Comparative Billing Report

March 9, 2015

CBR #: CBR201503
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 25: Nurse Practitioners

Introduction

This CBR focuses on nurse practitioners who submitted claims for evaluation and management (E/M) services appended with modifier 25. The *CPT® 2013 Professional Edition* manual defines modifier 25 as indicative of a "significant, separately identifiable E/M service by the same physician or other qualified health professional on the same day of the procedure or other service." In 2005, the Office of the Inspector General (OIG) released a report on Medicare payments for E/M services billed with modifier 25. The report "Use of Modifier 25" (OEI-07-03-00470), indicated that, out of $1.96 billion paid for claims using modifier 25, as much as $538 million was paid improperly. The OIG found that many providers appended the modifier to more than 50 percent of the services they billed, while other providers used modifier 25 on their E/M service when no other service was performed on the same day. Of the 431 claims audited, 35 percent did not meet program requirements.

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 with modifier 25 appended
- Average allowed minutes per visit for claim lines with modifier 25 and without modifier 25
- Average allowed charges per beneficiary summed for the one-year period regardless of the modifiers appended to the claim lines.

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 CPT® manual describes a modifier as providing "the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code." Procedure codes may be modified in certain situations to more precisely describe the service or item rendered.

According to Chapter 1 of the *National Correct Coding Initiative (NCCI) Policy Manual*, the use of modifier 25 applies to E/Ms performed on the same day as a minor procedure with a global period of 10 days or less. The modifier is also used when E/Ms are performed on the same date of service as x-rays and/or injections.

Per NCCI, "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 related to the decision to perform the procedure could include assessing the patient before, during, and after the procedure, informing the patient of possible risks and giving the patient instructions for post-operative care. According to *CPT® Assistant*, assessing the site, explaining the procedure, and obtaining informed consent are all services which are necessary for the performance of a medical procedure and are included in Medicare payments for the procedure.

According to Chapter I, Section E of the NCCI, "modifiers may be appended to Healthcare Common Procedure Coding (HCPCS)/CPT® codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT® code solely to bypass an NCCI edit if the clinical circumstances do not justify its use."

According to Chapter 12 of the *Medicare Claims Processing Manual*, a significant, separately identifiable E/M service may also be billed in addition to an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV). Modifier 25 should be appended to the medically necessary E/M service. Using this modifier identifies the E/M as significant from the IPPE or AWV code. The instructions go on to note the following: "Some of the components of a medically necessary E/M service (e.g., a portion of the history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service."

The American Academy of Family Physicians (AAFP) recommends a series of questions that may assist providers in determining if and when modifier 25 should be used. Their article titled, "Understanding When to Use Modifier 25," suggests providers ask themselves the following questions:

- Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
- Could the complaint or problem stand alone as a billable service?
- Is there a different diagnosis for this portion of the visit?
- If the diagnosis will be the same, did you perform extra provider work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

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 E/M 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."

The problem addressed must be distinct from the procedure and significant enough to warrant some kind of treatment by the provider. None of the E/M service documentation components may be used to support the performance of the procedure. Providers can audit their own medical records to see if they meet the requirements by using a marker to eliminate the documentation for the procedure or other services (including any related E/M service) from the note. The remaining documentation should be enough to support a significant level of service.

References

The coverage and documentation guidelines for this CBR are listed below.

- Medicare Manuals,
  http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/
  - *Medicare Claims Processing Manual*
    - Chapter 12, *Physicians/Nonphysician Practitioners*
      - *Selection of Level of Evaluation & Management Services*, Section 30.6.1
      - *Initial Preventive Wellness Examination (IPWE) and Annual Wellness Visit (AWV)*, Section 30.6.1.1
      - *Payment for Evaluation and Management Services Provided During Global Period of Surgery*, Section 30.6.6
      - *Surgeons and Global Surgery*, Section 40 to Section 40.2
  - *National Correct Coding Initiative Policy Manual*,
    http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
    - Chapter 1, *General Coding Policies*
      - *Evaluation and Management Services*, Section D
      - *Modifiers and Modifier Indicators*, Section E

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 July 1, 2013 to June 30, 2014 and includes only those claims where the rendering NPI specialty is denoted as nurse practitioner (50). This analysis was based on the latest version of claims available from the Integrated Data Repository as of January 26, 2015. 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 25

The percentage of claim lines with modifier 25 is calculated as follows:

$$\left(\frac{\textbf{Number of Claim Lines with Modifier 25}}{\textbf{Total Number of Claim Lines}}\right)\textbf{x}100$$

Your percentage was then compared to your state and the nation using a chi-squared test at the alpha value of 0.05.

Average Allowed Minutes per Visit with Modifier 25 and without Modifier 25

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 25 and without modifier 25 as follows:

$$\frac{\textbf{Total Weighted Value by Modifier Designation}}{\textbf{Total Number of Visits by Modifier Designation}}$$

Your average was then compared to your state 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:

$$\frac{\textbf{Total Allowed Charges}}{\textbf{Total Number of Beneficiaries}}$$

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

Comparison Outcomes

There are four 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
- **N/A** - Provider does not have sufficient data for comparison

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 and/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, claim line count, and distinct beneficiary count is included for each CPT® code, both with and without modifier 25.

Table 2: Summary of Your Utilization for E/M Codes and Modifier 25
July 1, 2013 - June 30, 2014

CPT®	Type	Allowed Charges	Claim Lines	Beneficiary Count
99211	With Modifier 25	$0.00	0	0
99211	Without Modifier 25	$0.00	0	0
99212	With Modifier 25	$20.04	1	1
99212	Without Modifier 25	$0.00	0	0
99213	With Modifier 25	$6,108.00	150	140
99213	Without Modifier 25	$6,683.66	158	145
99214	With Modifier 25	$10,814.40	172	158
99214	Without Modifier 25	$9,408.42	145	136
99215	With Modifier 25	$88.50	1	1
99215	Without Modifier 25	$91.76	1	1
TOTAL		**$33,214.78**	**628**	**452**

Please note, the totals may not be equal to the sum of the 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 type, and therefore is counted only once in the total.

Table 3 provides a comparison of your percentage of claim lines with modifier 25 to that of your state and the nation.

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

	Your Percentage of Modifier 25 Use	Your State's Percentage of Modifier 25 Use	Comparison with Your State's Percentage	National Percentage of Modifier 25 Use	Comparison with the National Percentage
Mod 25	52%	16%	Significantly Higher	17%	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 claims lines with modifier 25 and without modifier 25. Your averages are compared to that of your state and the nation.

Table 4: Average Allowed Minutes per Visit
with Modifier 25 and without Modifier 25
July 1, 2013 - June 30, 2014

Type	Your Average Minutes Per Visit	Your State's Average Minutes Per Visit	Comparison with Your State's Average	National Average Minutes Per Visit	Comparison with the National Average
With Mod 25	20.4	20.5	Does Not Exceed	18.9	Significantly Higher
Without Mod 25	19.9	19.8	Higher	19.0	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 state and the nation. The total allowed charges include E/M claim lines for established beneficiaries regardless of the modifiers attached to the claim line. This is the 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

	Your Average Charges Per Beneficiary	Your State's Average Charges Per Beneficiary	Comparison with Your State's Average	National Average Charges Per Beneficiary	Comparison with the National Average
Charges	$73.48	$136.61	Does Not Exceed	$126.20	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:

- Office of the Inspector General, http://oig.hhs.gov
  - *Use of Modifier 25*, November 2005, OEI-07-03-00470
  - *OIG Work Plan 2012/2013*
- Medicare Learning Network®, http://www.cms.gov/mlngeninfo
  - *Global Surgery Fact Sheet*, ICN 907166, August 2013
- American Association of Family Practice, http://www.aafp.org/fpm/2004/1000/p21.html
  - *Understanding When to Use Modifier 25*, October 2004
- *CPT® 2013 Professional Edition Manual*, http://www.ama-assn.org/ama
- *CPT® Assistant 2014*, http://www.ama-assn.org/ama

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 CBR201503 webinar on April 1, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at www.cbrinfo.net/cbr201503-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/cbr201503.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.