Comparative Billing Report

eGlobalTech

September 11, 2017

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

CBR#: CBR201708
Topic: Modifier 25: Dermatology
NPI#:1111111111
Fax#: (888)555-5555

Questions: Contact CBR Support
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Write to the return address above

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ANYTOWN, XX 55555-4444

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,

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Modifier 25: Dermatology

Introduction

CBR201708 focuses on physicians with a specialty of dermatology who submitted claims for established patient evaluation and management (E/M) services appended with modifier 25. Specifically, this CBR examines Current Procedural Terminology (CPT®) codes 99211 - 99215. The *CPT® 2016 Professional Edition (CPT® 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."

According to the *Medicare Quarterly Provider Compliance Newletter* (Volume 1, Issue 2 – February 2011), "Reviews by Recovery Auditors determined that providers are incorrectly billing E/M services provided by the surgeon the day before, the day of, and up to 90 days after major surgery, and 0-10 days after minor surgery." The OIG included E/M services during a global period in their FY 2012 and FY 2013 work plans.

Table 1 provides abbreviated descriptions for CPT® codes 99211 - 99215, as well as the typical times 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

This report is an analysis of established E/M services focusing on the following metrics:

- Percentage of services appended with modifier 25
- Average 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 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.

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 1 of the *National Correct Coding Initiative (NCCI) Policy Manual*, the use of modifier 25 applies to E/M services performed on the same day as minor procedures with global periods of 10 days or less. The modifier may also be appended to E/M services performed on the same date as services such as mole or actinic keratosis removals.

Per the *NCCI Policy Manual*, "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 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.

Chapter 1, Section E of the *NCCI Policy Manual* states the following regarding the Healthcare Common Procedure Coding System (HCPCS): "A modifier should not be appended to HCPCS/CPT® code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use."

Information on selecting the proper level of E/M code can be found in Chapter 12 Section 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.

Methods & Results

This report is an analysis of providers submitted as the "Rendering NPI" on Medicare Part B claims extracted from the Integrated Data Repository (IDR) based on the latest version of claims as of July 11, 2017. The analysis includes claims with dates of service from April 1, 2016 to March 31, 2017 and includes only those claim lines where the rendering NPI specialty is denoted as dermatology (07).

Table 2 provides a summary of your utilization of the CPT® codes and modifiers included in this CBR. The total allowed charges, allowed services, distinct visit count, and distinct beneficiary count are included for each CPT® code and modifier type. In addition, an overall "Total" row is included.

Table 2: Summary of Your Utilization of E/M Codes and Modifier 25
Dates of Service: April 1, 2016 – March 31, 2017

CPT®	Type	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
99211	With Mod 25	$33	1	1	1
99211	Without Mod 25	0	0	0	0
99212	With Mod 25	$300	6	6	6
99212	Without Mod 25	$260	4	4	4
99213	With Mod 25	$48,194	540	540	274
99213	Without Mod 25	$57,400	670	670	308
99214	With Mod 25	$2,676	22	22	19
99214	Without Mod 25	$6,799	53	53	39
99215	With Mod 25	$0	0	0	0
99215	Without Mod 25	$0	0	0	0
Total		**$115,662**	**1,295**	**1,295**	**422**

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the beneficiary and visit counts are unduplicated counts for each row and the total. For example, a beneficiary of multiple services with different CPT® codes and/or modifier types within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

There are over 11,800 dermatologists nationwide with allowed charges for the CPT® codes included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the modifier 25 related measurements studied and also were near or above the 50th percentile in allowed charges ($45,000), with at least 50 beneficiaries during this one-year period.

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

- The **state** peer group is defined as all rendering Medicare dermatologists practicing in the individual provider's state with allowed charges for the procedure codes included in this study
- The **national** peer group is defined as all rendering Medicare dermatologists in the nation with allowed charges for the procedure codes included in this study

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

Percentage of Services Appended with Modifier 25

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

$$\left(\frac{\textbf{Number of Services with Modifier 25}}{\textbf{Total Number of Services}} \right) \textbf{x } 100$$

Table 3 provides a statistical analysis of the percentage of established E/M services appended with modifier 25. Your percentage is compared to that of your state and the nation.

Table 3: Percentage of Services Appended with Modifier 25
Dates of Service: April 1, 2016 – March 31, 2017

Type	Number of Services with Modifier 25	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
With Mod 25	569	1,295	44%	65%	Does Not Exceed	61%	Does Not Exceed

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

Average 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 minutes per code. The total minutes per code are summed by modifier designation (with modifier 25 and without modifier 25) and divided by the total number of visits for the modifier. 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:

$$\frac{\textbf{Total Minutes by Modifier Designation}}{\textbf{Total Number of Visits by Modifier Designation}}$$

Table 4 provides a statistical analysis of the average minutes per visit for claim lines with modifier 25 and without modifier 25. Your average is compared to that of your state and the nation.

Table 4: Average Minutes per Visit with Modifier 25 and without Modifier 25
Dates of Service: April 1, 2016 – March 31, 2017

Type	Total Minutes	Total Number Visits	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
With Mod 25	8,715	569	15.32	16.15	Does Not Exceed	16.27	Does Not Exceed
Without Mod 25	11,415	727	15.70	15.43	Significantly Higher	15.36	Significantly Higher

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

Average Allowed Charges per Beneficiary

The average allowed charges, regardless of the modifiers, per beneficiary is calculated for the one-year period as follows:

$$\frac{\textbf{Total Allowed Charges}}{\textbf{Total Number of Beneficiaries}}$$

Table 5 provides a statistical analysis of the average allowed charges per beneficiary to that of your state and 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
Dates of Service: April 1, 2016 – March 31, 2017

Type	Total Charges	Total Number Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
Charges	$115,662	422	$274.08	$150.94	Significantly Higher	$122.70	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for Modifier 25: Dermatology are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at http://www.cbrinfo.net/cbr201708-recommended-links.

Medicare Manuals:

- *Medicare Claims Processing Manual*, Chapter 12, Section 30.6
- *National Correct Coding Initiative Policy Manual,* Chapter 1, Sections D, E

Centers for Medicare & Medicaid Services:

- *Medicare Quarterly Provider Compliance Newletter* (Volume 1, Issue 2 – February 2011)

Office of Inspector General:

- *OIG 2012 Work Plan*
- *OIG 2013 Work Plan*

American Medical Association:

- *CPT® 2016 Professional Edition*
- *CPT® 2017 Professional Edition*

University of Connecticut:

- For background on the statistical tests used in this CBR, the University of Connecticut provides resources for the t-test and the chi-square test at: http://researchbasics.education.uconn.edu/

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 CBR201708 webinar on October 11, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at http://www.cbrinfo.net/cbr201708-webinar.

If you are unable to attend, you may access a recording of the CBR201708 webinar five business days following the event at http://www.cbrinfo.net/cbr201708-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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