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Coding Issues

2017 HCPCS Code Changes

The following tables identify changes to Level II Healthcare Common Procedure Coding System (HCPCS) codes for 2017. All HCPCS code changes are effective for claims with dates of service on or after January 1, 2017

Code	New Descriptor	Old Descriptor
L1902	Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf	AFO, ankle gauntlet, prefabricated, off-the-shelf
L1904	Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated	Ankle orthosis, ankle gauntlet, custom fabricated

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Medicare Correct Coding Guidelines

Each supplier is ultimately responsible for the HCPCS code(s) they select to bill for the items provided. Resources like code determinations letters and DMECS are useful but many products have not been reviewed. For these un-reviewed products, each supplier must use their best judgment in selecting HCPCS codes for billing. Here are some tips that will help:

- Check the PDAC Product Classification Lists on DMECS. Although not every HCPCS code has an associated product list, many of the most commonly used codes do.
- Check the DME MAC publications for coding bulletins and coding guidelines related to products and HCPCS codes for specific information on the item of interest.
- Refer to the "long" code narrative. All codes have short and long descriptors. The long descriptor often provides more detail regarding the requirements for the code. Select the code with the descriptor that most closely describes the product.
- Most code narratives are written broadly to be all-inclusive. You may not find a specific code that perfectly matches a product. Use the code that most closely describes the item rather than a NOC (not otherwise classified) or miscellaneous code.
- Local Coverage Determination related Policy Articles often have additional information in the Coding Guidelines section. Coding guidelines provide additional information on the characteristics of products that meet a specific HCPCS code.
- Remember that price and fees are NOT part of correct coding. Selecting a code based upon the fee schedule almost always results in an incorrect coding determination. HCPCS codes describe the product not the price.
- Check with the PDAC. The PDAC Contact Center can provide information that will assist you in code selection. This assistance, however, is NOT considered a formal product review. The advice provided is not an official code determination. Items are not added to the DMECS Product Classification List based on a query to the PDAC Contact Center.
- Request that manufacturers submit their products for coding. Although some HCPCS codes require mandatory product review in order to use the code, for most codes product review is voluntary. Many manufacturers are responsive to their customer' requests for verified HCPCS coding.

Otto Bock C-Leg Coding-Correct Coding- Revised (10/6/2016)

The Otto Bock C-Leg is a microprocessor controlled prosthetic knee. The product is covered by Medicare for beneficiaries classified as K-level 3 or 4. The most recent HCPCS code determination for Medicare billing purposes was posted to the PDAC site in 2005. This HCPCS coding determination has been re-evaluated at the company's request. Effective for claims with dates of service on or after 10/6/2016, only the following codes may be used to bill Medicare for this product:

- L5828 – ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL

- L5845 – ADDITION, ENDOSKELETAL, KNEE-SHIN SYSTEM, STANCE FLEXION FEATURE, ADJUSTABLE

- L5848 – ADDITION TO ENDOSKELETAL KNEE-SHIN SYSTEM, FLUID STANCE EXTENSION, DAMPENING FEATURE, WITH OR WITHOUT ADJUSTABILITY

- L5856 – ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING AND STANCE PHASE, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE

This group of four codes are all-inclusive i.e., they describe all features and functions of the C-Leg. Other HCPCS codes including L5920, L5930, L5950, and L5999 must not be used for Medicare billing of the C-Leg.

Historically, some suppliers have billed HCPCS code L5930 (ADDITION, ENDOSKELETAL SYSTEM, HIGH ACTIVITY KNEE CONTROL FRAME) for C-Legs provided to beneficiaries classified as K-level 4, while not billing this code for K-level 3. All HCPCS codes assigned to a product must always be billed. The practice of partial billing of selected codes, for any product, is incorrect coding. As discussed above, L5930 is no longer assigned to the C-Leg and must not be billed for this product, regardless of which K-level is assigned.

Coding/Billing Reminder for Ultra-Light Materials: L5940, L5950 and L5960 (9/16/15)

HCPCS L5940-L5960 describes ultra-light materials that may only be used when materials such as carbon fiber, fiberglass, Kevlar® or other advanced composite lamination materials are used in the fabrication of a socket for an endoskeletal prosthesis. They are not used for ultralight materials used in other components of a prosthesis – e.g., knee/shin system, pylon, ankle, foot, etc. For codes L5940-L5960, the unit of service is per limb.

Suppliers are reminded that payment for HCPCS code L5940-L5960 will be allowed only when the claim is billed with one of the following endoskeletal system or socket HCPCS codes: L5301, L5312, L5321, L5331, L5341, L5700, L5701, L5702 or L5703.

Claims submitted to the DME MACs for HCPCS code L5940-L5960 without an endoskeletal system or socket will be denied as not medically necessary via ANSI code CO-50and ANSI Remark Code N115.

Appropriate Coding & Billing for Lower Limb Prosthetic Covers & Covering Systems (7/23/13)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received a high volume of submitted claims for lower limb prosthetic covers (L5704-L5707) and protective covering systems (L5962, L5964, and L5966) for the same lower limb prosthesis. The need for both of these is rare, and this article is intended to educate suppliers and providers about the occasions where both of these are considered to be reasonable and necessary.

Lower limb prosthetic covers (L5704–L5707) are complete products and afford shape, protection and waterproofing for normal daily usage of the prosthesis. They offer sufficient protection and weatherproofing for patients who require lower limb prosthetics.

Protective outer surface covering systems (L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that

which is afforded by L5704-L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. This type of product is separate from the covering that is already reimbursed as part of L5704–L5707 and is rarely necessary.

Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item. Again, this type of extra protection is not routinely necessary.

When billing for the protective outer surface covering systems (L5962, L5964 and L5966), information regarding the type of protective cover provided (i.e., manufacturer name, make, model or type,) must be included on claims in order to ensure correct coding.

Items Requiring Coding Review by the PDAC (10/10/2012)

Manufacturers and patient care facilities are reminded that a number of items require coding review by the Pricing, Data Analysis and Coding (PDAC) contractor; and a PDAC coding review is binding when billing Medicare. Here is a list of items which require a PDAC coding review:

- LSOs and TLSOs: Any prefabricated spinal orthoses described by codes L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637 and L0639. Any custom fabricated spinal orthoses fabricated by a central fabrication facility or manufacturer described by codes L0452, L0480-L0486, L0629, L0632, L0634, L0636, L0638 and L0640. If you fabricated a custom LSO or TLSO in-house and provide it directly to the patient, you don't have to have the product verified by the PDAC. However, you must be able to provide a list of materials used and a description of your fabrication process if requested.
- Diabetic Shoes and Inserts: All prefabricated diabetic shoe inserts, A5512, must be reviewed and verified by the PDAC. Custom fabricated inserts, A5513, also require PDAC coding verification if fabricated by a central fabrication facility or manufacturer. If you fabricate a custom insert in-house and provide it directly to the patient, you don't have to have the insert verified by the PDAC. However, you must be able to provide a list of materials used and a description of your fabrication process if requested.
- KOs: A prefabricated double upright knee orthosis described by code L1845.
- AFOs: A prefabricated multiligamentous support described by code L1906.
- Miscellaneous: A cervical collar described by code L0174 and a functional electric stimulator described by code E0770.

Claims for the above items will be denied if the items have not been reviewed by the PDAC and placed on the PDAC's Product Classification List.

Diabetic Inserts & Partial Feet Inserts (09/12/2012)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have issued guidance on how to bill for diabetic inserts (A5512 and A5513) when the patient also requires a partial foot insert (L5000).

The L5000 includes a rigid longitudinal arch support and includes the addition of materials to fill the void of the missing digits, and the addition of softer materials in areas where the residual limb makes contact with the insert. The L5000 is designed to provide standing balance and toe off support for the patient to improve their gait. Diabetic inserts are designed with multiple layers of materials varying in destiny to provide a protective function for the foot and is part of the patient's diabetes management efforts.

If the patient has diabetes and does not require the extra rigidity and support provided by the L5000, because they are only missing toes; excluding the big toe (hallux), you may only bill for the A5513 (custom diabetic insert) and not the L5000. In this scenario the customization of the A5513 includes the addition of materials to replace the missing digits.

If the patient has diabetes and requires the extra rigidity and support provided by the L5000, because they are missing the hallux or forefoot you may only bill for the L5000 and you may not also bill for an A5512 or A5513. In this scenario the provision of the L5000 includes the addition of materials to replace the missing digits, and the materials added to create the protective function as part of the patient's diabetes management.

Coding Guidelines for External Breast Prostheses: L8000, L8001 and L8002 (05/16/2012)

HCPCS code L8000 describes a bra, without an integrated breast prosthesis, which has pockets designed to hold mastectomy form/breast prosthesis adjacent to the chest wall and codes L8001 and L8002 describe mastectomy bras with integrated breast prosthesis. The L8000, L8001 and L8002 also include the following characteristics:

- May be constructed of any material including but not limited to cotton and polyester
- May included any type of closure and the closure may be located anywhere on the bra
- May be of any size
- May be constructed with or without integrated structural support ,e.g., an underwire

Any of the above features may not be billed as an add on or as a deluxe feature.

Concentric Joints (05/08/2012)

The Pricing, Data Analysis and Coding contractor (PDAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have revised the coding guidelines for the use of concentric adjustable torsion joints used with prefabricated and custom fabricated orthoses.

If the concentric adjustable torsion joints are used solely to provide an assistive function for joint motion, you may use the L2999 for lower extremity orthoses and L3999 for upper extremity orthoses. All other uses of concentric adjustable torsion joints must be coded and billed as the following:

- E1800 – Dynamic adjustable elbow extension/flexion device
- E1802 – Dynamic adjustable forearm pronation/supination device
- E1805 – Dynamic adjustable wrist extension/flexion device
- E1810 – Dynamic adjustable knee extension/flexion device
- E1815 – Dynamic adjustable ankle extension/flexion device

As a reminder any claim for an L2999 or L3999 must include either a narrative description of the item or the manufacturer name and model name/number.

Cosmetic Hand Restoration Coding (05/06/2012)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have stated that L6895 (addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated) should be used to describe and bill for all cosmetic features such as coloring, veins, hair, etc. Providers should no longer use L7499 (upper extremity prosthesis, not otherwise specified) to describe these cosmetic features.

AFO Coding Guidelines (12/21/2011)

The Pricing, Data Analysis and Coding (PDAC) Contractor has issued coding guidelines for three L codes related to Ankle Foot Orthoses (AFO).

- L2340 (addition to lower extremity, pre-tibial shell, molded to patient model), must provide a rigid overlapping interlocking anterior tibial control between the tibial tuberosity and extend to a point no greater than 3 inches proximal to the medial malleolus. The L2340 must also be fabricated from thermosetting materials, thermoplastics, or composite type materials.
- L1906 (AFO, multiligamentous ankle support, prefabricated, includes fitting and adjustment),must provided control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion and include wrap around straps, a rigid stirrup and foot plate, which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. The PDAC has also stated that no addition codes may be added to the L1906.
- L1960 (AFO, Posterior solid ankle, plastic, custom fabricated), the proximal border should extend to a height no greater than 1.5 inches distal to the apex of the head of the fibula.

Prosthetic Hand & Articulating Digits Coding Guidelines (12/21/2011)

The Pricing, Data Analysis and Coding (PDAC) Contractor has issued guidance on the proper use of the following two prosthetic codes:

- L6715 – Terminal device, multiple articulating digit, includes motor(s), initial issue or replacement.
- L6880- Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s).

When initially providing multiple articulating digits (e.g. finger or thumb) the code L6715 must be paired with a partial hand base code (L6000, L6010 or L6020). The L6715 may not be billed with the base code of L6025.

The L6880 is considered to be a complete hand prosthesis, which consists of the terminal device, all articulating digits and motors and all necessary components. The L6715 may not be used as an addition to the L6880; if the L6715 is used with the L6880 your claim will be denied.

If you are replacing a multiple articulating digit(s) as part of a repair, you may use the L6715 and the RB modifier.

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