Comparative Billing Report

January 12, 2015

CBR #: CBR201501
NPI #: 1111111111
Fax #: (888)555-5555

Organization Name
Full Name
123 Street Lane
Suite 4000
Anytown, XX 55555-4444

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
Modifier 59: Dermatology

Introduction

CBR201501 focuses on physicians specializing in dermatology who submitted claims for lesion biopsy and destruction services appended with modifier 59, a distinct procedural service. In 2005, the Office of the Inspector General (OIG) released a report on Medicare payments for services billed with modifier 59. The report, "Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits" (OEI-03-02-00771), indicated that 40 percent of modifier 59 claims billed for dates of service October 1, 2002 to September 30, 2003 failed to meet Medicare program requirements for payment. The specialty of dermatology was chosen due to the overall higher use of modifier 59 when compared with other physician specialties.

According to an article in Medicare Learning Network (MLN) Matters® (MM8863), "The National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) codes should not be reported together either in all situations or in most situations." The article then goes on to explain, "for PTP edits that have a correct coding modifier indicator of 1, the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers."

At this time, CPT® states modifier 59 is used to "identify procedures/services, other than evaluation and management (E/M) services, that are not normally reported together, but are appropriate under the circumstances." According to CPT®, "documentation submitted must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

In August 2014, the Centers for Medicare and Medicaid Services announced in Change Request 8863 that it had established four new HCPCS modifiers. These new modifiers, effective January 1, 2015, will selectively identify subsets of modifier 59. The new HCPCS modifiers are:

- **XE:** Separate Encounter, a service that is distinct because it occurred during a separate encounter,
- **XS:** Separate Structure, a service that is distinct because it was performed on a separate organ/structure,
- **XP:** Separate Practitioner, a service that is distinct because it was performed by a different practitioner, and
- **XU:** Unusual Non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

According to Change Request 8863, "modifier 59 is associated with high levels of manual audit activity leading to reviews and appeals. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment."

This CBR specifically examines the billing of dermatology CPT® codes 11101 and 17003 and use of modifier 59 and includes the following metrics:

- Percentage of claim lines with modifier 59 appended
- Percentage of visits billed with both a dermatology code and an E/M code
- Average allowed services per beneficiary summed for the one-year period

Table 1: Summary of Your Utilization for CPT® Codes and Modifier 59
July 1, 2013 - June 30, 2014

CPT®	Abbreviated Description	Type	Allowed Charges	Allowed Services	Claim Lines	Beneficiary Count
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion	With Mod 59	$955.14	30	26	25
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion	Without Mod 59	$381.93	12	11	11
17003	Destruction; 2 through 14 lesions	With Mod 59	$3,417.49	403	87	83
17003	Destruction; 2 through 14 lesions	Without Mod 59	$22,519.70	2,817	670	524
TOTAL			**$27,274.26**	**3,262**	**794**	**599**

Please note, the total number of beneficiaries may not be the sum of the "Beneficiary Count" for the four rows. It is likely the same beneficiary has billings for more than one CPT® code and therefore should not be counted more than once in the total.

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 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

Per the NCCI Policy Manual, "Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes." If another, more specific, NCCI modifier adequately describes the circumstance, it should be used instead of modifier 59.

According to Chapter I, General Correct Coding Policies, Section E, "modifiers may be appended to HCPCS/CPT® codes only if the clinical circumstances justify the use of the modifier. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled."

Each NCCI edit has an assigned modifier indicator. Modifiers can only be used when the modifier indicator for the code pair allows the code pair to be unbundled using NCCI associated modifiers. A modifier indicator of '0' specifies that a modifier is not allowed. A modifier indicator of '1' specifies that a modifier may be used to override the bundling edit when the medical record supports that the unusual conditions merit payment for two normally bundled procedures. A modifier indicator of '9' specifies that the edit is no longer applicable so a modifier is not required.

According to the NCCI manual (chapter 1, section R), "In general, NCCI procedure-to-procedure edits do not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on procedure."

In the data analyzed for CBR201501 Modifier 59: Dermatology, claims with dates of service from July 1, 2013 through June 30, 2014 were reviewed. Modifier 59 was appended to over 550,000 claim lines for CPT® code 11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion) and CPT® code 17003 (destruction; second through 14 lesions) combined. According to the NCCI physician edits, the modifier indicator for CPT® code 11101, which bundled in to CPT® code 11100, is '9' and the edit was removed in 1996. The modifier indicator for CPT® code 17003 is '0' when bundled in to CPT® code 17004 (destruction of premalignant lesions, 15 or more lesions) so the two codes can never be billed for the same date of service.

The following are examples of incorrect modifier 59 usage:

- Modifier 59 used on the second procedure code for services performed twice on the same day, using the same procedure code
- Modifier 59 used on evaluation and management codes
- Modifier 59 used for multiple administrations of the same injectable drug
- Modifier 59 used on code combinations not appearing in the National Correct Coding Initiative edits
- Modifier 59 appended to the column one code instead of the column two code
- Modifier 59 used when another, more accurate, modifier exists to identify the service

When the same non-laboratory procedure is performed twice on the same date of service, modifier 76 (repeat procedure or service by the same physician or other qualified health professional) should be used on the second claim line for the service. When the same laboratory procedure is performed twice on the same date of service, modifier 91 (repeat clinical diagnostic laboratory test) should be used on the claim line for the second service.

Providers should check their code pairs against the tables in the National Correct Coding Initiative edits prior to appending modifier 59 to any claim line.

References

The coverage and documentation guidelines for Modifier 59: Dermatology, are listed below. Please follow any specific guidelines pertinent to your region as required by your Medicare Administrative Contractor.

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

- National Correct Coding Initiative Manual, http://www.cms.gov/NCCI
  - Chapter I, *General Correct Coding Policies*
    - Modifiers and Modifier Indicators, Section E
    - Modifier 59 Article, http://www.cms.gov/Mod59
- Claims Processing Manual
  - Chapter 12, *Physician/Nonphysician Practitioners*
    - *Correct Coding Policy*, Section 30
- CMS Manual System
  - *Pub 100-20 One-Time Notification*, August 15, 2014
    - *Change Request 8863*, Transmittal 1422

Method

This report is an analysis of traditional fee-for-service Medicare Part B claims with allowed services for the CPT® codes listed in Table 1, with dates of service from July 1, 2013 to June 30, 2014, and includes only those claims where the rendering NPI specialty is denoted as dermatology (07). This analysis was based on the latest version of claims available from the Integrated Data Repository as of December 9, 2014. Your values are compared to the state and national values using either the chi-squared or t-test at the alpha value of 0.05.

Percentage of Claim Lines with Modifier 59

The percentage of claim lines with dermatology CPT® codes 11101 and 17003 and modifier 59 is calculated as follows:

$$\left(\frac{\textbf{Number of Claim Lines with Modifier 59}}{\textbf{Total Number of Claim Lines}}\right)\textbf{x}100$$

Percentage of Visits with a Dermatology Add On Code and an E/M Code

For this analysis, we looked at the dermatology CPT® codes 11101 and 17003. If a provider billed for one of the dermatology codes, as well as an established patient E/M codes CPT® 99211 - 99215 for a beneficiary on the same date of service, then this visit is referred to as a shared visit. The percentage of shared visits are calculated as follows:

$$\left(\frac{\textbf{Number of Shared Visits}}{\textbf{Total Number of Visits}}\right)\textbf{x}100$$

Average Allowed Services per Beneficiary

The average allowed services for dermatology CPT® codes 11101 and 17003 per beneficiary is calculated for the one-year period regardless of the modifiers as follows:

$$\left(\frac{\textbf{Total Allowed Services}}{\textbf{Total Number of Beneficiaries}}\right)$$

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 group. The statistical test gives the provider the benefit of the doubt since significance is based on the total number of claim lines, visits, or beneficiaries and the variability of those values.

Results

Table 2 provides a comparison of your percentage of claim lines with modifier 59 to that of your state and the nation.

Table 2: Percentage of Claim Lines with Modifier 59
July 1, 2013 - June 30, 2014

CPT®	Your Percentage of Modifier 59 Use	Your State's Percentage of Modifier 59 Use	Comparison with Your State's Percentage	National Percentage of Modifier 59 Use	Comparison with the National Percentage
11101	70%	25%	Significantly Higher	32%	Significantly Higher
17003	11%	10%	Higher	10%	Higher

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

Table 3 provides a comparison of your percentage of visits that share a dermatology CPT® 11101 or 17003 with an established patient E/M CPT® code 99211 - 99215. Your percentages are compared to that of your state and the nation.

Table 3: Percentage of Shared Visits
July 1, 2013 - June 30, 2014

Type	Your Percentage of Shared Visits	Your State's Percentage of Shared Visits	Comparison with Your State's Percentage	National Percentage of Shared Visits	Comparison with the National Percentage
E/M Visits	59%	68%	Does Not Exceed	69%	Does Not Exceed

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

Table 4 provides a comparison of your average allowed services per beneficiary to that of your state and the nation. The total allowed services include dermatology CPT® codes 11101 and 17003 regardless of the modifiers attached to the claim line. This is the total allowed services per beneficiary for the one-year time period under analysis.

Table 4: Average Allowed Services per Beneficiary
July 1, 2013 - June 30, 2014

Type	Your Average Services per Beneficiary	Your State's Average Services per Beneficiary	Comparison with Your State's Average	National Average Services per Beneficiary	Comparison with the National Average
Services	5.45	5.31	Higher	5.87	Does Not Exceed

A t-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:

Medicare Learning Network®, http://www.cms.gov/mlngeninfo

- MLN Matters®
  - *Specific Modifiers for Distinct Procedural Services*, MM8863
  - *Proper Use of Modifier 59*, SE1418

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

- *Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits*, November 2005, OEI-03-02-00771

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.

You are invited to join us for the CBR201501 webinar on February 4, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early.

Register online at http://www.cbrinfo.net/cbr201501-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/cbr201501.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.