

## Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

For calendar years (CYs) 2012 through 2015, Medicare allowable amounts for certain back, knee, elbow, and wrist orthotic devices increased from \$631.8 million to \$815.5 million. We are concerned about the relationship of these increased costs to prices per orthotic device, and specifically whether Medicare allowable amounts are comparable with payments made by select non-Medicare payers.

Our objective was to determine whether Medicare allowable amounts payments for certain orthotic devices were comparable with payments made by select non-Medicare payers.

### How OIG Did This Review

Our audit covered \$2.8 billion in Medicare allowable amounts for 7.9 million orthotic devices billed under 161 Healthcare Common Procedure Coding System (HCPCS) codes during CYs 2012 through 2015. We calculated a nonstatistical estimate of payment differences for the 161 HCPCS codes reviewed that was based on a comparison of Medicare allowable amounts and payments made by select non-Medicare payers. We estimated that Medicare would pay 80 percent of the payment differences and that the remaining 20 percent would be paid by the Medicare beneficiaries. We limited our analysis to orthotic devices paid under Medicare fee schedules for the 48 contiguous States and the District of Columbia.

## Medicare Allowable Amounts for Certain Orthotic Devices Are Not Comparable With Payments Made by Select Non-Medicare Payers

### What OIG Found

Medicare allowable amounts for certain orthotic devices are not comparable with payments made by select non-Medicare payers. For CYs 2012 through 2015, we estimated that Medicare and beneficiaries paid \$341.7 million more than select non-Medicare payers on 142 HCPCS codes and \$4.2 million less than select non-Medicare payers on 19 HCPCS codes. Of the net \$337.5 million payment difference, we estimated that Medicare paid \$270 million and Medicare beneficiaries paid \$67.5 million. Generally, Medicare allowable amounts are more than select non-Medicare payer payments because CMS does not routinely evaluate pricing trends for orthotic devices or payments made by select non-Medicare payers. Instead, CMS uses statutorily mandated fee schedule payments that have an economic update factor applied to them annually. In 2016, CMS was required to adjust certain durable medical equipment, prosthetics, orthotics, and supplies fee schedule amounts using information from the competitive bidding program, but this change did not affect the 161 orthotic device HCPCS codes reviewed for this report.

We identified 95 of the 161 codes for which the Medicare allowable amounts could be adjusted using existing legislative authority to make those amounts comparable with payments made by select non-Medicare payers. For the remaining 66 codes, CMS would be required to seek new legislative authority to make those adjustments.

### What OIG Recommends and CMS Comments

We recommend that CMS (1) review the allowable amounts for 161 orthotic device HCPCS codes for which Medicare and beneficiaries paid an estimated \$337.5 million more than select non-Medicare payers and adjust the allowable amounts, as appropriate, using regulations promulgated under existing legislative authority or if the allowable amounts cannot be adjusted using regulations promulgated under existing legislative authority, seek authority to align Medicare allowable amounts for these items with payments made by select non-Medicare payers; and (2) routinely review Medicare allowable amounts for new and preexisting orthotic devices to ensure that Medicare allowable amounts are in alignment with payments made by select non-Medicare payers or pricing trends.

In written comments on our draft report, CMS concurred with our recommendations and described its planned payment changes for certain orthotic devices.