BILLING & CODING PROTOCOLS

for Functional Orthotics

Specific Suggestions:

From **Documentation** to **Verification** to **Coding** to **Reimbursement**

By
Kathy Mills Chang, MCS-P, CCPC
Mario Fucinari, DC, CCSP, DAAPM, MCS-P
Brian Jensen, DC
Marty Kotlar, DC, CPCO, CBCS
K.S.J. Murkowski, DC, DCCT, DAACA

FOOT LEVELERS

BILLING & CODING PROTOCOLS

Introduction

This is indeed a great time to provide Chiropractic care to our patients. People want natural healthcare. They want to be healthy and vital. What about pain? Whether your patient requires functional orthotics or custom footwear, Foot Levelers will be there to aid you in providing customized care to your patients.

Foot Levelers strives to continue to help advance the Chiropractic profession as we have for over 60 years. This Billing and Coding Manual has been produced by Foot Levelers in conjunction with medical coding consultants who are knowledgeable in documentation, coding and compliance. The reality of the health care profession today is that third parties--not just the patient and the physician-- have an impact on the coverage and payment for medically necessary services. Insurers, legislators and regulators all have an impact.

This Billing and Coding Manual is an educational guide to the rules and regulations governing coding and billing of our products. The information contained herein is intended as general information only. It is not intended to serve as medical or legal advice or as a substitute for professional advice of a medical coding professional. While this document represents our best efforts to provide accurate information and useful advice, we cannot guarantee that third-party payers will recognize and accept our coding and documentation recommendations.

Medical coding is the shorthand used by insurers to understand your patient but it does not stand-alone, it must be supported with your documentation and evidence of medical necessity. Medical Billing is driven by medical necessity, but not that alone. The analysis of any medical claim is also dependent on state and federal laws and regulations, and by insurance and payer policies. Coverage of items and services may be dependent on the practitioner's licensure, scope of practice restrictions or other requirements in the state practice act. All of these are subject to change.

In short, not all billing and coding rules or patient care situations can be addressed in a single document. We have endeavored here to bring you the fundamental elements that will be used in your medical decision-making and claims filing.

Index

Disclaimer:

The information in this guide is provided by Foot Levelers for informational purposes only. It is each provider's responsibility to report the codes that accurately describe the products and services furnished to individual patients.

Laws and regulations regarding reimbursement change frequently. Providers are solely responsible for all decisions related to coding and billing including determining, if and under what circumstances, it is appropriate to seek reimbursement for products and services. Providers are advised to contact specific payers if they have any questions regarding billing, coverage and payment. Providers must check the complete and current year HCPCS, CPT, and ICD codes for most accurate reporting.

Insurance Coverage

Foot Levelers wants you to know...Insurance coverage of functional orthotics is an important consideration for most patients. Some benefits packages cover these items and some do not. When coverage is available, it generally will only reimburse members for the items if the items are considered medically necessary.

Even when a patient has coverage for functional orthotics in their benefits package, there is no guarantee that clinically appropriate orthotics will meet the criteria as a covered benefit under the plan. Third party payers often develop their own medical policies, which they use to determine whether items are considered medically necessary and, therefore, payable under the plan. Medical review policies for functional orthotics often spell out covered conditions and diagnosis codes, as well as the CPT and HCPCS codes considered appropriate for payment. Providers should always endeavor to locate medical review policy for orthotics and other ancillary services on the payor's website.

Even if the diagnosis for which you are ordering the orthotics is not considered a covered condition, some patients are willing to assume financial responsibility for prescribed orthotics.

Getting Started

Step 1 – Evaluate Medical Necessity and Document Your Clinical Decision Making

Taking a Patient History

Insurers will often look for a patient history to address the following symptoms where present:

- joint pain/stiffness
- weakness
- limitation of motion
- difficulty walking
- numbness/tingling in the lower extremities

It is important when taking a patient history to explore both past and current medical conditions that may affect patient care. Chronic conditions, and traumatic injuries could each benefit from functional orthotics. Additionally, it may be helpful to ask the patient about other treatments tried, or considered and ruled out. Where applicable, document why these prior alternatives did not work out favorably, or why they stopped working.

Examples of specific History questions:

- Are the symptoms affected by walking or standing or by climbing stairs?
- Do you avoid activity due to pain in your feet or lower extremities?
- Do you have to elevate your feet to get comfortable?
- Do you use any type of home remedies for your feet and lower extremities?
- Have you tried heel lifts, over the counter (OTC) analgesics, OTC insoles, rigid orthotics, padding, changing your shoes or injections?

The answers to these questions, when properly documented in the patient record, may help support your assessment that treatment is indicated and there is medical necessity for prescribing functional orthotics.

Examination And Diagnostic Testing

Once the patient history is established, the next step is the physical examination. The History, when combined with documentation of the physical examination and where called for, diagnostic testing (i.e., X-rays) will together provide objective evidence for medical necessity to support the use of functional orthotics in a treatment program.

When orthotics are being considered, it is recommended that your documentation describe patients' symptoms and medical diagnoses clearly. You may also include one or more of the following:

- 5 Red Flags of Pronation
- Global postural distortions
- Structural X-ray anomalies
- Functional squat test
- Range of motion
- Orthopedic/Neurological tests (see appendix B)
- Digital foot/posture assessment

Treatment Plan

To establish medical necessity and the clinical appropriateness of functional orthotics, it is vital to include your recommendations in the context of a broader treatment plan. A properly written treatment plan should be comprehensive and may include some of the following elements:

- Recommended level of care to include duration and frequency of follow up visits
- Methods of treatment to be utilized (i.e., adjustments, therapies, functional orthotics, rehab)
- Specific treatment goals, including goals for the functional orthotics
- Objective measures to evaluate treatment effectiveness and the effectiveness of functional orthotics
- Planned modalities and procedures, including those adjunctive treatments to support the necessity of functional orthotics

Step 2 – Coding for Coverage and Reimbursement

The process of filing claims for payment involves identifying the diagnosis and treatment for the payer. Transmitting that information is accomplished using coding systems designed to capture the relevant facts in a uniform system of shorthand alphanumeric codes. Because these codes will be your statement of services rendered to payers, the codes used must be accurate, complete and appropriately billed by the practitioner rendering the services.

The laws, rules and regulations regarding reimbursement and coding for orthotics and ancillary services can vary from payer to payer. Always check the carriers' medical review policy (MRP) to confirm which CPT and ICD codes

will qualify for orthotics and prosthetics. This policy should outline the approved diagnosis codes, the approved HCPCS billing codes and the other parameters associated with coverage. Remember, not all conditions for which you may prescribe orthotics may be covered under the insurance policy that the patient has.

The laws, rules and regulations regarding who can order and bill for orthotics and ancillary services can vary from state to state, and from payer to payer. Not all practitioners are authorized to write orders for orthotics so please check the payer policy on approved prescribers as well. Some items and services may be dependent on the ordering practitioners' licensure, scope of practice restrictions or other requirements in the practice act.

It is up to the practitioner to ensure that the codes and the services are matched. To ensure coding accuracy, individuals who are responsible for determining and reporting CPT, HCPCS, and ICD codes on medical claims should receive proper training.

Diagnosis Codes (ICD)

The diagnosis codes selected and reported must support the medical necessity for the functional orthotics. Even when a patient has a clinically appropriate reason for ordering functional orthotics, unless the stated diagnosis code is included for coverage in the medical review policy, it may not be considered medically necessary according to the carrier. Some individual carriers' policies may require a spinal-related diagnosis, an extremity-related diagnosis or both. For example, even though functional orthotics are prescribed for more than extremity conditions, supplying a lumbar diagnosis to a claim where the covered conditions are only extremity related would not be enough to meet the requirements for medical necessity.

The ICD codes identify diagnoses that can be linked to the recommended treatment and supplies. As noted, not all diagnoses are considered to support the medical necessity for prescribing orthotics. The conditions and diagnoses support the ordering of orthotics but the items may not meet the medical necessity guidelines set forth by the third party payer. Covered diagnosis codes can usually be found in the carrier's medical review policy.

TIP: *Listing the diagnosis codes associated with the treatment performed helps to demonstrate the basis for your medical judgment that the service being provided are medically necessary and should allow the insurance carrier to process the claim accurately.*

CPT Codes

CPT codes are utilized by medical professionals to document their medical, surgical, and evaluation and management (E/M) services. CPT codes are administered by the American Medical Association and are used under license by payers nationwide.

When coding claims with CPT codes, professionals must make accurate determinations about which codes best describe their services. Insurance payer rules, including those for procedural bundling rules, and proper modifier usage are all essential elements to know when reporting CPT codes.

The following codes may apply to the professional care you provide to patients in the process of evaluating the need for, and ordering, functional orthotics. This list is not meant to be exclusive; as noted, please check insurers benefit policy manuals for guidance on the proper CPT codes to select.

99201-99205 E/M Coding, New Patient:
A new patient is one who has NOT received any professional services from a physician or another physician of the same specialty who belongs to the same group practice within the past three years. Every new patient should have a history and examination. This new patient visit would often include a structural evaluation of the patient's lower extremities in conjunction with other appropriate examination procedures.

TIP: *Practitioners may be able to use the 3D BodyView® scanner as a tool to evaluate a new patient -- just as you would measure blood pressure and range of motion. Where the scan is taken on the same visit as 99201-99205 E&M service, the CPT code for a scan is not separately billable. Repeated Scans can be utilized to evaluate patient progress, where appropriate.*

99212-99215 E/M Coding, Established Patient:
An established patient as defined is one who HAS received professional services from a physician or another physician of the same specialty who belongs to the same group practice within the past three years. An evaluation must include an updated history or documentation of clinical decision-making. For established patients, it may be clinically indicated to evaluate an established patient for spinal or extremity conditions.

70000 Series Radiologic Examination (X-ray):
Some patients may require an X-ray. The following procedures and their codes may be clinically indicated. This list is not all-inclusive.

Foot – 73620, 73630, 73650, 73660
Ankle – 73600, 73610
Knee – 73560, 73562, 73564, 73565
Hip – 73500, 73510, 73520
Pelvis – 72170, 72190
Lumbar Spine – 72100, 72110
Thoracic Spine – 72070
Cervical Spine – 72040, 72050, 72052

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes.
This code can be billed the day the functional orthotics are dispensed to the patient, and may only be used for "custom fabricated" supports. This code includes the fitting of the functional orthotics, training in use, care and wearing time of the functional orthotics and brief instructions in exercises while the functional orthotics are in place. Direct one-on-one contact by the provider of service is required and it is a timed code, so be sure to properly document the time spent in your daily note.

97763 Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
This code is intended for established patients who have already received their functional orthotics. It is essential for the healthcare practitioner to follow-up with a patient after they have been provided with a pair of functional orthotics. The "checkout" visit would include assessing the patient's response to wearing functional orthotics, such as possible skin irritation or breakdown, determination if the patient is donning the functional orthotics appropriately, need for padding, underwrap or socks and tolerance to any dynamic forces being applied. This code requires direct one-on-one contact by the provider and is a timed code, so be sure to properly document the time spent in your daily note.

HCPCS (Healthcare Common Procedures Coding System)

HCPCS codes, pronounced "hick-picks", are used to identify supplies, equipment, and devices provided to patients. The similarity of the codes requires careful evaluation and selection of the proper HCPCS code. It is up to the ordering and billing practitioner to ensure that the codes reported match the items claimed..

There are short form and long form descriptors for each HCPCS code.

The following list of Codes is provided only as a resource for coding for Foot Levelers orthotics. Foot Levelers does not guarantee reimbursement or coverage under this code.

L3010–Foot, insert, removable, molded to patient model, longitudinalarch support, each
This is a second possible code related to reimbursement of functional orthotics. The code is very similar to L3020 and is the preferred code in some policies/states for functional orthotics.

L3020–Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each.
In 2012, representatives from the American Podiatric Medical Association (APMA), American Orthotic and Prosthetic Association (AOPA), and Prescription Footwear Association (PFA) met to discuss these orthotic codes. The organizations mutually agreed on the more detailed guidelines for the device codes. See Addendum B below. Although the detailed guidelines are not formally part of the HCPCS code descriptors, the guidelines have been adopted by some carriers as limitations on coverage.

Step 3 – Verification

Where a patient is fortunate enough to have insurance coverage, it is still crucial to determine whether functional orthotics are included among the patient's covered benefits. As with coverage for any other service you provide, beneficiaries will only be obtain insurance coverage for items that are covered under the terms of the policy that was purchased by the patient or their employer and the rules of the medical review policy as it relates to functional orthotics. You can check with each individual carrier before ordering. When verifying coverage, ask whether only a particular practitioner may act as the ordering practitioner, and whether coverage is dependent on a spinal-related diagnosis, an extremity-related diagnosis, or both.

Follow the Foot Levelers Verification Sheet for Orthotics (p. 14) to be sure that you ask the right questions about orthotics. This verification sheet is in addition to your standard verification of the patient's coverage. **Insurance Verification can be completed before your patient's appointment.**

Step 4 – Payment for Services: Billing and Claims Processing

Whether you are billing third party payers, or billing the patient directly, the process of billing for functional orthotics and associated extremity care is no different from any other clinical billing procedure.

When seeking reimbursement from a third party payer on behalf of your patient, accuracy and completeness are critical components in a successful claim.

Billing Insurance

Before any claim is filed, medical necessity should be established through history, exam, diagnosis and treatment plan.

1500 Form Completion

As previously discussed, proper diagnostic and procedural coding, once selected, must be properly listed on the billing form. Most insurers use the uniform billing form known as Form 1500.

When billing the functional orthotics supply code, L3010 or L3020, practitioners must bill each orthotic separately. That is, two line items will be used to indicate the right and left functional orthotics. While functional orthotics come in pairs, they are coded for each individual foot. The code represents only ONE functional orthotic.

The examples below demonstrate appropriate completion of boxes 21 and 24 of the 1500 billing form should be noted that there is more than one way to complete the form.

The following are examples only and must be completed using the correct codes for the patient treated.

Option 1 is to list a line item in box 24 of the 1500 form with the proper HCPCS code in box 24D, the properly linked diagnosis code in box 24E, the total charge for both functional orthotics in box 24F and a "2" in the units box, 24G.

Option 2 is to separate the pair of functional orthotics and list them on two separate lines.

On the first line of box 24, list the proper HCPCS code with an RT modifier in box 24D, the properly linked diagnosis code in box 24E and 50% of the total charge for the pair of functional orthotics in Box 24F. Place a 1 in the units box, 24G.

On the next line of box 24, list the code L3020 with an LT modifier in box 24D, the properly linked diagnosis code in box 24E, 50% of the total charge for the pair of functional orthotics in box 24F, and place a 1 in the units box, 24G.

If you were billing two pairs in any combination the second pair would be billed exactly the same way.

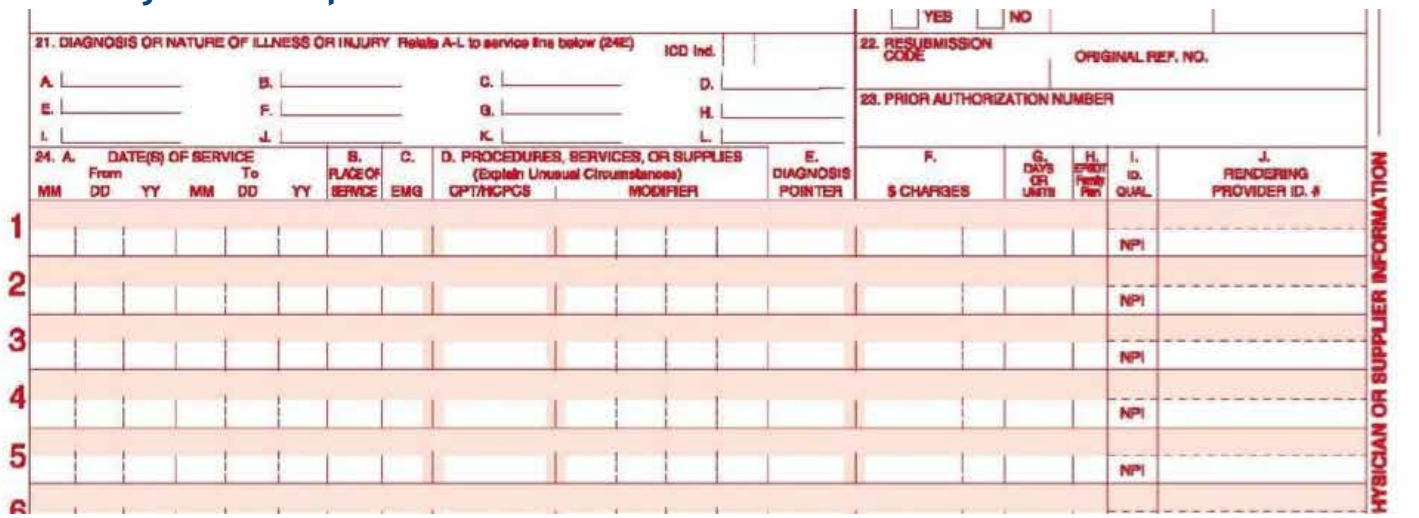
Discounts

If a practitioner decides to offer discounts, the total in each line item must reflect the discounted fee (e.g., 50% of the total charge for the functional orthotic pair.) Practitioners should reflect the correct dollar amount in box 24F, and follow the instructions above. For four functional orthotics, you will have (as in option one) two line items with a "2" in each units box, 24G.

As in option 2, a claim may have four separate line items indicating four functional orthotics, and two would have the RT modifier in box and two would have the LT modifier.

It is important to properly link the diagnosis code reported on the 1500 form in Box 21 to the service code performed in Box 24D. This is accomplished by listing the appropriate diagnosis indicator, A, B, C or D or multiple letters, in 1500 form Box 24E.

1500 Billing Form Example



Box 21

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS (Relate items A-L to item 24E by line)
A. M99.01 Segmental and somatic dysfunction of the cervical region
B. M72.2 Plantar fascial fibromatosis

Boxes 21, 24D and 24E
Box 21 is where you enter your ICD codes. Box 24D is where you enter your CPT/HCPCS codes. Box 24E is where you enter the diagnosis reference number(s) A-L as they relate to the diagnoses code positions in Box 21. A written description of your diagnosis codes in Box 21 is not necessary. Do not enter ICD-10 codes in Box 24E.

Self-Pay Patients

Patients who need functional orthotics may not have full insurance coverage; some may have partial insurance coverage or none at all. Many patients will agree to pay out of pocket for orthotics.

The following are some common scenarios that patients and providers face when covering the cost of functional orthotics, along with various approaches to assist you and your patient. This guidance is not intended to serve as medical or legal advice or as a substitute for professional advice of a medical coding professional.

Situation One: Your patient's insurance is Medicare.
Foot Levelers Wants You to Know: Medicare has very specific, rules for limited coverage of orthotics through their Durable Medical Equipment (DME) benefits. Functional orthotic inserts are covered by Medicare only when placed in a shoe attached to a brace. Functional orthotics are usually not placed in a shoe attached to a brace, and, therefore, are a non-covered service under Medicare.

Ordinarily, a practitioner cannot charge a Medicare patient more than the Medicare allowable fee for covered items. That is, Medicare remittances are payment in full, except for copayments and deductibles. When services are excluded under Medicare, such as orthotics when ordered by a DC, a practitioner must charge their actual fee to the patient for the orthotics.

If your patient has secondary insurance that will cover items Medicare will not cover, (MediGap), you can ask about whether the payer will require a denial letter from Medicare. (Medicare will often decline to issue a denial through the Part B carrier unless a claim is filed.) Modifiers would be used to indicate that the claim was filed to get a denial only. Check with the Medicare program Contractor (Carrier) if you have questions.

Situation Two: The carrier's contracted allowable fee schedule is lower than the provider's cost of the functional orthotics.
Some a carriers have a fee schedule for functional orthotics that will not cover for the quality of items you provide. There are solutions that allow you to provide custom functional orthotics from Foot Levelers.

Under some plans, the payer will authorize providers to offer an upgraded item of covered DME provided that the beneficiary agrees to be responsible for the difference between the charge for the upgrade and the payer's payment amount for the standard item. An upgrade usually consists of an item that includes an "excess component." An excess component is an item, feature, or expense for an item or feature that is in addition to, or is more extensive or more expensive than, the item that is covered under the payer's coverage requirements.

HCPCS billing code S1001 describes a deluxe/upgrade item requiring patient waiver. It allows a participating provider to provide an upgraded product under specific circumstances at the patient's request. Certain carriers may allow for billing of this code, thus allowing for the patient to pay the difference up to the full retail price of the functional orthotics.

You must get the patient's advance agreement when using the S1001 concept. Explain to the patient that the amount for covered orthotics allowed by their carrier represents a type of orthotic that is less comprehensive than the Foot Levelers functional orthotic you're recommending.

Point out the enhanced benefits that apply to the recommended orthotics, such as the leather composition, the increased Zorbacel for extra shock absorption, the three-arch support, and two-year warranty. Let them know that with the payor' advance permission, they can still receive this upgraded product while applying what the carrier will allow toward the total cost. They simply agree to pay the balance. A sample acknowledgement form is contained in Appendix A of this guide. (P. 11)

To use this code, consider the following steps for success:

When verifying coverage, find out if the carrier allows for the upgrade/upcharge with patient acknowledgement, using code S1001.

If S1001 is not allowed, consider requesting an amendment to your provider agreement. Notify provider relations that you wish to provide an upgraded supply to your patient that has a higher cost than the fee allowed under the contract. Let them know that the patient is willing to bear the cost of the difference between the allowable amount and the full price, and that you would like to amend your agreement to allow for that. We've provided a sample letter in Appendix A of this guide. (P.11)

Situation Three: You determine that the need for functional orthotics is clinically appropriate for your patient, but the carrier's policies do not ordinarily cover the diagnosis for which the orthotics were prescribed.

Foot Levelers Wants You to Know: If functional orthotics will not be covered by the carrier, or if the service is considered to be for the patient's comfort or convenience, the items would not meet the medical necessity requirement to be reimbursed by the carrier. In this scenario, the patient may be obligated to pay for the service out of pocket. Be sure to check the patient's policy and/or your provider contract to ensure your ability to pass the fees on to the patient and always check with the patient as well and whether written proof of advance notice signed by the patient is necessary.

The sample acknowledgement for provided in Appendix A of this guide can be crafted to meet your needs in this situation. (P.11)

Situation Four: You prescribe Sandalthotics®, Shoethotics® or custom flip-flops products in which the functional orthotic is built into or provided with a shoe.

Very few insurance carriers cover shoes that are not attached to a brace. The Shoethotics and Sandalthotics sold by Foot Levelers will usually not meet those coverage criteria. While the orthotic may be deemed medically necessary and therefore potentially "covered" by the 3rd party payer, it is unlikely that the shoe would be covered. In those instances, it is appropriate to bill the carrier for the orthotic and bill the patient for the corresponding shoe. The following is an example, with fees noted for example only:

- Patient purchased a Keen sandal with a built-in orthotic, and the total charge for the sandal with orthotic is $300.
- If one were purchasing the orthotic only in your office, the fee would be $210. Therefore, the patient would pay $90 for the shoe out of pocket.
- The carrier would be billed for the orthotic alone, as per customary orthotic billing protocol.
- Your medical record would reflect that you dispensed the full shoe with the custom functional orthotic for the condition, diagnosis and treatment plan. Your billing summary would reflect that the carrier was only billed for the orthotic and that the patient paid directly for the shoe.

Situation Five: Your patient has no third party insurance coverage for orthotics.

Foot Levelers Wants You to Know: The lack of third-party coverage does not negate the usefulness of functional orthotics. Some patients will pay cash for their functional orthotics if they understand the importance of the functional orthotics in their treatment plan. If you are a member of a Discount Medical Plan Organization (DMPO) like ChiroHealthUSA, you may be able to set a legal, discounted fee schedule for orthotics through such a plan.

Appendix A

On the following pages are a collection of letters to help your billing process. Individualize each of these letters to fit your practice.

Sample Letters

Request to Amend Provider Agreement to permit billing for Upgraded products

Date
XYZ Insurance Company
123 Anywhere Drive
Anytown, NY 12345
Re: Request to Amend Provider Agreement

Dear In-Network Provider Relations Department:

As a participating provider in your network plan, I am requesting an amendment to my provider agreement. There are certain clinical circumstances where I may need to provide an upgraded clinical product to a patient at the patient's request.

The upgraded recommended product that I am referring to is an orthotic (functional orthotics). I am requesting that my provider agreement be revised so that I may be allowed to have the patient pay the cost of the orthotic when it is in excess of the established allowable fee schedule since I'm prescribing and dispensing an upgraded item with a longer warranty and enhanced features and benefits.

I will have patients sign a consent form acknowledging that they have been informed that there are other less expensive products covered under your plan that may meet medical necessity. Additionally, when I submit the claim, I will use HCPCS code S1001 when providing a deluxe/upgrade item requiring patient waiver. This code has been developed for providers to use when billing for high-end equipment or an upgrade. The amount billed to the patient will represent the cost in excess will represent the actual fee charged by the practice, less the allowed amount from the carrier.

Please contact me with your response as soon as possible and let me know if any further information is needed.
Sincerely,

Sample Patient Acknowledgement Form for Non-Covered Products

Although your health insurance plan may cover many services and products provided in this office, unfortunately orthotics are either not covered at all when prescribed by a Chiropractor, or the amount allowed by your carrier is far below the amount of the cost of the type of orthotics we recommend. Accordingly, the functional orthotics I have recommended may not be covered under your insurance. In that instance, you are financially responsible for all non-covered items we order on your behalf. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay this office for the below listed product.

Product: Orthotics Date:_____ Amount:_____

Patient Acknowledgement:
I acknowledge that a certain portion of my care will not be covered by my health plan under the terms of my benefit plan. I acknowledge that I am signing this notice voluntarily and that it is not being signed after the product has been provided. .

I acknowledge that I have been told in advance by this office that the product listed above is either not covered by my health insurance plan, is not covered when delivered or ordered by this practitioner, or the amount allowed by my plan is not going to cover the cost of the recommended product.

I understand and agree to pay for this non-covered product at the time the product is provided.

I have had the opportunity to ask questions about my financial obligation and other treatment options. I understand I have the choice to consent to the order for this product and that by signing this form I am fully responsible for all non-covered products.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above and I agree to make financial arrangements with Dr. _____'s office.

Patient Signature_____ Date_____

**IMPORTANT INFO FOR IN-NETWORK PROVIDERS - Review your participating provider agreement/contract before implementing this form.

Sample Letter of Medical Necessity for Custom Functional Orthotics

Date
XYZ Insurance Company
123 Anywhere Drive
Anytown, NY 12345
RE: Jane Doe ID#: 12345

I am writing to provide the clinical justification to support my xx on behalf of Mrs. Doe for custom functional orthotics.

Mrs. Doe presented to our office on [date] for evaluation and treatment of [insert problem that warrants fitting of orthotics]. Diagnostic X-rays were taken on [date] indicating [give brief X-ray overview and denote any condition present]. An examination was performed on [date] and indicated [give brief examination overview listing positive findings and particularly those related to the need for orthotics]. Examination of the feet indicated [list the foot conditions that warrant the fitting of orthotics].

Outcome assessment tools were used with Mrs. Doe on [date]. On the Revised Oswestry Low Back Disability Questionnaire [or other similar questionnaires], she indicated that standing was limited to 10 minutes before pain required her to sit for a period of time. She also indicated that pain prevented her from walking more than 1/4 mile. This limited function was noted.

In my professional opinion, this patient will benefit from custom functional orthotics. X-rays were also done to verify need based on patient's history and complaints. My functional goals are designed with the purpose of supporting her body during walking and standing, Among the functional goals set for this patient is the goal to increase her tolerance to standing for up to a period of one hour at a time by [date].

The patient was casted/optically scanned on [date] and individually designed functional orthotics were ordered. A treatment plan was formulated utilizing a combination of Chiropractic treatment and passive and active therapy to bring this patient to a point of maximum improvement. A full explanation of the treatment plan can be found under separate cover.

Mrs. Doe will benefit from this proactive, well-balanced approach to her rehabilitation in this matter. Thank you for considering the necessity of these custom functional orthotics.

Sincerely,

Sample Letter of Medical Necessity for 97760, Orthotics Management and Training

Date
XYZ Insurance Company
123 Anywhere Drive
Anytown, NY 12345
RE: Mary Goodpatient ID#: 987654321

I am writing to provide the clinical justification you require to support my decision to provide orthotics management and training to Mrs. Goodpatient, in conjunction with her individually designed functional orthotics.

Mrs. Goodpatient presented to our office on [date] and on that day received her orthotics, which had been measured and ordered on [date]. On the date of the orthotics management and training, Mrs. Goodpatient had her individually designed functional orthotics dispensed to her and the following services were rendered:

- Her wearing schedule and instructions for care were given
- Proper fitting into the shoes was assured and trimming was performed
- Gait and station were examined
- [Add any other services here that were performed]

Given that 97760 is a timed code, it should be noted that approximately [number of minutes] was spent face to face with the patient performing this service. I have attached my office note for the day indicating the services that were rendered and the time that was spent.

Thank you for reconsidering the necessity of this service and I look forward to receiving payment as soon as possible.

Sincerely,

Sample Letter of Medical Necessity for CPT Code 97763

XYZ Insurance Company
123 Anywhere Drive
Anytown, NY 12345

The purpose of this letter is to provide you with information that will allow you to understand the medical reasonableness for the orthotic checkout procedural service (CPT code 97763) we provided to Mrs. Patient. We hope that this will allow you to authorize payment.

On [date], Mrs. Patient presented to my office with right-sided foot pain, foot swelling, foot pronation, low back pain and abnormal gait. Examination of the low back and bilateral lower extremities revealed [provide examination findings here]. Outcome assessment tools were also used with Mrs. Patient. The Revised Oswestry Low Back Disability Questionnaire indicated that standing was limited to only 10 minutes before the pain in her right foot and low back required her to sit. She also indicated that the right foot pain prevents her from walking more than a 1/4 mile. This limited function was noted and therefore the patient was fitted for and supplied with custom functional orthotics on [date].

On [date], Mrs. Patient returned to my office and stated that she feels better overall, however the foot swelling and pain on the right side is about the same.

On this visit it was necessary for me to re-assess the orthotics and decide if any modifications were necessary. This assessment included the patient's response to wearing the orthotics, possible skin irritation, determining if the patient is donning the orthotics properly and the need for additional padding or socks. It was my determination that the patient should continue wearing the individually designed functional orthotics as was originally prescribed, however she will now do specific ankle/foot exercises and ice the right foot for 15 minutes 3 times per day. The orthotics are being used to support her feet and spine during walking, standing and help protect the spine, bones and soft tissues from repetitive shock and stress. The objective is to promote proper biomechanical movement, prevent pain and possible re-injury. I was with the patient for 15 minutes performing the orthotic checkout service (CPT code 97763).

Please consider payment for this service, as it was clinically indicated and medically necessary.
Sincerely,

Sample Letter of Medical Neccessity and Pre-Authorization for Orthotics

Address
City, ST 12345
Re: Mr. Patient
ID#: 123-45-6789

Dear Insurance Company:

The purpose of this letter is to provide you with information that will assist you in determining the medical necessity for custom-fitted orthotics provided to Mr. Patient and to request authorization to supply and bill for the items.

On [date], Mr. Patient presented to my office with right foot pain, right ankle stiffness, [add additional conditions here]. Examination of the lumbar spine and right ankle/foot revealed [list positive findings that warrant ordering orthotics]. X-rays of the lumbar spine and right ankle/foot revealed [list positive findings that warrant ordering orthotics]. .

Outcome measurements of the patient's conditions were obtained via use of [Oswestry, Roland-Morris, LEFS]. The results revealed the following: [e.g., standing was limited to 10 minutes because of ankle stiffness and low back pain, foot pain prevented walking more than a 1/4 mile, etc.].

I am requesting your approval for the custom orthotics. The orthotics will provide the needed support when the patient is walking, standing and will help protect his foot, ankle and lower spine from excessive wear and tear as he performs his normal activities of daily living. The patient will be provided with detailed home care instructions on how to hasten the healing process. The objective is to promote proper biomechanical movement, prevent pain, prevent re-injury and help the patient reach his improvement goals as soon as possible. Please consider payment for the orthotics and thank you for your prompt consideration.

Please review this information as soon as possible and contact us if any further information is needed

Sincerely,

Verification Sheet for Orthotics

(This assumes that the doctor has done a thorough verification of coverage for general services, and this would be an addendum to the existing verification form when checking for coverage of functional orthotics.)

Patient Name:_____ Insured:_____
Insurance Company:_____ Ins. Co. Phone#:_____
Insured's ID#:_____ Insured's DOB:_____
Policy#:_____ Insured's Employer:_____Patient's DOB: _____

Circle One: Are custom-molded foot inserts (orthotics) covered under the patient's plan? **Y N**

If Yes:

1. Do you have specific written guidelines for the use of this code?	Y	N
If so, can you fax/email them to me? Can I find them online?	Y	N
2. Does the fee schedule have a maximum allowable (dollar limit) for L3010?	Y	N
Is this maximum amount per condition or per year?	Y	N
Is this part of a separate Durable Medical Equipment (DME) benefit?	Y	N
3. Does the fee schedule have a maximum allowable (dollar limit) for L3020?	Y	N
Is this maximum amount per condition or per year?	Y	N
Is this part of a separate Durable Medical Equipment (DME) benefit?	Y	N
4. What is the co-pay or co-insurance?	Y	N
5. Are there certain diagnosis codes necessary for reimbursement under the policy?	Y	N
If yes, what are they or where can I find them? _____		
6. Is a Letter of Medical Necessity/ preauthorization letter needed?	Y	N
Does this need to be submitted prior to or with the claim?	Y	N
7. Is a prescription from a physician required?	Y	N
If yes, can the RX be from a Doctor of Chiropractic?	Y	N
8. Do you cover Orthotics Management and Training, code 97760?	Y	N
What is the allowable amount? _____		
9. Do you cover Orthotics Checkout, code 97763?	Y	N
What is the allowable amount?		
10. Do you cover therapeutic exercises, code 97110?	Y	N
What is the allowable amount? _____		
11. Do you cover strapping/taping, such as code 29540?	Y	N
What is the allowable amount? _____		
12. Do you cover extraspinal manipulation, such as code 98943?	Y	N
What is the allowable amount? _____		

If No:

(TIP: Although the functional orthotics themselves may not be specifically covered, ancillary services are usually covered in most plans.)

1. Where can I find in writing that orthotics are not covered in order to explain it to my patient?	Y	N
2. Do you cover Orthotics Management and Training, code 97760?	Y	N
What is the allowable amount? _____		
3. Do you cover therapeutic exercises, code 97110?	Y	N
What is the allowable amount? _____		
4. Do you cover Orthotics Checkout, code 97763?	Y	N
5. Do you cover extraspinal manipulation, such as code 98943?	Y	N
6. Do you cover strapping/taping when billed as code 29540?	Y	N
7. Ask the following question if you are in network plan: If orthotics are not covered, can we accept payment directly from the patient?	Y	N

Name of Carrier for Claims Submission:_____

Address:_____

_____

Phone #:_____

Name of Rep:_____

Date and Time:_____

In/out of Network:_____

Appendix B

In 2012, representatives from the American Podiatric Medical Association (APMA), American Orthotic and Prosthetic Association (AOPA), and Prescription Footwear Association (PFA) met to discuss these orthotic codes. The organizations mutually agreed on the more detailed guidelines for the device codes. Although the detailed guidelines are not formally part of the HCPCS codes, the guidelines have been adopted by some carriers as the descriptors that they will follow.

L-Code Foot Orthotic Clarification
Participating Organizations:
American Orthotic and Prosthetic Association (AOPA)
American Podiatric Medical Association (APMA)
Pedorthic Footcare Association (PFA)

The following language has been approved by the American Podiatric Medical Association (APMA), American Orthotic and Prosthetic Association (AOPA), and Pedorthic Footcare Association (PFA) after a series of meetings, the most recent having occurred on May 13, 2016.

L3000 -- Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is a functional device, (reducing pathological forces) which has a molded heel cup and trim lines with a minimum of a 10 mm heel cup height to provide both medial and lateral directive forces to control the hind and fore foot. It may also have intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to control function and reduce pathological forces. HCPCS code L3000 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

L3010 -- Foot, insert, removable, molded to patient model, longitudinal arch support, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three-dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is an accommodative/functional device, which has a heel cup of less than 10 mm and is intended to control the forefoot through a longitudinal arch support. It may also have an intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to reduce pathological forces. HCPCS code L3010 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

L3020 -- Foot insert, molded to patient model, longitudinal/metatarsal support, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is an accommodative/functional device, which has a heel cup of less than 10 mm and is intended to control the forefoot through a Longitudinal Arch and metatarsal support. It may also have an intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to reduce pathological forces. HCPCS code L3020 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

L3030 -- Foot insert, removable, formed to patient foot, each Guideline: Prescription Custom Fabricated Foot insert, each, removable. This type of device is formed directly to the patient's foot through the use of an external heat source. The heat source should sufficiently and permanently alter the shape of the device, activating a resin, or other method by which the shape of the device is sufficiently and permanently altered in order to provide continuous contact with the unique characteristics of the plantar aspect of the patient's foot. It may also have an intrinsic or extrinsic post designed to control foot motion. This type of orthotic is an accommodative/functional device. This device is made of sufficiently rigid material to control foot motion and or reduce pathological forces. HCPCS code L3030 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

FOOT LEVELERS

800.553.4860

FootLevelers.com