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CBR201613: Modifier 25- Obstetrics/Gynecology (OB/GYN)

3:00 P.M. ET
October 5, 2016
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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 (LCDs) and Local Coverage Articles (LCAs) 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. Methods & Results
4. References & Resources
5. Q&A
6. Survey
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, you should be able to:

- Demonstrate a general understanding of **CBR201613: Modifier 25 - Obstetrics/Gynecology**
- Comprehend the analytical methods used to develop the report
- Locate policy references and resources
Sample CBR

Provided for each topic
http://www.cbrinfo.net/

Comparative Billing Report (CBR): NP1 111111111
Modifier 25: Obstetrics/Gynecology (OB/GYN)

Introduction
This CBR focuses on physicians with a specialty of obstetrix/gynecology who submitted claims for established patient evaluation and management (E/M) services appended with modifier 25. The CPT® 2015 Professional Edition manual defines modifier 25 as indicative of a "significant, separately identifiable E/M service by the same physician or other qualified health professional on the same day of the procedure or other service." Specifically, this CBR examines Current Procedural Terminology (CPT®) codes 99211 through 99215.

In 2005, the Office of the Inspector General (OIG) released a report on Medicare payments for E/M services billed with modifier 25. The report, "Use of Modifier 25" (OIG-07-03-00979), indicated that out of $1.36 billion paid for claims using modifier 25, as much as $558 million was paid improperly. The OIG found that many providers appended the modifier to more than 50 percent of the services they billed, while other providers used Modifier 25 on their E/M services when no other services were performed on the same day. Of the 431 claims audited, 35 percent did not meet program requirements.

Table 1 provides an abbreviated description for CPT® codes 99211 through 99215, as well as the typical time estimated by the CPT® manual.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Abbreviated Description</th>
<th>Typical Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Minimal Problem/Exam</td>
<td>5 Minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Problem Resolved/Exam</td>
<td>10 Minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Extended Problem/Exam</td>
<td>15 Minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Detailed Patient History</td>
<td>25 Minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive/Patient History</td>
<td>40 Minutes</td>
</tr>
</tbody>
</table>

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The metrics reviewed in this report are:
- Percentage of services with modifier 25 appended
- Average allowed minutes per visit for claim line with modifier 25 and without modifier 25
- Average allowed charges per beneficiary summed for the one-year period, regardless of the modifier appended to the claim line

Coverage and Documentation Overview
This portion of the CBR offers a brief look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. The information provided does not supersede or alter the coverage and documentation policies, as outlined in the Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs). Please refer any specific questions you may have to the MAC for your region.
CBR Purpose

**Designed to:**
- Provide information to the provider community
- Compare billing practices among Medicare providers and their peer groups

**Give providers an opportunity to:**
- Check their records against data in CMS files
- Review Medicare guidelines to ensure compliance
CBR Focus

Metrics:

- Percentage of Services with modifier 25
- Average Allowed Minutes per Visit with/without Modifier 25
- Average Allowed Charges per Beneficiary
Demographics

- 5,000 providers
- Medicare Fee-for-Service (FFS) claims data
- Billing patterns different from their peers
Webinar Materials

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWV</td>
<td>Annual Wellness Visit</td>
</tr>
<tr>
<td>CPT®</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>IPPE</td>
<td>Initial Preventative Physical Examination</td>
</tr>
<tr>
<td>LCAs</td>
<td>Local Coverage Articles</td>
</tr>
<tr>
<td>LCDs</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
</tbody>
</table>

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Coverage & Documentation Overview
Office of Inspector General (OIG):

- *Use of Modifier 25*, November 2005, OEI-07-03-00470
  - 29 million claims: filed with Modifier 25 in 2002
  - $1.96 billion: Medicare payments in 2002
  - 35% of services: Medicare criteria not met
  - $538 million: estimated improper payments
Other Investigations

New York State Office of the State Comptroller:


**Audited:** New York State Health Insurance Program claims

**Results:** 12.6% did not meet requirements for appending modifier 25
United States Attorney, Northern District of Georgia: September 2012

- Leading Oncology Practice to Pay $4.1 Million to Settle False Claims Act Investigation
  - Settlement with Georgia Cancer Specialists I, PC
  - 27 offices in Atlanta metro area
  - $4.1 million for violations of False Claims Act
Why Did I Get a CBR

Your billing is different from peers in:

- Your state
- The nation

Receiving a CBR is **NOT:**

- Indicative of wrongdoing
- An audit
What is a Modifier

Modifiers:

- Provide the means to report or indicate that a service or procedure performed has been altered by some specific circumstance but not changed in its definition or code.
- Are appended to CPT® and HCPCS codes to add specificity.
- Two types: Level I (CPT®) and Level II (HCPCS)
Modifier 25

Indicates:

“A significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service”
Surgical Package

Always includes:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate post-operative care, writing orders, post anesthesia care and routine follow up
Global period of 000 or 010 days:

- Minor surgical procedure
- In general, E/M services on the same date of service are included in the payment for the procedure
- Example: removal of a foreign body from a muscle or tendon sheath; simple
Major Procedures

Global period of 090 days:

- Major surgical procedure
- E/M performed on the same day as the minor procedure are payable when appended with Modifier 57, if the E/M was done in order to determine the need for the surgery
- Example: CPT® code 23650 – closed treatment of shoulder dislocation, with manipulation, without anesthesia
Medicare Physician Fee Schedule Database (MPFSDB)

Instructions:
Determine the Global Period

Medicare Physician Fee Schedule Database:

1. Physician Fee Schedule Search
   - Screen defaults to current year
2. Type of Information
3. Payment Policy Indicators
4. Single or multiple code range
   - Enter the appropriate code(s)
5. All Modifiers
6. Global
# Global Periods

<table>
<thead>
<tr>
<th>Global Fee Period</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>000</td>
<td>Zero Global Days</td>
</tr>
<tr>
<td>010</td>
<td>Ten Global Days</td>
</tr>
<tr>
<td>090</td>
<td>Ninety Global Days</td>
</tr>
<tr>
<td>XXX</td>
<td>Global Concept Does Not Apply</td>
</tr>
<tr>
<td>YYY</td>
<td>Defined by A/B MAC</td>
</tr>
<tr>
<td>ZZZ</td>
<td>Related to Another Procedure</td>
</tr>
<tr>
<td>MMM</td>
<td>Maternity Codes (usual global period does not apply)</td>
</tr>
</tbody>
</table>

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Well Woman Exam: HCPCS code G0101:

- Beneficiary receives additional services:
  - Evaluated and treated for new onset of menopausal symptoms: CPT® code 99212–25
  - Prescribed new medication
Modifier 25: Incorrect Use

Beneficiary has second appointment for non-healing wound:

- Debridement of skin and subcutaneous tissue for non-healing wound: CPT® code 11042 only
- No other conditions were addressed: CPT® code 99212–25 is not submitted
- Documentation reflects only the provider’s time, examination, and medical decision making to determine need for debridement

- **Do not submit** CPT® code 99212–25
Supporting Documentation

Documentation must support:

- History
- Exam
- Knowledge
- Work time
- Risk

Auditors must see additional work:

- Above and beyond what is usually required for the surgery/procedure
Verify the following:

- Key components of a problem-oriented E/M service
- Problem that can stand alone as a billable service
- Different diagnosis is not required
- If same diagnosis, documentation must support extra work beyond pre- or post-operative work associated with the procedure performed
Learn Proper Coding for Modifiers 59 and 25

- Key component: Above and beyond (same physician/same day)
- Additional history, exam, knowledge, skill, work time, and/or risk
- Separately identifiable E/M and non-E/M services
- No support for the performed procedure itself
IPPE/AWV & Same Day E/M

IPPE (Welcome to Medicare visit) or AWV:
- Modifier 25 is not appended
- No part of the documentation for the IPPE or AWV is used toward the medically necessary E/M

Additional E/M service:
- Modifier 25 is appended to the additional E/M service
## Typical Time for E/M Services

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Typical Time</th>
<th>Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5 Minutes</td>
<td>Minimal problem</td>
</tr>
<tr>
<td>99212</td>
<td>10 Minutes</td>
<td>Self-limited or minor</td>
</tr>
<tr>
<td>99213</td>
<td>15 Minutes</td>
<td>Low to moderate severity</td>
</tr>
<tr>
<td>99214</td>
<td>25 Minutes</td>
<td>Moderate to high severity</td>
</tr>
<tr>
<td>99215</td>
<td>40 Minutes</td>
<td>Moderate to high severity</td>
</tr>
</tbody>
</table>

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Use of Time to Determine the Level of E/M Service

**CPT® Manual:**

“When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family...then time may be considered as the key or controlling factor to qualify for a particular level of E/M services.”
Methods & Results
Medicare Part B Rendering Provider:

- By National Provider Identifier (NPI)
- Specialty of Obstetrics/Gynecology (16)
- CPT® codes 99211-99215
Peer Groups:

- Used for comparison with the individual providers

State:

- Medicare providers in the provider’s state

National:

- All Medicare providers in the Nation
Data Source

- CMS Integrated Data Repository (IDR)
- Extracted July 19, 2016
- DOS: January 1, 2015 – December 31, 2015
<table>
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<tr>
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<td>Problem Focused/Exam</td>
<td>10 Minutes</td>
</tr>
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<td>99213</td>
<td>Expanded Problem Focused/Exam</td>
<td>15 Minutes</td>
</tr>
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Table 2: Summary of Your Utilization for E/M Codes and Modifier 25
January 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Type</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>With Mod 25</td>
<td>$18.50</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>99211</td>
<td>Without Mod 25</td>
<td>$272.85</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>99212</td>
<td>With Mod 25</td>
<td>$366.18</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>99212</td>
<td>Without Mod 25</td>
<td>$1,053.73</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>99213</td>
<td>With Mod 25</td>
<td>$7,196.60</td>
<td>106</td>
<td>80</td>
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<td>99213</td>
<td>Without Mod 25</td>
<td>$18,206.25</td>
<td>269</td>
<td>182</td>
</tr>
<tr>
<td>99214</td>
<td>With Mod 25</td>
<td>$5,586.98</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>99214</td>
<td>Without Mod 25</td>
<td>$13,122.42</td>
<td>130</td>
<td>104</td>
</tr>
<tr>
<td>99215</td>
<td>With Mod 25</td>
<td>$2,199.71</td>
<td>16</td>
<td>15</td>
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<td>99215</td>
<td>Without Mod 25</td>
<td>$2,061.76</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$50,084.98</strong></td>
<td><strong>642</strong></td>
<td><strong>336</strong></td>
</tr>
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<td>CPT®</td>
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<td><strong>336</strong></td>
</tr>
</tbody>
</table>
Comparison Outcomes

There are four possible outcomes:

1. Significantly Higher
2. Higher
3. Does Not Exceed
4. N/A
Percentage of Services with Modifier 25

Calculated as follows:

\[
\left( \frac{\text{Number of Services with Modifier 25}}{\text{Total Number of Services}} \right) \times 100
\]
## Table 3: Percentage of Services with Modifier 25
### January 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th></th>
<th>Your Percentage of Modifier 25 Use</th>
<th>Your State’s Percentage of Modifier 25 Use</th>
<th>Comparison with Your State’s Percentage</th>
<th>National Percentage of Modifier 25 Use</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Mod 25</td>
<td>29%</td>
<td>23%</td>
<td>Significantly Higher</td>
<td>26%</td>
<td>Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha = 0.05.
## Calculating Percentage of Services with Modifier 25

### Table 2: Summary of Your Utilization for E/M Codes and Modifier 25
**January 1, 2015 – December 31, 2015**

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<td><strong>642</strong></td>
<td><strong>336</strong></td>
</tr>
</tbody>
</table>
Calculating Percentage of Services with Modifier 25 (cont.)

Calculated as follows:

\[
\left( \frac{\text{Number of Services with Modifier 25}}{\text{Total Number of Services}} \right) \times 100
\]

\[
\left( \frac{1 + 9 + 106 + 55 + 16}{642} \right) \times 100 \approx 29\%
\]
Average Allowed Minutes per Visit with and without Modifier 25

- Separate claim lines by those with and those without modifier 25
- Assign value to each CPT® code by typical minutes
- Multiply assigned value with number of services
- Visits with multiple claims are combined
Average Allowed Minutes per Visit with and without Modifier 25 (cont.)

Calculated as follows:

\[
\frac{\text{Total E/M Weighted Services by Modifier Designation}}{\text{Total Number of E/M Visits by Modifier Designation}}
\]
Table 4: Average Allowed Minutes per Visit with Modifier 25 and without Modifier 25 January 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>Type</th>
<th>Your Average Minutes Per Visit</th>
<th>Your State’s Average Minutes Per Visit</th>
<th>Comparison with Your State’s Average</th>
<th>National Average Minutes Per Visit</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Mod 25</td>
<td>19.79</td>
<td>16.70</td>
<td>Significantly Higher</td>
<td>19.11</td>
<td>Higher</td>
</tr>
<tr>
<td>Without Mod 25</td>
<td>18.07</td>
<td>17.22</td>
<td>Significantly Higher</td>
<td>18.27</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

A t-test was used in this analysis, alpha = 0.05.
Calculating Average Allowed Minutes per Visit with and without Mod 25

Table 2: Summary of Your Utilization for E/M Codes and Modifier 25
January 1, 2015 – December 31, 2015

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<tr>
<td>99215</td>
<td>With Mod 25</td>
<td>$2,199.71</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>99215</td>
<td>Without Mod 25</td>
<td>$2,061.76</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$50,084.98</strong></td>
<td><strong>642</strong></td>
<td><strong>336</strong></td>
</tr>
</tbody>
</table>
Calculating Average Allowed Minutes per Visit with and without Modifier 25 (cont.)

Calculated as follows:

\[
\frac{\text{Total E/M Weighted Services by Modifier Designation}}{\text{Total Number of E/M Visits by Modifier Designation}}
\]

\[
\left( \frac{1(5 \text{ mins.})+9(10 \text{ mins.})+106(15 \text{ mins.})+55(25 \text{ mins.})+16(40 \text{ mins.})}{1+9+106+55+16} \right) \approx 19.79
\]

\[
\frac{3,700}{187} \approx 19.79
\]
Average Allowed Charges per Beneficiary

Calculated as follows:

\[
\frac{\text{Total Allowed Charges}}{\text{Total Number of Beneficiaries}}
\]
Table 5: Average Allowed Charges per Beneficiary
January 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>Charges</th>
<th>Your Average Charges Per Beneficiary</th>
<th>Your State’s Average Charges Per Beneficiary</th>
<th>Comparison with Your State’s Average</th>
<th>National Average Charges Per Beneficiary</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges</td>
<td>$149.06</td>
<td>$105.80</td>
<td>Significantly Higher</td>
<td>$127.04</td>
<td>Higher</td>
</tr>
</tbody>
</table>

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

Table 2: Summary of Your Utilization for E/M Codes and Modifier 25  
January 1, 2015 – December 31, 2015

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Type</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>With Mod 25</td>
<td>$18.50</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>99211</td>
<td>Without Mod 25</td>
<td>$272.85</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>99212</td>
<td>With Mod 25</td>
<td>$366.18</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>99212</td>
<td>Without Mod 25</td>
<td>$1,053.73</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>99213</td>
<td>With Mod 25</td>
<td>$7,196.60</td>
<td>106</td>
<td>80</td>
</tr>
<tr>
<td>99213</td>
<td>Without Mod 25</td>
<td>$18,206.25</td>
<td>269</td>
<td>182</td>
</tr>
<tr>
<td>99214</td>
<td>With Mod 25</td>
<td>$5,586.98</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>99214</td>
<td>Without Mod 25</td>
<td>$13,122.42</td>
<td>130</td>
<td>104</td>
</tr>
<tr>
<td>99215</td>
<td>With Mod 25</td>
<td>$2,199.71</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>99215</td>
<td>Without Mod 25</td>
<td>$2,061.76</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$50,084.98</strong></td>
<td><strong>642</strong></td>
<td><strong>336</strong></td>
</tr>
</tbody>
</table>
Calculating Average Allowed Charges per Beneficiary (cont.)

Calculated as follows:

\[
\frac{\text{Total E/M Weighted Services by Modifier Designation}}{\text{Total Number of E/M Visits by Modifier Designation}} \approx 149.06
\]

\[
\left( \frac{50084.98}{336} \right) \approx 149.06
\]
References & Resources
CBR Website

http://www.cbrinfo.net

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

- **General Links:**
  [http://www.cbrinfo.net/recommended-links.html](http://www.cbrinfo.net/recommended-links.html)

- **CBR Specific Links:**
  **CBR201613:** Modifier 25–OB/GYN
  [http://www.cbrinfo.net/cbr201613-recommendedlinks.html](http://www.cbrinfo.net/cbr201613-recommendedlinks.html)
FAQs

- General FAQs:  
  [http://www.cbrinfo.net/faqs.html](http://www.cbrinfo.net/faqs.html)

- CBR Specific FAQs:  
  CBR201613: Modifier 25–OB/GYN  
  [http://www.cbrinfo.net/cbr201613-faqs.html](http://www.cbrinfo.net/cbr201613-faqs.html)
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
CBR Support Help Desk

- Monday–Friday: 9:00a.m. to 5:00p.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
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
We make every effort to address all questions submitted during our webinars. However, we cannot provide responses related to coding issues or to specific claims/scenarios. Since your Medicare Administrative Contractor (MAC) makes the determination to pay or deny a claim based on the CPT® codes, medical documentation and description of the circumstances, and we do not have access to this documentation, we cannot respond to these types of questions. Please contact your MAC with questions that we do not address or if you identify any claims discrepancies while reviewing your CBR. The contact information for your MAC is located at http://go.cms.gov/IMap.