National Trends in the Usage of DME and HCPCS Level II Codes in Medicare

By studying these figures, you can assess where your practice patterns lie.

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Customized reports of Part B Medicare data (BMAD) have been gathered by the American Podiatric Medical Association (APMA) for the benefit of its members for years. In recent years the data tables have been copyrighted by APMA as a membership benefit. This year, for the first time, DMERC (durable medical equipment regional carrier) data has been requested by the APMA BMAD subcommittee. This data was requested by the Committee to review trends in the utilization of DMERC supplies and HCPCS Level II codes.

It appears that DMERC and HCPCS Level II data is only a small portion of allowed dollars for podiatrists. The allowed dollar amount for podiatrists of the top 50 DMERC and Level II HCPCS codes for 2002 was 48 million dollars. This included almost 9.3 million dollars attributed to HCPCS G0127 (dystrophic nail trimming), a level II HCPCS code. If G0127 allowed dollars is subtracted from the total DMERC/HCPCS Level II allowed dollars, the allowed amount to podiatrists is approximately 38.7 million dollars for 2002. When compared to the total allowed dollars for podiatry for 2002 for all Medicare services, 1.31 billion dollars, the DMERC/HCPCS allowed dollars represents just 3% of the total.

Therapeutic Shoe Program

Let’s first take a closer look at the Therapeutic Shoe Program for diabetics.

Here are the top 10 states in which podiatrists were allowed the most dollars from dispensing off-the-shelf therapeutic depth shoes HCPCS A5500 in 2002

1. Mississippi - $2402 per DPM
2. Kentucky - $1833 per DPM
3. New Mexico - $1815 per DPM
4. Louisiana - $1766 per DPM
5. South Carolina - $1694 per DPM
6. Wisconsin - $1608 per DPM
7. Tennessee - $1499 per DPM
8. Florida - $1374 per DPM
9. North Carolina - $1368 per DPM
10. Delaware - $1284 per DPM

The following are the top 10 states with highest utilization per 1000 eligible Medicare patients for off-the-shelf added-depth shoes for diabetics (HCPCS A5500):

1. Florida - 12 individual shoes per 1000 eligible Medicare patients
2. New Jersey - 11 individual shoes per 1000 eligible Medicare patients
3. Delaware and Maryland (tied) - 10 individual shoes per 1000 eligible Medicare patients
5. New York - 9 individual shoes per 1000 eligible Medicare patients

6. New Mexico and Connecticut (tied) - 8 individual shoes per 1000 eligible Medicare patients
8. Wisconsin, Utah, and Louisiana (tied) - 7 individual shoes per 1000 eligible Medicare patients

HCPCS Code A 5500 was billed by podiatrists 164,081 times, representing approximately 82,040 pairs of therapeutic shoes. The total allowed amount of dollars to podiatrists for A5500 was $10,626,590.

Here are the top 5 states in which podiatrists were allowed the most dollars from dispensing custom therapeutic depth shoes (HCPCS A5501) in 2002:

1. North Carolina - $605 per DPM
2. Wyoming - $443 per DPM
3. Georgia - $434 per DPM
4. Mississippi - $268 per DPM
5. South Dakota - $260 per DPM

Podiatrists were allowed $1,245,794 for HCPCS A5501 in 2002. This represented 6,634 individual custom shoes.

The top 10 states on which podiatrists were allowed the most dollars from dispensing direct heat-formed inserts (HCPCS A5509) in 2002:

1. Mississippi - $2464 per DPM
2. Kentucky - $2033 per DPM
3. Louisiana - $1561 per DPM
4. Wisconsin - $1534 per DPM
5. South Carolina - $1325 per DPM
6. North Carolina - $1269 per DPM
7. Florida - $1040 per DPM
8. West Virginia - $1035 per DPM
9. New Mexico - $908 per DPM
10. Maryland - $852 per DPM

Podiatrists were allowed $8,517,195 for dispensing 259,815 HCPCS A5509 direct heat molded innersoles in 2002.

The Top 10 states in which podiatrists were allowed the most dollars from dispensing custom inserts (HCPCS A5511) in 2002:

1. Mississippi - $984 per DPM
2. Delaware - $942 per DPM
3. Nebraska - $881 per DPM
4. New Mexico - $828 per DPM
5. Florida - $779 per DPM
6. South Carolina - $732 per DPM
7. Missouri - $711 per DPM
8. Oklahoma - $710 per DPM
9. Wisconsin - $656 per DPM
10. Tennessee - $629 per DPM

Podiatrists earned $4,970,101 for dispensing 151,264 units of HCPCS A5511 custom innersoles in 2002.

The States with the lowest utilization of off-the-shelf therapeutic shoes for diabetics as measured by shoes allowed per 1000 eligible Medicare beneficiaries:

1. Alaska and North Dakota - 0
2. Arkansas, Hawaii/Guam, Minnesota, Montana, Puerto Rico, Vermont, and Washington - 1
3. Alabama, Arizona, District of Columbia, Idaho, Kansas, South Dakota, and Wyoming - 2

The Therapeutic Shoe Program for diabetics was reimbursed $25,359,680 to podiatrists in 2002. This represents allowed dollars for HCPCS codes A5500, A5501, A5509, and A5511. These codes represent off-the-shelf and custom-shoes, heat-molded and custom innersoles. The Therapeutic Shoe Program represents approximately 66% of the allowed dollars for DMERC and level II HCPCS codes excluding dystrophic nail trimming.

The above data should be taken into consideration when analyzing the 1997 OIG Report on Therapeutic Shoes, which may be found at http://oig.hhs.gov/oei/reports/oei-03-97-00300.pdf. According to this report, “Medicare allowances for added-depth shoes, custom-molded shoes, and inserts doubled from 1994 to 1996, going from $7 million to $13.9 million. In these three years, allowances for depth shoes more than doubled, rising from $2.1 million to about $5 million. Allowances for custom-molded shoes increased 50 percent from $3 million to $4.5 million. Allowances for inserts almost tripled, rising from $1.8 million to $4.4 million.”

According to the OIG Work Plan of 2003, Medicare allowed 87 million dollars for the Therapeutic Shoe Program in 2001. Therefore, using allowed dollars for 2001 for all providers compared to allowed dollars for podiatry in 2002, podiatry represents 29% of the Therapeutic Shoe Program.

Top Part B Medicare DMERC Oddities for 2002

1. HCPCS L1970, defined as “Ankle foot orthosis, plastic, with ankle joint, custom fabricated”, is ranked number 5 on DMERC and HCPCS codes allowed to podiatrists in 2002. The most allowed dollars went to Florida at $578,362. The next highest allowed dollars for this code went to California at $269,621. The total allowed dollars for this item for podiatrists in 2002 was $2,414,049 for 4,153 AFO’s.

Commentary: Obviously the Richie Brace and its competitors have found a place among podiatrists, especially in Florida and California.

2. HCPCS code L1930 was ranked number 9 in allowed charges to podiatrists at $856,567 for 2002, representing 4,674 devices. L1930 is defined as “Ankle foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment.”

Commentary: It is quite possible a large number of these braces have been billed when night splints were dispensed. Currently there is no code that fits the night splint when billing Medicare DMERC.

3. The Tibial Fracture Orthosis Conundrum - HCPCS code L2116 - was ranked number 10 in allowed charges to podiatrists at $609,597, representing 1525 devices. L2116 is defined as “Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment.” This code was billed heavily in Florida at $257,713 allowed dollars, almost 10 times the amount allowed by any other state. This HCPCS code was recommended improperly to podiatrists by a DME vendor when billing for cam walkers. Beware of vendors bearing gifts.

HCPCS code L2112 was ranked number 11 in allowed charges to podiatrists at $598,807, representing 1781 devices. L2112 is defined as “Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, soft, pre-fabricated, includes fitting and adjustment.” Again, many allowed dollars were attributed by Florida at $117,502, double that of Arizona and almost triple the next closest states of New Jersey and Ohio.

HCPCS L2114 was ranked 12 in allowed charges to podiatrists in 2002 at $551,624 for 1460 devices. L 2114 is defined as “Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, semi-rigid, pre-fabricated, includes fitting and adjustment.” Florida was allowed $111,705, followed next by Arizona at $82,012, Ohio at $42,409, and Illinois at $38,802.

Commentary: Interestingly, CPT codes billed for the treatment of tibial shaft fractures, CPT 27750 to 27759, were NOT among the top 300 CPT codes billed by podiatrists to Medicare in 2002, yet 4,766 tibial fracture AFO’s were billed by podiatrists. This HCPCS code was recommended improperly to podiatrists by a DME vendor when billing for cam walkers. Beware of vendors bearing gifts.

4. Podiatrists in Indiana were allowed $103,300 for HCPCS code Q1084, defined as metabolically active tissue. The next closest state was Georgia at $43,893 followed by New Jersey, Illinois, North Carolina, Pennsylvania, and Tennessee, which were all reimbursed in the $20,000 range.

Commentary: It is quite possible Indiana was one of the first states that allowed coverage for Apligraf.

5. Podiatrists in Texas were allowed $325,529 for 64 units of HCPCS K0011 defined as “Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking.” Five were allowed in Florida, and one in Louisiana. No other state seemed to find that code when walking through the HCPCS book.

Commentary: Much publicity has been associated with the billing of these devices by all physicians and apparently a few podiatrists were also involved.

6. Podiatrists in Montana were allowed $70,385 for HCPCS J7340, defined as “metabolically active dermal/epidermal tissue.” The next closest state was Florida at $41,167 followed by California at $32,461 and North Carolina at $19, 851.

7. Podiatrists in California were allowed $50,921 for HCPCS code L1906, defined as “multi-ligamentous ankle support,” followed closely by Florida at $47,975. The next closest state was Georgia at $17,807.

Commentary: This code is probably underutilized by podiatrists.

8. Podiatrists in Florida were allowed $158,893 for HCPCS code A6212, defined as less than 16 square cm foam dressings. The next closest state was California at $20,510, followed by New York at $3353. This HCPCS code represented the highest allowed amount for dressings.

Commentary: Most probably this represents the Polymem dressing used by some podiatrists after nail procedures. Read the DMERC rules to be certain that this product is being used for the stage and type of wounds as required by your local DMERC.

9. Podiatrists in Florida were reimbursed $98,092 for G0180 defined as "Physician certification services for Medicare-covered services provided by a participating home health agency (patient not present), including review of initial or subsequent reports of patient status, review of patient's responses to the oasis assessment instrument, contact with the home health agency to ascertain the initial implementation plan of care, and documentation in the patient's office record, per certification period." The next closest states were California and Louisiana at around $11,000 and Texas at over $10,000.

Commentary: While it may be permissible in some states for billing this code by podiatric physicians, physicians should be certain that they have met the requirements of their local Medicare carrier before billing it.

10. Podiatrists were allowed $132,273 for 700 units of L3000, defined as "Foot, insert, removable, molded to patient model, "UCB" type, Berkeley shell, each." Podiatrists were allowed $120,187 for 892 units of HCPCS L3020 defined as "Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each."

Commentary: Foot orthoses are statutorily excluded from the Medicare program unless they are part of shoes attached to a brace, according to the Region D DMERC Bulletin from the Spring of 1999, page 6. This item should be submitted appended with a –GY modifier when a denial is appropriate, but submission is performed at the request of a patient for possible coverage by his/her secondary insurer.

11. LOPS (loss of protective sensation policy) became effective July 1, 2002. During the last six months of 2002 we note the following:

a. G0245, the initial exam for a patient with LOPS, was billed just 1,773 times by podiatrists. Georgia and Massachusetts were the states with the most allowed frequency of 160 and 138, respectively. 25 states billed the code less than 20 times from July 1, 2002 until December 31, 2002.
b. G0246, the follow-up exam of a patient with LOPS, was billed 3,347 times by podiatrists. 22 states billed this code less than 20 times. Texas podiatrists were allowed this code 472 times, with Connecticut and Georgia just over 350 times. The next closest state was Massachusetts at 243 allowed times.

Commentary: Obviously the LOPS codes have been slow to be adopted, and for good reason. In fact, in many cases they reduce patient benefits, not expand them, which was a point missed by CMS when they created the national policy.

12. Texas podiatrists were allowed $34,947 for 51 units of HCPCS code E0277 defined as "Powered pressure-reducing air mattress." This was followed by California that allowed 8, Florida that allowed 7, and Louisiana that allowed 2. No other states billed this code.

Commentary: The coverage criteria are as follows for most states including Texas, "As per the Local Medical Review Policy on group 2 support surfaces which is covered if the patient meets:

a) Criterion 1 and 2 and 3, or
b) Criterion 4, or
c) Criterion 5 and 6.

1) Multiple stage II pressure ulcers located on the trunk or pelvis.

2) Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.

3) The ulcers have worsened or remained the same over the past month.

4) Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.

5) Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days).

6) The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).”

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