



Comparative Billing Report

September 28, 2015

CBR #: CBR201509
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. To support these goals, CMS has contracted with eGlobalTech, a professional services firm in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs provide comparative data on how an individual health care provider's billing and payment patterns for selected topics compare to his/her peers. The CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS' files, and review Medicare guidelines to ensure compliance. CBRs are for educational and comparison purposes and do not indicate the identification of overpayments. Please note, no reply is necessary.

Attached is a CBR that reflects your billing or referral patterns compared to peer providers' patterns for the same services in your state and nationwide. 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. 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.

- Toll Free Number: 1-800-771-4430
- Email: cbrsupport@eglobaltech.com
- Website: <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 in 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.

We hope you find the attached report informative.

Sincerely,

Susan M. Goodrich
CBR Project Director
eGlobalTech
Enclosure

Comparative Billing Report (CBR): NPI 1111111111 Modifiers 24 & 25: Orthopedic Surgeons

Introduction

This CBR focuses on orthopedic surgeons who submitted claims for established patient evaluation and management (E/M) services appended with modifiers 24 and/or 25. 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®) 2014 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 April 1, 2014 through March 31, 2015. Table 1 provides an abbreviated description for codes 99211 through 99215 as well as the typical time it takes to perform each.

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

CPT® codes, descriptors, and all other data only are copyright 2014 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

The metrics reviewed in this report are:

- Percentage of services appended with modifier 24
- Percentage of services 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 infection, 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

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- 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.”

Methods

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 April 1, 2014 to March 31, 2015, and includes only claims where the rendering National Provider Identifier (NPI) specialty is denoted as an orthopedic surgeon (20). This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR) as of August 21, 2015. Your values are compared to those of your state (MN) and national values using either the chi-squared or t-test at the alpha value of 0.05.

Percentage of Services with Modifier 24 and 25

The percentage of services with modifier 24 and 25 is calculated as follows:

$$\left(\frac{\text{Number of Services with Modifier}}{\text{Total Number of Services}} \right) \times 100$$

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

Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code description as seen in Table 1. This value is multiplied by the total allowed services for the code to arrive at the total weighted services per code. If multiple E/M services are allowed for a particular beneficiary and date of service, then these services are added together to get a total weighted value by visit. The average minutes allowed per visit are calculated separately for services with modifier 24, modifier 25, and with neither modifier as follows:

$$\left(\frac{\text{Total E/M Weighted Services by Modifier Designation}}{\text{Total Number of E/M Visits by Modifier Designation}} \right)$$

Average Allowed Charges per Beneficiary

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

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

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 their 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, and distinct beneficiary count are included for each CPT[®] code and modifier.

**Table 2: Summary of Your Utilization for E/M CPT[®] Codes and Modifiers 24 & 25
April 1, 2014 - March 31, 2015**

CPT [®]	Modifier	Allowed Charges	Allowed Services	Beneficiary Count
99211	24	\$0.00	0	0
99211	25	\$0.00	0	0
99211	Neither	\$0.00	0	0
99212	24	\$0.00	0	0
99212	25	\$0.00	0	0
99212	Neither	\$49.92	1	1
99213	24	\$0.00	0	0
99213	25	\$8,422.14	102	93
99213	Neither	\$8,917.56	108	99
99214	24	\$0.00	0	0
99214	25	\$6,193.95	51	49
99214	Neither	\$8,865.85	73	72
99215	24	\$0.00	0	0
99215	25	\$0.00	0	0
99215	Neither	\$150.00	1	1
TOTAL		\$32,599.42	336	276

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 services with modifiers 24 and 25 to that of your state and the nation.

**Table 3: Percentage of Services with Modifier 24 and 25
April 1, 2014 - March 31, 2015**

Modifier	Your Percentage of Modifier Use	Your State's Percentage of Modifier Use	Comparison with Your State's Percentage	National Percentage of Modifier Use	Comparison with the National Percentage
24	0%	3%	Does Not Exceed	2%	Does Not Exceed
25	46%	22%	Significantly Higher	26%	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 services with modifier 24, modifier 25 and with neither modifier. Your averages are compared to that of your state and the nation.

Table 4: Average Allowed Minutes per Visit by Modifier
April 1, 2014 - March 31, 2015

Modifier	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
24	N/A	15.56	N/A	16.32	N/A
25	18.33	17.86	Higher	16.79	Significantly Higher
Neither	19.10	16.75	Significantly Higher	16.73	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 is summarized regardless of the modifiers attached to the service. This is the average total allowed charges per beneficiary for the one-year time period under analysis.

Table 5: Average Allowed Charges per Beneficiary
April 1, 2014 - March 31, 2015

	Your Average Allowed Charges per Beneficiary	Your State's Average Allowed Charges per Beneficiary	Comparison with Your State's Average	National Average Allowed Charges per Beneficiary	Comparison with the National Average
Charges	\$118.11	\$107.12	Higher	\$135.27	Does Not Exceed

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

References & Resources

The coverage and documentation guidelines for modifiers 24 and 25 for Orthopedic Surgeons are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201509-recommended-links.html>.

Medicare Manuals

- National Correct Coding Initiative (NCCI) Policy Manual
 - *Chapter 1, General Correct Coding Policies*
 - * *Medical/Surgical Package, Section C*
 - * *Evaluation and Management (E&M) Services, Section D*
 - * *Modifiers and Modifier Indicators, Section E*
- Medicare Claims Processing Manual
 - *Chapter 12, Physician/Nonphysician Practitioners*
 - * *Correct Coding Policy, Section 30*

-
- *Selection of Level of Evaluation and 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

- *Modifier 24 Fact Sheet*

Medicare Learning Network®

- *Global Surgery Fact Sheet, August 2013, ICN907166*
- *Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors, Volume 1, Issue 2, February 2011, ICN905712*

Office of Inspector General

- *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 Medicare Administrative Contractor (MAC) to ensure you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201509 webinar on October 21, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201509-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201509 webinar five days following the event at the website, <http://www.cbrinfo.net/cbr201509-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201509-recommended-links.html>.

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