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CBR #: CBR202007
Therapeutic Injections and Infusions

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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 at https://cbrfile.cbrpepper.org/. Populate the fields, and in the "validation code" field, enter your unique validation code: 81CED8.

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org.

To request assistance or submit questions: Contact the CBR Help Desk 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 (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

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Therapeutic Injections and Infusions

Introduction

CBR202007 focuses on rendering providers that perform injection or infusion services on the same day as an evaluation and management (E/M) encounter. The CBR analysis reflects the submission of claims by providers for Current Procedural Terminology® (CPT®) codes for infusion or injection services, which includes CPT® codes 96365-96377.

In "Chapter XI: Medicine Evaluation and Management Services" of the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, the Centers for Medicare & Medicaid Services (CMS) states that "non-facility based E&M CPT® codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significantly and separately identifiable E&M service."

The *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 6.6% for office visits for all provider types, representing $1,017,331,298 in projected improper payments.

In "Chapter 12, Section 30" of the *Medicare Claims Processing Manual*, CMS provides the following guidance for the use of CPT® codes: "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. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national averages in any of the three metrics (i.e., greater than or equal to the 90th percentile), and
2. Has at least 30 total beneficiaries with claims for CPT® codes 96365-96377, and
3. Has at least $1,300 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 any coverage and documentation policies outlined by the Medicare Administrative Contractors' (MACs') Local Coverage Determinations.

Additional instruction about the guidelines for the assignment of the proper E/M code according to the service provided to the patient is provided in CMS' *Evaluation and Management Services Guide*.

Table 1 identifies the CPT® codes used in the CBR analysis.

Table 1: CPT® Code Descriptions

CPT® Codes	Description
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
+96366	Each additional hour (List separately in addition to code for primary procedure)
+96367	Additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
+96368	Concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
+96370	Each additional hour (List separately in addition to code for primary procedure)
+96371	Additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular
96373	Intra-arterial
96374	Intravenous push, single or initial substance/drug
+96375	Each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
+96376	Each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection

See Table 2 for a summary of your utilization of codes for therapeutic injection and infusion services: CPT® codes 96365-96377.

Table 2. Summary of Your Utilization of CPT® Codes for Therapeutic Injections and Infusion Services Between March 1, 2019, and Feb. 29, 2020.

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
96365-96377	$16,554	561	97

* The "Beneficiary Count" represents 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 claims for injections or infusions billed on the same day as an E/M encounter
2. Average allowed charge amount for injections or infusions billed with an E/M encounter
3. Percentage of beneficiaries who received an injection or infusion code and an E/M encounter on the same day

The CBR analysis focuses on providers that performed therapeutic injection or infusion services. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory 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 (TX) 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 greater than or equal to 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 less than or equal to the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

Methods and Results

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on June 23, 2020. The analysis includes claims with dates of service from March 1, 2019, through Feb. 29, 2020. For the trend analysis presented in Figure 1, claims represent dates of service between March 1, 2017, and Feb. 29, 2020.

There are 225,245 rendering providers nationwide who have submitted claims for therapeutic injection or infusion services. The total allowed charges for these claims were over $334 million during the analysis timeframe.

Metric 1: Percentage of Claims for Injections or Infusions Billed on the Same Day as an E/M Encounter

Metric 1 is calculated as follows:

- The count of unique claims where injection or infusion was billed on the same day as an E/M encounter is divided by the count of unique claims for injections or infusions. The result is multiplied by 100.

Table 3: Your Percentage of Claims for Injections or Infusions Billed on the Same Day as an E/M Encounter

Numerator	Denominator	Your Percentage	Your State Percentage	Comparison with Your State	National Percent	Comparison with National Percent
84	331	25.38%	55.31%	Does Not Exceed	50.05%	Does Not Exceed

Metric 2: Average Allowed Charge Amount for Injections or Infusions Billed with an E/M Encounter

Metric 2 is calculated as follows:

- The total allowed charge amount for injection or infusion services when an E/M encounter is billed on the same day is divided by the total unique claims when an injection or infusion was billed on the same day as an E/M encounter.

Table 4: Your Average Allowed Charge Amount for Injections or Infusions Billed with an E/M Encounter

Numerator	Denominator	Your Average	Your State Percentage	Comparison with Your State	National Percent	Comparison with National Percent
$4,317	84	$51.39	$19.69	Significantly Higher	$19.40	Significantly Higher

Metric 3: Percentage of Beneficiaries that Received an Injection or Infusion and E/M Encounter on the Same Day

Metric 3 is calculated as follows:

- The number of unique beneficiaries who received an injection or infusion on the same day as an E/M encounter is divided by the total number of unique beneficiaries who received an injection or infusion service. The result is multiplied by 100.

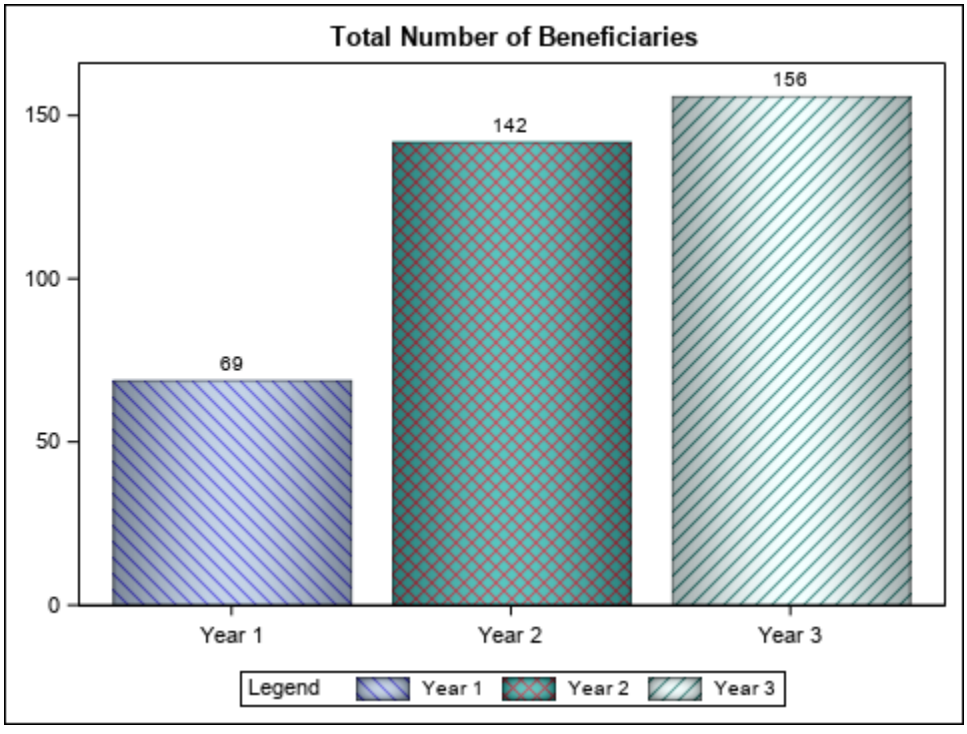
Table 5: Your Percentage of Beneficiaries Who Received an Injection or Infusion and E/M Encounter on the Same Day

Numerator	Denominator	Your Percentage	Your State Percentage	Comparison with Your State	National Percent	Comparison with National Percent
27	97	27.84%	84.62%	Does Not Exceed	79.70%	Does Not Exceed

Figure 1 illustrates number of total number of beneficiaries for whom CPT® Codes 96365-96377 were submitted. Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** March 1, 2017 – Feb. 28, 2018
- **Year 2:** March 1, 2018 – Feb. 28, 2019
- **Year 3:** March 1, 2019 – Feb. 29, 2020

Figure 1: Trend Over Time Analysis of Total Number of Beneficiaries for Whom CPT® Codes 96365-96377 Were Submitted



References and Resources

CPT® Professional Edition. American Medical Association.

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