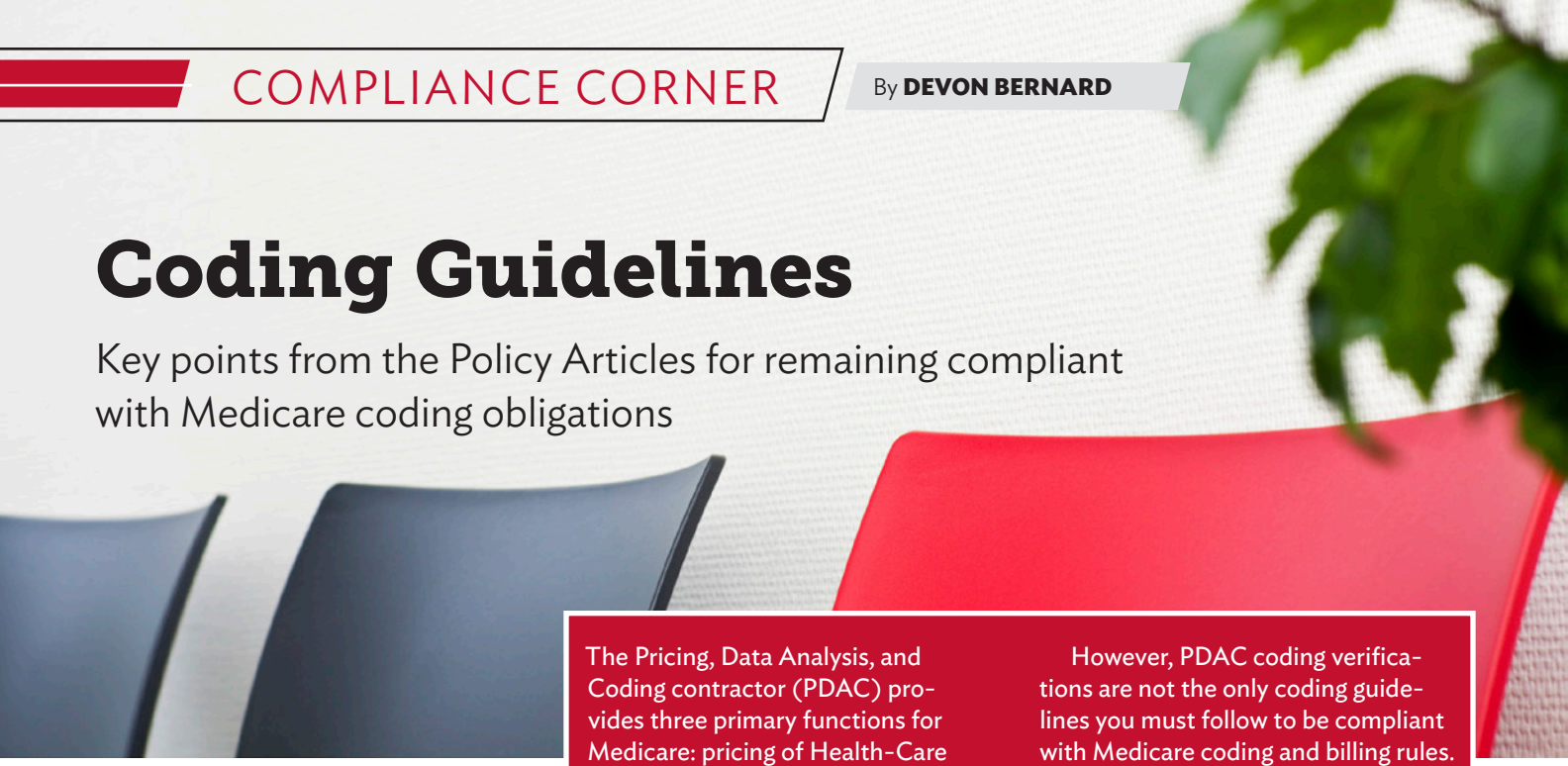
By **DEVON BERNARD**

Coding Guidelines

Key points from the Policy Articles for remaining compliant with Medicare coding obligations



The Pricing, Data Analysis, and Coding contractor (PDAC) provides three primary functions for Medicare: pricing of Health-Care Common Procedure Coding System (HCPCS) codes without Medicare allowables; data analysis, which is used to identify utilization patterns of HCPCS codes; and coding verification (either voluntarily or mandated by policy), which is used to establish coding guidance for specific products. Once a product has been reviewed by the PDAC and assigned a coding verification, the PDAC decision is binding for Medicare purposes, and any claims submitted to Medicare for that product must be coded according to the PDAC coding verification.

Failure to comply with PDAC coding verifications may place your Medicare claim at risk. Medicare claims for devices that are coded in conflict with a PDAC coding verification will be denied as incorrect coding. If they are inadvertently paid, they may be exposed to postpayment audit and overpayment determinations.

However, PDAC coding verifications are not the only coding guidelines you must follow to be compliant with Medicare coding and billing rules. Medicare Medical Policies—and, in particular, the Policy Article portion of those policies—provide you with some insights and guidelines for proper coding of Medicare claims. In addition, you should be aware of coding reminders and directives that are jointly released by the PDAC and your local durable medical equipment Medicare administrative contractor (DME MAC).

This month's *Compliance Corner* focuses on the coding guidelines portion of the Policy Articles for each of the major O&P policies. This article will not cover all of the information in each Policy Article but will feature some of the key points to ensure you remain compliant with Medicare coding obligations. This article does not address information relating to off-the-shelf vs. custom-fit devices as this topic has been addressed in recent *O&P Almanac* articles.

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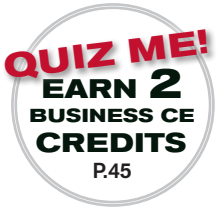

AFO/KAFO Policy

If you intend to provide, code, and bill for a multiligamentus ankle-foot orthosis (AFO), described by code L1906, you must adhere to a few coding guidelines to remain compliant in your coding. First, the AFO must have some type of hinge or joint-type mechanism, which will allow the ankle to dorsiflex and plantarflex. Second, the item must include a rigid stirrup and footplate and wraparound straps. If your AFO has these qualities, it meets the Policy Article definition of an L1906, but additional coding criteria must be met to remain compliant.

The L1906 is considered an all-inclusive code, meaning there are no addition codes that can be billed with the L1906 base code. If you use any addition codes,

you are no longer in compliance with the AFO/KAFO policy, and you could not submit your claim with the KX modifier. In addition, any item being coded as L1906 requires a written coding verification from the PDAC.

HCPCS code L2340 describes a pretibial shell, and in addition to being custom fabricated (molded to patient model), as described by the office L-code descriptor, three other components must be met to code for and bill code L2340. First, the shell must be rigid and the edges must overlap or interlock; in other words, it must wrap around and not just cover a portion of the tibia. Second, this rigid shell can be constructed from any type of thermosetting materials or any composite-type materials. Third, the L2340 has a height limit. The shell must extend between the tibial tuberosity to a point no greater than three inches proximal to the medial malleolus.

Since its creation in 2011, the L4631 was designed to describe a CROW boot. However, if you wish to use code L4631, the orthosis you provide must meet six specific coding criteria: The orthosis must keep the foot in a locked and fixed position of 0 degrees; it must contain a feature that allows for varus/valgus corrections; it must include a rocker bottom sole with a custom arch support; it must include some type of soft interface material; it must incorporate a rigid anterior tibial shell; and it may only be used with a patient who is ambulatory. If the orthosis you are providing doesn't meet all of these criteria, then L4631 would not be the appropriate code.

The coding guidelines do not allow for the use of addition codes with the L4631, such as the L1906, because the L4631 is all-inclusive. There may not be any additional codes like straps, closures, or features such as those found on a patellar tendon-bearing orthosis.

If any item—regardless of its design features, components, or fabrication method—is used solely to reduce pressure and off-load the foot, and is not treating any underlying orthopedic condition, then it must be coded as A9283; and it will be considered noncovered. For example, if you are using a CROW boot, even if it meets the above criteria, to just off-load the foot, then you must use code A9283 and not L4631.

KO Policy

The knee orthosis (KO) policy is unique in its approach to compliance with coding; the policy clearly indicates which addition codes can be used with which base codes, and which addition codes are considered included in the base code. However, the Policy Article does provide additional criteria that must be met to ensure appropriate coding, including the definition of flexion/extension joints, padding material for certain braces, and an explanation of the items requiring PDAC approval.

With a brace described by L1830, you must be sure that the stays (which must be rigid metal or rigid plastic) are located laterally and posteriorly, and that the interface/lining is made of canvas or a closed cell foam. Also, any thigh and calf cuffs must be of one-piece construction and held in place by a Velcro strap, or a similar strapping system.

Two KOs require PDAC coding approval: K0902 and L1845. If the item you are providing is considered a K0902 or L1845 and the brace has not received a PDAC coding verification, then you must use code A9270 and the KO will not be covered.

The last piece of coding criteria is the definition of an adjustable flexion and extension joint. It is a unicentric or polycentric joint that enables the practitioner to set limits on flexion and extension but allows the beneficiary free motion of the knee within those limits. The increments of adjustability, or set limits, must be at a minimum of 15 degrees.

Within the KO policy and the AFO/KAFO policy, there are directives from the PDAC and the DME MACs on the correct coding of concentric adjustable torsion joints used with prefabricated and custom-fabricated orthoses.

If the concentric adjustable torsion joints are used solely to provide an assistive function for joint motion, you may use code L2999. However, all other uses of concentric adjustable torsion joints, including for the treatment of contracture, must be coded as follows:

- E1810 – Dynamic adjustable knee extension/flexion device.
- E1815 – Dynamic adjustable ankle extension/flexion device.

External Breast Prosthesis Policy

The coding guidelines in the external breast prosthesis policy provide an in-depth description of the features of each type of mastectomy bra. HCPCS code L8000 describes a bra, without an integrated breast prosthesis, which has pockets designed to hold a mastectomy form/breast prosthesis adjacent to the chest wall.

Codes L8001 and L8002 describe mastectomy bras with integrated breast prostheses. The L8000, L8001, and L8002 also include the following characteristics and features:

- May be constructed of any material including, but not limited to, cotton and polyester.
- May include any type of closure/fastener, and the closure/fastener may be located anywhere on the bra.
- May be of any size.
- May be constructed with or without integrated structural support, e.g., an underwire.

Since the bras described by codes L8000, L8001, and L8002 can include any or all of the above features, you may not bill any of these features as an upgraded or deluxe feature, or as a miscellaneous add-on feature. In essence, the bras have become an all-inclusive code.

Lower-Limb Prosthesis Policy

The majority of the coding guidelines in the lower-limb prosthesis section are fairly straightforward; however, two require special consideration. The first is the proper coding/use of the suction socket codes (L5647 and L5652), and the second is the coding of repairs with labor code L7520.

Codes L5647 and L5652 are designed to describe the modification to a socket, and only the socket, to allow for the inclusion of a valve. L5647 and L5652 cannot be used to describe the components of a suspension locking mechanism.

Code L7520 may only be used in 15-minute increments to describe the time it took to actually furnish the repair. In other words, the L7520 may not be used to bill for the evaluation of problems, education, or gait training, or for the programming of electrical components. Also, code L7520 may be billed in conjunction with the L7510 (minor parts), but it may not be billed in conjunction with any other HCPCS codes; in essence, you may not bill additional labor on top of codes that have already reimbursed you for your labor.

Orthopedic Footwear Policy

If you are coding for a custom shoe attached to a brace, in order to be compliant with the policy and Medicare, you must use code L3649. Code L3649 will describe any and all types of custom shoes (e.g., high tops, depth inlay, high heels, etc.) and must be billed with the KX modifier.

Prosthetic shoes described by L3250 contain a custom-fabricated insert designed to accommodate for a toe or distal and/or partial foot amputation, and the purpose of the shoe is to hold the insert in place against or on the leg. Code L3250 is not designed, intended, or covered for shoes that are placed over any other prosthesis described in the lower-limb prosthesis policy (L 5010-L5600), which are suspended or held in place by other means.

Spinal Policy

A majority of prefabricated lumbosacral orthoses (LSOs) and thoracolumbosacral orthoses (TLSOs), including L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639, require a PDAC coding verification letter. A majority of the custom-fabricated LSOs and TLSOs, including L0452, L0480-L0486, L0629, L0632, L0634, L0636, L0638, and L0640, also require a PDAC coding verification letter. If you provide an LSO or TLSO that requires PDAC coding verification and the brace has not been verified, you must use code A9270, and your claim will be denied as a noncovered service. For custom-fabricated LSOs and TLSOs that are fabricated in-house, you are not required to obtain a PDAC coding verification. However, you must be able to provide a list of the materials used in the fabrication process and a description of your fabrication methods if requested by the DME MACs, or any other Medicare contractor.

The coding guidelines in the spinal policy also offer some clear rules on what constitutes a posterior panel and what makes a spinal orthosis a body jacket. A posterior panel "must encompass the paraspinal muscle bodies from one lateral border to another," and it must be tall enough to provide coverage to the anatomical markers indicated by the individual HCPCS codes. For example, a posterior panel for a TLSO described by code L0457 would have to encompass the paraspinal muscle bodies from one lateral border to another, and provide protection to and extend to the area of the sacrococcygeal junction and terminate just inferior to the scapular spine.

To be compliant for the coding of body jackets (L0458-L0464, L0480-L0492, L0639, and L0640), the item you are delivering/billing for must meet three specific criteria. First, the body jacket must be used to immobilize a specific area of the spine. Second, it must have a snug/close fit, and it must be designed to be worn under the patient's clothing. Third, the body jacket must have a rigid plastic shell with overlapping edges, and the shell must encircle the body; the shell also should be uniform in its construction (e.g., not have a plastic back and a nylon front).

PHOTOS: iStock.com/Johnny Greig

Surgical Dressings

If you are providing an A6545 (gradient compression wrap, nonelastic, below-knee, 30-50 mmhg, each), the wrap you are providing must be reviewed and approved by the PDAC. Remember that compression garments are only covered by Medicare when they are used in conjunction with a surgical dressing and the patient has an open-venous stasis ulcer.

Therapeutic Shoes for Persons With Diabetes

For diabetic shoe coding compliance, rather than reference the Policy Article coding guidelines, we will examine a coding clarification document released by the DME MACs regarding the proper coding of toe fillers and diabetic shoe inserts. The document states that a patient could not and should not receive both a custom diabetic shoe insert (A5513) and a partial foot toe filler (L5000) on the same foot. The patient should receive one or the other, and the proper coding depends on the need of the patient.

If the patient has diabetes and is missing toes or the forefoot, and doesn't require any extra rigidity or toe-off support for an improved gait, then the insert must be coded as A5513. The custom fabrication nature of the code would include the additional material needed to create a toe filler to accommodate the missing digit(s).

Code L5000 describes a shoe insert with a rigid longitudinal arch support with additional soft material added where contact is made with the residual limb/toes, and is designed to provide standing balance and toe-off support for improved gait. If the patient has diabetes and is missing the hallux or a forefoot, and additional rigidity and support is required for an effective gait, then the L5000 must be used instead of the A5513.

This article has addressed some aspects of the Policy Article portion of the Medicare policies; for details on the Local Coverage Determination portion of the Policy Article, which addresses coverage issues that involve medical necessity, see the *Reimbursement Page* article on page 16. CP

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