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Report to Congressional Committees

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Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed

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The Honorable Daniel P. Moynihan, Chairman
The Honorable Bob Packwood
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell, Chairman
The Honorable Carlos J. Moorhead
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski, Chairman
The Honorable Bill Archer
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Medicare pays for orthoses (braces) and prostheses (primarily artificial limbs) when beneficiaries need such items because of injury or illness. Until 1989, Medicare paid for these items on the basis of the charges made by those who supplied the items—primarily practitioners who specialize in making or fitting braces and artificial limbs but also some physicians.[1] Beginning in 1989, a fee schedule replaced the reasonable charge system as a means of paying for orthotic and prosthetic (O&P) items.

The industry expressed concerns about payment levels under the fee schedule. In 1990, the Congress directed us to study whether O&P practitioners should receive separate payments for their professional services in fitting patients. Based on discussions with your Committees' offices, we also agreed to review whether there were items covered under the O&P fee schedule that could be moved to a more appropriate payment category and whether the criteria used to determine patient eligibility for O&P items were consistent across the country.

Results in Brief

There is no need to establish separate fees for professional services because Medicare's payment amounts for braces and artificial limbs

[1]In this report, we use the term O&P practitioner to refer to people who specialize in providing and fitting braces and artificial limbs and general medical equipment suppliers who provide and fit these items; the term does not include physicians, physical therapists, or pharmacies who in some cases also furnish O&P items.

already include a component for the practitioner's professional services. This component ranged from 18 to 65 percent of payments for selected high-cost artificial limbs. Moreover, practitioners agree to accept Medicare fee schedule amounts as payment in full about 80 percent of the time, which indicates practitioners generally find payments high enough to cover their services.

With the assistance of two industry groups, we identified 42 items paid for under the O&P fee schedule that do not require professional fabrication or fitting services. These items included such things as sterile saline solutions, ostomy supplies, and off-the-shelf braces. Moving these items to a more suitable fee schedule category that covers items not requiring fitting would reduce Medicare costs by an estimated $12 million annually.

We also identified considerable variation in coverage criteria for braces and artificial limbs among Medicare's claims processing contractors. This variation in criteria could result in payments for the same item being authorized in some areas and being denied in others. Medicare's December 1992 action to reduce the number of contractors that pay brace and artificial limb claims from 54 to 4 should remedy this problem and result in more consistent criteria being used.

Background

Medicare is a federal health insurance program, authorized by title XVIII of the Social Security Act, that covers most people 65 years or older and some disabled people. The program helps pay for a broad range of services, from inpatient hospital care (part A of Medicare) to physician services and medical equipment used in the home (part B). Under Medicare, braces are classified as orthotics, artificial limbs as prosthetics, and ostomy supplies, urological supplies, and enteral and parenteral supplies and equipment[2] as prosthetic devices. In 1991, payments for braces and artificial limbs represented less than 1 percent of total part B payments ($311 million out of $45 billion).

The Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) administers Medicare and contracts with private insurance companies and Blue Shield plans to process and pay part B claims. These contractors, called carriers, pay claims originating in their geographic service area, which is usually an entire state.

[2]Enteral and parenteral supplies and equipment provide nutrients to individuals who are unable to swallow food or do not have a functioning gastrointestinal tract. These items are still paid for under the reasonable charge system.

In the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (P.L. 100-203, Dec. 22, 1987) the Congress created a fee schedule payment system for medical equipment used in the home and O&P items. Under the fee schedules, these items are assigned to one of six categories, with a different payment method for each category. The six categories are (1) inexpensive or routinely purchased items, (2) items requiring frequent and substantial servicing, (3) oxygen and oxygen equipment, (4) O&P items, (5) customized items, and (6) other covered items.

Each carrier established its fee schedule for O&P items on the basis of charges submitted during the 12-month period July 1986 to June 1987, the time period specified in OBRA 1987. If a sufficient number of charges were not available for an item during this period,[3] the carrier computed the fee schedule using gap-filling procedures, which included obtaining fees from other carriers or using O&P practitioner pricing manuals. To reduce variation in carrier reimbursement for similar items, OBRA 1987 included provision for regional fee schedules, to be phased in beginning January 1, 1992.[4] The regional fee schedules will be fully implemented by January 1, 1994.

Objectives, Scope, and Methodology

Through discussions with representatives of the congressional Committees with oversight responsibility for the Medicare program, we agreed that the specific objectives of this assignment would be to determine

- whether a separate fee schedule should be established for O&P practitioners' professional services,
- whether certain items classified as O&P could be reclassified and what the effect of such changes on Medicare costs would be, and
- whether medical coverage policies for braces and artificial limbs varied among selected carriers.

To address the first objective, we reviewed two issues. First, we assessed the industry's contention that physician charges for O&P items did not include charges for fitting items and thus had lowered fee schedule amounts. We reviewed the procedures 8 carriers used to establish fees for 24 high-cost, high-volume braces and artificial limbs, including recomputing the initial fees, excluding physician charges, for 5 of those

[3]HCFA's minimum requirements were three charges from each of four suppliers during the base period.

[4]Hawaii and Alaska are exempt from the regional fee schedules.

items. (App. II describes these 24 items, which accounted for 50 percent of total allowed charges for braces and artificial limbs during calendar years 1986-87.) Second, we compared average Medicare fee schedule payment rates to the charges made to practitioners by a central fabricator for the components of seven high-cost items. (These items are also described in app. II.)

For the second objective, with the assistance of industry groups, we identified items currently classified as O&P that have no service component and thus could be reclassified. (App. III describes these items.) For the third objective, we compared the coverage criteria for the 24 high-cost, high-volume braces and artificial limbs among the 8 carriers.

We did our work at HCFA's headquarters and eight carriers. We also contacted individual O&P practitioners and met with representatives from the main industry groups—the American Orthotic and Prosthetic Association (AOPA) and the Board for Orthotist Certification (BOC). (Details about our methodology, including a list of the eight carriers visited, are in app. I.)

Separate Fees for Professional Services Not Needed

A separate fee schedule for the professional services of O&P practitioners is not necessary. The industry believed that including physician charges in the data used to set fee schedule amounts had artificially lowered rates. The industry thought that physicians charged less because they could bill separately for their professional services by charging for office visits. However, we found that including physician charges had little effect on payment amounts.

Moreover, we found that current fee schedule amounts include a component for professional services. We compared the list prices manufacturers charged O&P practitioners for the components of selected high-cost artificial limbs to Medicare fee schedule amounts for these limbs. We found that from 18 to 65 percent of payments was available to cover the O&P practitioners' professional services. In addition, for about 80 percent of O&P claims, practitioners agree to accept the fee schedule amount as payment in full, which indicates they generally find payment rates sufficient.

Physician Billings Had Little Effect on Fees

Under the Medicare program, braces and artificial limbs are provided by several types of providers, including O&P practitioners, pharmacies,

physical therapists, and orthopedic surgeons and other physicians. The databases the carriers used to establish the fee schedules included charges from all types of providers for the July 1986-June 1987 period. AOPA officials believed that including physician charges in the databases lowered the payment rates established under the fee schedule. They believed physicians charged less for braces and artificial limbs than O&P practitioners because physicians may bill separately for their professional services. On the other hand, O&P practitioners cannot bill separately for their services, and their bills include charges for the components of the brace or artificial limb plus their services for patient evaluation, fitting, and adjustments.

As shown in table 1, physician charges for braces and artificial limbs during calendar years 1986-87 (which included the July 1986-June 1987 fee schedule base period) comprised less than 3 percent of total Medicare-approved charges for those items. O&P practitioner charges accounted for over 85 percent of total charges.

Table 1: Percentage of Total Medicare-Approved Charges for Braces and Artificial Limbs by Selected Provider Specialties, Calendar Years 1986-87

	Medicare-approved charges (%)	
Type of provider	**1986**	**1987**
O&P practitioners	86.9	88.9
Pharmacies	9.1	8.5
Others[a]	1.5	0.2
Subtotals, nonphysician specialties	**97.5**	**97.6**
Orthopedic surgeons	1.2	1.3
All other physicians	1.3	1.1
Subtotals, physician specialties	**2.5**	**2.4**
Total	**100.0**	**100.0**

[a]Category includes providers with miscellaneous specialty codes (dentists, chiropractors, public health agencies, etc.) and providers whose specialty code was unknown.

Source: HCFA part B Medicare annual data files.

To determine the effect that physician charges for O&P services had on the original O&P fee schedules, we selected five items that together accounted for over 25 percent of total Medicare-allowed charges for braces and artificial limbs in 1986-87. We recomputed the fee schedule rates for those items at six carriers[5] by excluding physician charges. We then compared

[5]Two of the eight carriers we visited could not find the initial charge data used for the five procedures. At the six carriers, these five items accounted for about 24 percent of total allowed charges for braces and artificial limbs during calendar years 1986-87.

those recomputed rates with the initial O&P fee schedules computed by the six carriers. The effect of excluding physician charges from the fee computation is shown in figure 1.

Figure 1: Percentage That 1989 Fee Schedule Rates Would Have Increased (Decreased) If Physician Charges Were Excluded From the Calculation for Five Braces and Artificial Limbs at Six Carriers
(Numbers in Percent)

Item and HCPCS[a] code	Carrier service area[b]					
	TX	FL	PA	CA (southern)	WI	SC
Back brace (L0500)	6.1	3.9	7.4	■	11.3	1.2
Ankle, foot brace (L1960)	1.5	●	1.7	▲	3.2	■
Below-knee artificial limb (L5100)	●	▲	●	▲	2.6	▲
Below-knee artificial limb, endoskeletal system (L5300)	(0.1)	●	▲	●	▲	▲
Sock for artificial limb (L8420)	●	●	●	●	●	▲

[a]HCFA Common Procedure Coding System. A description of these items is in appendix II.

[b]Carrier names are in appendix I.

■ — Gap-filled

● — Effect was negligible (less than ± 0.1 percent)

▲ — No physician charges

As figure 1 shows, excluding physician charges from the data used to calculate the fee schedule payment rate would have had limited effect on payment levels. For four of the five items, excluding physician charges would have had a negligible or minor effect on most fees. At least one carrier for each of these four items had no physician charges in its original database. The one item whose fee schedule payment rate was influenced by physician charges was the back brace, for which physicians had about 14 percent of approved volume during calendar years 1986-87. If physician charges had been excluded from the calculation of the fee schedule for

this item, the resulting payment rates would have been from 1 to 11 percent higher (an increase of $1 to $8 per item) at five of the six carriers.

Data Not Available to Determine Suppliers' Costs

To ensure proper fit of a brace or artificial limb, the supplier may need to see the patient several times. When dealing with Medicare beneficiaries, O&P practitioners charge one fee, which covers the cost of the brace or artificial limb and the service (including follow-up visits) for the beneficiary. Practitioners and industry representatives told us that the service component includes evaluating the patient and fitting and adjusting a device for a patient. They also said that the amount of time and number of visits needed varies by patient and by type of item; however, the O&P industry has not collected data that could be used to establish a reasonable fee based on the cost of items plus the service provided. HCFA does not have such data either.

The cost of a custom-fabricated brace or artificial limb varies from one supplier to another. Some O&P practitioners make their own braces or artificial limbs while others buy them from a central fabrication laboratory. Using price lists from a central fabricator, we identified the component cost for seven high-cost artificial limbs. In 1991, Medicare payments for these seven items accounted for 25 percent of total Medicare payments for braces and artificial limbs.

As shown in table 2, Medicare reimbursement amounts for each of the seven items are higher than the practitioners' costs to buy these artificial limbs from a central fabrication laboratory, which demonstrates that the current Medicare fee schedule payment rate includes a component for practitioner services. Because appropriate cost data were not available, we were unable to determine if the amounts provided by the Medicare fee schedules for professional services are reasonable in relation to the costs of furnishing the services. The Medicare payment rates for these high-cost items are generally based on the amount charged by O&P practitioners. Presumably, the practitioners included an amount for their services, and thus that amount is reflected in the payment rates.

Table 2: Amount That Average 1991 Medicare Fee Schedule Payment Rates of Eight Carriers Exceeded Charges of a Central Fabrication Laboratory for Seven Selected Artificial Limbs

HCPCS[a] code	Average Medicare fee schedule payment	Central fabrication laboratory charge	Difference (available for professional services)	
			Dollar	Percentage of average Medicare fee schedule payment
Below-knee artificial limb (L5100)	$1,709	$1,196	$513	30%
Below-knee artificial limb, endoskeletal system (L5300)	2,153	1,279	874	41
Above-knee artificial limb, endoskeletal system (L5320)	3,192	2,179	1,013	32
Test socket for artificial limb (L5620)	204	72	132	65
Below-knee socket insert for artificial limb (L5655)	206	160	46	22
Energy-storing foot add-on to artificial limb (L5976)	434	198	236	54
Flex foot system for artificial limb (L5980)	2,700	2,225	475	18

[a]HCFA Common Procedure Coding System. A description of these items is in appendix II.

One indicator of the adequacy of the fee schedule payment is the assignment rate[6] for Medicare claims. In calendar year 1991 (the latest period for which a full year's data were available), O&P practitioners' assignment rate was 85 percent for braces and 78 percent for artificial limbs. These assignment rates indicate that O&P practitioners are generally willing to furnish items at Medicare payment rates.

Further, to protect against the use of unreasonably high or low payment rates, HCFA instructed carriers to review their fees for O&P items and to adjust fees if necessary under their inherent reasonableness authority.[7] Seven of the carriers we visited had records of the inherent reasonableness reviews they performed in 1990. The 7 carriers reviewed 130 of their fees, and they increased 80 percent of them (104 fees) and decreased the remaining fees.

[6]By accepting assignment, the supplier agrees to accept Medicare's allowed charge as payment in full.

[7]In some instances, if the use of historical charge data results in Medicare payment amounts that are not inherently reasonable, Medicare has a provision for using alternative sources of data for setting payment amounts. Under this inherent reasonableness provision, HCFA told the carriers to review fees that were (1) above or below 30 percent of the national median fee or (2) above or below 20 percent of the national median fee when the item was among the top 50 by volume in each carrier area.

Some O&P Items Could Be Reclassified

Ostomy and urological supplies and other selected items currently categorized as braces and artificial limbs could be reclassified to the category for inexpensive or routinely purchased durable medical equipment (DME) because these items do not require a significant amount of service from the supplier.

O&P items typically require a professional service component, such as patient assessment, fitting, and adjustments, and charges for these services are included in the O&P practitioner's fee. Representatives from both AOPA and BOC agreed that ostomy and urological supplies do not have a significant service component. In addition, AOPA representatives identified 11 items (10 braces and a mastectomy bra) that in their opinion do not have a significant service component and could be reclassified. The International Association of Orthotics and Prosthetics, an industry association representing BOC-certified practitioners, told us that these items are sized and not made to order, but in its opinion, these items require adjustments to ensure proper fit and thus have a service component. We did not attempt to resolve this disagreement between the industry associations. We calculated savings possible from reclassifying the 11 items identified by AOPA to illustrate what savings may be possible.

If the payment basis for 31 common ostomy and urological supplies and the 11 other items was changed to the category for inexpensive and routinely purchased DME, Medicare payments would be reduced by more than $12 million annually. The savings would result because of the different payment rules applicable to each category. For an item in the inexpensive and routinely purchased category, the fee schedule rate in any carrier area cannot exceed the weighted average of all carrier fee schedule amounts for an item and cannot be less than 85 percent of that ceiling. For an item under the O&P fee schedule, the regional fees being phased in by January 1994 also are subject to a national ceiling and floor, but the ceiling for O&P items is 120 percent of the average allowed amount, and the floor is 90 percent of the average. The savings possible from reclassifying the 42 items we reviewed is summarized in table 3. This estimate of savings was based on fee schedule rates after the national ceilings and floors and regional fee schedules are fully phased in.

Table 3: Estimated Annual Savings to Medicare If Payment for Ostomy and Urological Supplies and Selected Other Items Was Made Under the Fee Schedule for Inexpensive or Routinely Purchased DME

Dollars in thousands

	Payments under		
Type of items	O&P fee schedule	Inexpensive or routinely purchased DME fee schedule	Annual savings to Medicare
Ostomy and urological supplies	$212,754	$201,043	$11,711
Selected other items	7,875	7,418	457
Total	**$220,629**	**$208,461**	**$12,168**

Current law does not specifically address coverage of items such as urological supplies. HCFA has classified them as prosthetic items because they replace an impaired body function. This classification enables Medicare to cover and pay for these items. To ensure there is no doubt that these items will be covered by the Medicare program if they are reclassified under the fee schedule for inexpensive or routinely purchased DME, we believe the Congress should amend the Social Security Act to clearly cover such supplies and to authorize the Secretary of HHS to reclassify such items.

Consistent Medical Policy Guidelines Are Needed

Carriers use different medical criteria when making coverage decisions for braces and artificial limbs. As a result, an item that may be approved for payment by one carrier may be denied payment by another. HCFA's reduction in the number of carriers processing claims for braces and artificial limbs to four should result in more consistent criteria being used.

Medicare carriers make coverage decisions on the basis of local medical policy and national guidance. The eight carriers we visited used varying medical coverage criteria for braces and artificial limbs. This variability can be seen, for example, in the criteria applicable to coverage for an energy-storing foot[8] as a substitute for a solid ankle, cushion heel foot (commonly called a SACH foot). One carrier routinely denied coverage for the energy-storing foot; two carriers allowed it if the patient's physician specifically justified this substitution based on certain medical conditions; and five carriers allowed it on the basis of the physician's prescription. In our opinion, more consistent medical policy for the payment of braces and artificial limbs is needed.

[8]The energy-storing foot is designed for persons with higher activity levels, particularly those involved in athletics.

HCFA has recognized the diversity among carrier interpretations of medical review policies and has announced plans to make those policies more consistent. In December 1992, HCFA announced that the processing of claims for DME, prosthetics, orthotics, and supplies will be consolidated at four regional carriers starting in October 1993. HCFA said that carriers have inconsistently interpreted coverage rules, utilization screens, and medical review requirements. HCFA believes one reason for the inconsistencies is that only a few large carriers have claims volumes for those items high enough to justify undertaking the extensive training needed to develop expertise in pricing claims and to establish comprehensive medical review guidelines. Under the new regional alignment, HCFA said that one critical task for regional carriers will be to consolidate local medical review policies into one regionwide medical review policy. The regional carriers will also be required to share their regional criteria with HCFA and with each other.

Conclusions

Because the O&P fee schedule payments for braces and artificial limbs cover the cost of the device and provide an amount for the related professional services furnished by the O&P practitioner, a separate fee schedule for the professional services of O&P practitioners is not necessary. Also, contrary to industry concerns, physician charges had little effect on Medicare's initial fee schedule payment rates.

We believe the Secretary of HHS should be authorized to revise the existing fee schedules by reclassifying some O&P items to the category for inexpensive and routinely purchased DME. If this were done, Medicare expenses would be reduced and at least some of the items that do not require a significant amount of service would be removed from the O&P fee schedule. To remove any doubt that ostomy and urological supplies and other reclassified items are covered under Medicare, the Congress should amend the Social Security Act to authorize the Secretary to reclassify such items.

Carriers use different medical criteria when deciding whether to pay for braces and artificial limbs. HCFA plans to have four regional carriers process claims for braces and artificial limbs, DME, and related supply items, and the regional carriers will be required to develop and share their regional medical review policies. This should result in more consistent criteria being used and limit the situations in which differences in medical criteria result in coverage disparities among carriers.

Recommendation to the Congress

We recommend that the Congress amend the Social Security Act to permit the Secretary of HHS to reclassify items currently covered as O&P items, such as ostomy and urological supplies and certain braces that the Secretary determines do not require significant amounts of fitting and adjustments, to the fee schedule for inexpensive or routinely purchased durable medical equipment.

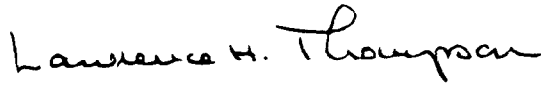
Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS said it strongly supported this recommendation but that our recommendation did not go far enough. HHS said that the President's budget for fiscal year 1994 contains a proposal to modify the method for setting the maximum payment rates for O&P and DME items (see app. IV).

As agreed with the Committees' offices, our objectives included whether certain items could be reclassified and what effect such action would have on Medicare costs. We did not attempt to determine what the proper level of payment should be or to evaluate whether setting ceilings differently would be appropriate.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of HHS; and other interested parties.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 512-7119 if you have any questions. Other major contributors to this report are listed in appendix V.



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Abbreviations

AOPA	American Orthotic and Prosthetic Association
BOC	Board for Orthotist Certification
DME	durable medical equipment
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HHS	Department of Health and Human Services
O&P	orthotic and prosthetic
OBRA 1987	Omnibus Budget Reconciliation Act of 1987
SACH	solid ankle, cushion heel

Objectives, Scope, and Methodology

Objectives

In the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, Nov. 5, 1990) the Congress required us to study the feasibility and desirability of establishing a separate fee schedule for use in paying suppliers of O&P items who also provide professional services. We were to take into account the costs to the providers of providing such services. Through discussions with the offices of the congressional Committees with oversight responsibility for the Medicare program,[1] we agreed to assess

- the extent that the 1989 fees for braces and artificial limbs established under the O&P fee schedule were affected by the inclusion of physicians' charges in the fee computation
- whether these fees include amounts for the service costs of O&P practitioners for selected high-cost, high-volume braces and artificial limbs,
- whether certain items such as ostomy and urological supplies currently paid under the O&P fee schedule could be categorized under another fee schedule category, and
- whether carriers' payment and medical criteria for braces and artificial limbs varied.

Scope

We contacted eight carriers to determine their payment and coverage policy for braces and artificial limbs. The eight carriers visited and the area each serves are identified in table I.1.

Table I.1: Carriers Visited and Their Service Areas

Carrier name	Service area
California Physicians' Service	Northern California
Blue Cross and Blue Shield of Florida, Inc.	Florida
Blue Cross and Blue Shield of Massachusetts, Inc.	Massachusetts
Pennsylvania Blue Shield	Pennsylvania
Blue Cross and Blue Shield of South Carolina	South Carolina
Blue Cross and Blue Shield of Texas, Inc.	Texas
Transamerica Occidental Life Insurance Company	Southern California
Wisconsin Physician Service	Wisconsin

We selected these carriers because claims in their service areas represented 36 percent of Medicare-allowed charges for O&P items in calendar year 1986 and 39 percent of such charges in 1987, they serve a

[1]The Subcommittee on Medicare and Long-Term Care, Senate Committee on Finance; the Subcommittee on Health, House Committee on Ways and Means; and the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

variety of geographic areas, and some of them were known to have developed medical coverage criteria for O&P items.

The information obtained from these carriers included

- reasonable charge and fee schedule pricing data for 24 high-cost, high-volume braces and artificial limbs covering calendar years 1989-92 (identified and described in app. II),
- medical coverage criteria for the 24 items,
- Medicare-approved part B charges for braces and artificial limbs by provider specialty for calendar years 1986-91, and
- the charge data the carriers used to establish the original 1989 fee schedule payment rates for five items (identified and described in app. II).

In addition, we obtained data on the prices a large central fabricator charged O&P practitioners for seven artificial limbs and related items (identified and described in app. II). We also contacted 28 O&P practitioners and representatives of the major industry groups—the American Orthotic and Prosthetic Association (AOPA) and the Board for Orthotist Certification (BOC).

Methodology

To determine the extent that fees for braces and artificial limbs were reduced by the inclusion of physician charges, we determined how much the initial fees would have been increased or decreased if charges from physicians had been excluded from the calculation for five items that accounted for over 25 percent of total Medicare-allowed charges for braces and artificial limbs in 1986-87.

We identified certain ostomy and urological supply items currently classified as O&P that have no significant service component and that could be reclassified to the fee schedule category for inexpensive or routinely purchased durable medical equipment (DME). AOPA and BOC representatives agreed with this selection. AOPA officials also identified 10 braces and a mastectomy bra as items they believed did not require a significant amount of service and could also be reclassified, but BOC did not agree with this list.

To estimate the effect that reclassifying these items would have on Medicare program costs, we compared estimated annual Medicare payments for 31 ostomy and urological supplies, 10 braces, and a mastectomy bra under the O&P fee schedules and the inexpensive and

routinely purchased DME fee schedules. We multiplied each carrier's 1991 volume for each of the 42 items by that carrier's fee schedule rates for the item to calculate total Medicare-allowed amounts. This was done for all carrier areas in the 48 contiguous states plus the District of Columbia. We multiplied those amounts by 80 percent to estimate national Medicare payments for each item. For this comparison, we used rates that would be in effect in 1994, after the transition to regional rates for the O&P fee schedule and the transition to national limits for the DME fee schedule. To remove the effect of inflation, the rates were stated in 1991 dollars. (The items used in these estimates are identified and described in app. III.)

Neither HCFA nor the O&P industry could provide adequate cost data to analyze the relationship between the cost of a brace or artificial limb and the payment that providers receive for such items and related services. We compared the charges from a large central fabricator for seven artificial limbs and related items with the average 1991 Medicare fee schedule payment rates for those same items in the eight carrier areas we visited. The difference between the central fabricator's charge and the average Medicare fee schedule payment rate would be the amount available to compensate O&P practitioners for their services.

We contacted, either in person or by telephone, 28 O&P practitioners who provided services in the 8 carrier areas visited. We obtained names from AOPA, BOC, two carriers, and one O&P practitioner. We obtained a description of the O&P practitioners' practices, including the evaluation, fitting, and adjustment services they provided. We also discussed with the O&P practitioners Medicare's reimbursement policies for braces and artificial limbs and the relationship between their costs and Medicare fees.

We also discussed Medicare's reimbursement policies for O&P with representatives of AOPA and BOC.

We did our work from November 1991 to December 1992, in accordance with generally accepted government auditing standards.

Code and Description of Braces and Artificial Limbs Selected for Pricing Analysis

HCPCS[a] code	Description of item
L0500[b]	Lumbar-sacral orthosis, flexible (lumbo-sacral surgical support), custom-fitted
L1940	Ankle-foot orthosis (AFO), molded to patient model, plastic
L1960[b]	AFO, posterior solid ankle, molded to patient model, plastic
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar "BK" orthosis)
L2020	Knee-ankle-foot orthosis (KAFO), double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis)
L2036	KAFO, full plastic, double upright, free knee, molded to patient model
L3805	Wrist-hand-finger orthosis, long opponens, no attachments
L4310	Multipodus or equal orthotic preparatory management system for lower extremities
L4320	Addition to AFO, multipodus (or equal) orthotic preparatory management system for lower extremities, flexible foot positioner with soft interface for AFO, with velcro closure, custom-fitted
L5100[bc]	Below-knee prosthesis, molded socket, shin, solid ankle, cushion heel (SACH) foot
L5200	Above-knee prosthesis, molded socket, single axis constant friction knee, shin, SACH foot
L5300[bc]	Below-knee prosthesis, molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5320[c]	Above-knee prosthesis, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing
L5530	Preparatory prosthesis, below-knee "PTB"-type socket, "USMC" or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5540	Preparatory prosthesis, below-knee "PTB"-type socket, "USMC" or equal pylon, no cover, SACH foot, laminated socket, molded to model
L5620[c]	Addition to lower extremity, test socket, below-knee
L5637	Addition to lower extremity, below-knee, total contact socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5655[c]	Addition to lower extremity, socket insert, below-knee (kemblo, pelite, aliplast, plastazote, or equal)
L5940	Addition, endoskeletal system, below-knee, ultra-light material (titanium, carbon fiber, or equal)
L5950	Addition, endoskeletal system, above-knee, ultra-light material (titanium, carbon fiber, or equal)
L5976[c]	All lower extremity prostheses, energy storing foot (Seattle, Carbon Copy II, or equal)
L5980[c]	All lower extremity prostheses, flex foot system
L8420[b]	Prosthetic sock, wool, below-knee

(Table notes on next page)

[a]HCFA Common Procedure Coding System.

[b]One of five items used to compare fee schedule rates computed by the carriers with rates that would have been computed if physician charges had been excluded from the database.

[c]One of seven items used to compare Medicare fee schedule payment rates with the cost of obtaining the artificial limb from a central fabricator.

Code and Description of Items Included Under the O&P Fee Schedule That Should Be Classified as Inexpensive or Routinely Purchased DME

HCPCS[a] code	Description of item
A4214	Sterile saline or water, 30 cc vial
A4310	Insertion tray without drainage bag and without catheter (accessories only)
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.)
A4320	Irrigation tray with bulb or piston syringe, any purpose
A4322	Irrigation syringe, bulb or piston
A4323	Sterile saline irrigation solution, 1000 ml
A4338	Indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.)
A4344	Indwelling catheter, Foley type, two-way, all silicone
A4347	Male external catheter with or without adhesive, with or without anti-reflux device
A4351	Intermittent urinary catheter; straight tip
A4354	Catheter insertion tray with drainage bag but without catheter
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube
A4358	Urinary leg bag; vinyl, with or without tube
A4362	Skin barrier; solid
A4363	Skin barrier; liquid (spray, brush, etc.) powder or paste
A4400	Ostomy irrigation set
A4402	Lubricant
A4454	Tape, all types, all sizes
A4455	Adhesive remover or solvent (for tape, cement, or other adhesive)
A4624	Tracheal suction catheter, any type
A4625	Tracheostomy care or cleaning starter kit
A5051	Pouch, closed; with barrier attached (1 piece)
A5052	Pouch, closed; without barrier attached (1 piece)
A5054	Pouch, closed; for use on barrier with flange (2 piece)
A5061	Pouch, drainable; with barrier attached (1 piece)
A5062	Pouch, drainable; without barrier attached (1 piece)
A5063	Pouch, drainable; for use on barrier with flange (2 piece system)
A5071	Pouch, urinary; with barrier attached (1 piece)
A5073	Pouch, urinary; for use on barrier with flange (2 piece)
A5114	Leg strap; foam or fabric
A5123	Skin barrier; with flange (solid, flexible, or accordion), any size
L0110	Cervical, craniostenosis, helmet, nonmolded
L0120	Cervical, flexible, nonadjustable (foam collar)

(continued)

HCPCS[a] code	Description of item
L0210	Thoracic, rib belt, custom-fitted
L0982	Stocking supporter grips
L1800	Knee orthosis (KO), elastic with stays
L1815	KO, elastic with condylar pads
L1825	KO, elastic knee cap
L1902	Ankle-foot orthosis, ankle gauntlet, custom-fitted
L3700	Elbow orthosis, elastic with stays
L3908	Wrist-hand-finger orthosis, wrist extension control cock-up, canvas or leather design, nonmolded
L8000	Breast prosthesis, mastectomy bra

[a]HCFA Common Procedure Coding System.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

JUN 8 1993

Ms. Janet L. Shikles
Director, Health Financing
and Policy Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicare: Separate Payment For Fitting Braces And Artificial Limbs Is Not Needed." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Principal Deputy Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office (GAO) Draft Report, "Medicare: Separate Payment for Fitting Braces and Artificial Limbs Is Not Needed"

Overview

Medicare pays for braces and artificial limbs when beneficiaries need such items because of injury or illness. Until 1989, Medicare paid for these items based on the charges made by those who supplied the items. Beginning in 1989, a fee schedule was established to pay for orthotic and prosthetic (O & P) items. Because of concerns expressed by the industry about payment levels under the fee schedule, Congress directed GAO to study the feasibility of separate fees for the professional services component.

In response to this request, GAO conducted a review and concluded that there is no need to establish separate fees for professional services because the payment amounts for braces and artificial limbs already include a component for the practitioner's professional services.

GAO Recommendation

We recommend that the Congress amend the Social Security Act to permit the Secretary of Health and Human Services to reclassify items currently covered as O & P items, such as ostomy and urological supplies and certain braces, that the Secretary determines do not require significant amounts of fitting and adjustments to the fee schedule for inexpensive or routinely purchased durable medical equipment.

Department Comment

While we strongly support this recommendation, we do not believe it goes far enough. GAO indicates that the above items do not require a significant amount of fitting or adjustment. Various other braces and artificial limbs that GAO examined do require fitting and adjustment. GAO also found that there is compensation for these services built into the rates since the actual cost of the various devices is only a fraction of the fee paid. GAO does not justify, however, why items that do not contain a service component should be subject to a limit at the national average, while the items that do should not.

The President's Fiscal Year 1994 budget contains a proposal to recompute the fee schedules for all O & P items as if the regional fee schedules had never been implemented, and to impose a limit at the median value as is proposed for durable medical equipment. Given that suppliers in half of the localities accept these rates or less, the median is a reasonable limit. Placing a limitation on geographical variation is desirable regardless of whether or not an item requires fitting or adjustment.

Technical Comments

Now on p. 2.

1. The word "orthosy" in line 5 of page 3 should be replaced with "ostomy."

Now on p. 2, footnote 2.

2. The first paragraph on page 4 indicates that under Medicare's fee schedule payment system, enteral and parenteral supplies and equipment are classified as prosthetics and prosthetic devices. We would point out that enteral and parenteral supplies and equipment are specifically excluded from Medicare's fee schedule system. See section 1834(h)(4)(B) of the Social Security Act.

Now on p. 3.

3. In the second paragraph on page 5, the language ". . . Medicare began a transition from carrier-specific fee schedules . . . ," should be replaced with ". . . OBRA 1987 provided for a transition from carrier-specific fee schedules . . . ,"

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