Orthotics Coding
Q & A

Here are some orthotics FAQ's
plus some current thoughts on ICD-10.

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Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

October 1, 2015… I told you so

At the time of this writing—July—despite a handful of Congresspersons submitting bills to eliminate ICD-10, delay ICD-10, and modify ICD-10 implementation, ICD-10 will be implemented on October 1…just a few weeks from now (DISCLAIMER: Keep in mind that Congress always has the opportunity to screw this up). Oh, by the way, if you haven't prepared your office by now, well, best of luck.

Good news, I think. On July 6, CMS and AMA announced guidance to Medicare Administrative Contractors (MACs) and providers "that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set." According to AMA President Steven J. Stack, MD, CMS "will be adopting policies to ease the transition to ICD-10 in response to physicians' concerns that inadvertent coding errors or system glitches during the transition to ICD-10 may result in audits, claims denials, and penalties under various Medicare reporting programs." CMS' actions include:

• Setting up an ICD-10 communications and coordination center, learning from best practices of other large technology implementations that will be in place to identify and resolve issues arising from the ICD-10 transition.

• Offering ongoing Medicare acknowledgement testing for providers through September 30th.

• Providing additional in-person training through the "Road to 10" for small physician practices.

• CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS's ICD-10 Coordination Center.

ue-based modifier, and meaningful use stage 2 involving ICD-10 code use in reporting. CMS also let their MACs know that if they have trouble determining specificity in claim processing, "an advance payment may be available if the claim is otherwise valid." Advance payment is made available when a Part B MAC "is unable to process claims within established time limits because

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The most important action, however, was unilateral—it doesn't appear that commercial payers were informed, advised, or included—that CMS will for one year allow claims to be processed for dates of services October 1, 2015 and beyond, even when the ICD-10 code submitted lacks code specificity [in order for providers to "get their diagnosis coding exactly right"].

CMS instructed its MACs and its various contract auditors not to deny claims "based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family." This one-year grace period also includes leniency to PQRS, val-

of administrative problems, such as contractor system malfunction or implementation problems." The provider is required to submit a request for advanced payment in those cases.

So, where does all this leave us? Subject to change/clarification between the time of this writing and publication, it leaves us with a bunch of questions:

1) How does CMS define the "right family" of codes? "Right family" does not appear to be an ICD-10 description.

2) Just how non-specific can we be in our ICD-10 coding? Does that mean

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we should attempt to be as specific as possible (and who would know?), or can we choose to code only the broad 3 character category code? If we code the first 5 of the previously required specific 7 character codes, will that be okay during the grace period? In other words, can doctors leave off the 6th (laterality) and 7th characters, and still be paid, or should they attempt the complete specific code, even if they blow the last character or two?

3) CMS unilaterally made this decision; will other payers follow suit? Can we have some payers that require the original specificity in code while others don't? Can some payers individually extend their non-specificity grace periods?

Hopefully, by the time this is published, we will have clarification. Doctors should try to complete specific coding (you will have to in one short year anyway) for the condition, symptom/sign, circumstance, etc. If, however, your interpretation of the CMS/AMA grace period is as a coding "get out of jail" card, I would strongly advise you to minimally use the "root" code—the highest level description and code—found in the Alphabetic Index of ICD-10. I, at least in July, assume that this is what CMS considered the "right family" code (a term CMS invented). Follow their further clarification. You can find it right after their clarification of the "X" modifiers.

**Topic of the Month:
Orthotics Coding**

Q: I have previously read that one should not bill and expect payment from Medicare for custom foot orthotics (e.g., L3000 x2); however, I have found that Medicare DOES reimburse L3000. Which is correct? If they don't reimburse L3000, why am I getting paid?

A: Medicare's medical policy (Medicare Benefit Policy Manual Chapter 15—Covered Medical and Other Health Services) reads:

"290—Foot Care (Rev. 1, 10-01-03) A3-3158, B3-2323, HO-260.9, B3-4120.1

B. Exclusions from Coverage
3. Supportive Devices for Feet
Orthopedic shoes and other supportive devices for the feet generally are not covered. However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, this exclusion does not apply to therapeutic shoes furnished to diabetics."

Unless the DMAC claim processing software has a glitch allowing erroneous payments (unlikely), the only way you can be paid as you claim from Medicare for L3000 is if you are applying the "RT" or "LT" anatomic modifier and a "KX" modifier. The "KX" modifier tells the Medicare software that the "requirements specified in the medical policy have been met" for L3000 to be paid. In other words, it is included in the shoe that is an integral part of a leg brace. And that would be a rare occurrence. If you have been applying a "KX" and getting paid when you shouldn't have been, you have set yourself up for some significant problems. The least of this is that you will be audited and asked for the money back and not be able to bill your patient…while paying the orthotic lab fees out of your pocket. Be very careful when applying the "KX" modifier. Make sure all the reimbursements for the device have truly been met.

Q: I would like to begin dispensing a "walking boot sock" (L2840) to my patients. Does Medicare cover this item?

A: L2840 is defined as "addition to lower extremity orthosis, tibial length sock, fracture or equal, each". DME Medicare Administrative Contractors (DMACs) policies specify "Socks (L2840, L2850) used in conjunction with orthoses are denied as non-covered (no Medicare benefit)." It has been recommended that if you want

to dispense the sock in addition to the walking boot, you bill the patient directly for the item. If the patient insists that you submit a claim for the sock, use code L2840 along with a "GY" (statutorily non-covered) modifier. If the patient does not ask you to submit the claim, you can collect your charge directly from the patient.

Q: For the CROW boot, are you just supposed to bill L4631 (ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch

For claims with dates of service on or after January 1, 2011, the correct HCPCS code for a CROW boot is: L4631.

support, plastic or other material, includes straps and closures, custom fabricated), or do you code a CROW boot with multiple codes (L1960, L2232, L2275, L2340, L2820, L3010)?

A: For claims with dates of service on or after January 1, 2011, the correct HCPCS code for a CROW boot is: L4631—ankle foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated.

This coding supersedes and replaces any previous instructions for coding a Charcot Restraint Orthotic Walker with multiple HCPCS component codes.

Q: Is there an explanation that differentiates off-the-shelf versus custom-fitted prefabricated orthotics?

A: According to the DMAC guidelines, "the following definitions are to be used for correct coding of off-the-shelf (OTS) orthotics:
• Items that are prefabricated.
• They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.

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• OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit an individual.

• This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary.

The term 'minimal self-adjustment' is defined at 42 CFR §414.402 as an adjustment the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification)

or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as OTS if the final fitting upon delivery to the patient requires minimal self-adjustment as described in this section [of the guideline].

Custom fitted orthotics are:
• Devices that are prefabricated.
• They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom-fitted.
• Classification as custom fitted requires substantial modification for fitting at the time of delivery in order

to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.

• This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individ-

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ual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as custom-fitted if the final fitting upon delivery to the patient requires substantial modification requiring expertise as described in this section [of the guideline]."
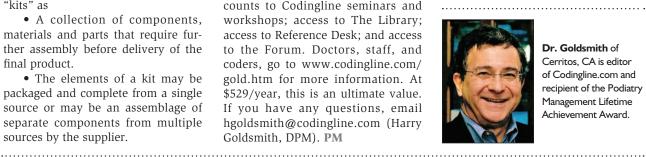
The DMAC guidelines define "kits" as

• A collection of components, materials and parts that require further assembly before delivery of the final product.

• The elements of a kit may be packaged and complete from a single source or may be an assemblage of separate components from multiple sources by the supplier.

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.

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