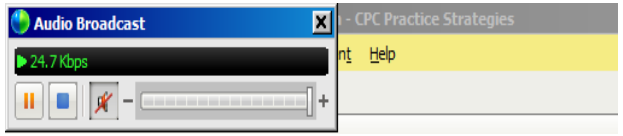
Thank you for joining us!

- We will start at 3 p.m. ET.
- You will hear silence until the session begins.
- Handout: Available at CBR.CBRPEPPER.org.
- A recording of today's session will be posted at the above location within two weeks.

- Please listen in by either:
  - Using your computer speakers (recommended): You automatically join the audio broadcast when entering the meeting (remember to increase your speaker volume; make sure you are not muted).



  - Dialing 1-415-655-0001 (passcode 736 893 203) (limited to 500 callers).

CBR201907 Modifier 25: Dermatology

July 10, 2019, 3 p.m. ET

About Today's Presentation

Phone lines will be muted the entire duration of the training.

Submit questions pertinent to the webinar using the Q&A panel.

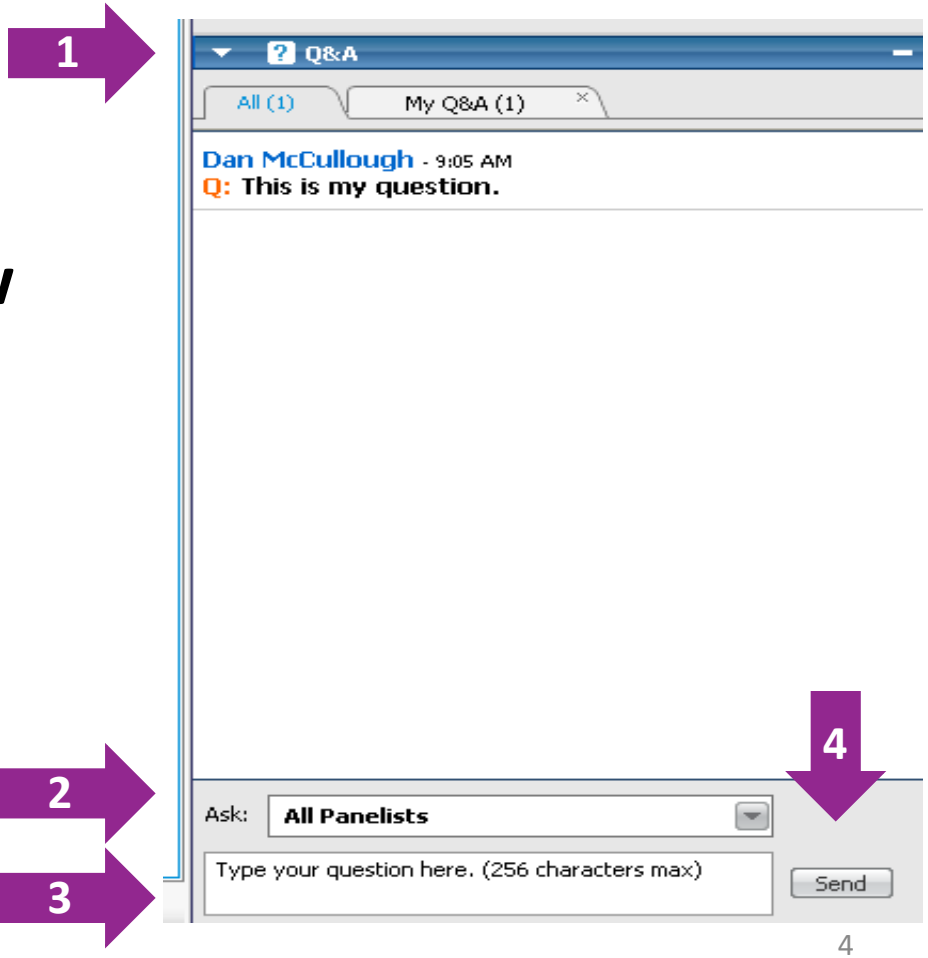
Questions will be answered verbally, as time allows, at the end of the session.

A "Q&A" document will be developed and posted at CBR.CBRPEPPER.org.

To Ask a Question in Split Screen

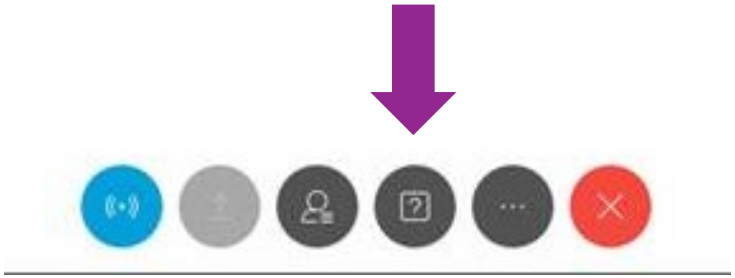
Ask your question in Q&A as soon as you think of it.

1. Go to the "**Q&A" window** located on the right side.
2. In the "Ask" box, select "All Panelists."
3. Type in your question.
4. Click the "**Send**" button.



To Ask a Question in Full Screen

1. Click on the “Q&A” button to bring up the Q&A window.
2. Type in your question (as in the previous slide).
3. Click the **“Send”** button.
4. Click “-” to close window to see full screen again.



Webinar Resources

Webinar Slides

Webinar Recording

Webinar Handout

Webinar Q&A will be posted at CBR.CBRPEPPER.org

CBR Help Desk: https://cbr.cbrpepper.org/Help-Contact-Us

Webinar Objective

- Understand the purpose and use of Comparative Billing Reports (CBRs).
- Comprehend the function of CBR201907: Modifier 25: Dermatology.
- Gather resources for further questions and inquiries.

Webinar Agenda

- What is a CBR?
- How to access your CBR
- Review a sample CBR
- CBR201907
- Helpful resources
- Questions

The CMS Definition of a CBR

- CBRs are free, comparative data reports.
- Centers for Medicare & Medicaid Services (CMS) defines a CBR as an educational resource and a tool for possible improvement.

History of the National CBR Program

The national CBR program is separate and not related to comparative billing reports that are produced by Medicare Administrative Contractors (MACs) in support of their individual provider education activities.

2010

- CMS implemented a national program to produce and disseminate CBRs to physicians, suppliers, pharmacies, and other health care providers.

2018

- CMS combined the CBR and the Program for Evaluating Payment Pattern Electronic Reports (PEPPER) programs into one contract.

2019

- RELI Group and its partners—TMF Health Quality Institute and CGS—begin producing CBRs and PEPPERs.

Why does CMS issue CBRs?

CBRs provide value to both CMS and providers

Value to CMS

- Supports the integrity of claims submission
- Summarizes claims data
- Provides an educational resource for possible improvement by providing coding guidelines information

Value to Providers

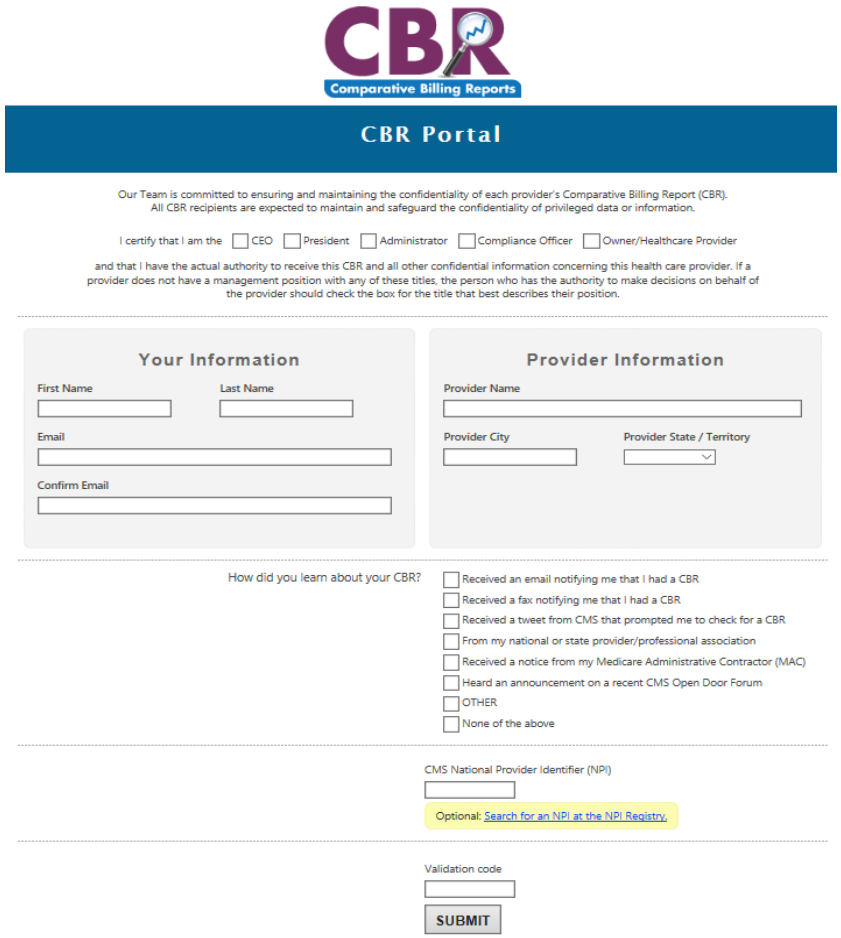
- Reflects providers' billing patterns as compared to their peers
- Provides specific coding guidelines and billing information
- Informs providers whose billing patterns differ from those of their peers

Why did I receive a CBR?

- A CBR was presented because your billing patterns differ from your peers' patterns, based on comparisons on a specialty or nationwide level.
  - Receiving a CBR is not an indication of or precursor to an audit.

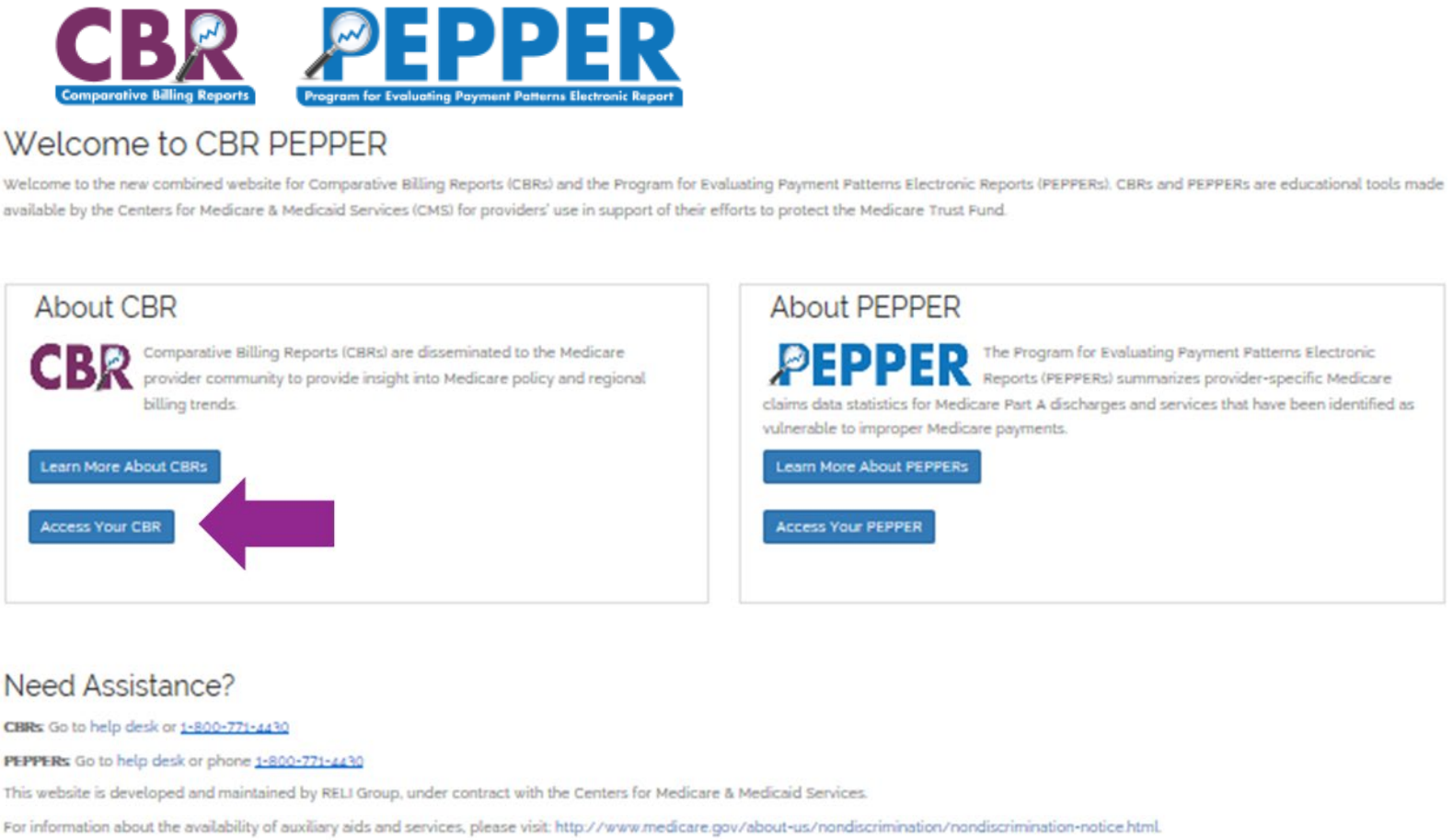
How to Access Your CBR

https://cbrfile.cbrpepper.org/



How to Access Your CBR

https://cbrpepper.org/



CBR 201907 Formatting

1. **Introduction**
   - Explanation of billing area and description of findings in the CBR
2. **Coverage and Documentation Overview**
   - Identification of claims data and CPT® code information
3. **Basic Coding Guidelines**
   - Itemization of CPT® codes and details of billing processes
4. **Metrics**
   - Explanation of the data and analysis used for the CBR
   - Detailed list of CPT® codes and the effect that the billing guidelines have on the CBR results
5. **Methods and Results**
   - Overall analysis results and individualized results comparing CBR recipients to other providers
6. **References and Resources**
   - Resources used for the CBR

CBR201907 Analysis and Focus

- CBR201907 summarizes statistics for services with dates of service from Feb. 1, 2018, through Jan. 31, 2019.
- 12,226 rendering providers billed allowed charges for dermatology services for established patient office visit codes.
- Analysis of rendering dermatology providers who billed CPT® codes 99211–99215 on Medicare Part B claims was extracted from the Integrated Data Repository, based on the latest version of claims as of May 24, 2019.

Dermatology Claims Vulnerability

2018 Medicare Fee-for-Service Supplemental Improper Payment Data Report

- Increase in improper payment rate for dermatology office visits:
  - 3.4 percent in 2017
  - 15.7 percent in 2018
- Increase in improper payment rates for overall dermatology services:
  - 2.4 percent in 2017
  - 7.2 percent in 2018
- Increase in payments of $112,780,230 in one year:
  - $68,407,080 in 2017
  - $181,187,310 in 2018

CBR201907 CBR Code Focus

- CBR201907 focuses on rendering providers who submitted claims to Medicare Part B for Dermatology Services for Established Patient Office Visits.

Dermatology Established Patient Office Visit Codes

- CPT® codes 99211, 99212, 99213, 99214, and 99215
- Submitted for Dermatology Services according to:
  - History
  - Exam
  - Medical decision-making
- A visit is defined as a single date of service for a beneficiary.

Use of Modifier 25

- The *CPT® 2019 Professional Edition* defines Modifier 25 as a "significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day of the procedure or other service."
- It should be used when the E/M service is above and beyond the usual pre- and post-operative work of a procedure.

Source: *CPT® 2019 Professional Edition*, American Medical Association

Use of Modifier 25, 2

- The *National Correct Coding Initiative (NCCI) Policy Manual* advises in Chapter 1:
  - 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.

Source: *National Correct Coding Initiative (NCCI) Policy Manual,* Centers for Medicare & Medicaid Services

Use of Modifier 25, 3

The *National Correct Coding Initiative (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."

Source: *National Correct Coding Initiative (NCCI) Policy Manual,* Centers for Medicare & Medicaid Services

Use of Modifier 25, 4

The *National Correct Coding Initiative (NCCI) Policy Manual* advises:

- 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.

Source: *National Correct Coding Initiative (NCCI) Policy Manual,* Centers for Medicare and Medicaid Services

Use of Modifier 25, 5

- The *National Correct Coding Initiative (NCCI) Policy Manual,* Chapter 1, Section E 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."

Source: *National Correct Coding Initiative (NCCI) Policy Manual,* Centers for Medicare & Medicaid Services

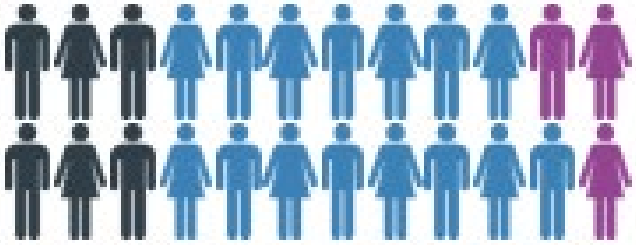
Use of Modifier 25, 6

- The *Medicare Claims Processing Manual,* Chapter 12, Section 30.6.1, advises the following regarding selecting the proper level of evaluation and management code:
  - "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 medical 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."

Source: *Medicare Claims Processing Manual*, Centers for Medicare & Medicaid Services

Peer Comparison Outcomes

- There are four possible outcomes for the comparisons between the provider and his/her peer groups:
  - **Significantly Higher** — A provider's value is above the 90th percentile from the peer specialty or national mean.
  - **Higher** — A provider's value is greater than the peer specialty or national mean.
  - **Does Not Exceed** — A provider's value is not higher than the peer specialty or national mean.
  - **N/A** — A provider does not have sufficient data for comparison.



The Criteria for Receiving a CBR201907

The criteria for receiving a CBR is that the provider:

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

About the 90th Percentile

- Statistics were calculated for each provider in three metrics, as well as for all providers in the nation. Each provider's values were compared to his/her peer specialty group's values, as well as the national values.
- Providers receiving a CBR have an outcome of "Significantly Higher" in any of the metrics.
- "Significantly Higher" means that a provider's value is above the 90th percentile from the peer specialty or national mean.
- These results look very different from the results of peers on a specialty or national level.

Metrics of Sample CBR

This report is an analysis of the following metrics:

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

Calculation of Metric 1

- The number of evaluation and management services (99211–99215) with Modifier 25, is divided by the total number of evaluation and management services with CPT® codes 99211–99215; services are defined as total allowed units:

$$\left(\frac{\text{Number of Services (CPT® code 99211-99215) with Mod 25}}{\text{Total Number of Evaluation and Management Services with CPT® code 99211-99215}}\right) \times 100$$

Calculation of Metric 2, Calculation 1

- The total minutes with Modifier 25 is divided by the total number of visits by modifier designation:

$$\frac{\text{Total Minutes with Mod 25}}{\text{Total Number of Visits by Modifier designation}}$$

Calculation of Metric 2, Calculation 2

- The total minutes without Modifier 25 is divided by the total number of visits by modifier designation:

$$\frac{\text{Total Minutes without Mod 25}}{\text{Total Number of Visits by Modifier designation}}$$

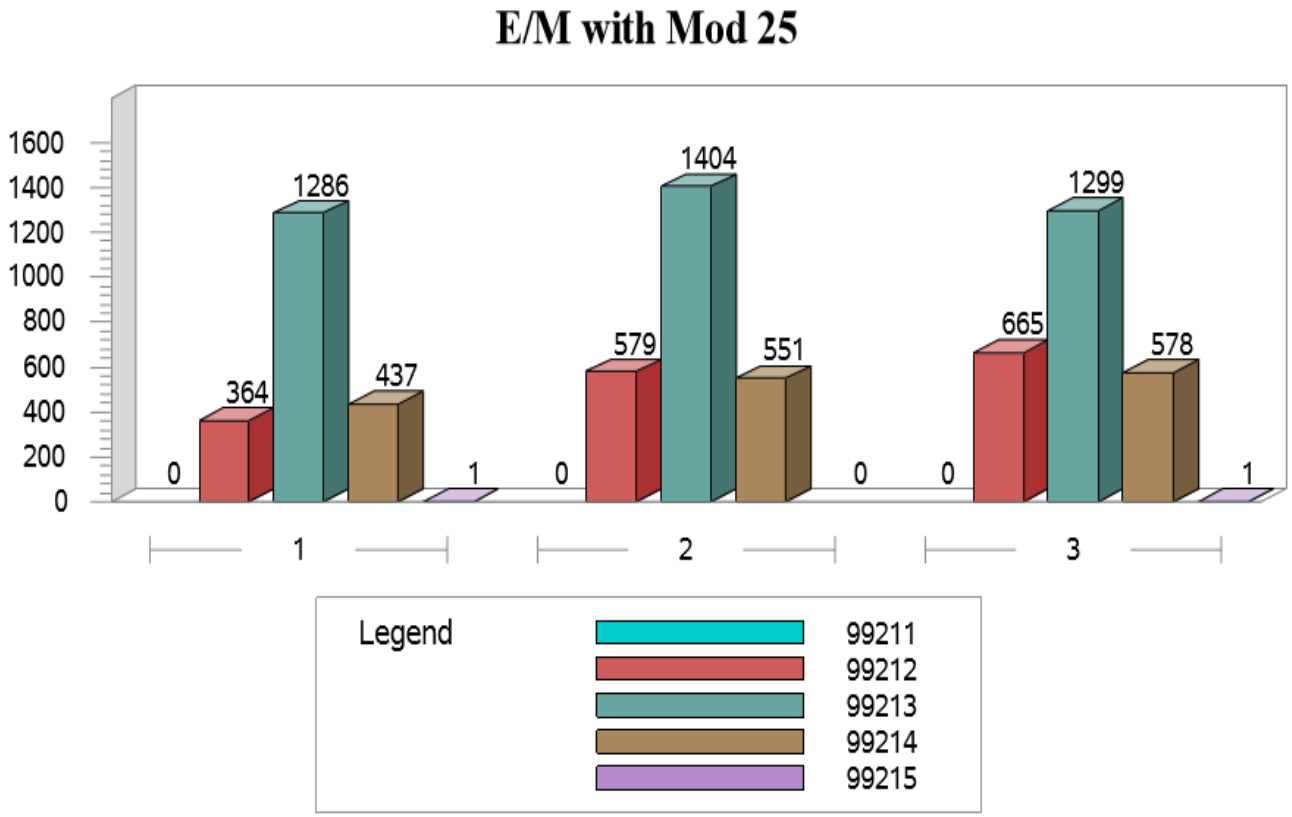
Calculation of Metric 3

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

$$\frac{\text{Total Allowed Charges of all Evaluation and Management Services}}{\text{Total Number of Beneficiaries}}$$

Provider Trends

Figure 1: Trend Over Time Analysis of Services



Year 1

- Feb. 1, 2016 – Jan. 31, 2017;

Year 2

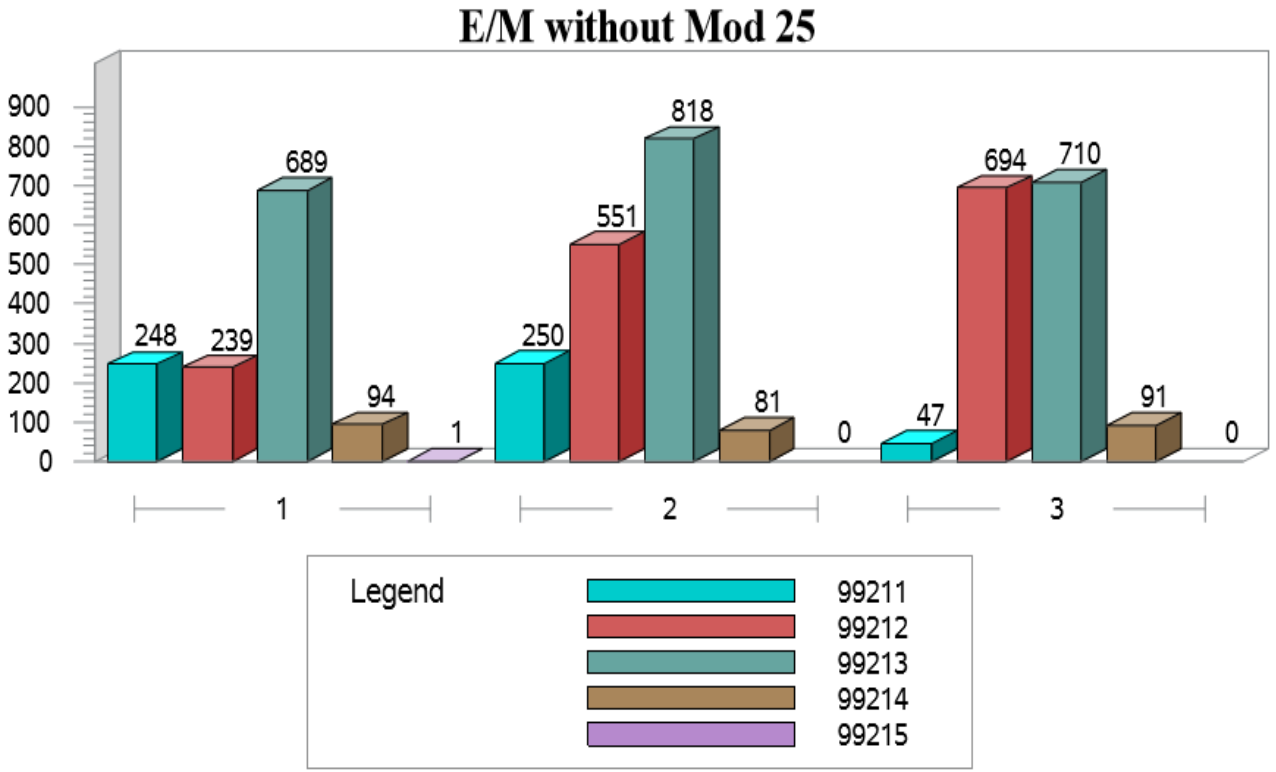
- Feb. 1, 2017 – Jan. 31, 2018;

Year 3

- Feb. 1, 2018 – Jan. 31, 2019

Provider Trends, 2

Figure 2: Trend Over Time Analysis of Services



Year 1

- Feb. 1, 2016 – Jan. 31, 2017;

Year 2

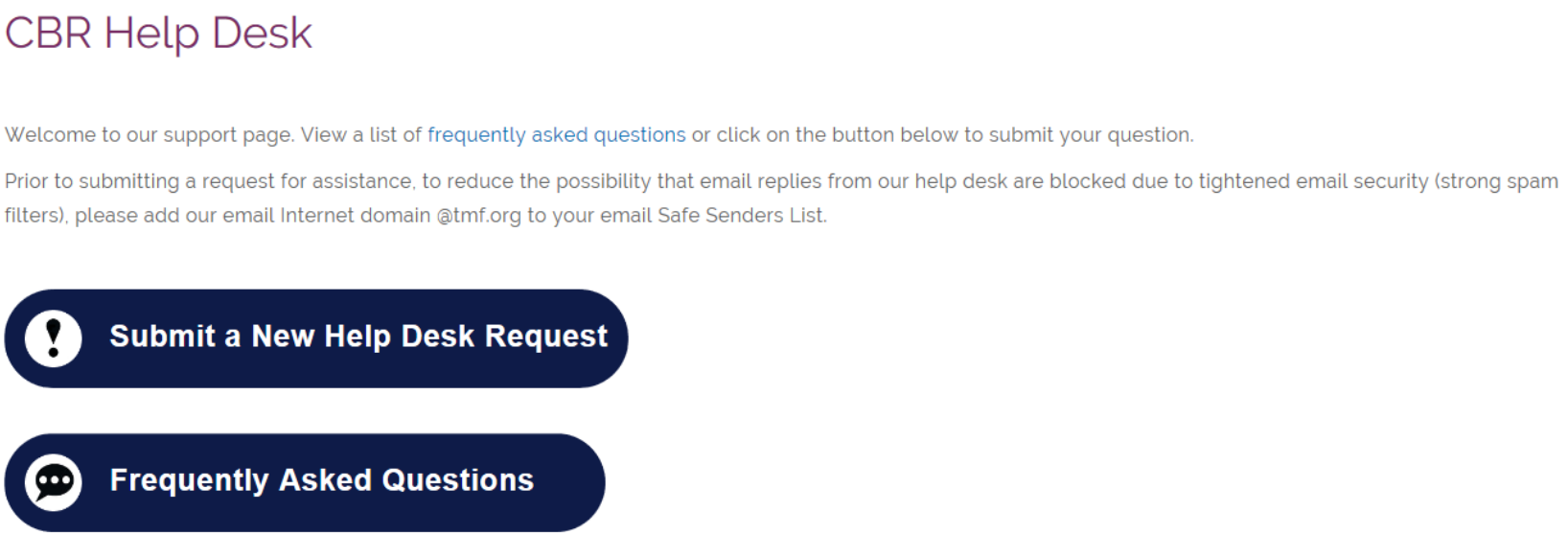
- Feb. 1, 2017 – Jan. 31, 2018;

Year 3

- Feb. 1, 2018 – Jan. 31, 2019

Helpful Resources

https://cbr.cbrpepper.org/Help-Contact-Us



Frequently Asked Questions

https://cbr.cbrpepper.org/FAQ

Frequently Asked Questions

The following questions represent frequently asked questions (FAQs) from the provider community about Comparative Billing Reports (CBRs) and the CBR project in general. FAQs pertaining to a specific CBR release/topic are available with the resources specific to each CBR release/topic.

- \+ What is a CBR?
- \+ Why am I getting this report?
- \+ I have a question about the CBR I received. Who should I contact?
- \+ Can I get specific claim data related to this report?
- \+ I have a question about my claims. Who should I contact?
- \+ I did not receive a CBR. Can I request one?
- \+ How will I know if I have a CBR available?
- \+ Is there a sample CBR that I can view?

Helpful Resources, 2

- 2018 Medicare Fee-for-Service Supplemental Improper Payment Data
- NCCI Policy Manual
- *CPT® 2017 Professional Edition*

Welcome to CBR Resources

This is the official site for information, training and support related to Comparative Billing Reports (CBRs).

CBRs are disseminated to the Medicare provider community to provide insight into Medicare policy and regional billing trends. The CBRs that are distributed to the provider community contain an analysis of billing practices across geographic and service areas. Medicare Administrative Contractors (MACs) have been producing and disseminating comparative billing reports to providers in their jurisdiction as part of their provider education efforts for many years. The Centers for Medicare & Medicaid Services (CMS) has formalized and expanded the program to the national level.

A CBR will present the results of statistical analyses that compare an individual provider's billing practices for a specific billing code or policy group with the billing practices of that provider's peer groups and national averages. Each CBR is unique to a single provider and is only available to that individual provider. CBRs are not publicly available.

Success stories: How your peers have used CBRs. Go to Success Stories

Upcoming Event: CBR0201906 Emergency Department Services

When: Tuesday, June 11, 2019
3:00 - 4:00 p.m. EDT
Topic: This session will review the Comparative Billing Report (CBR) 201906 on Emergency Department Services, released May 31, 2019.

CBR 201906:

Emergency Department Services

- Register for Upcoming Training
  When: Tuesday, June 11, 2019
  3:00 - 4:00 p.m. EDT
- Access Your CBR

CBR 201905:

Air Ambulance Transports

- Sample CBR: Mock Provider Data (PDF)
- Training: Recording and Handouts
- National/Specialty Data (XLSX)
- Access Your CBR

CBR 201904:

Vitamin D Testing

- Sample CBR: Mock Provider Data (PDF)
- Training: Recording and Handouts
- National/Specialty Data (XLSX)
- Access Your CBR

CBR 201903:

Subsequent Hospital Care

- Sample CBR: Mock Provider Data (PDF)
- Training: Recording and Handouts
- National/Specialty Data (XLSX)
- Access Your CBR

CBR 201902:

Office Visits, New and Established, Family Practitioners

- Sample CBR: Mock Provider Data (PDF)
- Training: Recording and Handouts
- National/State Data (XLSX)
- Access Your CBR

CBR 201901:

Intensity-Modulated Radiation Therapy

- Sample CBR: Mock Provider Data (PDF)
- Training: Recording and Handouts
- National/State Data (XLSX)
- Access Your CBR

Questions?