Practice Management: Coding and Billing

In this module…

- Contracting with insurances Vs. Running your practice as “cash-and-carry”
- HCPCS coding for pedorthic devices
- Medicare’s coverage for pedorthic devices
- Other payors
- Denials and appeals
- Terminology

- As of 2018, there were 953 health insurance companies in the United States.
  - 5 largest private health insurance companies:

Rank	Health insurance company	Market share	Total health plan enrollment in 2021
1	Kaiser Permanente	12.81%	8,228,765
2	Elevance Health (Anthem)	7.27%	4,670,236
3	HCSC (including BCBS plans)	6.88%	4,419,293
4	UnitedHealth Group	6.70%	4,306,492
5	Centene Corp.	6.17%	3,962,897

2021

Company	Market share	Revenue (billions)
UnitedHealth Group	15%	$189
Elevance Health (Anthem)	10%	$124
Kaiser Permanente	9%	$114
Centene (Ambetter)	9%	$110
Humana	7%	$86

2024

Not all pedorthic facilities are contracted with insurances.

- There are pros and cons to becoming a contracted provider for insurance plans. There are also benefits and disadvantages to not participating in the world of dealing with insurances.

- Contracted Provider
  - In many cases, patients are more likely to use you (and doctors more likely to refer to you) if you are in-network with their health insurance.
  - Discounted reimbursements – sometimes prohibitively so.
  - Wait for payment – 60, 90, 120 days or more.
  - Additional staff to do VOB, billing, work denials, appeals, etc.
  - Surety bonds, additional liability insurance, etc.
  - Pedorthic devices may be excluded anyway.
    - Or covered only for specific diagnoses

- Cash-and-Carry Practice
  - Patients may be reluctant to go out-of-network.
  - Patients may still be able to submit on their own for reimbursement.
  - You are able to charge a fee that is reasonable and fair for both you and the patient.
  - Prompt payment at the time services are provided.
  - Avoid headaches of audits, denials, payments delays, etc.

HCPCS Coding for Pedorthic Devices

HCPCS

- HCPCS Codes (Healthcare Common Procedure Coding System) – These are “billing codes” like A5500, A5514, L3020 or L5000.
  - Level 1 HCPCS codes are made up of the CPT (Current Procedural Terminology) code set.
  - Level 2 HCPCS codes include pedorthic devices
  - Level 3 HCPCS codes are local codes for Medicaid, etc.

Codes for Diabetic Footwear

A5500 - For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe

A5501 - For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe

A5503 - For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe

A5504 - For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe

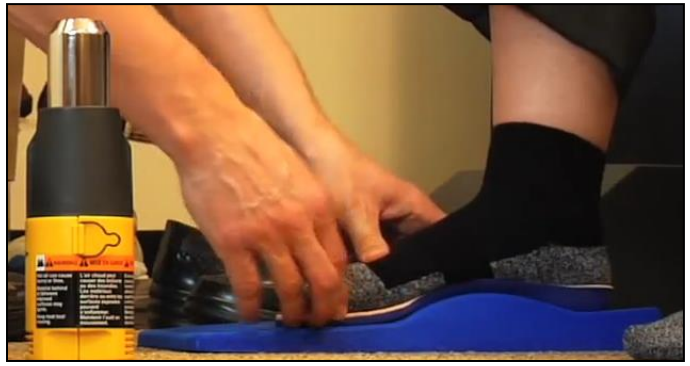
A5505 - For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe

A5506 - For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe

A5507 - For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe

Codes for Diabetic Footwear

A5512 - For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each



A5513 - For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

A5514 - For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each

L3000

- Actual descriptor: Foot, insert, removable, molded to patient model, 'ucb' type, [B]erkeley shell, each

- In 2016, AOPA, APMA and PFA decided that the “new” definition should be:
  - Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three dimensional model of the patient’s own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is a functional device, (reducing pathological forces) which has a molded heel cup and trim lines with a minimum of a 10 mm heel cup height to provide both medial and lateral directive forces to control the hind and fore foot. It may also have intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to control function and reduce pathological forces. HCPCS code L3000 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

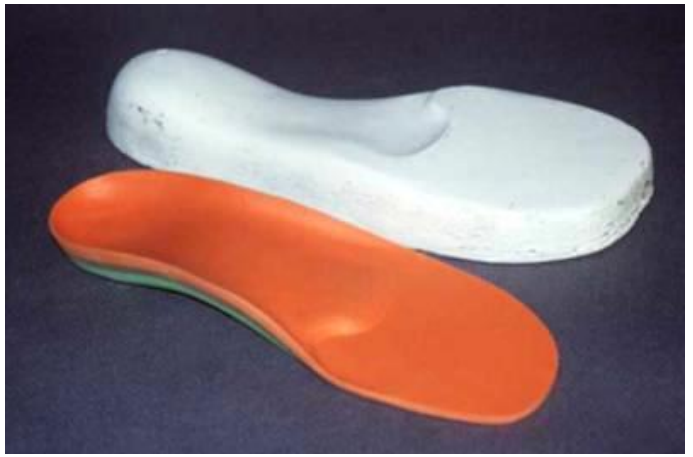
L3010

- Actual descriptor: Foot, insert, removable, molded to patient model, longitudinal arch support, each

- In 2016, AOPA, APMA and PFA decided that the "new" definition should be:
  - Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three dimensional model of the patient's own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is an accommodative/functional device, which has a heel cup of less than 10 mm and is intended to control the forefoot through a longitudinal arch support. It may also have an intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to reduce pathological forces. HCPCS code L3010 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

L3020

- Actual descriptor: Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each

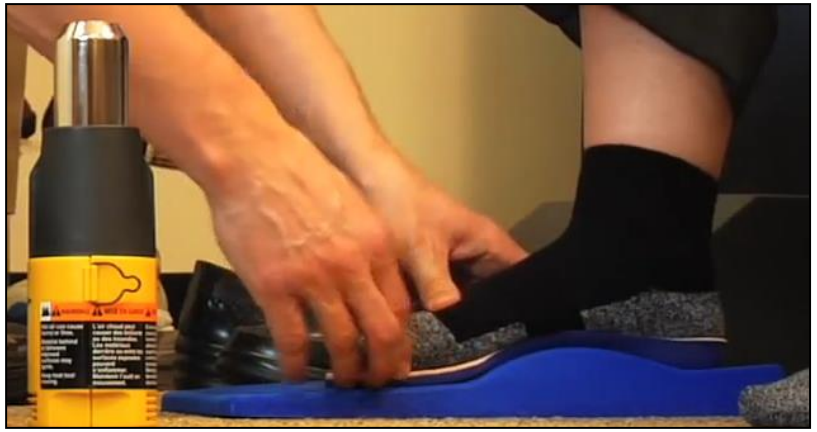


- In 2016, AOPA, APMA and PFA decided that the “new” definition should be:
  - Prescription Custom Fabricated Foot insert, each, removable. This type of device is fabricated from a three dimensional model of the patient’s own foot (e.g. cast, foam impression, or virtual true 3-D digital image). This type of orthotic is an accommodative/functional device, which has a heel cup of less than 10 mm and is intended to control the forefoot through a Longitudinal Arch and metatarsal support. It may also have an intrinsic or extrinsic posts designed to control foot motion. This device is made of a sufficiently rigid material to reduce pathological forces. HCPCS code L3020 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.

L3030

- Actual descriptor: Foot, insert, removable, formed to patient foot, each

- In 2016, AOPA, APMA and PFA decided that the “new” definition should be:
  - Prescription Custom Fabricated Foot insert, each, removable. This type of device is formed directly to the patient’s foot through the use of an external heat source. The heat source should sufficiently and permanently alter the shape of the device, activating a resin, or other method by which the shape of the device is sufficiently and permanently altered in order to provide continuous contact with the unique characteristics of the plantar aspect of the patient’s foot. It may also have an intrinsic or extrinsic post designed to control foot motion. This type of orthotic is an accommodative/functional device. This device is made of sufficiently rigid material to control foot motion and or reduce pathological forces. HCPCS code L3030 includes additions such as postings, padded top covers, soft tissue supplements, balance padding and lesion or structure accommodations. Other additions may be required as well.



Prefabricated Foot Orthoses

- L3040 - Foot, arch support, removable, premolded, longitudinal, each
- L3050 - Foot, arch support, removable, premolded, metatarsal, each
- L3060 - Foot, arch support, removable, premolded, longitudinal/ metatarsal, each

Partial Foot Prosthesis

- L5000 - Partial foot, shoe insert with longitudinal arch, toe filler

Footwear

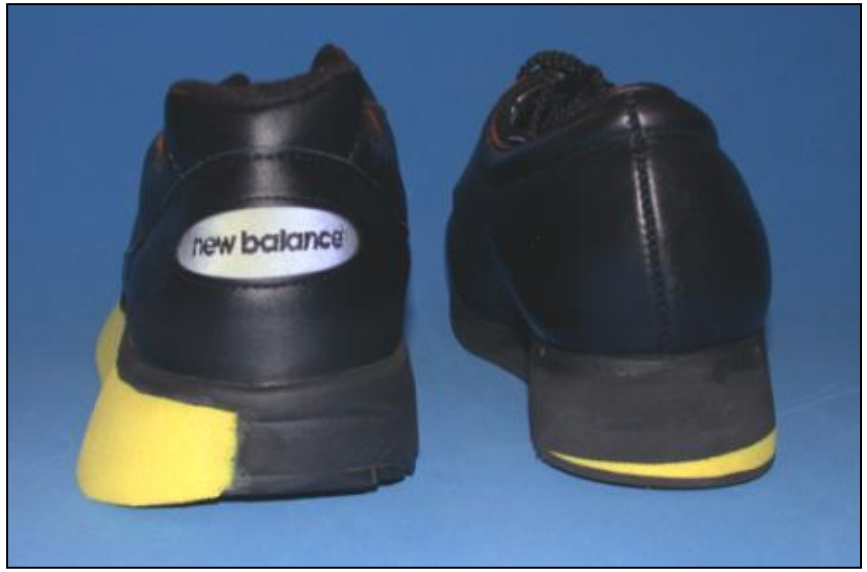
- L3215 - Orthopedic footwear, ladies shoe, oxford, each
- L3216 - Orthopedic footwear, ladies shoe, depth inlay, each
- L3217 - Orthopedic footwear, ladies shoe, hightop, depth inlay, each
- L3219 - Orthopedic footwear, mens shoe, oxford, each
- L3221 - Orthopedic footwear, mens shoe, depth inlay, each
- L3222 - Orthopedic footwear, mens shoe, hightop, depth inlay, each
- L3224 - Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)
- L3225 - Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)
- L3230 - Orthopedic footwear, custom shoe, depth inlay, each

Shoe Modifications

- L2360 - Addition to lower extremity, extended steel shank
- L3254 - Non-standard size or width
- L3300 - Lift, elevation, heel, tapered to metatarsals, per inch
- L3310 - Lift, elevation, heel and sole, neoprene, per inch
- L3320 - Lift, elevation, heel and sole, cork, per inch
- L3330 - Lift, elevation, metal extension (skate)
- L3332 - Lift, elevation, inside shoe, tapered, up to one-half inch
- L3334 - Lift, elevation, heel, per inch

Shoe Modifications

- L3340 - Heel wedge, sach
- L3350 - Heel wedge
- L3360 - Sole wedge, outside sole
- L3370 - Sole wedge, between sole
- L3390 - Outflare wedge
- L3400 - Metatarsal bar wedge, rocker
- L3410 - Metatarsal bar wedge, between sole
- L3420 - Full sole and heel wedge, between sole
- L3430 - Heel, counter, plastic reinforce



Arizona Brace®

https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2020/afo-arizona-type-correct-coding-revised

For the Arizona Short and Arizona Tall, or similar custom fabricated braces, only the following codes should be used:

HCPCS	Description
L1940	Ankle foot orthosis, plastic or other material, custom fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic below knee section

L2330 is used whether the closure is a lacer closure or a hook and loop closure. L2820 is used only if a soft interface, either leather or other material, is provided.

For the Arizona Extended and the Arizona Unweighting or similar custom fabricated braces, only the following codes should be used:

HCPCS	Description
L1960	Ankle foot orthosis, posterior solid ankle, plastic, custom-fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic below knee section

The following codes must not be used for these orthoses:

HCPCS	Description
L2275	Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
L2280	Addition to lower extremity, molded inner boot

For the Arizona Partial Foot model or similar orthosis, use codes:

HCPCS	Description
L1940	Ankle foot orthosis, plastic or other material, custom-fabricated
L2330	Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only
L2820	Addition to lower extremity orthosis, soft interface for molded plastic below knee section
L5000	Partial foot, shoe insert with longitudinal arch, toe filler.

Arizona Mezzo™

- L1907 - Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated
- L2330 - Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only

Richie Brace®

Richie Brace® – Standard
L1970 AFO, molded to patient model with ankle joint
L2820 Soft Interface

Richie Brace® – Standard with Arch Suspender
L1970 AFO, molded to patient model with ankle joint
L2820 Soft interface
L2275 Varus/Valgus correction

Richie Brace® - Dynamic Assist
L1970 AFO, molded to patient model with ankle joint
L2820 Soft interface
L2210 (2 hinges per brace) Tamarac doris-assist ankle joints

Richie Brace® - Gauntlet
L1940 Solid AFO shell
L2275 Varus/Valgus correction
L2330 Lacer
L2820 Soft interface

Richie Brace® - California AFO
L1940 Solid AFO shell
L2275 Varus/Valgus correction
L2330 Lacer
L2820 Soft interface

Richie Brace® - Solid AFO
L1960 Solid AFO shell

Richie Brace® - OTC
L1971 Pre-fab AFO

Medicare Coverage for Pedorthic Devices

When does Medicare cover shoes, mods and FOs?

- Medicare has limited coverage provisions for shoes, inserts, and shoe modifications used by beneficiaries. In order to be eligible for coverage, such items must qualify in either:

  (1) the benefit category for therapeutic shoes provisioned in the treatment of a diabetes-related condition(s) or

  (2) the benefit category for leg braces (to which the shoes and related items would be considered for coverage as integral components of the leg brace).

When does Medicare cover shoes, mods and FOs?

A modification of a custom molded or depth shoe will be covered as a **substitute for an insert**.

A5503: Rigid rocker bottoms or roller bottoms
A5504: Wedges
A5505: Metatarsal bars
A5507: Not otherwise specified modification of off-the-shelf depth inlay shoe or custom-molded shoe, per shoe
A5508: Deluxe feature of off-the-shelf depth inlay shoe or custom-molded shoe, per shoe

When does Medicare cover shoes, mods and FOs?

- Orthopedic shoes and other supportive devices for the feet generally are not covered. *However, this exclusion does not apply to such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace.*
- Shoes, inserts, and shoe modifications that are an integral component of a leg brace are referred to as orthopedic footwear (ORF). These shoes, inserts, and shoe modifications are only covered if they are an integral part of a covered leg brace that is described by HCPCS code L1900, L1920, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2050, L2060, L2080, or L2090.
- In addition to being an integral component of the covered leg brace, these products must also be medically necessary for the proper functioning of the leg brace. *When billing for ORF, the leg brace and ORF must be billed by the same supplier.*

When does Medicare cover shoes, mods and FOs?

- There are situations where a beneficiary may qualify for **both** a diabetic shoe and a leg brace. The CMS *Benefit Policy Manual* (CMS Pub. 100-02), Chapter 15, Section 140 reads:
- ***In situations in which an individual qualifies for both diabetic shoes and a leg brace, these items are covered separately.*** *Thus, the diabetic shoes may be covered if the requirements for this section are met, while the brace may be covered if the requirements of §130 [braces benefit] are met.*
- This means that the supplier of the therapeutic shoes provisioned in the treatment of a diabetes-related condition may bill separately for such shoes, while a different supplier may bill for the associated brace.

When does Medicare cover shoes, mods and FOs?

- The use of shoes, inserts or shoe modifications (L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3031, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3170, L3201, L3202, L3203, L3204, L3206, L3207, L3208, L3209, L3211, L3212, L3213, L3214, L3215, L3216, L3217, L3219, L3221, L3222, L3224, L3225, L3230, L3250, L3251, L3252, L3253, L3254, L3255, L3257, L3260, L3265, L3300, L3310, L3320, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3485, L3500, L3510, L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610, L3620, L3630, L3640, and L3649) must *not* be used on *braces that fit inside a shoe*. This is considered incorrect coding and is statutorily non-covered by Medicare.

Other Billing Considerations

Modifiers:

KX-Specific required documentation on file

**Must be appended to all claims for diabetic footwear

LT -Left Side

RT -Right Side

EY-No physician or other licensed health care provider order for this item or service. Use if there is not a completed order

GA-Properly completed ABN on file (when applicable)

Medicare Benefit Policy Manual
Publication 100-02 Chapter 15 Section 20.3

“If a custom-made item was ordered but not furnished to a beneficiary because the individual died, or because the order was canceled by the beneficiary, or because the beneficiary’s condition changed and the item was no longer reasonable and necessary or appropriate, ***payment can be made*** based on the supplier’s expenses.”

- Custom or customized items only
- Reimbursement is invoiced amount
- DOS will be date of cancellation/death
- You will need to produce the invoice if asked

Medically Necessary Upgrades

“An upgrade may be from one item to another within a single Health Insurance Common Procedure Coding System (HCPCS) code or may be from one HCPCS code to another. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.”

While boots achieve the same medical benefit, they are more expensive and have additional features that can be considered an upgrade. The provider can bill the boot as an upgrade for the difference. A signed ABN is required in this instance.

When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the LCD, the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL.

GK - Reasonable and necessary item/service associated with a GA or GZ modifier

GL - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

ABN must be obtained.

On one claim line the supplier bills with a GA modifier the HCPCS code that describes the item that was provided.

On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is covered based on the LCD. **(Note: The codes must be billed in this specific order on the claim.)**

Claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message.

The supplier may charge their "usual and customary" fee for the upgraded item that is provided.

According to Noridian Medicare, there are changes required when reporting the RT and LT modifier(s). Changes apply to HCPCS codes for Therapeutic Shoes for Persons with Diabetes (TSD).

"Effective for claims with dates of service (DOS) on or after 3/1/2019, suppliers must bill each item on two separate claim lines using the RT and LT modifiers and 1 UOS on each claim line. Do not use the combination RTLT modifier on the same claim line and bill with 2 units of service (UOS). Claim lines for HCPCS codes requiring the use of the RT and LT modifiers billed without the RT and/or LT modifiers or with the RT LT on a single claim line, will be rejected as incorrect coding."

Proper Medicare Claim

DOS	POS	CODE	MOD 1	MOD 2	MOD 3	CHARGES	QTY	TOTAL
1/13/23	12	A5500	KX	RT		87.85	1	87.85
1/13/23	12	A5500	KX	LT		87.85	1	87.85
1/13/23	12	A5514	KX	RT		53.47	1	$53.47
1/13/23	12	A5514	KX	LT		53.47	1	$53.47
1/13/23	12	A5514	KX	RT		53.47	1	$53.47
1/13/23	12	A5514	KX	LT		53.47	1	$53.47
1/13/23	12	A5514	KX	RT		53.47	1	$53.47
1/13/23	12	A5514	KX	LT		53.47	1	$53.47

How much to bill…

- Medicare
  - Will only pay you 80% of the allowable amount regardless of what you bill.
  - You may collect no more than 20% of the allowable amount from the patient or their secondary insurance.
- Medicaid
  - Different state-to-state
- VA
  - Varies from VA-to-VA. Will be on by P.O.
- Workers' compensation
  - Typically negotiated on a case-by-case basis
- Commercial insurances
  - Based on the fee schedule/contract that your company negotiated with the payor when they became a provider.
- Self-pay
  - You can charge whatever you like, but the free market will punish you if you are not being fair…

Billing for your time

- In most cases, a certified pedorthist is not able to bill for their time (evaluation, delivery, follow-up, etc.)
- There are cases where one can be for repairing a device.
- The TSPD A-codes are all-inclusive codes.

Denials

- Common billing pitfalls:
  - Failure to verify coverage
  - Failure to obtain referral
  - Failure to obtain prior authorization/pre-approval
  - Incorrect billing codes / modifiers
  - Incorrect date of service
  - Incorrect place of service
  - Incorrect diagnosis codes
  - Incorrect billing address
  - Incorrect number of units
  - Absence of referring physician’s NPI number
  - Referring physician not enrolled in PECOS
  - “Timely filing” stipulations

Appeals

- In most cases, you can appeal a denial.
- With Medicare, if you are confident that you are/were correct…appeal!
- The process with other carriers may be more complex and less likely to succeed.

Terminology

a

- Allowable (or Allowed Amount) – The allowable is the most that a particular payor will reimburse for a given billing code. The provider may bill whatever they want, but they will only receive the allowed amount from the insurance company.
- A-Codes – Are the billing codes used to bill for diabetic shoes and inserts (A5500-A5514)
- Affordable Care Act (Actually: Patient Protection and Affordable Care Act) – Health insurance reform enacted in 2010 with the stated goals of:
  - Making affordable health insurance available to more people. (Provides consumers with subsidies that lower costs for households with incomes between 100% and 400% of the federal poverty level.)
  - Expanding the Medicaid program to cover all adults with income below 138% of the federal poverty level.
  - Supporting innovative medical care delivery methods designed to lower the costs of health care generally.
- Advanced Beneficiary Notice (ABN) - Also known as a waiver of liability, is a notice a provider should give the patient before they receive a service if, based on Medicare coverage rules, the provider has reason to believe Medicare will not pay for the service.

b

- Benefit Period - When services are covered under a given plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date; typically one calendar year for health insurance plans.
  - The Medicare benefit period begins on January 1st and ends on December 31st.
  - Medicaid and commercial insurance plans may be different

C

- Coinsurance - A certain percent one must pay each benefit period after one has paid their deductible. This payment is for covered services only. The patients may still have to pay a copay.
  - For example, Medicare covers 80% for covered services so a beneficiary is responsible for the 20% coinsurance (either out-of-pocket or through a secondary insurance)
- Copayment - The amount a patient has to pay a healthcare provider at the time services are received. There may be a copay for each covered visit to your doctor, depending on the plan. Not all plans have a copay.
- Contract - The agreement between an insurance company and the policyholder, or between the insurance carrier and the provider.
  - The contract is precisely why we CANNOT advise our customers on which insurance plans “pay” better then others! How would we know what was or was not negotiated into the contract?!?
- CMS (Centers for Medicare and Medicaid Services)
- CPT (Current Procedural Terminology) - A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

d

- Deductible – This is the amount a patient has to pay out-of-pocket each benefit period before their insurance coverage kicks in.
  - For example, 2019 Medicare deductible is $135.50.
- DMEPOS (Durable Medical Equipment Prosthetic and Orthotic Supplies) – The branch of Medicare that oversees what our customers do.
- Date of Service (DOS) – Delivery date. Pedorthic devices cannot be billed until they have been delivered.
- DME MAC (DME Medicare Administrative Contractor (formerly DMERC)) - Private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or DME claims for Medicare Fee-For-Service (FFS) beneficiaries.
  - Jurisdictions A and D: Noridian Healthcare Solutions, LLC
  - Jurisdictions B and C: CGS Administrators, LLC

e

- Explanation of Benefits (EOB) – A document from the insurance carrier explaining how much of a claim was covered and at what rate, and/or what was denied and why.

f

- Fee Schedule – The list of allowable amounts for a specific payor.
  - With the exception of Medicare and Medicaid, most fee schedules are not available to the general public.

g

- GSA Contract (aka a Federal Supply Schedule) - Is an indefinite delivery, indefinite quantity (IDIQ), long-term contract under the MAS Program. A GSA contract is a five-year unfunded contract based on a particular company's commercial discounting structure.

h

- HMO (Health Maintenance Organization) – An HMO is a health insurance plan with no out-of-network benefits. The patient is required only to see participating providers. They must also select a primary care physician who will control whether a patient is referred to specialists.
- HSA (Health Savings Account) – An account that lets a person save pre-tax money for future health care expenses.

¡

- ICD-10 (International Classification of Diseases, Tenth Revision, Clinical Modification) - A system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States. The World Health Organization owns, develops and publishes the codes and national governments and other regulatory bodies adopt and use them.

j

- Jurisdictions (Medicare)
  - **Jurisdiction A:** Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont, and the District of Columbia.
  - **Jurisdiction B:** Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.
  - **Jurisdiction C:** Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia, as well as Puerto Rico and the U.S. Virgin Islands.
  - **Jurisdiction D:** Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, Guam, and Northern Mariana Islands.

k

- K-codes – Medicare will assign a temporary K-code to a new and/or questionable device or device category.
  - Example, the A5514 was previously K0903 while it was under consideration for permanent inclusion on the fee schedule.

|

- L-codes – are HCPCS codes for Orthotics and Prosthetics procedures and devices
- Local Coverage Determination (LCD) - Is a decision made by a Medicare Administrative Contractor (MAC) on whether a particular service or item is reasonable and necessary, and therefore covered by Medicare within the specific region that the MAC oversees.

m

- Modifiers – These are used in conjunction with HCPCS codes when submitting a claim to an insurance carrier. Modifiers often lead to confusion with our customers who are new to the diabetic shoe program and/or billing and coding.
- Medicaid – State administered health coverage for eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Program is jointly funded with state and federal money.
- Medicare - The federal health insurance program for people who are 65 or older, and certain younger people with disabilities.
- Medicare Replacement Plan - A type of Medicare health plan offered by a private company that contracts with Medicare to provide the Medicare Beneficiary with Part A and Part B benefits. If someone has a Medicare Replacement Plan…they do NOT have Medicare. Often called *Advantage* plans.

n

- Network provider (In-network provider) – A provider or supplier who is contracted to provide services for reimbursement from an insurance carrier.
- Non-participating provider (Medicare) – A provider who has signed up to accept Medicare but has not agreed to accept assignment (Medicare allowable rates) on *every* claim.

O

- Out-of-Pocket Maximum – Most insurances will have a maximum annual amount that the patient has to pay after which their coverage is 100% for the remainder of the year.
- Office of Inspector General - HHS OIG is the largest inspector general's office in the Federal Government, with approximately 1,600 dedicated to combating fraud, waste and abuse and to improving the efficiency of HHS programs. A majority of OIG's resources goes toward the government oversight of Medicare and Medicaid—programs that represent a significant part of the Federal budget and that affect this country's most vulnerable citizens. OIG's oversight extends to programs under other HHS institutions, including the Centers for Disease Control and Prevention, National Institutes of Health, and the Food and Drug Administration.

p

- Participating Provider (Medicare) – A provider who has signed up to accept Medicare and agrees to bill and accept assignment on every claim.
- Preferred Provider Organization (PPO) - A type of insurance plan that offers more extensive coverage for the services of healthcare providers who are part of the plan's network, but still offers some coverage for providers who are not part of the plan's network. PPO plans generally offer more flexibility than HMO plans, but premiums tend to be higher.
- PDAC (Pricing, Data Analysis and Coding) – The branch of Medicare that determines whether a product is “Medicare approved” and, therefore, billable.
  - https://www.dmepdac.com/
- Policy Article – According to Medicare, the term “article” to describe any bulletin article, website article, educational handout or any other non-LCD document intended for public release that contains coverage/coding statements or medical review related billing or claims considerations.
- PECOS - Provider, Enrollment, Chain and Ownership System. It is a database where physicians register with the CMS. CMS developed PECOS as a result of the Patient Protection and Affordable Care Act. The regulation requires all physicians who order or refer DMEPOS services or supplies to be enrolled in Medicare.

r

- Referral - A written order from a PCP for a patient to see a specialist or get certain health care services. In HMOs, a patient needs to get a referral before they can receive health care services from anyone except their PCP. Without a referral, the plan will not pay for the services.
- RAC Audit – A Medicare audit performed by a Recovery Audit Contractor. Any fee-for-service claim is subject to a RAC audit.

S

- Secondary Insurance – A secondary insurance typically picks up the 20% of the allowable amount for which a Medicare beneficiary is responsible.
- Supplemental Insurance – An additional insurance that provides coverage for services and/or devices not covered by Medicare.

t

- TPE (Targeted Probe and Educate) – CMS program designed to help providers and suppliers reduce claim denials and appeals through one-on-one help. TPE is intended to increase accuracy in very specific areas.
  MACs use data analysis to identify:
  - Providers and suppliers who have high claim error rates or unusual billing practices, and
  - Items and services that have high national error rates and are a financial risk to Medicare.
  - Providers whose claims are compliant with Medicare policy won't be chosen for TPE.

U

- UCR (Usual, Customary and Reasonable) - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

V

- Verification of Benefits (VOB) – A VOB specialist is someone who contacts insurance carriers to verify a) that a patient has active coverage; b) what is or is not covered; and c) what the patient will owe out-of-pocket.

W

- Waiting period — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

Z

- ZPIC Audit – More serious than a RAC audit is the Zone Program Integrity Contractor audit. ZPICs are responsible for ensuring the integrity of *all* Medicare claims. A ZPIC's main focus is to identify fraud and abuse. ZPICs are not conducting random reviews, but focused audits, when they suspect fraud and abuse.

The End