CERT

DME MAC OUTREACH & EDUCATION

Task Force for Error-Free Medicare Claims

Lower Limb Orthoses (LLO)

June 1, 2023

noridian Healthcare Solutions

CGS A CELERIAN GROUP COMPANY

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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Webinar Moderators and Presenters

- Jurisdiction A and D – Noridian Healthcare Solutions
  - Ruth Reese
- Jurisdiction B and C – CGS Administrators
  - Angie Cooper

Agenda

- Comprehensive Error Rate Testing (CERT) Data
- Medical Necessity Requirements
  - AFO/KAFOs
  - Knee Orthoses
- Documentation Requirements

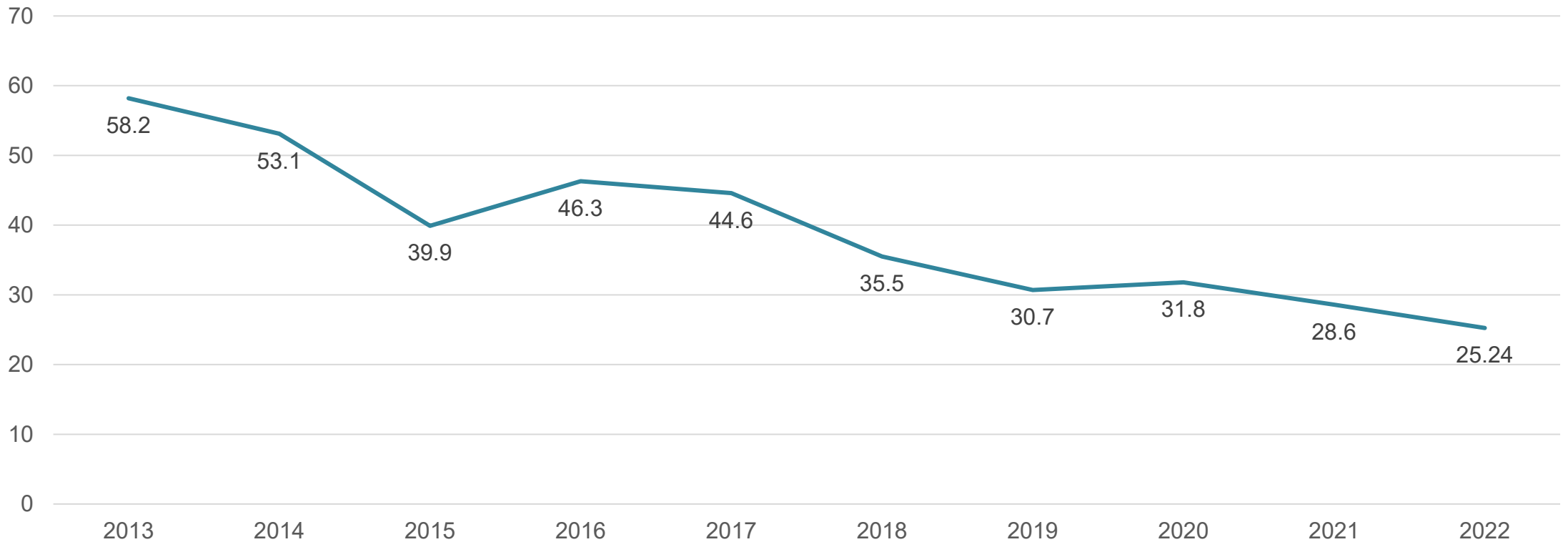
Comprehensive Error Rate Testing (CERT) Data

2022 Medicare Fee-for-Service Supplemental Improper Payment Data

Service Type	Improper Payment Rate	Projected Improper Payment Amount
Overall	7.46%	$31.46 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	**25.24%**	**$2.19 B**
Part B Providers	8.21%	$8.75 B
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	8.86%	$17.13 B
Hospital IPPS	2.99%	$4.12 B

Claims Submitted Dates: July 1, 2020 – June 30, 2021

DMEPOS Improper Payment Rate All DME MAC Trend



Top DMEPOS Improper Payment Rates by Service Type

Policy Group	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
CPAP	928	$247 M	24.1%
All Policy Groups with Less than 30 Claims	730	$211.8 M	31.2%
Lower Limb Orthoses	**676**	**$187.8 M**	**57.5%**
Infusion Pumps & Related Supplies	463	$118.4 M	18.3%
Surgical Dressings	428	$116.9 M	41.8%
Ventilators	362	$108.2 M	20.1%
Glucose Monitors	828	$105.8 M	118.5%
Lower Limb Prostheses	344	$96.4 M	25.1%
Oxygen Supplies/Equipment	525	$92.9 M	15.3%
Urological Supplies	352	$87.1 M	24.9%

Improper Payment Rates for Lower Limb Orthoses by Referring Provider

Referring Provider	Claims Reviewed	Projected Improper Payments	Improper Payment Rate
Family Practice	117	$52.8 M	70.8%
General Surgery	257	$41.9 M	46.4%
Internal Medicine	82	$38.2 M	77%
Podiatry	73	$11.8 M	30.8%
Nurse Practitioner	35	$11.5 M	70.6%
All Referring Providers	**676**	**$187.8 M**	**57.5%**

Top Root Causes of Improper Payments for LLO

Root Cause Description – Medical Necessity	Sample Claim Count
Base item on the claim is denied therefore the related addition to the base, accessory, or supply fee is denied	47
Documentation does not support medical necessity for the service or item billed	7
Root Cause Description – Insufficient Documentation	**Sample Claim Count**
Documentation to support coverage criteria – Inadequate or Missing	72
Description of the modification to the orthotic at the time of fitting – Inadequate or Missing	31
Proof of Delivery – Inadequate or Missing	31
Order – Missing	15
Attestation for unsigned documentation – missing	7

CERT Documentation Requests

- The CERT Review Contractor (CERT RC) requests and receives all medical records.
- Use the barcoded coversheet as your documentation coversheet
- Documentation may be submitted:
  - Mail or Fax
  - Electronic Submission of Medical Documentation (esMD)
    - Include a CID number or Claim number and the barcoded cover sheet in your file transmission.
  - CD or Email attachment
    - encrypted per HIPAA security rules
- Check the current status of a claim under CERT review by using the CERT C3HUB Claim Status Search
  - If CERT shows the review has been completed – refer to DME MAC CERT resources

CERT Contact Information

CERT Contractor Resources and Contacts

- Phone: 1.888.779.7477 or 1.443.663.2699
- E-mail: certprovider@nciinc.com

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)**.
- 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 letter/MRA, all recoupment activities will cease until the redetermination decision is made.

Medical Necessity Requirements

Ankle-Foot Orthoses (AFO)/Knee-Ankle-Foot Orthosis (KAFO)

Knee Orthoses

Ankle-Foot Orthosis (AFO) / Knee-Ankle-Foot Orthosis (KAFO)

Local Coverage Determination (LCD) L33686

AFOs Not Used During Ambulation

- L4396 or L4397 (Static or dynamic positioning ankle-foot orthosis)
  - Covered when criteria 1-4 or criterion 5 are met
    1. Plantar flexion contracture of the ankle (Group 1 Diagnosis Codes)
    2. Reasonable expectation of ability to correct contracture
    3. Contracture interference with functional abilities
    4. Used as a component of a therapy program

    OR

    5. The beneficiary has plantar fasciitis (Group 1 Diagnosis Codes)
       (Also applies to replacement interface L4392)
- Foot drop splint/recumbent positioning device (L4398) or replacement interface (L4394)
  - Denied as not reasonable and necessary

AFOs and KAFOs Used During Ambulation

AFOs:

- L1900, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2106, L2108, L2112, L2114, L2116, L4350, L4360, L4361, L4386, L4387 and L4631
- Covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who:
  1. Require stabilization for medical reasons and
  2. Have the potential to benefit functionally

KAFOs

- L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2126, L2128, L2132, L2134, L2136, and L4370
- Covered for ambulatory beneficiaries for whom an ankle-foot orthosis is covered and for whom additional knee stability is required

Custom-Fabricated AFO/KAFO

Covered for ambulatory beneficiaries when basic coverage criteria for prefabricated AFO/KAFO are met, and one of the following:

- Beneficiary could not be fit with a prefabricated AFO
- Condition necessitating the orthosis is expected to be permanent or of longstanding duration
- A need to control the knee, ankle or foot in more than one plane
- Beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury
- Beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions

Custom-Fabricated Addition Codes

- L2180, L2182, L2184, L2186, L2188, L2190, L2192, L2200, L2210, L2220, L2230, L2232, L2240, L2250, L2260, L2265, L2270, L2275, L2280, L2300, L2310, L2320, L2330, L2335, L2340, L2350, L2360, L2370, L2375, L2380, L2385, L2387, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2500, L2510, L2520, L2525, L2526, L2530, L2540, L2550, L2750, L2755, L2760, L2768, L2780, L2785, L2795, L2800, L2810, L2820, L2830
- Additions will be denied as not reasonable and necessary if either:
  - The base orthosis is not reasonable and necessary; or,
  - The specific addition is not reasonable and necessary

Knee Orthoses

LCD L33318

Prefabricated Knee Orthoses

- Knee orthosis with joints (L1810, L1812) or knee orthosis with condylar pads and joints with or without patellar control (L1820)
  - Covered for ambulatory beneficiaries who have weakness or deformity of the knee and require stabilization
- A knee orthosis with a locking knee joint (L1831) or rigid knee orthosis (L1836)
  - Covered for beneficiaries with flexion or extension contractures of the knee with movement on passive range of motion testing of at least 10 degrees (i.e., a nonfixed contracture)
  - Requires covered ICD-10 code from Group 1
- L1847 or L1848
  - Denied as not reasonable and necessary

Prefabricated Knee Orthoses(2)

- Knee immobilizer without joints (L1830)
  - Covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s).
  - Requires covered ICD-10 code from Group 2 or Group 4
- L1850 (Swedish Type)
  - Covered for a beneficiary who is ambulatory and has knee instability due to genu recurvatum - hyperextended knee, congenital or acquired
  - Requires covered ICD-10 code from Group 5

Knee Orthoses

Prefabricated: L1832, L1833, L1843, L1845, L1851, L1852

Custom Fabricated HCPCS: L1844, L1846

Coverage Path #1	Coverage Path #2
Recent injury or surgical procedure Requires covered diagnosis code from Group 2 or 4	Ambulatory and 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). Requires covered diagnosis from Group 4

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)
- 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 General Coverage Requirements

- L1834, L1840, L1844, L1846, L1860
- Coverage requires documented physical characteristic which requires use of custom fabricated instead of prefabricated
- Examples:
  - Deformity of leg or knee;
  - Size of thigh and calf;
  - Minimal muscle mass upon which to suspend an orthosis
- Consider prefabricated alternatives
- Not reasonable and necessary in treatment of knee contractors for non-ambulatory beneficiaries

Custom-Fabricated Knee Orthoses

HCPCS	Description	Coverage Criteria
L1834	Immobilizer w/out joints	Meets criteria for L1830 & custom-fabricated
L1840	Derotation orthosis	Instability due to internal ligamentous disruption Group 3 ICD-10 Codes
L1844	Adjustable flexion/extension joint w/medial-lateral and rotation control	Meets criteria for L1843, L1845, L1851, and L1852 Meets criteria for custom-fabricated Group 4 ICD-10 Codes
L1846	Adjustable flexion/extension joint w/medial-lateral and rotation control	Meets criteria for L1843, L1845, L1851, and L1852 Meets criteria for custom-fabricated Group 4 ICD-10 Codes
L1860	Modified supracondylar prosthetic socket	• Ambulatory • Knee instability due to hyperextended knee • Group 5 Codes

Addition Codes

- Grouped into 4 categories in relation to knee orthosis base codes:
  - Eligible for separate payment
  - Not reasonable and necessary
  - Not separately payable
  - Incompatible
- Tables located in the LCD and related Policy Article

Addition Codes Eligible for Separate Payment

The table lists addition codes which describe components or features that can be and frequently are physically incorporated in the specified prefabricated base orthosis.

- Addition codes may be separately payable if:
  - They are provided with the related base code orthosis; and
  - The base orthosis is reasonable and necessary; and
  - The addition is reasonable and necessary.
- Addition codes will be denied as not reasonable and necessary if the base orthosis is not reasonable and necessary or the addition is not reasonable and necessary.
- Located in the LCD
  - Separate tables for Prefabricated and Custom Fabricated HCPCS codes

Addition Codes - Not Reasonable and Necessary

- The table lists addition codes which describe components or features that can be physically incorporated in the specified prefabricated base orthosis but are considered not reasonable and necessary
  - These addition codes, if they are billed with the related base code, will be denied as not reasonable and necessary
  - Located in the LCD
    - Separate tables for Prefabricated and Custom Fabricated HCPCS codes

Miscellaneous Coverage Criteria

- Heavy duty knee joint codes (L2385, L2395) are covered only for beneficiaries who weigh more than 300 pounds
- Replacement removable soft interface (K0672)
  - Soft interfaces billed separately at the time of initial issue will be denied as not separately payable
  - Coverage is limited to a maximum of two (2) per year beginning one (1) year after the date of service for initial issuance of the orthosis
    - Additional replacement interfaces will be denied as not reasonable and necessary

Documentation Requirements

Signature Requirements

- Services provided/ordered/certified must be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies
- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received)
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry
- CMS Program Integrity Manual 100-8, Chapter 3, Section 3.3.2.4

Signature Attestation Statement

- Must be signed and dated by the author of the medical record entry
- Must contain sufficient information to identify the beneficiary
- CMS currently neither requires nor instructs providers to use a certain form or format
- Only considered when there is an associated medical record entry
- Attestation statements from someone other than the author of the medical record entry in question are not considered

Standard Written Order (SWO) Elements

SWO must be communicated to the supplier prior to claim submission and must contain:

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

Braces Dispensed by the Treating Practitioner

- A separate SWO is not required when the prescribing practitioner is:
  - Also the supplier
  - Permitted to furnish specific items of DMEPOS
  - 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
    - Critical to establishing medical necessity
  - Diagnosis code billed on claim
- Templates and forms
  - Corroborated with medical record

Orthotist/Prosthetist Records

- Considered in context
  - Documentation by physician and other practitioners
    - Provide additional details to demonstrate reasonable and necessary
- 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

Custom Fitted Orthotics

- Prefabricated
- Requires **more than minimal self-adjustment** for individualized fit
- Fitting requires expertise of certified orthotist/specialized training
- Modifications must involve altering the item beyond simple adjustments made by bending, trimming, or item molding; installing add-on components; or item assembly
- Example:
  - An individual with modifying expertise must trim it, bend it, mold it (with or without heat), or otherwise modify it for a specific patient
- Documentation of custom fitted orthotics must include a description of the modifications made at the time of delivery by the individual with expertise

Required Face-to-Face (F2F) Encounter and Written Order Prior to Delivery (WOPD) List

- L1832, L1833, and L1851 - Effective April 13, 2022
- L1843, L1932, L1940, L1951, L1960, L1970, L2005, L2036 – Effective April 17, 2023
- A complete SWO is required prior to delivery
- Face-to-face encounter within 6 months preceding the order
- MLN Matters Number: SE20007

F2F Encounter

- The treating practitioner must document and communicate to the DMEPOS supplier that they had a F2F encounter with the patient within the 6 months before the date on the written order/prescription.
- In-person or telehealth encounter between the treating practitioner and the patient.
  - Telehealth encounter must meet the requirements of 42 CFR 410.78 and 42 CFR 414.65.
- Supporting documentation includes subjective and objective information associated with diagnosing, treating, or managing a clinical condition for the DMEPOS item ordered.
- Suppliers must maintain the written order/prescription, and the supporting documentation provided by the treating practitioner to support payment for the item(s) of DMEPOS and make them available to CMS or its contractors upon request

Direct Delivery (Method 1)

- Beneficiary's name
- Delivery address
- Description of item(s) being delivered
  - Narrative description; or
  - HCPCS code; or
  - Long description of HCPCS code; or
  - Brand name/model number
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature
- Date of Service = Date received

Shipping Service (Method 2)

- Supplier Shipping Invoice:
  - Beneficiary's name
  - Quantity delivered
  - Description of item(s) being delivered
  - Package identification number
- Delivery service tracking slip:
  - Each beneficiary's package
  - Delivery address
  - Package identification number (tracking number)
  - Date delivered
  - Evidence of delivery
- Date of Service = Shipping date or date of delivery

Delivery to Nursing Facility on Behalf of a Beneficiary (Method 3)

- Can be delivered via methods 1 or 2
- Documentation demonstrating delivery; and
- Documentation from nursing facility demonstrating receipt and usage
  - Quantities delivered and used
    - Justify quantity billed

Thank You!