Comparative Billing Report

June 11, 2018

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
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CBR#: CBR201805
Knee Orthoses Referring Providers
NPI#: 1111111111
Fax#: (888)555-5555

Questions: Contact CBR Support
www.cbrinfo.net
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Write to the return address above

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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, to develop Comparative Billing Reports (CBRs).

What is a CBR?

A CBR is an educational tool that reflects your billing or referral 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 referral patterns differ from your peers' patterns within your state and/or across the nation. Receiving this CBR is not an indication or precursor to an audit for all recipients. Selected providers, however, may be referred for additional review and education. We hope the report assists you in identifying opportunities for improvement and helps you validate your current referring 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 July 11, 2018 from 3:00 p.m. – 4:00 p.m. ET. Space is limited so register early at www.cbrinfo.net/cbr201805-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/cbr201805-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
Knee Orthoses Referring Providers

Introduction

CBR201805 focuses on referring providers for off-the-shelf (OTS) 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 on the limb or body part that it is being used to brace. Knee orthoses 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.

According to the Office of Inspector General (OIG) *2017 Work Plan*, Medicare payments have almost tripled for certain types of knee braces since 2009. The *2016 OIG Work Plan* compared Medicare overpayments for braces to amounts of private insurance companies (non-Medicare payers). The OIG made these comparisons to identify potentially wasteful spending. Specifically, the OIG wanted to estimate the financial impact on Medicare and its beneficiaries by adjusting the fee schedule for knee braces to be more in line with non-Medicare payers.

The *2017 Medicare Fee-for-Service Supplemental Improper Payment Data* report lists lower limb orthoses with a projected improper payment rate of 66.7 percent, amounting to almost $320 million in projected improper payments. Since 2013, lower limb orthoses have been on the list of **Top 20 Service Types with Highest Improper Payments: DMEPOS**.

According to the *Medicare Learning Network* (*MLN) Fact Sheet*, **Provider Compliance Tips for Ordering Lower Limb Orthoses***,* "Insufficient documentation errors accounted for 92.2 percent of improper payments for lower limb orthoses for the 2017 reporting period. Additional types of errors included no documentation (2.1 percent), medical necessity (1.5 percent), and other (4.2 percent) for this service."

The metrics calculated for this report include the following:

- Percentage of beneficiaries receiving knee orthoses for both knees
- 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

Table 1 lists the Healthcare Common Procedure Coding System (HCPCS) codes and abbreviated descriptions for the knee orthoses covered in this CBR.

Table 1: HCPCS Codes and Abbreviated Descriptions

Custom-Fitted Knee Orthoses		Prefabricated Off-the-Shelf Knee Orthoses	
HCPCS Code	Description	HCPCS Code	Description
L1810	Knee orthosis, elastic with joints	L1812	Knee orthosis, elastic with joints
L1820	Knee orthosis, elastic with condylar pads and joints	L1830	Knee orthosis, immobilizer
L1831	Knee orthosis, locking knee	L1833	Knee orthosis, adjustable knee
L1832	Knee orthosis, adjustable knee	L1836	Knee orthosis, rigid without joints
L1834	Knee orthosis, without knee joint	L1848	Knee orthosis, double upright
L1840	Knee orthosis, de-rotation	L1850	Knee orthosis, Swedish
L1843	Knee orthosis, single upright	L1851	Knee orthosis, single upright
L1844	Knee orthosis, single upright	L1852	Knee orthosis, double upright
L1845	Knee orthosis, double upright		
L1846	Knee orthosis, double upright		
L1847	Knee orthosis, double upright		
L1860	Knee orthosis, modification		

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) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the DME MAC for your region.

In some cases, there may be two HCPCS codes that describe a particular prefabricated product. One code is used when the device is furnished OTS and a second code for the custom-fitted device.

OTS orthoses require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. Minimal self-adjustment is defined as an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist.

Custom-fitted orthoses require substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment. Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses.

Suppliers of any orthoses, other than OTS orthoses, must comply with standards outlined in Appendix C of the *MLN* article titled **DMEPOS Quality Standards**, which specifies that suppliers must possess specialized education, training, and experience in fitting, certification, and/or licensing.

There is a LCD and a LCA specifically written for the knee orthoses codes covered in this CBR. These documents provide guidance on coverage indications, limitations, and medical necessity to ensure that the knee orthoses provided meet Medicare requirements. These LCDs and LCAs are applicable to all DME jurisdictions.

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 April 3, 2018. The analysis includes claims with dates of service from January 1, 2017 to December 31, 2017.

There are over 89,000 providers nationwide with referrals for the knee orthoses HCPCS codes included in this study. Criteria for receiving the CBR are as follows:

- Provider is significantly higher than at least one of the peer groups on at least one of the measurements studied
- Provider is near or above the 90th percentile in allowed charges ($3,500) for the referrals
- Provider had referrals for at least 10 beneficiaries

Table 2 provides a summary of your referrals for the HCPCS codes included in this CBR.

Table 2: Mock Data Summary of Your Referrals for Knee Orthoses
Dates of Service: January 1, 2017 – December 31, 2017

Type	HCPCS Code	Allowed Charges	Allowed Services	Beneficiary Count
Custom-Fitted	L1810	$0	0	0
Custom-Fitted	L1820	$0	0	0
Custom-Fitted	L1831	$0	0	0
Custom-Fitted	L1832	$10,028	14	12
Custom-Fitted	L1834	$0	0	0
Custom-Fitted	L1840	$0	0	0
Custom-Fitted	L1843	$0	0	0
Custom-Fitted	L1844	$0	0	0
Custom-Fitted	L1845	$0	0	0
Custom-Fitted	L1846	$0	0	0
Custom-Fitted	L1847	$0	0	0
Custom-Fitted	L1860	$0	0	0
Custom-Fitted	**Subtotal**	**$10,028**	**14**	**12**
Off-the-Shelf	L1812	$0	0	0
Off-the-Shelf	L1830	$0	0	0
Off-the-Shelf	L1833	$0	0	0
Off-the-Shelf	L1836	$0	0	0
Off-the-Shelf	L1850	$0	0	0
Off-the-Shelf	L1851	$0	0	0
Off-the-Shelf	L1852	$1,844	2	1
Off-the-Shelf	**Subtotal**	**$1,844**	**2**	**1**
Total		**$11,873**	**16**	**13**

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 subtotal and total rows.

Statistics were calculated for each provider and the two peer groups: all providers in the nation with referrals for knee orthoses, and all providers in your state (e.g., NY) with referrals for knee orthoses. Each provider's values are compared to his/her peer group values. 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

Table 3 presents the percentage of beneficiaries receiving knee orthoses for both knees.

Table 3: Mock Percentage of Beneficiaries Receiving Knee Orthoses for Both Knees
Dates of Service: January 1, 2017 – December 31, 2017

Number of Beneficiaries with Both	Total Number of Beneficiaries	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
3	13	23%	25%	Does Not Exceed	21%	Higher

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

Table 4 shows the percentage of services defined as custom-fitted.

Table 4: Mock Percentage of Services Defined as Custom-Fitted
Dates of Service: January 1, 2017 – December 31, 2017

Number of Custom-Fitted	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
14	16	88%	45%	Significantly Higher	35%	Significantly Higher

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

Table 5 shows the percentage of 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 knee orthosis order was filled by the DMEPOS supplier.

Table 5: Mock Percentage of Services without a Visit to the Referring Provider
Dates of Service: January 1, 2017 – December 31, 2017

Number of Services without a Visit	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
2	16	13%	38%	Does Not Exceed	40%	Does Not Exceed

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

Table 6 shows the average allowed charges per beneficiary for the one-year period.

Table 6: Mock Average Allowed Charges per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Total Charges	Total Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
$11,872.55	13	$913.27	$651.72	Significantly Higher	$627.12	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for knee 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/cbr201805-recommended-links.

Centers for Medicare & Medicaid Services

- *2017 Medicare Fee-for-Service Supplemental Improper Payment Data*

Office of Inspector General

- *OIG Work Plan (2016, 2017)*

Medicare Manual:

- *Medicare Benefit Policy Manual,* Chapter 15, Section 130

Medicare Learning Network (MLN)

- *Provider Compliance Tips for Ordering Lower Limb Orthoses*
- *DMEPOS Quality Standard*