

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-1530

In the case of

Cornerstone Prosthetics
and Orthotics

(Appellant)

(Beneficiary)

DME MAC (Jurisdiction D)

(Contractor)

Claim for

Supplementary Medical
Insurance Benefits

(Part B)

(HIC Number)

(ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 1, 2011, which concerned the appellant's claim for Medicare coverage of an upper extremity prosthesis, specifically an articulating fingers and thumb user, which the appellant provided to the beneficiary on June 26, 2009. The ALJ determined that reimbursement for this equipment was included as part of the reimbursement for the hand prosthesis provided on that date, and thus no additional payment was due for the additional codes. The ALJ also held the appellant liable for the resulting non-covered costs. The appellant has asked the Medicare Appeals Council to review this action. The appellant's request for review, which includes procedural and evidentiary documents previously admitted into evidence, is entered into the record as Exhibit (Exh.) MAC-1.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

The Council has considered the record and exceptions and finds no basis to change the ALJ's decision.

BACKGROUND

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The beneficiary is a quadrimembral amputee, born without arms or legs, with a right transhumeral prosthesis. Based upon prosthetic equipment furnished to the beneficiary on June 26, 2009, the appellant submitted a claim for Medicare coverage under HCPCS¹ code L7007RT (electronic hand, switch or myoelectrical controlled, adult) and two line items under code L7499RT (upper extremity prosthesis, not otherwise specified). See Exh. 2 at 4. Specifically, the two L7499 line items represented five multi-articulating prosthetic fingers and a thumb user positional feature. See Exh. 4 at 2; see also Exh. 6 at 2. The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) reimbursed the appellant for the L7007 claim line, but denied coverage for the two L7499 line items. Exh. 2 at 1. Following the appellant's request for redetermination, the DME MAC again denied coverage for the two L7499 claim lines finding that coverage for the equipment represented by those claim lines was included in the reimbursement the appellant had received for the electric hand, switch or myoelectric controlled (L7007) which had also been provided to the beneficiary. Characterizing financial liability as "supplier responsibility," the DME MAC found the appellant liable for the resulting non-covered costs. Exh. 4 at 2-3.

The appellant requested reconsideration by a Qualified Independent Contractor (QIC). The QIC denied coverage finding that the "billing for procedure code L7499, upper extremity prosthesis is included in the allowance of procedure code L7007, electric hand, when provided at the same time. The items cannot be billed or charged separately. Therefore . . . no additional payment can be made." Exh. 8 at 2. The QIC held the appellant liable for the associated non-covered costs. *Id.*

In its subsequent request for an ALJ hearing, which included additional documentation not in the record before the QIC, the appellant noted that it had provided "the multi-articulating prosthetic fingers and thumb" to the beneficiary believing that they were not separately reimbursable. The appellant explained that it had billed Medicare in order to exhaust the claims appeal process prior to billing the beneficiary. Exh. 9 at 1. However, the appellant indicated that, subsequent to the QIC's reconsideration, -

¹ HCPCS, the Healthcare Common Procedure Coding System, is a coding system developed by CMS for processing, screening, identifying and paying Medicare claims. See 42 C.F.R. §§ 414.2 and 414.40.

it has come to our attention that these items should be covered. We have also recently discovered that several federal courts have found that Medicare/Medicaid reimbursement at low levels that make a covered item or service unavailable to beneficiaries when the item is intended by Medicare to be a covered item is not permitted. Medicare could not have intended for the L7007 code to include the sophisticated multi-articulating digits knowing that the cost of technology significantly exceeds the level of reimbursement established for that code. Therefore, at this time we are submitting documentation that had not been submitted previously. Enclosed you will find Form 20034, a statement from the vendor (Touch Bionics) addressing the issue about the fingers being excluded in the base code, L7007, a letter of medical necessity from the prosthetist and one from the referring physician, the referring physician's chart notes, the prosthetist's chart notes, a letter from the patient explaining that she had come to Cornerstone requesting this particular hand with multi-articulating fingers and thumb, Form 20031, original prescription, Medicare-compliant prescription, and vendor's information on the devices and their uses.

Exh. 9 at 1.

On June 14, 2010, the ALJ conducted a hearing by telephone. The appellant's representative, assisted by several individuals also in the appellant's employ, presented the appellant's case. The DME MAC was present as a non-party participant. Generally, the appellant offered testimony that the July 2007 development of the articulating prosthetic fingers and thumb user, postdated the January 2007 creation of the L7007 billing code. Thus, the appellant asserted that, as a practical matter, the L7007 code was meant to encompass predecessor equipment, which the appellant's witness identified, specifically, as a "3-jaw chuck grip." The appellant acknowledged that there was not a specific HCPCS code for the articulating prosthetic fingers and thumb user. However, the appellant testified that it had been advised by the DME manufacturer, Touch Bionics, that since reimbursement under the L7007 code would not cover the costs of the articulating prosthetic fingers and thumb user unit, the appellant should bill Medicare for that equipment under code

L7499 in addition to the general billing for L7007. See ALJ Hearing CD (June 14, 2010); see also Exh. 13 at 26-30.

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In the ensuing decision, the ALJ found good cause to admit into evidence the documentation offered by the appellant with its request for hearing. Dec. at 1. However, the ALJ denied coverage, reasoning that the appellant -

used the procedure code L7499 because they feel as though Medicare could not have intended for procedure code L7007 to include the sophisticated multiarticulating digits. As the QIC correctly found, the articulating prosthetic finger and thumb user cannot be billed when simultaneously billing procedure code L7007 because the articulating prosthetic finger and thumb user is included in the hand prosthesis. Therefore, upon a complete review of the file, applicable laws, rules and regulations, and the testimony at the hearing, this claim will not be covered by Medicare pursuant to Section 1862(a)(1) of the [Social Security] Act, Section 1833(3e) of the Act and Medicare policy guidelines.

Dec. at 4. The ALJ also found the appellant liable for the non-covered costs. *Id.*

The appellant's request for review is premised on its "belief that the ALJ had a lack of understanding regarding the Lcode (*sic throughout*) system used in the prosthetic and orthotics industry, and therefore did not have sufficient background information to make an informed decision." Exh.

MAC-1 at 1. The appellant explained that the Lcode system is not a bundled coding system. Rather, it is a system of "Base Codes," e.g., L7007, which describe the foundation of a device which, in most cases cannot be used alone, and "Addition Codes," e.g., L7499, used to indicate modifications to a device that are necessary to ensure proper fit and function for a patient. *Id.* at 2.

The appellant concedes that "there is not currently a specific Lcode for the fingers and thumb unit." However, the appellant references an October 31, 2008, letter from CMS to Touch Bionics (the manufacturer of this equipment) which indicates that L7499 is the appropriate billing code. See Exh. MAC-1 at 2; see also Exh. 13 at 1-2.

The appellant further notes that the L7007 and L7499 codes are not found on the CMS Mutually Exclusive Edit Table and thus are appropriately billed together. Exh. MAC-1 at 3. Finally, the appellant asserts that the ALJ misinterpreted the hearing testimony. The appellant reasons that the ALJ interpreted testimony from its representative as being that the articulating prosthetic fingers and thumb user was an integral part of the L7007 hand assembly, as provided. However, the appellant explains the testimony of its witness to be that the articulating prosthetic fingers and thumb user are "integral" in that the unit "would not meet the fundamental or functional needs for the patient if they were not provided." *Id.*

DISCUSSION

Based on our review of the record, which includes a written statement from the beneficiary (Exhibit 9, page 18), the Council recognizes the lifestyle improvement provided by the articulating prosthetic fingers and thumb user unit at issue. However, the question presented is the correct manner of Medicare reimbursement for these items of DME, not whether the fingers and thumb user was medically reasonable and necessary. Based on the facts and applicable law, the Council concludes that separate line item billings of code L7499 for the fingers and thumb unit is not warranted.

The October 31, 2008 letter from CMS to Touch Bionics does not carry the dispositive weight suggested by the appellant. In that letter, CMS noted that HCPCS code "L7499 was available for assignment by all payers." Mere assignment of a billing code does not import coverage. Moreover, prior to discussing the availability of the L7499 code, CMS also explained that there was insufficient information available upon which to base the coding change sought by Touch Bionics. Additionally, CMS found that no "insurer [had] identified a national program operating need to establish a separate code for these devices." Exh. 13 at 3-4

Moreover, CMS indicated that "individual [Medicare Administrative Contractors] have the necessary flexibility to classify specific products into HCPCS Level II code categories and establish their own coding instructions in accordance with their policies and program operating needs." CMS directed the manufacturer to submit billing questions to the DME MAC with jurisdiction for the particular billing area. Exh. 13 at 4.

The appellant's billing in this case is driven, not as the result of direct consultation with its DME MAC or CMS, either of whom may have articulated the applicable payment policy, but rather, upon the advice of the DME manufacturer, whose interest, understandably, is in maximum reimbursement. The Council recognizes that the articulating prosthetic fingers and thumb user were created *after* the code encompassing the hand prosthetic with the three-jaw chuck grip was established. The Council also accepts that the devices at issue may represent a significant technological advance over the previous design(s). However, like the HCPCS, the DME MAC (Noridian) DMEPOS Fee Schedule specifically employs the L7007 code to identify an "electric hand, switch or myoelectric controlled, adult." Barring any pertinent changes in coding classifications, the mere fact that an improved hand is subsequently developed does not make the improved hand any less an "electric hand" as envisioned by L7007, which encompasses the entire prosthetic.

Further certain arguments in the appellant's request for review are inherently contradictory and undercut by its hearing testimony. Before the Council, the appellant first asserts that a "Base Code," such as L7007, describes the foundation of a device which, in most cases cannot be used alone, while "Addition Codes," such as L7499, identify modifications to a device that are necessary to ensure proper fit and function for a patient. Exh. MAC-1 at 2. However, the appellant now interprets the hearing testimony of its primary witness to be that the prosthetic fingers and thumb user are an "integral part of the hand assembly" in that the unit "would not meet the *fundamental or functional* needs for a patient if they were not provided." *Id.* at 3 (emphasis added).

Thus, before the Council, the appellant describes the prosthetic fingers and thumb user to be both a *modification* to a device (reimbursable under code L7499) and an *integral, fundamental part* of the larger prosthetic device, without which it would not function. This fundamental part, whether a three jaw chuck grip or the articulating prosthetic fingers and thumb user, is included in the prosthetic that the L7007 code is intended to represent, that is, an electric hand.

Moreover, in response to a question from the ALJ, the appellant's primary witness testified that the L7007 device is inoperable without the fingers and thumb user. See ALJ Hearing CD at (approx.) minutes 21-22. If the L7007 code was created to represent an electric hand, it is not reasonable to expect reimbursement for the provision of an electric hand without

fingers under a billing code L7007. The fact that the current ⁷
"electric hand" represents an improvement over the unit in
existence at the time the code was created certainly presents
the conflict evident in this case, but does not, standing alone,
entitle a provider or manufacturer to additional Medicare
reimbursement.

The appellant has provided no basis for entitlement to
additional reimbursement for the articulating prosthetic fingers
and thumb user unit provided to the beneficiary. The appellant
has not challenged the ALJ's findings on liability.

The Council therefore adopts the ALJ decision.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: June 19, 2012