

RELI Group
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June 28, 2019

CBR #: CBR201907
Modifier 25: Dermatology

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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 the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

What is a CBR? A CBR is an educational tool that reflects your billing and/or prescribing patterns as compared to your peers' patterns for the same services in your state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities.

Why did I get a CBR? We are providing this report because your Medicare billing and/or prescribing patterns differ from your peers' patterns within your state/specialty and/or across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.

To access an electronic copy of your CBR: [Visit the secure CBR portal](https://cbrfile.cbrpepper.org) at <https://cbrfile.cbrpepper.org>.

Please visit the [CBR Website](https://cbr.cbrpepper.org) at <https://cbr.cbrpepper.org>, for a recorded webinar and additional resources.

To request assistance or submit questions: [Contact the CBR Help Desk](https://cbr.cbrpepper.org/Help-Contact-Us) at <https://cbr.cbrpepper.org/Help-Contact-Us> or call 1-800-771-4430 (M–F, 9 a.m.–5 p.m. ET).

Sincerely,

The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- [National Plan and Provider Enumeration System](https://nppes.cms.hhs.gov/#/) (NPPES): <https://nppes.cms.hhs.gov/#/>
- [Provider Enrollment, Chain, and Ownership System](https://pecos.cms.hhs.gov/pecos/login.do#headingLv1) (PECOS): <https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>



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Comparative Billing Report (CBR) 201907

June 28, 2019

Modifier 25: Dermatology

Introduction

CBR201907 focuses on rendering providers with a specialty of dermatology who submitted claims to Medicare Part B for established patient evaluation and management services (CPT® codes 99211-99215) with a modifier 25. These services will be referred to as “evaluation and management” or “E/M” for the purpose of this document. According to the “Medicare Fee-for-Service Supplemental Improper Payment Data” reports from 2017 and 2018, the projected improper payment rate for dermatology office visits increased from 3.4 percent in 2017 to 15.7 percent in 2018. The same report showed an increase in overall dermatology improper payment rates from 2.4 percent in 2017 to 7.2 percent in 2018. This represents an increase of payments from \$68,407,080 in 2017 to \$181,187,310 in 2018, a growth of \$112,780,230 in one year.

The criteria for receiving a CBR is that a provider:

1. Is significantly higher compared to either state or national averages or percentages in any of the three metrics (greater than the 90th percentile), and
2. Has at least 50 beneficiaries with claims submitted for 99211, 99212, 99213, 99214 or 99215, and
3. Has at least \$43,000 or more in total allowed charges.

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).

For the purposes of this CBR, dermatology services for established patient office visits were reviewed. The CPT® codes for these services are 99211, 99212, 99213, 99214, and 99215. The codes are part of the evaluation and management CPT® code set, and the following information should be included in the documentation of established patient evaluation and management codes:

- History
- Exam
- Medical Decision Making

According to the *CPT® 2017 Professional Edition*, modifier 25 is utilized to identify a “significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.”

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

The NCCI Policy Manual advises: “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 about selecting the proper level of evaluation and management 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 evaluation and management services documentation components may be used to support the performance of the procedure. Providers can audit their own medical records to determine whether they meet the requirements by using a marker to eliminate the documentation for the procedure or other services (including any related evaluation and management service) from the note. The remaining documentation should be enough to support a significant level of service.

Table 1 identifies CPT® codes that may be reported for established patient evaluation and management services, CPT® codes 99211-99215.

Table 1: CPT® Code Descriptions

CPT® Code	History/Exam/Medical Decision Making Guideline and Time Descriptor
99211	Minimal; 5 minutes
99212	Problem-focused/Problem-focused/Straightforward; 10 minutes
99213	Expanded problem-focused/Expanded problem-focused/Low; 15 minutes
99214	Detailed/Detailed/Moderate; 25 minutes
99215	Comprehensive/Comprehensive/High; 40 minutes

All patient documentation must support the assigned code for the level of patient encounter, using either the 1995 or 1997 guidelines to assign the code level.

Table 2 identifies a summary of your statistics for CPT® codes used to report evaluation and management services to established patients, with and without modifier 25.

**Table 2. Summary of Your Utilization of CPT® Codes for 99211-99215
Between Feb. 1, 2018 – Jan. 31, 2019**

CPT® Code	Type	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count*
99211	With Mod 25	\$0.00	0	0	0
99211	Without Mod 25	\$0.00	0	0	0
99212	With Mod 25	\$14,328.28	350	350	330
99212	Without Mod 25	\$81.26	2	2	2

CPT® Code	Type	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count*
99213	With Mod 25	\$309,331.94	4,531	4,531	2,991
99213	Without Mod 25	\$72,795.38	1,068	1,068	969
99214	With Mod 25	\$0.00	0	0	0
99214	Without Mod 25	\$0.00	0	0	0
99215	With Mod 25	\$0.00	0	0	0
99215	Without Mod 25	\$0.00	0	0	0
Total		\$396,536.86	5,951	5,951	3,707

* A visit or beneficiary is counted once per row of CPT® code level. The totals for “Visit Count” and “Beneficiary Count” are not sum totals; they represent distinct visits and unique beneficiaries for all the CPT® codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Percentage of services appended with modifier 25
2. Average minutes per visit for claim lines with modifier 25 and without modifier 25
3. Average allowed charges per beneficiary summed for one-year period, regardless of the modifiers appended to the claim lines.

The CBR team identified the services for established patient evaluation and management visits, with Medicare Part B claims submitted by dermatologists. Statistics were calculated for each provider, all providers in the state, and all providers in the nation.

- 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.

Each provider’s values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state (State) and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider’s value is above the 90th percentile from the state or national mean.
2. Higher — Provider’s value is greater than the state or national mean.
3. Does Not Exceed — Provider’s value is not higher than the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

Methods and Results

This report is an analysis of rendering providers in the dermatology specialty who submitted CPT® codes 99211, 99212, 99213, 99214, and 99215 on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims as of May 24, 2019. The analysis includes claims with dates of service from Feb. 1, 2018 through Jan. 31, 2019. For the trend analysis (Figure 1), claims represent dates of service between Feb. 1, 2016 and Jan. 31, 2019.

There are 12,226 rendering providers, nationwide with allowed charges for CPT® codes 99211, 99212, 99213, 99214, and 99215, billing a combined allowed amount of \$732.8 million for 5.4 million beneficiaries during the timeframe.

Metric 1: Percentage of Services Appended with Modifier 25

Metric 1 is calculated as follows:

- The number of evaluation and management services (99211-99215) with modifier 25 (numerator), is divided by the total number of evaluation and management services with CPT® codes 99211-99215 (denominator), and services are defined as total allowed units.

Table 3: Your Percentage of Services Appended with Modifier 25

Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
82.02%	57.81%	Significantly Higher	54.90%	Significantly Higher

Metric 2: Average Minutes per Visit with Modifier 25 and without Modifier 25

Metric 2 is calculated as follows:

A visit is defined as a single date of service by beneficiary. Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code description, found in Table 1. This value is multiplied by the total allowed services for the code to arrive at the total minutes. Generally, the total number of visits is equal to the total number of services by modifier designation. However, if multiple services were allowed for a particular beneficiary and date of service, then these services would be counted as one visit. The average minutes allowed per visit are calculated as follows:

- The total minutes with modifier 25 (numerator) is divided by the total number of visits by modifier designation (denominator)
- The total minutes without modifier 25 (numerator) is divided by the total number of visits by modifier designation (denominator).

Table 4: Your Average Minutes per Visit for Claim Lines with Modifier 25 and without Modifier 25

Type	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
With Mod 25	14.64	17.05	Does Not Exceed	16.76	Does Not Exceed
Without Mod 25	14.99	16.10	Does Not Exceed	15.95	Does Not Exceed

Metric 3: Average Allowed Charges per Beneficiary

Metric 3 is calculated as follows:

- The total allowed charges of evaluation and management claim lines of all Medicare Part B established patient evaluation and management visits (numerator) is divided by the total number of beneficiaries (denominator).

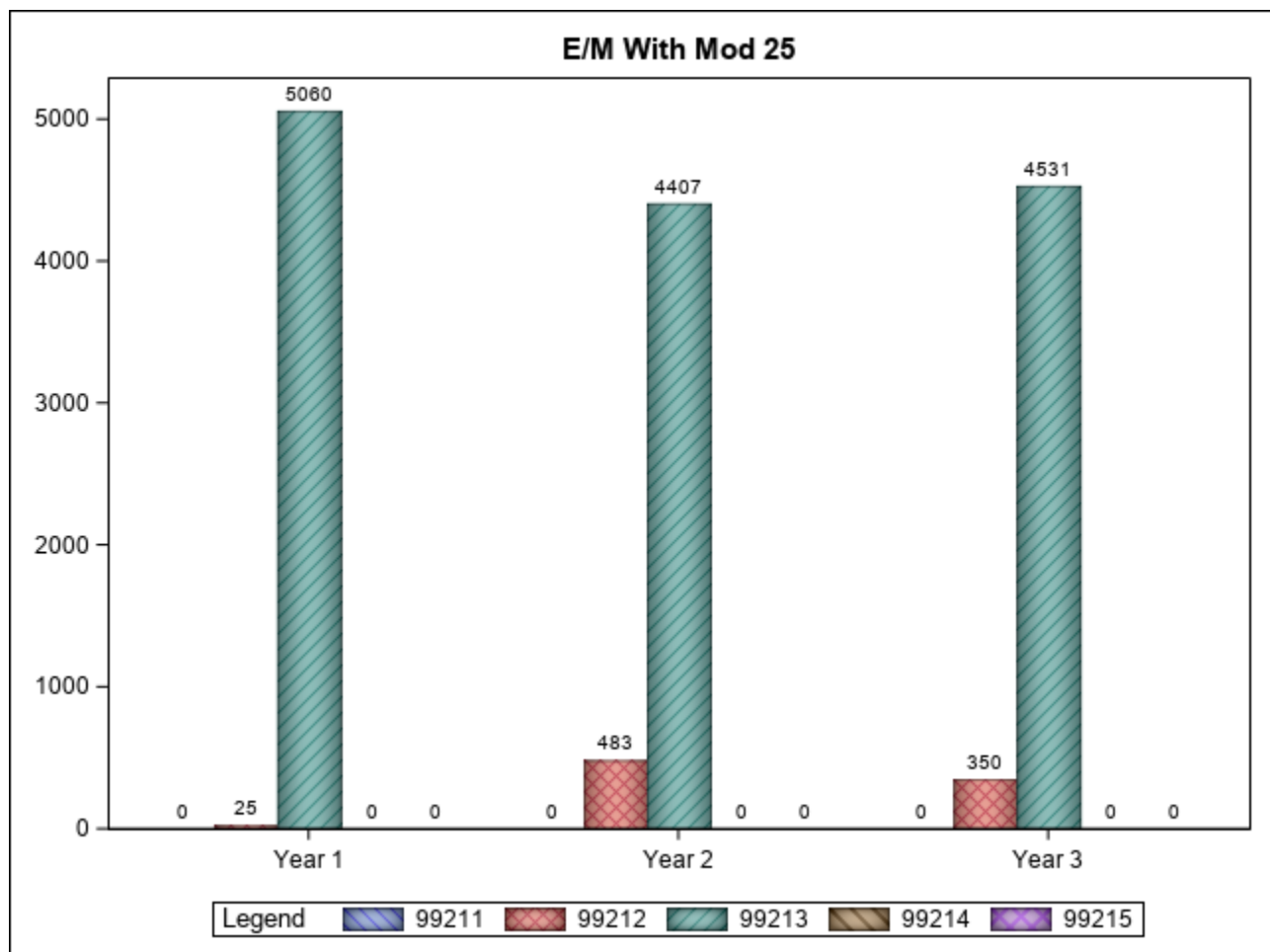
Table 5: Your Average Allowed Charges per Beneficiary

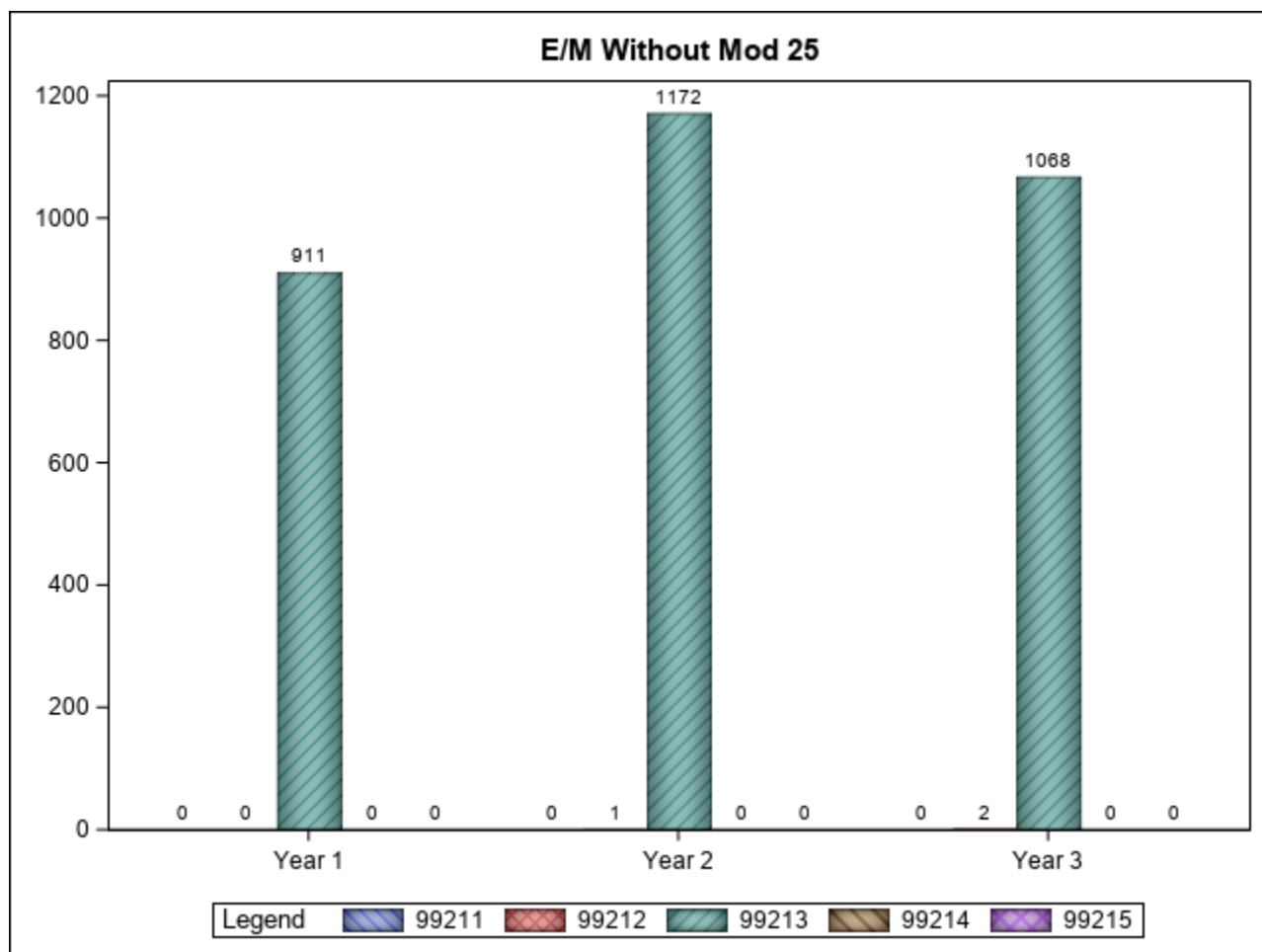
Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
\$106.97	\$118.94	Does Not Exceed	\$123.60	Does Not Exceed

Figure 1 illustrates the trend over time of services (units) for CPT® codes 99211, 99212, 99213, 99214 and 99215:

- Year 1: Feb. 1, 2016 – Jan. 31, 2017
- Year 2: Feb. 1, 2017 – Jan. 31, 2018
- Year 3: Feb. 1, 2018 – Jan. 31, 2019

Figure 1: Your Trend Over Time Analysis of Services





References and Resources

[2018 Medicare Fee-for-Service Supplemental Improper Payment Data](#)

[NCCI Policy Manual](#)

CPT® 2017 Professional Edition