Eli's Rehab Report

Coding Case Study: Billing Five or More Orthotics Codes? You May Have to Cut a Few

When it comes to fitting and dispensing orthotics, you should live by the "less is more" coding philosophy. Despite the wide range of orthotics fitting, handling and checkout codes, you should not report every code in this series for each patient.

Suppose your physiatrist sees a patient who has a leg-length discrepancy as a late effect of a tibial fracture (736.81, Unequal leg length [acquired]; and 905.4, Late effect of fracture of lower extremities). He performs a level-three E/M service, a biomechanical range-of-motion exam, and then fits the patient for an ankle-foot orthosis. Nine days later the patient returns to the office, and the physician shows her how to wear her new orthotic and how to remove it when necessary. The practice vastly overcodes both services, reporting the following codes for the first visit:

1. 99213 - Office or other outpatient visit for the E/M of an established patient
2. 95851 - Range-of-motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
3. 29799 - Unlisted procedure, casting or strapping
4. A4580 - Cast supplies (e.g., plaster).

The practice also reports these codes for the second visit:

5. 99002 - Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (e.g., designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed and are to be fitted and adjusted by the attending physician
6. 97504 - Orthotic(s) fitting and training, upper extremity(ies), lower extremity(ies), and/or trunk, each 15 minutes
7. 97703 - Checkout for orthotic/prosthetic use, established patient, each 15 minutes
8. L1980 - Ankle-foot orthosis (AFO), single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis), custom fabricated.

"This practice seems to be grossly over-reporting the procedures they performed for the orthotics fitting and dispensing," says **Ken Robertson**, who bills for three podiatrists in Atlanta. Reporting orthotics codes can be very complicated, but submitting twice the appropriate number of codes isn't a good substitute for accuracy.

Report E/M, Not 95851, for First Visit

The practice should pare down its claims considerably by reporting 99213 for the initial E/M visit, but not 95851 for the

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range-of-motion exam.

First, the practice reported both 99213 and 95851, but the National Correct Coding Initiative (NCCI) bundles 95851 into the E/M codes. Also, the November 2001 CPT Assistant states, "The testing would be included as part of the physical examination, one of the key components used to determine the level of E/M service."

If your physiatrist applied the plaster cast to create an orthotic mold, exclude 29799 from your claim. You should report this code only if you apply the cast to immobilize the patient's foot.

As for the casting supplies, the December 1998 CPT Assistant states, "The fabrication of the orthotic is not recognized as a distinct service, but rather a provision of materials and supplies that may be reported with a supply/material code (e.g., CPT code 99070 or HCPCS Level II code)."

Even though CPT Assistant supports reporting the casting supplies, Robertson reminds practices that whether you should report the HCPCS supply code (A4580) depends on carrier variability.

Most PM&R practices will therefore report only the E/M service and possibly the casting supplies for the first visit.

99002 Bundles Into Other Services

When the patient returns for her second visit, don't report 97504, 97703 and 99002, as did the practice in our example. Most carriers consider the orthotic fitting, training, handling and checkout to be part of the fee for the orthotic itself. If your carrier does not include these costs in the orthotic fee, select just one of these codes.

The NCCI considers the fitting and training code, 97504, mutually exclusive of 97703, so you can never report them together. In addition, Medicare does not allow any payment for 99002 because this service is always bundled into payment for other services rendered on the same day.

To determine whether you should report 97504 or 97703, ask yourself whether you trained the patient or adjusted the orthotic.

You should report 97504 if you train the patient to use the orthotic. Placing an orthotic in the patient's shoe does not constitute "training," however. You must actually work with the patient for at least 15 minutes, teaching her how to move appropriately with her new orthotic, to report code 97504.

If you spend at least 15 minutes examining the patient during functional activities to ensure that the orthotic fits properly, you can report 97703.

If, during the second visit, the physician manages the patient's condition and performs an E/M service in addition to fitting the patient for her orthotic, you can report an E/M code instead of the fitting, training and checkout codes.

Most PM&R practices will therefore report 97504, 97703 or an E/M code for the follow-up visit.

Bill Orthotic to DMERC

Most PM&R practices cannot report durable medical equipment (DME) items such as an ankle-foot orthosis to their normal Medicare carrier. DME claims are instead routed through one of four Durable Medical Equipment Regional Carriers (DMERCs).

You can bill a DMERC directly only if you have a DME supplier number, says **Richard C. Papperman, CHBME,** owner of Cape Professional Billing, a medical billing service in Cape May Court House, N.J.

If a medical practice wants to dispense its own DME supplies, it could do one of three things, Papperman says. The first is

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to acquire a DME supplier number and bill the supply directly to the DMERC. You should be sure that you have fully documented medical necessity for the supply in the office notes. And, you should always follow Stark laws (the government's anti-kickback laws) if you have a financial interest in the practice.

The second option is for the DME supplier to bill Medicare for the orthotic costs. The supplier pays your practice fair market rent to store an inventory of DME supplies, or sends you orthotics on an as-needed basis. You forward the paperwork to the supplier, and the supplier bills the DMERC directly.

A third option is to give the patient a prescription and a certificate of medical necessity (CMN), and have the patient pick up the orthotic at an independent dispensary. The local medical review policies for all four DMERCs state, "Ankle-foot orthoses described by codes L1900-L1990 ... are covered for ambulatory patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally." Once you're certain that your patient fits the DMERC's requirements, you should turn your attention to your CMN.

Concentrate on That CMN

"The questions on the CMN aren't hard, but if the form isn't completed correctly and the supplier doesn't look it over before dispensing the item, the product could be dispensed and then later rejected for payment by Medicare," Papperman says. "Unless the patient has already signed a properly completed advance beneficiary notice stating that he will pay should Medicare deny the charge, then the DME item becomes free to the patient."

He reminds physicians that although they have to write prescriptions up-front for suppliers to dispense DME items, they have up to 30 days to fill out the CMN. "Even so," he says, "whenever possible, a supplier should not dispense anything, especially big-ticket items, without a properly completed CMN."

Remember that the local DMERC carriers maintain very rigid requirements for orthotic reimbursement, so if you are ever in doubt, always contact your insurer to confirm that your patient is a candidate for the orthotic you've prescribed.

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