

RELI Group
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CBR #: CBR202003
Lower Extremity Joint Replacement

March 31, 2020

Organization Name 1
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City, State, ZIP

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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 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: Please access a recorded webinar 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](https://nppes.cms.hhs.gov/#/) (NPPES): <https://nppes.cms.hhs.gov/#/>
- [Provider Enrollment, Chain, and Ownership System](https://pecos.cms.hhs.gov/pecos/login.do#headingLv1) (PECOS): <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>

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Comparative Billing Report (CBR) 202003
March 31, 2020
Lower Extremity Joint Replacement

Introduction

CBR202003 focuses on rendering providers who perform lower extremity joint replacement (LEJR) procedures on patients with osteoarthritis (OA) without first attempting conservative measures. The CBR analysis reflects the submission of claims for Current Procedural Terminology® (CPT®) codes for LEJR, physical therapy services, and subacromial injections, as listed in Table 1 below.

In the [*2019 Medicare Fee-for-Service Supplemental Improper Payment Data*](#) report, the U.S. Department of Health and Human Services (HHS) includes major hip and knee replacement procedures in both the top 20 types of service with insufficient documentation errors and the top 20 types of service with medical necessity errors. The data indicates that the projected improper payment rate involving insufficient documentation errors is 3.6%, which represents \$245,099,295. Additionally, the data indicates that the projected improper payment rate involving medical necessity errors is 6.4%, which represents \$439,194,650.

Non-surgical interventions, including patient education, rest during pain exacerbations, activity modification, use of medications, exercise, and weight loss plans are examples of conservative treatment that are emphasized by Osteoarthritis Research Society International (OARSI) in the management of lower extremity complaints. OARSI addresses the benefits of these conservative treatments in its article [*OARSI Guidelines for the Non-Surgical Management of Knee Osteoarthritis*](#). The American College of Rheumatology and the American Association of Hip and Knee Surgeons also discusses these benefits in its article [*2017 American College of Rheumatology/American Association of Hip and Knee Surgeons Guideline for the Perioperative Management of Antirheumatic Medication in Patients with Rheumatic Diseases Undergoing Elective Total Hip or Total Knee Arthroplasty*](#).

For the purposes of this analysis and document, the terms “osteoarthritis” and “OA” reference a primary diagnosis of osteoarthritis of the hip or knee. Additionally, the term “conservative treatment,” within the context of this analysis and document, refers to conservative measures performed during the 12-month period preceding a LEJR.

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national averages or percentages in Metrics 1 or 2 (i.e., greater than or equal to the 90th percentile) or is significantly lower compared to either state or national percentages for Metric 3 (i.e., less than or equal to the 10th percentile), and
2. Has at least 10 beneficiaries with CPT® codes 27130 or 27447, and
3. Has at least \$15,000 or more in total allowed charges for CPT® codes 27130 or 27447

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 MACs' Local Coverage Determinations.

In [*Medicare Learning Network \(MLN\) Matters® Number SE1236*](#), CMS discusses the documentation of medical necessity for major joint replacement (hip and knee) procedures: “CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments...the medical records should contain enough **detailed** information to support the determination that major joint replacement surgery was reasonable and necessary for the patient. **Progress notes consisting of only conclusive statements should be avoided.** Consequently, the medical record must specifically document a complete description of the patients' historical and clinical findings.”

Table 1 identifies the CPT® and International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes used in the CBR analysis.

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

CPT®/ICD-10-CM Code	Description
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27447	Arthroplasty, knee, condyle and plateau; medical AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
97161	Physical therapy, evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy
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
20610	Arthrocentesis, aspiration, and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611	Arthrocentesis, aspiration, and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

CPT®/ICD-10-CM Code	Description
M16.XX	Osteoarthritis of hip
M17.XX	Osteoarthritis of knee

See Table 2 for a summary of your utilization of codes for LEJR.

Table 2. Summary of Your Utilization of CPT® Codes for LEJR Between Nov. 1, 2018, and Oct. 31, 2019

LEJR CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
27130	\$3600	2	2
27447	\$12,507	7	5
Total	\$16,107	9	7

*The total “Beneficiary Count” is not the sum total; it 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 with OA who received LEJR without prior conservative treatment
2. Average allowed amount per beneficiary with OA who received LEJR without conservative treatment
3. Average number of physical rehabilitation claims per beneficiary with OA with LEJR

The CBR analysis focuses on providers who performed LEJR procedures without first attempting conservative treatment. Additionally, the analysis is based on claims for beneficiaries who received LEJR procedures. 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 — The provider’s value is greater than or equal to the 90th percentile from the state or national mean (i.e., “Significantly Higher” for Metrics 1 and 2), or the provider’s value is less than or equal to the 10th percentile from the state or national mean (i.e., “Significantly Lower” for Metric 3 only).

2. Higher or Lower — The provider’s value is greater than the state or national mean (i.e., “Higher” for Metrics 1 and 2), or the provider’s value is less than the state or national mean (i.e., “Lower” for Metric 3 only).
3. Does Not Exceed or Is Not Below — The provider’s value is less than or equal to the state or national mean (i.e., “Does Not Exceed” for Metrics 1 and 2), or the provider’s value is greater than or equal to the state or national mean (i.e., “Is Not Below” for Metric 3 only).
4. Not Applicable (N/A) — The provider does not have sufficient data for comparison.

Methods and Results

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on Feb. 17, 2020. The analysis includes claims with dates of service from Nov. 1, 2018, through Oct. 31, 2019. For the trend analysis presented in Figure 1, claims represent dates of service between Nov. 1, 2016, and Oct. 31, 2019.

There are 20,346 rendering providers nationwide who have submitted claims for LEJR procedures. The total allowed charges for these claims were \$720.2 million during the analysis timeframe.

Metric 1: Percent of Beneficiaries with OA Who Received LEJR Without Prior Conservative Treatment

Metric 1 is calculated as follows:

- The count of beneficiaries with OA who received LEJR without conservative treatment (numerator) is divided by count of beneficiaries with OA who received LEJR (denominator). The result is multiplied by 100.

$$\left(\frac{\text{Beneficiaries w/ OA w/ LEJR w/out conservative treatment}}{\text{Beneficiaries w/ OA w/ LEJR}} \right) \times 100$$

Table 3: Your Percent of Beneficiaries with OA Who Received LEJR Without Prior Conservative Treatment

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
5	6	83.33%	62.68%	Higher	51.36%	Significantly Higher

Metric 2: Average Allowed Amount per Beneficiary with OA Who Received LEJR Without Conservative Treatment

Metric 2 is calculated as follows:

- The sum of the allowed amount for beneficiaries with OA who received LEJR without conservative treatment (numerator) is divided by the count of beneficiaries with OA who received LEJR without conservative treatment (denominator).

$$\frac{\text{Allowed amount for beneficiaries w/ OA w/ LEJR w/out conservative treatment}}{\text{Beneficiaries w/ OA w/ LEJR w/out conservative treatment}}$$

Table 4: Your Average Allowed Amount per Beneficiary with Diagnosis of OA Who Received LEJR Without Conservative Treatment

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
\$10,797	5	\$2159	\$888	Significantly Higher	\$840	Significantly Higher

Metric 3: Average Number of Physical Rehabilitation Claims per Beneficiary with OA with LEJR

Metric 3 is calculated as follows:

- The count of physical rehabilitation claims per beneficiary with OA performed one year prior to LEJR (numerator) is divided by the count of beneficiaries with OA who had a LEJR (denominator).

$$\frac{\text{Physical rehabilitation claims per beneficiary w/ OA performed prior to LEJR}}{\text{Beneficiaries w/ OA w/ LEJR}}$$

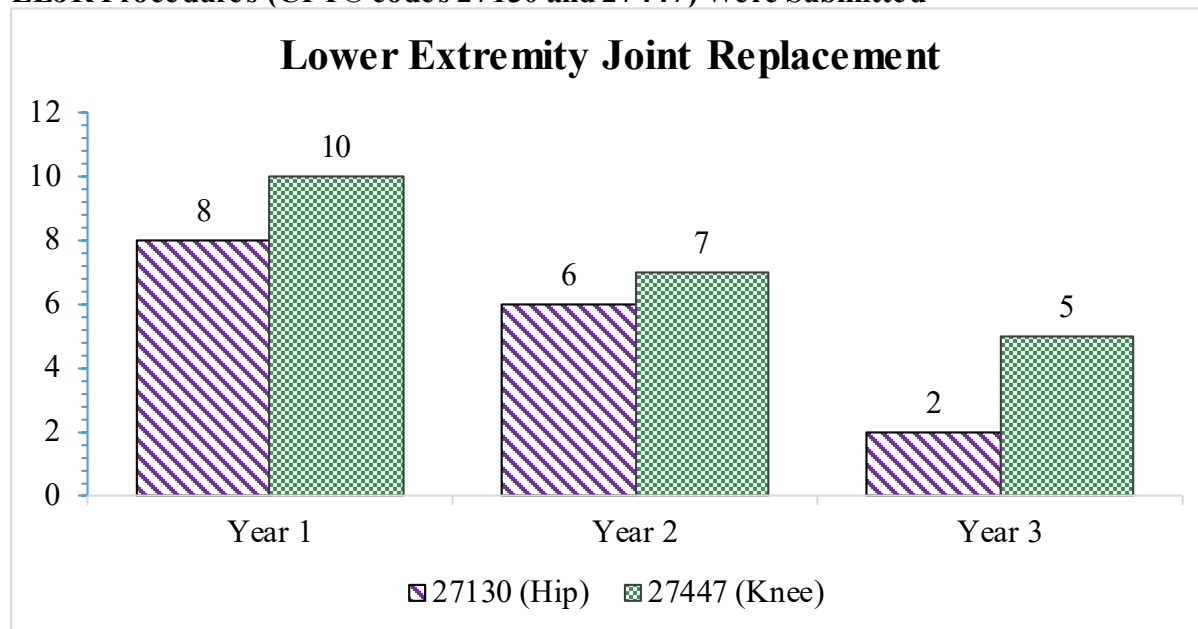
Table 5: Your Average Number of Physician Rehabilitation Claims per Beneficiary with OA with LEJR

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
1	6	0.17	0.38	Lower	0.50	Lower

Figure 1 illustrates the trend over time of the number of beneficiaries for whom claims with LEJR procedures (CPT® codes 27130 and 27447) were submitted. Year 1, Year 2, and Year 3 are defined as follows:

- Year 1: Nov. 1, 2016 – Oct. 31, 2017
- Year 2: Nov. 1, 2017 – Oct. 31, 2018
- Year 3: Nov. 1, 2018 – Oct. 31, 2019

Figure 1: Trend Over Time Analysis of Number of Beneficiaries for Whom Claims with LEJR Procedures (CPT® codes 27130 and 27447) Were Submitted



References and Resources

CPT® Professional Edition, American Medical Association.

ICD-10 Expert, 2020. American Academy of Professional Coders.

[2019 Medicare Fee-for-Service Supplemental Improper Payment Data](#), HHS. CMS. gov.

[2017 American College of Rheumatology/American Association of Hip and Knee Surgeons Guideline for the Perioperative Management of Antirheumatic Medication in Patients with Rheumatic Diseases Undergoing Elective Total Hip or Total Knee Arthroplasty](#), Goodman, Susan, et al., *Arthritis Care & Research*, August 2017, Volume 69, No. 8, Pages 1111-1124. Rheumatology.org.

[OARSI Guidelines for the Non-Surgical Management of Knee Osteoarthritis](#), McAlindon, T.E., et al., March 2014, *Osteoarthritis and Cartilage*, Volume 22, Issue 3, Pages 363-388. Oaris.org.

[MLN Matters Number SE1236](#), Sept. 17, 2012. Department of Health and Human Services, CMS. CMS. gov.