RELI Group
5520 Research Park Dr. #105
Catonsville, MD 2122

January 27, 2020

CBR #: CBR202001
Shoulder Arthroscopy

NPI #:
Fax #:
Email address:

Organization Name 1
Address 1
Address 2
City, State, ZIP

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 the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

What is a CBR? A CBR is an educational tool that reflects your billing and/or prescribing patterns as compared to your peers' patterns for the same services in your state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities.

Why did I get a CBR? We are providing this report because your Medicare billing and/or prescribing patterns differ from your peers' patterns within your state/specialty and/or across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. **As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.**

To access an electronic copy of your CBR: Visit the secure CBR portal at https://cbrfile.cbrpepper.org/. Populate the fields, and in the "validation code" field, enter your unique validation code: **(code here)**

For more information: Register for our free webinar, scheduled for Feb. 4, 2020 at 3 p.m. ET, at CBR.CBRPEPPER.org. If you are unable to attend the live event, you may access the recording and additional resources at CBR.CBRPEPPER.org.

To request assistance or submit questions: Contact the CBR Help Desk at https://CBR.CBRPEPPER.org/Help-Contact-Us or call 1-800-771-4430 (M–F, 9 a.m.–5 p.m. ET).

Sincerely,
The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

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Comparative Billing Report (CBR) 202001
January 27, 2020
Shoulder Arthroscopy

Introduction

CBR202001 focuses on rendering providers who perform shoulder arthroscopy procedures on beneficiaries without having attempted conservative treatment. The analysis in this CBR reflects the submission of claims for Current Procedural Terminology® (CPT®) codes for shoulder arthroscopy procedures performed on beneficiaries with shoulder complaints, including claims with the CPT® codes and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes outlined below in Table 1. The CPT® codes represent shoulder arthroscopy procedures, physical rehabilitation services, and sub-acromial injections. For the purposes of this document and analysis, the phrase "shoulder complaints" refers to the ICD-10-CM codes M75.4XX, M19.01X, and M75.1XX.

In the abstract for the study *Complications Associated with Arthroscopic Shoulder Surgery*, the National Center for Biotechnology Information (NCBI) says the following: "Shoulder arthroscopy presents increased risk of complications over knee arthroscopy in regard to vascular and neurologic injury, fluid extravasation, stiffness, iatrogenic tendon injury, and equipment failure. New techniques of increased complexity for subacromial surgery, rotator cuff repair, and arthroscopic instability present new problems related to implant failure, nerve injury, iatrogenic fracture, and capsular necrosis."

In the abstract for the study *Cost of Shoulder Surgery*, an assessment of the costs of shoulder surgery is presented. The study evaluated four groups of 50 patients representing four arthroscopy treatment interventions and found the following: "For group one, the average length of stay was three days and the average total cost was $9,444. For group two, the average stay was 1.7 days and the average cost was $8,675. For group three, the average stay was zero days and the average cost was $7,246. For group four, the average stay was five days and the average cost was $16,323."

In *The Costs Associated with the Evaluation of Rotator Cuff Tears Before Surgical Repair*, a study printed in the Journal of Shoulder and Elbow Surgery, the following data was compiled for a group of 92,688 patients: "A total of $161,993,100 was charged during the preoperative period, for an average of $1,748 per patient."

The criteria for receiving a CBR is that a provider:

1. Is significantly higher compared to either state or national percentages for Metric 1 (greater than or equal to the 90th percentile), or is significantly lower compared to either state or national percentages for Metric 3 (less than or equal to the 10th percentile), and
2. Has at least five beneficiaries with CPT® codes 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, or 29828, and
3. Has at least $600 or more in total allowed charges for claims with CPT® codes 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, or 29828.

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 any coverage and documentation policies outlined by the Medicare Administrative Contractors' (MACs') Local Coverage Determinations (LCDs).

Table 1 identifies the CPT® codes used in the CBR analysis for shoulder arthroscopy, physical rehabilitation, and sub-acromial injections, along with the ICD-10-CM diagnosis codes reflecting shoulder complaints.

Table 1: CPT® and ICD-10-CM Code Descriptions

CPT®/ICD-10-CM Code	Description
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	With repair of superior labrum tear from anterior, to posterior (SLAP) lesion
29819	With removal of loose body or foreign body
29820	Synovectomy, partial
29821	Synovectomy, complete
29822	Debridement, limited
29823	Debridement, extensive
29824	Distal claviculectomy including distal articular surface (Mumford procedure)
29825	With lysis and resection of adhesions, with or without manipulation
+29826	Decompression of subacromial space with partial acromioplasty, with coracoacromial ligament release, when performed
29827	With rotator cuff repair
29828	Biceps tenodesis
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy established plan of care
97165	Occupational therapy evaluation, low complexity
97166	Occupational therapy evaluation, moderate complexity
97167	Occupational therapy evaluation, high complexity
97168	Re-evaluation of occupational therapy established plan of care
97110	Therapeutic Procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

CPT®/ICD-10-CM Code	Description
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa; without ultrasound guidance
20604	With ultrasound guidance, with permanent recording and reporting
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa; without ultrasound guidance
20606	With ultrasound guidance, with permanent recording and reporting
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa; without ultrasound guidance
20611	With ultrasound guidance, with permanent recording and reporting
M75.4XX	Impingement syndrome of shoulder
M19.01X	Primary osteoarthritis, shoulder
M75.1XX	Rotator cuff tear or rupture, not specified as traumatic

Table 2 identifies a summary of your utilization of CPT® codes for shoulder arthroscopy (CPT® codes 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, and 29828) between Sept. 1, 2018, and Aug. 31. 2019.

Table 2. Summary of Your Utilization of CPT® Codes for Shoulder Arthroscopy Between Sept. 1, 2018, and Aug. 31, 2019

Shoulder Arthroscopy CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
Total	$10,036.81	26	16

*The "Beneficiary Count" represents unique beneficiaries for all the CPT® codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Percent of beneficiaries who had shoulder arthroscopy without conservative treatment within 12 weeks prior to shoulder arthroscopy
2. Average allowed amount per beneficiary who had shoulder arthroscopy without conservative treatment within 12 weeks prior to shoulder arthroscopy
3. Average number of physical rehabilitation claims per beneficiary by any physician within 12 weeks prior to shoulder arthroscopy

The CBR team analyzed the claims submitted by rendering providers for shoulder arthroscopy. Claims for beneficiaries treated for shoulder complaints who also underwent a shoulder arthroscopy procedure were analyzed to determine whether conservative treatments of physical therapy and sub-acromial injections were performed first for diagnoses that reflected shoulder complaints. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider's values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state [state code] and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher or Lower — Provider's value is greater than or equal to the 90th percentile from the state or national mean ("Significantly Higher" for Metric 1 only), or provider's value is less than or equal to the 10th percentile from the state or national mean ("Significantly Lower" for Metric 3 only).
2. Higher or Lower — Provider's value is greater than the state or national mean ("Higher" for Metric 1 only), or provider's value is less than the state or national mean ("Lower" for Metric 3 only).
3. Does Not Exceed or Is Not Below — Provider's value is less than or equal to the state or national mean ("Does Not Exceed" for Metric 1 only), or provider's value is greater than or equal to the state or national mean ("Is Not Below" for Metric 3 only).
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

Methods and Results

This report is an analysis of rendering providers who submitted claims for shoulder arthroscopy. The analyzed claims were extracted from the Integrated Data Repository, based on the latest version of claims available on Jan. 7, 2020. The analysis includes claims with dates of service from Sept. 1, 2018, through Aug. 31, 2019. For the trend analysis presented in Figure 1, claims represent dates of service between Sept. 1, 2016, and Aug. 31, 2019.

There are 17,154 rendering providers nationwide who have submitted claims for shoulder arthroscopy. The total allowed charges for these claims were $254.4 million during that timeframe.

Metric 1: Percent of Beneficiaries Who Had Shoulder Arthroscopy Without Conservative Treatment Within 12 Weeks Prior to Shoulder Arthroscopy

Table 3 shows your percent of beneficiaries treated for shoulder complaints who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy procedure. This is calculated as follows:

- The count of beneficiaries treated for shoulder complaints who had shoulder arthroscopy without a conservative treatment within 12 weeks prior to the shoulder arthroscopy procedure (numerator) is divided by the count of beneficiaries treated for shoulder complaints who had shoulder arthroscopy (denominator). The result is multiplied by 100.

$$\left(\frac{\text{Beneficiaries with shoulder arthroscopy without conservative treatment}}{\text{Beneficiaries with shoulder arthroscopy}}\right) \times 100$$

Your comparison in your state and in the nation is presented in Table 3.

Table 3: Your Percent of Beneficiaries Who Had Shoulder Arthroscopy Without Conservative Treatment Within 12 Weeks Prior to Shoulder Arthroscopy

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
15	16	93.75%	64.92%	Significantly Higher	68.30%	Significantly Higher

Metric 2: Average Allowed Amount per Beneficiary Who Had Shoulder Arthroscopy Without Conservative Treatment Within 12 Weeks Prior to Shoulder Arthroscopy

Table 4 shows the average allowed amount per beneficiary treated for shoulder complaints who also had shoulder arthroscopy without conservative treatment within 12 weeks prior to the procedure. This is calculated as follows:

- The sum of allowed amounts for beneficiaries treated for shoulder complaints who had a shoulder arthroscopy procedure without conservative treatment within 12 weeks prior to the procedure (numerator) is divided by the count of beneficiaries treated for shoulder complaints who also had shoulder arthroscopy without conservative treatment within 12 weeks prior to the procedure (denominator).

$$\frac{\text{Sum of allowed amounts for beneficiaries w/ shoulder arthroscopy w/o conservative treatment}}{\text{Count of beneficiaries w/ shoulder arthroscopy w/o conservative treatment}}$$

Your comparison in your state and in the nation is presented in Table 4.

Table 4: Your Average Allowed Amount per Beneficiary Who Had Shoulder Arthroscopy Without Conservative Treatment Within 12 Weeks Prior to Shoulder Arthroscopy

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
$9,745	15	$650	$996	Does Not Exceed	$1129	Does Not Exceed

Metric 3: Average Number of Physical Rehabilitation Claims per Beneficiary by Any Physician Within 12 Weeks Prior to Shoulder Arthroscopy

Table 5 shows the average number of physical rehabilitation claims per beneficiary by any physician within 12 weeks prior to shoulder arthroscopy. This is calculated as follows:

- The sum of physical rehabilitation claims per beneficiary treated for shoulder complaints within 12 weeks prior to shoulder arthroscopy (numerator) is divided by the number of beneficiaries treated for shoulder complaints who had shoulder arthroscopy (denominator).

$$\frac{\text{Rehabilitation claims prior to shoulder arthroscopy}}{\text{Beneficiaries with shoulder arthroscopy}}$$

Your comparison in your state and in the nation is presented in Table 5.

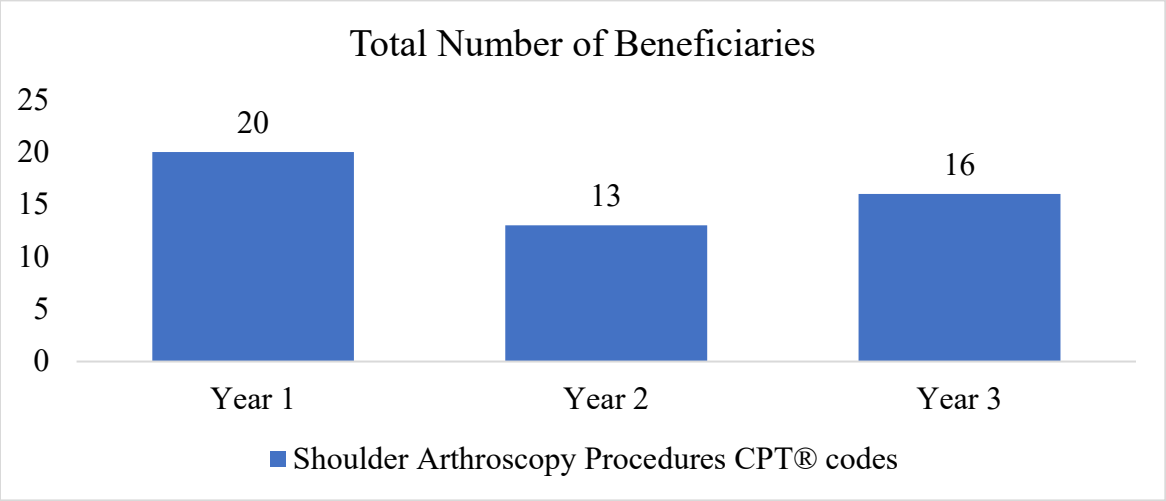
Table 5: Your Average Number of Physical Rehabilitation Claims per Beneficiary by Any Physician Within 12 Weeks Prior to Shoulder Arthroscopy

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
94	16	5.88	10.62	Lower	10.06	Lower

Figure 1 illustrates the trend over time of the total number of beneficiaries with submitted claims for shoulder arthroscopy procedures. Year 1, Year 2, and Year 3 are defined as follows:

- Year 1: Sept. 1, 2016 – Aug. 31, 2017
- Year 2: Sept. 1, 2017 – Aug. 31, 2018
- Year 3: Sept. 1, 2018 – Aug. 31, 2019

Figure 1: Analysis of Trends Over Time for Total Number of Beneficiaries with Submitted Claims for Shoulder Arthroscopy Procedures



References and Resources

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