DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Provider Compliance Tips for Spinal Orthoses

Provider Types Affected: Hospitals, DME providers and suppliers billing for spinal orthoses

Insufficient documentation causes most denials

Medicare's Recovery Auditors and Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) review Medicare claims to assure the services were reasonable and medically necessary. These personnel review medical records to determine the accuracy of the claim. These reviews reveal the following top reasons for denial of spinal orthoses claims:

- Lack of documentation or insufficient documentation
  - Unsupported medical necessity
  - Missing detailed written order
  - Required criteria for coverage undocumented
  - No response to Additional Documentation Requests (ADRs)
- Services billed were not rendered
  - Invalid or no proof of delivery in the supplier's records

Background and relevant Medicare policies

Medicare Policy

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements.

Detailed Written Orders

Chapter 5 of the "Medicare Program Integrity Manual" (publication 100-08, Chapter 5, Section 5.2.3) and related Local Coverage Article (LCA) **A52500** state that the supplier must have a detailed written order prior to submitting a claim. Although someone other than the physician may produce the detailed description of the item, the ordering physician must review the detailed description and personally sign and date the order.

Coverage Criteria

The LCA for Spinal Orthoses states that payments for spinal orthoses are included in payments to hospitals or Skilled Nursing Facilities (SNFs) in the following two circumstances:

- The supplier provides the orthosis to the beneficiary prior to an inpatient admission or Part A covered SNF stay and the medical necessity begins during the stay (for example, after spinal surgery)
- The supplier provides the orthosis to the beneficiaries during an inpatient stay prior to discharge and the beneficiary uses the item for medically necessary inpatient treatment or rehabilitation.

In both of these situations, the supplier should not submit claims to the DME MAC.

Conversely, payments for spinal orthoses are eligible for coverage by DME MACs in the following circumstance:

- The orthosis is medically necessary for a beneficiary after discharge from a hospital or Part A covered SNF stay and the supplier provides the orthosis to the beneficiary within two days prior to discharge home, and the orthosis is not needed for inpatient treatment or rehabilitation, but is left in the room for the beneficiary to take home.

Additional Documentation Requests

The "Medicare Program Integrity Manual" (Chapter 3, Section 3.2.3) further explains the importance of suppliers providing sufficient and timely submissions in response to ADRs. Reviewers may request additional documentation from providers to verify compliance with benefit category requirements. If the submitted documentation lacks evidence that the benefit category requirements were met, the reviewer issues a benefit category denial. If no documentation is received within the regular time frames or within a reasonable time following an extension, the reviewer denies the claim in full or in part.

Proof of Delivery

Chapter 4 of the "Medicare Program Integrity Manual" (Chapter 4, Section 4.26) states that suppliers must maintain proof of delivery documentation in their files for 7 years and the supplier must provide the documents to the DME MAC upon request.

Practical strategies to improve documentation and prevent denials of claims

To prevent claim denials, providers and suppliers should preserve documentation of the following items within their medical records:

- **Valid detailed written physician's order with the following items:**
  - A detailed description of the item to be dispensed
  - The beneficiary's name
  - The physician's name, signature, and signature date
  - The start date of the order (if different than the signature date)

- **Proof of delivery documentation with the following items:**
  - A detailed description of the item to be delivered including the brand name, serial number, narrative description, and quantity delivered
  - The beneficiary's name
  - The delivery address
  - The delivery date
  - Evidence of delivery including the recipient's signature and signature date

Please note that if a supplier uses a shipping service or mail order, the supplier should use the shipping date as the date of service on the claim.

Remember to check to make sure the orders and proofs of delivery are written in accordance with the coverage criteria outlined in the LCA. Review these documents to understand whether the payment for a spinal orthosis should be included in the payment to a hospital or SNF or whether the payment is eligible for coverage by the DME MAC. If you receive a documentation request from a Medicare review contractor, make sure to submit the documents prior to the specified due date.

Resources

Hyperlink Table

FOR MORE INFORMATION ABOUT…	RESOURCE
LCA A52500 for Spinal Orthoses	https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52500
"Medicare Program Integrity Manual," Publication 100-08, Chapter 5, Sections 5.2.3; 5.7; 5.8; and 5.9	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c05.pdf
"Medicare Program Integrity Manual," Publication 100-08, Chapter 3, Section 3.2.3	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
"Medicare Program Integrity Manual," Publication 100-08, Chapter 4, Section 4.26	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
"Medicare Program Integrity Manual," Publication 100-08, Chapter 12, Section 40.1 (A)	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c12.pdf
"Medicare Claims Processing Manual," Publication 100-04, Chapter 30, Section 50.13.4	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
"Medicare Benefit Policy Manual," Publication 100-02, Chapter 15, Section 110	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Title XVIII of the Social Security Act (SSA); Section 1862 (a)(1)(A)	http://www.ssa.gov/OP_Home/ssact/title18/1862.htm
The Review Contractor Directory – Interactive Map (CMS contractor contact information)	http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

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