



Comparative Billing Report

November 23, 2015

CBR #: CBR201511
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. 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,

A handwritten signature in black ink that reads "Susan M. Goodrich".

Susan M. Goodrich
CBR Project Director
eGlobalTech

Enclosure

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SAMPLE

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Comparative Billing Report (CBR): NPI 1111111111 Physical Therapy

Introduction

CBR201511 focuses on physical therapists in private practice who submitted claims for physical therapy services using current procedural terminology (CPT®) codes 97001, 97035, 97110, 97112, 97140, 97530, and G0283. This report examines the percentage of beneficiaries whose claims for those therapy services were submitted with modifier KX, the average number of minutes of therapy per visit, and average allowed charges per beneficiary. Only the aforementioned procedure codes appended with modifier GP, signifying services delivered under an outpatient physical therapy plan of care, were included for comparison.

According to Table F1 of the *Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payments Report*, physical therapists in private practice had an improper payment rate of 29.5 percent with projected improper payments of \$514M. The error rate increased significantly from the 2013 report when the error rate was reported at 18.7 percent.

Over 95 percent of the errors were the result of insufficient documentation. According to the *Medicare Fee-For-Service 2014 Improper Payments Report*, “Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the Comprehensive Error Rate Testing (CERT) contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order or a form that is required to be completed in its entirety.”

Many Medicare Administrative Contractors (MACs) have provided examples of insufficient documentation as part of their educational efforts aimed at physical therapists including:

- Missing/“or” incomplete plan of care/“or” treatment plan;
- Missing/illegible physician or Non-Physician Practitioner (NPP) signatures and dates;
- Missing certification/recertification; and
- Missing total time for procedures and modalities

Physical therapists play an important role in reducing the CERT error rate. Providers should ensure that billed services meet all Medicare documentation requirements and that the information is submitted timely should a request for medical records be received from the CERT contractor or MAC.

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 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

Chapter 15 of the *Medicare Benefit Policy Manual* refers to conditions of coverage and payment for outpatient physical therapy in section 220.1. The document states, “Outpatient therapy services...are payable only when furnished in accordance with certain conditions. The following conditions apply:

- Services are or were required because the individual needed therapy services (see 42CFR424.24(c), §220.1.3);
- A plan for furnishing such services has been established by a physician/NPP or by a therapist providing such services and is periodically reviewed by a physician/NPP (see 42CFR424.24(c), §220.1.2);
- Services are or were furnished while the individual is or was under the care of a physician (see 42CFR424.24(c), §220.1.1);
- In certifying an outpatient plan of care for therapy a physician/NPP is certifying that the above three conditions are met (42CFR424.24(c)). Certification is required for coverage and payment of a therapy claim.”

In addition to the above requirements, claims submitted for outpatient physical therapy must contain the NPI of the certifying physician identified for a physical therapy plan of care and the required functional reporting.

Section 220.1.2 of the manual provides instructions for establishing the plan of care. This section states that “services must relate directly and specifically to a written treatment plan.” The plan must contain the signature and professional identification of the person who established the plan as well as the date the plan was established. The plan must be established before treatment is begun. The plan of care must contain the diagnoses being treated, the long term goals of treatment as well as the type, amount, duration and frequency of therapy services.

Section 220.1.3 of the manual instructs providers about the therapy certification process. Per the manual, “Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.” If the patient was not under the care of the physician/NPP or did not need the treatment, the physician/NPP should not certify the plan of care. The provider should obtain certification as soon as possible after the plan of care is established which the manual dictates is within 30 days of the initial therapy treatment. Plans of care may be certified or recertified for the duration of treatment the physician/NPP deems necessary, up to a maximum of 90 calendar days. Treatment beyond the interval certified by the physician/NPP requires recertification.

Section 220.2 describes reasonable and necessary outpatient rehabilitation therapy services and describes the types of services and personnel that are payable under Medicare. The manual states “Services that do not require the performance of supervision of a therapist are not skilled and are not considered reasonable and necessary therapy services, even if they are performed or supervised by a qualified professional. Medicare coverage does not turn on the presence or absence of a beneficiary’s potential for improvement from therapy but rather on the beneficiary’s need for skilled care.”

Section 220.3 of the manual provides documentation requirements for therapy services. The manual states, “The documentation guidelines in sections 220 and 230 of this chapter identify the minimal expectations of documentation by providers or suppliers or beneficiaries submitting claims for payment of therapy services to the Medicare program.” Subsection B provides information regarding

the documentation to be submitted in response to requests for medical records. Providers should refer to the document for a full and complete description of these items:

- Evaluation and Plan of Care (may be one or two documents). Include the initial evaluation and any re-evaluations relevant to the episode being reviewed;
- Certification (physician/NPP approval of the plan) and recertifications when records are requested after the certification/recertification is due;
- Progress Reports (including Discharge Notes, if applicable) when records are requested after the reports are due;
- Treatment notes for each treatment day, (may also serve as progress reports when required information is included in the notes);
- A separate justification statement may be included either as a separate document or within the other documents if the provider/supplier wishes to assure the contractor understands their reasoning for services that are more extensive than is typical for the condition treated. A separate statement is not required if the record justifies treatment without further explanation.

Chapter 5 of the *Medicare Claims Processing Manual* refers to Part B outpatient rehabilitation and comprehensive outpatient rehabilitation facility services. The manual instructs providers on therapy caps and the therapy cap exceptions process stating, “The KX modifier, described in subsection D, is added to claim lines to indicate that the clinician attests that services at and above the therapy caps are medically necessary and justification is in the medical record.”

Methods

This report is an analysis of Fee-for-Service Medicare Part B claims with allowed services for the CPT® codes listed in Table 1 with dates of service from January 1, 2014 to December 31, 2014 extracted from the Integrated Data Repository (IDR) on October 12, 2015. The analyses are based on claims where the rendering NPI specialty is denoted as Physical Therapist in Private Practice (65) and each claim line was submitted with modifier GP.

For the purpose of this CBR, ‘peer group’ is defined as other rendering NPIs in your state or nation that meet the criteria described above. Your values, as the rendering provider, are compared to your state (WY) and national peer groups using the t-test or chi-square test at the alpha value of 0.05.

Percentage of Beneficiaries with Modifier KX

The percentage of your beneficiaries with at least one claim line with modifier KX is calculated as below:

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

Average Allowed Minutes per Visit for Selected CPT® Codes

Each allowed service for the selected CPT® codes 97035, 97110, 97112, 97140, and 97530 typically represents 15 minutes. Each allowed service for these codes is multiplied by 15 to arrive at the total weighted services per code. All weighted services are summed and divided by the total number of visits. A visit is defined as a single date of service by beneficiary. If a beneficiary has multiple

services for any or all of the selected CPT® codes for the same date of service, these services would be combined in the same visit. The average minutes allowed per visit are calculated as follows:

$$\frac{\text{Total Weighted Services for the Selected CPT® Codes}}{\text{Total Number of Visits with the Selected CPT® Codes}}$$

Average Allowed Charges per Beneficiary

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

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

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/her peer group. The statistical test gives the provider the benefit of the doubt since significance is based on the total number of services, and/or beneficiaries and the variability of those values.

Results

Table 1 provides a summary of your utilization of the CPT® codes, descriptions, total allowed charges, allowed services, distinct beneficiary count, and number of visits for the CPT® codes in this CBR.

Table 1: Summary of Your Utilization
January 1, 2014 - December 31, 2014

CPT®	Description	Allowed Charges	Allowed Services	Beneficiary Count	Visit Count
97001	Physical therapy evaluation	\$4,195.52	56	53	-
97035	Application of a modality, ultrasound, each 15 minutes	\$0.00	0	0	0
97110	Therapeutic procedure, exercises to develop strength, each 15 minutes	\$54,881.51	2,118	84	557
97112	Therapeutic procedure, neuromuscular reeducation, each 15 minutes	\$0.00	0	0	0
97140	Manual therapy techniques, each 15 minutes	\$3,972.50	175	53	165
97530	Therapeutic activities, direct patient contact, each 15 minutes	\$0.00	0	0	0
G0283	Electrical stimulation, unattended, other than wound care	\$0.00	0	0	-
TOTAL		\$63,049.53	2,349	84	557

CPT® codes and descriptors are copyright 2015 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

The visit count is only provided for the timed procedures since multiple services are likely to be billed on the same visit for these CPT® codes. Please note, the totals may not be equal to the sum of the rows. The number of beneficiaries and visits are unduplicated counts for each row and the total. It is likely that more than one CPT® code was billed for a particular beneficiary or visit and therefore are counted only once in the total. The total visit count includes only those visits with timed procedures.

Table 2 provides a comparison of your percentage of beneficiaries with modifier KX to that of your state and the nation.

Table 2: Percentage of Beneficiaries with Modifier KX
January 1, 2014 - December 31, 2014

Type	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage	National Percentage of Beneficiaries	Comparison with the National Percentage
Percent KX	31%	33%	Does Not Exceed	20%	Significantly Higher

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

Table 3 provides a comparison of your average allowed minutes per visit for CPT® codes 97035, 97110, 97112, 97140, and 97530. Your averages are compared to that of your state and the nation.

Table 3: Average Allowed Minutes per Visit for Selected CPT® Codes
January 1, 2014 - December 31, 2014

CPT® Code	Your Average Allowed Minutes per Visit	Your State's Average Allowed Minutes per Visit	Comparison with Your State's Average	National Average Allowed Minutes per Visit	Comparison with the National Average
Average Minutes	61.75	42.21	Significantly Higher	45.36	Significantly Higher

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

Table 4 provides a comparison of your average allowed charges per beneficiary to that of your state and the nation.

Table 4: Average Allowed Charges per Beneficiary
January 1, 2014 - December 31, 2014

Type	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	\$750.59	\$601.20	Significantly Higher	\$719.13	Higher

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

References & Resources

The coverage and documentation guidelines for Physical Therapy are listed below. Please follow the guidelines pertinent to your region. Links to all references and resources can be accessed at <http://www.cbrinfo.net/cbr201511-recommended-links.html>.

Table 5: LCDs & LCAs

MAC	LCDs & LCAs Prior to 10/01/15 (ICD-9)	LCDs & LCAs After 10/01/15 (ICD-10)
Cahaba Government Benefit Administrators	L30009	L34310
CGS Administrators	L31886, A50836	L34049, A52400
First Coast Service Options	L28992, L29024, L29289, L29399	L33413
National Government Services	L26884, A50612	L33631, A52862
Noridian Healthcare Solutions	A52030, A52032	A47198, A52758, A52762, A52775, A53281, A53303, A53304
Novitas Solutions	L32710, L27513	L35036, L35044
Palmetto GBA	L31581, A51958	L34428, A53065

Centers for Medicare & Medicaid Services

- The Supplementary Appendices for the Medicare Fee-for-Service 2013 Improper Payment Rate Report
- The Supplementary Appendices for the Medicare Fee-for-Service 2014 Improper Payments Report
- Medicare Fee-for-Service 2014 Improper Payments Report

Medicare Benefit Policy Manual

- Chapter 15 - Covered Medical and Other Health Services

Medicare Claims Processing Manual

- Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

The Next Steps

We encourage you to check with your 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 CBR201511 webinar on December 16, 2015 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201511-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201511 webinar five business days following the event at <http://www.cbrinfo.net/cbr201511-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201511-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.