

Comparative Billing Report



Comparative Billing Report Program
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CBR#: CBR201705 Anesthesia for
Lower Endoscopic Procedures
NPI#: 1111111111
Fax#: (888)555-5555

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 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.

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, please take time to review and update the appropriate Medicare provider enrollment system.

Sincerely,

A handwritten signature in black ink, appearing to read "Frank Gorton".

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111 Anesthesia Services for Lower Endoscopic Procedures

Introduction

CBR201705 focuses on Medicare Part B providers with allowed anesthesia service claims with CPT® code 00810 for lower endoscopic procedures (with the endoscope introduced distal to the duodenum). The metrics reviewed in this report include:

- Average time units appended per visit
- Percentage of visits billed without an allowed colonoscopy claim
- Percentage of visits appended with modifier AA

The number of colonoscopy screenings have increased since the Affordable Care Act (ACA) was enacted in 2011. Section 4104 of the ACA was revised in 2015 and defined colorectal cancer screening tests as preventive services. As such, the deductible and coinsurance were waived and a provision for moderate sedation is now included. In order to bill CPT® code 00810, there must be a corresponding colonoscopy service billed. If there is not an allowed colonoscopy service, then the anesthesia code would be considered not medically necessary and payment should be denied.

According to the *Medicare Fee-for-Service 2015 Improper Payments Report*, anesthesia was listed in the **Medicare Part B Top 20 Service Types with Highest Improper Payment Rates**. The improper payment rate was 11.4 percent with over \$241 million in improper payments. More than 78 percent of anesthesia claims were denied for insufficient documentation, while 17.7 percent were denied for incorrect coding. The improper payment rate decreased to 2.9 percent in 2016; however, improper payments were still high at almost \$59 million.

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 by 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.

Three MACs have LCDs for monitored anesthesia care:

- First Coast Service Options – LCD L33595
- Noridian Healthcare Solutions – LCD L34100
- Novitas Solutions – LCD L35049

According to Chapter 12 of the *Medicare Claims Processing Manual*, “Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.” A pre-anesthetic evaluation and exam, the anesthesia prescription, including medications and postoperative anesthetic care are also included.

Medicare Part B pays for anesthesia services and related care furnished by physicians, certified registered nurse anesthetists (CRNAs) or anesthesia assistants who are legally authorized to perform the services by the state where furnished. CMS established an exemption for CRNAs from the physician supervision requirement. The U.S. Territory of Guam and these states have opted out of the physician supervision regulation for CRNAs: Alaska, California, Colorado, Idaho, Iowa, Kansas, Kentucky, Minnesota, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Washington and Wisconsin.

Anesthesia time begins when the provider starts to prepare the patient for the induction of anesthesia. It does not end until the patient is safely placed under post-operative supervision. According to Chapter 12 of the *Medicare Claims Processing Manual*, “Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient...Anesthesia time is a continuous time period from the start of anesthesia until the end of an anesthesia service.” A provider can add blocks of time (around an interruption) as long as continuous anesthesia care is being furnished without interruption. Time should be combined and reported with the higher level procedure code. If multiple procedures are performed, payment would be based on the CPT® code with the highest base value and the time units would be the combined actual anesthesia time of the procedures.

Anesthesia time should be reported in minutes and then divided by 15 minutes to get the billable units. The time unit is rounded to one decimal place. Anesthesia payment is based on services being personally performed, medically directed or medically supervised. Modifiers frequently used with anesthesia services are listed below in Table 1:

Table 1: Modifiers Frequently Used with Anesthesia Services

Modifier	Description
AA	Anesthesia personally performed by physician
AD	Supervision of more than 4 procedures by physician
QK	Medical direction of 2, 3, or 4 procedures
QX	Medical direction of qualified non-physician anesthetist
QY	Medical direction of one qualified non-physician anesthetist
QZ	Qualified non-physician anesthetist performs without medical direction
PT	Colonoscopy screening converted to diagnostic procedure
33	Preventive Service
76	Repeat Procedure by same physician or qualified health care professional

When a preventive service is provided, and billed with HCPCS codes G0105 or G0121 (codes for screening colonoscopies), modifier 33 should be appended to the CPT® code. The PT modifier is appended in the second modifier position if, as a result of a screening colonoscopy, a diagnostic procedure is necessary. If a claim is submitted with CPT® code 00810 without appending modifier 33 or the PT modifier, MACs will apply the deductible and coinsurance.

Modifier 76 should be appended if the exact procedure is repeated by the same provider on the same day in a separate session. If the two procedures are performed by two providers in the same group with the same specialty it still qualifies as a repeat procedure. The provider should bill the services on two separate claim lines and append modifier 76 to the second service.

Methods & Results

This report is an analysis of rendering NPIs submitting Medicare Part B claims extracted from the Integrated Data Repository (IDR) based on the latest version of the claim as of April 13, 2017. The analysis includes claims with dates of service from January 1, 2016 to December 31, 2016.

There are over 65,000 providers nationwide with allowed charges for CPT® code 00810 that are included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied and also were above the 75th percentile in allowed charges (\$5,000), with at least 19 beneficiaries during this one-year period.

Table 2 provides a summary of your utilization of the procedure code included in this CBR. The total allowed charges, allowed services, and distinct visit and distinct beneficiary counts are included in this table. Your percentages and averages, denoted in Tables 3 through 5, are calculated from your utilization of the procedure code summarized in Table 2, using the formulas that follow.

Table 2: Summary of Your Utilization of CPT® Code 00810
January 1, 2016 – December 31, 2016

CPT® Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
00810	\$13,368	83	83	82

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

- The **state** peer group is defined as all rendering Medicare providers practicing in the individual rendering provider's state with claims of allowed charges for the procedure code included in this study
- The **national** peer group is defined as all rendering 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 (WI) and the nation using statistical analysis. 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.

Average Number of Time Units Appended per Visit

A visit is defined as a single date of service by beneficiary. Generally, the total number of visits should be equivalent to the total number of services since the provider should combine the time associated with procedures and bill only for the CPT® code with the highest base value. Multiple services per visit should only be reported in cases where modifier 76 is appended for repeat procedures. The average time units appended per visit are calculated as follows:

$$\frac{\text{Total Time Units}}{\text{Total Number of Visits}}$$

Table 3 provides a statistical analysis of the average time units appended per visits. Your average is compared to that of your state and the nation.

Table 3: Average Time Units Appended per Visits
January 1, 2016 – December 31, 2016

Total Time Units	Total Number of Visits	Your Average	Your State's Average	Comparison with Your State's Average	National Average	Comparison with the National Average
212.3	83	2.56	2.50	Higher	2.27	Significantly Higher

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

Percentage of Visits Billed without an Allowed Colonoscopy Claim

Medicare Part B claims were searched for colonoscopy services CPT® codes 45300-45398, G0105, and G0121. Any beneficiary that did not have an allowed service for one of these CPT® codes on the date of service of the anesthesiology service, was flagged as a visit without an allowed colonoscopy service.

The percentage of visits without an allowed colonoscopy claim is calculated as follows:

$$\left(\frac{\text{Number of Visits without Colonoscopy}}{\text{Total Number of Visits}} \right) \times 100$$

Table 4 provides a statistical analysis of the percentage of visits without an allowed colonoscopy claim. Your percentage is compared to that of your state and the nation.

Table 4: Percentage of Visits without an Allowed Colonoscopy Claim
January 1, 2016 – December 31, 2016

Visits without Colonoscopy	Total Number of Visits	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
1	83	1%	7%	Does Not Exceed	4%	Does Not Exceed

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

Percentage of Visits with Modifier AA

The national and state percentages of visits appended with modifier AA is based only on those claim lines where the rendering NPI's specialty is a physician. All claim lines with a specialty of '32', '43', '50', '80', '97' were removed from calculations of the peer percentages; however, the individual provider (regardless of the specialty) was compared to those peer values. The percentage of visits appended with modifier AA is calculated as follows:

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

Table 5 provides a statistical analysis of the percentage of visits appended with modifier AA. Your percentage is compared to that of your state and the nation.

Table 5: Percentage of Visits Appended with Modifier AA
January 1, 2016 – December 31, 2016

Visits with Modifier AA	Total Number of Visits	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
76	83	92%	27%	Significantly Higher	47%	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for Anesthesia are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201705-recommended-links>.

LCDs:

- First Coast Service Options – LCD L33595
- Noridian Healthcare Solutions – LCD L34100
- Novitas Solutions – LCD L35049

University of Connecticut:

- Anova, Regression, and Chi-Square
- t-Test

Affordable Care Act:

- Section 4104 – Removal of Barriers to Preventive Services in Medicare

Medicare Manual:

- *Medicare Claims Processing Manual*
 - Chapter 12 – Section 50
 - Chapter 14 – Section 10.4

Centers for Medicare & Medicaid Services:

- *Medicare Fee-for-Service 2015 Improper Payments Report*
- *Medicare Fee-for-Service 2016 Improper Payments Report*

Kaiser Family Foundation

- Coverage of Colonoscopies Under the Affordable Care Act's Prevention Benefit

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 CBR201705 webinar on July 12, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201705-webinar>.

If you are unable to attend, you may access a recording of the CBR201705 webinar five business days following the event at <http://www.cbrinfo.net/cbr201705-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.

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

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