Orthotics R Us

Here are some answers to some commonly-asked questions.

BY HARRY GOLDSMITH, DPM

Question: *We cast a patient for custom foot orthotics. When we got the orthotics back from the lab, we called the patient and left a message. Actually we have called four times now. He does not respond. Can we mail him the orthotics and list the dispensing date as the date of mailing so we can submit the claim?*

Response: The answer is clear when it comes to dispensing and billing orthotics to Medicare—You cannot bill for covered orthotic devices, DME, or therapeutic shoes/inserts until you dispense them to the patient. You must meet Medicare's dispensing requirements as the supplier.

The answer is not clear with non-Medicare payers. In the past, it was common to bill commercial payers for foot orthotics at the time (day) the impression cast was taken or the impression cast was sent to the lab. The reason was obvious. The office would be responsible for the lab cost of custom devices regardless of whether the orthotics were picked up or not.

I am not aware of any written requirements by commercial payers that providers follow Medicare's dispensing/billing process. Over the years, the "Medicare" policy has frequently become the uniform office policy of foot and ankle practices (i.e., bill the payer at the time orthotics are dispensed). If you want to do otherwise, you should check with the individual payer first to ensure you are not violating contractual policy.

Personally, I would recommend adopting the Medicare dispensing/billing policy. At the same time, I would echo those who recommend taking a deposit from patients with commercial plans (this presumes there is no contract language prohibiting deposits). The deposit can be refunded (minus patient contract obligations) if the commercial plan denies payment for the orthotics.

Question: *I was at a recent seminar where I heard one of the speakers say you can separately bill both the impression casting and foot orthotics. I am unaware you could bill for a casting. Isn't the impression casting bundled with the orthotics payment?*

Response: The bundling of impression casting with the foot orthotic DME, again, varies depending on the commercial payer. While there is no regular CPT code representing the impression casting service, there is a HCPCS code: S0395 (impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic). You can't get more specific than S0395.

Unfortunately, not all payers with foot orthotic benefits recognize S0395. Some still want you to bill CPT 29799 (unlisted casting code). Some will bundle the impression casting (with or without additional payment) into the L3000, L3010, or L3020 allowance.

Before you resign yourself to not bill for the impression casting, it would be worth your while to contact the payer and get in writing the payer policy regarding independent impression casting payment. If the payer has nothing in writing, and you feel that the professional service (which takes 15-20 minutes to perform) is independent of the supply (i.e., foot orthotics), I recommend billing S0395-RT, S0395-LT. One way or another, you will find out whether the payer recognizes not only the independent professional service performed in a foot and ankle specialist's office, but also the code.

Obviously, if the payer denies the code or the additional casting charge because the allowance is "built-into" the foot orthotic allowance, you cannot bill the patient for the impression casting. If that is the case, and you feel that the foot orthotic allowance in no way reflects the supply and the professional service, you should appeal.

You cannot bill for covered orthotic devices, DME, or therapeutic shoes/inserts until you dispense them to the patient.

Question: *I typically perform a biomechanical examination on my patients prior to determining the type of foot orthotics to have fabricated. I was billing CPT 96000, and I was not only recently denied but was also asked for medical records on a number of my patients for whom I had previously also billed CPT 96000. Am I going to have a problem here?*

Continued on page 106

Orthotics R Us *(from page 105)*

Response: Probably. CPT 96000 is defined as "comprehensive computer-based motion analysis by video-taping and 3-D kinematics." It is not the typical office-based lower extremity biomechanical examination. It is described to include "services performed as part of a major therapeutic or diagnostic decision-making process. Motion analysis is performed in a dedicated motion analysis laboratory (i.e., a facility capable of performing videotaping from the front, back, and both sides; computerized 3-D kinematics; 3-D kinetics; and dynamic electromyography). Code 96000 may include 3-D kinetics and stride characteristics. Codes 96002-96003 describe dynamic electromyography."

Now, if that is what you are doing in your office, your office better be designated a facility by your state, and you better have a dedicated motion analysis lab in your facility. If you are going to bill the code, you have to have and do it all. And there has to be a clear medical necessity for performing a comprehensive computer-based motion analysis. It should be noted that the common example for motion analysis is pre-surgical evaluation of a cerebral palsy patient requiring staged lower extremity releases.

In the past, a number of podiatrists billed CPT 95851 (range of motion measurements and report [separate procedure]; each extremity) and CPT 95831 (muscle testing, manual [separate procedure] with report; extremity). CPT 95851 appears to be a reasonable code representing a medically necessary biomechanical study comprising a quantitative range of motion evaluation of the lower extremity (hip to metatarsal-phalangeal joints). If one is billing CPT 95851 for the biomechanical report, it would or should include muscle testing (not separately reported). Of course, billing CPT 95851 is all well and good, but it does not mean that the payer will reimburse the evaluation independent of an E/M service. As a matter of fact, many payers bundle the biomechanical examination into the musculoskeletal component of the E/M service allowance. Other payers question the performance of a comprehensive (separately billable) biomechanical examination as being the standard of care evaluation prior to fabricating foot orthotics.

The bundling of impression casting with the foot orthotic DME, again, varies depending on the commercial payer.

Question: *We have been consistently denied when billing United Healthcare Community Plan for custom foot orthotics. We have tried numerous diagnosis codes including diabetes, plantar fasciitis, pronation, pes planus, etc. While we are not as familiar with all the ICD-10 codes for these conditions, we still have not found one that will get them covered. They always ask for notes, we send them in, and then they deny them. The problem is that the plan states that orthotics ARE covered. Am I within my rights to charge the patients for them as a non-covered item? I explain to the patient that despite what their plan states, they will not be covered. I also tell them that if by some miracle this particular claim gets paid, I will happily refund their money. Also, just to make sure, is L3000 the proper code to bill?*

Response: The obvious question to you is: what did the explanation of benefits say was the reason for the denial? Was it medical necessity, inappropriate or non-supportive diagnosis, frequency, etc.? The next question is: what did the provider rep from United Healthcare Community Plan say when you asked why you were denied? Did they give you or direct you to the benefit language and limitations?

A payer may direct you to a single specific foot orthotic code it wants you to bill, regardless of the type of device dispensed.

If their custom foot orthotic benefit is limited, e.g., diabetes with some specific complication of the lower extremity, and the diabetes diagnosis code you submitted on your claim isn't the code programmed into their editing software, you will get a denial. If your patient has plantar fasciitis and you dispense custom foot orthotics as a first line treatment, and the plan language states the benefit will only be considered after six months of conservative therapy, you will get a denial if they review your records. Check with the plan for more information on their coverage.

Which leads to the second part of your question: Am I within my rights to charge the patients for them as a non-covered item?

If the contract you signed with United Healthcare Community Plan specifically states you are not allowed to charge the patient directly for denied items or service because of medical necessity, you cannot bill the patient even if the patient signs a waiver. Again, check with the plan to see if you are allowed to bill the patient for denied items.

Lastly, regarding L3000 as the proper code. A payer may direct you to a single specific foot orthotic code it wants you to bill, regardless of the type of device dispensed. That is "okay" as long as you have that information in writing prior to submission of the claim. Having said that, specifically L3000 is the proper custom foot orthotic code a foot and ankle specialist would bill if the lab

Continued on page 108

Orthotics R Us *(from page 106)*

creates a custom device with a heel seat specifically included to stabilize the rearfoot and therefore the remainder of the foot. How do I know this? The following is an excerpt from an L3000 opinion published in the Members Only section of the APMA website:

"L3000—Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each

Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three-dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is a functional device, (reducing pathological forces) which has a molded heel cup and trim lines 10 mm or greater in height to provide both medial and lateral directive forces to control the hind- and forefoot. It may also have intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to control function and reduce pathological forces. HCPCS code L3000 includes additions such as postings, padded top covers, soft tissue supplements, balance padding, and lesion or structure accommodations. Other additions may be required as well."

No other custom foot orthotic code, L3010, L3020, or L3030, provides a 10 mm or greater heel cup.

Just a reminder regarding L3030: it is defined as "foot insert, removable, formed to patient foot, each." That means it is formed directly to the patient's foot through the use of an external heat source, and not created through a mold or scan. No one typically does this.

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It's L3000-RT, L3000-LT.

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