

Comparative Billing Report



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

ORGANIZATION NAME
FULL NAME
123 STREET LANE
SUITE 4000
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,

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

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

November 6, 2017

CBR#: CBR201709
Topic: Emergency Department Services
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

This page is left blank intentionally

This page is left blank intentionally

Comparative Billing Report (CBR): NPI 1111111111 Emergency Department Services

Introduction

CBR201709 focuses on providers of all specialties who submitted claims for emergency department services using Current Procedural Terminology (CPT®) codes 99281 through 99285.

Based on the *Medicare Fee-for-Service 2016 Improper Payments Report*, emergency department services had a 12.4 percent improper payment error rate with a projected improper payment amount of \$268 million. Emergency department services submitted with CPT® code 99285 had an improper payment rate of 6.4 percent.

According to an OIG report titled **Coding Trends of Evaluation and Management Services**, physicians have shifted their billing of emergency department services from lower level to higher level codes over time. Per the report, from 2001 to 2010, “Physicians’ billing of the highest level code (99285) rose 21 percent, increasing from 27 to 48 percent. During the same time, physicians’ billing of all other codes decreased. Physicians billed the lowest level code (99281) less than 3 percent of the time.”

Table 1 provides the key components for the CPT® codes for emergency department services.

Table 1: CPT® Codes, History/Examination, and Medical Decision Making

CPT® Code	History/Examination	Medical Decision Making
99281	Problem Focused	Straight Forward
99282	Expanded Problem Focused	Low Complexity
99283	Expanded Problem Focused	Moderate Complexity
99284	Detailed	Moderate Complexity
99285	Comprehensive	High Complexity

CPT® codes and descriptors are copyright 2016/2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

This report is an analysis of emergency department services focusing on the following metrics:

- Percentage of services billed with CPT® code 99285
- Percentage of services appended with modifier 25
- Average allowed charges for all Medicare Part B services per visit

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.

In the absence of a National Coverage Determination (NCD) or LCD, MACs determine if an item or service is reasonable and necessary based on the guidelines outlined in the *Medicare Program Integrity Manual* (Chapter 3, Section 3.6.2.2). Service is considered “reasonable and necessary if the item or service meets the following criteria:

- It is safe and effective;
- It is not experimental or investigational; and
- It is appropriate, including the duration and frequency in terms of whether the service or item is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary’s condition or to improve the function of a malformed body member;
 - Furnished in a setting appropriate to the beneficiary’s medical needs and condition;
 - Ordered and furnished by qualified personnel; and,
 - One that meets, but does not exceed, the beneficiary’s medical need.”

Title XVIII of the Social Security Act [Section 1862 (a) (1) (A)] excludes incurred items or services which “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Basic Coverage Criteria

Medicare prohibits payment for any claim which lacks the necessary information to process a claim. Guidelines on selecting the appropriate evaluation and management (E/M) codes can be found in the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.1), which state: “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.”

Per the *NCCI Policy Manual* (Chapter 1, Section E), “ Modifier 25 should only be appended to the claim when the evaluation and management performed was over and above what would normally be required for the procedure.” The service should be significant and separately identifiable, and should be performed by the same provider on the same day of the procedure or other service.

History, physical exam, and medical decision making are the key requirements for emergency department services. These components should be based on the urgency of the patient’s clinical condition and/or mental status. This concept is known as the “acuity caveat” or the emergency medicine caveat. Documentation should include differential diagnoses, procedures, diagnostic studies, interventions, and risk factors if the provider is unable to obtain the history. Depending on the patient’s emergency situation and acuity level, emergency department providers may order additional tests and/or procedures at the time of the visit; however, these services must be beyond what is bundled in with a procedure code and the provider should include documentation that the services are medically necessary.

Time is not used in the descriptive CPT® definition of emergency department E/M services. These services typically have varying intensity. Since emergency room providers usually have multiple encounters with a number of patients over an extended period of time, it may be difficult for them to provide an accurate account of face-to-face time with the patient.

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 September 12, 2017. The analysis includes claims with dates of service from July 1, 2016 to June 30, 2017.

Table 2 provides a summary of your utilization of the CPT® codes included in this CBR. The total allowed charges, allowed services, distinct visit count, and distinct beneficiary count are included for each CPT® code. A visit is defined as a single date of service for each beneficiary. In addition, an overall “Total” row is included.

Table 2: Summary of Your Utilization of Emergency Department Services
Dates of Service: July 1, 2016 – June 30, 2017

CPT® Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
99281	\$0	0	0	0
99282	\$0	0	0	0
99283	\$5,536	92	92	86
99284	\$15,418	135	135	129
99285	\$60,271	358	358	343
Total	\$81,225	585	585	529

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 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 130,000 providers 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 measurements studied, and also were near or above the 80th percentile in allowed charges (\$50,000), with at least 200 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 providers 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 providers in the nation with allowed charges for the procedure codes included in this study

Your metrics were compared to your state (NJ) 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 Billed with CPT® Code 99285

The percentage of services billed with CPT® code 99285 is calculated as follows:

$$\left(\frac{\text{Number of Services with CPT® Code 99285}}{\text{Total Number of Services}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of emergency department services billed with CPT® code 99285. Your percentage is compared to that of your state and the nation.

Table 3: Percentage of Services Billed with CPT® Code 99285
Dates of Service: July 1, 2016 – June 30, 2017

Number of Services with CPT® Code 99285	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
358	585	61%	61%	Does Not Exceed	55%	Significantly Higher

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

Percentage of Services Appended with Modifier 25

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

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

Table 4 provides a statistical analysis of the percentage of emergency department services appended with modifier 25. Your percentage is compared to that of your state and the nation.

Table 4: Percentage of Services Appended with Modifier 25
Dates of Service: July 1, 2016 – June 30, 2017

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
221	585	38%	9%	Significantly Higher	11%	Significantly Higher

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

Average Allowed Charges for all Medicare Part B Services per Visit

The average allowed charges of all Medicare Part B services per visit submitted by the same provider on the same date of service as the emergency department (ED) service is calculated as follows:

$$\frac{\text{Total Allowed Charges For All Part B Services at ED}}{\text{Total Number of Visits}}$$

Table 5 provides a statistical analysis of the average allowed charges of all Medicare Part B services per visit. Your average is compared to that of your state and the nation.

Table 5: Average Allowed Charges of All Medicare Part B Services per Visit
Dates of Service: July 1, 2016 – June 30, 2017

Total Charges All Part B Services	Total Number Visits	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
\$84,385.39	585	\$144.25	\$156.99	Does Not Exceed	\$143.74	Higher

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

References & Resources

The coverage and documentation guidelines for emergency department services are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201709-recommended-links>.

Social Security Act:

- Title XVIII, Section 1862 (a) (1) (A)

Medicare Manuals:

- *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1
- *Medicare Program Integrity Manual*, Chapter 3, Section 3.6.2.2

Office of Inspector General:

- Coding Trends of Evaluation and Management Services

Centers for Medicare & Medicaid Services:

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

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 CBR201709 webinar on December 13, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201709-webinar>.

If you are unable to attend, you may access a recording of the CBR201709 webinar five business days following the event at <http://www.cbrinfo.net/cbr201709-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:

CBR Program
eGlobalTech
7127 Ambassador Road, Suite 150
Baltimore, MD 21244