

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

Medicare Payments for Orthotics

Carrier Perspectives



**JUNE GIBBS BROWN
Inspector General**

**MARCH 2000
OEI-02-99-00121**

OFFICE OF INSPECTOR GENERAL

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OEI's New York Regional Office prepared this report under the direction of John I. Molnar, Regional Inspector General, and Renee C. Dunn, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Demetra Arapakos, *Project Leader*
Vincent Greiber

HEADQUARTERS

Stuart Wright, *Program Specialist*
Scott Horning, *Technical Support*
Barbara Tedesco, *Statistician*

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EXECUTIVE SUMMARY

PURPOSE

To review carrier policies and procedures and obtain their perspectives on Medicare reimbursement for orthotics.

BACKGROUND

This study, a follow-up to a 1997 Office of Inspector General report entitled “Medicare Orthotics” (02-95-00380), was conducted to determine what changes, if any, have occurred with Medicare orthotics. We have also prepared a companion report entitled “Medicare Reimbursement for Orthotics” which examines the extent of inappropriate Medicare reimbursement for orthotics.

Orthotics are rigid devices, often called braces, which are applied to the outside of the body as a means of support. They are categorized into one of three groups of devices: custom fitted, which require alterations to a prefabricated product; custom fabricated, which are made for a specific patient from his/ her individual measurements; and molded to patient model, which are created from a cast of the patient’s body part. Add ons, such as straps and linings, are billed separately. Suppliers of orthotics include certified orthotists, medical equipment companies, and physicians’ offices. Medicare claims for orthotics are processed and paid by one of four Durable Medical Equipment Regional Carriers (DMERCs).

We combined two methods for this inspection. First, we collected and reviewed written policies for orthotics from each of the four DMERCs. We also conducted structured telephone interviews with staff from all four carriers.

FINDINGS

Carriers still lack policies for some groups of orthotics

As noted in the 1997 OIG report on orthotics, while general coverage guidelines exist for all orthotic devices, specific guidelines are lacking for two groups - upper limb devices and hip devices. The devices in these two groups represent approximately two-thirds of all orthotic codes. Without specific policies, they lack distinctive medical and fitting requirements that may restrict payment for some devices.

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Carrier practices still focus on assuring the appropriateness of orthotic claims

Carriers utilize different billing practices for orthotics claims. All four have payment screens and edits to isolate claims that may require additional scrutiny. Carriers also conduct post-payment reviews to monitor orthotic payments. Some conduct these reviews for specific codes or groups of devices, such as high dollar codes and devices from groups that lack specific policies. Carriers also use different procedures for dealing with problem suppliers, including conducting pre-payment reviews of and requesting additional information from problematic suppliers.

Carriers suggest strengthening the orthotics billing process with better documentation and improved coding

All carriers recognize the importance of adequate medical and supplier documentation to assure the appropriateness of orthotic claims. They suggest that physicians write more detailed orthotic prescriptions which address the patient's specific needs and diagnosis; Carriers also recognize that coding for orthotics is problematic and offer suggestions to improve it. These include clarifying or eliminating "miscellaneous" codes and restricting certain codes to certain types of patients.

All four carriers recommend developing standards for orthotic suppliers

All four carriers believe there should be standards for suppliers of orthotics, particularly because they say not all providers are qualified to supply orthotic devices. One argues that orthotic suppliers are neither licensed nor reviewed; another states that "it's reasonable that certain types of custom fabricated orthotics are only made by qualified people." Some carriers do caution, however, that credentialing suppliers may not solve all of the problems associated with unqualified individuals crafting orthotics, since credentialed orthotists might supervise an unreasonable number of orthotic fitters.

RECOMMENDATIONS

We recommend that HCFA work with the DMERCs to strengthen the billing process for orthotics.

In doing this, they may want to consider the practices and suggestions discussed in this report, such as developing additional screens and edit; requiring suppliers to submit a patient diagnosis as part of their claim; establishing more specific guidelines for "miscellaneous" codes; and continuing to educate physicians and suppliers on documentation and coding.

We also recommend that HCFA establish standards for suppliers of custom molded and custom fabricated orthotic devices.

Suppliers of these devices must be skilled in fitting and crafting an orthosis to the individual measurements of the patient. We believe that establishing standards would help to ensure that suppliers providing custom molded and fabricated devices have such skills and that the devices they supply are appropriate.

Comments

We received comments on the draft report from the Health Care Financing Administration. The HCFA generally concurs with our recommendations. In response to our recommendation that standards be required for suppliers of custom molded and fabricated devices, HCFA states that it is currently working on a proposed rule that will set general provider standards but not specific standards for custom orthotic suppliers. Given the specialized training and skills necessary for fitting and creating custom molded and fabricated devices, we continue to believe in the importance of additional standards for suppliers providing custom devices. The full comments are presented in Appendix A.

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INTRODUCTION

PURPOSE

To review carrier policies and procedures and obtain their perspectives on Medicare reimbursement for orthotics.

BACKGROUND

This study, a follow-up to a 1997 Office of Inspector General report entitled “Medicare Orthotics” (02-95-00380), was conducted to determine what changes, if any, have occurred with Medicare orthotics. In the 1997 report, we found that at least 19 percent of orthotics provided are medically unnecessary and that durable medical equipment companies more likely than orthotists to supply the questionable orthotics. We have also prepared a companion report entitled “Medicare Reimbursement for Orthotics” which examines the extent of inappropriate Medicare reimbursement for orthotics.

Additionally, in September, 1999, the OIG released another follow-up report entitled “Medicare Payments for Orthotic Body Jackets” (04-97-00390). That study reported that while Medicare payments for orthotic body jackets had decreased, 42 percent of claims for these devices were upcoded. This upcoding was attributed in part to a lack of coding uniformity and standardization.

Orthotics

Orthotics are rigid devices, often called braces, which are applied to the outside of the body as a means of support. An orthotic device differs from a prosthetic in that, rather than replacing a body part, it supports and/ or rehabilitates existing body parts. Orthotic devices are usually customized for an individual’s use and are not appropriate for anyone else. They have evolved in recent years to also include off the shelf devices that can serve functions similar to custom fitted components with little or no alteration necessary. New computer programs are also available which can design orthotic devices based on the patient’s individual measurements. Examples of orthotics include spinal body jackets, hip abductors, and knee braces.

Individuals requiring orthotics range from the severely disabled, such as paraplegics or quadriplegics, to those who require an ankle brace for better gait or are recovering from a temporary back injury. An individual may need to wear the orthotic continuously for the duration of his or her lifetime, every day until the condition improves, or for some other

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time frame as prescribed by a physician.

There are several different ways in which an orthotic may be supplied. Typically, a physician prescribes the orthotic and refers the patient to an orthotist or other orthotic supplier. Orthotic devices may also be supplied by a clinic, hospital, or nursing home. Some orthosis prescriptions are very specific, while others are more general. The supplier uses these prescriptions, as well as their own examination of the patient, to determine the device needed. If a device needs to be made, the patient is likely to return to the supplier to have the device fitted. Ideally, the supplier also instructs the patient on how to put on, take off, and maintain the device, and provides follow-up care, although this is not required for payment.

Medicare Orthotics: Coverage and Payments

Orthotic devices are primarily covered under Medicare Part B. As with all Medicare Part B services, covered orthotics must be reasonable and necessary for the diagnosis or treatment of an illness or injury. In order to meet Health Care Financing Administration (HCFA) coverage requirements, an orthotic must be a rigid or semi-rigid device used either to support a weak or deformed member or to restrict or eliminate motion in a diseased or injured part of the body. Orthotic claims must have a prescription and/ or a certificate of medical necessity signed by a physician.

Orthotic devices are classified into one of 465 different codes (L0100 through L4380) in the Common Procedure Coding system HCFA uses for billing. These L-Code listings give a brief description of the device. These listings also define the device as one of three types:

- *Custom fitted*, which require substantial adjustments to a prefabricated item by a specially trained professional to meet the needs and/or unique shape of an individual patient;
- *Custom fabricated*, which are made for a specific patient from his/her individualized measurements and/ or pattern; or
- *Molded to patient model*, whereby a cast is made of the specified body part and is used to create an orthotic device.

Some orthotics may also have additional components which are billed separately. For example, an ankle-foot orthosis may require special strap, joints, or linings that have their own codes and are therefore billed in addition to the basic device.

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Durable Medical Equipment Regional Carriers

Orthotic claims are processed and paid for by one of four regional carriers called DMERCs (Durable Medical Equipment Regional Carriers). In October 1993, HCFA began processing all Medicare Part B claims for medical equipment, supplies, orthotics, and prosthetics through these carriers. Their establishment was intended to help eliminate the inconsistency of coverage and reimbursement for medical equipment that had been problematic in the past. The DMERCs are divided into regions A, B, C, and D and cover the entire country. The DMERCs ensure that coverage requirements are met before approving payment and provide educational services to suppliers.

Orthotic Suppliers

Any supplier with a HCFA provider number can provide and bill for orthotics, and no verification is done on their ability to provide orthotics. Suppliers need no financial investment and experience, and little verification is done of their applications. Suppliers of orthotic devices include orthotists, medical equipment companies, pharmacies, and doctors' offices. Some general medical equipment suppliers may have an orthotist on staff. Suppliers may manufacture the devices in their own workshops or obtain them from other companies.

Of all these supplier types, only orthotists have professional certification to provide specialist services. An orthotist provides care to patients with disabling conditions of the musculoskeletal structure of the body. At the request of, and in conjunction with physicians, the orthotist assists in formulating prescriptions for orthoses and examines and evaluates the patients' orthotic needs in relation to their functional loss. More specifically, the orthotist:

- ▶ formulates the device's design and selects materials and components;
- ▶ makes all necessary casts, measurements, model modifications, and layouts;
- ▶ performs fittings, including static and dynamic alignments;
- ▶ evaluates the orthosis on the patient;
- ▶ instructs the patient in its use; and
- ▶ maintains patient records.

As of now, no State licenses orthotists, although some are considering licensing legislation for the future. However, there are two organizations which do offer orthotist certification: the American Board for Certification in Orthotics and Prosthetics, Inc., (ABC), and the Board of Certification (BOC). The ABC sets standards of competency and grants a Certified Orthotist (CO) credential. To qualify for ABC certification on orthotics, an individual must have a college degree, have completed a postgraduate orthotist certificate program from an accredited institution, and have at least one year of

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patient management experience. The candidate must also pass two written exams and a three-day clinical exam that tests the ability to design, fabricate, and fit a variety of orthoses. Certified practitioners must meet continuing education requirements every five years to renew their credentials. Currently, there are approximately 3,000 ABC certified orthotists in the United States.

The BOC also certifies orthotists and there are currently more than 900 BOC certified orthotists. In order to sit for the BOC certification exam, which includes written and practical components, the applicant is required to have one or more of the following: a bachelor's degree with a major in orthotics or prosthetics; an associate degree in a related field, or; one or more years of orthotics/ prosthetics education, training and/ or supervised work experience, including intensive study. In addition, all prospective BOC orthotists must document that they have had a minimum of two years (3,900 hours) of experience providing direct patient services.

METHODOLOGY

We combined two methods for this inspection. First, we collected and reviewed written policies for orthotics from each of the four DMERCS. We also conducted structured telephone interviews with staff from all four carriers.

Carrier Policy Review

We collected the most recent policies on orthotics from each of the regional carriers. We then reviewed these policies, specifically looking at device definitions, indications, coverage and payment rules, coding guidelines, documentation requirements, and medical criteria. We also compared the policies to look for any similarities and differences between them.

Interviews

We conducted telephone interviews with staff from each of the four DMERCs - three with the medical director and one with the medical affairs coordinator. During our interviews, we discussed current practices and changes in policies and procedures relating to orthotics, suggestions for improving these policies and procedures, and the qualifications of orthotic suppliers.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

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FINDINGS

Carriers still lack specific policies for some groups of orthotics

As noted in the 1997 OIG report on orthotics, while general coverage guidelines exist for all orthotic devices, specific guidelines are lacking for two groups - upper limb devices and hip devices. The devices in these two groups represent approximately two-thirds of all orthotic codes. Without specific policies, they lack distinctive medical and fitting requirements that may restrict payment for some devices. None of the four carriers have made changes to their orthotics policies since 1997. However, one medical director reports that the DMERCs are discussing developing policies for upper limb devices; no final changes have yet been made.

Carriers' practices still focus on assuring the appropriateness of orthotic claims

Screens and edits. Payment screens and edits are installed in all the DMERCs' automated systems to isolate claims that may require additional scrutiny. These screens and edits are used to identify multiple billings for the same device, multiple suppliers for one beneficiary or one code, and high dollar amounts. For example, one carrier has edits for duplicate equipment and place of service, certain diagnoses, and specific suppliers. At another carrier, the electronic billing system routinely selects ankle positioning splint claims for review. Of the four carriers, only one has edits that can be changed based on the specifications of different codes. One carrier has no edit for medical necessity, while another has no edits for frequent billings.

While two carriers believe that existing screens and edits are sufficient, the remaining two think additional screens and edits would be helpful. Suggestions for improvement include: screens for new codes; a one year edit for duplicate devices supplied within the same year; edits based on supplier type; and customized screens for specific devices.

Post-payment reviews. All four DMERCs utilize a variety of post-payment reviews to monitor payments for orthotics. For example, one conducts post-payment reviews on claims for orthotics that are not governed by specific policies, such as upper limb devices, since these are considered to be more vulnerable to fraud. Some carriers conduct reviews for specific codes or groups of codes. One conducts focused medical reviews of high dollar codes, while another reviews codes that are increasing in utilization. Two carriers request random samples of beneficiary records or products to look at medical necessity, coding, and co-payments.

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Supplier reviews. Carriers also use different procedures for dealing with problem suppliers. Two in particular conduct pre-payment reviews of claims submitted by suppliers identified as problematic. At one carrier, suppliers who have miscoded claims must correct their coding errors and send information on items they are actually providing before being reimbursed, whereas suppliers of devices with questionable medical necessity are asked to send additional information from the patient’s medical record. In another region, suppliers who are under review are not allowed to file their claim electronically but instead must send a hard copy along with other supporting documentation.

Carriers suggest strengthening the orthotics billing process with better documentation and improved coding

All carriers recognize the importance of adequate medical and supplier documentation to assure the appropriateness of orthotic claims. While medical records are not routinely requested and reviewed by carriers, they do suggest that physicians write more detailed orthotic prescriptions which address the patient’s specific needs and diagnosis. One medical director points out that while suppliers of other equipment must submit a patient diagnosis with their claim, orthotic suppliers are not governed by the same requirement. He believes that mandatory diagnosis codes would not only ease automated claim processing but would also allow carriers to check against physician records and “tell the world what conditions we will pay for.” In fact, at one carrier ankle positioning splint claims are only paid when accompanied by an appropriate diagnosis. With regard to suppliers, one medical director thinks that claims for custom fabricated and molded devices submitted without proof of touching the patient should be denied; he says that, “I deny claims when (the supplier) doesn’t touch the part of the body the orthosis is for.”

Carriers recognize that coding for orthotics is problematic and offer suggestions to improve it. First, devices that suppliers consider difficult to categorize according to established guidelines can be coded as ‘miscellaneous.’ One medical director suggests that these codes make automated processing of codes difficult, and another director suggests eliminating miscellaneous codes altogether, including codes for “miscellaneous” suppliers such as hospital interns. Also, medical directors believe certain codes should be restricted. For example, one says that custom made devices should be reserved for athletes and other extremely active people as well as older persons whose shapes are constantly changing. Another suggests that certain codes be limited to patients unable to undergo surgery. One medical director notes that the amount of clinical literature outlining what is an appropriate and legitimate orthosis is limited and likens the current coding process to “asking for a calculator and getting a computer.”

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All four carriers recommend developing standards for orthotic suppliers

All four carriers believe there should be standards for suppliers of orthotics, particularly because they say not all providers are qualified to supply orthotic devices. One argues that orthotic suppliers are neither licensed nor reviewed; he adds that orthotics is the only unregulated healthcare industry. The medical director of one carrier states that “it’s reasonable that certain types of custom fabricated orthotics are only made by qualified people”; similarly, another reports that “in order to provide good quality items, it is helpful to have someone who is knowledgeable” supplying the device. Finally, one medical director makes the point that non-trained suppliers now have access to inexpensive off-the-shelf devices and are less critical about selecting their patients, therefore resulting in over-utilization of these devices.

Some carriers do caution, however, that credentialing suppliers may not solve all of the problems associated with unqualified individuals crafting orthotics. One medical director says, “hiring a certified orthotist to sit on the staff and sign off on all DME that is supplied be the DME supply store chain is no solution.” Another believes that credentialing would create problems with orthotists on staff who would “supervise” an unreasonable number of orthotic fitters.

Carriers also believe that more instruction and education for orthotic suppliers and physicians would solve problems with miscoding and medical necessity. They believe there is a general lack of understanding on orthotic policies. One carrier suggests publishing an instruction booklet for suppliers with coding guidelines to assist them with accurately coding their devices. Another says that physicians should become more knowledgeable of when an orthosis should be prescribed for their patient.

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RECOMMENDATIONS

We recommend that HCFA work with the DMERCs to strengthen the billing process for orthotics.

In doing this, they may want to consider the practices and suggestions discussed in this report, such as developing additional screens and edits; requiring suppliers to submit a patient diagnosis as part of their claim; establishing more specific guidelines for “miscellaneous” codes; and continuing to educate physicians and suppliers on documentation and coding.

We also recommend that HCFA establish standards for suppliers of custom molded and custom fabricated orthotic devices.

Suppliers of these devices must be skilled in fitting and crafting an orthosis to the individual measurements of the patient. We believe that establishing standards would help to ensure that suppliers providing custom molded and fabricated devices have such skills and that the devices they supply are appropriate.

Comments

We received comments on the draft report from the Health Care Financing Administration. The HCFA generally concurs with our recommendations. In response to our recommendation that standards be required for suppliers of custom molded and fabricated devices, HCFA states that it is currently working on a proposed rule that will set general provider standards but not specific standards for custom orthotic suppliers. Given the specialized training and skills necessary for fitting and creating custom molded and fabricated devices, we continue to believe in the importance of additional standards for suppliers providing custom devices. The full comments are presented in Appendix A.

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APPENDIX A

In this appendix, we present in full the comments from the Health Care Financing Administration.

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RECEIVED

2000 FEB 23 PM 3:55

The Administrator
Washington, D.C. 20201

OFFICE OF INSPECTOR
GENERAL

DATE: FEB 22 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments for Orthotics: Inappropriate Payments and Carrier Perspectives," (OEI-02-99-00120 and OEI-02-99-00121)

Thank you for the opportunity to review the above referenced reports. The objectives of these reports are to determine the extent of inappropriate Medicare payments for orthotics and to review carrier policies and procedures and obtain their perspectives on Medicare reimbursement for orthotics. This study is a follow up to a 1997 OIG report entitled "Medicare Orthotics" (OEI-02-95-00380).

Our specific comments are as follows:

OIG Recommendation

HCFA should require suppliers to maintain a description of how custom fabricated and molded devices are made.

HCFA Response

We concur. HCFA agrees that any efforts that can be undertaken to provide better descriptors and/or more efficient billing should be undertaken. However, HCFA feels the current industry guidance, in the form of the American Orthotics and Prosthetics Association's *Illustrated Guide to Orthotics and Prosthetics* will not provide the detail needed. This guide is currently used by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) and the supplier community and is often described as lacking in detail and not up to date. We feel that when an effort is begun to strengthen the overall billing process for orthotics, a vital part of this effort must be the development of more informative descriptions of orthotic products, their fabrications, and acceptable usage.

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OCIG	_____ /
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Date Sent	2-23

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OIG Recommendation

HCFA should develop product classification lists for all major groups of orthotic devices.

HCFA Response

We concur. HCFA is in the stages of preparing a program memorandum (PM) that is currently in the Change Management clearance process (Change Request #1083) on one device and will consider developing lists for the other groups on an ongoing basis. This PM instructs the SADMERC to develop and publish a product classification list for Body-jacket code L0430, described as Thoracic-Lumbar-Sacral Orthosis, anterior-posterior-lateral control, with interface material, custom fitted.

OIG Recommendation

HCFA should educate the supplier community.

HCFA Response

We concur. We agree that increased education of the supplier community will enhance their understanding of coding requirements and procedures. To this end, carriers are required to set aside space in each supplier bulletin to DME issues. HCFA will assure that this issue is included in an upcoming bulletin.

OIG Recommendation

HCFA should work with DMERCs to strengthen the billing process for orthotics.

HCFA Response

We concur. HCFA is working to improve the billing processes for orthotics by developing additional screens and edits that require suppliers to submit a patient diagnosis as part of their claim. We are also establishing more specific guidelines for "miscellaneous" codes.

OIG Recommendation

HCFA should require standards for suppliers of custom molded and custom fabricated orthotic devices.

HCFA Response

We concur in part. HCFA is currently working on a proposed rule that will set general provider standards. This proposal should be published in 2000. We do not anticipate issuing standards specific to providers of custom molded and custom fabricated orthotic devices.

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