Comparative Billing Report

April 6, 2015

CBR #: CBR201504
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. CBRs are for educational and comparison purposes. They are not indicative of overpayments being identified. 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. Please note, we recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed for the CBR report. 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
Ophthalmology

Introduction

CBR201504 focuses on ophthalmologists who submitted claims for any of the following services: extracapsular cataract removals, general ophthalmological services, and/or evaluation and management (E/M) services. As indicated in the *Office of Inspector General Work Plan Fiscal Year 2015*, Medicare allowed more than $6.8 billion for services provided by ophthalmologists in 2010. National data analysis comparing claims from July 1, 2013 through June 30, 2014 also showed a 22% increase in payments to $8.3 billion.

The OIG reported on E/M services in its May 2012 report titled, *Coding Trends of Medicare Evaluation and Management Services*. The report details how physicians increased their billing of the two highest level E/M services (CPT®codes 99214 and 99215) by 17% between 2001 and 2010.

According to *Coding for Complex Cataract Surgeries*, the total number of cataract surgeries in 2001 was 1.58 million, of which 2.7% were coded as complex. Based on the latest claims data from the Integrated Data Repository (IDR), complex cataract surgeries now make up 9% of all cataract surgeries.

Table 1 provides a summary of your utilization of the current procedural terminology (CPT®) codes included in this CBR.

Table 1: Summary of Your Utilization
July 1, 2013 - June 30, 2014

CPT® Code	Abbreviated Description (Typical Minutes when Applicable)	Allowed Charges	Allowed Services	Beneficiary Count
66982	Extracapsular cataract removal, complex	$8,370.17	10	8
66984	Extracapsular cataract removal, routine	$45,877.56	69	53
92002	General ophthalmology intermediate, new	$81.94	1	1
92004	General ophthalmology comprehensive, new	$299.16	2	2
92012	General ophthalmology intermediate, established	$7,075.78	82	82
92014	General ophthalmology comprehensive, established	$46,490.72	373	368
99201	E/M focused, new (10 mins)	$0.00	0	0
99202	E/M expanded, new (20 mins)	$0.00	0	0
99203	E/M detailed, new (30 mins)	$428.20	4	4
99204	E/M comprehensive, MDM* moderate, new (45 mins)	$18,062.46	112	112
99205	E/M comprehensive, MDM* high, new (60 mins)	$606.09	3	3
99211	E/M minimal, established (5 mins)	$0.00	0	0
99212	E/M focused, established (10 mins)	$433.30	10	10
99213	E/M expanded, established (15 mins)	$15,412.28	214	168
99214	E/M detailed, established (25 mins)	$26,009.58	246	220
99215	E/M comprehensive, established (40 mins)	$0.00	0	0
TOTAL		**$169,147.24**	**1,126**	**820**

*Medical Decision Making

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 therefore is counted only once in the total.

The metrics reviewed in this report include:

- The percentage of complex extracapsular cataract surgeries (CPT® code 66982) vs. routine extracapsular cataract surgeries (CPT® code 66984)
- The percentage of services for comprehensive vs intermediate level general ophthalmological services for new and established patients, CPT® codes 92002 through 92014
- The average number of minutes for new and established patient E/M services, CPT® codes 99201 through 99215

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 Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

Basic Coverage Criteria

Seven MACs have LCDs and/or LCAs covering cataract extraction procedures. These MACs, which specifically refer to complex cataract extractions, state that in order for CPT® code 66982 to be reasonable and necessary, the operative note should indicate that the surgery required devices or techniques that are not generally used in routine cataract surgery. According to LCA A52100, *Complex Cataract Surgery: Appropriate Use and Documentation*, examples of situations which could justify the use of this code include, but are not limited to, use of intraocular dyes, mechanical expansion of the pupil using hooks, and insertion of iris retractors through additional incisions. Links to LCDs, LCAs, and references are located at http://www.cbrinfo.net/cbr201504-recommended-links.html.

The *CPT® 2013 Professional Edition Manual* describes comprehensive ophthalmological services as a "general evaluation of the complete visual system" and the service includes "history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, and basic sensorimotor examination." A comprehensive exam *often* includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. A comprehensive eye examination *always* includes initiation of diagnostic and treatment programs.

The 2014 *Evaluation and Management Services Guide* dictates that "a single organ system examination involves a more extensive examination of a specific organ system." During a comprehensive eye examination, the physician must perform all elements identified by a bullet; and document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Elements in the box surrounded by a shaded border include:

- Test visual acuity (does not include determination of refractive error)
- Gross visual field testing by confrontation

- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexae (lids, lacrimal glands and drainage, orbits and preauricular lymph nodes)
- Examination of pupils and irises including shape, direct and consensual reaction, size and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium and tear film
- Slit lamp examination of the anterior chambers including depth, cells, and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
- Measurement of intraocular pressures (except in children and patients with trauma or infection)

Ophthalmic examination through dilated pupils (unless contraindicated) of:

- Optic discs including size, cup to disc ratio, appearance and nerve fiber layer
- Posterior segments including retina and vessels (eg, exudates and hemorrhages)

The elements found in the unshaded box of neurological/psychiatric contain a brief assessment of mental status including:

- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, and agitation)

Detailed examinations, as described in CPT® codes 99203 or 99214, require the performance and documentation of at least nine elements identified by a bullet. Expanded problem focused examinations, as described in CPT® codes 99202 or 99213, require the performance and documentation of at least six elements identified by a bullet. When the physician performs and documents one to five elements identified by a bullet the level of examination is problem focused as described in CPT® codes 99201 or 99212.

According to CPT®, the components of history, examination and medical decision making are considered the key components in selecting the level of E/M service unless the visit consists primarily of counseling and coordination of care. For new patient E/Ms, all three of the key components must meet the level of service billed. For established patient E/Ms, two of the three key components must meet the level of service billed.

Chapter 12 of the *Medicare Claims Processing Manual*, section 30.6.1 - Selection of Level of Evaluation and Management Service 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."

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 ophthalmology (18). This analysis was based on the latest version of claims available from the IDR as of February 24, 2015. Your values

are compared to your state (IA) and national values using either the chi-squared or t-test at the alpha value of 0.05.

Percentage of Complex Extracapsular Cataract Removals (CPT® Codes 66982 & 66984)

The percentage of complex extracapsular cataract removals is calculated as follows:

$$\left(\frac{\textbf{Number of Complex Extracapsular Cataract Removals}}{\textbf{Total Number of Extracapsular Cataract Removals}}\right)\textbf{x}100$$

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

Percentage of Comprehensive General Ophthalmological Services by Patient Type (CPT® Codes 92002-92014)

The percentage of comprehensive general ophthalmological services is calculated separately for new and established patients as follows:

$$\left(\frac{\textbf{Number of Comprehensive General Ophthalmological Services by Patient Type}}{\textbf{Total Number of General Ophthalmological Services by Patient Type}}\right)\textbf{x}100$$

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 E/M Visit by Patient Type (CPT® Codes 99201-99215)

Each E/M CPT® code is assigned a value that corresponds to the the typical minutes described in the CPT® code description in Table 1. This value is multiplied by the total allowed services for this code to arrive at the total weighted services per code. All weighted services are summed by patient type (new and established) and divided by the total number of visits by patient type. A visit is defined as a single date of service by beneficiary. Generally, the total number of visits is equal to the total number of services by patient type. However, if multiple E/M services are allowed for a particular beneficiary and date of service then these services would be combined in the same visit. The average allowed minutes per visit are calculated separately for new and established patients as follows:

$$\left(\frac{\textbf{Total E/M Weighted Services by Patient Type}}{\textbf{Total Number of E/M Visits by Patient Type}}\right)$$

Your average was 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 comparison of your percentage of complex extracapsular cataract removals to that of your state and the nation.

Table 2: Percentage of Complex Extracapulsar Cataract Removals
July 1, 2013 - June 30, 2014

	Your Percentage of Complex Cataracts	Your State's Percentage of Complex Cataracts	Comparison with Your State's Percentage	National Percentage of Complex Cataracts	Comparison with the National Percentage
Complex	13%	16%	Does Not Exceed	9%	Higher

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

Table 3 provides a comparison of your percentage of comprehensive general ophthalmological services for new and established patients to that of your state and the nation.

Table 3: Percentage of Comprehensive General Ophthalmological Services by Patient Type
July 1, 2013 - June 30, 2014

Patient Type	Your Percentage of Comprehensive Services	Your State's Percentage of Comprehensive Services	Comparison with Your State's Percentage	National Percentage of Comprehensive Services	Comparison with the National Percentage
New	N/A	90%	N/A	91%	N/A
Established	82%	73%	Significantly Higher	61%	Significantly Higher

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

Table 4 provides a comparison of your E/M average allowed minutes for new and established patients to that of your state and the nation.

Table 4: Average Allowed Minutes per E/M Visit by Patient Type
July 1, 2013 - June 30, 2014

Patient Type	Your Average E/M Minutes per Visit	Your State's Average E/M Minutes Per Visit	Comparison with Your State's Average	National Average E/M Minutes Per Visit	Comparison with the National Average
New	44.87	40.82	Significantly Higher	42.01	Significantly Higher
Established	20.13	19.71	Higher	18.21	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for ophthalmology are listed below. Please follow the guidelines pertinent to your region. You can access these documents on the CBR website at http://www.cbrinfo.net/cbr201504-recommended-links.html.

- Office of Inspector General (OIG) *Work Plan fiscal year 2015*
- OIG *Coding Trends of Medicare Evaluation and Management Services, May 2012*
- Medicare Learning Network® *Ophthalmology Resource Information*
    - *Medicare Vision Services Fact Sheet* - ICN 907165, July 2014
    - *Evaluation and Management Services Guide* - ICN 006764, November 2014
    - *MLN Matters® Number 5853*
    - *How to Use the Medicare NCCI Tools* - ICN 901346, January 2013
- *Coding for Complex Cataract Surgeries©*, Riva Lee Asbell 2004
- *National Correct Coding Initiative (NCCI) Policy Manual*
    - Chapter 1 - *General Correct Coding Policies*
    - Chapter 8 - *Surgery: Endocrine, Nervous, Eye and Ocular Adnexa, and Auditory Systems*, CPT® Codes 60000-69999
- *Medicare Claims Processing Manual*
    - Chapter 12 - Physicians/Nonphysician Practitioners
- *CPT® 2013 & 2014 Professional Edition Manuals*

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 CBR201504 webinar on April 29, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online and/or access a recording of the webinar five business days following the event at the website http://www.cbrinfo.net/cbr201504-webinar.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.