



Comparative Billing Report

December 21, 2015

CBR #: CBR201512
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

Comparative Billing Report (CBR): NPI 1111111111 Home Evaluation and Management Services

Introduction

This CBR focuses on providers of all specialties who submitted claims for established patient home evaluation and management (E/M) services using current procedural terminology (CPT®) codes 99347 through 99350. This report examines the percentage of services appended with modifier 25, the average allowed minutes per visit with modifier 25 appended, the average allowed minutes without modifier 25 appended, and the average allowed services per beneficiary.

According to a May 2012 report by the Office of Inspector General (OIG) titled, “Coding Trends of Medicare Evaluation and Management Services,” physicians increased their billing of higher level E/M services from 2001 to 2010. E/M services increased by 48 percent from \$22.7 billion to \$33.5 billion while Medicare payments for all Part B goods and services increased by 43 percent between 2001 and 2010. During this same time period, the OIG determined that physicians increased their billing for two of the highest paying home services (CPT® codes 99349 and 99350) by 14 percent and nine percent, respectively; however, physicians decreased their billing for two of the lowest paying home services (CPT® codes 99347 and 99348). The report found that the average Medicare payment amount per E/M service increased by 31 percent, from approximately \$65 to \$85, during the time period under review. The report stated that several factors were involved in the increase, including changes in physicians’ billing practices. Billing of higher level E/M services increased in all service types. The OIG’s investigation found that physicians who consistently billed for higher level E/M codes and physicians who did not consistently bill for higher level codes treated beneficiaries of similar ages and with similar diagnoses. Physicians billing higher level E/M codes practiced in nearly all states and represented similar specialties.

E/M services are 50 percent more likely to be paid in error than other Part B services, according to the CMS report titled, “Medicare Fee-for-Service 2011 Improper Payments Report.” Errors in payment were found to be the result of coding errors and insufficient documentation.

As a follow-up to their 2012 report, the OIG conducted medical review of a sample of Part B claims for services rendered during 2010. The OIG detailed the findings in a May 2014 report titled, “Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010.” The OIG found that physicians who routinely coded their claims high were more likely to have incorrectly coded and insufficiently documented claims than physicians who did not routinely code their claims at the highest levels. The review revealed that 42 percent of claims were incorrectly coded, which included downcoding as well as upcoding, and 19 percent lacked documentation.

The *CPT® 2014 Professional Edition* manual defines modifier 25 as indicative of a “significant, separately identifiable evaluation and management (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 OIG released a report on Medicare payments for E/M services billed with modifier 25. The report, “Use of Modifier 25,” 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 services when no other services were performed on the same day. Of the 431 claims audited, 35 percent did not meet program requirements.

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

The LCDs in this section were written for the purpose of providing further guidance regarding medical necessity and documentation requirements for home evaluation and management services. The language in this section may also refer to the domiciliary setting because the LCDs discussed also instruct providers on correct billing of domiciliary services. Your MAC may not have an active LCD covering the services included in this report. In the absence of a National Coverage Determination (NCD) or LCD, MACs follow the guidance given in the *Medicare Program Integrity Manual*, Chapter 3 (Section 3.6.2.2 - Reasonable and Necessary Criteria). The guidelines state that an item or service is “reasonable and necessary if the item or service meets the following criteria:

- It is safe and effective;
- It is not experimental or investigational; and
- It is appropriate, including the duration and frequency in terms of whether the service or item is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary’s condition or to improve the function of a malformed body member;
 - Furnished in a setting appropriate to the beneficiary’s medical needs and condition;
 - Ordered and furnished by qualified personnel; and,
 - One that meets, but does not exceed, the beneficiary’s medical need.”

Title XVIII of the Social Security Act [Section 1862 (a) (1) (A)] excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act [Section 1862 (a) (7)] excludes routine physical examinations and services.

Title XVIII of the Social Security Act [Section 1833 (e)] prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

The *Medicare Claims Processing Manual*, (Chapter 12 - Physician/Nonphysician Practitioners, Section 30.6.14.1) covers home services billed under CPT® codes 99341 through 99350. The manual states, “Home services codes 99341- 99350 are paid when they are billed to report evaluation and management services provided in a private residence. A home visit cannot be billed by a physician unless the physician was actually present in the beneficiary’s home.” A beneficiary does not have to be confined to the home in order to receive these services. The medical record must, however, document why the visit was required and also why it was necessary for the visit to occur at the beneficiary’s residence instead of the physician’s office or outpatient setting.

MACs who have performed post-payment review of home visits have found the documentation often did not support the level of service or the frequency of services billed. According to Wisconsin Physicians Service Insurance Corporation LCD L34643, home care visits must meet the following criteria to be reimbursable by Medicare:

- The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit. Medical necessity must exist for each individual visit being made in the home or domiciliary facility. The service or visit must be medically reasonable and necessary and not for the convenience of the physician or qualified Nonphysician Practitioner or patient.
- The service must be of equal quality, as if it were performed in the office, including frequency of visits, which should be consistent with the frequency at any other site of service for that particular code, and beneficiary condition. It is expected that the frequency of the visits for any given medical problem addressed in the home setting will not exceed that of an office setting.
- The minimum level of documentation of a home visit should be that which is rendered in the office with the expectation that the level of documentation, given the fact that home visits historically have had a higher level of reimbursement, would be more complex.

Please note, the above criteria have been abbreviated from the original document for the purpose of this letter. Please see the original document for the complete list of requirements.

First Coast Service Options LCD, L33817, covering home and domiciliary visits states, “Many elderly patients have chronic conditions, such as hypertension, diabetes, orthopedic conditions, and abnormalities of the toenails. The mere presence of inactive or chronic conditions does not constitute medical necessity for any setting (home, rest home, office etc). There must be a chief complaint or a specific reasonable and medically necessary need for each visit. The document instructs providers to include the following elements in the medical record to support the medical necessity of the visit:

- Reason for the encounter and relevant history
- Physical examination findings, and prior diagnostic test results, if applicable
- Assessment, clinical impression or diagnosis
- Medical plan of care”

According to Chapter I 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, those services with a global period of 10 days or less. The modifier is also used with E/Ms performed on the same date as services such as x-rays and 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 and 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.

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.”

The problem addressed must be distinct from the procedure and significant enough to warrant some kind of treatment by the physician. None of the E/M services’ 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.

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 July 1, 2014 to June 30, 2015 extracted from the Integrated Data Repository (IDR) on November 9, 2015.

The CBR team is aware that the “Independence at Home Demonstration” is an on-going project designed to test the effectiveness of providing primary care services to a selected group of beneficiaries in their homes. If your practice is participating in this project, your billings for home services is expected to be different than your peers.

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

Percentage of Services with Modifier 25

The percentage of your services with modifier 25 is calculated as below:

$$\left(\frac{\text{Total Number of Your Services with Modifier 25}}{\text{Total Number of Your Services}} \right) \times 100$$

Average Allowed Minutes per Visit

Each allowed service represents a number of minutes. The number of minutes is shown in the description of the code in Table 1. Each allowed service for these codes is multiplied by these minutes 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 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:

Total Weighted Services
Total Number of Visits

Average Allowed Services per Beneficiary

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

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

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 either the statistical test does not confirm a significance or there is insufficient data for comparison
- **Does Not Exceed** - Provider's value is not higher than the peer value
- **N/A** - Provider does not have data for comparison

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, and distinct beneficiary count for the CPT® codes in this CBR.

Table 1: Summary of Your Utilization
July 1, 2014 - June 30, 2015

| CPT® | Description | Mod Type | Allowed Charges | Allowed Services | Beneficiary Count |
|--------------|---|----------------|---------------------|------------------|-------------------|
| 99347 | Established patient, self-limited or minor problem, typical time 15 minutes | With Mod 25 | \$0.00 | 0 | 0 |
| 99347 | Established patient, self-limited or minor problem, typical time 15 minutes | Without Mod 25 | \$0.00 | 0 | 0 |
| 99348 | Established patient, low to moderate severity problem, typical time 25 minutes | With Mod 25 | \$0.00 | 0 | 0 |
| 99348 | Established patient, low to moderate severity problem, typical time 25 minutes | Without Mod 25 | \$0.00 | 0 | 0 |
| 99349 | Established patient, moderate to high severity problem, typical time 40 minutes | With Mod 25 | \$288.06 | 2 | 1 |
| 99349 | Established patient, moderate to high severity problem, typical time 40 minutes | Without Mod 25 | \$140,523.50 | 976 | 160 |
| 99350 | Established patient, moderate to high severity problem, typical time 60 minutes | With Mod 25 | \$0.00 | 0 | 0 |
| 99350 | Established patient, moderate to high severity problem, typical time 60 minutes | Without Mod 25 | \$198.57 | 1 | 1 |
| TOTAL | | | \$141,010.13 | 979 | 160 |

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

Please note, the totals may not be equal to the sum of the rows. The number of beneficiaries shows unduplicated counts for each row and the total. It is likely that more than one CPT® code was billed for a particular beneficiary and therefore are counted only once in the total.

Table 2 provides a comparison of your percentage of your services with modifier 25 to that of your state and the nation.

Table 2: Percentage of Services with Modifier 25
July 1, 2014 - June 30, 2015

| Type | Your Percentage of Services | Your State's Percentage of Services | Comparison with Your State's Percentage | National Percentage of Services | Comparison with the National Percentage |
|----------------|-----------------------------|-------------------------------------|---|---------------------------------|---|
| Percent Mod 25 | 0% | 22% | Does Not Exceed | 23% | Does Not Exceed |

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

Table 3 provides a comparison of your average allowed minutes per visit. Your averages are compared to that of your state and the nation.

Table 3: Average Allowed Minutes per Visit
July 1, 2014 - June 30, 2015

| 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 |
|----------------|--|--|--------------------------------------|--|--------------------------------------|
| With Mod 25 | 40.00 | 26.61 | Higher | 31.97 | Higher |
| Without Mod 25 | 40.02 | 35.82 | Significantly Higher | 40.32 | Does Not Exceed |

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

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

Table 4: Average Allowed Services per Beneficiary
July 1, 2014 - June 30, 2015

| Type | Your Average Allowed Services per Beneficiary | Your State's Average Allowed Services per Beneficiary | Comparison with Your State's Average | National Average Allowed Services per Beneficiary | Comparison with the National Average |
|----------|---|---|--------------------------------------|---|--------------------------------------|
| Services | 6.12 | 3.70 | Significantly Higher | 3.23 | Significantly Higher |

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

References & Resources

The coverage and documentation guidelines for Home Evaluation and Management Services 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/cbr201512-recommended-links.html>.

LCDs - Current

- Wisconsin Physicians Service Insurance Corporation: L34643
- First Coast Service Options: L33817

LCDs - Retired

- Wisconsin Physicians Service Insurance Corporation: L31613
- First Coast Service Options: L29161, L29421

Office of Inspector General

- Coding Trends of Medicare Evaluation and Management Services
- Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010

Centers for Medicare & Medicaid Services

- Medicare Fee-for-Service 2011 Improper Payments Report
- Independence at Home Demonstration

Social Security Administration

- Title XVIII of the Social Security Act
 - Section 1862 (a) (1) (A), Section 1862 (a) (7), Section 1833 (e)

Medicare Manuals

- *Medicare Claims Processing Manual*, Chapter 12, Physician/Nonphysician Practitioners
 - Section 30.6.14 - 30.6.14.1
 - Section 30.6.1 - Selection of Level of Evaluation & Management Services
 - Section 30.6.1.1 - Initial Preventive Wellness Examination (IPWE) and Annual Wellness Visit (AWV)
 - Section 30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery
 - Section 40 to Section 40.2 - Surgeons and Global Surgery
- *Medicare National Correct Coding Initiative (NCCI) Policy Manual*
 - Section D - Evaluation and Management Services
 - Section E - Modifiers and Modifier Indicators
- *Medicare Program Integrity Manual*, Chapter 3, Section 3.6.2.2

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 CBR201512 webinar on January 20, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201512-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201512 webinar five business days following the event at <http://www.cbrinfo.net/cbr201512-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201512-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.