RELI Group
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February 28, 2023

CBR #: CBR202302
Immunosuppressive Drugs

NPI #: 1234567890
Fax #: 1-XXX-XXX-XXXX

Organization Name
Address1
Address2
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.

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. The report is not an indication of wrongdoing, and can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication of, 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.

This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation.

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: AccessCode.

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org. Register for a live webinar on March 8, 2023, 3 p.m. ET.

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

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Comparative Billing Report (CBR) 202302
February 28, 2023

Immunosuppressive Drugs

Introduction

CBR202302 focuses on rendering providers that submitted claims to Medicare Part B for immunosuppressive drugs. The analysis will focus on Healthcare Common Procedure Coding System (HCPCS) codes J7503, J7507, J7518, and J7527, as well as modifier KX. For the purposes of this document and analysis, these HCPCS codes, as a group, will be referred to as "immunosuppressive drugs."

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on Jan. 31, 2023. The analysis includes both paid and unpaid claims with dates of service from Oct. 1, 2021, through Sept. 30, 2022. For the trend analysis presented in Figure 1, claims represent dates of service between Oct. 1, 2019, and Sept. 30, 2022.

The *2022 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 23.7% for immunosuppressive drugs, which represents $63,087,097 in improper payments. The types of errors that comprise the improper payment rate include a 50.6% improper payment rate attributed to insufficient documentation and a 12.9% improper payment rate attributed to medical necessity errors.

In the *2022 HCPCS Level II Expert*, modifier KX is defined as follows: "The provider should append modifier KX when expectations are in effect and the beneficiary qualifies for an exception." An August 2017 report from the Office of Inspector General (OIG) found that "Medicare Part B paid for some immunosuppressive drugs billed with the KX modifier that were not eligible for Part B payment." The report further states that "[t]he Centers for Medicare & Medicaid Services' (CMS) intention for the KX modifier was to signify an attestation by the pharmacy that it had documentation proving that a beneficiary's organ transplant occurred when the beneficiary was eligible for Medicare coverage."

In "Chapter 17, Section 80.3," of the Medicare Claims Processing Manual, CMS provides the following guidance for the use of the KX modifier: "The use of the KX modifier is not required. In the case of immunosuppressive drugs, submission of the KX modifier is intended for adjudicating claims when the supplier attests that it maintains documentation that the beneficiary was eligible for Medicare Part A on the date of his/her transplant, but where Medicare cannot identify a claims record indicating the transplant was paid for by fee-for-service Medicare. The additional information provided by the use of the KX modifier permits Medicare to reasonably assume that a Medicare payment for an organ transplant was made. For claims received on and after July 1, 2008, DME MACs will accept claims for immunosuppressive drugs without a KX modifier but will deny such claims if CMS cannot identify a record of a claim indicating that the transplant was paid for by fee-for-service Medicare."

After review of, and research into, the improper payment rate, this CBR was created to analyze the possible threat associated with immunosuppressive drugs to the Medicare Trust Fund. The expectation is that rendering providers of immunosuppressive drugs will maintain proper coding documentation procedures and confirm appropriate use of modifier KX.

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national percentages in either of the two metric calculations (i.e., greater than or equal to the 90th percentile), and
2. Has at least 3 beneficiaries with claims submitted for immunosuppressive drugs, and
3. Has at least $3,000 in total charges for immunosuppressive drugs.

Coverage and Documentation Overview

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

Table 1: HCPCS Code Descriptions

HCPCS Codes	Description
J7503	Tacrolimus, extended release, (Envarsus XR), oral, .25 mg
J7507	Tacrolimus, immediate release, oral, 1 mg
J7518	Mycophenolic acid, oral, 180 mg
J7527	Everolimus, oral, .25 mg

Table 2 provides summaries of your utilization of HCPCS codes for immunosuppressive drugs.

Table 2: Summary of Your Utilization of HCPCS Codes for Immunosuppressive Drugs Between Oct. 1, 2021, and Sept. 30, 2022

HCPCS Codes	Allowed Charges	Claim Lines	Units	Beneficiary Count*
J7503	$0	0	0	0
J7507	$765	33	1,575	4
J7518	$4,264	36	2,940	4
J7527	$0	0	0	0
Total	**$5,029**	**69**	**4,515**	**5**

*A beneficiary is counted once per row of HCPCS code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the HCPCS codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Percentage of immunosuppressive drug claim lines submitted, per code
2. Percentage of immunosuppressive drug claim lines submitted with modifier KX

The CBR analysis focuses on rendering providers with specialty A5 (i.e., pharmacy) that submitted claims for immunosuppressive drugs. 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 [StateName] and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider's value is greater than or equal to the 90th 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

There are 21,427 rendering providers nationwide that have submitted claims for immunosuppressive drugs. The total allowed charges for these claims were over $235 million during the analysis timeframe.

Metric 1: Percentage of Immunosuppressive Drug Claim Lines Submitted, per Code

Metric 1 is calculated as follows:

- The total number of unique claim lines for J7503 is divided by the total number of unique claim lines for immunosuppressive drugs.
- The total number of unique claim lines for J7507 is divided by the total number of unique claim lines for immunosuppressive drugs.
- The total number of unique claim lines for J7518 is divided by the total number of unique claim lines for immunosuppressive drugs.
- The total number of unique claim lines for J7527 is divided by the total number of unique claim lines for immunosuppressive drugs.

Table 3: Percentage of Immunosuppressive Drug Claim Lines Submitted, per Code

Code	Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
J7503	0	69	0.00%	2.44%	Does Not Exceed	12.84%	Does Not Exceed
J7507	33	69	47.83%	67.99%	Does Not Exceed	63.60%	Does Not Exceed
J7518	36	69	52.17%	28.90%	Significantly Higher	21.81%	Significantly Higher
J7527	0	69	0.00%	0.67%	Does Not Exceed	1.75%	Does Not Exceed

Metric 2: Percentage of Immunosuppressive Drug Claim Lines Submitted with Modifier KX

Metric 2 is calculated as follows:

- The total count of unique claim lines for all immunosuppressive drugs with the KX modifier is divided by the count of unique claim lines for all immunosuppressive drugs.

Table 4: Percentage of Immunosuppressive Drug Claim Lines Submitted with Modifier KX

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
69	69	100.00%	99.98%	Significantly Higher	99.63%	Significantly Higher

Figure 1 illustrates the trend over time analysis for the number of beneficiaries who had claims submitted for immunosuppressive drugs. Figure 2 illustrates the number of paid claims submitted for Immunosuppressive Drugs, per month, for year 3.

Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** October 1, 2019 – September 30, 2020
- **Year 2:** October 1, 2020 – September 30, 2021
- **Year 3:** October 1, 2021 – September 30, 2022

Figure 1: Total Number of Beneficiaries Who Had Claims Submitted for Immunosuppressive Drugs, Trend Over Time

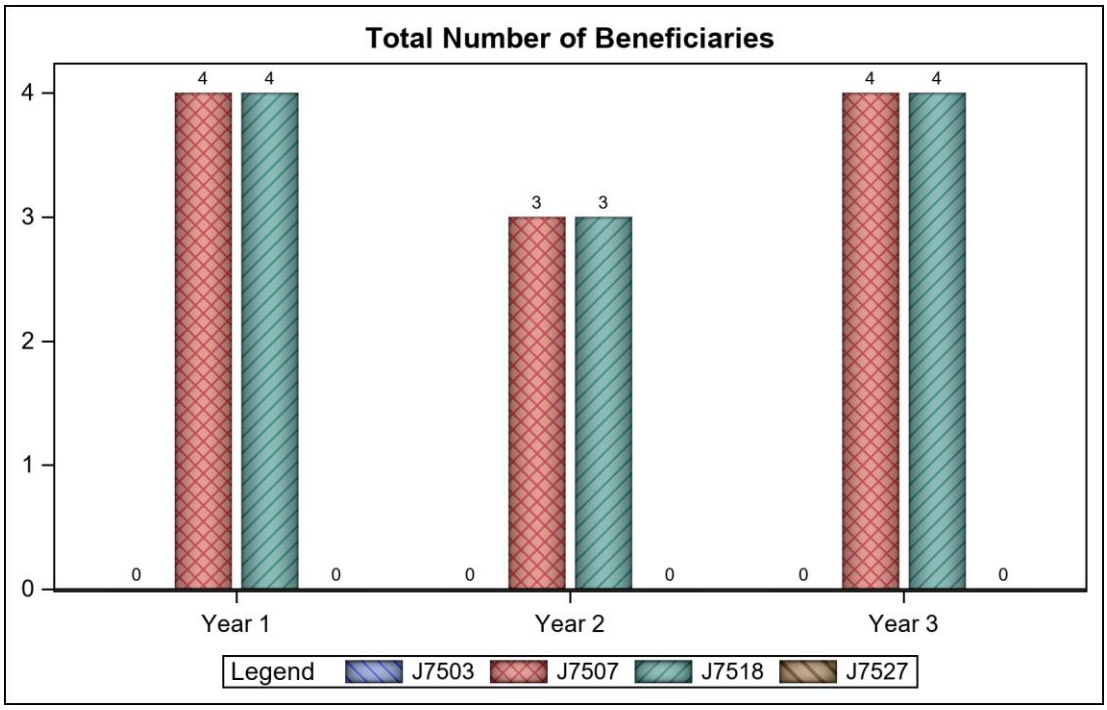
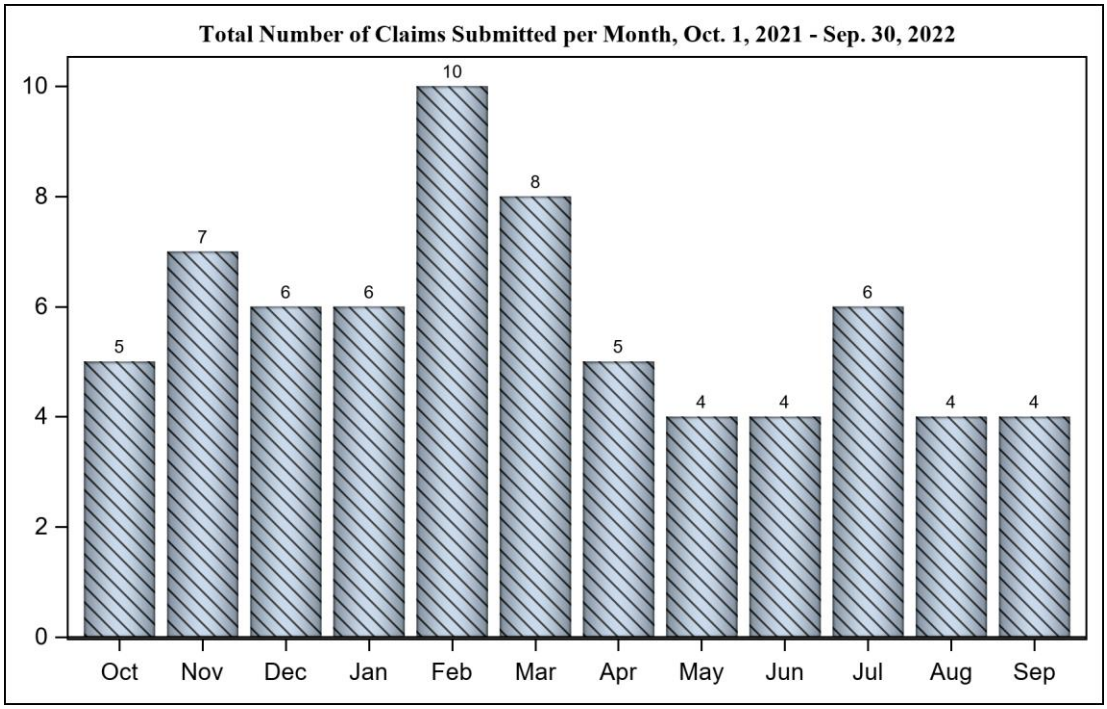


Figure 2: Total Number of Paid Claims Submitted for Immunosuppressive Drugs, per Month, for Year 3



References and Resources

2022 HCPCS Level II Expert. American Academy of Professional Coders.

2022 Medicare Fee-for-Service Supplemental Improper Payment Data. U.S. Department of Health and Human Services (HHS). CMS.gov.

CMS and Its Claims Processing Contractors Issued Conflicting Guidance on the Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims. OIG. oig.hhs.gov.

Medicare Claims Processing Manual, "Chapter 17, Section 80.3," CMS