The Practice Management of Off-loading

BY JONATHAN MOORE, DPM, MS

While it is quite clear that much has been postulated on the topic of “off-loading the diabetic foot”, there has been little discussed regarding the practical issues of knowing what products to use and when and how to get reimbursed for them (if you can get reimbursed for them).

It is not my intent to convince the reader to start off-loading your complicated diabetic or non-diabetic patients who have orthopedic conditions or those that need off-loading for wound healing (as not doing so is below the standard of care). The purpose of this article is to share some key principles on the practice management of off-loading or stabilizing the challenging foot or ankle.

The problem is that what we consider the standard of care or even common knowledge doesn’t always translate into practice.

Stephanie Wu, DPM recently published an article in Diabetes Care demonstrating that less than 2% of the over 900 clinical practices that treat plantar ulcers surveyed in the U.S. were using what most consider the “gold standard” in off-loading—the total contact cast (TCC). Less than

TABLE 1

Physician Office Setting—Reimbursement

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Descriptor</th>
<th>Medicare Physician Reimbursement Physician Office (National Average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 29445</td>
<td>Application of rigid total contact leg cast</td>
<td>(137.26)</td>
</tr>
<tr>
<td>Q4037</td>
<td>Cast supplies, short leg cast, adult (11 years +), plaster</td>
<td>(14-15.00)</td>
</tr>
<tr>
<td>Q4038</td>
<td>Cast supplies, short leg cast, adult (11 years +), fiberglass</td>
<td>(30-40.00)</td>
</tr>
</tbody>
</table>

1) TCCs must be applied by experienced technicians who have at least 20-30 minutes to apply each cast. Rushing this process or not using the right technique or materials can have disastrous results. Not only is time a factor, but lack of experience applying is also a key issue despite favorable reimbursement (Table 1).

Less than 16% of clinics studied were using a removal cast walker (RCW).

Less than 16% of clinics studied were using a removal cast walker (RCW). Most of the clinics, according to the study, were using shoe modifications only.1

While the benefits of the TCC are widely published2-12 why is there such a disconnect with its utilization among providers? Here are some thoughts:

2) Many practitioners are not familiar with coding and billing procedures with TCCs and are even less aware of correct documentation requirements. Even for those who are familiar with proper billing and coding for application of TCCs, many don’t find the reimbursement worth the inordinate amount of time it takes to apply them.

3) With several studies having been done recently regarding the comparable benefits of RCWs (versus the TCC), many practitioners have adopted the use of these tools instead of the TCC.13,14

4) Technological advancements in the areas of biological...
tissues and dressings that require frequent inspection and application make TCC use difficult. 5) The disability, risk for falling, further ulceration, and infection along with the potential for other ailments with the use of a TCC discourage many from utilizing this tool despite the fact

Continued on page 122

FIGURE 1

FOOT AND ANKLE PRESCRIPTION FORM

Patient Name: ___________________________ Date: ___________________________

DX:
- Achilles contracture 727.81
- Instability of Joint/Antikle 718.87
- Achilles tendonitis/bursitis 726.71
- Ankle fusion 755.89
- Ankle osteoarthritis 715.17
- Apophysitis 732.5
- Arthritis (Osteo) 719.80.
- Arthritis (Rheum) 714.0
- At Risk/History of Fall (V15.88)
- Bunion 727.1
- Heel spur 726.73
- Cavovarus foot (acq) 735.75
- Cubitus foot 736.73
- Charcot 713.5
- Charcot-Marie-Tooth: 356.1
- Claw toe 735.5
- CVA-other late effects: 438.9
- Diabetes 250.____ (must include 2 digits)
- DJD 715.0, 715.
- Drop Foot-other: 738.79
- Equinus foot 736.72
- Gait abnormality/staggering 781.2
- Hallux Rigidus 735.2
- Hallux Valgus (acq) symptomatic 735.0
- Hammer toe 735.4
- Leg Length Discrepancy acq, 736.81
- Metatarsalgia 726.70
- Muscle weakness 728.87
- Neuroma 355.6
- Peroneal Tendinitis 726.79
- Pes planus (acq) 734.
- Pes planus (cong.) 754.61
- Plantar fasciitis 728.71
- Rupture, Tendon, Ankle & Foot (727.68)
- Sesamoiditis 733.99
- Stress fracture unspec, 733.10
- Tarsal tunnel 355.5
- Tendonitis, Tibialis (726.72)
- Tibialis Tendinitis (posterior or anterior) 726.72
- Unspecified deformity of the ankle/foot, acq., 736.70
- Other:

- Anticipated Length of need: □ 1 mos □ 3 mos □ 6 mos □ 1 year □ > 1 year
- Goals of treatment: Resolution of symptoms, stabilization of an injured area, reduction of pain, increase mobility or primarily address an orthopedic condition.
- The primary objective of this device is to address an orthopedic condition.
- I hereby certify that the product prescribed above is medically necessary in order to support/stabilize or facilitate rapid recovery for the condition for which they have presented. The items were dispensed in new, not substandard, condition and the patient was verbally taught how to use the product at home. Wear, break-in information was dispensed along with the 30 DME supplier standards.

Physician Signature ___________________________ Date ___________________________
that it may be the “gold standard.”

6) Despite Medicare’s stated restriction of utilizing RCWs for “pressure relief,” many still use RCWs because they reimburse better and are easier to administer than a TCC.

On the other hand, why the disconnect between studies highlighting the benefits of RCWs (their comparability to the TCC) and actual utilization?

1) Medicare’s mandate that RCWs are not reimbursable for the purpose of “relieving pressure” has significantly curtailed the utilization of RCWs for the purpose of off-loading the complicated foot; however, the lack of information discussing circumstances in which the use of a RCW would be appropriate is disconcerting.

2) Once again, there is a considerable lack of understanding regarding documentation for utilization of RCWs, even for those who have a clear orthopedic condition that qualifies one for application of a RCW. Not knowing exactly what qualifies as an “orthopedic condition” has confused enough podiatric doctors to further lower utilization.

3) Clearly, as RCWs are removable and compliance among some is poor, the RCW may not be the best option under some circumstances. Despite the fact that any RCW can be easily converted into a non-removable RCW with the use of fiberglass or plaster, this technique is apparently not being employed by most podiatric physicians.15

The bottom line is that NOT off-loading appropriately and utilizing the proper tools for the needs of your patient falls well below the standard of care.

In our practice, we use both RCWs and TCCs, though the majority of our patients are off-loaded with RCWs. Our office utilizes the Ossur pneumatic RCW, the Ossur DH, the Bledsoe Conformer, and the Zero G suspension ankle foot orthosis (AFO).

**TCC Coding**

The application of a TCC (CPT 29445: application of a rigid total contact cast, half leg, adult) unfortunately does not account for the cost of casting materials in the practice expense relative value unit (PE-RVU) calculation used by Medicare and other payers to establish a payment fee for application. There is a 0-day global with the utilization of CPT 29445.

While cast supplies are usually only payable with a diagnosis of a fracture or a dislocation, CMS’ directive on cast supplies does allow for an exception with a TCC—i.e., supply codes may be used with a diagnosis of Charcot (CPT 713.5) and/or foot ulcer (CPT 707.1X). The directive, however, only permits for 1 supply unit to be billed, no matter how much material is utilized. Some Medicare carriers continue to incorrectly reject the supply codes for TCC despite the CMS directive. The result is that practitioners will need to file for a redetermination when a TCC is billed with a diagnosis other than fracture or dislocation.

Unlike the RCW, planter ulcerations are an appropriate indication for the TCC (CPT 707.06, 707.7, 707.10, 707.12, 707.13, 707.14, 707.15, 707.19).

CPT 29445 is bundled into most debridement codes (CPT 11042, 97597). The only allowance for the use of the “59” modifier is when another ulcer is being treated on another site or limb where the TCC is being applied (e.g., TCC on RLE and you performed a debridement on the left foot).

Despite innovations in TCC application, like the TCC-EZ® (Derma Sciences) which has made application time much quicker, widespread utilization is still not apparent. We have used the TCC-EZ system and, though much easier to apply, there is still a steep learning curve.

For purposes of laying a groundwork for our discussion regarding the practice management aspect of off-loading, below is the language that has been adopted by Medicare regarding the use of RCWs.

---

**TABLE 2**

**Quick ICD-9 Dx Code Reference List Commonly Used for Richie Brace Prescriptions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateral Ankle Instability</td>
<td>718.87</td>
</tr>
<tr>
<td>Calc-fib Ligament Sprain</td>
<td>854.02</td>
</tr>
<tr>
<td>Charcot Foot</td>
<td>094.0 [713.5]</td>
</tr>
<tr>
<td>Diabetic Charcot Joint, 250.6</td>
<td>(add the appropriate diabetic 5th digit) and [713.5]</td>
</tr>
<tr>
<td>Degenerative Joint Disease of Ankle &amp; Rearfoot</td>
<td>715.17, 719.47</td>
</tr>
<tr>
<td>Tarsal Coalition, 755.87</td>
<td></td>
</tr>
<tr>
<td>Adult Acquired Flatfoot (PTTD)</td>
<td>734</td>
</tr>
<tr>
<td>Rupture, Tendon; Ankle and Foot</td>
<td>727.68</td>
</tr>
<tr>
<td>Pronation, Acquired, 736.79</td>
<td></td>
</tr>
<tr>
<td>Tendinopathy of Ankle</td>
<td>726.72, 726.79</td>
</tr>
<tr>
<td>Tibial</td>
<td></td>
</tr>
<tr>
<td>Peroneal</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from www.richiebrace.com/pdf/quick%20icd9%20code%20list.doc
HCPCS codes L4360 and L4386 are ankle-foot orthoses that are referred to as walking boots. Walking boots that are used to provide immobilization as treatment for an orthopedic condition or following orthopedic surgery are eligible for coverage under the brace benefit. When walking boots are used primarily to relieve pressure, especially on the sole of the foot, or are used for patients with foot ulcers, they are non-covered—no benefit category. Medicare covers therapeutic shoes, as described in the Therapeutic Shoes for Diabetics LMRP, for the prevention and treatment of diabetic foot ulcers.

GY Modifier
Suppliers must add a GY modifier to HCPCS codes L4360 and L4386 if the walking boot is only being used for the treatment or prevention of a foot ulcer. The absence of a GY modifier indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery.

The absence of a GY modifier indicates that the walking boot is being used as part of the treatment for an orthopedic condition or following orthopedic surgery.
If a patient has an underlying orthopedic condition along with an ulcer, make sure your note reflects that you are treating both conditions separately.

In the above case, a good RCW will stabilize the deformity, reduce pain, swelling, but secondarily it may aid in healing an ulcer.

In our practice, the debridement that we perform and the wound dressings that we dispense are used as the primary treatment modality for the ulceration, while the underlying deformity that we are also treating will be addressed primarily by the RCW.

As with many areas in Medicare policy, we are left to try to interpret correctly what they want from us in order for us to remain compliant.

In the case of utilizing RCWs in practice, there are several vital tools that must be in place in order to remain compliant.

If a patient has an underlying orthopedic condition along with an ulcer, make sure your note reflects that you are treating both conditions separately.

For example, your assessment should look something like this:

**Assessment and Plan**

1) Severe TN joint collapse with associated osteoarthritis and intrinsic muscle atrophy right foot. X-rays have been evaluated which reveal ___ (See x-ray report). The patient’s deformity along with their neuropathy and diabetes make this patient significantly higher at risk for ulceration and amputation. Today, the patient was dispensed a RCW (specific name along description of product; L4360/L4386) for the primary purpose of stabilizing this patient’s deformity, improving mobility, reducing pain, and to allow the patient to resume activities of daily activity. The patient was educated regarding surgical intervention and the patient was given written and oral educational material to make him aware of his condition. Prognosis: Good (See attached prescription)

2) Wagner Grade 2 ulcer plantar aspect of right TN joint. The ulcer measures 3 cm x 1 cm with a depth of 4mm. There is neither drainage nor signs of infection, but the wound is full thickness. The wound is dry with keratotic borders. The bases of the wound is ____. Today the patient was prescribed Amerigel Hydrogel Saturated Gauze (number of products dispensed along with A code). (see attached prescription).

3) Diabetes/Neuropathy Risk Category 3.

It should be made clear that along with proper documentation in the note, a prescription is placed into the medical record with detailed information about the product including the goals of treatment and instructions for use. Figure 1 illustrates an example of what should be incorporated into a prescription for an RCW.

It is often the case that, no matter what the actual statistics demonstrate, cries of “overutilization” and audits scare many doctors from using the tools that would help their patients. However, doctors need to be made aware of the policy along with
the tools for proper documentation and then be allowed to use their common sense instead of being motivated by fear of an audit.

To be clear, one should not submit a RCW for reimbursement to Medicare if the primary purpose of the device is to offload or remove pressure. It is my opinion that even if the ulcer patient has a qualifying orthopedic condition, if notes are not clear as to your goals and objectives and if x-rays or no further evidence of treatment of the orthopedic condition are evident, the RCW should NOT be billed for reimbursement.

Medicare 2009 BMAD data indicates that podiatric physicians, on average, dispensed approximately 4 pneumatic and non-pneumatic walking casts per year. Clearly, there does not appear to be a financially motivated over-utilization of these types of devices, but rather just the opposite. It may be simply that providers simply don’t understand how to document properly and remain compliant with Medicare DME supplier standards.

**Commonly Used In-Office Removable Cast Walkers**

**Ossur Equalizer Air Walker (short/tall) L4386**

While this product is well known for its indications in post surgical or trauma cases, this device possesses characteristics that are also valuable in those patients who have orthopedic deformity that requires stabilization for healing.

While pneumatic products are indicated primarily in cases where there is edema or swelling, we find this to often be the case clinically. If the patient has no swelling or edema, a non-pneumatic device should be considered.

This device is easy to put on and is lighter than some of the other devices on this list, but it also is not indicated in very heavy patients as the softer interface material can break down rapidly. The rocker-bottom component is designed to promote a more natural, stable gait while providing comfort with the foam liner.\(^\text{16}\)

Obviously this device does not have a plantar insole that has the shock absorbing hexagon pieces like the DH Off-loader, but in the event that you want to add more shock absorption to the Equalizer, a Peg Assist (from Darco) can be placed into the bed. (www.ossur.com)

**Ossur DH Off-loader (L4360)**

The DH Off-loading walker has been used in comparative studies with the TCC which highlight the DH’s offloading characteristics and even its similar offloading capabilities.\(^\text{13,14}\)

As this product is designed

[Continued on page 126]
specifically to remove plantar pressure, it is fundamentally a non-pneumatic walking boot with a patented pressure relief insole to assist in the healing of plantar ulcers. As such, this product has been deemed inappropriate to submit for reimbursement to Medicare if its primary purpose is to off-load. If the primary goal of the RCW is to off-load, it is a non-covered item. If the primary intent of using this or any like RCW is to address an orthopedic condition whereby stabilizing foot and ankle at 90° is a part of the objective, according to Medicare policy, there should be coverage if medical justification is maintained in the patient’s record.

Though the DH Walker is an effective “off-loading” RCW, it can serve the same purpose as a non-pneumatic walking boot with a rocker bottom for added gait stabilization and orthopedic stabilization. The DH Walker, like the Ossur Equalizer Walker, has a construct that is supportive yet the shell is plastic, which can be difficult for larger patients (www.ossur.com).

**Bledsoe Conformer/Charcot Conformer L4360**

Another product that can be used for both immobilization of the foot and ankle from trauma, Charcot or any other orthopedic condition, and also features characteristics that reduce foot pressure, is the Bledsoe Conformer.

Diabetic Boot. We have used the product with good success for years as it has a solid aluminum shell with an over-1-inch pre-molded dual density foot bed. In many ways this device is comparable to a TCC in that it facilitates even weight distribution, reducing peak pressures that cause ulceration. The aluminum boot shell is adjustable to fit most leg sizes.

With a stable construct, rocker-bottom base, and excellent multi-density foot bed, this product is a good option for your complicated diabetic patients with orthopedic deformity. The Bledsoe Conformer does have a pneumatic option and there is a slightly different design available in the Charcot Conformer (L4360). This design possesses a winged patellar tendon bearing plate attached in order to enhance weight transfer away from the foot. Pollo used the Bledsoe Conformer boot in a comparison study with the TCC, finding that there was comparable or even better reduction of plantar peak pressures.

The **Zero-G** is an excellent alternative for the severe orthopedic condition that requires maximum stabilization (even in very heavy patients) along with the need for off-loading.

**Zero-G Suspension AFO (Universal Medical, LLC.) L1970, L2220, L2220, L2265**

The Zero-G Suspension AFO is another excellent option for the Charcot patient, or patients presenting with an orthopedic condition co-existing with ulceration. The Zero-G has similar characteristics to the Bledsoe Conformer, but with some additional features. First, the adjustable leather calf corset lacer serves as an extremely effective component providing a total contact, hydrostatic lift of the inverted cone shape of the calf providing enhanced off-loading of the foot.

Additionally, the double upright malleable metal uprights with adjustable joints serve as a very strong construct for stabilization and structural support. Additionally, the excellent foot bed features a layer of 1/4 inch Plastizote overlying a 1 inch thick memory foam. While boasting one of the most shock-absorbing foot beds on the market, this AFO has an optional donning pad tool which is used to suspend the foot in the boot during application. Once the boot is secured firmly around the leg and foot, the donning pad is removed, helping to further “suspend” the foot, thereby reducing plantar pressures.

The Zero-G Suspension AFO comes with a SmartKnit® seam-free sock for soft interface along with an Evenup.
shoe lift for the contralateral side. Because this product is an L1970 and not a L4360 or L4386, (L1970, Ankle Foot Orthosis, Plastic Or Other Material With Ankle Joint, Prefabricated, Includes Fitting And Adjustment) additional documentation, including a medical justification document should be utilized.

Though the Zero-G AFO reimburses considerably higher than the L4060/L4386, this product does have a higher cost. However, in my experience the Zero-G is an excellent alternative for the severe orthopedic condition that requires maximum stabilization (even in very heavy patients) along with the need for off-loading (www.zerogbrace.com).

Pearls for utilization of any RCW for Medicare billing consideration:

1) Document thoroughly what the primary purpose of the RCW will be.
2) If there is a primary orthopedic condition that is being treated, make sure that it has been thoroughly assessed with X-ray or other imaging.
3) Make sure that your notes reflect that you are providing other treatment options and consideration for the orthopedic condition other than simply dispensing a walker.
4) If a significant orthopedic deformity coincides with an ulceration, make sure your treatment plan is specific to each condition with your goals and objectives for each indicating the primary treatment modality for each.
5) Follow Medicare DME supplier standards by having a prescription in the chart for each and every item dispensed (appropriate to be an order incorporated into the body of the note) signed pickup form, wear/warranty/fitting instructions, and medical justification in your note.
6) Do NOT dispense a RCW for Medicare billing if the primary goal of the RCW is to offload or remove pressure.

7) All of the above RCWs can be made non-removable with either fiberglass or plaster. If done properly, the fiberglass will still allow further use of the RCW unless the straps or

Continued on page 128
the fabric become damaged. Consider an under-layer of material over your RCW so as not to ruin the material or the functionality of the RCW.

Although there has been much confusion regarding the practice management of off-loading, this article should provide some assistance to the podiatric practitioner to become better at getting wounds healed and getting their patients more active faster. While the TCC remains the gold standard for off-loading, there are additional options that can be equally effective if utilized in a compliant and ethical fashion. PM

Disclaimer: Every effort has been made to ensure the accuracy of this information. However, the author does not represent, guarantee, or warranty that the coding, coverage, and payment information is error-free and/or that payment will be received. The ultimate responsibility for verifying coding, coverage, and payment information accuracy lies with the reader.

References
7 Wukich DK, Motko J. Safety of total contact casting in high-risk patients with neuropathic foot ulcers. Foot Ankle Int 25(8):556-60.
16 Hanft JR, Surprenant MS. The use of the fixed ankle walker for the treatment of plantar diabetic foot ulcerations. ACFAS Abstract presented at: Joint Annual Meeting and Scientific Seminar, American College of Foot and Ankle Surgeons; February 8-12, 2000; Miami, Fla.