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CERT
DME MAC Outreach & Education
Task Force for Error-Free Medicare Claims

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Healthcare Solutions

Together We Can Reduce CERT Errors

DME CERT Outreach and Education Task Force
Knee Orthoses
National Webinar – November 3, 2021

Today's Webinar Moderators and Presenters

- Ruth Reese - Provider Outreach and Education Representative
- Angie Cooper - DME CERT Task Force Co-Coordinator
- Jurisdiction A: Ruth Reese
- Jurisdiction B: Angie Cooper
- Jurisdiction C: Angie Cooper
- Jurisdiction D: Ruth Reese

Agenda

- Overall 2020 CERT Error Results
- Coverage Criteria for Knee Orthoses
- Documentation Requirements
- Resources
- Questions

CERT Errors

Comprehensive Error Rate Testing (CERT)

2020 Improper Payment Rates and Projected Improper Payment

CERT: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	6.3%	$25.7 B
DMEPOS	**31.8**	**$2.8 B**
Part A (excluding Hospital Inpatient Prospective Payment System (IPPS))	6.2%	$10.9 B
Part A (Hospital IPPS)	3.0%	$3.6 B
Part B Providers	8.1%	$8.4 B

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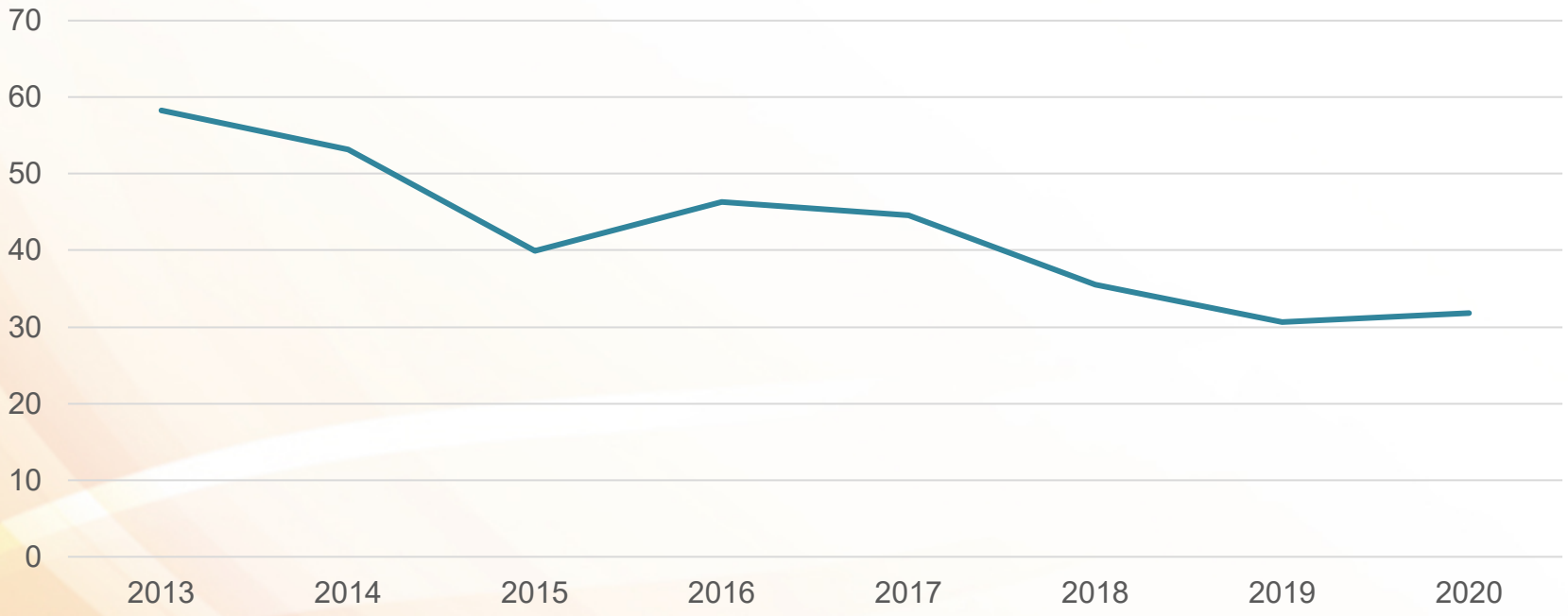
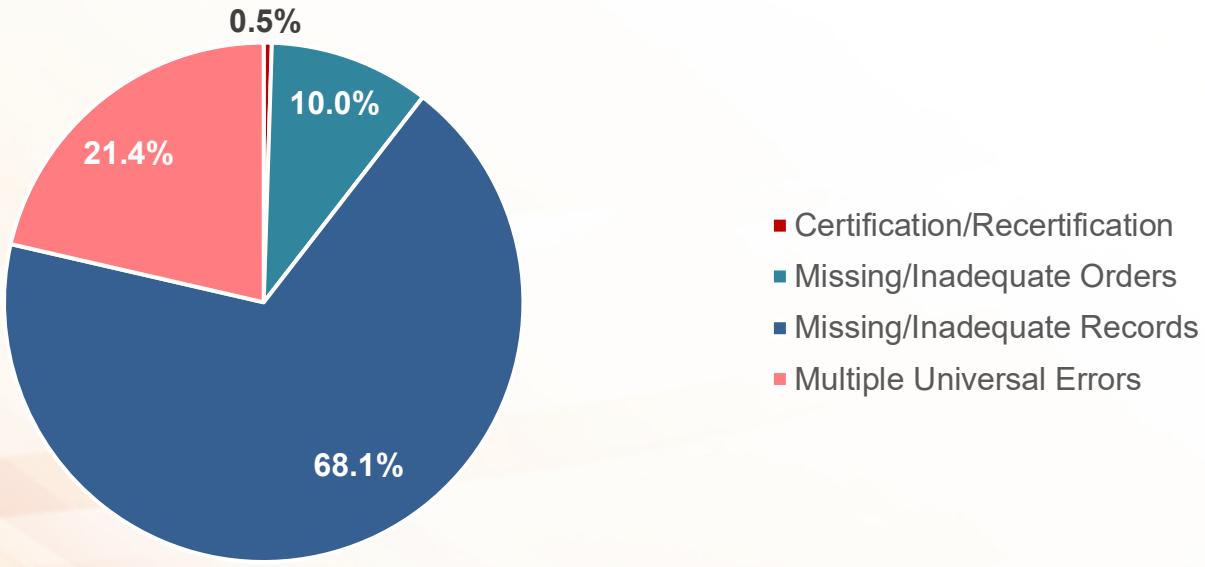
DMEPOS Improper Payment Rate All DME MAC Trend

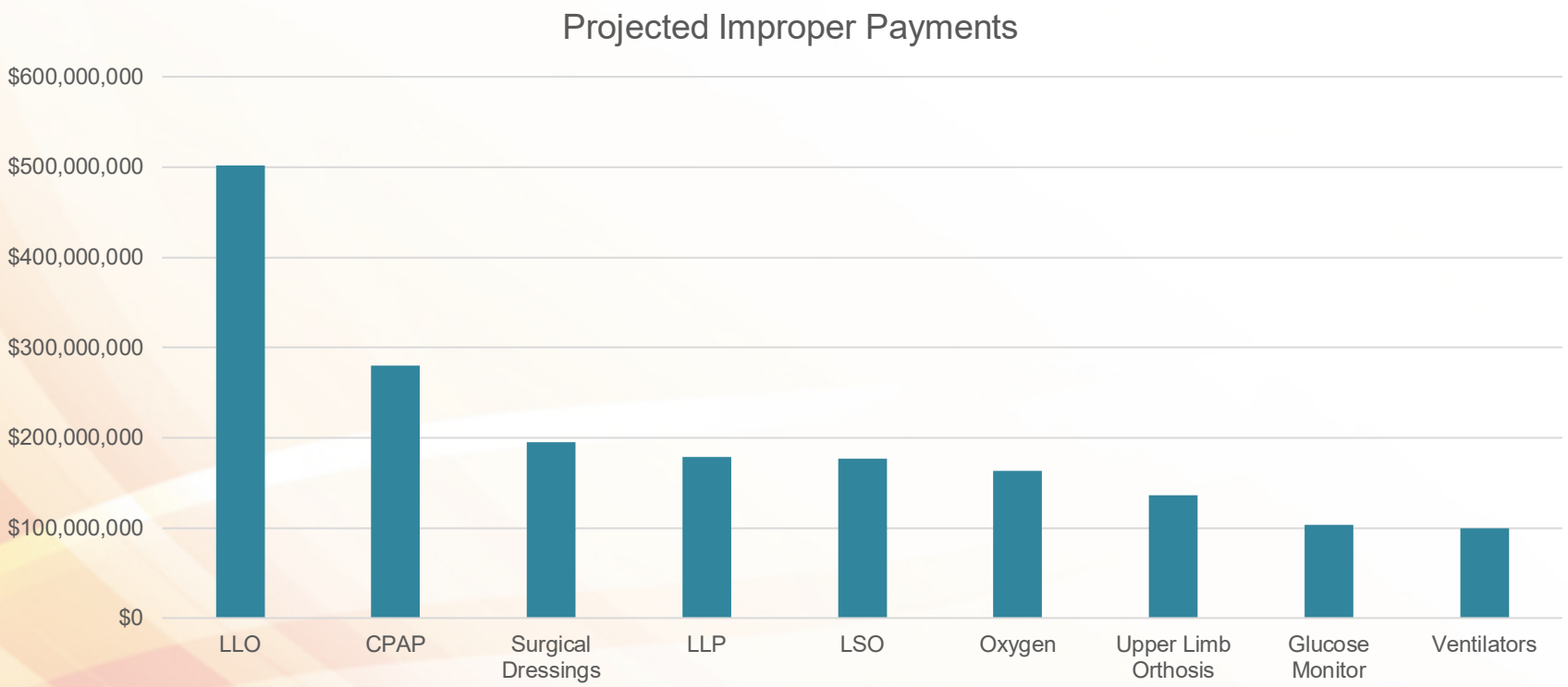


Top Root Causes of Insufficient Documentation Errors in DMEPOS

- Orders – Missing or inadequate
- Documentation to support coverage criteria – Missing or inadequate
- Proof of delivery – Missing or inadequate



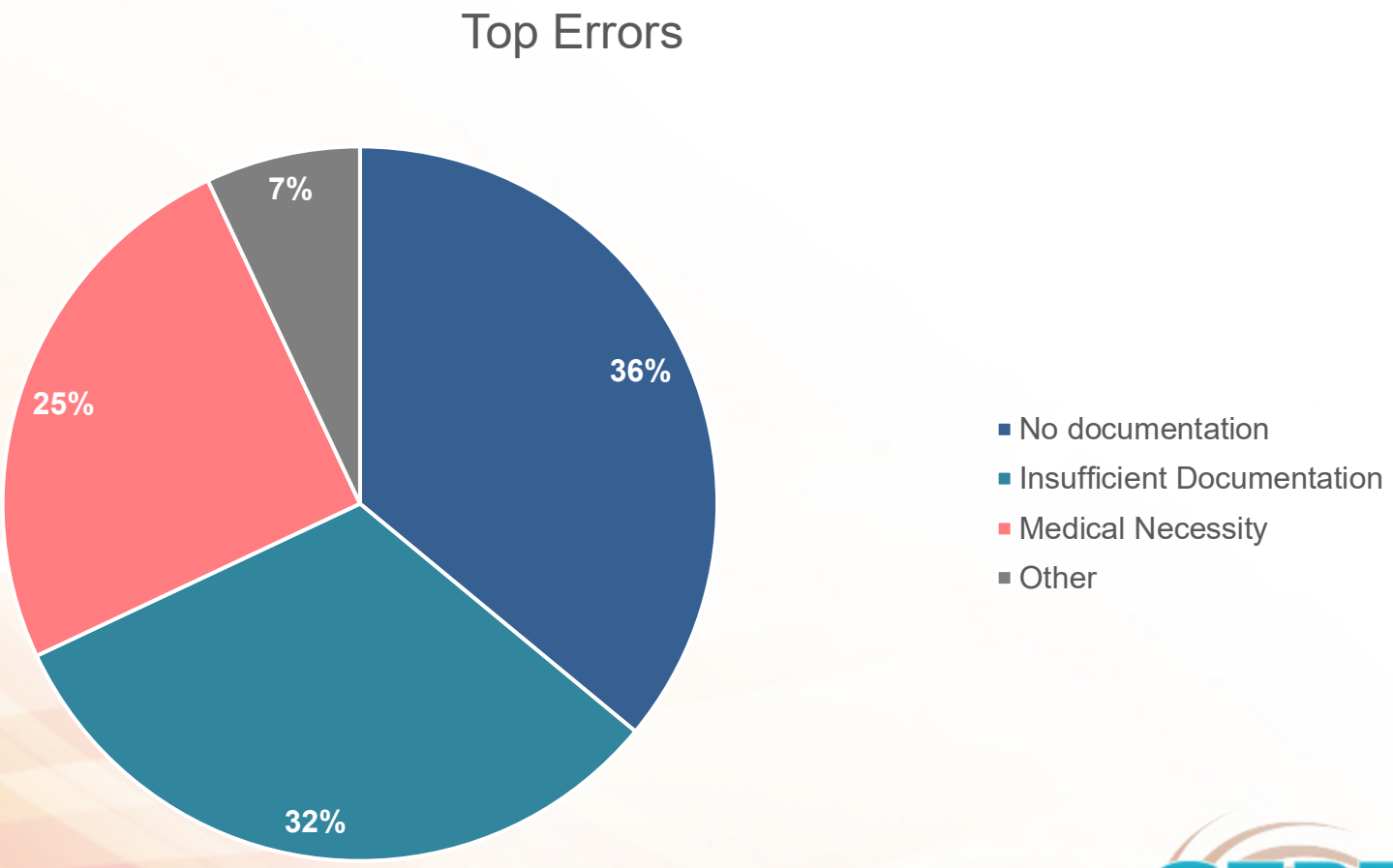
Top Policies with Errors
ALL DME MACs



Improper Payment Rates for Lower Limb Orthoses

- November 2020 report period:
  - Claims submitted July 1, 2018 – June 30, 2019
- Number of lower limb orthoses claims reviewed by the CERT contractor during their 2020 reporting period: 794
- Overall error rate for lower limb orthoses: 65.7%
- Lower limb orthoses projected improper payments: $501.2M

2020 CERT Data: Lower Limb Orthoses Errors



Lower Limb Orthoses Current CERT Error Trends

- Medical documentation that supports an examination of knee instability and an objective description of joint laxity (such as joint testing, anterior draw, posterior draw, or valgus/varus test) from the treating practitioner
- Supplier documentation does not include sufficiently detailed description of the modifications necessary at the time of fitting the custom fitted orthosis to the beneficiary

CERT Documentation Requests

- Documentation may be submitted the following ways
  - Via Postal Mail to: CERT Documentation Center
1510 East Parham Road
Henrico, Virginia 23228
  - Via Fax to: 1.804.261.8100
    - Use the barcoded cover sheet as the only coversheet.
    - Do not add your own cover sheet—this slows down the receipt and identification process
    - Send a separate fax transmission for each individual claim.
  - Via Electronic Submission of Medical Documentation (esMD):
    - Include a CID# or Claim number and the barcoded cover sheet in your file transmission.
    - Information on esMD can be found at https://www.cms.gov/esMD

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CERT Documentation Requests

- Via CD:
  - The images should be encrypted per HIPAA security rules.
  - If encrypted, the password and CID# must be provided via email to CERTMail@nciinc.com or via fax to 1.804.264.9764
  - Must contain only images in TIFF or PDF format.
- Via Email Attachment:
  - The email attachment(s) should be encrypted per HIPAA security rules.
  - If encrypted, the password and CID# must be provided via phone to 1.888.779.7477 or via fax to 1.804.264.9764
  - Must contain only attachments in TIFF or PDF format.

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CERT Contact Information

- CERT Documentation Center
  - Customer Service: 1.443.663.2699
  - Toll Free: 1.888.779.7477
  - Email: certprovider@nciinc.com
  - Website: https://c3hub.certrc.cms.gov/
- DME MAC CERT Resources
  - JA: https://med.noridianmedicare.com/web/jadme/cert-reviews/cert
  - JB: https://www.cgsmedicare.com/jb/claims/cert/index.html
  - JC: https://www.cgsmedicare.com/jc/claims/cert/index.html
  - JD: https://med.noridianmedicare.com/web/jddme/cert-reviews/cert

Appeal Rights from CERT Audits

- If the CERT contractor finds errors with the claim in question, the supplier will receive an Overpayment Demand Letter and a revised Medicare Remittance Advice (MRA) statement.
- If the supplier does not agree with the outcome of the CERT review, they should file an appeal to the Redeterminations department of their DME MAC within 120 days of the date on the demand letter or MRA.
  - If a redetermination is filed to the appropriate DME MAC within 30 days of the overpayment demand letter, all recoupment activities will cease until the redetermination decision is made.

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Coverage of Knee Orthoses

Definitions

- **Orthosis (Brace):**
  - Rigid or semi-rigid devices used for purpose of supporting weak or deformed body member or restricting or eliminating motion in diseased or injured part of body
- **Prefabricated Orthosis:**
  - Both “off-the-shelf” (OTS) and custom-fit items are considered prefabricated braces for Medicare coding purposes
  - Manufactured in quantity without specific beneficiary in mind
- **Custom Fabricated Orthosis:**
  - Individually-made for specific beneficiary starting with basic material
  - Involves more than trimming, bending, or making other modifications to substantially prefabricated item

Definitions OTS vs Custom Fit

Off-the-Shelf (OTS) Orthotics	Custom-Fitted Orthotics
Prefabricated	Prefabricated
May or may not be supplied as kit that requires some assembly	May or may not be supplied as kit that requires some assembly
Requires minimal self-adjustment for fitting (by beneficiary or supplier)	Requires more than minimal self-adjustment for individualized fit
Fitting does not require expertise of certified orthotist/specialized training	Fitting does require expertise of certified orthotist/specialized training

Minimal Self-adjustment vs. More than Minimal Modification

Minimal Self-adjustment (Off-the-Shelf)	More than Minimal Self-Adjustment (Custom-Fitted)
Beneficiary, caregiver, or supplier can perform adjustment	Changes made to achieve individualized fit during final fitting at time of delivery
Does not require certified orthotist or individual with specialized training	Does require certified orthotist or individual with specialized training
Examples: • Adjustment of straps and closures • Bending or trimming for final fit or comfort	Trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment

Individuals with Expertise to Perform Modifications

- Certified Orthotist that has been certified by
  - American Board for Certification in Orthotics and Prosthetics, Inc.
  - Board for Orthotics/Prosthetist Certification
- Individuals with specialized training to provide custom-fitting services include
  - Physician
  - Treating practitioner
    - Physician assistant (PA)
    - Nurse practitioner (NP)
    - Clinical nurse specialist (CNS)
  - Occupational therapist (OT)
  - Physical therapist (PT)

Correct Coding of Prefabricated Orthoses

- Dictated by actions taken at time of fitting
  - Custom-fit (requiring expertise)
  - Off-the-Shelf (requiring minimal self-adjustment)
- Parallel HCPCS codes that describe identical type of items
  - Which code to use depends on final fitting upon delivery
- Some HCPCS codes do not make a distinction between prefabricated provided as custom-fit or OTS
  - Joint DME MAC and PDAC Publication dated March 2021:
    - Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf – Correct Coding

Correct Coding of Prefabricated Orthoses (2)

- Custom fit provided directly to beneficiary as off-the-shelf
  - No custom fitting completed
  - No corresponding OTS HCPCS code
    - Must use miscellaneous code L2999
    - Claim narrative required
      - HCPCS code of item provided
      - OTS
      - Supplier retail price (SRP)
      - Example: L1820 OTS $150 SRP

Custom-Fabricated

- Individually made for a specific beneficiary
- Fabricated using
  - Clinically-derived and rectified castings, tracings, measurements, other images
- Use of basic materials
  - Plastic, metal, leather, or cloth in form of sheets, bars, other forms
- Involves substantial work
  - Vacuum forming, cutting, bending, molding, sewing, drilling, and finishing
- Requires a positive model of beneficiary

Prefabricated Knee Orthoses

- Knee orthosis with joints (L1810, L1812); or
- Knee orthosis with condylar pads and joints with/without patellar control (L1820)
- Covered for:
  - Ambulatory beneficiaries who have weakness or deformity of knee; and
  - Require stabilization
- Knee orthosis with locking knee joint (L1831); or
- Rigid knee orthosis (L1836)
- Covered for:
  - Flexion or extension contractures with movement on passive range of motion testing of 10 degrees
    - Requires covered Group 1 diagnosis code

Prefabricated Knee Orthoses (2)

HCPCS	Description	Covered for:
L1830 (off-the-shelf)	Knee immobilizer without joints	Either Path 1 or Path 2
L1833 (off-the-shelf) **L1832** (custom fit)	Knee orthosis with adjustable knee joints	Either Path 1 or Path 2
L1843 (custom fit) **L1845** (custom fit) **L1851** (off-the-shelf) **L1852** (off-the-shelf)	Knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control	Either Path 1 or Path 2

Path 1:

- Recent injury or surgical procedure to knee(s); and
- Group 2 or Group 4 diagnosis codes

Path 2:

- Ambulatory; and
- Objective description of joint laxity; and
- Knee instability due to condition specified in the Group 4 diagnosis codes

Prefabricated Knee Orthoses (3)

- Swedish type, prefabricated (L1850)
  - Beneficiary is ambulatory; and,
  - Knee instability
    - Genu recurvatum – hyperextended knee
      - » Congenital or acquired
  - Requires covered Group 5 diagnosis code

Documentation of Knee Instability

- Knee instability must be documented by:
  - examination of the beneficiary and
  - objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).
- Claims will be denied as not reasonable and necessary when the beneficiary does not meet the criteria for coverage.
- For example, they will be denied if only pain or a subjective description of joint instability is documented.
- The appearance of a covered diagnosis code is not sufficient documentation to meet coverage criteria.

Custom Fabricated Knee Orthoses

- L1834, L1840, L1844, L1846, L1860
- Custom fabricated requires
  - Documented physical characteristic requiring custom fabricated instead of prefabricated
- Situations which meet criterion for custom fabricated
  - Deformity of leg or knee
  - Size of thigh and calf
  - Minimal muscle mass upon which to suspend orthosis
- Consider prefabricated alternatives

Custom Fabricated Knee Orthoses (2)

- Knee immobilizer without joints (L1834)
  - Covered if criteria 1 and 2 are met
    1. Coverage criteria for prefabricated orthosis code L1830 met; and,
    2. General criterion for custom fabricated orthosis met

Custom Fabricated Knee Orthoses (3)

- Derotation knee orthosis (L1840)
  - Instability due to internal ligamentous disruption
    - Requires covered Group 3 diagnosis code
- Knee orthosis with adjustable flexion and extension joint (L1844 and L1846)
  - Coverage criteria for prefabricated L1843, L1845, L1851,L1852 met
  - General criterion for custom fabricated orthosis met
  - Requires covered Group 4 diagnosis code

Custom Fabricated Knee Orthoses (4)

- Knee orthosis with modified supracondylar prosthetic socket (L1860)
  - Ambulatory
  - Knee instability
    - Genu recurvatum – hyperextended knee
  - Requires covered Group 5 diagnosis code

Miscellaneous Coverage Criteria

- Heavy duty knee joint (L2385, L2395)
  - Beneficiaries weighing more than 300 pounds
- Replacement removable soft interface (K0672)
  - Maximum two per year
    - Beginning one year after date of service initial orthosis
  - Additional replacement interfaces
    - Denied as not reasonable and necessary

Miscellaneous Coverage Criteria (2)

Concentric Adjustable Torsion-style Mechanisms

- L2999
  - Covered under brace benefit
  - Assist knee joint extension in absence of co-existing joint contracture
- E1810
  - Custom fit
  - Covered under DME benefit
  - Treatment of contractures
    - Dynamic adjustable knee extension/flexion
    - Includes soft interface material

Miscellaneous Coverage Criteria (3)

L2999

- Lower extremity orthoses not otherwise specified
- Used when no other code applies
- Claim must include
  - Manufacture's name
  - Product name
  - Model name/number
  - Custom fabricated
    - Description
      - » What makes item unique
      - » Breakdown of charges

Addition Codes

- Code tables within LCD and Policy Article
  - Eligible for separate payment
  - Not reasonable and necessary
  - Not separately payable
  - Incompatible

Knee Orthoses Included in Hospital or SNF Stay

- Payment for orthoses are included in the payment to a hospital or skilled nursing facility (SNF) if:
  - The orthosis is provided to a beneficiary prior to an inpatient hospital admission or Part A covered SNF stay; and
  - The medical necessity for the orthosis begins during the hospital or SNF stay (e.g., after surgery);

  Or

  - The orthosis is provided to a beneficiary during an inpatient hospital or Part A covered SNF stay prior to the day of discharge; and
  - The beneficiary uses the item for medically necessary inpatient treatment or rehabilitation.
- **A claim must not be submitted to the DME MAC in this situation**

Hospital or SNF Stay

- Payment for knee orthoses delivered to a beneficiary in a hospital or a Part A covered SNF stay is eligible for coverage by the DME MAC if:
  1. The orthosis is medically necessary for a beneficiary after discharge from a hospital or Part A covered SNF stay; and
  2. The orthosis is provided to the beneficiary within two days prior to discharge to home; and
  3. The orthosis is not needed for inpatient treatment or rehabilitation, but is left in the room for the beneficiary to take home.
- **The date of service is the date of discharge.**

Modifiers

- **LT** - Left side
- **RT** – Right side
- Note: Suppliers must submit bilateral items on two separate claim lines using the RT and LT modifiers and 1 Unit of Service (UOS) on each claim line
- **EY** – No physician or other licensed health care provider order for this item or service.
- **GA** – Valid Advanced Beneficiary Notice (ABN) was obtained.
- **GZ** – ABN not obtained.
- **KX** – Requirements specified in the medical policy have been met.

Documentation Requirements

SWO Required Elements

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
  - Description can be either a general description (e.g., knee brace), a HCPCS code, a HCPCS code narrative, or a brand name/model number.
  - Must list each separately billed item
- Quantity to be dispensed (if applicable)
- Treating practitioner name or NPI
- Treating practitioner's signature

SWO Exception

- A separate SWO is not required when the prescribing practitioner is:
  - Also the supplier
  - Is permitted to furnish specific items of DMEPOS
  - Is permitted to fulfill the role of the supplier in accordance with any applicable laws and policies.
- In such cases, a separate order is not required, but the medical record must still contain all of the required order elements.

Medical Records

- Detailed documentation in treating practitioner's records
  - Medical necessity of item billed
  - Focused history and examination of impacted body part
    - This is critical to establishing medical necessity
  - Diagnosis code billed on claim
- Supplier generated templates and forms
  - Must be corroborated within medical record
- Information intended to demonstrate compliance
  - May be included on prescription
  - Must be corroborated by medical record

Orthotist/Prosthetist Records

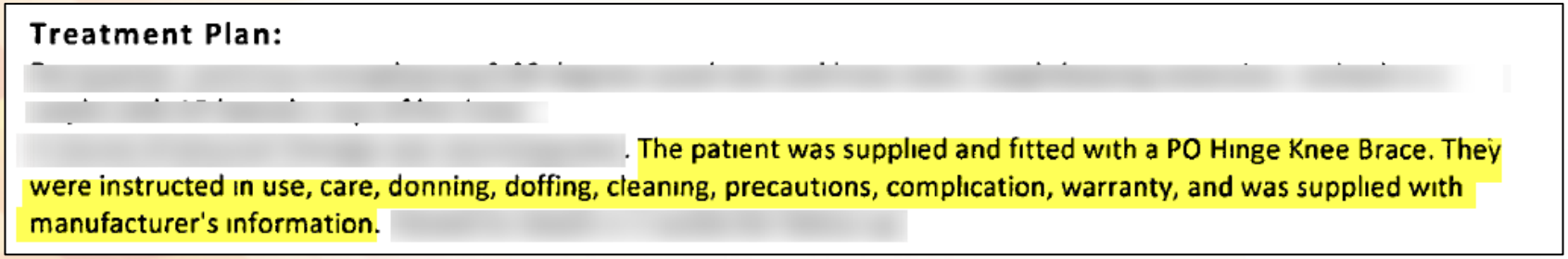
- Considered in context of
  - Documentation made by physician and other practitioners
    - Provide additional details to demonstrate reasonable and necessary
- O&P notes are expected to
  - Corroborate and provide details consistent with physician/practitioner records
- Conflict between prescriber notes and O&P record
  - DME MAC would likely deny payment
- Payment may not be provided solely based on O&P documentation
  - Absence of physician/practitioner documentation
  - DME MACs may deny payment

Documentation of Custom Fitted Orthoses

- Documentation of More than Minimal Self-Adjustment:
  - L1810, L1832, L1843, L1845, L1847
  - Must be sufficiently detailed to include
    - A detailed description of modifications necessary at time of fitting
    - Information must be available upon request

Example of Insufficient Documentation

- Billed: L1832 – Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit specific patient by individual with expertise
- Claim Denied
  - Supplier documentation does not include sufficiently detailed description of modifications necessary at time of fitting custom fitted orthosis to beneficiary
  - Records do not support that the person who did custom fitting for orthosis has expertise of certified orthotist or individual who has equivalent specialized training in provision of orthotics



Treatment Plan:

[redacted]. The patient was supplied and fitted with a PO Hinge Knee Brace. They were instructed in use, care, donning, doffing, cleaning, precautions, complication, warranty, and was supplied with manufacturer's information. [redacted]

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Documentation of Custom Fabricated Orthoses

- L1834, L1840, L1844, L1846, L1860
- Detailed documentation in treating practitioner's records
  - Supporting medical necessity
    - As described in LCD
  - Corroborated by functional evaluation in orthotist or prosthetist's records.
    - Information must be available upon request

Documentation Requirements

- Suppliers must
  - Provide product specified by prescribing practitioner
  - Medical record must justify need for type of product
    - Prefabricated versus custom fabricated
  - Bill HCPCS code that accurately reflects
    - Type of orthosis; and
    - Appropriate level of fitting
  - Detailed documentation in supplier's records that justifies HCPCS code
- Diagnosis code that necessitates need must be included on claim

Method 1: Direct to Beneficiary

- Date of service = Date beneficiary received the item (date of delivery)
- Proof of delivery must include:
  - Beneficiary's name
  - Delivery address
  - Quantity delivered
  - A description of item(s) being delivered. Description can be either a narrative description (e.g., knee brace), a HCPCS code, long description of a HCPCS code, or a brand name/model number
  - Date delivered
  - Beneficiary (or designee) signature:
    - During COVID-19, document in beneficiary record appropriate date of delivery and that a signature was not able to be obtained because of COVID-19

Method 2: Shipping Service

- Date of service = Shipping date or date of delivery
- Delivery documentation must include:
  - Beneficiary's name
  - Delivery address
  - Delivery service's package ID number, supplier invoice number or alternative method that links supplier's delivery documents with delivery service's records
  - A description of item(s) being delivered. Description can be either a narrative description, a HCPCS code, long description of a HCPCS code, or a brand name/model number.
  - Quantity delivered
  - Date delivered
  - Evidence of delivery

Method 3: Delivery to Skilled Nursing Facility (SNF)

- Proof of delivery must include:
  - Documentation demonstrating delivery of item(s) to facility by supplier or delivery entity; and,
  - Documentation from nursing facility demonstrating receipt and/or usage of item(s) by beneficiary.
    - Quantities delivered and used by beneficiary must justify quantity billed.

Reasonable Useful Lifetime (RUL)

One Year	Two Years	Three Years
Prefabricated Knee Orthoses		
L1810	L1831	L1836
L1812	L1832	L1843
L1820	L1833	L1845
L1830	L1850	L1851
		L1852

Custom-Fabricated Knee Orthoses
Three years

Resources

Knee Orthoses Resources

- Local Coverage Determination (LCD): Knee Orthoses (L33318) https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33318&ver=47&contractorName=5&contractorNumber=389%7C1&lcdStatus=all&sortBy=title&bc=7
- Local Coverage Article: Knee Orthoses - Policy Article (A52465) https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52465&ver=36
- Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)
  - https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=55426

Resources

- Jurisdiction DME MAC Websites:
  - Jurisdiction A – https://med.noridianmedicare.com/web/jadme/
  - Jurisdiction B – https://www.cgsmedicare.com/jb
  - Jurisdiction C – https://www.cgsmedicare.com/jc
  - Jurisdiction D – https://med.noridianmedicare.com/web/jddme/

Questions?

Disclaimer

The DME MAC CERT Outreach and Education Task Force consists of representatives from each of the DME MACs and is independent from the CMS CERT Team and CERT Contractors, who are responsible for the calculation of the Medicare Fee-for-Service Improper Payment Rate.

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Thank You!