

Comparative Billing Report



Comparative Billing Report Program
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CBR#: CBR201807
Licensed Clinical Social Workers
NPI#: 1111111111
Fax#: (888)555-5555

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Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430
M-F 9:00 a.m. – 5:00 p.m. ET
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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 or referral patterns compared to your peers' patterns for the same services in your state and nationwide. No reply is necessary as this report is for educational purposes.

Why did I get a CBR?

You received this CBR because your billing patterns differ from your peers' patterns within your state and/or across the nation. Receiving this CBR is not an indication or precursor to an audit for all recipients. Selected providers, however, may be referred for additional review and education. We hope the report assists you in identifying opportunities for improvement and helps you validate your current billing patterns.

Optional - Next Steps

- Contact your Medicare Administrative Contractor (MAC) for specific billing or coding questions
- Visit www.cbrinfo.net for additional resources
- Attend our free webinar September 12, 2018 from 3:00 p.m. – 4:00 p.m. ET. Space is limited so register early at www.cbrinfo.net/cbr201807-webinar
- If you are unable to attend the live webinar, a recording will be available within 5 business days following the event at www.cbrinfo.net/cbr201807-webinar

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Licensed Clinical Social Workers (LCSWs)

Introduction

CBR201807 focuses on licensed clinical social workers (LCSWs) who submitted claims for Medicare Part B services. According to the *2017 Medicare Fee-for-Service Supplemental Improper Payment Data* report, the improper payment rate was 18.3 percent for LCSWs, with nearly \$82 million in projected improper payments. The majority of the codes billed were for psychotherapy. The *Medicare Learning Network* publication, **Medicare Quarterly Provider Compliance Newsletter**, states that insufficient documentation of the amount of time spent with the patient for psychotherapy services was the main cause of payment errors. Other errors were attributed to insufficient documentation of the modalities involved, failure to document the patient's progress, and failure to update the treatment plan.

According to an August 2017 Office of Inspector General (OIG) announcement (**Medicare Part B Payments for Psychotherapy Services**), the OIG would review payments for psychotherapy services to "determine whether they were allowable in accord with Medicare documentation requirements." Per the announcement, Medicare allowed almost \$1.2 billion for psychotherapy services in calendar year 2016 and "allowed \$185 million in inappropriate outpatient mental health services, including psychotherapy." Their review found improper payments for almost half of the psychotherapy services.

Our analysis of claims for the period, January 1, 2017 to December 31, 2017, found that the charges per beneficiary for psychotherapy services provided by LCSWs are almost twice as high as the charges per beneficiary provided by psychiatrists.

Metrics

This report is an analysis of the following metrics:

- Average minutes per visit, individual psychotherapy
- Average number of visits per beneficiary for the one-year period
- Average charges per beneficiary for the one-year period

Table 1 provides abbreviated descriptions of the Current Procedural Terminology (CPT®) codes included in this CBR.

Table 1: CPT® Codes and Abbreviated Descriptions

CPT® Code	Abbreviated Description
90785	Interactive complexity
90791	Psychiatric diagnostic evaluation
90832	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes
90845	Psychoanalysis
90846	Family psychotherapy, 50 minutes
90847	Family psychotherapy including patient, 50 minutes
90853	Group psychotherapy

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

According to the *CPT® 2017 Professional Edition*, psychotherapy is defined as “the treatment of mental illness and behavioral disturbances in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.”

CPT® codes 90832, 90834, and 90837 describe psychotherapy with the patient. Psychotherapy is a time-based code with typical times listed as 30, 45, and 60 minutes, respectively. CPT® codes 90839 and 90840 are billed for crisis psychotherapy. Psychotherapy times are for face-to-face

services with the patient and/or family members. The patient must be present for all or the majority of the service. The description of these codes changed as of January 1, 2017. The words “and/or family” were removed from the descriptors and time was added to the family psychotherapy code descriptors to provide a clearer distinction between individual and family therapy.

Per the *MLN Matters*® article titled **Medicare Payments for Part B Mental Health Services**, the medical record should document chronologically the care of the patient. Documentation should include the reason for encounter, physical examination findings, prior diagnostic test results, assessment, clinical impression and diagnosis, a plan for care, the date, and legible identity of the observer. Documentation should also note the progress and response to any treatment changes. The codes reported on the claim must be supported by documentation in the medical record.

The *Medicare Benefit Policy Manual* (Chapter 15, Section 170) outlines the requirements for a LCSW as follows:

- Possess a master’s or doctor’s degree in social work
- Performed at least two years of supervised clinical social work
- Licensed or certified in the state where services are performed
- Has completed at least 2 years or 3,000 hours of post master’s degree supervised clinical social work if in a state that does not provide licensure or certification

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 based on the latest version of claims as of May 15, 2018. The analysis includes claims with dates of service from January 1, 2017 to December 31, 2017 where the rendering provider’s specialty is denoted as LCSW (80).

There are over 43,000 LCSWs nationwide with allowed charges for the CPT® codes included in this study. Criteria for receiving the CBR are:

- Provider is significantly higher in at least two of the peer comparisons
- Provider is near or above the 50th percentile in allowed charges (\$5,000)
- Provider had at least 10 beneficiaries

Table 2 provides a summary of your utilization for the CPT® codes included in this CBR.

Table 2: Mock Summary of Your Utilization
Dates of Service: January 1, 2017 – December 31, 2017

CPT® Code	Allowed Charges	Allowed Services	Visits*	Beneficiary Count
90785	\$0	0	0	0
90791	\$2,426	24	24	24
90832	\$442	9	9	4
90834	\$28,435	435	435	33
90837	\$8,567	87	87	26
90839	\$0	0	0	0
90840	\$0	0	0	0
90845	\$0	0	0	0
90846	\$0	0	0	0
90847	\$741	9	9	5
90853	\$0	0	0	0
Total	\$40,611	564	564	40

* A visit is defined as a unique date of service between a beneficiary and a provider.

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the visit and beneficiary counts are unduplicated counts for each row and the total. For example, a beneficiary receiving 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.

Statistics were calculated for each provider and the two peer groups: all LCSWs in the nation billing the CPT® codes included in this study, and all LCSWs in your state (e.g., CA) billing these codes. Each provider's values are compared to his/her peer group values. 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

Table 3 presents the average minutes per individual psychotherapy visit. This metric is based on the typical times listed for CPT® codes 90832, 90834, 90837, 90839, and 90840.

Table 3: Mock Average Minutes per Psychotherapy Visit
Dates of Service: January 1, 2017 – December 31, 2017

Number of Minutes	Number of Psychotherapy Visits	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
25,065	564	44.16	55.75	Does Not Exceed	49.86	Does Not Exceed

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

Table 4 shows the average number of service dates, or visits per beneficiary for the one-year period, using the CPT® codes listed in Table 1.

Table 4: Mock Average Number of Visits per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Number of Visits	Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
564	40	14.10	10.89	Significantly Higher	9.75	Significantly Higher

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

Table 5 shows the average allowed charges per beneficiary for the one-year period, using the CPT® codes listed in Table 1.

Table 5: Mock Average Allowed Charges per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Charges	Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
\$40,611.09	40	\$1,015.28	\$956.74	Higher	\$724.38	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for LCSWs are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201807-recommended-links>.

Centers for Medicare & Medicaid Services:

- *2017 Medicare Fee-for-Service Supplemental Improper Payment Data*

Office of Inspector General:

- Medicare Part B Payments for Psychotherapy Services

Medicare Manuals:

- *Medicare Benefit Policy Manual, Chapter 15*

Medicare Learning Network:

- *Medicare Quarterly Provider Compliance Newsletter*
- *Medicare Payments for Part B Mental Health Services*

American Medical Association:

- *CPT® 2017 Professional Edition*