Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train/.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf.

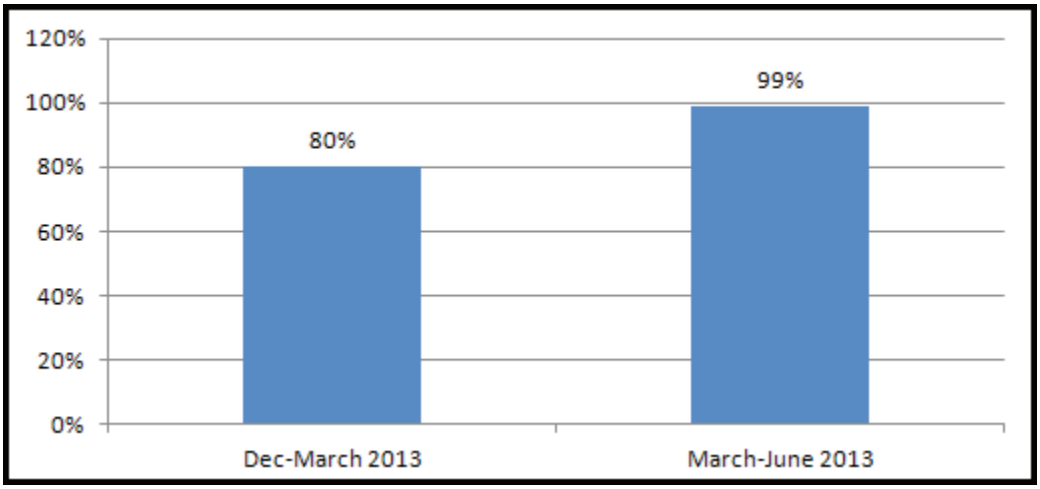
Second Quarter Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1960)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code L1960. The second quarter edit effectiveness results from March 2013 through June 2013 are as follows:

The L1960 review involved 225 claims of which 221 were denied. This resulted in an overall error rate of 99%.

Historical Data of the Error Rate for L1960 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 27% of L1960 claims received a denial as the treating physician's records don't provide detailed documentation to support medical necessity of custom rather than prefabricated orthosis

For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support the medical necessity of custom-fabricated rather than a prefab orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

- 21% of L1960 claims received a denial as criteria 1–5 were not met

AFO's and KAFO's that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

1. The beneficiary could not be fit with a prefabricated AFO; or,
2. The condition necessitating the orthosis is expected to be permanent or of longstanding duration more than 6 months); or,

3. There is a need to control the knee, ankle or foot in more than one plane; or,
4. The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
5. The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

- 16% of L1960 claims received a denial as the documentation was insufficient to support basic coverage criteria

Ankle-foot orthoses (AFO) described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

- 7% of L1960 claims received a denial as no documentation was provided to support the reason for replacing the item

Replacement of a complete orthosis or component of an orthosis due to loss, significant change in the beneficiary's condition, or irreparable accidental damage is covered if the device is still reasonable and necessary. The reason for the replacement must be documented in the supplier's record.

Replacement components (e.g., soft interfaces) that are provided on a routine basis, without regard to whether the original item is worn out, are denied as not reasonable.

Going Forward

Based on high error rate, Noridian will continue with the Prepayment Widespread Review.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot/Ankle-Knee-Foot Local Coverage Determination (LCD) L142 and Policy Article A19800.

Noridian provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train/.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf.

Second Quarter Results of Widespread Prepayment Review of Claims for Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L1970 and L4360)

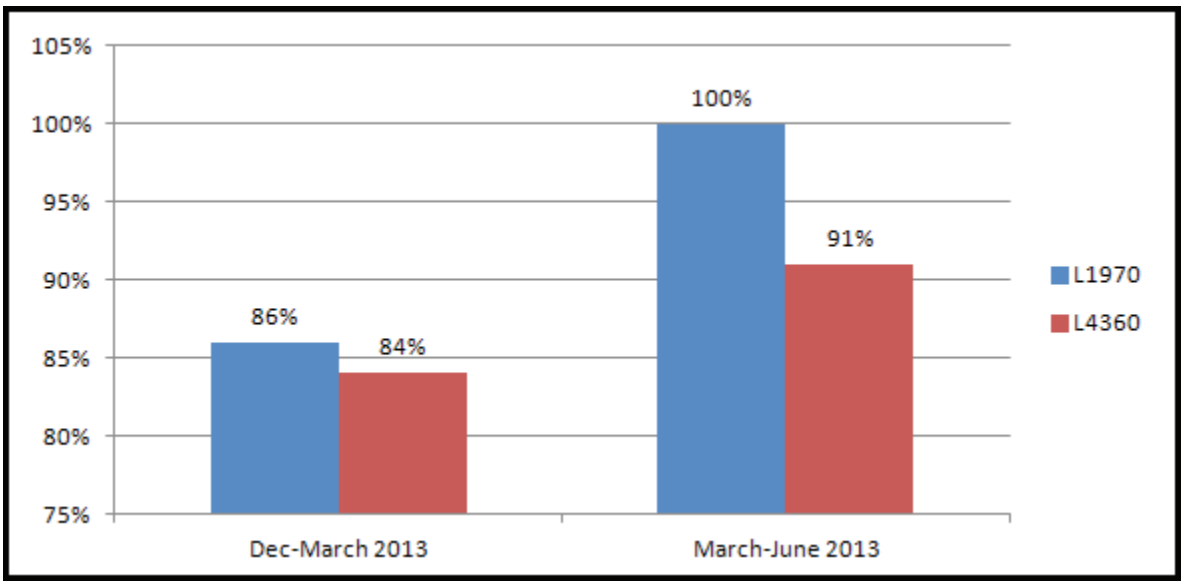
Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS codes L1970 and L4360. The second quarter edit effectiveness results from March 2013 through June 2013 are as follows:

The L1970 review involved 20 claims of which 20 were denied. This resulted in an overall error rate of 100%.

The L4360 review involved 1,170 claims of which 1,063 were denied. This resulted in an overall error rate of 91%.

Historical Data of the Error Rate for L1970 and L4360 Review



Primary Documentation Errors that Resulted in Denial of Claims

- 19% of L4360 claims received a denial as the documentation was insufficient to support basic coverage criteria
- 12% of L1970 claims received a denial as the documentation was insufficient to support basic coverage criteria

Ankle-foot orthoses (AFO) described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

- 19% of L4360 claims received a denial as no proof of delivery was submitted
- 18% of L4360 claims received a denial as no detailed written order or dispensing order was provided

No proof of delivery was submitted.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

No detailed written order or dispensing order was provided.

All items billed to Medicare require a prescription. An order for each new or full replacement item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. 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
- 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
- Physician signature (if a written order) or supplier signature (if verbal order)