February 10th, 2025

The Honorable Pamela Beidle,
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

Re: **Report on the "L" codes utilization within the All-Payer Claims Database and cost impact of Orthoses coverage as per the requirements of SB 614 (Chs. 822 and 823 of the Acts of 2024) (MSAR # 15605)- Stakeholder Feedback, Letter of Information**

Dear Chair Beidle and Committee Members:

The advocates on behalf of So Every BODY Can Move respectfully submit this letter of information for Senate Bill (SB) 406- Maryland Medical Assistance Program and Health Insurance – Coverage for Orthoses (So Every Body Can Move Act).

In keeping with the requirements of Senate Bill (SB) 614/House Bill (HB) 865, *Maryland Medical Assistance Program (Medical Assistance) and Health Insurance - Coverage for Prostheses (So Every Body Can Move Act)* (Chs. 822 and 823 of the 2024 Acts), the Maryland Department of Health (MDH), in collaboration with the Maryland Health Care Commission (MHCC), and in consultation with the Maryland Insurance Administration (MIA), completed a report on the review of the utilization of "L" codes and related codes within the All-Payer Claims Database; as well as, analysis of the cost impact of requiring coverage for medically necessary orthoses for physical activity.

The comprehensive report includes some information which must be addressed during this legislative session. The items below specifically reference items in report provided by MDH on January 2, 2025:

1) Page 2, bottom of paragraph 2: *"While coverage for prosthetic devices for medical necessity is a mandated benefit for both commercial payers and Medicaid in Maryland, coverage of prostheses for whole-body health was not mandated until SB 614… (Chs. 822 and 823 of the 2024 Acts), was passed."*

   This is an inaccurate interpretation of the legislation. According to the NIH, whole-body health (or whole person health) involves looking at the whole person—not just

separate organs or body systems—and considering multiple factors that promote either health or disease[1]. The reason for including the phrase whole body health in the legislation is that when we provide patients with prostheses/orthoses, we are treating the patient in their entirety as a person; we evaluate them by more than just their body segment in order to ensure that the intervention is medically necessary. More specifically, we use that term because a primary, daily use prosthesis or orthosis is typically not designed, nor capable of being used for, completion of all possible activities that an able-bodied person can complete.

In this case (SB 614/HB 865) and for the legislation this year (HB 383), activity-specific prostheses and orthoses could be used for activities like running where a daily use prosthesis or orthosis could not. Therefore, it is medically necessary to provide patients with a secondary device in order to achieve whole body health. What did not previously exist (prior to last year) was coverage for activity-specific prostheses, which will improve whole body health. **Prostheses, orthoses, and associated codes that might benefit a patient's whole-body health, but are not related to physical activity should not be included in coverage for last session's updated statute, nor this year's legislation.**

2) Page 3, paragraph 2: *"One of the key assessments providers use in determining the prostheses or orthoses to prescribe for an individual is an assessment called the Medicare Functional Classification Level (MFCL) (also known as a K-level assessment) which is performed in order to determine the maximum rehabilitation and mobility that an individual could achieve were they to be provided with appropriate physical and occupational therapies as well as prostheses and orthoses."*

   This is an incorrect statement. K-levels (functional levels) are only used to determine current function or functional potential for unilateral lower limb prosthetic users (bilateral lower extremity users do not need to be classified based on Medicare guidelines). K-levels are not applicable for orthosis users or any upper limb users (prostheses or orthoses). There is no functional level scale for orthosis users. K-levels are only used as a guide for the process of prescribing and reimbursement for unilateral lower limb prosthesis users.

3) Page 4, paragraph 2: *"Nearly 60,000 Marylanders with Medical Assistance have claims or encounters associated with prostheses and orthoses every year (see Table 1)."*

   This claims data needs to be show separation between prosthesis users and orthosis users in order to properly predict data trends. There will be significantly fewer prosthesis users in the states vs orthosis users. Cost of prosthetic devices will be higher than orthotic devices, though the quantity/units of orthoses billed would likely be significantly higher compared to prostheses.

4) Page 6, bottom of paragraph 2: *"Unit cost trends demonstrate variations across markets between CY21 – 23, with average cost per unit…"*

To expand on the point above, there will be significant differences in the cost of prosthetic vs orthotic services. Providing an average cost per unit without a clear delineation between prostheses and orthoses does not allow for the ability to calculate accurate cost projections or understand possible cost implications of the new law and HB 383, which is only addition of coverage for activity-specific orthoses.

5) Page 7, top line and Table 2: "*…average cost per unit increasing from $162 in CY21 to $172 in CY23; however, when these unit costs are evaluated across total utilization and unduplicated individuals, the unit cost shows a consistent reduction in unit cost (CY21: 3.4% down to 3.0% in CY23)"*

   Our interpretation of this statement is that the average cost per unit increases from 2021 - 2023, meaning that the codes being billed on average are going up in cost or have a higher reimbursement for the provider, but the number of codes/units being billed is decreasing (as seen in total units column and unit cost trends column). Therefore, this is a downward trend in the overall cost to the insurance for prostheses and orthoses.

6) Page 10, paragraph 2: *"MDH's clinicians reviewed the Fee Schedule and determined that 258 orthotic "L" codes on the Fee Schedule met the criteria wherein a provider might prescribe an individual multiple sets of the same orthotic "L" code"*

   MDH has provided a copy of the codes; 25 are off-the-shelf (OTS) orthoses, 18 are for fracture treatment/post-operative, and 35 are orthopedic shoe codes/shoe additions. These are not custom orthoses for physical activity, and therefore would not be relevant to the expanded coverage proposed in HB383.

7) Page 10, paragraph 4: *"In CY22, there were 37,396 total Medicaid participants who utilized the aforementioned list of 258 "L" codes for orthoses; in CY23 this number increased to 38,420"*

   The number of individuals who received orthoses increased per the report, but the actual number of orthoses provide decreased. This is evident in Table 3 (page 11).

8) Page 11, paragraph 2: *"Using CY23 data as a baseline, MDH projected expected orthoses costs for CY24, CY25, and CY26 under the existing coverage policy"*

   It is unclear why is there an expected upward trend in cost in the projected data (Tables 4 and 5), whereas the actual data provided showed a downward trend in cost (Table 3).

9) Page 12, paragraph 1: *"…among amputees receiving a prosthesis, approximately 95% are initially assessed at a K-level of 2 or 3, and with physical activity, a subset of individuals are able to increase their mobility by at least one K-level, potentially*

resulting in the need for new orthoses paired with higher K-level prostheses required to participate in whole-body health activities. Among Maryland Medicaid MCO participants, 68% of the population utilizing orthoses are less than 50 years of age, suggesting that they may be more likely to reap the benefits of therapies that would allow them to expand their capacity to participate in whole-body health activities potentially requiring new orthoses."

Data used to determine utilization for prosthetic users is not an accurate way to calculate projected utilization for orthotic users.

10) Page 21: *"Assumptions used to estimate the cost of expanding coverage to include whole-body health…FFS and MCO populations will increase their use of orthoses equally at a rate of 30% if the orthoses benefit is expanded to include whole-body health"*

This assumption was based off of the Minnesota actuary report, which can be found here: https://mn.gov/commerce-stat/insurance/industry/policy-data-reports/62J/MN-AIR-Evaluation%20Report-Prosthetics-Orthotics-508.pdf

- The Minnesota legislation is different than HB 383. Minnesota's report is inclusive for insurance fairness for prostheses and orthoses, coverage for everyday and activity-specific orthoses and prostheses, as well as shower/bathing devices. HB 383 only expands coverage for custom orthoses for physical activity. To determine prevalence and utilization in Minnesota, the Minnesota Department of Health provided the Actuarial Research Corporation with a list of CPT/HCPCS procedural codes to use in order to complete their analysis. **Of the 26 codes used for their analysis, only 4-6 of the codes are relevant for HB 383.**

11) Page 21: *"Limitations in determining implications of expanding orthoses coverage to include whole-body health…K-levels: MDH has no way to capture the K-level of MCO or FFS participants."*

This is accurate. However, there is no way to capture K-level for their orthosis users because K-level functional levels are not an existing classification for orthosis users.

Main takeaway: The methodology used in the report to calculate the fiscal cost of HB 383 does not provide an accurate projection for utilization or cost.

We, the stakeholders, have already reached out and met with MDH to discuss the information detailed above, specifically:

- the interpretation of "whole-body health" as it relates to the intention of the legislation
- a revision of cost projections using only custom orthoses relevant to the proposed coverage expansion

- a separation of utilization data for prostheses and orthoses in order to more accurately show costs associated with utilization

MDH has agreed to revise the cost study calculations using the coding data provided by the advocates to ensure the calculations are relevant to SB 406/HB 383. We are committed to working with the Committee to determine whether there are amendments that can be made to the legislation to ensure that intention and interpretation are properly aligned in order to limit the fiscal impacts of SB 406.

If you would like to discuss this further, please do not hesitate to contact Sheryl N Sachs, MSPO, CPO, lead advocate, at sebcm.md@gmail.com.

Best,

Kyle Stepp

Kyle Stepp
Strategic Partnerships Lead
So Every BODY Can Move

Citations:

1- https://www.nccih.nih.gov/health/whole-person-health-what-it-is-and-why-its-important