# Comparative Billing Report

October 15, 2014

CBR #: CBR201408
NPI #: 1111111111
Fax #: (888)555-5555

Organization Name
Full Name
123 Street Lane
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Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. In an effort to accomplish these goals, CMS has contracted with eGlobalTech, a professional services firm in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs are designed to educate providers on their billing or referral patterns for selected topics through a comparison to other providers across their state and the nation. As CBRs are for educational purposes, no reply is necessary.

Attached is a CBR that reflects your billing or referral patterns compared to peer providers' billing or referral patterns for the same services in your state and nationwide. We hope you find this CBR beneficial as an educational tool to assist you in identifying opportunities for improvement. If you have any questions regarding this CBR, or if you want to change the way you receive CBRs in the future, please contact the CBR Support Help Desk via:

- Calling the Toll Free Number, 1-800-771-4430;
- Sending an email to cbrsupport@eglobaltech.com;
- Visiting the website at http://www.cbrinfo.net.

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system.

You can update your National Provider Identifier (NPI) contact information on NPPES at https://nppes.cms.hhs.gov/NPPES. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at 1-800-465-3203 or email customerservice@npienumerator.com.

For more information regarding the Medicare enrollment process or to obtain a copy of the Medicare enrollment application for your provider type, refer to http://www.cms.gov/MedicareProviderSupEnroll.

We thank you for your cooperation and hope you find the attached report informative.

Sincerely,

Susan M Goodrich

Susan M. Goodrich
CBR Project Director
eGlobalTech

Enclosure

**Comparative Billing Report (CBR): NPI 1111111111**
**Podiatry: Debridement of Ulcers and Wounds**

## Introduction

This CBR focuses on podiatrists who billed claims for debridement services for Medicare Part B beneficiaries for dates of service between January 1, 2013 and December 31, 2013. A review of 2013 claims data supports that podiatrists accounted for 43 percent of all debridement services billed to Medicare using current procedural terminology (CPT®) codes 97597-97598 and 11042-11047. According to the 2012 Comprehensive Error Rate Testing (CERT) report, the specialty of podiatry had a 7.4 percent error rate with a total projected improper payment amount of $131,795,384. The 2012 report also found that of the claims audited, 50.1 percent were insufficiently documented while 47.2 percent were incorrectly coded.

In addition, the 2007 report by the Office of the Inspector General (OIG) described similar results in their document titled, "Medicare Payments for Surgical Debridement Services in 2004" OEI-02-05-00390. In this report, "reviewers determined that 39 percent of surgical debridement services were billed with a code or modifier that did not accurately reflect the service provided." Of the 39 percent that were coded incorrectly, 21 percent were upcoded and reimbursed at a higher rate than should have been allowed. In many instances, the service performed was actually a non-covered routine foot care service.

This CBR specifically examines billing for debridement of ulcers and wounds and active wound care management. The CBR includes metrics regarding the distribution of services, the percentage of visits with more than one unit of service, and the percentage of claim lines with modifiers 58 and 59 appended.

The CPT®codes included in this CBR and your utilization of these codes are displayed below in Table 1.



**Table 1: Summary of Your Utilization for Debridement**
**January 1, 2013 - December 31, 2013**

| CPT® | Abbreviated Description | Allowed Charges | Claim Lines | Modifier 58 | Modifier 59 | Allowed Services |
|---|---|---|---|---|---|---|
| 97597 | Debridement, epidermis and/or dermis; first 20cm or less | $0.00 | 0 | 0 | 0 | 0 |
| 97598 | Debridement, epidermis and/or dermis; each additional 20cm | $0.00 | 0 | 0 | 0 | 0 |
| 11042 | Debridement, subcutaneous tissue; first 20cm or less | $4,704.27 | 41 | 6 | 31 | 41 |
| 11045 | Debridement, subcutaneous tissue; each additional 20cm | $0.00 | 0 | 0 | 0 | 0 |
| 11043 | Debridement, muscle and/or fascia; first 20cm or less | $4,128.38 | 52 | 0 | 51 | 52 |
| 11046 | Debridement, muscle and/or fascia; each additional 20cm | $1,360.18 | 20 | 0 | 20 | 20 |
| 11044 | Debridement, bone; first 20cm or less | $0.00 | 0 | 0 | 0 | 0 |
| 11047 | Debridement, bone; each additional 20cm | $0.00 | 0 | 0 | 0 | 0 |
| **TOTAL** | | **$10,192.83** | **113** | **6** | **102** | **113** |

## Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare Guidelines. **The information provided does not supersede or alter the coverage and documentation policies as outlined in the Medicare Administrative Contractor (MAC) local coverage determinations (LCDs) and Policy Articles.** Please refer any specific questions you may have to the MAC for your region.

### Basic Coverage Criteria

The procedure codes in this CBR are discussed in 25 current and future LCDs covering all 56 U.S. states and territories. A total of eight MACs oversee claims adjudication for these services, and coverage guidelines vary by jurisdiction. Providers should follow the coverage indications, limitations and medical necessity guidance given for their state or territory. Providers may determine which MAC processes their claims by going to http://go.cms.gov/IMap.

The Medicare Coverage Database allows providers to search national coverage determinations and LCDs by coverage determination identification number, geographic area/region, key words, and CPT®codes. The database can be found at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

For the purposes of education, all of the LCDs which contained references to any of the codes were reviewed for the CBR which focuses on areas of similarity. A complete list of the LCDs can be found at http://www.cbrinfo.net/cbr201408-recommended-links.html.

Most of the LCDs reviewed define wound care as the care of wounds that do not follow the normal repair process either due to characteristics of the wound itself or because of patient comorbidities that adversely affect healing. Standard wound care is multi-faceted and based on the specific type of wound. Aspects may include optimization of nutrition, off-loading of pressure and adequate glucose control for diabetic ulcers, debridement to remove devitalized tissue, and appropriate dressings and treatment to resolve infections as necessary.

Medicare coverage for wound care requires medical record documentation to support the medical diagnosis, wound characteristics, indications for debridement, patient comorbidities affecting healing, and level/depth of tissue removed as well as patient specific goals and responses to treatment. The patient's record should support that the wound is improving in response to the care being provided. It would not be medically reasonable or necessary to continue a given type of wound care without evidence of improvement.

According to CPT®, wound debridement codes are reported by the depth of tissue that is removed and the total surface area of the debrided tissue measured in square centimeters. Active wound care management codes 97597-97598 describe the debridement of fibrin, devitalized epidermis and/or dermis, exudate, debris, and biofilm using devices such as high pressure waterjet, scissors, scalpel and/or forceps. These codes include wound assessment, instructions for ongoing care, and the use of a whirlpool, when utilized. These codes are billed by the total surface area of the devitalized and/or necrotic tissues removed and are used for debridement of tissue that does not extend beyond the level of the dermis.

In order to report procedure codes 11042-11047, the debridement must extend below the dermis. When the same depth of tissue is removed from different anatomic sites, the area of tissue removed is summed. When different depths of tissue are removed from the same anatomic site, only the deepest level of debridement is reported. When different depths of tissue are removed from different anatomic sites, report each level of debridement (11042 and/or 11043 and/or 11044), and append the 59 modifier to one or two of the codes, as applicable. Modifier 59 indicates a distinct procedure or service.

CPT® modifier 58 indicates a staged or related procedure or service performed by the same physician during the post-operative period of another procedure. All CPT® codes analyzed in this CBR have been assigned "000" global days. This means that there is no pre-operative period, no post-operative days and evaluation and management visits on the day of the procedure are generally not payable as a separate service. This also means that when debridements are repeated, the subsequent services do not require the 58 modifier appended.

Limitations to coverage common among multiple LCDs indicate that the wound being debrided must contain necrotic, devitalized, fibrotic or other tissue or foreign matter that is interfering with the normal wound healing process; the presence or absence of this tissue must be documented in the medical record. Many of the LCDs researched for our CBR indicated several services that would not be covered as debridement including:

- Removal of necrotic tissue by cleansing or scraping (other than by scalpel or curette)
- Chemical applications and moist-to-dry or wet-to-dry dressings
- Dressing of small or superficial lesions
- Trimming of callus or fibrinous material from the margin of an ulcer
- Paring or cutting of corns or non-plantar calluses
- Washing bacterial or fungal debris
- Removal of secretions and coagulation serum from normal skin surrounding an ulcer
- Incision and drainage of abscesses, debridement of mycotic nails, or debridement of burns

Frequent billing errors found during audits of medical records of wound debridement services include:

- CPT® 11043 reported when muscle and tendon are visible, but not actually surgically debrided
- CPT® 11044 reported when bone is visible, but not actually surgically debrided
- Billing multiple "initial" CPT® codes, such as 11043 and 11044, for the same wound site
- Billing based on the size of the wound and not the actual area of devitalized tissue removed

Common medical necessity errors found during audits of medical records of wound debridement services include:

- Documentation which states that the wound bed was clean with 100 percent granulation tissue
- Documentation that the wound was debrided by being scrubbed with a 4 x 4 gauze pad
- Documentation supporting trimming of callus with no selective debridement

## References

The coverage and documentation guidelines are listed below. Please follow the guidelines pertinent to your region.

**Table 2: Local Coverage Determinations**

| Contractor | Current LCD | Future LCD (After 10/1/2015) |
|---|---|---|
| Cahaba Government Benefit Administrators, LLC | L30004 | L34290 |
| CGS Administrators, LLC | L31835 | L34032 |
| First Coast Service Options, Inc. | L28774, L28776, L29128, L29146 | L33566 |
| National Government Services, Inc. | L26884, L27373 | L33614 |
| Noridian Healthcare Solutions, LLC | L24374, L33496 | L34199, L34243 |
| Novitas Solutions, Inc. | L27547, L32687 | L35125, L35139 |
| Palmetto GBA | L31705 | L33460 |
| Wisconsin Physicians Service Insurance Corporation | L28572, L30135 | L34587 |

Office of Inspector General, http://oig.hhs.gov

- *Medicare Payments for Surgical Debridement Services in 2004*, May 2007, OEI-02-05-00390

Comprehensive Error Rate Testing (CERT), https://www.cms.gov/CERT

- *Improper Medicare Fee-For-Service Payments Report*, May 2008
- *The Supplementary Appendices for the Medicare Fee-for-Service 2012 Improper Payment Rate Report*, 2012

Medicare Manuals, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/

- *National Correct Coding Initiative (NCCI) Policy Manual*, Revision Date: 1/1/2014 - Chapter 1, General Correct Coding Policies, Section E Modifiers and Modifier Indicators
- *Chapter 3, Surgery: Integumentary System, CPT Codes 10000 - 19999*, Sections H and I
- Modifier 59 Article: *Proper Usage Regarding Distinct Procedural Service*
- *Medicare Claims Processing Manual*
    - *Chapter 12, Physicians/Nonphysician Practitioners*, Section 40, Surgeons and Global Surgery
- *Medicare Benefit Policy Manual*
    - *Chapter 15, Covered Medical and Other Health Services*, Section 290, Foot Care
    - *Chapter 16, General Exclusions from Coverage*, Section 30, Foot Care

## Method

This report is an analysis of Medicare Part B claims with allowed services for the CPT® codes listed in Table 1, with dates of service from January 1, 2013 to December 31, 2013. This analysis was based on the latest version of claims available from the Integrated Data Repository as of August 22, 2014. Your values are compared to the state and national values using a chi-squared test at the alpha value of 0.05.

### Distribution of Allowed Services by CPT® Code Group

The distribution of allowed services by CPT® code group is the percent of total allowed services that each CPT® code group represents of the total allowed services. CPT® codes are grouped by depth of tissue removed since they are not in sequential order. The percent for each CPT® code is calculated for you, your state, and the nation as follows:

$$\left(\frac{\textbf{Total Allowed Services for the CPT® Code Group}}{\textbf{Total Allowed Services for all Four CPT® Code Groups}}\right)\textbf{x}100$$

### Percentage of Visits with More than One Allowed Service

For this analysis a visit refers to all allowed services on a date of service for a single beneficiary. The percentage of visits with more than one allowed service for you, your state, and the nation are calculated as follows:

$$\left(\frac{\textbf{Number of Visits with More than One Allowed Service}}{\textbf{Total Number of Visits}}\right)\textbf{x}100$$

### Percentage of Claim Lines With Modifiers 58 and 59

The percentage of claim lines with modifiers 58 and 59 are calculated separately for each modifier. The percent for you, your state, and the nation are calculated as follows:

$$\left(\frac{\textbf{Number of Claim Lines with the Modifier}}{\textbf{Total Number of Claim Lines}}\right)\textbf{x}100$$

### Comparison Outcomes

There are three possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** - Provider's value is higher than the peer value and the statistical test confirms a significance
- **Higher** - Provider's value is higher than the peer value but the statistical test does not confirm a significance
- **Does Not Exceed** - Provider's value is not higher than the peer value

A provider's value may be greater than the value of his peer. The statistical test gives the provider the benefit of the doubt since significance is based on the total number of claim lines and/or beneficiaries and the variability of those values.

## Results

Figure 1 is a graphical representation of your distribution of allowed services by CPT® code group for you, your state (MO) and the nation. Table 3, following the figure, provides additional information on the distributions of allowed services by CPT® code group for you, your state, and the nation. The first column of table 3 indicates the CPT® codes that are described by that particular row. Your overall distribution of allowed services is **significantly different** than your peers.

**Figure 1: Distribution of Allowed Services by CPT® Code Group**
**January 1, 2013 - December 31, 2013**

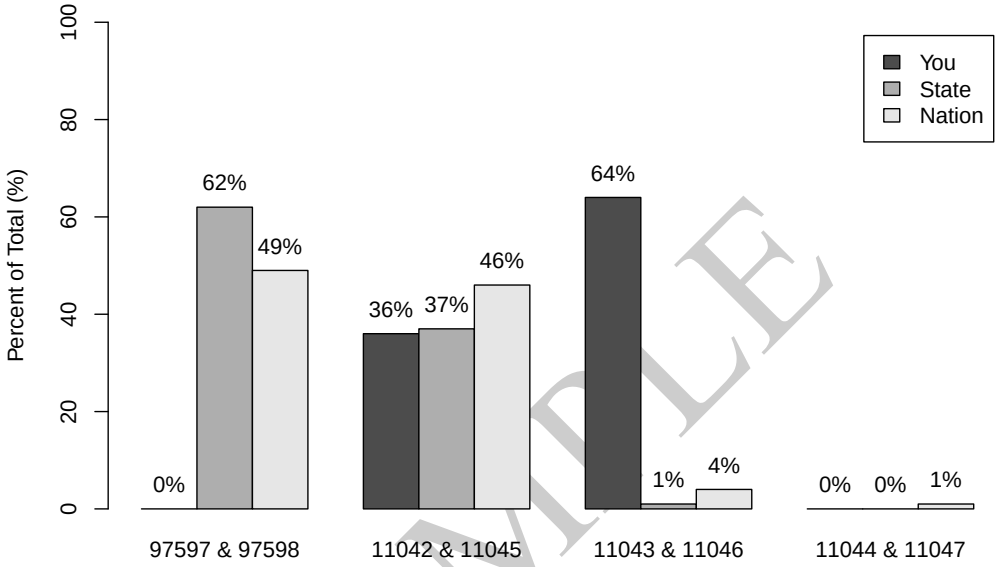




**Table 3: Distribution of Allowed Services by CPT® Code Group**
**January 1, 2013 - December 31, 2013**

| CPT® Code Group | Your Percentage of Allowed Services | Your State's Percentage of Allowed Services | National Percentage of Allowed Services |
|---|---|---|---|
| 97597 & 97598 | 0% | 62% | 49% |
| 11042 & 11045 | 36% | 37% | 46% |
| 11043 & 11046 | 64% | 1% | 4% |
| 11044 & 11047 | 0% | 0% | 1% |

A chi-square test was used in this analysis, alpha=0.05. Please note due to rounding the columns may not add to 100%

Figure 2 is a graphical representation of the percentage of visits with more than one allowed service. Table 4, following the figure, provides a statistical comparison of your percentage of visits that have more than one allowed service with the percentages of visits that have more than one allowed service for your state and the nation.

**Figure 2: Percentage of Visits with More than One Allowed Service**
**January 1, 2013 - December 31, 2013**

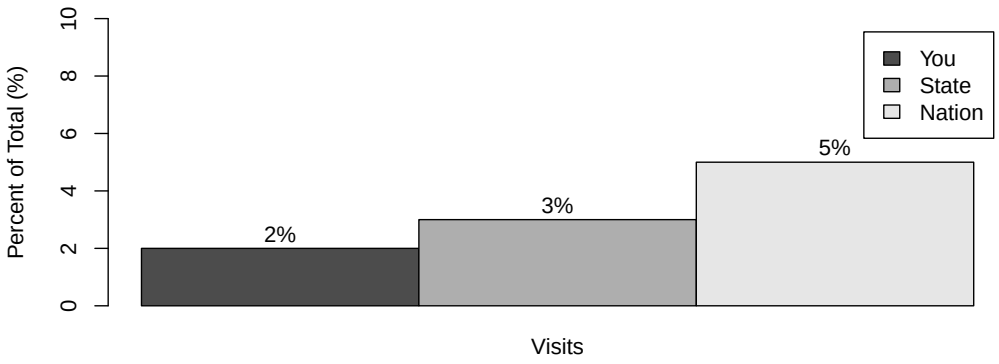


**Table 4: Percentage of Visits with More than One Allowed Service**
**January 1, 2013 - December 31, 2013**

| | Your Percentage of Visits | Your State's Percentage of Visits | Comparison with Your State's Percentage | National Percentage of Visits | Comparison with the National Percentage |
|---|---|---|---|---|---|
| Visits | 2% | 3% | Does Not Exceed | 5% | Does Not Exceed |

A chi-square test was used in this analysis, alpha=0.05.



Figure 3 is a graphical representation of the percentage of claim lines with modifiers 58 and 59. Table 5, following the figure, provides a statistical comparison of your percentages of claim lines with modifier 58 and modifier 59 with the percentages for your state and the nation.

**Figure 3: Percentage of Claim Lines with Modifiers 58 and 59**
**January 1, 2013 - December 31, 2013**

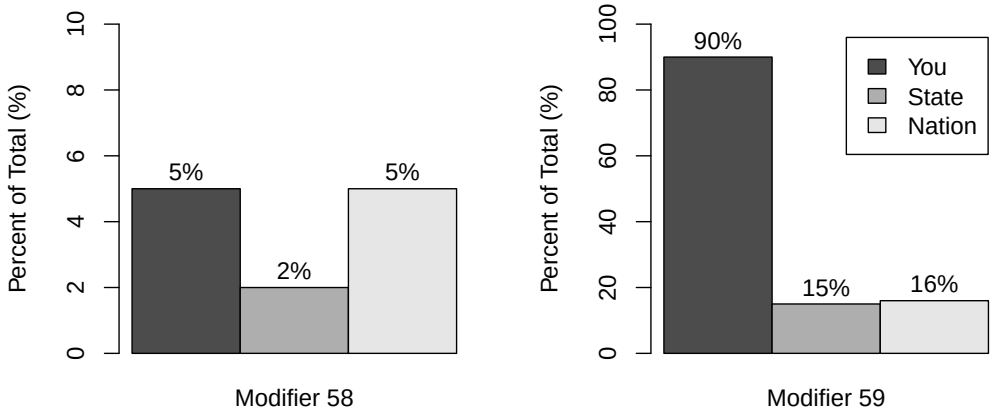

**Table 5: Percentage of Claim Lines with Modifiers 58 and 59**
**January 1, 2013 - December 31, 2013**

| Modifier | Your Percentage of Claim Lines | Your State's Percentage of Claim Lines | Comparison with Your State's Percentage | National Percentage of Claim Lines | Comparison with the National Percentage |
|---|---|---|---|---|---|
| 58 | 5% | 2% | Higher | 5% | Does Not Exceed |
| 59 | 90% | 15% | Significantly Higher | 16% | Significantly Higher |

A chi-square test was used in this analysis, alpha=0.05.

## Resources

The following resources are pertinent to this CBR and may assist providers with developing policies to address areas of concern:

- Social Security Act, http://www.ssa.gov/OP_Home/ssact/title18/1862.htm
  - Exclusions - Section 1862(a)(1)(A)
- Medicare Learning Network®, www.cms.gov/mlngeninfo
  - Fact Sheet - Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals, October 2011, ICN 006948
  - MLN Matters Article®
    - Foot Care Coverage Guidelines, SE1113

## The Next Steps

We encourage you to check with your MAC to ensure you meet Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

Join us for the CBR201408 webinar on October 29, 2014 from 3:00 - 4:30 PM ET. Space is limited, so please register early.

Register online at www.cbrinfo.net/cbr201408-webinar.html.

If you are unable to attend, you may access a recording of the webinar five business days following the event at the website above.

For detailed links to information listed in the references and resources section, visit: http://www.cbrinfo.net/cbr201408.html.

If you have any questions or suggestions relating to this CBR, please contact the CBR Support Help Desk via email at CBRSupport@eglobaltech.com or via telephone at (800) 771-4430.