

# Comparative Billing Report



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CBR#: CBR201703  
Topic: Sudomotor-Function Testing  
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**Questions:** Contact CBR Support  
www.cbrinfo.net  
(800) 771-4430 / M-F 9 am – 5 pm 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 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](mailto:customerservice@npienumerator.com).

Sincerely,

A handwritten signature in cursive script, appearing to read 'Frank Gorton'.

Frank Gorton  
CBR-Program Director  
eGlobalTech

Enclosure

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# Comparative Billing Report (CBR): NPI 1111111111

## Sudomotor-Function Testing

### Introduction

CBR201703 is an analysis of claims submitted for sudomotor-function tests. Specifically, this CBR examines services billed by referring providers with Current Procedural Terminology (CPT®) code 95923. The metrics reviewed in this report include:

- Percentage of services without diagnosis codes that support medical necessity
- Percentage of services rendered by providers who are not neurologists
- Percentage of beneficiaries receiving multiple services (over a 3-year period)
- Percentage of a referring provider's beneficiaries who received sudomotor-function testing

According to a *Wall Street Journal (WSJ)* article published August 10, 2016, Medicare payments for sweat testing are increasing since “a device became available that allows doctors to perform tests in their offices.” In 2014, Medicare spending increased to \$16.7 million for the desktop devices, which was almost ten times the amount paid in 2012. The *WSJ* analysis determined that most of the increase was driven by less than 10 percent of providers.

Section 1862(a) (1) (A) of the Social Security Act (SSA) states Medicare will not pay for items or services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Diagnostic tests are reimbursed only when they are medically necessary and are used to diagnose and/or treat a specific condition or disease.

The autonomic nervous system (ANS) controls physiologic processes in the body that are not under conscious control such as blood pressure, heart rate and digestion. Diseases that affect the ANS are known as autonomic neuropathies. These conditions can be congenital or acquired; they can also occur as an isolated condition or along with other diseases. Many autonomic neuropathies are treatable and have little clinical relevance, while others can be debilitating, leading to increased morbidity and mortality rates. ANS disorders can affect any body system. They may be primary disorders or they may be secondary to another disorder. They can originate in either the central or peripheral nervous system. ANS testing can be grouped into the following general categories:

- Cardiovagal innervation
- Vasomotor adrenergic innervation
- Sudomotor-function testing

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According to Wisconsin Physician Service (WPS) **Final Comments and Responses** article, CPT® code 95923 was “designed for careful, detailed autonomic nervous system testing under controlled conditions. Such studies typically take about two hours to perform.” The article was written to address inappropriate use by some providers of autonomic billing codes. It states “certain stakeholders share the concern that over-utilization of autonomic billing codes may be occurring with the use of several devices on the market that claim to perform complete autonomic assessment in 10-15 minutes. However, such devices have not been scientifically validated and may provide misleading or erroneous results.” Per the American Academy of Neurology (AAN), “There are no automated devices currently on the market that, when used alone, are sufficient to bill for autonomic testing using 95921–95924. Billing code 95943 is the only code appropriate for autonomic testing using automated devices.”

## 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.

### Basic Coverage Criteria

As stated in Cahaba Government Benefit Administrator’s LCD L34500: “Autonomic function testing is covered as reasonable and necessary when used as a diagnostic tool to evaluate symptoms indicative of vasomotor instability, such as hypotension, orthostatic tachycardia, and hyperhidrosis after more common causes have been excluded by other testing, and the ANS testing is directed at establishing a more accurate or definitive diagnosis or contributing to clinically useful and relevant medical decision making...”

Sudomotor–function testing (CPT® 95923) is used to evaluate and document neuropathic disturbances that may be associated with pain. The quantitative sudomotor axon reflex test (QSART), thermoregulatory sweat test (TST), sympathetic skin responses, and silastic sweat imprints are tests of sympathetic cholinergic sudomotor function. A list of the covered diagnoses can be found in National Government Services’ LCD L36236.

Testing for sudomotor function must be performed by appropriate specialists utilizing FDA approved devices with general professional standards. Per LCD L36236, physicians that specialize in autonomic disorders “must have knowledge, training, and expertise to perform and interpret these tests, and to assess and train personnel working with them. This training and

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expertise must have been acquired within the framework of an accredited residency and/or fellowship program or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, and designated for the American Medical Association (AMA) category I credit by an ACCME (Accreditation Council for Continuing Medical Education) or SMS (State Medical Society) accredited CME provider.” The testing takes between 90 and 120 minutes to be performed correctly.

Diagnostic testing is allowed once per year to confirm or exclude a specific autonomic disease. After confirming the diagnosis, repeat testing may be performed to check changes in a patient’s clinical condition or to see how well the patient is responding to therapeutic intervention; however, repeat testing is expected no more than once per year. A provider may perform up to four tests, but only a single unit of the CPT® code should be billed for the date of service.

## Methods & Results

This report is an analysis of Medicare Part B claims. The recipients of this report are the referring providers. This includes claims that were referred to different rendering providers, as well as self-referrals. This data was extracted from the Integrated Data Repository (IDR) based on the latest version of claims as of February 8, 2017. The analyses are based on claims that were billed globally (without modifier 26 or modifier TC) or billed for the technical component only (with modifier TC).

Claims analysis indicates that you referred a total of **466** beneficiaries with dates of service from October 1, 2013 to September 30, 2016 for all Part B Medicare procedure codes. Table 1 provides a summary of your referrals of CPT® Code 95923 by date of service. The total allowed charges, allowed services, and distinct beneficiary count are included for each year. In addition, an overall “Total” row is included summarizing the utilization for the three-year period. Your percentages and averages, denoted in Tables 2 through 5, are calculated from your utilization of the procedure code summarized in Table 1.

**Table 1: Summary of Your Referrals of CPT® Code 95923  
October 1, 2013 – September 30, 2016**

<b>Dates of Service</b>	<b>Allowed Charges</b>	<b>Allowed Services</b>	<b>Beneficiary Count</b>
Oct 2013 - Sep 2014	\$17,616	93	91
Oct 2014 - Sep 2015	\$40,890	231	179
Oct 2015 - Sep 2016	\$1,569	9	9
<b>Total</b>	<b>\$60,075</b>	<b>333</b>	<b>219</b>

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Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the number of beneficiaries are unduplicated counts for each row and the total. A beneficiary receiving this procedure in multiple years 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 referring Medicare providers located in the individual referring provider's state (as determined by NPES) with claims of allowed charges for the procedure code included in this study
- The **national** peer group is defined as all referring Medicare providers in the nation with claims of allowed charges for the procedure code included in this study

Your metrics were compared to your state (NY) 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, or beneficiaries and the variability of those values.

### **Percentage of Services without Diagnosis Codes that Support Medical Necessity**

As detailed above, diagnostic tests are reimbursed only when they are medically necessary and are used to diagnose and/or treat a specific condition or disease. This metric was designed to focus on providers who are referring this specific test at rates above their peers, using the diagnoses defined in the LCDs referenced in this document. Since this analysis encompasses time periods for ICD-9 and ICD-10 diagnosis codes, the ICD-9 diagnosis codes converted from the ICD-10 list are also included with the list of diagnoses. All diagnosis codes submitted with the claim were searched for these codes. The percentage of services without diagnosis codes that support medical necessity is calculated as follows:

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$$\left( \frac{\text{Number of Services without Indicated Diagnoses}}{\text{Total Number of Services}} \right) \times 100$$

Table 2 provides a statistical analysis of the percentage of services without diagnosis codes that support medical necessity. Your percentage is compared to that of your state and the nation.

**Table 2: Percentage of Services without Diagnosis Codes that Support Medical Necessity  
October 1, 2013 – September 30, 2016**

	Number of Services	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
<b>Services without Indicated Diagnoses</b>	34	10%	34%	Does Not Exceed	22%	Does Not Exceed

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

### **Percentage of Services Rendered by Providers Who are Not Neurologists**

Specialized training and expertise in autonomic disorders are required by the rendering provider in order to use the FDA approved devices required to bill CPT® code 95923. Since this knowledge must have been acquired within the framework of an accredited residency, fellowship program, or extensive continued medical education activities most common to neurologists, this metric focuses on those providers that refer this procedure to rendering providers who are not defined as neurologists on their claims. Although a provider of any specialty can acquire the necessary training needed, rendering providers of specialties other than neurology may not have the extensive training and/or certification required to perform and interpret this test. The percentage of services rendered by providers who are not neurologists is calculated as follows:

$$\left( \frac{\text{Number of Services Rendered by Providers Who are Not Neurologists}}{\text{Total Number of Services}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of services rendered by providers who are not neurologists. Your percentage is compared to that of your state and the nation.

**Table 3: Percentage of Services Rendered by Providers Who are Not Neurologists  
October 1, 2013 – September 30, 2016**

	Number of Services	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
<b>Services Not Rendered by Neurologists</b>	333	100%	76%	Significantly Higher	85%	Significantly Higher

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

### **Percentage of Beneficiaries Receiving Multiple Services (Over 3-Year Period)**

Sudomotor-function testing is performed to confirm or exclude a specific autonomic disease. Repeat testing is only necessary if there is a change in clinical status or in response to a therapeutic intervention. Although repeat testing is allowable, the majority of beneficiaries would not benefit from multiple tests. This metric was designed to identify potential overutilization of this service. The percentage of beneficiaries receiving multiple services (over 3-year period) is calculated, as follows:

$$\left( \frac{\text{Number of Beneficiaries Receiving Multiple Services}}{\text{Total Number of Beneficiaries}} \right) \times 100$$

Table 4 provides a statistical analysis of the percentage of beneficiaries receiving multiple services (over 3-year period). Your percentage is compared to that of your state and the nation.

**Table 4: Percentage of Beneficiaries Receiving Multiple Services (Over 3-Year Period)  
October 1, 2013– September 30, 2016**

	Number of Beneficiaries	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
<b>Beneficiaries with Multiple Services</b>	55	25%	24%	Higher	21%	Significantly Higher

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



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## Percentage of a Referring Provider's Beneficiaries Who Received Sudomotor-Function Testing

Due to the increase in billing for sudomotor-function testing, this metric was designed to identify potential overutilization and improper use of this service. The percentage of a referring provider's beneficiaries who received sudomotor-function testing (CPT® code 95923) is calculated, as follows:

$$\left( \frac{\text{Number of Beneficiaries Referred by Provider Who Received Code 95923}}{\text{Total Number of Beneficiaries Referred by Provider}} \right) \times 100$$

Table 5 provides a statistical analysis of the percentage of a referring provider's beneficiaries who received sudomotor-function testing. Your percentage is compared to that of your state and the nation.

**Table 5: Percentage of a Referring Provider's Beneficiaries  
Who Received Sudomotor-Function Testing  
October 1, 2013– September 30, 2016**

	Number of Beneficiaries	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
<b>Beneficiaries Receiving CPT® Code 95923</b>	219	47%	4%	Significantly Higher	2%	Significantly Higher

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

## References & Resources

The coverage and documentation guidelines for sudomotor-function testing are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201703-recommended-links>.

### LCDs & LCAs

- Cahaba Government Benefit Administrators - LCD L34500
- First Coast Service Options (FCSO) - LCD L33609
- National Government Services (NGS) - LCD L36236, LCA A54403
- Novitas Solutions - LCD L35395 LCA A54954
- Wisconsin Physicians Service (WPS) - LCD L35124

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### **Social Security Act**

- Section 1862(a) (1) (A)

### **Medicare Administrative Contractors**

- WPS Final Comments Autonomic Function Testing

### **American Academy of Neurology**

- Model Coverage Policy – Autonomic Testing

### ***Wall Street Journal***

- WSJ: More Doctors are Ordering In-Office Medical Tests—and It's Driving up Medicare Spending

### **American Medical Association (AMA)**

- CPT<sup>®</sup> codes, descriptors and other data are copyright 2015/2016 AMA

### **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 CBR201703 webinar on May 10, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201703-webinar>.

If you are unable to attend, you may access a recording of the CBR201703 webinar five business days following the event at <http://www.cbrinfo.net/cbr201703-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](mailto:CBRsupport@eglobaltech.com) or via telephone at (800) 771-4430.

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