eGlobalTech

CBR201408
Podiatry: Debridement of Ulcers and Wounds

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## Contents

**Introduction** ......................................................... 1
**CBR Focus** .............................................................. 2

**Coverage & Documentation** ........................................... 2
**CPT® Codes** .............................................................. 3
**ACTIVE WOUND CARE MANAGEMENT** ......................... 4
**Tissue Removal** .......................................................... 5
**Coverage Criteria** ...................................................... 7
**Patient Documentation** ................................................ 8
**Wound Documentation** .................................................. 9
**Procedure Documentation** ............................................. 9
**National Correct Coding Initiative** ................................. 11

**References** .............................................................. 12
**Locating LCDs in the Medicare Coverage Database** ............ 12
**Coding** ................................................................. 13

**Methods & Results** ................................................... 14
**Provider Peer Groups** .................................................. 14
**Data Used in Analysis** .................................................. 15
**Table 1** ................................................................. 15
**Test Outcomes** .......................................................... 16
**Distribution of Allowed Services** .................................... 16
**Figure 1** ................................................................. 17
**Table 3** ................................................................. 18
**Calculations** ............................................................. 18
**Percentage of Visits with More Than One Allowed Service** ... 19
**Figure 2** ................................................................. 19
**Table 4** ................................................................. 20
**Percentage of Claim Lines with Modifiers 58 and 59** ............ 20
**Figure 3** ................................................................. 20
**Table 5** ................................................................. 21
**Calculations** ............................................................. 21

**Resources** .............................................................. 22
**CBR Website** ............................................................ 22
**FAQs** ................................................................. 22
**Additional Resources** .................................................. 23

**Next Steps** ............................................................. 23
**Contact Information** ................................................... 23
**Updating Your Address** ................................................ 24

**Questions & Answers** .................................................. 24
Introduction

Good afternoon everyone, and welcome to the Comparative Billing Report (CBR) webinar to discuss *CBR201408 on Podiatry: Debridement of Ulcers and Wounds*. My name is Molly Wesley, and I am with eGlobalTech. We, along with our partner Palmetto GBA, have been contracted by the Centers for Medicare & Medicaid Services (CMS) to produce and distribute CBRs. We are responsible for conducting the statistical analysis central to the data contained in each CBR, developing and disseminating the reports, ensuring data integrity and privacy, and providing customer service and educational outreach opportunities.

Today we are going to give you a general overview of the CBR, which is on the policy group related to debridement of ulcers and wounds. Our overview will include coverage policy and documentation requirements for items included in the topic, source references, the methods used to produce the report, additional resources available to you, and then we will be taking your questions at the end of the presentation. At the conclusion of the Question and Answer (Q&A) session, we will provide you with a brief survey to complete. We welcome and value your feedback.

Please note that due to time constraints, we may be limited in the number of questions we will be able to answer this afternoon. However, those questions received at the time of registration or during our Q&A session that are relevant to today’s CBR topic, will be included in a formal Q&A document that will be posted to the CBR website within thirty days from today.

By the end of this webinar you should have a general understanding of this CBR which focuses on podiatry providers and the debridement of ulcers and wounds, as well as how the data was analyzed. You should also be able to locate policy references and resources.

If you did not receive a CBR in the mail or via fax, you may download a copy of the Sample CBR by visiting [http://www.cbrinfo.net/cbr201408-sample-cbr.html](http://www.cbrinfo.net/cbr201408-sample-cbr.html). A Sample CBR is pro-
duced for each topic, and you may find it beneficial to have a copy of a CBR available to reference during the webinar.

The CBR is developed to provide education to the provider community by comparing a provider’s billing patterns to those of his/her peers. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules and to improve the level of care that they provide their Medicare patients. Also, we would like to ensure your understanding that receipt of this Comparative Billing Report is not a precursor to an audit. There is no assumption of wrong doing on your part for being selected to receive a CBR. Rather, CBRs give you an opportunity to compare yourselves to your peers and check your records against the data in CMS’ files.

**CBR Focus**

The CBR focuses on podiatry providers who billed for debridement services and examines the following:

1. Distribution of services for Current Procedural Terminology (CPT®) code groups by depth of service rendered
2. Percentage of visits with more than one service
3. Percentage of claim lines with modifier 58 and/or modifier 59

Approximately 5,000 podiatry providers were selected to receive this CBR. These providers were selected by National Provider Identifiers (NPI) and by an analysis of paid claims data that identified them as having different billing patterns when compared to their peers. This CBR focuses on podiatrists who billed claims for debridement services for Medicare Part B beneficiaries. The methods and results portion of this webinar will provide you with more information on the statistical analysis and NPI selection process.

And now I will be turning it over to Cyndi Wellborn who will discuss the coverage and documentation criteria for today’s topic as well as the references that you may refer to for further information.

**Coverage & Documentation**

Thank you Molly and good afternoon. My name is Cyndi Wellborn. I am a Registered Nurse with Palmetto GBA. My job title is Lead Analyst, but my primary responsibility is researching policy and billing guidelines for the topics of our CBRs. Today, I will present an overview of coding, billing and coverage guidelines as they pertain to debridement services. In this CBR, we focused on those services billed by providers with a specialty of podiatry because our research showed that physicians who practice podiatry billed for these services more frequently than any other specialty. The guidelines would be applicable to other specialties as well.
We choose our CBR topics based on reports by other agencies to determine if there are areas of vulnerability. Using 2004 claims data, the Office of Inspector General (OIG) [see http://oig.hhs.gov] found that podiatrists billed 66% of surgical debridement services covered by Medicare while general surgeons billed 10%. Of the 64% of services which did not meet Medicare requirements, OIG auditors determined that 39% of surgical debridement services were billed with a code or modifier that did not accurately reflect the service provided [see Medicare Medical Payments for Surgical Debridement Services in 2004, May 2007, OEI–02–05–00390 at https://oig.hhs.gov/oei/reports/oei-02-05-00390.pdf]. Specifically, 21% were up-coded, meaning that the service was reimbursed at a higher rate than what was supported by the medical record. Of the services that were miscoded, 20% were actually routine foot care services which should not have been covered by Medicare.

We also found that the Comprehensive Error Rate Testing (CERT) error rate rose from 3.7% in 2008 to 7.4% in 2012. The 2012 total estimated improper payment amount was $131,795,384.00 [see The Supplementary Appendices for the Medicare Fee-for-Service 2012 Improper Payment Rate Report, Release Date: January 27, 2014 at http://www.cms.gov/apps/ama/license.asp?file=/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesNovember2012CERTReport.pdf].

Based on the claims filed for services in 2013, we found that podiatrists billed 43% of the codes in the CBR compared to slightly over 14% by general surgeons.

**CPT® Codes**

Debridement is the removal of dead, damaged or infected tissue to improve the healing potential of the remaining healthy tissue. We will not be discussing non-selective debridement (CPT® code 97602) because Medicare considers that to be a bundled service and does not allow separate reimbursement. We will be discussing two different types of debridement, Excisional/Surgical debridement (CPT® codes 11042–11047) and “Active Wound Care Management” (CPT® codes 97597–97598). These vary by the depth, amount and type of tissue removed.

Debridement service CPT® codes 11042–11047 are found in the “Surgery” section of the CPT® 2013 Professional Edition. The section, “Skin, Subcutaneous, and Accessory Structures,” is found under the heading “Integumentary System.” Debridement may be necessary following injuries and infections but are most often used to aid in the healing of chronic wounds and ulcers. The CPT® codes are reported by depth of tissue that is removed and by surface area of the tissue that is removed. Our CBR does not include education on the “excision” of pressure ulcers (CPT® codes ranging from 15920–15999), nor did it include debridement of eczematous skin,
removal of mesh or debridement of burns. The pound sign or hashtag (#) symbol denotes that the code has been resequenced and is not in progressive numeric order. The plus sign (+) denotes that the service is an add-on procedure and should only be billed in conjunction with the primary code.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>CPT® Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11042</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11045</td>
<td>#+ each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>11043</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis and subcutaneous tissue if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11046</td>
<td>#+ each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>11044</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>11047</td>
<td>#+ each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

I would like to note here that a typo was made in the table that contains the code descriptions in the CBR sent to providers and the Sample CBR. Under the CPT® Code Description column heading, the letters “sq” of sq cm were left out. Each of the descriptions under this column refer to “square centimeters.”

**ACTIVE WOUND CARE MANAGEMENT**

Wound debridement CPT® codes 97597 and 97598 are also called “Active Wound Care Management,” are found in the “Medicine” section of the CPT® codebook under the heading “Physical Medicine and Rehabilitation.” In this part of the book, we find many services billed by physical and occupational therapists. These codes may be billed by physicians and non-physician practitioners as well. These codes describe the removal of epidermis and/or dermis, exudate, fibrin, debris and biofilm from an open wound using devices such as high pressure water jet, scissors, scalpel and forceps. If whirlpool is used, topical applications are made or instructions are given to the patient, these services are not billed separately because they are also included in the code description.
### Tissue Removal

All debridement services are billed based on the area of tissue removed from the wound and not exclusively by the depth of tissue that is visible. CPT® codes from the integumentary system, **11042–11047**, require that the tissue removed be at least at the subcutaneous depth. Removal of the first 20 square centimeters of subcutaneous tissue is billed with procedure code **11042** and each additional 20 square centimeters is billed with the add-on code **11045**. Removal of tissue which includes muscle and/or fascia is billed with primary code **11043** for the first 20 square centimeters of tissue removed and add-on code **11046** for each additional 20 square centimeters removed. The removal of bone would be billed with primary code **11044** for the first 20 square centimeters of bone removed and the add-on code **11047** for each additional 20 square centimeters of bone removed. For our analysis, we grouped codes together which described the same depth of tissue.

<table>
<thead>
<tr>
<th>Level of Tissue</th>
<th>Related CPT® Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidermis</td>
<td>97597–97598</td>
</tr>
<tr>
<td>Dermis</td>
<td>97597–97598</td>
</tr>
<tr>
<td>Subcutaneous</td>
<td>11042 / 11045</td>
</tr>
<tr>
<td>Muscle / Fascia</td>
<td>11043 / 11046</td>
</tr>
<tr>
<td>Bone</td>
<td>11044 / 11047</td>
</tr>
</tbody>
</table>

In *excisional debridement*, the documentation would normally include *at least one* of the following: bleeding tissue; removal of viable tissue; and increasing wound size by width, length or depth. For all of the CPT® codes in this CBR, the physician should add together tissues removed from multiple wounds *with the same depth of debridement to come up with a combined area*. For instance, if the patient had three square centimeters debrided from three wounds at the depth of the subcutaneous layer, the physician should bill one unit of CPT® code **11042** because three times three equals nine (3 x...
The physician would calculate the amount of tissue removed by multiplying the length of the tissue by the width of the tissue. In order to bill an add-on code, the amount of tissue removed must be larger than 20 square centimeters which is approximately half the size of a credit card. The add-on CPT® codes 11045, 11046 or 11047 are billed for “each additional 20 square centimeters or part thereof.” So, if the provider removed a piece of necrotic muscle tissue that measured six centimeters by six centimeters (6 cm x 6 cm), he/she would bill one unit of CPT® code 11043 and one unit of CPT® code 11046. CPT® code 11043 is used for the first 20 square centimeters and CPT® code 11046 for the next 16 square centimeters, for a total of 36 square centimeters.

If the patient has multiple wounds with different depths of tissue being removed, such as five square centimeters (5 sq cm) removed from the subcutaneous layer on the bottom of the right foot, ten square centimeters (10 sq cm) of muscle removed from the side of the right foot and three square centimeters (3 sq cm) of bone removed from the left heel, then one unit of each initial code could be billed and two lines should have modifier 59 appended.

These codes (CPT® codes 97597–97598) are sometimes referred to as selective debridement. CPT® code 97597 is reported for the first 20 square centimeters or less and is billed once per session. CPT® code 97598 is billed for each additional 20 square centimeters or part thereof and is billed in addition to the primary code (CPT® code 97597). Unlike excisional debridement, the physician does not remove any living tissue.

The terms fibrin, exudate, debris and biofilm refer to substances found in wounds which interfere with normal wound healing. The removal of these substances is necessary to get the healing process back on track. However, removal of these substances when they are not integrated into the tissue and without removal of tissue does not meet the definition of debridement and may not be reported as such.

The only CPT® codes that can be billed when only the epidermis and/or dermis is debrided are 97597 and 97598 (when applicable). As we noted on an earlier slide, the description of active wound care management includes the word open wound. Some local coverage determinations include verbiage about the definition of an ulcer that states that there must be a break in the epidermis and/or dermis before debridement is medically necessary.

The CPT® code description for 11042/11045 includes the debridement of the epidermis and dermis, when those tissues are removed in conjunction with the removal of subcutaneous tissue. This prevents billing CPT® code 97597/97598 in addition to CPT® code 11042 for the same wound.

Many LCDs state that Medicare will cover up to five surgical debridement procedures (CPT® codes 11043 and/or 11044) per patient per year. For those contractors’ services beyond the fifth surgical debridement, the use of
CPT® codes [11043 and/or 11044] will only be payable upon medical review of records that demonstrate the medical reasonableness and necessity via the appeals process. Some LCDs limit the place of service for debridement procedures of muscle/fascia and bone to a hospital (either inpatient or outpatient) or to an ambulatory surgery center. The code description for CPT® codes 11043/11046 includes epidermis, dermis and subcutaneous tissue, when those tissues are debrided in conjunction with muscle and/or fascia in the same wound.

Care must be taken when billing this [11044 CPT®] code. If a wound involves exposed bone, but the debridement procedure did not remove bone, CPT® code 11044 cannot be billed. Some LCDs also note “that repeated debridements are not the same service as the original debridement service. Subsequent surgical debridement of muscle or bone is usually not necessary. Debridement of muscle and/or bone greater than two additional debridements, should raise the question of whether the complicating factors are controlled adequately. Further debridement of muscle and/or bone may not be justified without adequate control of the underlying condition(s) leading to the complicating factors (i.e. infection, abscess, vascular insufficiency, nutritional compromise etc.).”

The description for CPT® codes 11044/11047 includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia when those tissues are debrided in conjunction with bone in the same wound.

As we have stated on earlier slides, coding/billing is based on the size of the tissue removed, not necessarily the size of the wound itself. “Eighty-four percent of wounds measured during visits to hospital wound clinics had surface area measurements of less than 20 square centimeters” [see The Debridement Dilemma Returns, Today’s Wound Clinic, Volume 5, Issue 1, January/February 2011 at http://www.todayswoundclinic.com/debridement-dilemma-returns]. Based on this statistic, only 10% of debridement procedures would require an add-on code. However, this study found that when a wound measured more than 20 square centimeters, the average area was 79 square centimeters. So most wounds are small, but when they are large, they are very large and would usually require the addition of more than one unit of the add-on code.

**Coverage Criteria**

Slide 35 of our policy references section will list the Local Coverage Determinations (LCDs) that cover the U.S. and its’ territories. All LCDs for debridement can be found on the reference page of CBR201408 located on the CBR website at [http://www.cbrinfo.net/cbr201408-recommended-links.html](http://www.cbrinfo.net/cbr201408-recommended-links.html). In addition, a provider can determine which Medicare Administrator Contractor (MAC) is responsible for their claims by going to the website [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index).
html. Once at this website, providers can click on the state they are interested in reviewing on the interactive map.

For instance, if you select Maryland, you can see that the A/B MAC is Novitas Solutions, Incorporated. The Durable Medical Equipment Medicare Administrative Contractor (DME MAC) is NHIC, Corp. and the Home Health and Hospice (HH+H) contractor is CGS Administrators, LLC. Links to the websites as well as telephone numbers are provided.

Now we’ll talk about some of the information that we found was common in most of the local coverage determinations we reviewed.

**Patient Documentation**

These are some general patient documentation guidelines compiled from the 25 current and future local coverage determinations that included references to the codes in this CBR. Providers should check the LCDs in their state or territory to ensure their documentation meets the requirements for coverage. The LCD for your jurisdiction may be more or less detailed in its requirements. All documentation must be maintained in the patient’s medical record and available to the contractor upon request. The patient’s medical record should support the ICD-9 code submitted on the claim as well as the procedure code billed. Every page should contain the identity of the patient.

Documentation should include a treatment plan which outlines the frequency and duration of the expected service. While the appropriate interval and frequency of debridement depends on the patient’s clinical situation and the extent of the wound, most LCDs dictate that debridement services are not expected to be medically necessary more frequently than once a week because the tissue does not regrow rapidly. Treatment plans for a patient requiring frequently repeated debridement should ensure that pressure...
reduction and infection control have been addressed. Several LCDs state that the rationale and medical necessity of more than eight debridement services must be clearly documented in the medical record. The documentation should include the diagnosis and any underlying conditions the patient has that could affect the normal wound healing process.

**Wound Documentation**

The medical record should include the indications for debridement and wound characteristics. This could also include tunneling, undermining and necrosis, for example. Some contractors recommend photographs be taken before and after debridement in cases of prolonged duration.

Most LCDs state that there should be evidence of improvement, which includes but is not limited to measurable changes, in at least some of the following areas: drainage, inflammation, swelling, pain, wound measurements (diameter, depth, tunneling), granulation tissue, necrotic tissue and/or slough. Such evidence must be documented with each visit. A wound that shows no improvement after 30 days requires a new approach, which may include a reassessment of underlying infection, metabolic, nutritional or vascular problems inhibiting wound healing or a new plan of care or treatment method. When the goal of the treatment plan is only to prevent progression of the wound, it should be documented clearly in the medical record and the plan should include the development of a non-skilled maintenance program.

**Procedure Documentation**

The debridement CPT® code selected should be based on the level of tissue removed. One common error is reporting a CPT® code that describes the depth of tissue visible (such as muscle), but not actually surgically debrided. It would not be appropriate to bill more than one CPT® code for the same wound when tissue is removed from different levels,
such as muscle and bone. Only the deepest level of tissue removed should be reported because the CPT® code descriptions include the levels above the deepest level of debridement. For instance, CPT® code 11043 describes debridement, muscle and/or fascia (includes epidermis, dermis and subcutaneous tissue, “if performed”).

The medical record should include the type of instrument used in the debridement. If anesthesia is used during the debridement procedure, the type used should be part of the patient’s medical record. Now we’ll talk about global periods and modifiers.

**Global Periods and Modifiers**

One of the metrics reviewed in this CBR was the use of modifiers 58 and 59. Modifier 58 is frequently used in podiatry. According to our data, we found proper as well as improper usage. Modifier 58 is reported to indicate that a related service took place during the global period of another procedure performed by the same provider. All of the codes in this CBR are classified as having zero global days, meaning that there is no pre-operative period, and no post-operative days. In addition, visits on the day of the procedure are generally not payable as a separate service because the initial evaluation for minor surgical procedures includes the evaluation and management necessary to perform the service. Post-procedure instructions provided to the patient on the same date of service as the debridement are included in the payment for the service. Our data showed that many providers appended the 58 modifier to debridement services when there were no procedures in the patient’s claims history that had a global period. Repeated debridement procedures would not require the 58 modifier because the debridement codes don’t carry a global period. Some local coverage determination coding guideline articles state that procedures submitted with the 58 modifier may be subject to medical review. In cases where the debridement does follow a procedure with a global period, the documentation must reflect that the second procedure was planned at the time of the initial procedure, as well as the rationale for the staged procedure.

Modifier 59 identifies procedures and services that are not normally reported together but are appropriate under the circumstances. Some LCDs refer to modifier 59 and clarify that while it is appropriate to be used in some instances, it should not be used alone when other modifiers, such as those that describe toes (TA through T9), for example, are needed to clarify the
procedure. According to the Centers for Medicare and Medicaid Services MLN Matters® Number MM8863, the modifier is “associated with considerable abuse and high levels of manual audit activity; leading to reviews and appeals.” The two most common billing errors associated with the 59 modifier are when it is used to define a distinct service or a separate anatomic site. According to CMS, providers use the 59 modifier to cause payments to be made for the very code combinations the National Correct Coding Initiative tables were set up to prevent.

**National Correct Coding Initiative**

According to the National Correct Coding Initiative (NCCI), “it is inappropriate to report debridement, 11000, 11042–11047, 97597–97598 with adjacent tissue transfer (CPT® codes 14000–14350) for the same lesion/injury.” The NCCI manual states “if lesion removal, incision, or repair requires debridement of non-viable tissue surrounding the lesion, incision, or injury in order to complete the procedure, the debridement is not separately reportable.” Per NCCI, “Simple debridement of a skin wound (CPT® codes 11000, 11042–11045, 97597–97598) prior to a graft/skin substitute is included in the skin graft/skin substitute procedure (CPT® codes 15050–15431) and should not be reported separately.”

Some of the more common exclusions, as found in the LCDs we researched include: washing of bacterial or fungal material from a lesion; dressing small or superficial wounds or performing non-selective debridement; removal of secretions/coagulation serum from normal skin surrounding an ulcer; incision and drainage of abscesses (including paronychia), trimming and debriding nails, avulsion of nail plate, etc.

On this slide, we have listed some of the more common documentation and medical necessity errors found during audits performed by recovery audit contractors and MAC contractors such as Cahaba Government Benefit Administrators. These included: billing for removal of muscle when muscle is visible but not debrided; billing multiple initial CPT® codes for the same wound; basing area of tissue removed on total size of wound, not the area of tissue removed; documenting 100% granulation tissue; documenting debridement using 4 x 4 gauze.

Providers should ask themselves the following questions if they receive a CBR:

1. Have I followed the guidelines for my jurisdiction?
2. Have I used the correct procedure codes?
3. Have I appended modifiers correctly?
4. Have I correctly calculated my units of service (UOS) for these services?

Our findings do not imply any wrong doing on your part but if your CBR supports that your utilization differs significantly from your peers, it may be
Now I’ll tell where you can find reference material on debridement services. A complete list of links is available at [http://www.cbrinfo.net/cbr201408-recommended-links.html](http://www.cbrinfo.net/cbr201408-recommended-links.html). Once at the home page click on CBR Releases then choose CBR201408, then recommended links.

**Locating LCDs in the Medicare Coverage Database**

On a previous slide (slide 22), we showed you how to determine which contractor paid your claims. This link [see [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)] will take providers to an overview of local coverage determinations. On this page (Welcome to the Medicare Coverage Database), you will enter the number of the LCD into the Document ID field and hit Search By ID. You will then be directed to a license agreements page which prohibits you from making copies of and reselling the CPT manual. Once you accept, you will be directed to the LCD document. Please note, some of the LCDs that we’ve chosen for this CBR will be watermarked as future in anticipation of the change from ICD-9 to ICD-10 which is now scheduled for October of 2015. The next slide [see table below] includes the names of the “Medicare MACs” to the left, the “Current LCD” and the “Future LCD.”

The local coverage determinations below include coverage instructions for some or all of the CPT® codes in this CBR. If any of the procedure codes appeared in an LCD, we listed the number here. Some of the LCDs include instructions for other types of providers, such as physical and occupational therapists, who also perform non-excisional debridement.
Chapter 15 of the Medicare Benefit Policy Manual [see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf], Sections 290.F (Covered Medical and Other Health Services) and 290.G (General Exclusions from Coverage) give instructions for applying foot care exclusions. Services that are normally considered routine and not covered by Medicare include: the cutting or removal of corns and calluses; trimming cutting, clipping, or debriding of nails; other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury or symptoms involving the foot. However, there are underlying conditions that could justify coverage for routine foot care, those exceptions are also included in this section of the manual. Some of these conditions, such as diabetes and multiple sclerosis for example, require that the patient be under the active care of a doctor of medicine or osteopathy who documents the condition.


**Coding**

Cover repair codes, tissue transfers, grafts and flaps. Providers will also find an article specific to the use of modifier 59 on the general NCCI page under downloads [see Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service at the bottom of the http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/ webpage].

Other references that we noted were helpful during the research of this CBR were the below articles. [The following two references were included on the slide:


Now, I will turn the presentation over to Craig DeFelice who will go over the Method and Results section.

**Methods & Results**

Good afternoon, my name is Craig DeFelice. I am a Statistical Analyst with Palmetto GBA. I will be explaining the data, statistical analysis, and tables provided in this CBR.

For the Debridement CBR, an individualized report was sent to about 5,000 Medicare Part B providers, identified by NPI submitted on the claim as Rendering NPI.

Each report contains the provider’s billing history and patterns and compares him to his peers. These comparisons are given so that each provider is aware of where he stands among his peers, and allows him to see how his billing is different than his peers.

**Provider Peer Groups**

For this CBR, each provider is compared to two peer groups. First, the state peer group. The state peer group is defined as all Medicare providers with allowed charges for the debridement codes covered in this CBR in the provider’s state. The National Plan and Provider Enumeration System (NPPES) is used to determine the state of the provider’s location and the national peer group. The national peer group is defined as all Medicare providers in the nation with allowed charges for the debridement codes covered.
**Data Used in Analysis**

Analysis was based on the latest version of claims as of August 22, 2014. This data was extracted from the CMS Integrated Data Repository (IDR) and loaded into Palmetto GBA’s Statistical Analysis Data Warehouse. This report includes claims with dates of service between January 1, 2013 and December 31, 2013.

**Table 1**

This slide is an example of the **Summary of Your Utilization for Debridement** [see Table 1 in the report]. In order to read this table, we will look at an example: the summary for CPT® code 11042. Look at the far left column named CPT® and find the row marked CPT® code 11042. From left-to-right we find the following:

- **Abbreviated Description:** this covers a brief explanation of what the code covers. For this row, we are looking at “Debridement, subcutaneous tissue; first 20cm or less”
- **Allowed Charges:** this a sum of the allowed charges of all claim lines billed under the CPT® code. In this sample we find the provider billed $4,704.27 under CPT® code 11042
- **Claim Lines:** this indicates how many claim lines the provider billed under the CPT® code. For this example we find 41 claim lines were billed under CPT® code 11042
- **Modifier 58:** this indicates how many claim lines for the CPT® code were billed with modifier 58 on them. This sample provider billed six lines for CPT® code 11042 with modifier 58
- **Modifier 59:** this indicates how many claim lines for the CPT® code were billed with modifier 59 on them. For this sample the provider billed 31 lines for CPT® code 11042 with modifier 59
- **Allowed Services:** this column indicates how many allowed services a provider has billed for the CPT® code. In this example the provider billed 41 allowed services for CPT® code 11042

Please note the total row provides a sum of the information contained in the eight CPT® codes. In this example, the number of claim lines is equal to the number of allowed services. In general, this is not the case.
**Test Outcomes**

For Table 3, the *Distribution of Allowed Services by CPT® Code Group* analysis did not compare each code group individually, but instead compared the provider’s distribution of codes to his peer’s distribution of codes. This could result in either the provider’s distribution being **Significantly Different** or **Not Significantly Different** than that of his peers.

In Table 4 and Table 5, there are three possible comparisons between the provider and the peer groups: **Significantly Higher** is displayed if the provider’s value is higher than the value of the peer group and the statistical test used confirms significance; **Higher** is displayed if the provider’s value is higher than the value of the peer group, but the statistical test does not confirm significance; **Does Not Exceed** is displayed if the provider’s value is not higher than the value of the peer group.

**Distribution of Allowed Services**

The first analysis [see Figure 1 and Table 3] studies the *Distribution of Allowed Services by CPT® Code Group*. It is calculated as the “Total Allowed Services for the CPT® Code Group” divided by the “Total Allowed Services for all Four CPT® Code Groups” and then multiplied by 100. This percentage is calculated for each of the four CPT® code groups.

The first paragraph of the results section (page six in the CBR) shows the result of this first analysis. As you can see in this sample, the distribution of services was found to be **Significantly Different** than at least one of his peer groups in either the state or the nation. The data that was analyzed to deduce significance will be discussed in the following two slides.

<table>
<thead>
<tr>
<th>Distribution of Allowed Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Calculated for each CPT® code group</td>
</tr>
<tr>
<td>• Calculation:</td>
</tr>
</tbody>
</table>
| \[
| \left( \frac{\text{Total Allowed Services for the CPT® Code Group}}{\text{Total Allowed Services for all Four CPT® Code Groups}} \right) \times 100 |
|  |

45
**Figure 1**

On this slide, we find a graphical representation of the of the percentages found in the *Distribution of Allowed Services by CPT® Code Group* analysis. There are a few points of interest in this figure that are consistent for all figures used in this CBR.

First, direct your attention to the legend in the top right of the figure. This legend indicates the shade used to identify the provider or his two peer groups. Next, please bring your attention to the bottom of the figure. Across the bottom of this figure, we see the categories analyzed in each analysis. In this case, the four CPT® code groups are the categories of interest. Finally, along the left hand side of the figure, we see a scale from 0 to 100, representing the percent of the total population. Also, note above each bar is a percentage to denote the height of each bar.

For an example of how to interpret this, let’s look at the three bars located over the CPT® code group 11042 & 11045. The darkest bar on the left with 36% above it represents that 36% of the provider’s total allowed services was in this CPT® code group. The middle bar represents that 37% of the provider’s state’s total allowed services were in this CPT® code group. And finally the lightest bar on the far right shows that 46% of the nation’s allowed services were for the CPT® code group 11042 & 11045.

If it is the case that a provider is significantly different than one of his peers, this graphic [*Figure 1*] will aid the provider in determining how their allowed services differ than his peers. In the Sample CBR, the provider was marked as *Significantly Different* [in the Results paragraph]. This was shown [as highlighted text] on the previous slide. The provider might infer from this that he is billing a disproportionate amount of the 11043 & 11046 CPT® code group.
**Table 3**

Table 3 is an example of the analysis of the “Distribution of Allowed Services by CPT® Code Group.” This table contains the data used in the figure in the previous slide [Figure 1]. For example, the row marked CPT® code group 11042 & 11045 contains the height of the bars, respectively: 36%, 37%, and 46% for the provider, his state, and the nation.

**Table 3: Calculations**

Let’s walk through an example of how a the provider’s percentage of allowed services was calculated for the CPT® code group 11043 & 11046. [Refer to the highlighted portions of slide 50 which shows Table 1.]

We find this provider has 52 allowed services for CPT® code 11043 and 20 allowed services for CPT® code 11046. This is a total of 72 allowed services for the CPT® code group 11043 & 11046. Furthermore, the provider has 113 total allowed services.

We find that 72, the “Total Allowed Services for the CPT® Code Group,” divided by 113, the “Total Allowed Services for all Four CPT® Code Groups,” multiplied by 100 is approximately 64 [highlighted in yellow on slide 51]. The provider’s other percentages can be calculated in a similar manner.
**Percentage of Visits with More Than One Allowed Service**

The Percentage of Visits with More Than One Allowed Service, is calculated as the “Number of Visits with More Than One Allowed Service” divided by the “Total Number of Visits” and then multiplied by 100. For this analysis, a visit refers to all allowed services for a particular beneficiary on a specific date of service.

While it is possible for a provider to bill the additional codes for multiple services, this analysis doesn’t just consider those types of multiple services. It is also possible for a provider to bill different CPT® codes for a beneficiary on the same date of service. For example, a provider could bill one CPT® code for a patient’s left foot and another for the right foot, to result in multiple services on the same day.

**Figure 2**

*Figure 2 [see slide 53] is a graphical representation of the Percentage of Visits with More Than One Allowed Service per visit. The figure has the same basic construction as before. The category in this case is “Visits” referring to the percentage of total visits. For this provider, 2% of his total visits had more than one service, 3% of his state’s total visits had more than one service and 5% of the nation’s total visits had more than one service.*
Table 4

Table 4 is an example of the **Percentage of Visits with More Than One Allowed Service** analysis. The values for the provider’s percentage of visits, the state’s percentage of visits, and the national percentage of visits (respectively 2%, 3%, and 5%) match the heights of the bars for Figure 2. As the provider’s percentage is smaller than the state or national peer group’s percentage, **Does Not Exceed** is marked for each comparison column.

**Percentage of Claim Lines with Modifiers 58 and 59**

The “Percentage of Claim Lines with Modifiers 58 and 59” are calculated as follows: The “Total Number of Claim Lines with the Modifier” divided by the “Total Number of Claim Lines” and then multiplied by 100. There are two separate calculations here, one for modifier 58 and one for modifier 59.

**Figure 3**

Figure 3 is a graphical representation of the analysis performed for the **Percentage of Claim Lines with Modifiers 58 and 59**. Two separate charts are provided in this figure, each having the same basic structure of the previous figures. Please note that the scale for the chart on the left (“Modifier 58”) can be different from the scale of the chart on the right (“Modifier 59”). In this case, the scale ranges from 0%-10% on the left chart, while the chart on the right ranges from 0% to 100%.
For the results of the percent of claim lines with modifier 58, we look at the chart on the left. We find 5% of the provider’s claim lines, 2% of his state’s claim lines, and 5% of the nation’s claim lines, had modifier 58 on them.

Similarly, we can look at the chart on the right for the results of the percent of claim lines with modifier 59. We find 90% of the provider’s claim lines, 15% of his state’s claim lines, and 16% of the nation’s claim lines, had modifier 59 on them.

**Table 5**

Table 5 is an example of the **Percentage of Claim Lines with Modifiers 58 and 59**. Direct your attention to the row associated with modifier 58. As before, the percentages match up with the chart associated with modifier 58 [refer to the chart in Figure 3]. In this example, we find the provider’s percentage of 5% is greater than his state’s percentage of 2%, but this result was not found significant according to the results of the chi-squared test, and therefore Higher was marked in “Comparison with Your State’s Percentage” column. When we compare the provider to the nation, we find that 5% is not bigger than 5% so Does Not Exceed is marked in the corresponding column.

For modifier 59, however, we find the provider’s percentage [90%] was greater than the percentage of his state (at 15%) and the nation (at 16%). Furthermore, the results of the chi-squared test confirm significance; and therefore Significantly Higher was marked in both comparison columns.

**Table 5: Calculations**

Let’s walk through an example of how the provider’s percentage of claim lines with modifier 59 was calculated.

This provider has 102 claim lines with modifier 59, as indicated by the “Total” row under the “Modifier 59” column [see Table 1]. Also, the provider had 113 total claim lines, as shown by the “Total” row under the “Claim Lines” column. We find that...
102, the “Number of Claim Lines with Modifier 59,” divided by 113, the “Total Number of Claim Lines,” multiplied by 100 is approximately 90 [highlighted in yellow in the example on slide 60]. The provider’s percentage for modifier 58 can be calculated in a similar manner.

This will conclude the Method and Results portion. [A statistical debriefing is available for this CBR at http://www.cbrinfo.net/cbr201408-statistical-debriefing.html.] And now Molly will go over the section on resources.

Resources

Thank you Craig. And now, I will review the educational information and resources that you may utilize to ensure that you are meeting Medicare guidelines for debridement services.

**CBR Website**

In addition to the actual CBR, there are a number of resources available that will provide you with more information on the CBR program. Again, our website is http://www.cbrinfo.net/. The website includes a great deal of information for the provider and supplier community. On this site you will find more information on: eGlobalTech and Palmetto GBA; The most current CBR release as well as previous releases; CBR support material that is created to give providers and suppliers various tools they can utilize when reading their CBRs; CBR dissemination information; Recommended Links; Frequently Asked Questions; and contact information for our help desk.

**FAQs**

Our website has two distinct FAQ sections. The first answers general CBR questions, such as “What is a CBR?” [http://www.cbrinfo.net/faqs.html] and “How do I update my address?” Additional FAQ pages are provided for each CBR release. For example, on the CBR201408 Podiatry: Debridement of Ulcers and Wounds FAQ page [http://www.cbrinfo.net/cbr201408-faqs.html] you will find questions and answers specific to this CBR, such as “How are the peer groups defined?” and “How was the data obtained for this report?”
**ADDITIONAL RESOURCES**

The following resources are pertinent to this CBR and may assist you with developing policies to address any areas of concern. Please note that we provide links to all of the resources referenced in this webinar on our website.

The first document listed here is the Social Security Act. Section 1862 of the Act lists things that are excluded from coverage; among them you will find routine foot care [http://www.cbrinfo.net/assets/cbr201408-sample-cbr.pdf].


**Next Steps**

After receiving a CBR, there are some additional steps that you may choose to take with this information in hand. For example, we encourage you to perform a self-audit. Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly. Self-audits help providers and suppliers identify coverage and coding errors. To aid in this effort, we recommend you use the Coverage & Documentation Overview and References sections discussed earlier and supplied in each CBR as a guide.

**Contact Information**

If you have any questions regarding the CBR program, we encourage you to contact us. The CBR Support Help Desk [http://www.cbrinfo.net/contact-us.html] is available from 9:00 a.m. to 5:00 p.m. ET Monday through Friday. Listed
here we have the toll free number, which is 1–800–771–4430 and our email address is cbrsupport@eglobaltech.com. Both the telephone number and the email address are located on the actual CBR and the CBR website for your convenience.

Providers should contact the Medicare Administrative Contractor, or MAC, for their geographic area for assistance with questions about a specific claim, documentation requirements and billing and coding questions [see http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/]. We encourage you to check with your MAC to ensure that you are meeting the standards for all services that you are providing. MAC contact information is easily accessible on the CBR website.

**Updating Your Address**

eGlobalTech receives all contact information used in producing and disseminating the CBRs from the information providers and suppliers add to the National Plan and Provider Enumeration System, or NPPES [see https://nppes.cms.hhs.gov/NPPES].

The mailing address and fax number listed with each report is the one on file in the NPPES system. If your CBR lists an incorrect address or was sent to an incorrect fax number, you are advised to update this information in NPPES. This link is provided here, but we also have a link on the CBR website.

**Questions & Answers**

And now, we will be moving on to the Question and Answer portion of the Webinar. As I previously mentioned, you will be able to submit questions via the chat function that we will enable. Any questions that we are not able to address this afternoon, will be answered and posted in a detailed Q&A document which we will be posting to our website [http://www.cbrinfo.net/assets/cbr201408-webinar-questions-and-answers.pdf] along with an MP4 of the webinar [http://www.cbrinfo.net/assets/cbr201408-webinar-recording.mp4] and a handout of the presentation [http://www.cbrinfo.net/assets/cbr201408-webinar-handout.pdf]. They will be made available within 30 days of today.

Please stay through the end of the Question and Answer session so that we can receive your feedback on the Comparative Billing Report, our website, and the webinar itself.

Debra, we are now ready to move onto the Q&A session. Thank you all for your time.