PROVIDER COMPLIANCE TIPS FOR ORDERING LOWER LIMB ORTHOSES

UPDATES

- Replaced the earlier year's data with 2019

INTRODUCTION

This publication is meant to educate providers on coverage and proper billing of lower limb orthoses.

PROVIDER TYPES AFFECTED

Physicians and other practitioners who write prescriptions for lower limb orthoses
BACKGROUND

The 2019 Medicare Fee-for-Service improper payment rate for lower limb orthoses was 63.5 percent, representing a projected improper payment more than $297,988,587.¹

REASONS FOR DENIALS

Insufficient documentation errors accounted for 61.7 percent of improper payments for lower limb orthoses for the 2019 reporting period. Additional types of errors included no documentation (1.0 percent), medical necessity (32.5 percent), and other (4.5 percent) for this service.¹

TO PREVENT DENIALS

The majority of the improper payments were due to insufficient documentation,¹ 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 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 durable medical equipment (DME) item is missing or inadequate

The Medicare Braces Benefit (Social Security Act 1861(s)(9)) covers ankle-foot orthoses (AFO) and knee-ankle foot orthoses (KAFO). 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 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. Items that do not meet the definition of a brace are statutorily noncovered, no benefit.²

Medicare covers AFO not used during ambulation described by codes L4396 or L4397 if you meet either all of criteria 1–4 or criterion 5:

1. Plantar flexion contracture of the ankle (see Diagnosis Codes That Support Medical Necessity, Group 1 Paragraph page 9 LCD L33686) with dorsiflexion on passive range of motion testing of at least 10 degrees (i.e., a non-fixed contracture); NOTE: To support this criterion, documentation must demonstrate the beneficiary’s pre-treatment passive range of motion as measured by a goniometer, and show a proper stretching program carried out by professional staff (in a nursing facility) or a caregiver (at home)

2. Reasonable expectation of the ability to correct the contracture
3. Contracture interferes or is expected to interfere significantly with the beneficiary’s functional abilities
4. Used as a component of a therapy program, which includes active stretching of the involved muscles and/or tendons

¹ 2019 Medicare Fee-for-Service Supplemental Improper Payment Data
² Medicare Benefit Policy Manual, Chapter 15, Section 130
5. The beneficiary has plantar fasciitis (see Diagnosis Codes That Support Medical Necessity Group 1 Codes section)

Medicare covers AFO used during ambulation described by codes L1900, L1902-L1990, L2106-L2116, L4350, L4360, L4361, L4386, L4387, and L4631 for ambulatory beneficiaries with weakness or deformity of the foot and ankle who:

1. Require stabilization for medical reasons
2. Have the potential to benefit functionally

Medicare covers KAFO described by codes L2000-L2038, L2126-L2136, and L4370 for ambulatory beneficiaries for whom an AKO is covered and for whom added knee stability is required.

NOTE: For additional AFO and KAFO coverage requirements, please see Local Coverage Determination (LCD): Ankle-Foot/Knee-Ankle-Foot Orthosis (L33686).


42 CFR §414.402 establishes that correct coding of AFO and KAFO items is dependent upon whether there is a need for “minimal self-adjustment” during the final fitting at the time of delivery. The differentiating factor for proper coding is the need for minimal self-adjustment at the time of fitting by the beneficiary, caretaker for the beneficiary, or supplier.

- This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training.
- Code items requiring minimal self-adjustment as off-the-shelf orthoses. For example, adjustment of straps and closures and bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

RESOURCES

Table 1. Lower Limb Orthoses Resources

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<th>RESOURCE</th>
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(3) Local Coverage Determination (LCD): Ankle-Foot/Knee-Ankle-Foot Orthosis (L33686)
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<tr>
<th>RESOURCE</th>
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<td>Local Coverage Determination (LCD): Knee ORTHOSES (L33318)</td>
<td><a href="https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33318&amp;ver=47&amp;Cn-trctr=All&amp;ReasonforChangeType=final&amp;Reason-forChange=All&amp;UpdatePeriod=0&amp;CoverageSelection=Local&amp;ArticleType=All&amp;PolicyType=Final&amp;s=All&amp;KeyWord=orthoses&amp;KeyWordLook-Up=Title&amp;KeyWordSearchType=And&amp;bc=gAAAA-CAAAAAA&amp;">https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33318&amp;ver=47&amp;Cn-trctr=All&amp;ReasonforChangeType=final&amp;Reason-forChange=All&amp;UpdatePeriod=0&amp;CoverageSelection=Local&amp;ArticleType=All&amp;PolicyType=Fi-nal&amp;s=All&amp;KeyWord=orthoses&amp;KeyWordLook-Up=Title&amp;KeyWordSearchType=And&amp;bc=gAAAA-CAAAAAA&amp;</a></td>
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<td>Social Security Act 1861(s)(9)</td>
<td><a href="https://www.ssa.gov/OP_Home/ssacttitle18/1861.htm">https://www.ssa.gov/OP_Home/ssacttitle18/1861.htm</a></td>
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Please [Contact your MAC](https://www.ssa.gov/OP_Home/ssacttitle18/1861.htm) for any updates or changes to the Policy Article (PA) and the LCD regarding policy and general documentation requirements.

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