

Medicare Lower Limb Orthosis Coverage and Documentation Checklist



Dispensing Order

Lower limb orthoses and related supplies may be delivered upon receipt of a dispensing order. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item(s)
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order.
- Use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).
- Physician signature (if a written order) or supplier signature (if verbal order).
- May be hand-written or electronic.
- Physician's name, credentials, address, phone, NPI.

Detailed Written Order

A detailed written order must be obtained prior to claim submission and must contain:

- Beneficiary name.
- Detailed description of the item(s) to be provided.
- If ordering a custom order the order must state "custom",
- Treating physician's signature.
- Date of physician's signature. Signature and date stamps are not acceptable.
- Start date of order (if the start date is different than the signature date),
- Involved side of the body.
- Dispensing order date/time must precede delivery.
- Description of each item provided including base codes and features described by add-on codes.
- Order should be in compliance with state laws.

New Order Requirements

A new order is required if:

- There is a change in supplier.
- There is a change in the item(s) frequency of use, or amount prescribed.
- There is a change in the length of need or a previously established length of need expires.
- State law requires a prescription renewal

Physician's Patient Record Documentation to support order for AFO/KAFO

The following documentation must be part of the beneficiary's medical record prior to receiving the AFO/KAFO. If Medicare conducts a review and determines that the documentation does not support the need for the orthosis, the claim will be denied, and return payment will be requested.

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For AFOs **not** used during ambulation there should be documentation in the physician's records that either all of criteria 1-4 are met or criterion 5 is met as follows:

1. The patient presents or is diagnosed with plantar flexion contracture of the ankle (ICD-10 diagnosis code M24.573) with dorsiflexion on passive range of motion testing of at least ten degrees (i.e., a non-fixed contracture).
 - Documentation of the pretreatment passive range of motion must be measured with a goniometer and documented in the medical record.
 - Documentation of an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home), and
2. Physician documents that there is a reasonable expectation of the ability to correct the contracture, **and**
3. Evidence of the contracture is interfering or expected to interfere significantly with the patient's functional abilities, **and**
4. The static ankle foot orthosis is used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons (if applicable), **or**
5. Documentation of the patient being diagnosed with plantar fasciitis (ICD-10 diagnosis code M72.2) (if applicable).

Note: For AFOs and knee ankle foot orthoses (KAFO) used during ambulation, there should be documentation in the physician's records stating that the following 3 coverage criteria are met:

1. **Documentation of the patient presenting with weakness or a deformity of the foot and ankle, requiring stabilization for medical reasons.**
2. **Documentation of the patient's potential to benefit functionally.**
3. **Need for KAFO when knee involvement is present.**

Additional Coverage Criteria Based on Custom Molded/ Fabricated Orthosis

- The patient could not be fit with a **prefabricated** AFO/KAFO, or
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than six months), or
- There is a need to control the knee, ankle or foot in more than one plane, or
- The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury, or
- The patient has a healing fracture, which lacks normal anatomical integrity or anthropometric proportions.

Also Note

- Any presence of swelling, tenderness, contractures, spasticity, joint laxity, instability, specific area of deformity.
- The affected side.
- Clinical course to date.
- Therapeutic interventions and results
- Prognosis
- Functional limitations
- Impact of the deficits on Activities of Daily Living
- Diagnoses causing the symptoms.
- Co-morbidities
- Ambulatory aids/assistance
- Patient's name should be on every page.

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Orthotist Records

- Patient's name should be on every page.
- Functional evaluation, which collaborates the physician's documentation.
- Recommendation for orthosis: type/brand and fit, custom/custom fit/OTS, rationale based on physician order.
- State whether patient meets the Medicare criteria for a custom AFO/KAFO.
- If criteria are met, document which criteria qualify for a custom AFO/KAFO.
- Chart note for each visit, phone calls, consultation and/or any contact with patient, family or caregivers.
- Copy of medical record notes from physician, therapist, etc. documenting the need/criteria for the AFO/KAFO.
- Orthotist's printed name, signature and date on each note.

Replacement AFO/KAFO and Components

- Provide proof of the AFO/KAFO being lost, stolen or irreparably damaged
- A new order is needed.
- Document the continued need beyond the first six months of the date of service and every six months thereafter.
- For replacement components billed with code L2999, there must also be a Healthcare Common Procedure Coding System (HCPCS) code or the manufacturer name and model name/number of the base orthosis. This information should be entered in the narrative field of an electronic claim.

Proof of Delivery

- Suppliers are required to maintain proof of delivery in their files.
- Proof of delivery (POD) documentation must include:
 - Beneficiary name
 - Delivery address
 - Quantity delivered
 - Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
 - Date delivered
 - Legible, hand-written beneficiary signature (if signed by a designee, indicate relationship to beneficiary).
 - Date of signature
- The date of signature on the delivery slip must be the date that the item was received by the beneficiary or designee.

Beneficiary Authorization

- Beneficiary agrees prior to delivery that Medicare can pay the supplier directly when the supplier has accepted assignment.
- Beneficiary authorizes release of his/her medical information in order to process the claim.

Advance Beneficiary Notice (ABN) if appropriate

The Advance Beneficiary Notice of Noncoverage (ABN) is a written notice the supplier gives to a Medicare beneficiary before providing items and/or services that are expected to be denied by Medicare.

- Beneficiary signs a statement indicating an understanding that Medicare may disallow the claim.
- If ABN is appropriate, signed and the claim is denied, the patient is responsible for payment.
- If no ABN is signed and the beneficiary states no knowledge that the claim might be denied, the patient is not responsible for the payment.
- Blanket ABNs (to every patient) are not acceptable.

Continued Use/Medical Need

Ongoing supplies and rental DME items require documentation in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the date of service. Timely, documentation is defined as a record in the preceding 12 months unless otherwise specified in the policy. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- Timely documentation in the beneficiary's medical record showing usage of the item

Modifiers

- EY – No physician or other licensed health care provider order for this item or service
- GA – Waiver of liability statement on file
- GZ – Item or service expected to be denied as not reasonable and necessary
- KX – Requirements specified in the medical policy have been met
- LT – Left side
- RT – Right side

Reminders

- HCPCS L2999 must include either a narrative description of the item (for custom fabricated items) or the manufacturer name and model name/number (for prefabricated items).
- HCPCS L4205 must include an explanation of what is being repaired. A claim for code L4210 must include a description of each item that is billed.
- When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, there must be documentation in the patient's medical record supporting the medical necessity for the higher utilization.

This coverage and documentation checklist is current as of 1 Sept 2015. It is based on the Local Coverage Determinations (LCD) and Policy Articles of the four (4) DME MAC Jurisdictions. The LCDs and Policy Articles are subject to change, please check your local jurisdictions LCDs and Policy Articles for the latest coverage information.