BILLING AND CODING PROTOCOLS FOR SPINAL PELVIC STABILIZERS

Specific Suggestions from Verification to Proper Coding

by Kathy Mills Chang
John D. Davila, DC
Brian Jensen, DC
Marty Kotlar, DC, CHCC, CBCS
K. Jeffrey Miller, DC, DABCO
K.S.J. Murkowski, DC, DCCT, DAACO

Recommended by:

BACKtalk systems inc
BREAKTHROUGH COACHING
The Masters Circle
Target Coding

FOOT LEVELERS
Getting Started

Billing and coding patients for Spinal Pelvic Stabilizers can be a complicated issue, so Foot Levelers has teamed with experts in the field to create this guide. Its purpose is to help simplify the process so patients can get the best care, while healthcare professionals save time and hassle by using accurate, appropriate billing and coding procedures.

The laws, rules and regulations regarding reimbursement for orthotics and ancillary services vary greatly from state to state. Always check your state’s laws to verify which codes apply and work best for your practice.

Follow these four steps:
Step 1 – Establish Medical Necessity/Patient Exam/Diagnosis/Treatment Plans
Step 2 – Coding
Step 3 – Verification
Step 4 – Billing

Step 1 – Establish Medical Necessity/Patient Exam/Diagnosis/Treatment Plans

The majority of patients who present (history) with neuro musculoskeletal conditions of the spine and extremities are found to have excessive pronation of the feet. In order to properly document the patients’ need for Spinal Pelvic Stabilizers, you must establish medical necessity through the history, examination, diagnosis and treatment plan.

HISTORY FORM
It’s important when taking a patient history to explore all conditions that could benefit from orthotic fitting. The typical spinal-related questions, as well as questions about shoe size/width, foot pain and activity level, should be asked. Examples of specific questions are:

• Are the symptoms affected by walking, standing or 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 therapies for your feet and lower extremities?

In addition to standard evaluation and management guidelines, it is assumed that a typical patient history will also include asking questions about the following:

• stiffness
• joint pain
• weakness
• limitation of motion
• difficulty walking
• numbness in the spine or extremities

These findings may help establish the medical necessity of Stabilizers and associated spinal care.

EXAM
Using correct regional examination and x-ray findings will help provide the objective evidence required for medical necessity to support the implementation of Stabilizers in a treatment program. In addition to standard evaluation and management guidelines, it is recommended that a typical exam will include one or more of the following:

• Five Red Flags of pronation
• Global postural distortions
• Structural x-ray anomalies

DIAGNOSIS
It is imperative that appropriate diagnosis codes are documented to justify treatment. The codes listed must also be properly linked on the 1500 billing form to the treatment and supplies. The appropriate diagnosis codes should justify the clinical treatments related to the spinal and extremity regions.

It’s also important to verify individual carriers, policies and your state scope of practice for coverage specifications that may require a spinal-related diagnosis, an extremity-related diagnosis or both.

TREATMENT PLAN
A crucial component in the billing and coding process is a properly written treatment plan. In order to establish the medical necessity for the use of Stabilizers and associated spinal care, your documentation should include the following elements:

• Recommended level of care to include duration & frequency of visits
• Methods of treatment to be utilized (i.e. adjustments, therapies, Stabilizers, rehab)
• Specific treatment goals
• Objective measures to evaluate treatment effectiveness
• Planned modalities
Step 2 – Coding

DIAGNOSIS CODES
Frequently, doctors ask if there are certain diagnosis codes that tend to represent medical necessity for prescribing Stabilizers. Remember, even though Stabilizers are prescribed for more than extremity conditions, applying a lumbar diagnosis to a claim without an extremity diagnosis typically won’t be enough to meet the requirements for medical necessity.

The following is a list of diagnosis codes that, if appropriate for your patient’s condition, could lend themselves to medical necessity for Stabilizers and associated spinal care. This list is not meant to be all inclusive; please check benefit policy manuals to see what diagnosis codes are required.

The laws, rules and regulations regarding reimbursement for orthotics and ancillary services vary greatly from state to state. Always check your state’s laws to verify which codes apply and work best for your practice.

(TIP: This typically happens during the verification process.)

355.5 Tarsal tunnel syndrome
355.6 Morton’s metatarsalgia
355.6 Morton’s Neuroma
355.6 Morton’s Toe
355.6 Lesion to plantar nerve
715.07 Osteoarthrosis, generalized, ankle and foot
715.17 Osteoarthrosis, localized, primary, ankle and foot
718.46 Contracture of the knee joint
718.47 Contracture of ankle and foot joint
719.06 Swelling of the knee joint
719.07 Swelling ankle and foot joint
719.46 Knee pain
719.47 Foot/Ankle Pain
719.56 Stiffness of knee joint, not elsewhere classified
719.57 Stiffness of joint, ankle and foot, not elsewhere classified
719.7 Difficulty in walking
726.70 Metatarsalgia
726.71 Achilles bursitis or tendinitis
726.72 Tibialis Tendonitis
726.73 Calcaneal spur
728.71 Plantar Fascial fibromatosis
728.71 Plantar Fascitis
729.5 Pain in limb
735.0 Hallux valgus (acquired)
735.1 Hallux varus (acquired)
735.2 Hallux rigidus
735.3 Hallux malleus
735.5 Acquired claw toe
736.79 Foot Pronation
754.50 Talipes Varus
754.61 Congenital pes planus
(congenital rocker bottom flat foot)
781.2 Abnormality of gait
781.92 Abnormality of posture
844.9 Shin splints
845.02 Sprain and strain of calcaneofibular (ligament)

PARTIAL LIST OF ICD-9 CODES THAT LINK MOST APPROPRIATELY WITH CPT CODES 97760 AND 97762:
718.47 Contracture of ankle and foot joint
719.7 Difficulty in walking
719.07 Swelling ankle and foot joint
729.5 Pain in limb
719.47 Pain in ankle and foot joint
781.2 Abnormality of gait
781.92 Abnormality of posture

PARTIAL LIST OF ICD-9 CODES THAT LINK MOST APPROPRIATELY WITH CPT CODES 97116:
355.5 Tarsal tunnel syndrome
355.6 Lesion of plantar nerve
355.71 Causalgia of lower limb
781.0 Abnormal involuntary movements
781.3 Lack of coordination

PARTIAL LIST OF ICD-9 CODES THAT LINK MOST APPROPRIATELY WITH CPT CODES 97110:
722.10 Displacement of lumbar intervertebral disc without myelopathy
722.52 Degeneration of lumbar or lumbosacral intervertebral disc
724.02 Lumbar spinal stenosis
724.2 Low back pain
724.3 Sciatica
724.6 Lumbosacral or sacroiliac pain, instability, ankylosis
847.2 Lumbar sprain and strain
726.71 Achilles bursitis or tendinitis
727.06 Tenosynovitis of foot and ankle
845.11 Sprain and strain of tarsometatarsal (joint) (ligament)
845.12 Sprain and strain of metatarsophalangeal (joint)
PARTIAL LIST OF SPINAL ICD-9 CODES FOR SUPPORTIVE TREATMENT TO THE FOOT OR ANKLE:
739.1 Cervical Segmental Dysfunction
739.2 Thoracic Segmental Dysfunction
739.3 Lumbar Segmental Dysfunction
739.4 Sacral Segmental Dysfunction
739.5 Pelvic Segmental Dysfunction
737.30 Scoliosis
846.0 Sacroiliac SP/ST
738.5 Acquired Deformity of the Back or Spine
738.4 Acquired Spondylolisthesis
722.6 Degeneration of Intervertebral Disc, NOS
738.6 Acquired Pelvic Deformity
719.5 Joint Stiffness
959.6 Hip Thigh Injury
721.3 Lumbosacral Spondylosis without Myelopathy
720.02 Sacroilitis, NOS
959.7 Injury to Knee, Leg, Ankle, Foot

PARTIAL LIST OF EXTREMITIES ICD-9 CODES FOR SUPPORTIVE TREATMENT TO THE FOOT OR ANKLE:
714.7 Rheumatoid Arthritis, Ankle/Foot
715.7 Osteoarthritis, Ankle/Foot
718.87 Joint Derangement, Ankle/Foot
726.70 Enthesopathy of Ankle
727.68 Rupture of Tendons, Foot/Ankle
726.73 Calcaneal Spur
727.1 Bunion
728.71 Plantar Fibrometosis
728.87 Muscle Weakness
733.94 Stress Fracture of Metatarsals
736.79 Acquired Deformity, Foot/Ankle
754.61 Congenital Pes Planus (Flat Feet)
755.61 Coxa Valga, Congenital
845.01 Sprain of Deltoid, (Ligament Ankle)
855.62 Coxa Vera, Congenital
845.02 Sprain of Calcaneofibular Ligament
845.03 Sprain of Tibiotalar Ligament
845.13 Sprain of Interphalangeal Joint/Toe

Neuro-musculoskeletal diagnostic codes generally fall into 3 areas:
Nervous system conditions  320-389
Musculoskeletal Conditions  710-739
Injuries  800-848

CPT/HCPCS Codes
These are codes that may apply in the process of billing for Stabilizers and associated spinal and extremity care. A range of procedural and supply codes may be appropriate because Stabilizers may be ordered for spinal pelvic stabilization, extremity conditions, or both. This list is not meant to be all inclusive; please check benefit policy manuals to see what procedural and supply codes are required.

99201-99205 Evaluation & Management Coding, (E&M)
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 & examination. This should include a structural evaluation of the patient’s lower extremities in conjunction with other appropriate examination procedures.

(TIP: Use the Associate® Platinum scanner as a tool to evaluate your new patient just as you would measure blood pressure and range of motion. Remember, the scan is not separately billable if on the same visit as 99201-99205.)

99212-99215 E&M Coding Established Patient:
An established patient is 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.
It may be clinically indicated to evaluate an established patient for spinal or extremity conditions. In addition to examination procedures for determining the additional need for treatment with Stabilizers and associated spinal conditions, the evaluation must include an updated history and/or documentation of clinical decision making.

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

The laws, rules and regulations regarding x-rays of extremities vary greatly from state to state. Always check your state’s laws to verify which codes apply and work best for your practice.

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
**29000 Series Strapping/Taping:**
Strapping/taping may be clinically indicated in order to restore optimal joint dynamics and help improve the overall alignment of the body. Many doctors will use strapping/taping to estimate the degree of relief the patient will experience with custom-made stabilization products.

Ankle and/or Foot – 29540  
Knee – 29530  
Hip – 29520  
Low Back – 29220  

**L3020 Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each:**
This is the most appropriate supply code to describe Foot Levelers’ Stabilizers. However, some carriers may require the use of other codes. It is vital that questions regarding the use of these codes are asked during the verification process.

**L3030** is a second possible code related to reimbursement of Stabilizers. The code is very similar to L3020 and is the preferred code in some policies/states for Stabilizers. The similarity of the codes and the differences between different policies/states mandate that the verification process described in this text be followed carefully. Verification of both codes is vital.

**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 Stabilizers are dispensed to the patient, and may only be used for “custom fabricated” supports. This code includes the fitting of the Stabilizers, training in use, and wearing time of the Stabilizers and brief instructions in exercises while the Stabilizers 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.

**97762 Checkout for orthotic/prosthetic use, established patient, 15 minutes.** This code is intended for established patients who have already received the Stabilizers. It is essential for the healthcare practitioner to follow-up with a patient after they have been provided with a pair of Stabilizers. The “checkout” visit would include assessing the patient’s response to wearing Stabilizers, such as possible skin irritation or breakdown, determination if the patient is donning the Stabilizers 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.

**97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.** Therapeutic exercise is used to restore strength, range of motion and endurance. Therapeutic exercises may be necessary for a documented loss or restriction of joint motion, strength, functional capacity or mobility, which has resulted from a specific disease or condition. This is also a way to ease adaptation time by breaking up fixations and strengthening weak muscles in the feet. It’s also possible to use this code for specific core strengthening exercises, stretching or tubing that may be done with rehab equipment such as the Thera-Ciser™. Use this code when using a treadmill to acclimate the patient to walking with the orthotics. Isokinetic foot exercises may increase range of motion and reduce adhesions. Lumbar stabilization exercises, when used in conjunction with the Spinal Pelvic Stabilizers, are excellent for core strengthening. Using a gymnastic ball for stretching or strengthening exercises can also be coded as therapeutic exercises, with documented medical necessity.

**98943 Extraspinal Chiropractic Manipulative Treatment** may be necessary during a course of treatment when an extremity needs to be treated in addition to the spinal region(s). The five extraspinal regions are the head, including the TMJ, but excluding the atlanto-occipital joint, the lower extremities, upper extremities, anterior ribs, and abdomen. This code is billed only once per encounter, regardless of the number of extraspinal regions adjusted.

---

**Step 3 – Verification**

It’s crucial to verify insurance coverage to determine whether Stabilizers are included in the patient’s benefits. Be sure to check with each individual carrier as well as your state scope of practice that may require a spinal-related diagnosis, an extremity-related diagnosis or both. It’s recommended that you place a separate call to verify Stabilizer coverage. Do not perform this verification with verification of general insurance benefits.

Follow the Foot Levelers Verification Sheet for Orthotics (p. 6) and get all the questions answered.

This verification sheet is in addition to your standard verification of coverage.

(TIP: Verification can be done before patient comes in. You can copy this sheet and place it on back side of your existing verification form)
# 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 Stabilizers.)

<table>
<thead>
<tr>
<th>Patient Name: ________________________________________</th>
<th>Insured: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company: ________________________</td>
<td>Ins. Co. Phone#: _____________________</td>
</tr>
<tr>
<td>Insured’s ID# ________________________</td>
<td>Insured’s DOB: ________________________</td>
</tr>
<tr>
<td>Policy # ________________________</td>
<td>Insured’s employer: ____________________</td>
</tr>
<tr>
<td>Patient’s DOB: ________________________</td>
<td></td>
</tr>
</tbody>
</table>

**Are custom molded foot inserts (orthotics) covered typically billed as code L3020?**  

<table>
<thead>
<tr>
<th>If yes:</th>
<th>Circle One</th>
<th>If no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have specific written guidelines for the use of this code?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>If so, can you fax/email them to me?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Can I find them online?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>2. Does the fee schedule have a maximum allowable (dollar limit) for L3020?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Is this maximum amount per condition or per year?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Is this part of a separate durable medical equipment (DME) benefit?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>3. Does the fee schedule have a maximum allowable (dollar limit) for L3030?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Is this maximum amount per condition or per year?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Is this part of a separate durable medical equipment (DME) benefit?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>4. What is the co-pay or co-insurance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Are there certain diagnosis codes necessary for reimbursement under the policy?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>If yes, what are they or where can I find them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Is a Letter of Medical Necessity/preauthorization letter needed?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>Does this need to be submitted prior to or with the claim?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>7. Is a prescription from a physician required?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>If yes, can the RX be from a Doctor of Chiropractic?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>8. Do you cover code 98943 when performed by a DC?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you cover Orthotics Management and Training, code 97760?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you cover Orthotics Checkout, code 97762?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you cover therapeutic exercises, code 97710?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you cover strapping/taping, such as code 29540?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Do you cover extraspinal manipulation, such as code 98943?</td>
<td>Y N</td>
<td></td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If yes: Y, if no: N)

**TIP: Although the Stabilizers themselves may be specifically not covered, ancillary services are usually covered in most plans.**

<table>
<thead>
<tr>
<th>Circle One</th>
<th>If no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Where can I find in writing the orthotics are not covered in order to explain it to my patient?</td>
<td>Y N</td>
</tr>
<tr>
<td>2. Do you code 98943 when performed by a DC?</td>
<td>Y N</td>
</tr>
<tr>
<td>3. Do you cover Orthotics Management and Training, code 97760?</td>
<td>Y N</td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
</tr>
<tr>
<td>4. Do you cover therapeutic exercises, code 97710?</td>
<td>Y N</td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
</tr>
<tr>
<td>5. Are rehabilitative codes, such as 97710 covered under the policy?</td>
<td>Y N</td>
</tr>
<tr>
<td>What is the allowable amount?</td>
<td></td>
</tr>
<tr>
<td>6. Do you cover Orthotics Checkout, code 97762?</td>
<td>Y N</td>
</tr>
<tr>
<td>7. Do you cover extraspinal manipulation, such as code 98943?</td>
<td>Y N</td>
</tr>
<tr>
<td>8. Do you cover strapping/taping, when billed as code 29540?</td>
<td>Y N</td>
</tr>
<tr>
<td>9. Ask the following question if you are in network plan: If orthotics are not covered, can we accept payment directly from the patient?</td>
<td>Y N</td>
</tr>
</tbody>
</table>

Name of Carrier for Claims Submission: _____________________
Address: ____________________________________________

Phone #: ___________________________________________
Name of rep: ________________________________________
Date and time: _______________________________________
In/out of Network: _________________________________

FLML-0217-09_BILLING.indd 6 4/3/09 11:04:01 AM
Step 4 – Billing

The process of billing for Stabilizers and associated spinal and extremity care is no different than any other clinical billing procedure. These important concepts must be conveyed in the billing process in order to increase the probability of reimbursement. Appropriate medical necessity for the services rendered must be clearly identified. This section will include examples of the completion of the 1500 billing form, diagnosis linking, letters of medical necessity, discussion of non-covered services, and an explanation of dealing with uninsured or underinsured patients in need of Stabilizers for spinal and extremity conditions.

(TIP: Make sure that all billing procedures are properly documented in your office’s standard operating procedure manual. Specific billing procedures discussed here can be added as an addendum to other primary procedures in your manual.)

INSURANCE
To begin the process, there should be established medical necessity through history, exam, diagnosis, and treatment plan. Verification and code selection should have also occurred.

1500 FORM COMPLETION
As previously discussed, proper diagnostic and procedural coding, once selected, must be properly listed on the billing form. When billing the Stabilizers supply code, L3020, you must bill two line items to indicate both the right and left Stabilizer. While Stabilizers come in pairs, they are coded for each individual foot. The code represents only ONE Stabilizer. The examples below demonstrate appropriate completion of the form in boxes 21 and 24 of the 1500 billing form. It should be noted that there is more than one way to complete the form. Both examples are provided here.

Option one is to list a line item in box 24 of the 1500 form with the L3020 in box 24D, the properly linked diagnosis code in box 24E, the total charge for both Stabilizers in box 24F, and a “2” in the units box, 24G.

Or

Option two is to separate the pair of Stabilizers, and list them on two separate lines. On the first line of box 24, list the code L3020 with an RT modifier in box 24D, the properly linked diagnosis code in box 24E, 50 percent of the total charge for the pair of Stabilizers in box 24F, and do not use 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 percent of the total charge for the pair of Stabilizers in box 24F, and do not use the units box, 24G.

<table>
<thead>
<tr>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
<th>Days or Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/HCPCS</td>
<td>Modifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L3020</td>
<td>4</td>
<td>$300.00</td>
<td>2</td>
</tr>
<tr>
<td>Or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L3020 RT</td>
<td>4</td>
<td>$150.00</td>
<td>1</td>
</tr>
<tr>
<td>L3020 LT</td>
<td>4</td>
<td>$150.00</td>
<td>1</td>
</tr>
</tbody>
</table>

If you are billing two pairs in any combination, including Shoethotics® and Sandalthotics®, the second pair would be billed exactly the same. Even if you decide to reduce the fee for the second pair, to pass along a multiple pair discount, just reflect the correct dollar amount in box 24F, and follow the instructions above. For a total of four Stabilizers, you will either have (as in option one) two line items with a “2” in each units box, 24G. In this example, the total in each line item will be 50 percent of the total charge for the Stabilizer pair. Or, as in option two above, you may have four separate line items indicating four Stabilizers, and two would have the RT modifier in box and two would have the LT modifier.

<table>
<thead>
<tr>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
<th>Diagnosis Code</th>
<th>Charges</th>
<th>Days or Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/HCPCS</td>
<td>Modifier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L3020</td>
<td>4</td>
<td>$600.00</td>
<td>4</td>
</tr>
<tr>
<td>Or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L3020 RT</td>
<td>4</td>
<td>$300.00</td>
<td>2</td>
</tr>
<tr>
<td>L3020 LT</td>
<td>4</td>
<td>$300.00</td>
<td>2</td>
</tr>
</tbody>
</table>

(TIP: It’s also recommended that orthotic services be billed separately from any other services (ex. an adjustment) provided on the same day. This will avoid interference with reimbursement for other services if the orthotic claim has to be reviewed.)
**DIAGNOSIS LINKING**

It's 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, 1, 2, 3 or 4 or multiple numbers, in 1500 form Box 24E.

**BOX 21.**
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1. 724.2 Lumbalgia (low back pain; low back syndrome
2. 739.3 Lumbar region
3. 719.47 Pain in joint (ankle and foot; arthralgia)
4. 728.71 Plantar fascial fibromatosis

**BOX 24D.**
CPT/HCPCS
1. 98940 CMT — 1-2 spinal regions
2. 97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported).
   This is timed code of 15 minutes each.

**BOX 24E.**
DIAGNOSIS REFERENCE NUMBER
1, 2
3, 4

**BOXES 21, 24D and 24E**

Box 21 is where you enter your ICD-9 codes. Box 24D is where you enter your CPT/HCPCS codes. Box 24E is where you enter the diagnosis reference number(s) 1, 2, 3 or 4 as they relate to the 4 diagnoses code positions in Box 21. A written description of your diagnoses codes in Box 21 is not necessary. Do not enter ICD-9 codes in Box 24E. You should try to fill all 4 positions in Box 21 (only if clinically indicated).

In the above example Box 24D indicates that a patient received a lumbar region chiropractic adjustment (98940) and orthotic management and training for the foot and ankle (97760). Box 24E indicates that CPT code 98940 links to diagnoses codes 724.2 (lumbar pain) and 739.3 (lumbar segmental dysfunction/subluxation) using diagnosis reference numbers 1 and 2.

Box 24E also indicates that CPT code 97760 links to diagnoses codes 719.47 (ankle and foot pain) and 728.71 (plantar fasciitis) using diagnosis reference numbers 3 and 4.

(TIP: Listing the diagnosis code associated with the treatment performed helps to justify the rationale for the service being provided and should allow the insurance carrier to process the claim accurately.)

**BILLING NON-COVERED AND UNDER-COVERED SERVICES**

Some carriers and contracts limit coverage for Stabilizers to a fee schedule potentially lower than the doctor’s cost. The following are examples of strategies you can use to help assist the patient in recouping the cost of the Stabilizers.

**OTHER POSSIBLE PAYMENT STRATEGIES:**

1. Contracted allowable fee schedule is lower than the doctor’s cost of the Stabilizer.

   There is a HCPCS code, S1001 – Deluxe/upgrade item requiring patient waiver – which allows a participating provider, under certain circumstances, to provide an upgraded product to a patient at the patient’s request despite a lower contracted fee schedule. 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 Stabilizers. Patient acknowledgement must be obtained prior to providing the supply/product. A sample patient notice/acknowledgement has been provided in this document for you to use. There are two steps for you to do in this situation:

   a. Find out if their carrier allows for the upgrade/upcharge (see sample provider agreement amendment letter on page 9). Request an amendment to their provider agreement: If the previous strategy is not possible with this carrier, 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 if the contract may not allow you to do so, you would like to amend it to do that. Show the sample letter to the provider if necessary.

   b. Get the patient to agree and get patient to sign acknowledgement agreement (see sample form for non-covered products on page 9).
a. SAMPLE PROVIDER AGREEMENT AMENDMENT LETTER

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 be made 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 despite a lower contracted rate. The upgraded recommended product that I am referring to is orthotics (Spinal Pelvic Stabilizers). I am requesting that my provider agreement be revised so that I may be allowed to have the patient pay the cost in excess of the established allowable fee schedule.

I will have patients sign a consent form acknowledging that they have been informed that there are other products available at the standard out-of-pocket price that may meet medical necessity. Additionally, when I submit the claim, I will use HCPCS code S1001. HCPCS code S1001 is used 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 will represent the cost in excess of the cost of standard equipment. I am also requesting that HCPCS code S1001 be denied as “patient responsibility” and not a provider write off.

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

Sincerely,

Dr. Doctor

b. SAMPLE PATIENT ACKNOWLEDGEMENT FORM FOR NON-COVERED PRODUCTS

Dear Patient:

Your health insurance plan requires you to be responsible for co-payments, co-insurance and deductibles for covered services and products as well as those services/products that exceed benefit limits. You are also financially responsible for all non-covered services and products.

The below listed product is not covered according to your health insurance plan. 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: 03-15-09  Amount: $300.00

Patient Acknowledgement:

I ______________________ (patient name), acknowledge that I have been told in advance by this office that the product listed above is not covered by my health insurance plan and I agree to pay for this non-covered product at the time the product is provided. I have also been told that there are other products available at the standard out-of-pocket price that meets medical necessity.

___________________________________

Patient Signature

___________________________________

Date

**IMPORTANT:** Review your in-network participating provider agreement/contract before implementing this form.
OTHER POSSIBLE PAYMENT STRATEGIES (CONTINUED)

2. Convenience vs. Not Medically Necessary:
When billing insurance, the doctor must keep in mind that the service he or she is providing meet criteria for reimbursement and these rules hold true for private insurance and Medicare. Below, we quote Cigna as an example.

CIGNA HealthCare Definition of Medical Necessity for Physicians requires that the service billed meet all three of the following criteria for reimbursement:

a. in accordance with the generally accepted standards of medical practice;

b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and

c. not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

Therefore, if the service is considered to be for the patient’s comfort or convenience, the service would not meet the medical necessity requirement to be reimbursed by the carrier. Because of this, based on contract, the patient would be required to pay for the service “out of pocket” and not be reimbursed by the carrier.

3. Sample Letter of Medical Necessity/Appeal Letter
Occasionally a letter of medical necessity may be requirement to be reimbursed by the carrier. Because of this, based on contract, the patient would be required to pay for the service “out of pocket” and not be reimbursed by the carrier.

There are three template letters:
- one for Stabilizers (page 10).
- one for 97760 (page 11).
- one for 97762 (page 11).

SAMPLE LETTER OF MEDICAL NECESSITY FOR CUSTOM-MADE STABILIZERS

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

I am writing to provide the clinical justification you require to support my decision to fit Mrs. Doe with custom-made orthotics.

Mrs. Doe presented to our office on 8-08-200X for evaluation and treatment of [insert problem here that warrants fitting of orthotics].

X-rays were taken on 8-08-200X indicating [give brief X-ray overview and denote any condition related that may be present].

An examination was performed on 8-08-200X 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 administered to Mrs. Doe on 8-05-200X. 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 and, in my professional opinion, this patient will benefit from custom-made orthotics. My functional goals are designed with the purpose of supporting her body during walking and standing, and helping to protect the spine, bones, and soft tissues from damaging shock stress as she moves. 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 10-01-0X.

The patient was casted/optically scanned on 10-01-0X and 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-made orthotics.

Sincerely,
Dr. Doctor
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 custom-made orthotics.

Mrs. Goodpatient presented to our office on 01-23-0X and on that day received her custom-made orthotics which had been measured and ordered on 01-23-0X. On the date of the orthotics management and training, Mrs. Goodpatient had her custom 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 XXX minutes of time 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 code and I look forward to receiving payment as soon as possible.

Sincerely,
Dr. Doctor

---

SAMPLE LETTER OF MEDICAL NECESSITY FOR CPT CODE 97762

Date
XYZ Insurance Company
123 Anywhere Drive
Anytown, NY 12345
Re: Mrs. Patient ID#: 123-45-6789

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 97762) we provided to Mrs. Patient. We hope that this information will allow you to authorize payment.

On March 15, 200X, 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 ¼ mile. This limited function was noted and therefore the patient was fitted for and supplied with custom orthotics on March 18, 200X.

On March 24, 200X, 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 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 custom 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 97762).

Please consider payment for this service, as it was clinically indicated and medically necessary. Feel free to contact me if any further information is needed.

Sincerely,
Dr. Doctor
OTHER POSSIBLE PAYMENT STRATEGIES (CONTINUED)

4. Medicare
We are often asked by doctors treating Medicare patients who have supplier numbers how they can bill Medicare for the Stabilizers. While L3020 is the most appropriate code to bill, Medicare will not approve Foot Levelers’ Stabilizers for L3020 without details of the manufacturing process. However, due to the proprietary nature of manufacturing, these details will not be released. Therefore, Stabilizers for Medicare patients will always be an excluded service under Medicare and you may charge the patient your full fee. See the sample patient ABN acknowledgement form.

Even though Medicare and its supplements do not cover Stabilizers, there are rare cases when secondary coverage is available.

[TIP: The difference between covered and non-covered:
Covered – Carrier/Medicare will consider for reimbursement.
Non-covered – Carrier/Medicare will NOT consider for reimbursement.]

5. Cash Patients
Surveys show that for an average chiropractic practice, approximately 70 percent of patients have some kind of insurance they wish to use for care. It’s estimated that about 40 percent of insurance companies cover Spinal Pelvic Stabilizers. This means that many of your patients will pay cash for their Stabilizers. It is reasonable to expect them to be willing to do so if they understand the importance of the Stabilizers in their treatment plan. However, it’s important to have some strategies in place.

• Make sure you do not have a non-compliant, dual fee schedule: When you have different fees for the same service for different types of patients, it could be non-compliant. For example, your published fee schedule for L3020 is $250 per foot, but you wish to extend a time of service discounted fee of $150 per foot to uninsured or underinsured patients. This is outside the boundaries of what’s reasonable according to the Office of Inspector General of the Department of Health and Human Services. Therefore, one easy way to be compliant is to join a cash discount network, which your patient can join, and then access a discounted fee schedule of your choosing. Regardless of how you set your fees, be sure you are not in danger by offering non-compliant discounts.

• Offer reasonable payment plans: For some patients, the cost of Stabilizers may be prohibitive. However, when bundled in with the other portions of care the patient is responsible for, and broken into monthly payment plans, it eliminates the patient feeling like they have to pick and choose which care they can afford. Supplies like Stabilizers may seem like the thing to go. It’s easy to bundle the entire patient’s portion into an estimated amount out of pocket. Then, work out as many months of payments you feel comfortable carrying. Keeping the patient on an automated payment plan, on file, allows you to be in control. Be sure you check your local area for all the legalities of doing so, but this is a wonderful way to serve the patient and make all the care they need affordable.

• Collect half down before ordering: If your patient is able to purchase the Stabilizers outright, be sure you collect at least half down when placing your order. This will usually be about the cost for the doctor. Therefore, if there was any problem later, your costs would be covered.

Make copies of the Exam Form (p. 13) and Spinal Pelvic Stabilizers Clinical Record of Necessity (p. 14) to include with your documentation.
Spinal Pelvic Stabilizers Clinical Record of Necessity

Patient’s Name:____________________________________________________  Age:_________  Date:________________________________

Occupation:____________________________________________________________________  #Hrs/Wk:______________________________

Does patient stand or walk on hard surfaces?  □ YES  □ NO

Related Complaints:
- FLAT FEET
- BUNIONS
- CORNS
- OTHER:__________________________
- PAIN WHILE STANDING
- PAIN WHILE WALKING
- PAIN WHILE RUNNING

History of problems/injuries to:
- FEET
- ANKLES
- KNEES
- LEGS
- HIPS
- PELVIS
- SPINE
- OTHER:__________________________

Recreational Activities:
- WALKING
- ANKLES
- FOOTBALL
- BASEBALL
- WEIGHT-LIFTING
- AEROBICS

Foot Screening:
- Standing
- Walking Gait
- Arch/Palpation
- Patella Alignment

Standing Patella Alignment
- Low (Pronation)
- Inwardly Rotated

Standing Patella Alignment
- High (Supination)
- Outwardly Rotated

Foot Abductor Muscle Response Test
- Post Foot Adjusting or Taping

Postural Stability Indicator
- (Navicular Drop Test)
- Left
- Right

Seated:
- Enhanced:
- No Change:
- Amt of Drop:
- Difference L vs R:

Standing:
- Enhanced:
- No Change:
- Amt of Drop:
- Difference is ≥ 3mm

Orthotics are indicated if:
- Amt of Drop is ≥ 4mm, or
- Difference is ≥ 3mm

Enhanced:
- Left
- Right

No Change:
- Left
- Right

Enhanced:
- Left
- Right

No Change:
- Left
- Right

Primary Diagnosis: Foot and ankle lesions can alter the mechanics of gait, cause stress on other lower limb joints, and contribute to postural pain syndromes and delay response to care. In this case, the primary condition(s) is (are):
- LOW BACK PAIN
- HIP PAIN
- KNEE PAIN
- SCOLIOSIS
- ABNORMAL GAIT
- OTHER:

Concurrent Conditions Include:
- PES PLANUS
- HEEL SPURS
- SHIN SPLINTS
- PLANTAR FASCITIS
- METATARSALGIA
- OTHER:

Gait Analysis and Biomechanical Evaluation: Attached.

Date of Exam:____________

Casting Technique Used:
- Physician-supervised functional, weightbearing negative cast
- Physician-supervised functional, weightbearing scan

Prognosis:
- The custom-made orthotics will normalize foot and lower extremity biomechanics while being worn.
- Response to care will be affected by the patient constantly wearing the prescribed orthotics.
- Because the underlying foot conditions are of a permanent nature, it will be medically necessary to wear custom-made orthotics indefinitely.
- Regular evaluations will monitor patient response and need for any modifications in the prescription.
- Re-evaluation scheduled for:__________________________

Doctor’s Name:_____________________________  Address:____________________________________

© 2009 FootLevelers
The procedures described in this guide are dependent first and foremost on patient need and medical necessity. In the absence of patient need and medical necessity, the services, their fees and billing process should not occur.

The laws, rules and regulations regarding reimbursement for orthotics and ancillary services vary greatly from state to state. Always check your state’s laws to verify which codes apply and work best for your practice.

The information contained in this guide is for educational purposes and is not intended to be and is not legal advice. The laws, rules and regulations regarding the establishment and operation of a healthcare facility vary greatly from state to state and are constantly changing. Foot Levelers does not engage in providing legal services. If legal services are required, the services of a healthcare attorney should be attained. The information in this publication is for educational purposes only and should not be construed as written policy for any federal agency.

No part of this publication covered by the copyright herein may be reproduced, transmitted, transcribed, stored in a retrieval system or translated into any language in any form by any means (graphics, electronic, mechanical, including photocopying, recording, taping or otherwise) without the expressed written permission of Foot Levelers. Foot Levelers assumes no liability for data contained or not contained in this publication and assumes no responsibility for the consequences attributable to or related to any use or interpretation of any information or views contained in or not contained in this guide. CPT® is a registered trademark of the AMA. The AMA does not directly or indirectly assume any liability for data contained or not contained in this guide. This guide provides information in regard to the subject matter covered. Every attempt has been made to make certain that the information in this guide is 100 percent accurate, however it is not guaranteed.

For additional assistance, please call Foot Levelers at 1.800.553.4860