Stay Tuned for Webinar

CBR201501
Modifier 59: Dermatology

Begins at 3:00 P.M. ET
CBR201501
Modifier 59: Dermatology
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 material 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 (LCD) and policy articles for the A/B Medicare Administrative Contractors (MAC) or DME Medicare Administrative Contractors (DME MAC). Please refer any specific questions you may have to the A/B 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.
Webinar Outline

1. Introduction
2. Coverage & Documentation Overview
3. References
4. Methods & Results
5. Resources
6. Next Steps
7. Contact Information
8. Q&A
9. Survey
Webinar Requirements

- Landline for conference call (cell phones are not recommended)
- Wired (not wireless) broadband internet connection
- PC computer using Windows or Mac operating system
- Android or iPad tablets
- Latest version of Adobe Flash installed
Webinar Protocol

- All attendee lines are muted
- Submit questions via chat when prompted by speaker
- Submit questions during the Q&A session at the end of webinar
- Ask questions pertinent to webinar
- Contact MAC for specific claims questions
Webinar Objective

Upon completion of this webinar the participant should be able to:

- Demonstrate a general understanding of the CBR for Modifier 59: Dermatology (07)
- Comprehend the report methods used to develop the report
- Locate policy references and resources
Sample CBR

- Provided for each topic
- http://www.cbrinfo.net/
CBR Purpose

Designed to:

- Provide education to the provider community
- Compare billing practices among Medicare providers and their peer groups

Gives providers an opportunity to:

- Check their records against data in CMS files
- Review Medicare guidelines to ensure compliance
Focus

This CBR examines:

- Percentage of claim lines with modifier 59 appended
- Percentage of visits billed with both a dermatology add-on code and evaluation and management (E/M) code
- Average allowed services for CPT® codes 11101 and 17003, per beneficiary, summed for the one-year period
Demographics

- 5,000 dermatology providers
- Data from claims paid by traditional Fee For Service (FFS) Medicare
- Billing patterns different from their peers
Webinar Materials

- References and Resources
- Webinar slides
- MP4 of webinar
- Webinar Handout
- Webinar Q&A Handout

Recommended Links:
http://www.cbrinfo.net/cbr201501-recommended-links.html

Resources from event:
http://www.cbrinfo.net/cbr201501-webinar.html
Acronyms

**CERT:** Comprehensive Error Rate Testing
**CR:** Change Request
**MPFS:** Medicare Physician Fee Schedule
**NCCI:** National Correct Coding Initiative
**OEI:** Office of Evaluation and Inspections
**OPPS:** Outpatient Prospective Payment System
**PTP:** Procedure-to-Procedure
**RAC:** Recovery Audit Contractors
**ZPICs:** Zone Program Integrity Contractors
Coverage & Documentation
Overview
Office of Inspector General

Part B Payments
Fiscal Year 2003

Review of Claims with Modifier 59

- Services Not Distinct - 15%
- Code Pairs Met Program Requirements - 60%
- Services Not Adequately Documented - 25%

Code Appended by Modifier 59

- Primary Code Only - 11%
- Secondary Code Only - 76%
- Both Primary and Secondary Codes - 13%

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Use of Modifier 59 to Bypass Medicare’s National Correct Coding Initiative Edits, OEI-03-02-00771, November 2005,
http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf

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False Claims Act

United States Attorney’s Office Investigation

- Duke University Health System, Inc.
  - Includes: Duke University Hospital, Duke Regional Hospital, and Duke Raleigh Hospital

- False Claims
  - Allegation: Increasing Billing and Unbundling Claims to Medicare, Medicaid, and TRICARE
  - Settlement of $1 Million


2013 CERT Report

$2.4 Billion

$770 Million

$450 Million

$320 Million

Projected Payments with Modifier 59:
- MPFS Payments

Projected Errors:
- Total One-Year Errors
- OPPS Errors
- MPFS Errors

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Specific Modifiers for Distinct Procedural Services. Transmittal: 1422, Change Request: 8863, Effective: January 1, 2015,
CPT® Modifiers

Provide the means to report or indicate that a service or procedure performed has been altered by some circumstance but not changed in its definition or code

- Append CPT® and Healthcare Common Procedure Coding System (HCPCS) codes to add specificity
  - Level I (CPT®)
  - Level II (HCPCS)
NCCI Edits Overview

Apply to services rendered by same provider on the same date to the same beneficiary

- Pairs of HCPCS codes
- Generally not billed together
- Two column format
  - Column 2: generally not payable with Column 1 code
  - Under certain circumstances, a provider may bill for both services in a code pair by including a modifier to bypass the edit

How to Use the Medicare National Correct Coding Initiative (NCCI) Tools, ICN: 901346, January 2013
# Modifier Indicators

<table>
<thead>
<tr>
<th>Modifier Indicator</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (Not Allowed)</td>
<td>A modifier cannot be used to bypass the edit</td>
</tr>
<tr>
<td>1 (Allowed)</td>
<td>A modifier can be used to bypass the edit</td>
</tr>
<tr>
<td>9 (Not Applicable)</td>
<td>The edit has been deleted or no longer applies</td>
</tr>
</tbody>
</table>

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How to Use the Medicare National Correct Coding Initiative (NCCI) Tools, ICN: 901346, January 2013,
## Understanding NCCI Edits

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>* = In existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Code</td>
<td>CPT Code</td>
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<td></td>
<td></td>
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<tr>
<td>11056</td>
<td>64450</td>
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<td>64530</td>
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<td>*</td>
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<tr>
<td>11056</td>
<td>69990</td>
<td></td>
<td>20000605</td>
<td>*</td>
<td>0</td>
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</table>

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Modifier 59

“Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.”
Bypassing of NCCI Modifier 59 Edits

Commonly misused to describe a different procedure or surgery

- Two procedures/surgeries cannot be reported together if performed at the same anatomic site or patient encounter
  - Several exceptions apply to procedures performed at same patient encounter

Specific Modifiers for Distinct Procedures, Change Request 8863, August 15, 2014
Use of Modifier 59
Prior to 2015

Documentation must support a:

- Different session
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury (or area of injury in extensive injuries)

Specific Modifiers for Distinct Procedures,
Change Request 8863, August 15, 2014
Modifier 59 Concerns

- Most widely used modifier
- Incorrect use of modifier to bypass NCCI edits
- Most commonly abused modifier
- Abuse siphons off funds from compliant providers
- Associated with high levels of manual audit activity, appeals and civil fraud and abuse cases

Specific Modifiers for Distinct Procedures, Change Request 8863, August 15, 2014
**-X {EPSU} Modifiers**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>XE</td>
<td>Separate Encounter</td>
<td>A service that is distinct because it occurred during a separate encounter</td>
</tr>
<tr>
<td>XP</td>
<td>Separate Practitioner</td>
<td>A service that is distinct because it was performed by a different practitioner</td>
</tr>
<tr>
<td>XS</td>
<td>Separate Structure</td>
<td>A service that is distinct because it was performed on a separate organ/structure</td>
</tr>
<tr>
<td>XU</td>
<td>Unusual Non-overlapping Service</td>
<td>The use of a service that is distinct because it does not overlap usual components of the main service</td>
</tr>
</tbody>
</table>

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*Specific Modifiers for Distinct Procedures*, Change Request 8863, August 15, 2014,
Using the \(-X\{EPSU\}\) Modifiers

**Effective:** January 1, 2015

**Implementation:** January 5, 2015

- CMS will initially accept either a modifier 59 or a more selective \(-X\{EPSU\}\) modifier as correct coding
- Rapid migration to the more specific modifiers is encouraged
- Modifiers are valid before national edits are in place
# Modifier 59: Correct Use

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>CPT/HCPCS</td>
<td>EMG</td>
</tr>
<tr>
<td>08 01 13</td>
<td>08 01 13</td>
<td>99213</td>
<td>25</td>
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<tr>
<td>08 01 13</td>
<td>08 01 13</td>
<td>11100</td>
<td>59</td>
</tr>
<tr>
<td>08 01 13</td>
<td>08 01 13</td>
<td>11101</td>
<td></td>
</tr>
<tr>
<td>08 01 13</td>
<td>08 01 13</td>
<td>17004</td>
<td></td>
</tr>
</tbody>
</table>
Incorrect Use of Modifier 59: Example 1

<table>
<thead>
<tr>
<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
<th>CPT/HCPCS</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
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<td>15</td>
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<td></td>
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<td></td>
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<tr>
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<td>15</td>
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<td>09</td>
<td>15</td>
<td>13</td>
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<td>11101</td>
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<td>15</td>
<td>13</td>
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<td></td>
<td>88305</td>
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</tbody>
</table>
## Incorrect Use of Modifier 59: Example 2

<table>
<thead>
<tr>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY MM DD YY</td>
<td>EMG</td>
<td>CPT/HCPCS</td>
</tr>
<tr>
<td>11 11 13 11 11 13</td>
<td>11100</td>
<td>59</td>
</tr>
<tr>
<td>11 11 13 11 11 13</td>
<td>88305</td>
<td></td>
</tr>
</tbody>
</table>
# Incorrect Use of Modifier 59: Repeat Procedure

<table>
<thead>
<tr>
<th></th>
<th>Date(s) of Service From MM/DD/YY</th>
<th>Date(s) of Service To MM/DD/YY</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01 05 14 01 05 14</td>
<td></td>
<td></td>
<td></td>
<td>11623</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>01 05 14 01 05 14</td>
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<td></td>
<td></td>
<td>11622</td>
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</tr>
<tr>
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<td>01 05 14 01 05 14</td>
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<td></td>
<td></td>
<td>11622 59</td>
<td></td>
</tr>
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<tr>
<td>5</td>
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</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Incorrect Use of Modifier 59: Add-on Code

<table>
<thead>
<tr>
<th>From MM/DD/YYYY</th>
<th>To MM/DD/YYYY</th>
<th>Place of Service</th>
<th>Procedures, Services or Supplies (Explain Unusual Circumstances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>03 15 14</td>
<td>03 15 14</td>
<td></td>
<td>17000</td>
</tr>
<tr>
<td>03 15 14</td>
<td>03 15 14</td>
<td></td>
<td>17003 59</td>
</tr>
</tbody>
</table>
# Claims Lines Analyzed in CBR201501

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 59 Added to Claim</th>
<th>Claim Lines with Modifier 59</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>11101</td>
<td>32.3 %</td>
<td>240,545</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure); each separate/additional lesion</td>
</tr>
<tr>
<td>17003</td>
<td>9.9 %</td>
<td>309,961</td>
<td>Destruction premalignant lesions each; second through 14 lesions</td>
</tr>
</tbody>
</table>

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References
CMS Transmittals

- **Table of Contents**

- **Specific Modifiers for Distinct Procedural Services.** CMS. Transmittal 1422, Change Request 8863, Effective Date: January 1, 2015
Chapter I—General Correct Coding Policies
- Section D—Evaluation and Management (E&M) Services
- Section E—Modifiers and Modifier Indicators

Chapter III—Surgery: Integumentary System
- Section B—Evaluation and Management (E&M) Services
- Section E—Lesion Removal
- Section L—General Policy Statements

Claims Processing Manual

Index to Claims Processing Manual

Chapter 12, Physicians/Non-physician Practitioners, Section 30—Correct Coding Policy
Methods and Results
Report Data

Medicare Part B *Rendering* Provider
- Located by National Provider Identifier (NPI)

Peer groups
- For comparison with the individual providers
Comparison Groups

**State:** Medicare providers with allowed charges for CPT® codes 11101 and 17003 in the provider’s state

**National:** All Medicare providers in the nation with allowed charges for CPT® codes 11101 and 17003
Data Source

CMS Integrated Data Repository (IDR)

- Extracted: December 9, 2014
- Dates of Service:
  July 1, 2013 – June 30, 2014
# Table 1

## Summary of Your Utilization for CPT® Codes and Modifier 59
### July 1, 2013 – June 30, 2014

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Abbreviated Description</th>
<th>Type</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Claim Lines</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>11101</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion</td>
<td>With Mod 59</td>
<td>$955.14</td>
<td>30</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>11101</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion</td>
<td>Without Mod 59</td>
<td>$381.93</td>
<td>12</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction; 2 through 14 lesions</td>
<td>With Mod 59</td>
<td>$3,417.49</td>
<td>403</td>
<td>87</td>
<td>83</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction; 2 through 14 lesions</td>
<td>Without Mod 59</td>
<td>$22,519.70</td>
<td>2,817</td>
<td>670</td>
<td>524</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>$27,274.26</strong></td>
<td><strong>3,262</strong></td>
<td><strong>794</strong></td>
<td><strong>599</strong></td>
</tr>
</tbody>
</table>

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Understanding Table 1

Summary of Your Utilization for CPT® Codes and Modifier 59
July 1, 2013 – June 30, 2014

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Abbreviated Description</th>
<th>Type</th>
<th>Allowed Charges</th>
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<td>599</td>
</tr>
</tbody>
</table>

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Comparison Outcomes

Four possible outcomes:
1. Significantly Higher
2. Higher
3. Does Not Exceed
4. Not Applicable (N/A)
Percentage of Claim Lines with Modifier 59

- Calculated as follows:

\[
\left( \frac{\text{Number of Claim Lines with Modifier 59}}{\text{Total Number of Claim Lines}} \right) \times 100
\]

- The percentage is calculated for each CPT® code
## Table 2

### Percentage of Claim Lines with Modifier 59
**July 1, 2013 – June 30, 3014**

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Your Percentage of Modifier 59 Use</th>
<th>Your State’s Percentage of Modifier 59 Use</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Modifier 59 Use</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11101</td>
<td>70%</td>
<td>25%</td>
<td>Significantly Higher</td>
<td>32%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>17003</td>
<td><strong>11%</strong></td>
<td><strong>10%</strong></td>
<td>Higher</td>
<td>10%</td>
<td>Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha=0.05.
### Calculating Percentage of Claims Lines with Modifier 59

#### Summary of Your Utilization for CPT® Codes and Modifier 59
**July 1, 2013 – June 30, 2014**

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Abbreviated Description</th>
<th>Type</th>
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<tr>
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<td>3,262</td>
<td>794</td>
<td>599</td>
</tr>
</tbody>
</table>

\[
\left( \frac{87}{87 + 670} \right) \times 100 \approx 11
\]

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Percentage of Visits with Dermatology Add-on Code and E/M Code

- Calculated as follows:

\[
\left( \frac{\text{Number of Shared Visits}}{\text{Total Number of Visits}} \right) \times 100
\]

- A *Visit* refers to all services on a date

- A *Shared Visit* refers to a visit with a dermatology billing in addition to an E/M billing
Table 3

Percentage of Shared Visits
July 1, 2013 – June 30, 2014

<table>
<thead>
<tr>
<th>Type</th>
<th>Your Percentage of Shared Visits</th>
<th>Your State’s Percentage of Shared Visits</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Shared Visits</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M Visits</td>
<td>59%</td>
<td>68%</td>
<td>Does Not Exceed</td>
<td>69%</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha=0.05.
Average Allowed Services per Beneficiary

- Calculated as follows:

\[
\left( \frac{\text{Total Allowed Services}}{\text{Total Number of Beneficiaries}} \right)
\]

- Average number of services for the one-year period
Table 4

Average Allowed Services per Beneficiary
July 1, 2013 – June 30, 2014

<table>
<thead>
<tr>
<th>Type</th>
<th>Your Average Services per Beneficiary</th>
<th>Your State’s Average Services per Beneficiary</th>
<th>Comparison with Your State’s Average</th>
<th>National Average Services per Beneficiary</th>
<th>Comparison with the National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>5.45</td>
<td>5.31</td>
<td>Higher</td>
<td>5.87</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

A t-test was used in this analysis, alpha=0.05.
Calculating Average Allowed Services per Beneficiary

Summary of Your Utilization for CPT® Codes and Modifier 59
July 1, 2013 – June 30, 3014

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Abbreviated Description</th>
<th>Type</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Claim Lines</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>11101</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion</td>
<td>With Mod 59</td>
<td>$955.14</td>
<td>30</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>11101</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane; each separate/additional lesion</td>
<td>Without Mod 59</td>
<td>$381.93</td>
<td>12</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction; 2 through 14 lesions</td>
<td>With Mod 59</td>
<td>$3,417.49</td>
<td>403</td>
<td>87</td>
<td>83</td>
</tr>
<tr>
<td>17003</td>
<td>Destruction; 2 through 14 lesions</td>
<td>Without Mod 59</td>
<td>$22,519.70</td>
<td>2,817</td>
<td>670</td>
<td>524</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>$27,274.26</td>
<td>3,262</td>
<td>794</td>
<td>599</td>
</tr>
</tbody>
</table>

\[
\left(\frac{3262}{599}\right) \approx 5.45
\]

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Resources
CBR Website

www.cbrinfo.net

- About Us
- CBR Releases
- CBR Support
- Education
- Recommended Links
- FAQs
- Contact Us

Comparative Billing Reports

Comparative Billing Reports (CBRs) are educational tools administered by the Centers for Medicare & Medicaid Services (CMS). They are developed and disseminated under contract by eGlobalTech, a woman-owned Federal services firm based in Arlington, VA.

The CBRs are disseminated to the provider community to provide insight into billing trends across regions and policy groups. A/B MACs have been producing and disseminating limited numbers of CBRs to targeted providers for many years. CMS has now formalized and expanded the program to a national level. The program also includes a CBR Support help desk that providers can contact to ask questions regarding the CBRs. Following the release of each CBR, eG3T will hold an educational teleconference or webinar to educate providers on the substance of the CBR and to provide an opportunity for providers to ask questions.

The CBR is just one tool that CMS uses in its ongoing efforts to protect the integrity of the Medicare Trust Fund. Other efforts include:
FAQs

General FAQs

CBR Specific FAQs

- CBR201501 Modifier 59: Dermatology

http://www.cbrinfo.net/cbr201501-faqs.html

Proper Use of Modifier 59. *MLN Matters®,* SE1418.  

For more information about the Medicare Learning Network®:  
Additional Resources

  http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf

  http://www.asha.org/News/2014/Medicare-Clarifies-Billing-Modifiers-for-Therapy-Services/

  http://www.apta.org/PTinMotion/News/2014/9/29/59Modifier/
Next Steps
Provider Self-audit

- Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly.
- Self-audits allow providers and suppliers to identify coverage and coding errors.
- Refer to the following CBR sections for assistance:
  - Documentation and Billing
  - References
Contact Information
CBR Support Help Desk

Monday–Friday: 9:00 a.m. to 5:00 p.m. ET
- Toll Free 1–800–771–4430
- Email: cbrsupport@eglobaltech.com
Contacting MACs

Providers should contact the Medicare Administrative Contractor (MAC) for assistance with:

- Claim Information
- Documentation Requirements
- Billing and Coding

Locate Your MAC:
NPPES

National Plan & Provider Enumeration System

- Source for mailing address used for the CBR
- Correct your mailing information at https://nppes.cms.hhs.gov/NPPES
Questions & Answers