MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

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PRINT-FRIENDLY VERSION

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Archive of previous Medicare Quarterly Provider Compliance Newsletters

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

INTRODUCTION

Learn about avoiding common billing errors and other erroneous activities when dealing with the Medicare Fee-For-Service (FFS) Program. This newsletter includes guidance to help health care professionals address and avoid the top issues of the particular quarter.

There are more than one billion claims processed for the Medicare FFS program each year. MACs process these claims, make payments to more than one million health care professionals in accordance with Medicare regulations, and provide education on how to submit accurately coded claims.

Despite actions to prevent improper payments, it is impossible to prevent them all due to the large volume of claims. The Medicare Learning Network's® Medicare Quarterly Provider Compliance Newsletter helps health care professionals to understand the latest findings identified by MACs and other contractors such as Recovery Auditors and the Comprehensive Error Rate Testing (CERT) review contractor, in addition to other governmental organizations such as the Office of the Inspector General (OIG).

We (CMS) release the newsletter on a quarterly basis. An archive of previously issued newsletters, which includes keyword and provider-specific indices, is available on the CMS website.

Physicians

Non-Physician Practitioners

Providers & Suppliers

Durable Medical Equipment Suppliers

RECOVERY AUDITOR FINDING - NEW ISSUE #0144 – PREFABRICATED KNEE ORTHOSES: MEDICAL NECESSITY & DOCUMENTATION REQUIREMENTS

DMES PHY NPP

Provider Types Affected: Durable Medical Equipment (DME) Suppliers and Physicians or Non-Physician Practitioners (NPPs) who supply Lower Limb Orthoses

Problem Description: Suppliers may be furnishing Off-the-Shelf (OTS) Knee Orthoses to beneficiaries where the situation doesn't meet all Medicare coverage requirements. This review will determine if the orthoses are reasonable and necessary for the patient's condition based on the documentation in the medical record. Medicare will deny claims that don't meet the indications of coverage and medical necessity requirements.

Background:
Prefabricated Knee Orthoses (HCPCS: L1810, L1812, L1820, L1830, L1831, L1832, L1833, L1836, L1843, L1845, L1847, L1848, L1850, L1851, L1852):

A knee flexion contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 0 degrees extension or greater (that is, hyperextension) by passive range of motion. (0 degrees knee extension is when the femur and tibia are in alignment in a horizontal plane.) (LCD L33318)

A knee extension contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 80 degrees flexion or greater by passive range of motion. A contracture is distinguished from the temporary loss of range of motion of a joint following injury, surgery, casting, or other immobilization. (LCD L33318)

Knee Orthoses are covered under the Medicare Braces Benefit (Social Security Act Section 1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device, which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Items that are not rigid enough to be capable of providing the necessary immobilization or support to the body part for which it is designed don't meet the statutory definition of this benefit. Items that don't meet the definition of a brace are statutorily noncovered and there is no benefit. (LCA A52465)

Per Local Coverage Article (LCA) A52465, both OTS and custom-fit items are considered prefabricated braces for Medicare coding purposes. 42 CFR section 414.402 establishes that correct coding of knee orthoses items is dependent upon whether there is a need for "minimal self-adjustment" during the final fitting at the time of delivery.

Local Coverage Determination (LCD) for Knee Orthoses (LCD L33318) and related Local Coverage Article (LCA) for Knee Orthoses (LCA A52465) provide detailed guidance on the coverage requirements for these orthoses.

RECOVERY AUDITOR FINDING: NEW ISSUE #0107- Custom Fabricated Knee Orthoses: Medical Necessity & Documentation Requirements

Custom Fabricated Knee Orthoses (HCPCS: L1834, L1840, L1844, L1846, L1860)
There is a separate approved RAC issue, #0107, for Custom Fabricated Knee Orthoses. This issue shares the same LCD and LCA as New Issue #0104.

Medicare covers a custom fabricated orthosis when there is a documented physical characteristic which requires the use of a custom fabricated orthosis instead of a prefabricated orthosis. Examples of situations which meet the criterion for a custom fabricated orthosis include, but aren't limited to:

- Deformity of the leg or knee
- Size of thigh and calf
- Minimal muscle mass upon which to suspend an orthosis

Although these are examples of potential situations where a custom fabricated orthosis may be appropriate, suppliers must consider prefabricated alternatives such as pediatric knee orthoses in beneficiaries with small limbs, or straps with additional length for large limbs.

When providing custom fabricated orthoses, you must:

- Provide the product that is specified by the prescribing practitioner
- Be sure that the prescribing practitioner's medical record justifies the need for the type of product (Prefabricated versus Custom Fabricated)
- Only bill for the HCPCS code that accurately reflects both the type of orthosis and the appropriate level of fitting
- Have detailed documentation in your records that justifies the code selected

You must include the beneficiary's condition (diagnosis code) that necessitates the need for the knee orthosis on the claim.

Custom fabricated orthoses (L1834, L1840, L1844, L1846, L1860) aren't reasonable and necessary in the treatment of knee contractures in cases where the beneficiary is nonambulatory.

Local Coverage Determination (LCD) for Knee Orthoses (LCD L33318) and related Local Coverage Article (LCA) for Knee Orthoses (LCA A52465) provide detailed guidance on the coverage requirements for these orthoses.

General Requirement Reminders

- Suppliers must have a Standard Written Order (SWO) before submitting a claim. If the supplier bills for an item addressed in this policy without first receiving a completed SWO, Medicare denies the claim as not reasonable and necessary.
- For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must have a signed SWO before delivering the DMEPOS item to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, Medicare denies the claim as not reasonable and necessary.
- For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, Medicare denies the claim(s) as not reasonable and necessary.
- An item or service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles.
- Proof of Delivery (POD) is a Supplier Standard and DMEPOS suppliers must maintain POD documentation in their files. POD documentation must be made available to the Medicare contractor upon request.

Resources

You will want to review the following educational materials to learn more about coding and billing for prefabricated knee orthoses and to assist in correctly documenting claims featuring prefabricated Knee orthoses.

- Social Security Act §1861(s)(9) (Medicare Braces Benefit), available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- 42 CFR 424.57 for DMEPOS Quality Standards, available at https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-57.pdf
- 42 CRF 414.402 available at https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec414-402.pdf
- Local Coverage Determination for Knee Orthoses (LCD L33318), available at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33318
- Local Coverage Article for Knee Orthoses (LCA A52465), available at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52465 - Revision effective 2/02/2021
- The Medicare Program Integrity Manual, Chapter 4, Section 4.26.2, 4.26.3, which you'll find at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf
- Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (LCA A55426), which you'll find at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=55426

RECOVERY AUDITOR FINDING - NEW ISSUE #0167 – ANKLE-FOOT ORTHOSES & KNEE-ANKLE-FOOT ORTHOSES WITHIN THE REASONABLE USEFUL LIFETIME: EXCESSIVE UNITS

P&S

Provider Types Affected: Suppliers and physicians who supply DME for Medicare beneficiaries

Problem Description: The recovery auditors will examine claims for Ankle-Foot Orthoses or Knee-Ankle-Foot Orthoses with dates of service within the reasonable useful lifetime of a previously paid identical Orthoses (identical HCPCS codes), for the same anatomical site. Medicare denies such claims for not meeting the reasonable useful lifetime requirement.

Background:
Ankle-Foot Orthoses HCPCS: L1900, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990

Knee-Ankle-Foot Orthoses HCPCS: L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2126, L2128, L2132, L2134, L2136, L4350, L4360, L4361, L4370, L4386, L4387, L4396, L4397, L4631

Recovery auditors are doing an automated review of claims involving Ankle-Foot Orthoses and Knee-Ankle-Foot Orthoses to see how often suppliers billed Medicare for such devices for beneficiaries who had a prior claim for the same equipment on the same area of the body. Medicare payment would be impermissible under the Reasonable Useful Lifetime requirement. The auditors used claims that had a “paid claim date,” which was less than 3 years prior to the automated review date. The auditors are covering all DME MAC jurisdictions in this review.

We remind DME providers and suppliers that according to the Medicare Benefit Policy Manual Chapter 15, Section 110.2, “The reasonable useful lifetime of DME is determined through program instructions. In the absence of program instructions, A/B MACs (B) may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear isn't covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.”

Finding:
When you bill Medicare for either ankle-foot orthoses or knee-ankle-foot orthoses on behalf of Medicare beneficiaries, take care in preparing the claim to ensure that the provision of such orthoses isn't in violation of the reasonable useful lifetime requirement. Such claims, when paid, are improper payments that may require recoupment from Medicare.

Recommendations:
You should always be aware of the reasonable useful lifetime requirement for both ankle-foot and knee-ankle-foot orthoses when dealing with this issue for Medicare beneficiaries. Understand the rules and requirements for repair and/or replacement of these orthoses and how the reasonable useful lifetime requirement dictates what Medicare can cover.

Resources

DME providers and suppliers can read more about this topic in the following publications:

- Chapter 15, Section 110.2 of the Medicare Benefit Policy Manual, "Repairs, Maintenance, Replacement, and Delivery" (Issued February 13, 2015), which you willl find at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.
- Fact Sheet: "Provider Compliance Tips for Ordering Lower Limb Orthoses." Updated as of September 2020, which you will find at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceTipsforOrderingLowerLimbOrthoses-ICN909467.pdf.