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05/05/22

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Pertinent Changes and Points of Discussion

- NEW - Medicare Face-to-Face and Written Order Prior to Delivery (WOPD) for Orthoses
- NEW - Medicare Prior Authorization for Orthoses
- Competitive Bid
- Custom Fitted vs OTS
- Same/Similar
- Related LCD’s and Medical Necessity

Medicare Orthotic Face-to-Face and WOPD

Effective April 13, 2022, 7 non-PMD HCPCS - E0748, L0648, L0650, L1832, L1833, L1851, and L3960 will require a complete order prior to the item's delivery (WOPD) and must meet the following Face-to-Face requirements:

- For all items requiring a face-to-face encounter, a practitioner visit is required within six months preceding the order.
- The encounter must be used to gather subjective and objective information associated with diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.
- The face-to-face encounter must be documented in the pertinent portion of the medical record (for example, history, physical examination, diagnostic tests, summary of findings, progress notes, treatment plans or other sources of information that may be appropriate). The supporting documentation must include subjective and objective, beneficiary specific information used for diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.
- If the encounter is performed via telehealth, the requirements for telehealth services and payment for telehealth services must be met.
- A supplier must maintain the written order/prescription and the supporting documentation provided by the treating practitioner and make them available to CMS and its agents upon request.

Medicare Orthotic Prior Authorization

CMS selected five HCPCS codes **L0648, L0650, L1832, L1833, and L1851** subject to required prior authorization. Implementation of this requirement will be completed in three phases:

- **Phase one - April 13, 2022**
  New York, Illinois, Florida, and California

- **Phase two - July 12, 2022**
  Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington.

- **Phase three - October 10, 2022**
  All remaining states and territories not included in phase 1 or phase 2

Prior Authorization should be requested with the DMEMAC of the patient's residence. The Prior Auth Request (PAR) must include the Standard Written Order (SWO) and chart notes supporting the medical necessity of the item. The PAR can be requested via Mail, Fax, esMD, or the DMEMAC Provider Portal. PAR cannot be requested until need for the item has been established (cannot obtain Prior Auth for a scheduled surgery).

Medicare has categorized the PAR's into 3 types of submissions – Initial Submission, Resubmission, and Expedited Submission. The current estimated turnaround time for Initial Submission and Resubmission is 10 days. The Expedited Submission is estimated at 2 days.

Important Links – F2F/WOPD and Prior Auth

Prior Auth and Pre-Claim Review Initiatives

Face-to-Face and WOPD Requirements

Federal Register Notice

Required Face-to-Face Encounter and Written Order Prior to Delivery List (PDF)

Required Prior Authorization List (PDF)

Emergent Situations – Prior Auth or ST Modifier?

ST MODIFIER = Related to TRAUMA/INJURY/SURGERY

To use the ST modifier on a claim:

- Beneficiary must have an acute/emergent medical condition or surgery that requires the use of the brace
- Practitioner must include reason for immediate use of the DMEPOS item within the medical records
- Reason must be related to trauma, injury, or surgery supported by the ICD10 codes in the medical record

Claims billed with the ST modifier are subject to 100% prepayment review

Physicians are NOT exempt from prior auth

Emergent and Competitive Bidding

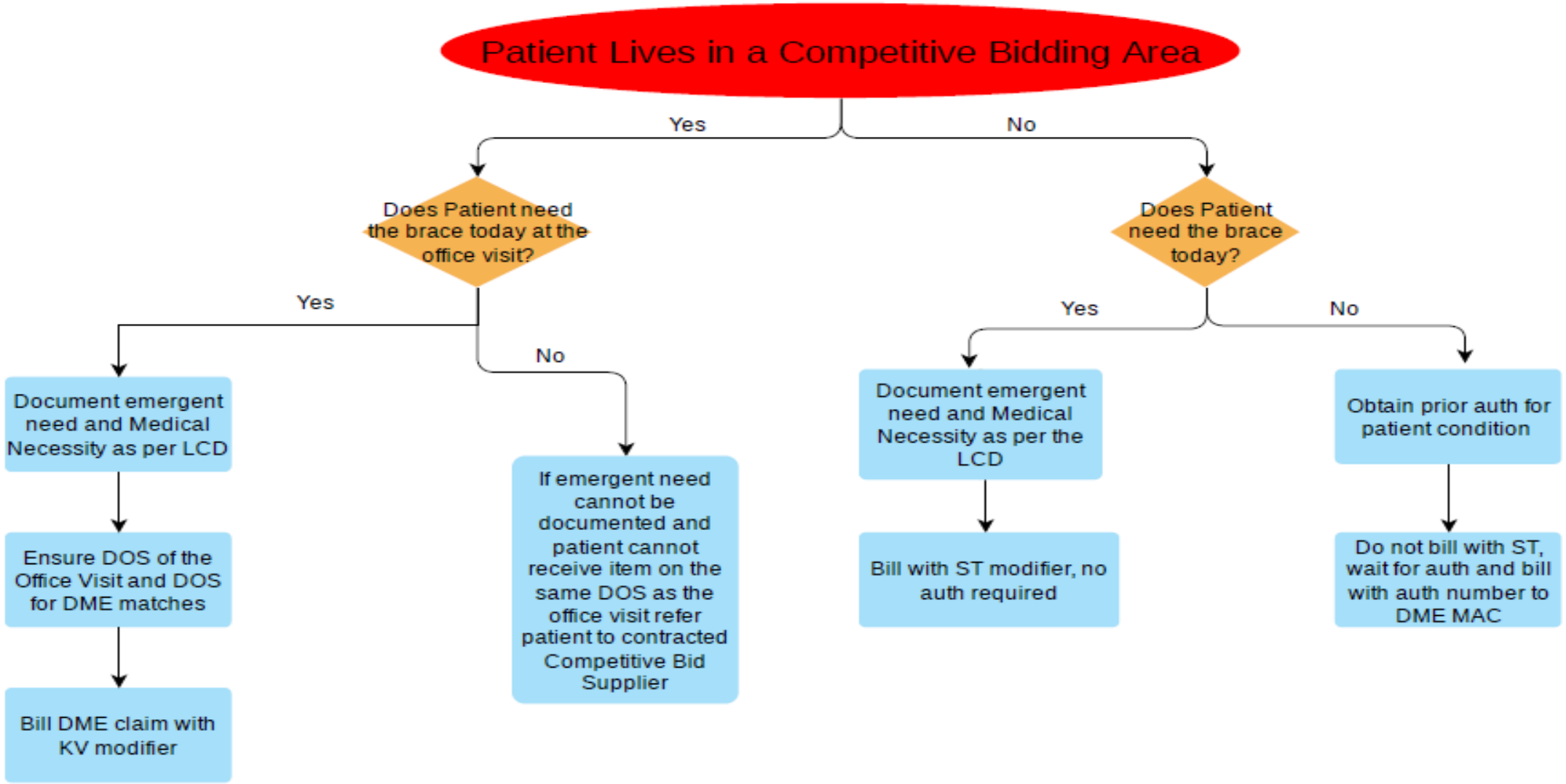
- KV modifier used in place of the ST modifier
- Use of the KV modifier conveys immediate need
- Must bill with all other applicable modifiers (KX, LT/RT, CG)
- DOS of DME item must match the DOS for the office visit
- Items billed with the KV modifier will be subject to 10% prepayment review

Denial Situations – **Refer to contracted Competitive Bid Supplier**

- Office "Visit" is within the Global Period (non chargeable visit)
- Office "Visit" is the date of surgery
- DME is dispensed after the office visit (non chargeable visit)

Since the DOS of the DME item does not match or coincide with the DOS of a chargeable office visit, the claim will be denied by Medicare.

FLOW CHART


Patient Lives in a Competitive Bidding Area
Yes
No
Does Patient need the brace today at the office visit?
Does Patient need the brace today?
Yes
No
Yes
No
Document emergent need and Medical Necessity as per LCD
Ensure DOS of the Office Visit and DOS for DME matches
Bill DME claim with KV modifier
If emergent need cannot be documented and patient cannot receive item on the same DOS as the office visit refer patient to contracted Competitive Bid Supplier
Document emergent need and Medical Necessity as per the LCD
Bill with ST modifier, no auth required
Obtain prior auth for patient condition
Do not bill with ST, wait for auth and bill with auth number to DME MAC

Custom Fitted vs OTS

Requirement for a Custom Fitted HCPC Code

- Must meet Medical Necessity as per LCD or Medical Policy guidelines
- Proof that item has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
- Be prepared to provide proof of certification or training for the individual with expertise
- If the above cannot be proven, bill the OTS code
- Commercial payors are enforcing these requirements and asking for proof of custom fitting

Split Coding Crosswalk – Custom Fitted vs OTS

Split Coding Crosswalk

Custom Fitted	Examples	Off The Shelf
L0626	Exos FORM 626	L0641 *
L0627	Exos FORM 627	L0642 *
L0631	Exos FORM 631	L0648 *
L0637	Exos FORM 637	L0650 *
L1810	Reaction Knee Brace	L1812 *
L1832	X-Act ROM or Playmaker	L1833 *
L1843	Clima-Flex OA	L1851 *
L1845	Armor	L1852 *
L3760	X-Act ROM Elbow	L3761
L3807	ComfortFORM Wristw/ Abducted Thumb	L3809
L3915	Custom Wrist Brace	L3916
L3923	Exos STS	L3924
L4360	AirSelect	L4361
L4386	MaxTrax Non-pneumatic	L4387
L4396	Dorsal Night Splint	L4397
L3760	Xact ROM Elbow	L3761

DJO

* - *Subject to Competitive Bidding*

Same/Similar RUL (Reasonable Useful Lifetime)

Canes/Crutches – E0100-E0116 – RUL 5 years

Walkers – E0100-E0149 RUL 5 years

Spine – L0450-L0651 – RUL 5 years

AFO/KAFO – L1900-L4631 – RUL 5 years

Knee – L1810-L1860

- L1810, L1812, L1820, L1830 = 1 year
- L1831, L1832, L1833 = 2 years
- L1834, L1836, L1840, L1843, L1844, L1845, L1846, L1850, L1851, L1852, L1860 = 3 Years

All other HCPC codes should be verified for SAME – RUL 5 years

- This includes Upper Extremity which currently only has a ”Same” category and no “Similar”

Noridian Same/Similar Chart:

https://med.noridianmedicare.com/web/jddme/topics/same-or-similar

Knee - L1830, L1832, L1833, L1843, L1845, L1851, L1852

Criteria 1

The patient has had a recent injury to or surgical procedure on the knee(s);

- (e.g. ACL, PCL, LCL, MCL reconstruction repair, Arthroscopy and knee manipulation).

Synovial injection or any other injection does not qualify; and

- *The documentation must "correspond to the need of what is being ordered." In an audit, the DME MAC will review the beneficiary's medical record to determine if, at the time the brace was provided to the patient as part of his or her rehabilitation plan, it was recent enough to be effective.*

Current "recent" determination is 3 months for CGS, 30 days for Noridian

The patient has a covered diagnosis that supports the medical necessity **Group 2 Code** sections

L1832, L1843, L1845 must have custom fitted documentation

Knee - L1832, L1833, L1843, L1845, L1851, L1852

Criteria 2

The patient must be ambulatory; and

The patient must have knee instability that is documented by examination of the beneficiary and objective description of joint laxity due to a condition specified in the Diagnosis Codes that Support Medical Necessity **Group 4 Codes** section

L1832, L1843, L1845 must have custom fitted documentation

- Custom FABRICATED Braces (L1844 and L1846)- Criteria Set 1 OR 2 must be met and medical records must support/demonstrate why the patient will not fit into an OTS Brace

  - A deformity of the knee or leg that interferes with fitting
  - Disproportionate size of thigh and calf
  - Minimal Muscle Mass upon which to suspend an orthosis

The patient must have knee instability that is ***"documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test)."*** **(**Medicare LCD Knee Orthosis (L33318))

Common objective evidence supporting joint laxity	Does not support a coverage for joint laxity
Description ✓Positive for ligamentous laxity ✓Varus/Valgus laxity or instability ✓Patellar laxity or instability ✓Joint laxity ✓Incompetent or deficient anterior/posterior cruciate ligament Tests ✓Stress test ✓Anterior/posterior Drawer test ✓Lachman's test ✓Pivot Shift Test ✓Dial Test ✓Posterior Sag Sign test	✘Osteoarthritis; Severe Osteoarthritis ✘Varus/Valgus deformity ✘Patient complaint of laxity (subjective); instability, unstable knee or giving way ✘Bone on Bone; Obesity ✘Pseudo laxity ✘Crepitus or Crepitation ✘Narrowing of the joint space ✘Tenderness at the joint line ✘Meniscus tear ✘Peroneal nerve dysfunction ✘High Q angle ✘McMurray's or Apley's test

SPINE BRACING

A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

A simple statement in the medical records that the patient has back pain is not sufficient to establish coverage.

It's important that the medical records mention the need for the brace or the fact that the beneficiary would benefit from the use of a brace.

If a spinal orthosis is provided and the coverage criteria are not met, the item will be denied as not medically necessary.

All custom fitted codes need documentation of custom fitting