Billing for Ankle Foot Orthoses

These case presentations demonstrate proper coding.

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Several previous installments on DME for DPM's presented an introduction to Ankle Foot Orthoses (AFO's). Those articles presented information regarding AFO's:

1) Classification.
2) Medicare and some private third-party coverage guidelines.
3) Casting and fabrication approaches.
4) Laboratory choices.

The purpose of this installment will be to:

1) Present several clinical scenarios.
2) Discuss the types of AFO required for the presented clinical scenario.
3) Provide the appropriate HCPCS codes and required modifiers.
4) Illustrate an acceptable CMS 1500 format which will assure payment.

Disclaimer: These are summarized case histories from actual patient files and modified in order to present as diverse a group of clinical examples as possible. All patient identifiable information has been changed for purpose of HIPAA compliance. The HCPCS and ICD-9 codes used here may be further referenced with many commercially accepted sources. There is certainly no substitute for verification with your DMAC or third-party payment.

Due to the variety of rules for many private payers regarding provider exclusion and prior authorization, the information provided is not a guarantee of payment.

Certainly other surgical and non-surgical options exist for these patients. The purpose of these examples is solely to illustrate one approach to treatment with an appropriate prescription and billing rationale.

Clinical Case #1

This patient was an active, well-developed athletic 52 year old male presenting with left rear foot pain which is interfering with his daily ability to run five miles. He weighs 215 lbs, is 5' 10" and has gained about 25 lbs. in the last three years. Previous treatment with multiple well-constructed functional orthotics has failed to resolve his pain. He has peroneal spasms at the end of his runs, and after long periods of normal weight-bearing.

Radiographs and CT scans are positive for a tarsal coalition. The patient's left knee was stable in gait and there was no spasticity noted. He had controlled plantar fasciitis on the right foot with custom-made UCBL-type foot orthotics, which are irreparably worn and did not fit well due to weight gain and deterioration of the plastic shell over the last few years.

The patient was treated with a non-pneumatic CAM-walker on the left foot for three weeks. At this time, his symptoms were improving with resolution of the peroneal spasms and far less pain. The patient was advised to have a podiatric-type AFO made for the left foot with simultaneous replacement of the right foot UCBL foot orthotic.

He was cast in the neutral position bilaterally with a leg-length AFO casting sock on the left foot and a plaster slipper cast on the right.

Prescription Details and Rationale

Left foot: A custom-hinged, podiatric-type AFO with appropriate forefoot and rear foot posting, custom uprights, and a 30 mm. depth heel cup for the left foot. The uprights and foot plate were padded with a soft tissue interface.

Right foot: A custom-made, UCBL-type device with a deep heel cup, rear foot and forefoot posting adequate for correction, soft tissue interfacing to reduce shock in the arch and an appropriate top cover. The right devices were made of equal thickness so as to ensure no iatrogenic-induced limb-length discrepancy.

Main Clinical Points

A non-pneumatic CAM-walker was prescribed in the absence of acute or significant edema. Had the patient had significant edema, a pneumatic CAM-walker would have been more appropriate.

In the absence of spasticity, stable knee and tolerable ankle motion, a patient of less than 250lbs and 6’4” in height may be prescribed a podiatric length hinged AFO. A UCBL-type foot orthotic was prescribed for the right side and posted based on the biomechanical findings as the patient has had previous success with custom orthotics.

Billing Details

1) LT/RT modifiers are required for all HCPCS codes. A GY modifier is used when billing Medicare, as foot orthotics are not covered by Medicare statute.
2) Non-pneumatic CAM-walker left foot: L4386 LT
3) Custom-hinged AFO left (L1970 LT) with modifications of:
A. Soft tissue interface for molded plastic, Below-Knee Section, left foot only. L2820 LT
B. Addition to lower extremity, varus/valgus correction, plastic modification. L2275 LT
4) Custom foot orthotic, UCBL, right foot. L3000 GY RT
5) The diagnosis for all orthotic services for the left foot points to tarsal coalition, 755.67, while the right foot points to plantar fasciitis, 728.71.

Additional Points to Consider

The bill for a non-Medicare patient would not require a GY modifier and may or may not be covered dependent on foot orthotic coverage rules.

A letter of medical necessity (if required) to private third party payers should include the following:

A) Previous success of custom foot orthotics, patient’s weight gain, irreparable wear of the device.

B) Failure of foot orthotics to control the patient’s left foot pain.

C) Successful treatment with CAM-walker should predict success with AFO.

Clinical Case #2

This patient was an active 6’5” well-developed, non-diabetic, active 83 year old male who presented with bilateral ankle and subtalar pain which was interfering with his daily ability to walk without pain. He could not walk more than half a block without significant peroneal spasms and pain in the rear foot. Previous treatment with multiple orthotics has failed to

resolve his pain. X rays and CT were positive for significant subtalar arthritis. The patient lacked any hallux valgus or hammertoe deformities. The patient's left knee was stable but he had an unstable right knee with genu recurvatum with a drop foot, due to a stroke.The patient needed some temporary fixation of the left side in order to allow his peroneal spasms to subside, but should be able to function well with a hinged AFO after a temporary period of rest (i.e., one month).

The patient had significant edema due to venous insufficiency and has had previous ulcerations. His edema is well-controlled when he wears his prescribed support stockings (not covered by Medicare).

The patient was cast in the neutral position with a leg-length AFO casting sock by STS.

Prescription Details and Rationale

The following devices were prescribed:

Bilateral custom traditional height AFO (due to his height podiatric length devices were inappropriate), with appropriate rear foot post and custom uprights; 30 mm. depth heel cups; the uprights are padded with a soft Plastizote material and the foot plate was padded with a Spenco cover.

Left Side: Hinged AFO with a temporary pin to be placed posterior to the hinge screw in order to provide an AFO which is temporarily solid on the right side. This may be removed after one month in order to allow it to function as a hinged AFO.

Right Side: Solid AFO: Due to an unstable knee, a hinged AFO would be contraindicated.

Billing Details

1) LT/RT modifiers with all HCPCS codes.
2) Hinged Left (L1970) Solid Right (L1960 RT)
3) Soft tissue interface for molded plastic, below-knee section, bilateral. L2820 LT RT use 2 units, as billed on one line
4) Addition to lower extremity, varus valgus correction, plastic modification. L2275 LT RT use 2 units as billed on one line
5) Temporary fixation of a hinged AFO.

While the left device is temporarily hinged, it is designed to function as both a hinged and non-hinged device. Since the main long-term intended use of this device will be to function as a hinged device, I feel it is appropriate to bill the left device as hinged device.

Clinical Case #3

This patient was a 79 year old non-diabetic male with a right-sided drop foot secondary to a CVA three years ago. When he was initially seen post-CVA his Achilles strength was no more than plus 2. His dorsi-flexion capability of the Achilles has progressed nicely (+3-4 strength) with physical therapy. He had sensitivity plantar to the third and fourth metatarsal heads due to recent surgical excision of a solitary plantar fibroma. The patient had a previous Achilles tear of the left foot prior to his CVA. This was surgically repaired with no sequalae. The patient is currently wearing a solid AFO on the right side and has been having increased lower back and knee pain. He has no knee instability or genu recurvatum.

Prescription Details and Rationale

The patient was prescribed a spiral-type AFO with additional graphite lamination to provide added strength and durability. While quite thin, it can provide sufficient dorsi-flexion assist allowing the patient to wear normal shoe gear because this type of brace does not contain bulky hinges. Due to the patient's recent foot surgery, some accommodation was made in the foot bed of the AFO, with additional soft tissue padding. The patient also received an over-the-counter pre-fabricated orthotic requiring some minimal adjustment to avoid an iatrogenic limb-length discrepancy. The inherent thinness of this type of AFO may otherwise avoid the need for a contra-lateral foot orthotic. He was instructed to purchase sneakers or shoes with a rubber sole.

Billing Details

L1951 Spiral AFO
L2755 Graphite lamination
L2820 Soft tissue Interface
L3040 Pre-fabricated foot orthotic

Use LT/RT modifiers on all HCPCS codes.
Use GY modifier for L3040 as it is statutorily non-covered.

Billing Points to Consider

His medical status has changed since the initial AFO was dispensed, resulting in his need for a new AFO prior to the five year period of lifespan. The left foot off-the-shelf device is statutorily non-covered by Medicare; therefore no separate diagnosis was used for his right foot.

Clinical Case #4

This patient was an 83 year old male with a recent stroke which has primarily affected his left lower extremity. He could

walk only a few steps with the assistance of a walker. His neurologist has informed me that there is little potential for this gentleman to progress beyond this stage and he is in need of an AFO primarily to treat his contractures. He currently has a maximum of -15 degrees of passive dorsi-flexion and has more than 25 degrees of dorsi-flexion from his maximum plantar-flexed position. He is under an active treatment program with a physical therapist for his contractures. His neurologist has provided me with a prescription for a pre-fabricated AFO.

The patient was fitted with a pre-fabricated solid AFO which was heat-molded to his lower extremity (L4396).

Prescription Rationale

The patient is essentially non-ambulatory and is only utilizing the device to treat his contractures. There should be minimal wear and tear on this device and a simple off-the- shelf, pre-fabricated device should be sufficient. Since the patient is under an active physical therapy program, and there is more than 10 degrees of passive dorsi-flexion, a recombinant device would be covered.

Billing Details

The single HCPCS code used here must have a LT RT modifier.

Since the patient is primarily non-ambulatory, use of an ambulatory pre-fabricated device (L1930) would be incorrect. Since the referring physician actually prescribed the AFO, he is the referring physician, and it is his UPIN that is used for this claim, and not that of Dr. Jones.

Clinical Case #5

A 59 year old non-insulin dependent diabetic 6’5’ and 255 lbs on Medicare because of other disabilities, presented after hearing a pop on the anterior medial aspect of his left foot and development of a foot drop the next day. He also had a plantar-flexed first metatarsal head with a pre-ulcerative area on the same foot. The patient previously was treated many years ago for plantar fasciitis for his right foot and he wears a foot orthotic which is in need of replacement. The patient was seen three days after onset of symptoms, and sonography confirms an anterior tibial tendon rupture. Five days later, the patient was placed in a CAM-walker and underwent surgical correction with grafting. He was evaluated at an appropriate time post- operatively for orthotics.

Prescription Details and Rationale

The patient was cast in the neutral position for a custom AFO with Tamarack hinges to assist dorsiflexion, and a plantar

flex stop to resist plantar-flexion. A soft tissue interface to pad the device was also added. He is also cast for a UCBL with corrective posting and soft tissue padding, negative heel modification and LA padding (soft) for the right foot. He was also dispensed therapeutic shoes under the Medicare Therapeutic Shoe Program after we received a certification letter from his PCP.

The rationale behind using a dorsi-flexion assist device with Tamarack hinges vs. a carbon graphite brace is that at the time of casting, there was still a substantial loss of anterior tibial function, disuse atrophy of the Achilles, and an inability of the foot to reach a 90 degree position with the lower leg.

The anterior tibial tendon graft site was intact as documented by sonographic video imaging. A spiral AFO device minimally requires that the foot be able to achieve a 90 degree angle with the leg on passive range of motion. In his present clinical state the use of a spiral AFO would have allowed the heel to lift out of the shoe. This is because a spiral AFO on its own could not under this circumstance exert enough dorsiflexory force.

Billing Details

Use LT/RT modifiers with all HCPCS codes
Use KX modifier with any HCPCS code billed under the Medicare Therapeutic Shoe Bill
Use GY modifier to indicate statutorily non-covered services under Medicare
L1970 Ankle foot orthotic with hinge
L2210
L2220
L2820
L3000
A5500 Added-depth therapeutic shoes

No therapeutic inserts are billed. Suppliers may, however, bill for a combination of services covered under the Medicare Therapeutic Shoe Bill and those covered (and non-covered) under Medicare’s rules regarding orthotics and prosthetics.

Summary

As can be seen from the presented cases, matching the patient’s needs with an appropriate device can be a daunting task. Utilizing the services of a knowledgeable laboratory with experienced orthotists to assist you in choosing the appropriate device is only part of the task. Knowledge of the proper codes is of paramount importance, as many of the above devices may cost upwards of $600.00 or more.