Comparative Billing Report

February 9, 2015

CBR #: CBR201502
NPI #: 1111111111
Fax #: (888)555-5555

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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 specialty 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
Modifiers 24 & 25: Specialty Surgeons

Introduction

CBR201502 focuses on specialty surgeons who submitted claims for evaluation and management (E/M) services appended with modifiers 24 and/or 25. For the purposes of this CBR, we will define a specialty surgeon as those surgeons who list their area of surgical practice as something other than general surgery or orthopedic surgery. The specialties included in this CBR are:

14 - Neurosurgery
24 - Plastic and Reconstructive Surgery
28 - Colorectal Surgery
33 - Thoracic Surgery
40 - Hand Surgery
77 - Vascular Surgery
78 - Cardiac Surgery
85 - Maxillofacial Surgery
91 - Surgical Oncology

The Office of Inspector General (OIG) included a review of modifiers during the global surgery period as part of their 2012 and 2013 work plans. These work plans cite prior OIG reports which have shown improper use of modifiers during the global surgery period. One report indicated that 35 percent of the E/M services audited did not meet Medicare program requirements for the use of modifier 25.

Reviews by other agencies also support the findings of the OIG. According to the *Medicare Quarterly Provider Compliance Newsletter, Volume 1, Issue 2* dated February 2011, "Reviews by recovery auditors determined that providers are incorrectly billing E/M services provided by the surgeon the day before, the day of, and up to 90 days after major surgeries and 0-10 days after minor surgery."

According to the Medicare Learning Network® *Global Surgery Fact Sheet* (ICN 907166), the global surgery payment for Medicare includes the following services:

- Pre-operative visits after the decision is made to operate
- Intra-operative services that are a necessary part of a surgical procedure
- All additional medical or surgical services required of the surgeon during the post-operative period because of complications, which do not require additional trips to the operating room
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery
- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

According to the *Current Procedural Terminology (CPT®) 2013 Professional Edition* description, modifier 24 should be used to describe an "unrelated evaluation and management service by the same physician or other qualified health care professional during a post-operative period." Modifier 25 should be used to describe a "significant, separately identifiable evaluation and management

service by the same physician or other health care professional on the same day of the minor procedure or other service."

This CBR specifically examines E/M services for established patients, CPT® codes 99211 through 99215, appended with modifiers 24 and/or 25. The time period under review includes claims with dates of service from July 1, 2013 through June 30, 2014.

Table 1: CPT® Codes, Abbreviated Descriptions, and Typical Times

CPT®	Abbreviated Description	Typical Time
99211	Minimal Problem/Exam	5 Minutes
99212	Problem Focused/Exam	10 Minutes
99213	Expanded Problem Focused/Exam	15 Minutes
99214	Detailed Patient History/Exam	25 Minutes
99215	Comprehensive Patient History/Exam	40 Minutes

The metrics reviewed in this report are:

- Percentage of claim lines appended with modifier 24
- Percentage of claim lines appended with modifier 25
- Average minutes per visit, with and without modifiers 24 and/or 25
- Total charges per beneficiary for the year for the codes included in the CBR regardless of the modifiers appended

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

The *Medicare Claims Processing Manual*, chapter 12 (Physician/Nonphysician Practitioners) covers the guidelines for payment for E/M services provided during the global period of surgery in Section 30.6.6 and requirements for global surgeries in Section 40.2.

Modifier 24 is appended to unrelated E/M services that occur during the post-operative period that follows a procedure or surgery. In order for a physician to append modifier 24, the documentation must support that the visit was unrelated to the surgery. According to the *Medicare Claims Processing Manual*, "A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation." Modifier 24 is also used by the transplant physician for post-operative E/M services necessary to manage immunosuppressive therapy during the postoperative period of a transplant. Modifier 24 is used when the surgeon manages chemotherapy during the postoperative period of a procedure.

According to the Wisconsin Physician Services Health Insurance *Modifier 24 Fact Sheet*, it would not be appropriate to add modifier 24 in the following instances:

- For a surgical complication or injection, this treatment is part of the surgery package
- For treatment of a post-operative wound infection
- When the surgeon admits the patient to a skilled nursing facility for a condition related to the surgery
- When the medical record does not clearly indicate the E/M was unrelated to the surgery
- When the E/M occurs outside the post-operative period

A review of claims for this CBR indicate that the primary diagnosis appears to be directly related to the surgery in many instances. Examples of this include:

- Non-healing surgical wound
- Other post-operative infection
- Disruption of external surgical wound
- Encounter for removal of sutures
- Encounter for change or removal of surgical dressing

Information on the global surgical package can be found in chapter 12, section 40 of the *Medicare Claims Processing Manual*. Medicare instructions state that only those postoperative complications which require a return trip to the operating room (OR) are covered outside of the global surgical package. Medicare defines an operating room "as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR)."

Modifier 25 is used to denote a significant, separately identifiable E/M service that takes place on the same date of service as a minor procedure or surgery. Modifier 25 is not used on the same date of service as a procedure or surgery which is considered to be a major surgery. When a major surgery is performed on the same date that the physician determined the need for surgery, modifier 57 (decision for surgery) should be appended to the claim line.

In order for a physician to append modifier 25, the documentation must support that the patient's condition required a significant examination that was above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.

Per the *National Correct Coding Initiative (NCCI) Policy Manual*, chapter 1 (General Correct Coding Policies), "In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant separately identifiable E&M service *unrelated* to the decision to perform the minor surgical procedure is separately reportable with modifier 25."

Services that would be related to the decision to perform the procedure could include assessing the patient before, during and after the procedure, as well as informing the patient of possible risks and giving the patient instructions for post-operative care.

In the case of each modifier, the separately billed E/M code must meet documentation requirements for the level selected. Information on selecting the proper level of E/M code can be found in chapter 12, section 30.6.1, of the *Medicare Claims Processing Manual*. The manual states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

References

The coverage and documentation guidelines for Modifiers 24 & 25: Specialty Surgeons, are listed below. Please follow any specific guidelines pertinent to your region as required by your MAC.

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

- *National Correct Coding Initiative (NCCI) Policy Manual*, http://www.cms.gov/NCCI
    - *Chapter 1, General Correct Coding Policies*
        - *Evaluation and Management (E&M) Services*
        - *Modifiers and Modifier Indicators*
- *Medicare Claims Processing Manual*, Publication 100-04
    - *Chapter 12, Physician/Nonphysician Practitioners*
        - *Selection of Level of Evaluation & Management Services*, Section 30.6.1
        - *Payment for Evaluation and Management Services Provided During Global Period of Surgery*, Section 30.6.6
        - *Surgeons and Global Surgery*, Section 40
        - *Definition of a Global Surgical Package*, Section 40.1
        - *Billing Requirements for Global Surgeries*, Section 40.2

Wisconsin Physician Services Health Insurance, http://wpsmedicare.com

- *Modifier 24 Fact Sheet*

Methods

This report is an analysis of traditional fee-for-service Medicare Part B claims with allowed services for the CPT® codes for established E/M procedures listed in Table 1, with dates of service from July 1, 2013 to June 30, 2014, and includes only those claims where the rendering National Provider Identifier (NPI) specialty is denoted as a specialty surgeon as defined above. Due to the large quantity of claims submitted by general surgeons (02) and orthopedic surgeons (20), these specialties are excluded from this analysis. If a provider submitted claims with multiple surgeon specialties, then all of that provider's claims will be included under the specialty with the highest allowed charges. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR) as of January 6, 2015. Your values are compared to those of your specialty and all specialty surgeons' (national) values using either the chi-squared or t-test at the alpha value of 0.05.

Percentage of Claim Lines with Modifier 24 and 25

The percentage of claim lines with established E/M CPT® codes 99211 - 99215 and the modifiers 24 and 25 are calculated as follows:

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

Your percentages of claim lines with each modifier were then compared to the percentages of your specialty and the nation using a chi-squared test at the alpha value of 0.05. Claims where both modifiers 24 and 25 were appended are included in both modifier calculations.

Average Minutes per Visit with Modifier 24, Modifier 25 and Neither Modifier

Each CPT® code is assigned a value that corresponds to the the typical minutes described in the CPT® code description. This value is then multiplied by the number of services on the claim line. If multiple claim lines are allowed for a particular beneficiary and date of service, then these lines are added together to get a total weighted value by visit. The average minutes allowed per visit are calculated separately for claim lines with modifier 24, modifier 25, and with neither modifier as follows:

$$\left(\frac{\textbf{Total Weighted Value by Modifier Designation}}{\textbf{Total Number of Visits by Modifier Designation}}\right)$$

Your average was then compared to your specialty and the nation using a t-test at the alpha value of 0.05.

Average Allowed Charges per Beneficiary

The average allowed charges per beneficiary is calculated for the one-year period regardless of the modifiers as follows:

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

Your averages were then compared to your specialty and the nation using a t-test at the alpha value of 0.05.

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 summary of your utilization of the CPT® codes and modifiers included in this CBR. The total allowed charges, allowed services, claim lines count, and distinct beneficiary count is included for each CPT® code and modifier.

Table 2: Summary of Your Utilization for CPT® Codes and Modifiers 24 and 25 July 1, 2013 - June 30, 2014

CPT®	Modifier	Allowed Charges	Allowed Services	Claim Lines	Beneficiary Count
99211	24	$0.00	0	0	0
99211	25	$0.00	0	0	0
99211	Neither	$0.00	0	0	0
99212	24	$0.00	0	0	0
99212	25	$84.60	2	2	2
99212	Neither	$504.36	12	12	9
99213	24	$211.95	3	3	2
99213	25	$4,238.16	60	60	53
99213	Neither	$7,769.62	110	110	80
99214	24	$208.18	2	2	2
99214	25	$12,066.34	116	116	105
99214	Neither	$7,393.90	71	71	65
99215	24	$0.00	0	0	0
99215	25	$139.20	1	1	1
99215	Neither	$836.74	6	6	6
TOTAL		**$33,278.58**	**381**	**381**	**261**

Please note, the totals may not be equal to the sum of the rows. Claims which have both modifier 24 and 25 appended would be counted in both modifier rows. The number of beneficiaries is an unduplicated count for each row and the total. It is likely the same beneficiary has billings for more than one CPT® code and modifier, and therefore is counted only once in the total.

Table 3 provides a comparison of your percentage of claim lines with modifiers 24 and 25 to that of your specialty (77) and the nation.

Table 3: Percentage of Claim Lines with Modifier 24 and 25
July 1, 2013 - June 30, 2014

Modifier	Your Percentage of Modifier Use	Your Specialty's Percentage of Modifier Use	Comparison with Your Specialty's Percentage	National Percentage of Modifier Use	Comparison with the National Percentage
24	1%	2%	Does Not Exceed	2%	Does Not Exceed
25	47%	16%	Significantly Higher	14%	Significantly Higher

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

Table 4 provides a comparison of your average allowed minutes per visit for claim lines with modifier 24, modifier 25 and with neither modifier. Your averages are compared to that of your specialty and the nation.

Table 4: Average Minutes per Visit by Modifier
July 1, 2013 - June 30, 2014

Modifier	Your Average Minutes per Visit	Your Specialty's Average Minutes per Visit	Comparison with Your Specialty's Average	National Average Minutes per Visit	Comparison with the National Average
24	19.00	17.36	Higher	16.81	Higher
25	21.56	16.51	Significantly Higher	16.60	Significantly Higher
Neither	19.02	16.73	Significantly Higher	17.11	Significantly Higher

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

Table 5 provides a comparison of your average allowed charges per beneficiary to that of your specialty and the nation. The total allowed charges is summarized regardless of the modifiers attached to the claim line. This is the average total allowed charges per beneficiary for the one-year time period under analysis.

Table 5: Average Allowed Charges per Beneficiary
July 1, 2013 - June 30, 2014

Category	Your Average Allowed Charges per Beneficiary	Your Specialty's Average Allowed Charges per Beneficiary	Comparison with Your Specialty's Average	National Average Allowed Charges per Beneficiary	Comparison with the National Average
Charges	$127.50	$120.94	Significantly Higher	$118.77	Significantly Higher

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

- *Global Surgery Fact Sheet ICN 907166*, August 2013,
- *Medicare Quarterly Provider Compliance Newsletter, Guidance to Address Billing Errors*, Volume 1, Issue 2 - February 2011

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

- *Use of Modifier 25*, November 2005, OEI-07-03-00470
- *Evaluation and Management Services During Global Surgery Period, Work Plan Fiscal Year 2010*
- *Evaluation and Management Services: Use of Modifiers During the Global Surgery Period (New), Work Plan Fiscal Year 2012*
- *Evaluation and Management Services - Use of Modifiers During the Global Surgery Period, Work Plan Fiscal Year 2013*

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 CBR201502 webinar on March 4, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early.

Register online at http://www.cbrinfo.net/cbr201502-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/cbr201502.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.