Fact Sheet

Billing Orthotics to 3rd Party Payers

Practices that dispense and bill Durable Medical Equipment (DME) to third-party payers must pay close attention to the billing requirements of the carrier being billed, which often vary from carrier to carrier. Several factors come into play when billing directly to third-party payers:

- What diagnosis codes are considered medically necessary, and therefore payable, according to the carrier's Medical Review Policy (MRP)? Is the diagnosis/condition the doctor assigned for your patient included?
- Are the billing codes that describe the orthotics your office dispensed listed in the MRP as covered billing codes?
- After verifying the patient's third-party coverage, are orthotics a covered benefit? If so, how often can they be dispensed and paid for by the carrier?
- Will the carrier pay for more than one pair of orthotics in a period of time?
- Do you know the allowable fee for the orthotics according to the provider fee schedule? If so, is it going to cover the cost of the orthotics?
- Does the carrier you're billing require that a certified DME provider or company bill all DME? If so, are you considered this type of provider? If not, there may be no coverage for the patient for DME dispensed directly by the doctor.

Billing orthotics on your CMS-1500 billing form is not very different from billing other services. Figure 1 shows an example of the billing section of the form and how it might look if billing for a diagnosis of Plantar Fascial Fibromatosis. Notice that one pair of orthotics was prescribed and dispensed for a total actual fee of $250 for the pair. The bill includes both the left and right orthotic, and each line item represents one unit of the pair. (Example provided for educational purposes only)

Fig. 1

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): 05 14 17 QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M72.2 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
05 25 17	05 25 17	11		L3020	RT	A	125 00	1		NPI	123456789
05 25 17	05 25 17	11		L3020	LT	A	125 00	1		NPI	123456789

25. FEDERAL TAX I.D. NUMBER SSN EIN: 12-3456789
26. PATIENT'S ACCOUNT NO.: 789
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE: $ 250 00
29. AMOUNT PAID: $
30. BALANCE DUE: $ 250 00

If the carrier's allowance included coverage for **two** pair of orthotics and each pair cost $250.00, Figure 2, below, illustrates how billing might differ. Notice that each line item represents **two units each** for the left and right orthotic, for a total of two pair.

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Fact Sheet

Fig. 2

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 05 14 17 QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. M72.2 B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
05	25	17	05	25	17	11		L3020	RT	A	125 00	2		NPI	123456789
05	25	17	05	25	17	11		L3020	LT	A	125 00	2		NPI	123456789
														NPI	
														NPI	
														NPI	
														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 12-3456789
26. PATIENT'S ACCOUNT NO. 789
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $ 500 00
29. AMOUNT PAID $
30. BALANCE DUE $ 500 00

It's important to understand the meaning of a **Medically Unlikely Edit** (**MUE**). A MUE is a Medicare unit of service claim **edit** applied to healthcare claims against a procedure code for services rendered by one provider/supplier to one patient on a single day. An MUE for an HCPCS/CPT code is the maximum units of service that a provider would report *under most circumstances* for a single beneficiary on a single date of service. Commercial carriers sometimes use these edits to screen for unlikely circumstances that should not be paid (e.g., It may be unlikely to dispense two pair of orthotics to the same patient, on the same day.) The edit might capture the service and automatically deny it, but if the coverage has been verified, and it allows for two pair, and they are medically necessary, don't hesitate to appeal the denial. The documentation in the patient's clinical record should reflect the medical necessity for more than one pair and outline the details needed to justify the order.

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