



Comparative Billing Report

September 6, 2016

CBR #: CBR201613
Topic: Modifier 25:
Obstetrics/Gynecology (OB/GYN)
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 headquartered 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,

Virna Elly
CBR Program Director
eGlobalTech
Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Modifier 25: Obstetrics/Gynecology (OB/GYN)

Introduction

This CBR focuses on physicians with a specialty of obstetrics/gynecology who submitted claims for established patient evaluation and management (E/M) services appended with modifier 25. The *CPT® 2015 Professional Edition* manual defines modifier 25 as indicative of a “significant, separately identifiable E/M service by the same physician or other qualified health professional on the same day of the procedure or other service.” Specifically, this CBR examines Current Procedural Terminology (CPT®) codes 99211 through 99215.

In 2005, the Office of the Inspector General (OIG) released a report on Medicare payments for E/M services billed with modifier 25. The report, “Use of Modifier 25” (OEI-07-03-00470), 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.

Table 1 provides an abbreviated description for CPT® codes 99211 through 99215, as well as the typical time assigned by the *CPT® Manual*.

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

The metrics reviewed in this report are:

- Percentage of services with modifier 25 appended
- Average allowed minutes per visit for claim lines with modifier 25 and without modifier 25
- Average allowed charges per beneficiary summed for the one-year period, regardless of the modifiers appended to the claim lines

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 *CPT® Manual* describes a modifier as providing “the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code.” Procedure codes may be modified in certain situations to describe more precisely the service or item rendered.

According to Chapter I of the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, 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 the *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 the *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 *NCCI* Chapter I, Section E states the following regarding the Healthcare Common Procedure Coding System (HCPCS): “Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.”

According to Chapter 12 of the *Medicare Claims Processing Manual*, a significant, separately identifiable E/M service may be billed in addition to an Initial Preventive Physical Examination (IPPE) or an Annual Wellness Visit (AWV). Modifier 25 should be appended to the medically necessary E/M service. Using this modifier identifies the E/M as significant from the IPPE or AWV code. The instructions go on to note the following: “Some of the components of a medically necessary E/M service (e.g., a portion of the history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.” 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, §30.6.1 of the *Medicare Claims Processing Manual* which 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 determine 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.

According to the American College of Physicians' *ACP Internist*[®] article "Learn Proper Coding for Modifiers 59 and 25," documentation must be extensive enough that the additional service is readily identifiable to auditors who might review the claim. The article states, "The E/M service must require additional history, exam, knowledge, skill, work time and/or risk above and beyond what is usually required for the procedure, and these must be included in the documentation."

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 January 1, 2015 to December 31, 2015 and includes only those claims where the rendering NPI specialty is denoted as Obstetrician or Gynecologist (16). This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR), as of July 19, 2016. Your percentages and averages denoted in Tables 3-5 are calculated from the data supplied from your utilization of the E/M CPT[®] codes in Table 2 using the formulas below. Your values are compared to your state (LA) and national values, using either the chi-squared or t-test at the alpha value of 0.05.

Percentage of Services with Modifier 25

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

$$\frac{\text{Number of Services with Modifier 25}}{\text{Total Number of Services}} \times 100$$

Average Allowed Minutes per Visit with Modifier 25 and without Modifier 25

Each CPT[®] code is assigned a value that corresponds to 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 modifier designation (with modifier 25 and without modifier 25) and divided by the total number of visits by modifier designation. 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 modifier designation. 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 minutes allowed per visit are calculated separately for services with modifier 25 and without modifier 25, as follows:

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

Average Allowed Charges per Beneficiary

The average allowed charges, regardless of the modifiers, 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 significance
- **Higher** - Provider's value is higher than the peer value, but either the statistical test does not confirm 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 sufficient data for comparison

It is important to note that significance is based on the total number of services, 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, both with and without modifier 25.

**Table 2: Summary of Your Utilization for E/M Codes and Modifier 25
January 1, 2015 - December 31, 2015**

CPT®	Type	Allowed Charges	Allowed Services	Beneficiary Count
99211	With Mod 25	\$18.50	1	1
99211	Without Mod 25	\$272.85	15	11
99212	With Mod 25	\$366.18	9	9
99212	Without Mod 25	\$1,053.73	26	22
99213	With Mod 25	\$7,196.60	106	80
99213	Without Mod 25	\$18,206.25	269	182
99214	With Mod 25	\$5,586.98	55	53
99214	Without Mod 25	\$13,122.42	130	104
99215	With Mod 25	\$2,199.71	16	15
99215	Without Mod 25	\$2,061.76	15	15
Total		\$50,084.98	642	336

Please note that 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. Since it is likely that a beneficiary would have billings for more than one CPT® code and modifier type, he/she would be counted in the beneficiary count in each applicable row. However, this beneficiary would be counted only once in the total.

Table 3 provides a comparison of your percentage of services with modifier 25 to that of your state and the nation.

**Table 3: Percentage of Services with Modifier 25
January 1, 2015 - December 31, 2015**

	Your Percentage of Modifier 25 Use	Your State's Percentage of Modifier 25 Use	Comparison with Your State's Percentage	National Percentage of Modifier 25 Use	Comparison with the National Percentage
With Mod 25	29%	23%	Significantly Higher	26%	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 claim lines with modifier 25 and without modifier 25. Your averages are compared to that of your state and the nation.

**Table 4: Average Allowed Minutes per Visit
with Modifier 25 and without Modifier 25
January 1, 2015 - December 31, 2015**

Type	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
With Mod 25	19.79	16.70	Significantly Higher	19.11	Higher
Without Mod 25	18.07	17.22	Significantly Higher	18.27	Does Not Exceed

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 include E/M claim lines for established beneficiaries, regardless of the modifiers attached to the claim line. This is the total allowed charges per beneficiary for the one-year time period under analysis.

**Table 5: Average Allowed Charges per Beneficiary
January 1, 2015 - December 31, 2015**

	Your Average Charges Per Beneficiary	Your State's Average Charges Per Beneficiary	Comparison with Your State's Average	National Average Charges Per Beneficiary	Comparison with the National Average
Charges	\$149.06	\$105.80	Significantly Higher	\$127.04	Higher

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

References & Resources

The coverage and documentation guidelines for this CBR are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201613-recommended-links.html>.

Office of Inspector General

- Use of Modifier 25, November 2005, OEI-07-03-00470
- Work Plans: 2010, 2012, 2013

Medicare Manuals

- *National Correct Coding Initiative Policy Manual for Medicare Services*, Chapter 1 - General Correct Coding Policies
 - Section D - Evaluation and Management (E&M) Services
 - Section E - Modifiers and Modifier Indicators
- *Medicare Claims Processing Manual*, Chapter 12 - Physician/Nonphysician Practitioners,
 - Section 30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
 - Section 30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery
 - Section 40.1 - Definition of a Global Surgical Package
 - Section 40.2 - Billing Requirements for Global Surgeries

Medicare Learning Network® (MLN®)

- “Global Surgery Fact Sheet” March 2015, ICN907166
- “Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors,” Volume 1, Issue 2, February 2011, ICN905712

American College of Physicians™

- *ACP Internist*®, “Learn Proper Coding for Modifiers 59 and 25”, July/August 2012

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 CBR201613 webinar on October 5, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201613-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201613 webinar five business days following the event at <http://www.cbrinfo.net/cbr201613-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201613-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.

For written correspondence, postal mail can be sent to the following address:

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