

# Comparative Billing Report



Comparative Billing Report Program  
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January 9, 2017

CBR#: CBR201701

Topic: Knee Orthoses

NPI#: 1111111111

Fax#: (888)555-5555

**Questions:** Contact CBR Support  
[www.cbrinfo.net](http://www.cbrinfo.net)  
(800)771-4430 / M-F 9 A.M. – 5 P.M. ET  
[cbrsupport@eglobaltech.com](mailto:cbrsupport@eglobaltech.com)  
Write to the return address above

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, to develop Comparative Billing Reports (CBRs).

## *What is a CBR?*

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

## *Why did I get a CBR?*

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.
- Factors such as region, subspecialty, and patient acuity can be factors in differences in billing patterns. These factors are not evident in claims data reviewed for this report.

## *What should I do with this CBR?*

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

## *Do I need to reply to explain my utilization?*

- No reply is necessary, as this report is for educational purposes.

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 (800) 465-3203 or email [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Frank Gorton".

Frank Gorton  
CBR-Program Director  
eGlobalTech

Enclosure

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## Comparative Billing Report (CBR): NPI 1111111111 Knee Orthoses

### Introduction

CBR201701 focuses on suppliers who submitted claims for off the shelf and custom fitted prefabricated knee orthoses, also known as braces. The *Medicare Benefit Policy Manual* (Chapter 15, Section 130) defines braces as “rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.” The device must provide support and counterforce on the limb or body part that it is being used to brace. They are covered by Medicare Part B when they are furnished on a physician’s order or incident to a physician’s services. Items that do not meet Medicare’s definition of a brace are not covered.

The metrics reviewed in this report are:

- Percentage of beneficiaries receiving knee orthoses for both knees
- Percentage of knee orthoses received without a visit to the referring physician (within 30 days)
- Average allowed charges per beneficiary

The Office of Inspector General (OIG) includes orthotic braces in their *Work Plan Fiscal Year 2016* report and compares Medicare overpayments for braces to amounts of private insurance companies (non-Medicare payers). The OIG made these comparisons in an effort to identify potentially wasteful spending. They also want to calculate the financial impact on Medicare and its beneficiaries of adjusting the fee schedule for orthotic braces to be more in line with non-Medicare payers. The *Work Plan* includes reviews of Medicare Part B payments to verify that documentation is present to support medical necessity. They are also following up on prior OIG reports, which found that many services billed were not medically necessary. In addition, the OIG determined that some beneficiaries were receiving multiple braces, the documentation did not meet Medicare guidelines, and often the referring physician had not seen the beneficiary.

According to the *Medicare Fee-for-Service 2015 Improper Payment Report*, the calculated improper payment rate for lower limb orthoses was 52.8 percent in 2014, while it was 46.3 percent in 2015. In both 2014 and 2015, lower limb orthoses were listed in the **Top 20 Service Types with Highest Improper Payments: DMEPOS**. Individuals or medical supply companies that employed individuals with an orthotic accreditation had improper payment rates between 43.2 percent and 58.7 percent in 2014.

Noridian Healthcare Solutions is currently conducting a service specific review of claims with Healthcare Common Procedure Coding System (HCPCS) code L1833 that were submitted

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between December 2015 and March 2016. Out of 650 claims reviewed, 589 were denied resulting in an overall improper payment rate of 92 percent (at time of publication of this CBR). The top denial reasons were: documentation requested was not received, documentation did not support knee instability, documentation did not support a description of joint laxity, and documentation did not support a condition specified in the Group 4 Codes section of LCD L33318. Noridian is continuing the Prepayment Service Specific Review based on these results.

Table 1 lists each of the HCPCS codes and an abbreviated description for each of the knee orthoses covered in this CBR.

**Table 1: HCPCS Codes and Abbreviated Descriptions**

<b>Prefabricated Off the Shelf Knee Orthoses</b>		<b>Prefabricated Custom Fitted Knee Orthoses</b>	
<b>HCPCS Code</b>	<b>Description</b>	<b>HCPCS Code</b>	<b>Description</b>
K0901	Single upright, thigh and calf with adjustable joint, medial-lateral and rotation control	L1810	Elastic with joints
K0902	Double upright, thigh and calf with adjustable joint, medial-lateral and rotation control	L1820	Elastic with condylar pads and joints, with or without patellar control
L1812	With joints	L1831	Locking knee joint(s), positional orthosis
L1830	Immobilizer, canvas longitudinal	L1832	Adjustable knee joints, positional orthosis, rigid support
L1833	Adjustable knee joints, positional rigid support	L1843	Single upright, thigh and calf with adjustable joint, medial-lateral
L1836	Rigid without joint(s); includes soft interface material	L1845	Double upright, thigh and calf with adjustable joint, medial-lateral and rotation control
L1850	Swedish type		

Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS)

## **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 by the Medicare Administrative Contractors (MACs), in Local Coverage Determinations (LCDs), or in Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

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## Basic Coverage Criteria

LCD L33318 states “A knee flexion contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 0 degrees extension or greater (i.e., hyperextension) by passive range of motion. (0 degrees knee extension is when the femur and tibia are in alignment in a horizontal plane). A knee extension contracture is a condition in which there is shortening of the muscles and/or tendons with the resulting inability to bring the knee to 80 degrees flexion or greater by passive range of motion. A contracture is distinguished from the temporary loss of range of motion of a joint following injury, surgery, casting, or other immobilization.”

The HCPCS codes covered in this CBR have specific criteria that must be met to be considered reasonable and medically necessary. If these criteria are not met, the orthosis will be denied. LCD L33318 includes the criteria and the five groups of diagnosis codes that support medical necessity for the orthoses in this CBR. Each HCPCS code listed in LCD L33318 has a specific diagnosis group; however, this list is not all-inclusive.

Medicare requires a prescription for all items billed. Knee orthoses are delivered based on a dispensing prescription. The dispensing order may be verbal or written and must be kept on file. The order may also be a detailed written order (DWO). The beneficiary’s name, the date of the order, a **detailed description of the item being ordered** and the prescribing practitioner’s signature are required on both the dispensing order and the DWO. The supplier’s signature is sufficient if the dispensing order is a verbal order. An EY modifier should be appended when submitting a claim if the prescription requirements are not met. A new order/prescription is required when there is a change in supplier or if the item needs to be replaced.

A prescription is not considered part of the medical record. Providers or suppliers can issue an Advance Beneficiary Notice (ABN) to beneficiaries when Medicare is expected to deny the services. The signed ABN allows the beneficiary to accept financial responsibility if Medicare does not pay for the services. Chapter 5 (Section 5.8) of the *Medicare Program Integrity Manual (PIM)* states “The supplier should also obtain as much documentation from the patient’s medical record as they determine they need to assure themselves that coverage criteria for an item have been met. If the information in the patient’s medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed ABN of possible denial has been obtained. Documentation must be maintained in the supplier’s files for seven (7) years from date of service.”

Suppliers should bill for the HCPCS code that accurately describes the orthosis and the fitting, and it must be the product that is specified by the prescribing practitioner. The medical record and documentation should be detailed and show justification for the need of the product.

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## Methods & Results

This report is an analysis of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims with dates of service from July 1, 2015 to June 30, 2016. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR) as of November 8, 2016. Your percentages and averages, denoted in Tables 3 through 5, are calculated from your utilization of the HCPCS codes in Table 2, using the formulas below. Your values are compared to your state (NY) and the nation, using either the chi-square or t-test at the alpha value of 0.05.

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

**Table 2: Summary of Your Utilization**  
**July 1, 2015 – June 30, 2016**

HCPCS Code	Allowed Charges	Allowed Services	Beneficiary Count
K0901	\$229,855.89	269	151
K0902	\$0.00	0	0
L1810	\$0.00	0	0
L1812	\$0.00	0	0
L1820	\$526.96	4	4
L1830	\$184.90	2	2
L1831	\$0.00	0	0
L1832	\$24,637.66	34	32
L1833	\$62,358.55	95	58
L1836	\$0.00	0	0
L1843	\$863.46	1	1
L1845	\$919.42	1	1
L1850	\$0.00	0	0
<b>Total</b>	<b>\$319,346.84</b>	<b>406</b>	<b>249</b>

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the number of beneficiaries is an unduplicated count for each row and the total. Since a beneficiary may have received multiple items in the list, he/she would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

### Percentage of Beneficiaries Receiving Knee Orthoses for Both Knees

The OIG found high improper payment rates due to insufficient documentation for beneficiaries receiving multiple knee orthoses. This metric was designed to focus on suppliers who provided knee braces to beneficiaries for both knees at a rate that exceeds his/her peers. Although receiving a brace for both knees may be justifiable, the percentage of beneficiaries needing

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braces for both knees should be comparable across all suppliers if the documentation is sufficient to support the products. Beneficiaries with allowed claims for at least two services with modifiers RT and LT from the same supplier were selected. The percentage of beneficiaries receiving knee orthoses for both knees was calculated, as follows:

$$\left( \frac{\text{Number of Beneficiaries Receiving Knee Orthoses for Both Knees}}{\text{Total Number of Beneficiaries}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of beneficiaries receiving knee orthoses for both knees. Your percentage is compared to that of your state and the nation.

**Table 3: Percentage of Beneficiaries Receiving Knee Orthoses for Both Knees**  
**July 1, 2015 – June 30, 2016**

	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage of Beneficiaries	National Percentage of Beneficiaries	Comparison with the National Percentage of Beneficiaries
Both Knees	63%	27%	Significantly Higher	24%	Significantly Higher

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

### **Percentage of Knee Orthoses Received Without a Visit to the Referring Physician**

Since Medicare requires a prescription stating medical necessity for all items billed, this metric was designed to focus on suppliers who provided knee braces to beneficiaries who do not have a Medicare Part B claim from the physician listed on the DMEPOS claim as referring physician within 30 days of receiving the orthosis. The percentage of knee orthoses received without a visit to the referring physician within 30 days prior to receiving the knee orthosis was calculated, as follows:

$$\left( \frac{\text{Number of Services Without a Visit to the Referring Physician}}{\text{Total Number of Services}} \right) \times 100$$

Table 4 provides a statistical analysis of the percentage of knee orthoses received without a visit to the referring physician within 30 days prior to receiving the knee orthoses. Your percentage is compared to that of your state and the nation.

**Table 4: Percentage of Knee Orthoses Received Without a Visit to the Referring Physician**  
**July 1, 2015 – June 30, 2016**

	Your Percentage of Services	Your State's Percentage of Services	Comparison with Your State's Percentage of Services	National Percentage of Services	Comparison with the National Percentage of Services
Without Referral	94%	28%	Significantly Higher	38%	Significantly Higher

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

### Average Allowed Charges per Beneficiary

The average allowed charges per beneficiary was calculated for each DMEPOS supplier of prefabricated knee orthoses to potentially identify wasteful spending and overutilization of these items. The average allowed charges per beneficiary was calculated, as follows:

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

Table 5 provides a statistical analysis of the average allowed charges per beneficiary. Your percentage is compared to that of your state and the nation.

**Table 5: Average Allowed Charges per Beneficiary**  
**July 1, 2015 – June 30, 2016**

	Your Average Charges per Beneficiary	Your State's Average Charges per Beneficiary	Comparison with Your State's Average Charges per Beneficiary	National Average Charges per Beneficiary	Comparison with the National Average Charges per Beneficiary
Charges	\$1,282.52	\$489.07	Significantly Higher	\$581.22	Significantly Higher

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

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## References & Resources

The coverage and documentation guidelines for this CBR are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201701-recommended-links>.

### Local Coverage Determination:

- LCD L33318

### Office of Inspector General (OIG):

- Work Plan Fiscal Year 2016
- Medicare Payment for Orthotics – Inappropriate Payments
- Medicare Payments for Orthotics – Carrier Perspectives

### Medicare Manuals:

- *Medicare Program Integrity Manual*, Chapter 5 - Items and Services Having Special DME: Review Considerations
  - Section 5.8 – Supplier Documentation

### Medicare Administrative Contractors:

- Noridian Healthcare Solutions
  - Knee Orthosis (HCPCS L1833) Quarterly Results of Service Specific Prepayment Review

## The Next Steps

We encourage you to check with your MAC to ensure that 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 CBR201701 webinar on February 8, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201701-webinar>.

If you are unable to attend, you may access a recording of the CBR201701 webinar five business days following the event at <http://www.cbrinfo.net/cbr201701-webinar>.

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

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