



MEDICARE QUARTERLY PROVIDER COMPLIANCE NEWSLETTER

Guidance to Address Billing Errors

Volume 10, Issue 3

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[Archive of previous Medicare Quarterly Provider Compliance Newsletters](#)

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. Medicare Administrative Contractors (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 RAC and the Comprehensive Error Rate Testing (CERT) review contractor, in addition to other governmental organizations such as the Office of the Inspector General (OIG).

The Centers for Medicare & Medicaid Services (CMS) releases 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.

COMPREHENSIVE ERROR RATE TESTING (CERT): LOWER LIMB ORTHOSIS-KNEE ORTHOSIS

Durable Medical Equipment (DME) Suppliers and Physicians or Non-Physician Practitioners (NPPs) who write prescriptions for Lower Limb Orthoses

Background: Lower limb orthosis is a covered item under the Medicare Braces Benefit ([Social Security Act §1861\(s\)\(9\)](#)). For coverage under this benefit, an 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 sufficiently rigid to be capable of providing the necessary immobilization or support to the body part for which it is designed do not meet the statutory definition of the Braces Benefit.

Lower limb orthoses include orthoses for the knee, Ankle-Foot Orthoses (AFO) or Knee-Ankle-Foot Orthoses (KAFO). There are three types of lower limb orthoses:

- Off-The-Shelf (OTS)
- Custom fitted
- Custom fabricated

OTS lower limb orthoses are prefabricated, may or may not be supplied as a kit, require minimal self-adjustment for fitting at the time of delivery and the fitting does not require the expertise of a certified orthotist or an individual with equivalent training. Custom fitted lower limb orthoses are also prefabricated, may or may not be supplied as a kit, and require **more than** minimal self-adjustment for fitting at the time of delivery by the expertise of a certified orthotist or an individual with equivalent training. Custom fabricated lower limb orthoses are individually made for the specific beneficiary (no other beneficiary would be able to use this orthosis) starting with the basic materials and involves substantial modification work. For custom fabricated orthoses, there must be detailed documentation in the medical record to support the medical necessity of custom fabricated rather than a prefabricated orthosis.

The term “minimal self-adjustment” is defined in [42 CFR §414.402](#) as an adjustment the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and does not require the services of a certified orthotist or an individual who has specialized training.

More than minimal self-adjustment is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has specialized training in the provision of orthotics in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

PREFABRICATED KNEE ORTHOSES (HCPCS Codes L1810, L1812, L1820, L1830 - L1833, L1836, L1843, L1845, L1847, L1848, L1850, L1851, L1852)

A knee flexion contracture is a condition in which there is shortening of the muscles or tendons or both, 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). A knee extension contracture is a condition in which there is shortening of the muscles or tendons or both 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.

A knee orthosis with joints (L1810, L1812) or knee orthosis with condylar pads and joints, with or without patellar control (L1820) are 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 a rigid knee orthosis (L1836) is covered for beneficiaries with flexion or extension contractures of the knee with movement on passive range of motion testing of at least 10 degrees (that is, a nonfixed contracture) (refer to the Group 1 Codes in the “ICD-10 Codes that are Covered” section of the [Knee Orthoses Local Coverage Article](#)).

A knee immobilizer without joints (L1830), or a knee orthosis with adjustable knee joints (L1832, L1833), or a knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (L1843, L1845, L1851, L1852), are covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s).

Knee orthoses L1832, L1833, L1843, L1845, L1851 and L1852 are also covered for a beneficiary who is ambulatory and has knee instability due to a condition specified in the Group 4 Codes in the “ICD-10 Codes that are Covered” section of the Knee Orthoses Local Coverage Article.

A knee orthosis, Swedish type, prefabricated (L1850) is covered for a beneficiary who is ambulatory and has knee instability due to genu recurvatum - hyperextended knee, congenital or acquired (refer to the Group 5 Codes in the "ICD-10 Codes that are Covered" section of the Knee Orthoses Local Coverage Article).

For codes L1832, L1833, L1843, L1845, L1850, L1851, and L1852, knee instability must be documented by examination of the beneficiary and objective description of joint laxity (for example, varus/valgus instability, anterior/posterior Drawer test).

Claims for L1832, L1833, L1843, L1845, L1850, L1851, or L1852 will be denied as not reasonable and necessary when the beneficiary does not meet the above criteria for coverage. For example, they will be denied if only pain or a subjective description of joint instability is documented.

There is no proven clinical benefit to the inflatable air bladder incorporated into the design of code L1847 or L1848, so, claims billed for these items will be denied as not reasonable and necessary.

Finding: Insufficient Documentation Causes Improper Payments

According to the 2019 Medicare Fee-For-Service (FFS) Supplemental Improper Payment Data report, the improper payment rate for lower limb orthoses was 63.5 percent, accounting for 1.0 percent of the overall Medicare FFS improper payment rate. The projected improper amount for lower limb orthoses during the 2019 report period was \$298.0 million. The majority (61.7 percent) of the improper payments were due to insufficient documentation, which means that something was missing from the submitted medical records to support payment for the item(s) billed. Those claims with insufficient documentation, based on Medicare guidelines, lacked one or more of the following:

- A valid provider's order that includes all elements required by regulation, Medicare program manuals, and Medicare Administrative Contractor (MAC) specific guidelines
- Proof of delivery is missing or inadequate per regulations and Medicare program manuals
- Clinical documentation to support the medical necessity of the DME item is missing or inadequate

Example of Improper Payments due to Insufficient Documentation – Clinical documentation to support medical necessity is missing or inadequate

A supplier billed for HCPCS L1820 (Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment) and in response to the CERT review contractor's request for documentation, submitted the following for the billed date of service:

- Written order
- Proof of delivery
- Progress notes documenting knee pain, no instability in the anterior/posterior/varus/valgus directions, 5/5 strength with flexion/extension of knees; x-ray results supporting degenerative changes

There was no documentation to support that the beneficiary had knee weakness or a deformity requiring stabilization. In addition, there was no documentation to support the prefabricated orthosis was fitted

and adjusted at the time of delivery. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recouped payment from the provider.

Example of Improper Payments due to Insufficient Documentation – Clinical documentation to support medical necessity is missing or inadequate

A supplier billed for HCPCS L1843 (Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise) and in response to the CERT review contractor's request for documentation, submitted the following for the billed date of service:

- Written order
- Proof of delivery
- Progress notes documenting beneficiary with bilateral primary osteoarthritis of knee, reported bilateral knee pain, Genu Varum deformity, negative Lachman's test, no laxity during varus and valgus stress tests, and no ligamentous instability

There was no documentation to support knee instability with an objective description of joint laxity, recent injury or surgical procedure on the knee(s). Additionally, there was no documentation to support the prefabricated orthosis had more than minimal self-adjustment by an individual with expertise at the time of delivery as required per Medicare policy. The CERT review contractor scored this claim as an insufficient documentation error and the MAC recouped payment from the provider.

Resources:

You may want to review the following information to help avoid these billing errors:

- Social Security Act §1861(s)(9) (Medicare Braces Benefit), which is available at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- 42 CFR 424.57 for DMEPOS Quality Standards, which is available at <https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec424-57.pdf>
- 42 CFR §414.402 which is 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 (L33318), which is available at <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33318>
- Local Coverage Determination for Ankle-foot/Knee-ankle Foot Orthosis (L33686), which is available at <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33686>
- Local Coverage Article for Knee Orthoses (A52465), which is available at <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52465>
- Local Coverage Article Ankle-Foot/Knee-Ankle-Foot Orthoses (A52457), which is available at <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52457>
- The CERT provider website at <https://certprovider.admedcorp.com/>
- The CERT program website at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html>

RAC FINDING: VISITS TO PATIENTS IN SWING BEDS: INCORRECT CODING

Provider Types Affected: Physicians and Non-Physicians Practitioners (NPPs)

Background: Under New Issue #0038, the RACs are approved to review visits to inpatient swing beds for correct coding, in all MAC jurisdictions. If the inpatient care is billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is billed by the hospital as nursing facility care, then the nursing facility codes apply. The review identifies paid claims with type of bill 18X. The RACs exclude the swing bed admit and discharge dates to identify incorrectly used CPT Evaluation and Management (E/M) codes:

- 99221, 99222, and 99223 (under New or Established Patient Initial Hospital Inpatient Care Services)
- 99231-99233 (under Subsequent Hospital Care)
- 99238-99239 (under Hospital Discharge Services)

A June 2019 MLN Matters® Swing Bed Services Fact Sheet available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SwingBedFactsheet.pdf> provides hospitals and Critical Access Hospitals (CAHs) additional swing bed guidance.

Resources:

You may want to review the following information to help avoid these billing errors:

- June 2019 MLN Matters® Swing Bed Services Fact Sheet, which is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SwingBedFactsheet.pdf>
- Social Security Act (SSA) § 1861(e), which is available at http://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6.9 (D) - Visits to Patients in Swing Beds, which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- The CMS Swing Bed webpage at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed>