

Solving the “Medicare Puzzle” of Increased Prosthetic Foot Costs: 2005-2010

Developed in Response to Draft LCD, Lower Limb Protheses (DL33787), released by CMS July 2015

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Summary

The tone of the Draft LCD for lower limb prostheses is based on rationing prosthetic technology to the most able amputees while restricting it from the remainder of that community. While changes to an LCD should be based on scientific evidence, the Draft LCD in question seems to be more influenced by economic motives. Chief among these is the uninformed speculation included in a 2012 magazine article that misrepresents changes in Medicare spending on prosthetic feet in 2005 and 2010. The majority of the increases in spending within the magazine article can be justified by a proper understanding of allowed versus reimbursed payments, annual increases in the Medicare fee schedule and the introduction of a new, expensive billing code associated with new technology that carries low utilization rates. The remainder of the differential reflects changes in Medicare’s demographics as their beneficiaries became younger. Any changes in LCD policies should be driven by peer-reviewed, published evidence in the scientific literature, rather than uninformed speculations in the popular press.

Introduction

The prevailing tone in the Draft LCD for Lower Limb Prostheses (**DL33787**), released by CMS in July 2015 is one of rationing modern era prosthetic components to the most able lower limb amputees while restricting access to such technology from the remainder of the amputee population. The motivation for this approach to the new prosthetic coverage policy is unclear. However, the first reference appearing at the top of the LCD Bibliography may suggest the undertones within this magazine article may have strongly influenced the authors of the proposed LCD.

Medicare's Provider Integrity Manual is clear as to the types of evidence that should support changes in coverage LCD's. According to section 13.7.1 – "Evidence Supporting LCDs"

"Contractor LCDs shall be based on **the strongest evidence available**. The extent and quality of supporting evidence is key to defending challenges to LCDs. The initial action in gathering evidence to support LCDs shall always be a **search of published scientific literature** for any available evidence pertaining to the item or service in question.

In order of preference, LCDs should be based on:

- Published authoritative evidence derived from definitive **randomized clinical trials** or other **definitive studies**, and
- General acceptance by the **medical community** (standard of practice), as supported by sound **medical evidence** based on:
 - **Scientific data** or **research studies** published in **peer-reviewed medical journals**;
 - Consensus of **expert medical opinion** (i.e., recognized authorities in the field); or
 - Medical opinion derived from consultations with **medical associations** or other **health care experts.**"

Nowhere within this list are magazine news articles written by freelance journalists. It is unfortunate to note however, within these stated guidelines the first reference cited to support the proposed changes of the Draft LCD was not a randomized clinical trial, a peer-reviewed research study from a respected medical journal, consensus expert medical opinion, nor any form of published scientific literature. Rather, the LCD cites an Associated Press (AP) news article written by a freelance author:

Alonso-Zalvidar R. Medicare puzzle: Big rise in artificial feet costs. AP Mobile News. February 16, 2012.

Failing any reasonable standard for published scientific literature, the foundations and conclusion of the article are both misleading and inaccurate, lacking any reasonable awareness of the prosthetic profession. The article was not peer-reviewed by knowledgeable experts in the field nor did the author have the knowledge, credentials or qualifications to reasonably render any relevant or applicable insights into the complexities of Medicare's reimbursement of prosthetic feet. Furthermore, as will be detailed here, it can be seen that the writer was careless with his investigation into Medicare spending.

The premise of the article is summarized in the author's statement below:

Medicare paid \$94 million for artificial feet in 2010, according to research conducted for The Associated Press. That was nearly \$35 million more than in 2005, even though in 2010, Medicare covered about 1,900 fewer such prostheses”

This conclusion is unfortunately inaccurate and fails to fully account for numerous influencing factors. These issues include reimbursed versus allowed charges, gradual increases in Medicare’s fee schedule due to inflation, the creation of new billing codes to reflect newly developed technologies and a shift in the demographics of Medicare beneficiaries that occurred during the cited 5 year period to reflect a younger and more active population.

Allowed vs Reimbursed Charges

The reported \$94 million paid by Medicare in 2010 is a striking figure that must have captured the targeted reading audience. Medicare data however shows this spuriously glamorized number is misleading and inaccurate. Medicare did not pay \$94 million. That figure represents the allowed charges for prosthetic feet during 2010. The actual payments during that period were substantially less, at just over \$74 Million. Thus, 20 million dollars’ worth of public outrage, was based on this error alone (Table 1).

HCPCS	2005			2010		
	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT	ALLOWED SERVICES	ALLOWED CHARGES	PAYMENT
L5970	1,332	\$ 230,473	\$ 182,428	629	\$ 125,755	\$ 100,132
L5970	0	\$ -	\$ -	137	\$ 27,330	\$ 21,146
L5974	3,455	\$ 740,792	\$ 588,306	1,626	\$ 389,411	\$ 307,697
L5972	7,512	\$ 2,386,458	\$ 1,893,929	6,680	\$ 2,402,820	\$ 1,913,863
L5975	1,461	\$ 548,029	\$ 436,651	1,013	\$ 426,672	\$ 340,710
L5978	1,451	\$ 384,001	\$ 302,236	603	\$ 178,540	\$ 141,750
L5973	0	\$ -	\$ -	200	\$ 3,054,545	\$ 2,411,472
L5976	4,650	\$ 2,318,445	\$ 1,836,149	2,291	\$ 1,286,647	\$ 1,013,362
L5979	4,648	\$ 9,200,315	\$ 7,276,402	2,243	\$ 4,970,747	\$ 3,931,629
L5980	4,793	\$ 15,348,236	\$ 12,073,149	5,248	\$ 18,967,559	\$ 14,974,401
L5981	7,265	\$ 18,400,974	\$ 14,467,171	11,345	\$ 32,163,083	\$ 25,364,886
L5987	1,636	\$ 9,370,792	\$ 7,323,451	4,626	\$ 29,943,555	\$ 23,518,357
L5990	446	\$ 645,661	\$ 509,984	142	\$ 233,046	\$ 184,008
Total	38,649	\$59,574,175	\$46,889,857	36,783	\$94,169,709	\$74,223,415

Table 1: Medicare’s “allowed charges” and “payments” for prosthetic feet in 2005 and 2010.

Based on Medicare’s data shown above, the increase from 2005 to 2010 was not \$35 million but just over \$27 million.

Increases in the Fee Schedule

The reporter’s next oversight was a failure to account for increases in the Medicare fee schedule during the intervening 5 year period. This consideration accounts for an additional 8.2 million dollars of unwarranted public outrage. **Had those prosthetic feet provided in 2010 been reimbursed under the 2005 fee schedule, Medicare would have only paid \$66 million (or roughly \$30 million less than the \$94 million stated within the cited article) (Table 2).**

HCPCS	2005			2010			
	ALLOWED SERVICES	PAYMENT	2005 Payment Per Device	ALLOWED SERVICES	PAYMENT	2010 Payment Per Device	2010 payments at 2005 pricing
L5970	1,332	\$ 182,428	\$ 136.96	629	\$ 100,132	\$ 159.19	\$86,146
L5971	0	\$ -	\$ -	137	\$ 21,146	\$ 154.35	\$ 21,146
L5974	3,455	\$ 588,306	\$ 170.28	1,626	\$ 307,697	\$ 189.24	\$276,870
L5972	7,512	\$ 1,893,929	\$ 252.12	6,680	\$ 1,913,863	\$ 286.51	\$1,684,165
L5975	1,461	\$ 436,651	\$ 298.87	1,013	\$ 340,710	\$ 336.34	\$302,757
L5978	1,451	\$ 302,236	\$ 208.29	603	\$ 141,750	\$ 235.07	\$125,602
L5973	0	\$ -	\$ -	200	\$ 2,411,472	\$ 12,057.36	\$ 2,411,472
L5976	4,650	\$ 1,836,149	\$ 394.87	2,291	\$ 1,013,362	\$ 442.32	\$904,649
L5979	4,648	\$ 7,276,402	\$ 1,565.49	2,243	\$ 3,931,629	\$ 1,752.84	\$3,511,396
L5980	4,793	\$ 12,073,149	\$ 2,518.91	5,248	\$ 14,974,401	\$ 2,853.35	\$13,219,255
L5981	7,265	\$ 14,467,171	\$ 1,991.35	11,345	\$ 25,364,886	\$ 2,235.78	\$22,591,887
L5987	1,636	\$ 7,323,451	\$ 4,476.44	4,626	\$ 23,518,357	\$ 5,083.95	\$20,707,997
L5990	446	\$ 509,984	\$ 1,143.46	142	\$ 184,008	\$ 1,295.83	\$162,372
Foot Total	38,649	46,889,857		36,783	74,223,415		66,005,713

Table 2: Medicare's payments for prosthetic feet in 2005 and 2010 with an additional column showing Medicare's 2010 reimbursement had they been paid under the 2005 fee schedule.

Simply by taking into account the difference between allowable and reimbursed costs and fee schedule increases, the \$35 million increase in prosthetic foot costs is reduced to under \$20 million

Introduction of a New Prosthetic Foot

The AP article also failed to observe that on January 1, 2010 Medicare introduced a new billable foot code, L5973. This code provided coverage for new technology that was not available in 2005. The code is used to reimburse for prosthetic feet with microprocessor control. With an average reimbursement of over \$12,000 per unit, the cost of such feet is more than 5 times more expensive than the most commonly used foot reimbursed by Medicare, the L5981. The reimbursement of a comparatively small number of such feet, 200 units, accounts for an addition \$2.4 million of the cost increases observed between 2005 and 2010. Alternatively, 200 out of 36,783 total units (0.5%) accounted for 12.6% of the remaining \$19.1 million increase. Provision of 200 out of 36,783 total units highlights very selective use of these expensive devices on patients. Despite the undertones of the magazine article, prosthetists are in fact very diligent and aware of cost and spending and do not over utilize expensive devices.

Changing Medicare Population

The majority of the \$35 million cost increase put forward in the cited article is explained by the three considerations of actual reimbursement, fee schedule increases and the introduction of a new very expensive but rarely provided foot type. The remainder requires a consideration of the altered demographics of Medicare Beneficiaries during the time period in question.

Medicare statistics indicate that between 2005 and 2010 the greatest growth in number of beneficiaries was in the 65-69 category and under 65 category. Viewed collectively, **the growth in the number of Medicare beneficiaries under 69 years old (+21%) was more the three times that of those 70 years and**

older (+6%) (Table 3). Thus, during the 5 year period in question, the average age of Medicare beneficiaries became younger. The reduced age will encompass increased activity levels.

Medicare Age Distribution Number in Thousands*							
	Total	Under65 Years	65-69Years	70-74Years	75-79Years	80-84Years	85 Years or Over
2005	42,500	6,723	9,905	8,352	7,251	5,493	4,777
2010	47,664	8,033	12,096	9,138	7,169	5,617	5,612
		1,310	2,191	786	-82	124	835
		3,501		1,663			

Table 3: Age distribution of Medicare beneficiaries between 2005 and 2010.

Shift in Prosthetic Foot Types

Between 2005 and 2010, the number of Medicare beneficiaries over the age of 70 increased by 1.6 million. By contrast, there was an addition of 3.5 million new beneficiaries under the age of 70. Given this shift, it is reasonable to expect a similar shift in the activity levels of the amputees.

More active amputees require prosthetic feet designed to facilitate a more active lifestyle. Unsurprisingly, the foot type most conducive to the active lifestyles that often characterize relatively younger amputees (ie, younger than 65 years old) experienced greater utilization (Table 4).

HCPCS	2005			2010			
	ALLOWED SERVICES	PAYMENT	2005 Payment Per Device	HCPCS	ALLOWED SERVICES	PAYMENT	2010 Payment Per Device
L5987	1,636	\$ 7,323,451	\$ 4,476.44	L5987	4,626	\$ 23,518,357	\$ 5,083.95

Table 4: Utilization of the L5987 foot code in 2005 and 2010.

So while there was a nominal decrease in the *number* of feet provided (<5%), there was a substantial shift in the *types* of feet provided, consistent with changes in Medicare demographics. Similar, though less pronounced increases were observed in the provision of related carbon fiber feet (L5980 and L5981). Furthermore, it should be highlighted the L5987 code is for prosthetic feet that incorporate a vertical shock absorbing feature, which from the reference cited within the LCD Bibliography, (Gard and Konz, 2003), has been shown in a research study to provide benefits to the amputee user. Thus, the utilization of these feet stands on sound scientific justification. Viewed collectively, the increased utilization of these prosthetic foot types to meet the needs of younger beneficiaries accounts for the remainder of the cited increases in Medicare spending for prosthetic feet.

Conclusion

According to Medicare’s Policy Integrity Manual, changes to an LCD should be based on sound evidence taken from published scientific literature. Unfortunately, the tone of the Draft LCD seems to be more based on the careless observations of a journalist who misinterpreted Medicare data that he was not qualified to reasonably and accurately interpret. Accusations of a 60% increase in prosthetic foot costs over a 5 year period are quickly corrected by taking into account the differences between allowed and reimbursed costs, Medicare’s own fee schedule increases and the creation of a new billing code to accompany a new technology that is rarely utilized but has a

high reimbursement. The remainder of this differential is explained by a shift in Medicare beneficiary demographics to a younger, more active population. Changes to LCD policies should be motivated by scientific evidence rather than the uninformed speculations of the popular media.

References

Alonso-Zalvidar R. Medicare puzzle: Big rise in artificial feet costs. AP Mobile News. February 16, 2012.

Gard, S.A., Konz, R.J., 2003. The effect of a shock-absorbing pylon on the gait of persons with unilateral transtibial amputation. *J. Rehabil. Res. Dev.* 40, 109-124.

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