

Comparative Billing Report



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CBR#: CBR201702
Topic: Physical Therapy
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Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430 / M-F 9 A.M. – 5 P.M. ET
cbrsupport@eglobaltech.com
Write to the return address above

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, to develop Comparative Billing Reports (CBRs).

What is a CBR?

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

Why did I get a CBR?

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.
- Factors such as region, subspecialty, and patient acuity can be factors in differences in billing patterns. These factors are not evident in claims data reviewed for this report.

What should I do with this CBR?

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

Do I need to reply to explain my utilization?

- No reply is necessary, as this report is for educational purposes.

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 (800) 465-3203 or email customerservice@npienumerator.com.

Sincerely,

A handwritten signature in black ink that reads 'Frank Gorton'.

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111

Physical Therapy

Introduction

CBR201702 focuses on physical therapists in private practice who submitted claims for physical therapy services using Current Procedural Terminology (CPT®) codes 97001, 97002, 97035, 97110, 97112, 97140, 97530, and Healthcare Common Procedure Coding System (HCPCS) code G0283 billed with the GP modifier, signifying services delivered under an outpatient physical therapy plan of care. This report examines the percentage of beneficiaries whose claims were submitted with the KX modifier, the average minutes of therapy per visit, and average allowed charges per beneficiary. This CBR is a rerun of CBR201511 which was disseminated in November 2015.

Table 1: Physical Therapy Procedure Codes and Abbreviated Descriptions

CPT® / HCPCS Codes	Description
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97035	Application of a modality, ultrasound, each 15 minutes
97110	Therapeutic procedure, exercises to develop strength, each 15 minutes
97112	Therapeutic procedure, neuromuscular reeducation, each 15 minutes
97140	Manual therapy techniques, each 15 minutes
97530	Therapeutic activities, direct patient contact, each 15 minutes
G0283	Electrical stimulation, unattended, other than wound care

CPT® codes and descriptors are copyright 2015-2016 American Medical Association. All rights reserved. Applicable FARS/DFARS apply. Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS).

According to the *Medicare Fee-for-Service 2015 Improper Payments Report*, physical therapists in private practice had an improper payment rate of 23.4 percent with projected improper payments of more than \$400 million. This was a decrease from the *Medicare Fee-for-Service 2014 Improper Payments Report* rate of 29.5 percent with projected improper payments of \$514 million. More than 95 percent of the errors were the result of insufficient documentation. The

Executive Summary of the *2014 Comprehensive Error Rate Testing (CERT)* report states “Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the 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.”

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 Contractors’ (MACs) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

According to the *Medicare Benefit Policy Manual* (Chapter 15, Section 230.4), Medicare requires a therapist in private practice (TPP) to be enrolled as a private practitioner in order to bill Medicare directly. Services must be furnished in the therapist’s or group’s office or in the beneficiary’s home. Individuals working as employees of an institutional provider are not included in private practice. Chapter 15 also refers to conditions of coverage and payment for outpatient physical therapy. Section 220.1 states “Since the outpatient therapy benefit under Part B provides coverage only of therapy services, payment can be made only for those services that constitute therapy. In cases where there is doubt about whether a service is therapy, the contractor’s local coverage determination (LCD) shall prevail.” It goes on to state “Outpatient therapy services...are payable only when furnished in accordance with certain conditions.” These include:

- Services are or were required based on the individual needs
- A plan for furnishing such services has been established by a physician, non-physician practitioner (NPP) or therapist and reviewed by the physician periodically
- Services are or were furnished while the individual is or was under the care of a physician or NPP
- Services are or were furnished on an outpatient basis

When certifying an outpatient plan of care for therapy, a physician/NPP is attesting that the above conditions are met. Certification is required for coverage and payment of a therapy claim. Medicare does not require a physician’s order; however, an order provides documentation that the beneficiary is under the care of a physician and that the beneficiary needs therapy services. Additional certification is not required if the signed order includes a plan of care. Instructions for

establishing the plan of care are outlined in Chapter 15, Section 220.1.2 of the *Medicare Benefit Policy Manual*: “The services must relate directly and specifically to a written treatment plan as described in this chapter. The plan...**must be established before treatment is begun**...The signature and professional identity...of the person who established the plan, and the date it was established must be recorded with the plan.” The plan of care must include 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 *Medicare Benefit Policy Manual* provides the following guidelines for the therapy certification process: “Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.” Delayed certification is allowed; however, the date the certification is signed determines if it is timely or delayed. The CMS publication titled *Physical, Occupational, and Speech Therapy Services* gives the following guidance on delayed certification: “Delayed certification and recertification requirements shall be deemed satisfied where, at any later date, a physician/NPP makes a certification accompanied by a reason for the delay. Certifications are acceptable without justification for 30 days after they are due. Delayed certification should include one or more certifications or recertifications on a single signed and dated document.”

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 *Medicare Benefit Policy 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 that certified by the physician/NPP requires recertification.

A description of reasonable and necessary outpatient rehabilitation therapy services is also found in the *Medicare Benefit Policy Manual* (Chapter 15, Section 220.2) and outlines the types of services and personnel that are payable under Medicare. It states “Services that do not require the performance or 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...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.” When responding to requests for medical records, providers should document “no less than the frequency required in Medicare policy:

- 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;

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- Certification (physician/NPP approval of the plan) and re-certifications when records are requested after the certification/re-certification 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* (Section 10.3.1) states the following about the therapy cap exceptions process: “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.” When the therapy cap has been reached and continued therapy is medically necessary, the KX modifier should be appended to the claim along with supporting documentation.

Effective January 1, 2017, Medicare replaced the two codes for billing evaluations and re-evaluations. CPT® code 97001 was replaced by CPT® codes 97161, 97162, and 97163 representing low, moderate, or high complexity. CPT® code 97002 was replaced by CPT® code 97164. The new code descriptors require specific components and typical face-to-face times for reporting and billing Medicare.

Methods & Results

This report is an analysis of Medicare Part B claims with dates of service from July 1, 2015 to June 30, 2016. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR) as of December 8, 2016 where the rendering NPI specialty is denoted as Physical Therapist in Private Practice (65) and each claim line was submitted with modifier GP.

Table 2 provides a summary of your utilization of the procedure codes included in this CBR. The total allowed charges, allowed services, and distinct beneficiary count are included for each procedure code. The visit count is only provided for the timed procedures since multiple services are likely to be billed on the same visit for these procedure codes. The value will be “-” if it is not a timed procedure. In addition, an overall “Total” row is included. Your percentages and averages, denoted in Tables 3 through 5, are calculated from your utilization of the procedure codes summarized in Table 2, using the formulas below.

**Table 2: Summary of Your Utilization
July 1, 2015 – June 30, 2016**

CPT® / HCPCS Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
97001	\$10,066	124	-	114
97002	\$0	0	-	0
97035	\$48	4	0	2
97110	\$94,927	3,442	1,550	218
97112	\$37,241	1,117	941	188
97140	\$34,356	1,394	1,300	209
97530	\$12,554	339	312	97
G0283	\$1,214	110	-	37
Total	\$190,407	6,530	1,788	228

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the number of visits and beneficiaries are unduplicated counts for each row and the total. A beneficiary receiving multiple items in the list would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

Metrics were calculated from your utilization and for each of the following peer groups:

- The STATE peer group is defined as all Medicare providers located in the provider’s state (as determined by NPPES) with allowed charges for the procedure codes included in this study and whose specialty is Physical Therapist in Private Practice (65).
- The NATIONAL peer group is defined as all Medicare providers in the nation with allowed charges for the procedure codes included in this study and whose specialty is Physical Therapist in Private Practice (65).

Your metrics were compared to your state (NJ) and the nation, using either the chi-square or t-test at the alpha value of 0.05. 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 the statistical test does not confirm significance
- 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 charges, services, visits, or beneficiaries and the variability of those values.

Percentage of Beneficiaries with KX Modifier

As detailed above, the KX modifier indicates that the services are at or above the therapy caps. This metric was designed to focus on providers that are billing this modifier at rates above their peers. Although adding this modifier is justifiable, the percentage of beneficiaries needing additional care should be comparable across providers in the peer groups. The percentage of beneficiaries with KX modifier appended is calculated as follows:

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

Table 3 provides a statistical analysis of the percentage of beneficiaries with the KX modifier. Your percentage is compared to that of your state and the nation.

**Table 3: Percentage of Beneficiaries with the KX Modifier
July 1, 2015 – June 30, 2016**

	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage of Beneficiaries	National Percentage of Beneficiaries	Comparison with the National Percentage of Beneficiaries
Percentage of KX	43%	37%	Higher	21%	Significantly Higher

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

Average Minutes per Visit

The average minutes per visit was calculated for each provider of physical therapy to identify potential overutilization of these services. Since each service submitted under CPT® codes 97035, 97110, 97112, 97140, and 97530 typically represent 15 minutes with the patient, this measure is an average of all services, with the associated minutes, that the physical therapist spends with the patient on a visit. This measure is calculated by adding all services for these selected CPT® codes, multiplying the sum of the services by 15 minutes, then dividing by the total number of visits. A visit is defined as a single date of service between each beneficiary and the provider. The average minutes allowed per visit are calculated as follows:

$$\frac{\text{Total Allowed Services for Selected CPT® Codes} \times 15 \text{ Minutes}}{\text{Total Number of Visits}}$$

Table 4 provides a statistical analysis of the average minutes per visit. Your percentage is compared to that of your state and the nation.

**Table 4: Average Minutes Per Visit
July 1, 2015 – June 30, 2016**

	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
Minutes	52.81	44.85	Significantly Higher	45.67	Significantly Higher

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

Average Allowed Charges per Beneficiary

The average allowed charges per beneficiary was calculated for each provider of physical therapy to potentially identify overutilization of services for all of the procedure codes included in this report. The average allowed charges per beneficiary was calculated, as follows:

Total Allowed Charges **Total Number of Beneficiaries**

Table 5 provides a statistical analysis of the average allowed charges per beneficiary. Your percentage is compared to that of your state and the nation.

**Table 5: Average Allowed Charges per Beneficiary
July 1, 2015 – June 30, 2016**

	Your Average Charges per Beneficiary	Your State's Average Charges per Beneficiary	Comparison with Your State's Average Charges per Beneficiary	National Average Charges per Beneficiary	Comparison with the National Average Charges per Beneficiary
Charges	\$835.12	\$908.46	Does Not Exceed	\$724.03	Significantly 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. A complete list of web links is located at

<http://www.cbrinfo.net/cbr201702-recommended-links>.

Office of Inspector General (OIG):

- Questionable Billing for Medicare Outpatient Therapy Services OEI-04-09-00540, December 2010

Medicare Manuals:

- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual

Centers for Medicare & Medicaid Services

- Medicare Fee-for-Service 2015 Improper Payments Report
- Medicare Fee-for-Service 2014 Improper Payments Report
- Physical, Occupational, and Speech Therapy Services

American Medical Association (AMA)

- CPT® 2015, 2016, 2017 Professional Editions
- HCPCS 2015, 2016 Level II Code Books

The Next Steps

We encourage you to check with your MAC to ensure that 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 CBR201702 webinar on March 29, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201702-webinar>.

If you are unable to attend, you may access a recording of the CBR201702 webinar five business days following the event at <http://www.cbrinfo.net/cbr201702-webinar>.

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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