Silver Ring Splints

The following information was obtained through communications with CGS and CMS. This is deemed accurate to the best knowledge of the authors and vetted through the ASHT Practice Division. It is recommended to verify coverage in your area due to DME coverage varies from state to state. In addition, a standard written order is required to bill Medicare for an L-code.

- CGS states therapists cannot bill L3933 for a silver ring splint since therapist are not custom fabricating the silver ring splint. For example, therapists are not cutting, bending, or molding the silver ring splint directly to the patient.
- If a therapist or organization wants to bill an L-code for the silver ring splint, the correct code is L3927. The Medicare allowable rate for Jurisdiction B for L3927 is $36.53.
    - The description for HCPCS code L3927: Finger orthosis (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, off-the-shelf as maintained by CMS falls under Additional Miscellaneous Orthotics, Upper Extremities (https://cgsmedicare.com/jb/pubs/news/2021/10/cope23779b.html)

- Noridian noted that providers have been advised by some coding sources to report a splint application code for the application of "off the shelf" or pre-packaged splints. While it may be appropriate to bill for the actual splint, Noridian strongly disagrees with the advice to bill separately for the application of these splints. The application of the pre-packaged splint is a packaged service when performed on the same day as an E/M service or other procedure but, in no case, may this type of splint application be separately billed. (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=56112)

- Per CGS: CGS does not pre-select codes for providers; in fact, guidelines from the Centers for Medicare & Medicaid Services (CMS) prohibit Medicare Administrative Contractors (MACs), including CGS, from selecting a code or modifier for you. However, we are happy to provide you with guidelines and resources to assist you in making informed decisions and selecting the code (and modifier, if appropriate) that accurately represents the service provided.

(https://cgsmedicare.com/partb/pubs/news/2015/0415/cope29081.html)

Scenarios

1) The patient pays the Silver Ring company directly for the splint. However, the therapist evaluated the patient (measurements and function), determines the appropriate design, instructs on proper wear/care of the orthosis, and then assists with the minor adjustments following the patient receiving the Silver Ring splint. What do you bill?

Initial Evaluations - (CPT ® 97161-97163,97165-97167)

Therapy evaluation and formal testing services involve clinical judgment and decision-making. Therapy evaluations can only be billed when the medical record supports the completion of a medically necessary comprehensive evaluation or formal test. Documentation must support that the service was needed based on the patient's current clinical status or condition.

(https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53309)

Orthotic(s) management and training (including assessment and fitting when not otherwise reported) (CPT 97760)

In situations where the case is more straight forward and does not require a full evaluation 97760 is also an option.

https://www.aota.org/practice/practice-essentials/coding/orthotics/orthotics-faqs#:~:text=97760%20and%2097761%20are%20utilized,if%20an%20orthotic%20is%20fabricated.

2) The patient is billed for the Silver Ring directly from the healthcare organization/clinical provider. However, the therapist completed the measurements to order the orthosis and assists with the minor adjustments following the patient receiving the Silver Ring splint. What do you bill?

L3927

If the orthotic is not fabricated on-site, it will most likely have an appropriate L code for billing. Some practitioners will send the client to a supplier who will bill Medicare directly for the orthotic. Others may choose to keep a supply of these orthotics in the therapy clinic and bill Medicare when they are dispensed. If billing an L code for the orthotic, 97760 and 97761 should only be used for the initial orthotic or prosthetic encounter when training is completed during that encounter and training alone exceeds 8 minutes. Payment for fitting a custom-fit orthotic is included in the L code and should not be separately billed.

(https://www.aota.org/practice/practice-essentials/coding/~/link.aspx?_id=B12912168B804BE08230523C222E178F&_z=z)