthotics and Prosthetics Association (AOPA), and PFA (Pedorthic Foot Care Association) on their respective websites.

Providers accused by third-party payers of improper billing of custom foot orthotics remain largely unaware that the consensus opinions have been used to successfully challenge these allegations.

The coding confusion does not end with custom orthotic providers; it extends to the insurance carriers themselves whose sole motivation is to pay much less for L3020 than for L3000. The work product and costs to orthotic providers are generally similar if not identical for both types of orthotics. Then why the confusion? Many theories abound, but in a nutshell, it is always about money. In this case, perhaps even more impor-

tantly, it's about a coding structure relatively untouched since the early 1960s.

The most common assumption is that there must be a critical heel cup depth which defines an L3000 and differentiates it from an L3020 or L3010.

A critical measurement defining an L3000 would make this discussion far simpler and remove a great deal of controversy surrounding custom foot orthotics. There is no exact

strength, higher durometer yet thinner materials.

There is, however, another thought process one should use to challenge the insurance carrier. The position should be made that the coding should be based on the potential physiological and biomechanical changes a device can impart on the patient as opposed to its physical appearance. The intent of the UCBL device in the early 1960s was to make a device which would actually change

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depth requirement defined by either HCPCS or the UCBL (the developer of the prototypical device). Because of the extreme depth of the prototypical device, it remains the main argument which insurance carriers use to justify their argument that many modern custom foot orthotics do not describe the L3000 code. Their rationale is that the depth and bulk of the devices made today are too shallow to provide the correction provided by the original UCB type orthotic.

If one were to examine the original device(s) used at the UCBL lab over 60 years ago, one cannot compare those materials and manufacturing processes to today's higher

the vectors of force affecting the foot rather than accommodating the patient's symptoms. This novel idea (at the time) is what really is at the heart of the matter.

Because modern materials and technology impart significant physiological changes with a much slimmed down model, it should be the only question one needs to answer regarding coding foot orthotics. That is, what is the intended physiological change the prescriber has in mind for a specific patient's orthotic?

If the intent is to simply off-load the patient's IPK with a dress shoe device and place it into a backless shoe, then this device should be

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coded as an L3020 (or L3010), depending on whether there is a met pad in addition to the L.A. support. If the intent is to correct a rearfoot or forefoot varus and this can be corrected with intrinsic posting with minimal heel cup depth, then one should be able to make the argument that they have met the intended goal of the original UCBL device. That is, while it does not look the same as the original UCBL-type device, it functions in a similar fashion. Hence, it should be able to be described as a “UCB-Type Device” as per the HCPCS definition. This argument has been successfully used in courtrooms, much to the chagrin of many insurance carriers.

As for the payment differential called for by insurance carriers, there is no justification for any payment disparity between these two custom-type foot orthotics. The costs of evaluating the patients are the same or equivalent for patient work-up no matter which device is fabricated. The providers’ costs of fabricating these devices also has minimal, if any, disparity. One could actually make the case that “Levy” molds of yesteryear (some made without a heel cup) continued to be handmade, and for the most part are more costly compared to their thermal plastic brethren.

These devices require more bulk and cannot correct many biomechanical issues which can be addressed by more slimmed down thermal plastic devices. These plastic devices are often manufactured directly from a scanned image, then automatically milled directly from a computer image with much less human input. Other than playing some mind games with providers (what else is new?), there simply is no justification for payment disparity based on the coding structure alone.

The likelihood of any changes to the definitions for custom (or off-the-shelf) foot orthotics is very unlikely. Since the HCPCS coding structure is owned by the HCPCS Common Work Group (a CMS committee), there is no reason to expect CMS to put any financial resources

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towards change for a DMEPOS item they do not cover. Thus we circle back to the consensus opinion summarized in the second paragraph of this article, which has provided a more modern interpretation of custom foot orthotic coding.

Professional societies should never cower away from presenting their opinions on HCPCS coding and, in this case, they certainly have not. CMS may never wish to intercede here to make changes to the L3XXX code definitions. Yet it is private third-party carriers who are looking at the CMS definitions for guidance, all with a blind eye to modern day technology. Perhaps their only intent is to minimize their fiduciary expenditures in developing reimbursement policies and simultaneously reducing their expenditures for covered services.

As providers and patient advocates, we need to remain active in discussions with carriers, so as to avoid post-payment audits. These often require expensive legal challenges, almost all of which have been won by providers, but at what cost? As more insurance carriers lose the battle over L3000 vs L3020, perhaps the more modern day interpretation advocated here will finally be adopted by all, leaving the antiquated HCPCS definitions where they belong: an important part of HCPCS history. **PM**



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