eGlobalTech

CBR201601
Domiciliary Evaluation and Management Services
Webinar Questions and Answers

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INTRODUCTION

These questions are excerpted from the CBR201601 – Domiciliary Evaluation and Management (E/M) Services webinar. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides only or select a specific section of the webinar. All of these options are available from the CBR website page titled, CBR201601 Webinar Information (http://www.cbrinfo.net/cbr201601-webinar.html).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled, Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAAAA%3d%3d&

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

GENERAL

Q. What is a comparative billing report (CBR), and how does my practice get one? We share a Tax ID with a different institution and have had issues with getting our EOBs and other mailings.

A. Comparative Billing Reports (CBRs) are educational reports that provide comparative data on how an individual health care provider’s billing and payment patterns for specific topics compare to his/her peers. We are unable to produce CBRs on an ad-hoc basis by request; however, our support team can determine if a CBR was created for you. For assistance, contact the CBR Support Help Desk by telephone at 1-800-771-4430 or by email at
Q. How can I get a copy of the report before the webinar?
A. Our CBR website provides links to all of the CBR releases, as well as supplemental information. To review a copy of a mock provider’s CBR letter prior to or after the webinars, please visit our website at the following link: All CBR Releases.

Q. What are the goals of the CBR, and where can I find resources that have comprehensive tools and guides?
A. CBRs are disseminated to the provider community to provide insight into billing trends across regions and policy groups. CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance. References and resources for Domiciliary E/M Services are available at the following link: CBR201601 Recommended Links.

Q. How can administrative or coding personnel obtain data for these CBR reports?
A. A CBR letter is sent only to the individual provider. We do not share a provider’s information with anyone, as we want to ensure that we preserve privacy; however, providers are welcome to share their CBRs with their own healthcare organizations if they desire. If you need to change a fax number or mailing address for a CBR, please contact the CBR Support Help Desk by email at cbrsupport@eglobaltech.com or by telephone at (800) 771-4430.

Q. How can I locate LCD L33817 that was referenced in the letter?
A. First Coast Service Options (FCSO) LCD L33817 was effective on October 1, 2015 and can be found by entering the LCD number in the Document ID search on the Medicare Coverage Database (MCD) page. Current LCDs can be accessed from the following page: Medicare Coverage Database (MCD). ICD-9 LCDs and Articles are no longer displayed on the CMS MCD since they were retired on September 30, 2015. They are now available only from the MCD Archives found on the following website: MCD Archive Site.

Q. Do CBRs trigger audits?
A. CBRs do not trigger audits and are strictly for informational and educational purposes. The CBR team does not have access to medical records and does not conduct medical chart reviews. A CBR provides data concerning billing and payment patterns for specific services to individual health care providers so that they may assess how their own billing practices compare to that of their peers in their states and the nation. Providers may find data in the CBR useful for conducting self-audits of their procedures and billing practices and may benefit from the information available on the CBR website at the link, Self-Audit Help.
**CLINICAL & BILLING**

**Q. What are the documentation requirements for domiciliary services?**
A. Documentation for domiciliary E/M services must show that each, individual visit to the beneficiary is medically necessary, and should include how the visit will affect the plan of treatment. The record should also show the reason the physician visited the patient at home/domiciliary facility instead of the patient visiting the physician in the office. If home visits are being made in addition to regular office visits, the record must state why concurrent care is required. The provider should include information regarding coordination of care with an attending physician, a physical examination commensurate with the presenting problem and the results of any previous tests. See the following link for more information: [Medicare Claims Processing Manual, Chapter 12, Section 30.6.14.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf).

**Q. Can you bill domiciliary codes for beneficiaries living in apartments or in assisted living facilities?**
A. The CPT® codes listed in CBR201601 include the following places of service:
- 13 – Assisted Living Facility
- 14 – Group Home
- 33 – Custodial Care Facility
- 55 – Residential Substance Abuse Facility

If the beneficiary is living in a private residence that is not affiliated with any type of congregate living situation, codes from the home services category (CPT® 99341 – 99350) should be used. CPT® codes 99341 – 99345 describe new patient visits, and CPT® codes 99347 – 99350 describe established patient visits.

**Q. I am a psychiatrist formally trained to provide psychotherapy. CPT® code 90833 (psychotherapy by MD) is not payable without an additional E/M code. The lower E/M codes exist for the claims for assisted living facility is CPT® code 99334 (15 min visit). What other options do we have?**
A. Psychotherapy is payable without an evaluation and management code. CPT® code 90832 describes 30 minutes of psychotherapy with patient and/or family. CPT® code 90834 describes 45 minutes of psychotherapy with patient and/or family and CPT® code 90387 describes 60 minutes of psychotherapy with patient and/or family. None of these codes involve an additional E/M. According to the [CPT® 2014 Professional Edition](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf) manual, “Some psychiatric patients receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician or other qualified health care professional. To report both E/M and psychotherapy, the two services must be significant and separately identifiable.” When both services are reported, CPT® code 90833 is used for 30 minutes of psychotherapy with an E/M code, CPT® code 90836 is used for 45 minutes of therapy with an E/M code and CPT® code 90838 is used for 60 minutes of psychotherapy with an E/M code. When an E/M is billed on the same day as psychotherapy by the same provider, the type and level of E/M service is based on the key components of history, examination and medical decision making. The time associated with the E/M components is not included.
in the time billed for the psychotherapy service. The CPT® Manual can be accessed from the
American Medical Association (AMA) website at [AMA Store](https://commerce.ama-assn.org/store/).

**Q. Must all time spent with patients in domiciliary facilities be face-to-face time?**

A. According to documentation reviewed, domiciliary visits require providers to spend face-to-face time with their patients. The requirements for FCSO are documented in LCD L33817, which state the following: “Payment for this type of service is based on face-to-face time with the patient alone or with the patient and family or caregiver and the work performed during that time is documented in the chart, such as direct patient assessment, care coordination etc. Travel time and related expenses are not separately billable services.” Please follow this link for more information about face-to-face encounters: [LDC L33817](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33817&ContrId=370&ver=3&ContrVer=1&Date=10%2f05%2f2015&DocID=L33817&bc=iAAAAAgAAAAAAA%3d%3d&).

**Q. Can a provider treat multiple patients in the same facility on the same date?**

A. A provider can visit multiple patients on the same date, but the documentation has to show the medical necessity of each patient’s visit. Also, service is based on face-to-face time spent alone with each patient. The guidelines from Wisconsin Physician Services (WPS) may be helpful and state the following: “Residential Care Facilities/Rest Homes/Assisted Living Facilities visits occur in the beneficiary’s own personal living space or a room set aside for such visits.” To access the WPS document, see the attachment titled, “Billing and Coding Guidelines” at the following link: [LDC L34643](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34643&ContrId=143&ver=13&ContrVer=1&CptHcpcsCode=99341&bc=gAAAAABAAAAAAA%3d%3d&).

**METHODS & RESULTS**

**Q. There was no explanation of the results and their use. Is it good or bad to be higher or lower than your peers for the various measures?**

A. There is no assumption of wrongdoing on your part, regardless of the results of your CBR. We recognize that providers may have very good reasons for having different billing patterns than their peers. For instance, practice patterns can vary because of geographic location and/or sub-specialties. There may also be other reasons that are not apparent in the claims data reviewed. However, if your CBR indicated that you are **Significantly Higher** than your peers, we encourage you to perform a self-audit, as this can help to identify any coverage and coding errors. To aid in this effort, we recommend use of the Coverage and Documentation Overview and References supplied in each CBR as a guide. We also have a [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html) page on our website with instructions and advice on how to begin the self-audit process. For more information, visit the following website link: [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).
Q. How are the results of the measures in these reports being used by Medicare?
A. CBRs help the Centers for Medicare & Medicaid Services (CMS) address potential over-utilization in the Medicare Fee-for-Service (FFS) program. Each CBR contains tables and/or graphs, as well as an explanation of the findings. The goal of these reports is to help providers better understand Medicare billing rules and improve the level of care they provide to their Medicare patients. To review state and national statistics used in the data analyses, please visit the following CBR web link: CBR201601 Statistical Debriefing.

Q. How does methodology account for severity of illness such as multiple complex medical issues, post hospital care or care to prevent hospitalization?
A. The CBR team understands that some providers may care for more patients with severe/complex illnesses; therefore, these practitioners may provide more services to their patients. CBRs contain tables and/or graphs along with an explanation of findings comparing providers' billing and payment patterns to those of their peers. The CBR process does not include reviewing medical records and or diagnoses noted on claim forms. If more information is needed, please contact the Help Desk by telephone at 1-800-771-4430 or by email at CBRSupport@eglobaltech.com.

Q. Wouldn't it be considered good to have more allowed minutes per visit?
Doesn't it mean more time is spent with patients, on average?
A. The CBR is designed for providers to compare their results to peers in their states and the nation. We do not draw any conclusions regarding the number of allowed minutes spent with a patient; however, medical necessity must be considered for treatment of all patients. Chapter 12 of the Medicare Claims Processing Manual details the criteria required stating, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code.” To review more information about medical necessity, please follow this link: Medicare Claims Processing Manual, Chapter 12, Section 30.6.14.1. If interested, the average minutes per visit for each state and the nation can also be reviewed on the CBR website at the link titled, CBR201601 Statistical Debriefing.
REFERENCES & RESOURCES

CBR201601 Webinar Information (http://www.cbrinfo.net/cbr201601-webinar.html)

Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=ambulance&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAMAAAAAM%3d%3d&)


CBR201601 Sample CBR (http://www.cbrinfo.net/cbr201601-sample-cbr.html)

All CBR Releases (http://www.cbrinfo.net/all-cbrs.html)

CBR201601 Recommended Links (http://www.cbrinfo.net/cbr201601-recommended-links.html)


Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)


AMA Store https://commerce.ama-assn.org/store/

LDC L33817 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33817&ContrId=370&ver=3&ContrVer=1&Date=10%2f05%2f2015&DocId=L33817&bc=iAAAAAaAAAA%3d%3d&)

LDC L34643 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34643&ContrId=143&ver=13&ContrVer=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=99341&bc=qAAAAABAAAAAAA%3d%3d&)

CBR201601 Statistical Debriefing (http://www.cbrinfo.net/cbr201601-statistical-debriefing.htm)