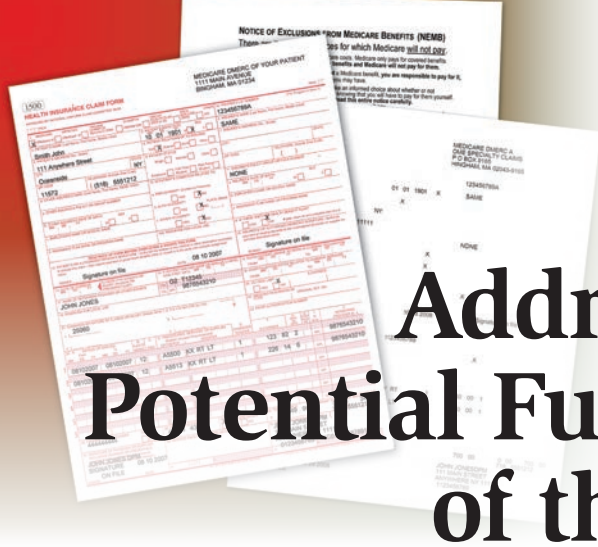

Addressing the Potential Functional Capacity of the Patient

Failure to do this could result in an audit.

BY PAUL KESSELMAN, DPM

With the end of the Public Health Emergency, CMS and its agencies have notably reinstated both pre-and post-payment audits. One glaring reason why audits involving orthotics and prosthetics often result in negative outcomes is due to failing to address the potential functional capacity of the patient using the prescribed/dispensed device.

What does the Medicare Administrative Contractor (MAC) on a pre-payment Target Probe and Educate (TPE), or the SMRC (Supplemental Review Contractor) or Recovery Audit Contractor (RAC) on their post payment audits, infer by a lack of addressing the functional capacity of the patient with the device?

In the simplest of terms, the auditors are indicating there is a lack of supportive documentation of the expected outcome for the patient utilizing the device. To provide clinical relevance to this, along with documentation tips, let's look at two clinical scenarios. The first patient is one requiring an acutely needed device (CAM boot) and the second patient is one requiring a custom fabricated device (e.g., Hinged AFO with soft tissue supplement) for PTTD.

Patient #1

Patient number one has a recent acutely diagnosed second metatarsal left foot fracture which is stable and non-displaced. What else needs to be documented to support the need for and the type of a CAM boot?

Is the foot edematous? Does the patient have PAD or neuropathy posing a threat if s/he were to be placed into a circumferential closed dressing (cast, Unna boot)? Will the CAM boot allow the patient to ambulate without crutches and to perform their ADL's (e.g., showering with a shower chair) better than with a cast or Unna boot? Will the CAM boot provide not only immobilization, but provide adjustable compression? All these likely run through your mind when examining and discussing the care plan with the patient.

The above may all seem rather simple to discuss, but how many providers document this from the perspective of the device's properties, along with the potential benefits they afford the patient? Taking this a bit further, now that one may have decided to place the patient in a CAM boot, which type is needed, a pneumatic or non-pneumatic boot? If a pneumatic boot is required, why? If the patient does not have edema or fluctuating edema, then perhaps a less expensive but equally effective non-pneumatic boot L4386/7 is all that is needed.

No matter which CAM boot is required, providers should also provide supportive documentation on whether an off-the-shelf (OTS)(the higher number code of the pair) or one which is custom-fitted (lower number of the paired code) is medically necessary. Since custom fitted devices are paid the same as their off-the-shelf partners, why bill for the custom fit version? (L4386 vs. L4387, or L4360 vs. L4361).

Competitive bidding may eventually force OTS products into a much lower reimbursement.

Competitive bidding may eventually force OTS products into a much lower reimbursement. Thus, to avoid wholesale changes to a practice's billing patterns, the charting should justify which HCPCS code of the pair is being billed. The chart should support:

The type of CAM boot (Pneumatic vs. Non-Pneumatic) and OTS vs. a custom fit. Using a pneumatic custom fit CAM boot as an example, the medical necessity and improved functional capacity for this device can be supported by these facts:

The patient has a fracture which is not displaced but requires immobilization to facilitate their ability to walk and perform their ADLs with minimal if any assistance and with reduced pain. Healing of the frac-

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ture must also be promoted. The patient has PAD,and placing them in a circumferential cast with fluctuating edema is contradictory to good medical practice. Utilizing a pneumatic CAM boot allows the patient to perform self-examination of their leg/foot/ankle at regular intervals and report any untoward outcomes (erythema, bullae, ulcerations, etc.) to the office.

The medical necessity for a pneumatic boot is further supported by the need to provide adjustable compression due to fluctuating edema, which cannot be provided by a non-pneumatic boot, cast, or surgical shoe. Finally, the custom fitting by heating and molding the upright performed by the physician allows for the adjustment of the device in order to custom fit the pneumatic CAM Boot. This allows for accommodation of the osseous prominences of the talar head and navicular tuberosity.

Patient #2

Now let's look at the patient with chronic PTTD who is being dispensed a custom fabricated hinged AFO (L1970) with a below-knee soft tissue liner (supplement) L2820. What needs to be documented from the perspective of functional improvement?

Out of the six requirements in the AFO LCD 33686, most providers will document only one of these two:

1) The patient needs the device for more than six months.

2) The patient has a deformity in more than one plane.

While the policy stipulates that only one of the six qualifiers are needed, if all the medical necessity is documented as only one of the above two qualifiers, it is likely the chart will fail the audit.

Why? Because the auditors will ask these two questions:

- *Why does the patient require the device for more than six months?*

The chart should document that the patient's condition is chronic and is only stabilized (and please stipulate how) when using the AFO. Some suggestions include noting that the patient's deformity is so severe that it is not expected to ever resolve; or provide an estimate for the patient's recovery and document what else (e.g., physical or occupational therapy or future surgery) is planned.

- *Does the patient have a deformity in more than one plane?*

The chart should document that the patient's condition is chronic and is only stabilized (and please stipulate how) when using the AFO.

Answering in the affirmative is insufficient and a misinterpretation of the LCD. The policy states: There is a need to control the knee, ankle, or foot in more than one plane. Hence the documentation emphasis should include both the anatomical/physiological issue involving more than one plane and why the correction is needed in more than one plane.

In the case of chronic PTTD, the documentation may include facts that the multiplane deformity (frontal, transverse, and sagittal) involving the subtalar joint is causing significant pain in the ankle and subtalar joint, which is not being adequately controlled with pain and anti-inflammatory agents and other treatments. X-ray and MRI findings may also be included.

Furthermore, a custom fabricated AFO which controls these joints by holding them in neutral position and resisting the deforming forces has the potential to reduce the patient's pain throughout the gait cycle; this improves the patient's gait and ability to perform his/her own ADLs with less assistance. The documentation for medical necessity, if it is to be considered complete, needs to mention both the anatomical deformities and how the AFO will improve the patient's condition.

If the above two questions are now satisfied, has this passed the medical necessity part of the audit, at least from the functional capacity perspective? For those voting no, you are correct. If one reviews the narrative, s soft tissue liner (L2820) was noted. To support the medical necessity for L2820, the chart needs to document both the existence of soft tissue atrophy and what the supplement will do to avoid further trauma. An example might include information that the patient's lower leg has significant soft tissue atrophy and there are several osseous prominences in and around the talonavicular joint. The shearing forces of the AFO lower leg segment and foot plate require these anatomical areas to be further protected, such as via a BK segment soft tissue supplement to minimize the risk of ulceration, thereby promoting patient comfort and compliance.

The issues addressed within this article may appear to be minor documentation challenges from the clinician's perspective. However, these are significant in the sense that they may draw serious attention from auditors. Functional perspective is a huge part of the decision-making process on whether the patient's chart passes on the merits of medical necessity. The chart must include both information on the patient's deformity but also the rationale for the potential benefit of whatever device is being prescribed. The need to communicate this information within the patient's chart cannot be overemphasized. Simply put, including some perspective on improved functional capacity with the device will increase the chance of charts receiving an approval from the auditor! **PM**

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Council for the DME MACs' NSC and provider portal subcommittees. He is a noted expert on durable medical equipment (DME) and an expert for Codingline.com and many third-party payers. Dr. Kesselman is also a medical advisor and consultant to many medical manufacturers and compliance organizations.