Comparative Billing Report

August 22, 2016

CBR #: CBR201612
Topic: PAP/RAD & Accessories
NPI #: 1111111111
Fax #: (888)555-5555

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Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm headquartered in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs provide comparative data on how an individual health care provider's billing and payment patterns for selected topics compare to his/her peers. CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS' files, and review Medicare guidelines to ensure compliance. CBRs are for educational and comparison purposes and do not indicate the identification of overpayments. **Please note, no reply is necessary**.

Attached is a CBR that reflects your billing or referral patterns compared to peer providers' patterns for the same services in your state and nationwide. We recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed for the CBR. We hope you find this CBR beneficial as an educational tool to assist you in identifying opportunities for improvement. If you have any questions regarding this CBR or if you want to change the way you receive CBRs in the future, please contact the CBR Support Help Desk.

- Toll Free Number: 1-800-771-4430
- Email: CBRsupport@eglobaltech.com
- Website: http://www.cbrinfo.net

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system.

You can update your National Provider Identifier (NPI) contact information in NPPES at https://nppes.cms.hhs.gov/NPPES. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at 1-800-465-3203 or email customerservice@npienumerator.com.

We hope you find the attached report informative.

Sincerely,

Virna Elly
CBR Program Director
eGlobalTech

Enclosure

Comparative Billing Report (CBR): NPI 1111111111
Positive Airway Pressure Devices and Respiratory Assist Devices and Accessories

Introduction

This comparative billing report (CBR) focuses on suppliers who dispensed Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for positive airway pressure (PAP), respiratory assist devices (RAD), and accessories to Medicare beneficiaries. The metrics in this report include:

- Average allowed services per beneficiary by category
- Percentage of most costly services by selected categories
- Average allowed charges per beneficiary

The categories, Healthcare Common Procedure Coding System (HCPCS) codes, and descriptions included in this CBR are listed in Table 1 below:

Table 1: PAP Devices, RADs and Accessories by Category and HCPCS Code

Category	HCPCS Code	Description
Filters	A7038	Filter, disposable
Filters	A7039	Filter, non-disposable
Humidifiers	E0561	Humidifier, non-heated
Humidifiers	E0562	Humidifier, heated
Masks	A7027	Combination oral/nasal mask
Masks	A7030	Full face mask
Masks	A7034	Nasal interface
Other	A7028	Replacement oral cushion for combo mask
Other	A7029	Replacement nasal pillows for combo mask
Other	A7031	Replacement facemask interface
Other	A7032	Replacement nasal cushion for mask
Other	A7033	Replacement nasal pillows for cannula
Other	A7035	Headgear
Other	A7036	Chinstrap
Other	A7044	Oral interface
Other	A7045	Replacement exhalation port
Other	A7046	Replacement water chamber
PAP Devices	E0470	RAD without back-up rate feature
PAP Devices	E0471	RAD with back-up rate feature
PAP Devices	E0601	Continuous positive airway pressure (CPAP) device
Tubing	A4604	Tubing with heating element
Tubing	A7037	Tubing without heating element

The Office of Inspector General (OIG) has found that PAP devices, RADs and accessories are vulnerable to fraud, waste, and abuse. In their April 2012 report titled *Claim Modifier Did Not Prevent Medicare From Paying Millions in Unallowable Claims for Selected Durable Medical Equipment*, OIG investigators reviewed claims appended with the KX modifier. By adding the KX modifier, the supplier attests that the claim meets the Medicare coverage criteria and that the specific required documentation, which varies based on the DMEPOS item, is on file before the claim is submitted to the contractor. Sixty-five (65) percent of the items related to RADs and 59 percent of the items related to continuous positive airway pressure (CPAP) devices reviewed had one or more errors. The OIG also included the billing trends of RADs and CPAP devices in their Work Plan Fiscal Year 2016.

In another OIG report titled *Replacement Schedules for Medicare Continuous Positive Airway Pressure Supplies*, investigators assert that "in 2012, HHS's Centers for Medicare & Medicaid Services (CMS) found that beneficiaries receiving continuous positive airway pressure (CPAP) treatment for obstructive sleep apnea may have received more supplies (e.g., masks, tubing) than medically necessary; however, the quantities did not exceed the established replacement schedule. Providing more supplies than necessary may lead to wasteful spending." The study revealed that "as part of the review, CMS staff telephoned beneficiaries who had claims for CPAP replacement supplies prior to the inception of the competitive bidding program, but no claims for supplies thereafter. The beneficiaries reported that they had more than enough supplies on hand, often multiple months' worth, and, therefore, did not need to obtain additional supplies after the competitive bidding program began." Given the findings included in the report, CMS concluded that the study "suggests that beneficiaries received replacement supplies before they became medically necessary."

According to *The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report*, CPAP devices had an improper payment rate of 40.4 percent, and RADs had an improper payment rate of 67.7 percent. The 2014 Comprehensive Error Rate Testing (CERT) Claims Data found HCPCS code E0601 to have an error rate of 34 percent, E0470 to have an error rate of 57 percent, and E0471 to have an error rate of 48 percent. The overall improper payment rate for PAP devices and accessories was 53 percent.

Ongoing reviews of CPAP devices by CGS Administrators ®, LLC and Noridian Healthcare Solutions, Inc. have found high error rates due to the following:

- Missing or insufficient documentation
- Missing written order prior to delivery
- No evidence of face-to-face clinical evaluation prior to sleep study
- Invalid sleep studies
- Missing evidence of continued device usage
- Insufficient documentation to support above normal supply usage

Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. **The information provided does not supersede or alter the coverage and documentation policies, as outlined in the Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

Basic Coverage Criteria

Suppliers must receive, and maintain on file, all required physician-generated documentation to ensure coverage and reimbursement.

Initial Three Months Coverage Requirements for HCPCS code E0601:

- Signed and dated prescription or Detailed Written Order (DWO) from treating physician
- Face to face clinical evaluation
- Valid sleep study
- Documentation beneficiary received instruction from supplier in proper use of the device

Continued Coverage for HCPCS code E0601:

- Documentation of beneficiary compliance
- Face to face re-evaluation

According to LCD L33800, RADs (E0470 and E0471) may be covered if the beneficiary has a diagnosis from one of four clinical disorder groups. These groups are restrictive thoracic disorders, severe chronic obstructive pulmonary disease (COPD), central sleep apnea (CSA), and complex sleep apnea (CompSA). The beneficiary must have had a facility-based sleep study and meet additional criteria outlined in LCD L33800.

Devices E0601, E0470, and E0471 are considered "capped" rental items and are paid on a monthly rental basis, not to exceed 13 months. After 13 months of rental, the title for the capped rental item must be transferred to the beneficiary. Once the beneficiary owns the item, Medicare pays for reasonable and necessary maintenance and servicing.

CPAP and RAD supplies are considered non-consumable supplies. LCD L33718 states: "For non-consumable supplies, i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies), the supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill)." Contact with the beneficiary should take place no sooner than 14 calendar days prior to the shipping date. Suppliers should not deliver refills without a refill request from the beneficiary and must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. There is a list of PAP/RAD supplies and their replacement schedules available in LCD L33718.

Methods

This report is an analysis of DMEPOS claims with allowed services for the HCPCS codes listed in Table 1 with dates of service from January 1, 2015 to December 31, 2015. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR), as of June 30, 2016. Your percentages and averages denoted in Tables 3-5 are calculated from the data supplied from your utilization in Table 2, using the formulas below. Your values are compared to your state (RI) and national values using either the chi-squared or t-test at the alpha value of 0.05.

Average Allowed Services per Beneficiary by Category

The average services per beneficiary for you, your state, and the nation are calculated, as follows:

$$\frac{\textbf{Total Allowed Services by Category}}{\textbf{Total Number of Beneficiaries with Allowed Services by Category}}$$

Percentage of Allowed Services for Most Costly HCPCS Code by Selected Categories

Several of the categories analyzed in the report have HCPCS codes that are more costly than the other codes in the category, and the data indicates that there is sufficient variation among the suppliers billing practices. The percentage of allowed services for the most costly HCPCS codes by category is calculated, as follows:

$$\left(\frac{\textbf{Total Allowed Services for Most Costly HCPCS Codes by Category}}{\textbf{Total Allowed Services for the Category}}\right) \textbf{x}100$$

Average Allowed Charges per Beneficiary

The average allowed charges per beneficiary is calculated for the one-year period, as follows:

$$\frac{\textbf{Total Allowed Charges}}{\textbf{Total Number of Beneficiaries}}$$

Comparison Outcomes

There are four possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** - Supplier's value is higher than the peer value and the statistical test confirms significance
- **Higher** - Supplier's value is higher than the peer value, but either the statistical test does not confirm significance or there is insufficient data for comparison
- **Does Not Exceed** - Supplier's value is not higher than the peer value
- **N/A** - Supplier does not have sufficient data for comparison

It is important to note that significance is based on the total number of services or beneficiaries and the variability of those values.

Results

Table 2 provides a summary of your utilization of the HCPCS codes and categories included in this CBR. The total allowed charges, allowed services, and distinct beneficiary count are included for each HCPCS code and category subtotal. In addition, an overall "Total" row is included.

Table 2: Summary of Your Utilization
January 1, 2015 - December 31, 2015

Category	HCPCS Code	Allowed Charges	Allowed Services	Beneficiary Count
Filters	A7038	$19,119.65	7,714	1,607
Filters	A7039	$5,780.55	803	803
Filters	**Subtotal**	**$24,900.20**	**8,517**	**1,707**
Humidifiers	E0561	$0.00	0	0
Humidifiers	E0562	$50,466.63	344	337
Humidifiers	**Subtotal**	**$50,466.63**	**344**	**337**
Masks	A7027	$1,265.61	9	9
Masks	A7030	$78,872.07	743	743
Masks	A7034	$74,259.69	1,135	1,135
Masks	**Subtotal**	**$154,397.37**	**1,887**	**1,887**
Other	A7028	$2,318.19	57	10
Other	A7029	$740.00	46	9
Other	A7031	$57,498.10	1,382	472
Other	A7032	$48,971.27	2,150	396
Other	A7033	$29,851.52	1,752	302
Other	A7035	$28,876.29	1,400	1,400
Other	A7036	$850.19	77	77
Other	A7044	$81.00	1	1
Other	A7045	$0.00	0	0
Other	A7046	$9,399.56	676	676
Other	**Subtotal**	**$178,586.12**	**7,541**	**2,022**
PAP Devices	E0470	$37,930.40	374	165
PAP Devices	E0471	$72,025.24	279	124
PAP Devices	E0601	$146,049.70	3,566	1,507
PAP Devices	**Subtotal**	**$256,005.34**	**4,219**	**1,795**
Tubing	A4604	$22,673.40	521	521
Tubing	A7037	$16,578.50	1,115	1,115
Tubing	**Subtotal**	**$39,251.90**	**1,636**	**1,620**
-	**Total**	**$703,607.56**	**24,144**	**3,180**

Please note that the totals may not be equal to the sum of the rows. The number of beneficiaries is an unduplicated count for each row and the total. Since it is likely that a beneficiary would have billings for more than one HCPCS code and modifier type, he/she would be counted in the beneficiary count in each applicable row. However, this beneficiary would be counted only once in the subtotal and total.

Table 3 provides a statistical analysis of the average services per beneficiary by category. Your average is then compared to that of your state and the nation.

Table 3: Average Allowed Services per Beneficiary by Category
January 1, 2015 - December 31, 2015

Category	Your Average Services per Beneficiary	Your State's Average Services per Beneficiary	Comparison with Your State's Percentage	National Average Services per Beneficiary	Comparison with the National Percentage
Filters	4.99	6.00	Does Not Exceed	8.88	Does Not Exceed
Humidifiers	1.02	1.29	Does Not Exceed	2.53	Does Not Exceed
Masks	1.00	1.33	Does Not Exceed	1.79	Does Not Exceed
Other	3.73	4.46	Does Not Exceed	6.45	Does Not Exceed
PAP Devices	2.35	5.45	Does Not Exceed	5.43	Does Not Exceed
Tubing	1.01	1.47	Does Not Exceed	1.77	Does Not Exceed

A t-test was used in this analysis, alpha=0.05.

Table 4 provides a percentage of allowed services for most costly HCPCS codes by selected categories of your state and the nation. The most costly HCPCS codes for each of the selected categories of analysis are denoted on the table.

Table 4: Percentage of Allowed Services for Most Costly HCPCS Code by Selected Categories
January 1, 2015 - December 31, 2015

Category (most costly HCPCS codes)	Your Percentage of Allowed Services	Your State's Percentage of Services	Comparison with Your State's Average	National Percentage of Services	Comparison with the National Average
Filters (**A7039**)	9%	4%	Significantly Higher	6%	Significantly Higher
Masks (**A7027, A7030**)	40%	52%	Does Not Exceed	42%	Does Not Exceed
PAP Devices (**E0470, E0471**)	15%	17%	Does Not Exceed	19%	Does Not Exceed
Tubing (**A4604**)	32%	32%	Does Not Exceed	26%	Significantly Higher

A chi-square test was used in this analysis, alpha=0.05.

Table 5 provides a comparison of your average allowed charges per beneficiary to that of your state and the nation. The total allowed charges is summarized, regardless of the categories attached to the service. This is the average total allowed charges per beneficiary for the one-year time period under analysis.

Table 5: Average Allowed Charges per Beneficiary
January 1, 2015 - December 31, 2015

	Your Average Allowed Charges Per Beneficiary	Your State's Average Allowed Charges Per Beneficiary	Comparison with Your State's Average	National Average Allowed Charges Per Beneficiary	Comparison with the National Average
Charges	$221.26	$512.61	Does Not Exceed	$676.17	Does Not Exceed

A t-test was used in this analysis, alpha=0.05.

References & Resources

The coverage and documentation guidelines for DMEPOS PAP devices, RADs and accessories are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at http://www.cbrinfo.net/cbr201612-recommended-links.html.

NCD: 240.0 National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy for obstructive Sleep Apnea (OSA)

LCDs - Active on 10/01/15 :

- CGS Administrators®, LLC; L33718, L33880
- Noridian Healthcare Solutions, Inc.: L33718, L33880
- Palmetto GBA, LLC: L36593 (active on 06/13/2016)

LCDs - Retired on 09/30/15:

- CGS Administrators®, LLC; L5023, L11518
- National Government Services, Inc.: L27228, L27230
- NHIC, Corp.: L11504, L11528
- Noridian Health Solutions, Inc.: L171, L11493

Department of Health and Human Services, Office of Inspector General (OIG):

- Work Plan: Fiscal Year 2016
- Replacement Schedules for Medicare Continuous Positive Airway Pressure Supplies, OEI-07-12-00250/June 2013
- Claim Modifier Did Not Prevent Medicare From Paying Millions in Unallowable Claims for Selected Durable Medical Equipment (A-04-10-04004/April 2012)

Centers for Medicare & Medicaid Services (CMS):

- Comprehensive Error Rate Testing (CERT) 2014 Claims Data
- *The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report*

Noridian Healthcare Solutions, Inc., Continous Positive Airway Devices (HCPCS E0601KH and E0601KJ) Quarterly Results of Service Specific Prepayment Review

CGS Administrators ®, LLC, Status Report for Quarter 4 - 2015: HCPCS Code E0601 Service-Specific Prepayment Review

The Next Steps

We encourage you to check with your MAC to ensure you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201612 webinar on September 21, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at http://www.cbrinfo.net/cbr201612-webinar.html.

If you are unable to attend, you may access a recording of the CBR201612 webinar five business days following the event at http://www.cbrinfo.net/cbr201612-webinar.html.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at CBRsupport@eglobaltech.com or via telephone at (800) 771-4430.

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