# Comparative Billing Report

February 1, 2016

CBR #: CBR201602
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,

Susan M Goodrich

Susan M. Goodrich
CBR Project Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Electrodiagnostic Testing (EDX)

## Introduction

CBR201602 focuses on providers that perform nerve conduction studies (NCS) and needle electromyography (EMG) on beneficiaries covered by traditional fee-for-service Medicare. The metrics reviewed in this report are:

- Average allowed charges per beneficiary
- Average weighted services by category
- Percentage of visits with NCS only CPT® codes

Current Procedural Terminology (CPT®) categories, codes, and descriptions included in this CBR and your utilization of these codes are shown in the table below:

**Table 1: Summary of Your Utilization**
**October 1, 2014 - September 30, 2015**

| CPT® | Category | Description | Allowed Charges | Allowed Services | Beneficiary Count |
|---|---|---|---|---|---|
| 95905 | NCS | needle measurement & recording | $0.00 | 0 | 0 |
| 95907 | NCS | 1-2 studies | $0.00 | 0 | 0 |
| 95908 | NCS | 3-4 studies | $366.42 | 3 | 3 |
| 95909 | NCS | 5-6 studies | $1,587.68 | 11 | 11 |
| 95910 | NCS | 7-8 studies | $28,774.37 | 151 | 150 |
| 95911 | NCS | 9-10 studies | $31,923.06 | 140 | 139 |
| 95912 | NCS | 11-12 studies | $1,805.78 | 7 | 7 |
| 95913 | NCS | 13 or more studies | $2,031.68 | 7 | 7 |
| **Subtotal** | NCS | | **$66,488.99** | **319** | **302** |
| 95860 | EMG | 1 extremity | $239.22 | 2 | 2 |
| 95861 | EMG | 2 extremities | $334.33 | 2 | 2 |
| 95863 | EMG | 3 extremities | $0.00 | 0 | 0 |
| 95864 | EMG | 4 extremities | $0.00 | 0 | 0 |
| 95865 | EMG | larynx | $0.00 | 0 | 0 |
| 95866 | EMG | hemidiaphragm | $0.00 | 0 | 0 |
| 95867 | EMG | cranial nerve, unilateral | $0.00 | 0 | 0 |
| 95868 | EMG | cranial nerve, bilateral | $0.00 | 0 | 0 |
| 95869 | EMG | thoracic paraspinal | $0.00 | 0 | 0 |
| 95870 | EMG | 1 extremity, nonparaspinal | $0.00 | 0 | 0 |
| **Subtotal** | EMG | | **$573.55** | **4** | **4** |
| 95885 | NCS & EMG | NCS & EMG, limited | $1,310.22 | 23 | 21 |
| 95886 | NCS & EMG | NCS & EMG, complete | $25,784.85 | 288 | 179 |
| 95887 | NCS & EMG | NCS & EMG, non-extremity | $0.00 | 0 | 0 |
| **Subtotal** | NCS & EMG | | **$27,095.07** | **311** | **199** |
| **Total** | | | **$94,157.61** | **634** | **343** |

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, counted only once in the total.

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## 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) or Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region. We encourage providers to use the resource information to reference the specific policy for their jurisdiction. All LCDs reference the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) policies.

### Basic Coverage Criteria

1. Is my service covered by Medicare?
   - Current Perception Threshold and Sensory Nerve Conduction Threshold (sNCT) Tests are not covered and should be reported with CPT® code G0255, not with CPT® codes 95905-95913 (NCD 160.23).
   - NCS performed with fixed anatomic templates and portable hand-held devices should not be reported with CPT® codes 95907-95913.
   - Screening tests for polyneuropathy of diabetes and end stage renal disease are not covered.
   - Special note: Both EMG and NCS are usually required for a clinical diagnosis of peripheral nervous system disorders. NCS alone is considered a screening exam. Screenings are not usually covered by Medicare. Exception: NCS for carpal tunnel syndrome.
2. Do I possess the required credentials to perform NCS and EMG services?
   - The LCD for all geographic regions requires special training in electrodiagnostic medicine. This training is commonly included in neurology and physical medicine programs, and if included in your state's scope of practice, physical therapy. However, all other specialties require additional credentials prior to performing these services for a Medicare beneficiary. Providers should confirm this information with the local LCD and state board.
3. Am I correctly coding my EMG and NCS services?
   - Use CPT® codes 95860-95864 and 95867-95870 when NO NCS are performed that day
   - Use CPT® codes 95885, 95886, and 95887 when NCS and EMG are performed on the same day
   - Use CPT® codes 95870 or 95885 when four or less muscles are tested
   - Use CPT® codes 95860-95864 or 95886 when five or more muscles are tested
4. Am I correctly calculating the units of service (UOS)?
   - Report CPT® codes 95905 once per upper extremity, maximum of two
   - Report CPT® codes 95907-95913 with ONLY one (1) UOS
   - Report CPT® codes 95860-95865 with ONLY one (1) UOS
   - Report CPT® codes 95885 or 95886 once per extremity, maximum of four
   - Report CPT® codes 95885 and 95886 combined limited to maximum of four, per patient when all 4 extremities are tested

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## 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 October 1, 2014 to September 30, 2015. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR) as of January 4, 2016. For each analysis below, you will be compared to the specialty that is listed on the claim. If you bill under multiple specialties, you will be compared to the specialty with which you have the highest allowed charges (13). If you bill in a specialty that has less than 10 providers billing for these codes, you will be assigned to the default specialty of other (OT).

### Average Allowed Charges per Beneficiary

The average allowed charges per beneficiary for you, your specialty, and the nation are calculated as follows:

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

### Average Weighted Services by Category

Further analysis focuses on the average weighted services per beneficiary for the three categories: NCS, EMG, and the combined NCS & EMG. Table 1 shows that CPT® codes 95907 - 95913 in the NCS category represent multiple studies for each unit of service submitted on the claim. To adjust for the number of studies, the number of submitted services is weighted for each of those CPT® codes. For example, if 95909 (5-6 studies) was submitted with one service, the weighted services would be calculated as 1x5=5 since the minimum number of studies for this CPT® code is 5. If this CPT® code was submitted with two services, then the weighted services would be 2x5=10. The average weighted services per beneficiary is calculated as follows:

$$\left(\frac{\textbf{Total Weighted Services by Category}}{\textbf{Total Number of Beneficiaries in the Category}}\right)$$

### Percentage of Visits with NCS CPT® Codes Only (Excludes Carpal Tunnel)

The percentage of visits with NCS only CPT® codes (95905-95913) submitted without a CPT® code that includes an EMG (95860-95970, 95885-95887) was calculated as follows:

$$\left(\frac{\textbf{Total Number of Visits with NCS Only CPT}^{\circledR}\textbf{ Codes}}{\textbf{Total Number Visits}}\right)\textbf{x}100$$

A visit is defined as all submitted services for a beneficiary on a single date of service. Visits in which the beneficiary had a diagnosis code of carpal tunnel (354.0) were not counted in the number of visits with NCS only CPT® codes.

### 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

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The statistical test (chi-square or t-test) used in each analysis can be identified from the following tables. These tests give the provider the benefit of the doubt since significance is based on the total number of services and/or beneficiaries, as well as the variability of those values.

## Results

Table 2 provides a statistical analysis of the average allowed charges per beneficiary and compares those results with others in your specialty code and the nation.

**Table 2: Average Allowed Charges per Beneficiary**
**October 1, 2014 - September 30, 2015**

| CPT® Code | Your Average Allowed Charges per Beneficiary | Your Specialty's Average Allowed Charges per Beneficiary | Comparison with Your Specialty's Average | National Average Allowed Charges per Beneficiary | Comparison with the National Average |
|---|---|---|---|---|---|
| Allowed Charges | $274.51 | $299.72 | Does Not Exceed | $303.53 | Does Not Exceed |

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

Table 3 provides a statistical comparison of average weighted services per beneficiary for each category to that of your specialty and the nation. Each category was analyzed separately.

**Table 3: Average Weighted Services per Beneficiary**
**October 1, 2014 - September 30, 2015**

| CPT® Code | Your Average Weighted Services per Beneficiary | Your Specialty's Average Weighted Services per Beneficiary | Comparison with Your Specialty's Average | National Average Weighted Services per Beneficiary | Comparison with the National Average |
|---|---|---|---|---|---|
| NCS | 8.44 | 8.35 | Higher | 8.33 | Higher |
| EMG | 1.00 | 1.46 | Does Not Exceed | 1.47 | Does Not Exceed |
| NCS & EMG | 1.56 | 1.73 | Does Not Exceed | 1.77 | Does Not Exceed |

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

Table 4 provides a statistical comparison of the percentage of visits with NCS only CPT® codes and compares those results with others in your specialty code and the nation

**Table 4: Percentage of Visits with NCS CPT® Codes Only**
**October 1, 2014 - September 30, 2015**

| Type | Your Percentage of Visits | Your Specialty's Percentage of Visits | Comparison with Your Specialty's Percentage | National Percentage of Visits | Comparison with the National Percentage |
|---|---|---|---|---|---|
| NCS Only Visits | 27% | 7% | Significantly Higher | 10% | Significantly Higher |

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

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## References & Resources

The coverage and documentation guidelines for Electrodiagnostic Testing (EDX) 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/cbr201602-recommended-links.html.

**Table 5: LCDs & LCAs**

| Medicare Administrative Contractor (MAC) | Active 10/01/15 | Retired 09/30/15 |
|---|---|---|
| Cahaba Government Benefit Administrators, LLC | L34265, A54669 | L33068, A52230 |
| CGS Administrators, LLC | L35897, A54158, A54159 | L35737 |
| First Coast Service Options, Inc. | L34859 | L34480 |
| National Government Services, Inc. | L35098 | L33386 |
| Noridian Healthcare Solutions, LLC | L34325 | L33476 |
| Novitas Solutions, Inc. | L35081 | L29547 |
| Palmetto GBA | L35048 | L34606 |
| Wisconsin Physicians Service Insurance Corporation | L34594 | L31346 |

**Office of Inspector General:**

- Questionable Billing for Medicare Electrodiagnostic Tests, April 2014, OEI-04-12-00420
- Work Plans: Fiscal Year 2013 and Fiscal Year 2014

**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
- *Medicare Program Integrity Manual*, Chapter 3, Verifying Potential Errors and Taking Corrective Actions
- *Medicare National Coverage Determinations Manual*, Sensory Nerve Conduction Threshold Tests, Chapter 1, Section 160.23
- *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, Chapter I, Sections V (Medically Unlikely Edits)

**Medicare Learning Network® (MLN®):**

- Revised Modification to the Medically Unlikely Edit (MUE) Program, January 2015 ICN:904183
- Medically Unlikely Edits (MUE) and Bilateral Procedures, MLN Matters® Number: SE1422

**American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM):**

- Model Policy for Needle Electromyography and Nerve Conduction Studies, Position Statement

**American Medical Association (AMA):**

- *CPT® 2014 Professional Edition*
- *CPT® 2015 Professional Edition*
- *CPT® Changes 2006: An Insider's View*

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## 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 aforementioned references and resources as a guide.

You are invited to join us for the CBR201602 webinar on March 2, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at http://www.cbrinfo.net/cbr201602-webinar.html.

If you are unable to attend, you may access a recording of the CBR201602 webinar five business days following the event at http://www.cbrinfo.net/cbr201602-webinar.html.

For detailed links to information listed in the references and resources section, visit http://www.cbrinfo.net/cbr201602-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.

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