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Special Edition CBR #: CBR202010
Orthoses Referring Providers

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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.

CMS routinely distributes an educational tool, known as a CBR, to the provider community in a variety of Medicare Fee-for-Service service areas. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns for the same services in his/her state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. Receiving a CBR is not an indication or precursor to an audit, and it requires no response on a provider's part. Selected providers, however, may be referred for additional review and education as a part of CMS' routine CBR Program.

Periodically, CMS develops and distributes "Special Edition" CBRs, which offer more extensive education and resources to a subset of the provider community. Unlike routine CBRs, Special Edition CBRs include a series of up to four educational letters.

This initial Special Edition CBR educational letter is sent to selected providers based on criteria and metrics established through claim data review and research. After receiving this initial Special Edition CBR you may receive up to three additional Special Edition CBR educational letters. Each Special Edition CBR educational letter will include comparison and educational data. Criteria for receiving future Special Edition CBR educational letters is as follows:

- Letter #2 will be sent to the same pool of providers selected to receive Special Edition CBR letter #1, based on criteria and metrics established through research. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #2.
- Letter #3 will be sent to the top 50% of letter #2 recipients. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #3.
- Letter #4 will be sent to any provider who remains an outlier based on the defined criteria. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #4.

We hope that this Special Edition CBR series can help enhance your billing and/or prescribing practices and support internal compliance activities.

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 Special Edition 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 Special Edition 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, Jan.6, 2021 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. For each Special Edition CBR release there will be a webinar to follow. According to the criteria described above, you may receive additional Special Edition CBRs. Please be on the lookout for another letter around June 2021.

To request assistance or submit questions: Contact the CBR Help Desk at https://cbr.cbrpepper.org/Help-Contact-Us.

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

Orthoses Referring Providers

Introduction

CBR202010 focuses on providers listed as referring providers on claims for off-the-shelf and custom-fitted prefabricated orthoses products using Healthcare Common Procedure Coding System (HCPCS) codes L0642, L0648, L0650, L1820, L1833, L1851, L1971, L2397, L3170, L3660, L3760, L3761, L3908, L3916, and L3960. For the purposes of this document and analysis, these 15 L-codes will be referred to as "target codes."

The *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 26.3% for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), with 78.5% of the improper payments due to insufficient documentation and 12.0% due to medical necessity errors. In this report, HCPCS codes L0650 and L1851 are included in the "Top 20 Service-Specific Overpayment Rates" list. HCPCS code L0650 has an error rate of 30.0%, representing over $78 million in overpayments, and HCPCS code L1851 has an error rate of 76.47%, representing over $59 million in overpayments.

In *Medicare Allowable Amounts for Certain Orthotic Devices Are Not Comparable with Payments Made by Select Non-Medicare Payers*, an October 2019 Report in Brief, the Office of Inspector General (OIG) explores the Medicare allowable amounts for certain orthotic devices as compared to select non-Medicare payers for calendar years 2012 through 2015. In the report, the OIG recommends adjusting the allowable amounts for these orthotic devices, as appropriate, as well as creating routine reviews for Medicare allowable amounts for new and preexisting orthotic devices.

In a media release titled *Nationwide Brace Scam*, the OIG brought nationwide attention to the vulnerability of durable medical equipment to improper payments.

The criterion for receiving a CBR is that the provider is listed as a referring provider on claims with at least $50,000 or more in total paid charges for L-codes L0642, L0648, L0650, L1820, L1833, L1851, L1971, L2397, L3170, L3660, L3760, L3761, L3908, L3916, and L3960.

Coverage and Documentation Overview

Table 1 identifies the HCPCS target codes used in the CBR analysis.

Table 1: HCPCS Code Descriptions

HCPCS Codes	Description
L0642	Lumbar orthosis (LO), sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design prefabricated, off-the-shelf
L0648	Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

HCPCS Codes	Description
L0650	Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf
L1820	Knee orthosis (KO), elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L1833	Knee orthosis (KO), adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf
L1851	Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medical-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
L1971	Ankle-foot orthosis (AFO), plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L2397	Addition to lower extremity orthosis, suspension sleeve
L3170	Foot, plastic, silicone or equal, heel stabilizer, prefabricated, off-the-shelf, each
L3660	Shoulder orthosis (SO), figure of eight design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf
L3760	Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L3761	Elbow orthosis (EO), with adjustable position locking joint(s), prefabricated, off-the-shelf
L3908	Wrist-hand orthosis (WHO), wrist extension control cock-up, non molded, prefabricated, off-the-shelf
L3916	Wrist-hand orthosis (WHO), includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf
L3960	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design, prefabricated, includes fitting and adjustment

See Table 2 for a summary of your referrals for the target codes.

Table 2. Summary of Your Referrals for Target Codes Between Jun. 1, 2019, and May 31, 2020

HCPCS Codes	Paid Amount from Your Referrals	Number of Paid Orthoses from Your Referrals	Beneficiary Count	Count of Beneficiary State Codes
Total	$2,880,603	6,413	1,835	14

Metrics

This report is an analysis of the following metrics:

1. Percentage of beneficiaries referred for target codes
2. Percentage of paid amounts for target codes
3. Percentage of suppliers for target codes

The CBR analysis focuses on providers listed as referring providers on claims for HCPCS target codes. 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 referring Medicare providers practicing in the individual provider's state or territory with referrals resulting in paid claims for the target codes included in this study.
- The national peer group is defined as all referring Medicare providers in the nation with referrals resulting in paid claims for the target codes included in this study.

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

1. Significantly Higher — Provider's value is greater than or equal to the 80th percentile from the state or national mean.
2. Higher — Provider's value is greater than the state or national mean.
3. Does Not Exceed — Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — 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 Sep. 23, 2020. The analysis includes claims with dates of service from June 1, 2019, through May 31, 2020. For the trend analysis presented in Figure 1, claims represent dates of service between June 1, 2017, and May 31, 2020.

There are 126,684 referring providers nationwide who are listed as referring providers on claims for the target codes. The total paid amount for these claims were over $353,149,399 during the analysis timeframe.

Metric 1: Percentage of Beneficiaries Referred for Target Codes

Metric 1 analyzes the beneficiaries listed on claims for L-codes on which you were the referring provider.

Metric 1 is calculated as follows:

- The number of unique beneficiaries with claims submitted for any of the target codes (numerator), is divided by the number of unique beneficiaries with claims submitted with any L-code (denominator).

Table 3: Percentage of Beneficiaries Referred for Target Codes

Numerator	Denominator	Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
1,835	1,845	99.46%	36.12%	Significantly Higher	37.37%	Significantly Higher

Metric 2: Percentage of Paid Amount for Target Codes

Metric 2 analyzes the paid amount on claims for the HCPCS target codes on which you were referring provider.

Metric 2 is calculated as follows:

- The total paid amount for claims with any of the target codes (numerator) is divided by the total paid amount for claims submitted with any L-codes (denominator).

Table 4: Percentage of Paid Amount for Target Codes

Numerator	Denominator	Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
$2,880,603	$2,932,825	98.22%	23.05%	Significantly Higher	29.00%	Significantly Higher

Metric 3: Percentage of Suppliers for Target Codes

Metric 3 analyzes the supplying providers who submitted claims and were paid for the HCPCS target codes which you are listed as the referring provider.

Metric 3 is calculated as follows:

- The number of unique suppliers who submitted claims with any of the target codes (numerator) is divided by the unique suppliers who submitted claims with any of the L-codes (denominator).

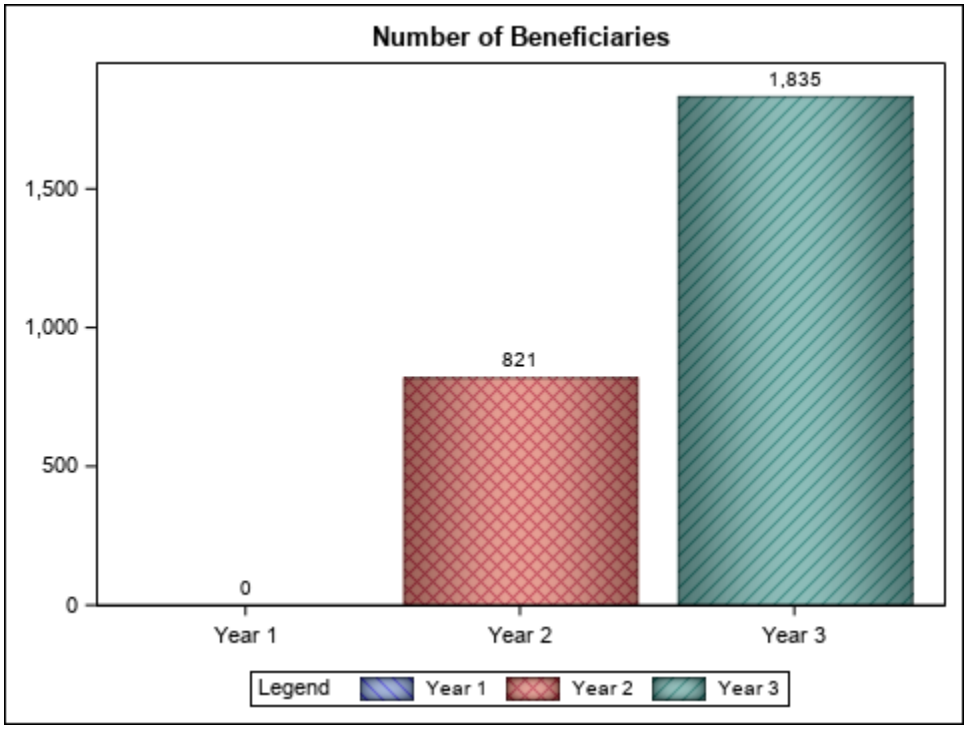
Table 5: Percentage of Suppliers for Target Codes

Numerator	Denominator	Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
73	73	100.00%	4.82%	Significantly Higher	58.63%	Significantly Higher

Figure 1: Trend Over Time Analysis of Number of Beneficiaries You Referred for Target Codes. Year 1, Year 2, and Year 3 are defined as follows:

- Year 1: June 1, 2017 – May 31, 2018
- Year 2: June 1, 2018 – May 31, 2019
- Year 3: June 1, 2019 – May 31, 2020

Figure 1 Trend Over Time Analysis of Number of Beneficiaries You Referred for Target Codes



References and Resources

HCPCS Level II Expert. AAPC.

2019 Medicare Fee-for-Service Supplemental Improper Payment Data. U.S. Department of Health and Human Services. CMS.gov.

Medicare Allowable Amounts for Certain Orthotic Devices Are Not Comparable With Payments Made by Select Non-Medicare Payers. OIG. oig.hhs.gov.

Nationwide Brace Scam. OIG. oig.hhs.gov.