Comparative Billing Report

March 19, 2018

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

CBR#: CBR201802
Spinal Orthoses Referring Providers
NPI#: 1111111111
Fax#: (888)555-5555

Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430
M-F 9:00 a.m. – 5:00 p.m. ET
cbrsupport@eglobaltech.com
Write to the return address above

ORGANIZATIONAL NAME
FULL NAME
123 STREET & LANE
SUITE 4000
ANYTOWN, XX 55555-4444

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 your peers' patterns for the same services in your state and nationwide. No reply is necessary as this report is for educational purposes.

Why did I get a CBR?

You received this CBR because your billing patterns differ from your peers' patterns in your state and/or across the nation. Receiving this CBR is not an indication of, or precursor to, an audit. We hope the report assists you in identifying opportunities for improvement and helps you validate your current billing patterns.

Optional - Next Steps

- Contact your Medicare Administrative Contractor (MAC) for specific billing or coding questions
- Visit www.cbrinfo.net for additional resources
- Attend our free webinar April 11, 2018 from 3:00 p.m. – 4:00 p.m. ET. Space is limited so register early at www.cbrinfo.net/cbr201802-webinar
- If you are unable to attend the live webinar, a recording will be available within 5 business days following the event at www.cbrinfo.net/cbr201802-webinar

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Enclosure

Comparative Billing Report (CBR): NPI 1111111111
Spinal Orthoses Referring Providers

Introduction

CBR201802 focuses on the referring providers for off-the-shelf and custom-fitted prefabricated spinal 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." Braces are covered by Medicare Part B, Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) 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 include:

- Percentage of allowed services defined as custom-fitted
- Percentage of allowed services submitted without a visit to the referring provider within 90 days of the DMEPOS service date
- Average charges per beneficiary for the one-year period

The Office of Inspector General (OIG) includes orthoses in the *Work Plan Fiscal Year 2017* report and compares Medicare overpayments for braces to those of private insurance companies (non-Medicare payers). The OIG made these comparisons in an effort to identify potentially wasteful spending and to adjust the fee schedule for orthoses to be more in line with non-Medicare payers. The *Work Plan* also includes reviewing medical necessity. They found that, in many cases, the documentation submitted did not support medical necessity for the services billed; more specifically, there were indications that some beneficiaries were receiving multiple braces and often the referring physician had not seen the beneficiary prior to ordering the equipment.

Since 2013, lumbar-sacral orthoses (LSO) have been on the DMEPOS list of **Top 20 Service Types with Highest Improper Payments**. According to the 2017 *Medicare Fee-for-Service Supplemental Improper Payment Data,* which included claims submitted July 1, 2015 through June 30, 2016, LSO had an improper payment rate of 52.5 percent. The 2017 report indicated that the overall improper payment rate for all DMEPOS items was 44.6 percent, making the projected improper payment amount for DMEPOS items $3.7 billion for this reporting period.

Healthcare Common Procedure Coding System (HCPCS) Codes

CBR201802 is an analysis of the following HCPCS codes:

- **Prefabricated Custom-Fitted Spinal Orthoses**

L0627: Lumbar orthosis, sagittal control, with rigid anterior and posterior panels
L0631: Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels
L0637: Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels

- **Prefabricated Off-the-Shelf Spinal Orthoses**

L0642: Lumbar orthosis, sagittal control, with rigid anterior and posterior panels
L0648: Lumbar-sacral orthosis, sagittal control with rigid anterior and posterior panels
L0650: Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior panels

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), Local Coverage Determinations (LCDs), or Local Coverage Articles (LCAs)**. Please refer any specific questions you may have to the MAC for your region.

A prescription is not considered part of the medical record. Chapter 5 (Section 5.8) of the *Medicare Program Integrity Manual* 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 Advance Beneficiary Notice (ABN) of possible denial has been obtained. Documentation must be maintained in the supplier's files for seven (7) years from date of service." Providers or suppliers issue an ABN to beneficiaries when Medicare is expected to deny the billed item(s) or service(s). The signed ABN allows the beneficiary to accept financial responsibility if Medicare does not pay for the services.

Suppliers must bill for the product that is specified by the referring practitioner using the appropriate HCPCS code. The medical record and documentation should be detailed and show justification for the product.

Methods & Results

This report is an analysis of providers submitted as the "Referring NPI" on Medicare Part B DMEPOS claims extracted from the Integrated Data Repository based on the latest version of claims as of January 24, 2018. The analysis includes claims with dates of service from October 1, 2016 to September 30, 2017.

Table 1 provides a summary of your referrals for 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 1: Mock Data **Summary of Your Referrals for Spinal Orthoses Dates of Service: October 1, 2016 – September 30, 2017**

Type	HCPCS Code	Allowed Charges	Allowed Services	Beneficiary Count
Custom-Fitted	L0627	$0	0	0
Custom-Fitted	L0631	$0	0	0
Custom-Fitted	L0637	$23,747	21	21
Off-the-Shelf	L0642	$0	0	0
Off-the-Shelf	L0648	$17,267	18	18
Off-the-Shelf	L0650	$18,075	16	16
	Total	**$59,089**	**55**	**55**

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the beneficiary counts are unduplicated counts for each row and the total. For example, a beneficiary receiving multiple services with different HCPCS codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

There are over 65,000 referring providers nationwide with allowed charges for the HCPCS codes included in this study. Those who received the CBR were significantly higher than at least one of the peer groups on at least one of the measurements studied. Also, the CBR recipients were near or above the 90th percentile in allowed charges ($5,000), with at least ten referred beneficiaries for spinal orthoses during this one-year period.

Peer Groups

Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all referring Medicare providers practicing in the individual provider's state with allowed charges for the procedure codes included in this study. The practicing state was determined by the state of the most recently activated enrollment ID from the Provider Enrollment, Chain, and Ownership System (PECOS), or from the National Plan and Provider Enumeration System (NPPES) if no active records are found in PECOS.

- The **national** peer group is defined as all referring Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Comparison Outcomes

Your metrics were compared to your state (e.g., California) and the nation using statistical analysis. There are four possible outcomes for the comparisons between the provider and the peer groups:

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

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

Percentage of Allowed Services Defined as Custom-Fitted

The percentage of allowed services defined as custom-fitted spinal orthoses is calculated as follows:

$$\left(\frac{\textbf{Number of Services Defined as Custom-Fitted}}{\textbf{Total Number of Services}} \right) \textbf{x } 100$$

Table 2 provides a statistical analysis of the percentage of allowed services defined as custom-fitted (HCPCS code L0627, L0631 or L0637). Your percentage is compared to that of your state and the nation.

Table 2: Mock **Percentage of Services Defined as Custom-Fitted**
Dates of Service: October 1, 2016 – September 30, 2017

Number of Custom-Fitted Services	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
21	55	38%	14%	Significantly Higher	17%	Significantly Higher

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

Percentage of Allowed Services Submitted without a Visit to the Referring Provider within 90 days of the DMEPOS Service Date

The percentage of allowed services submitted without a visit to the referring provider within 90 days of the DMEPOS service date is calculated as follows:

$$\left(\frac{\textbf{Number of Services without Visit to Referring Provider}}{\textbf{Total Number of Services}} \right) \textbf{x } 100$$

Table 3 provides a statistical analysis of the percentage of allowed services submitted without a visit to the referring provider within 90 days of the DMEPOS service date. The service date is defined as the date that the spinal orthosis order was filled by the DMEPOS supplier. Your percentage is compared to that of your state and the nation.

Table 3: Mock **Percentage of Services without Visit to Referring Provider Dates of Service: October 1, 2016 – September 30, 2017**

Number of Services without Visit	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
3	55	5%	53%	Does Not Exceed	51%	Does Not Exceed

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

Average Allowed Charges per Beneficiary for the One-Year Period

The average allowed charges per beneficiary for all services submitted during the one-year period is calculated as follows:

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

Table 4 provides a statistical analysis of the average allowed charges per beneficiary for the one-year period. Your average is compared to that of your state and the nation.

Table 4: Mock **Average Allowed Charges per Beneficiary Dates of Service: October 1, 2016 – September 30, 2017**

Total Charges	Total Number Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
$59,089.11	55	$1,074.35	$924.00	Significantly Higher	$1,043.58	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for Spinal Orthoses are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at http://www.cbrinfo.net/cbr201802-recommended-links.

Centers for Medicare & Medicaid Services:

- *Medicare Fee-for-Service Supplemental Improper Payment Data (2017)*
- *Appendices Medicare Fee-for-Service Improper Payments Report (2013-2016)*
- *HCPCS 2017 Index*

Office of Inspector General:

- *Work Plan Fiscal Year 2017*

Medicare Manuals:

- *Medicare Program Integrity Manual, Chapter 5*
- *Medicare Benefit Policy Manual, Chapter 15*

Medicare Learning Network:

- *DMEPOS Quality Standards*

For written correspondence, postal mail can be sent to the following address:

CBR Program
eGlobalTech
7127 Ambassador Road, Suite 150
Baltimore, MD 21244