CBR201709:

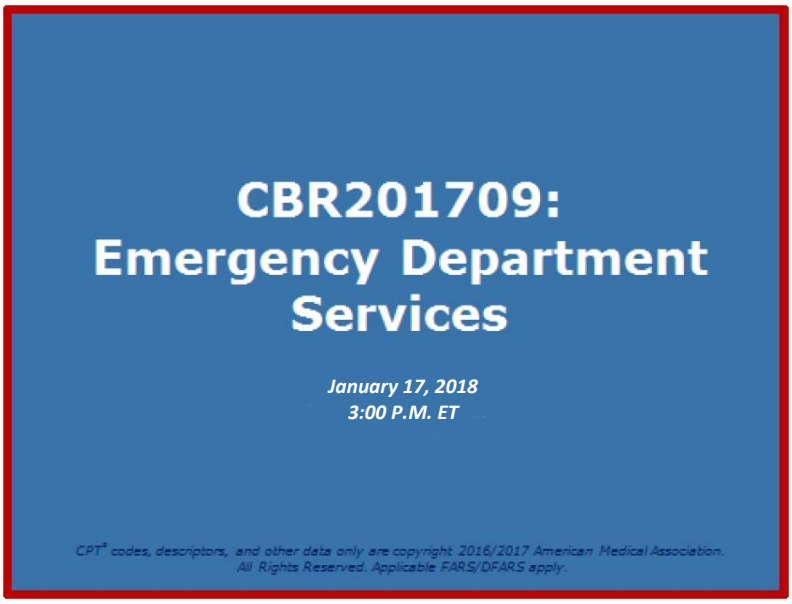
Emergency Department Services

Webinar Handout

CONTENTS

INTRODUCTION

Good afternoon everyone, and welcome to the Comparative Billing Report (CBR) webinar, **CBR201709: Emergency Department Services**. My name is Nick Grant, and I work for eGlobalTech. We also have our subcontractor from Palmetto GBA on the webinar today. We are contracted by the Centers for Medicare & Medicaid Services (CMS) to produce CBRs. Our teams conduct the data analyses, develop and disseminate the reports, ensure data integrity and privacy, and provide customer service and educational outreach.



So, before we get started, I just want to point out that we ensure the accuracy of the contents of the CBR at the time of publication; however Medicare policy does change frequently, so some of the materials in the CBR may change without further notice. Please make sure you are staying up to date with Medicare Program requirements. Coverage and documentation policies can be accessed from the CMS website page titled **Medicare Coverage Database** (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

I would also like to point out that the information in the CBR is 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 (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). The MAC for your region can be accessed from the following website link: **Review Contractor Directory-Interactive Map** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Today, we will give you an overview of the **Emergency Department Services** CBR; and we will discuss coverage policy and documentation requirements for items included in the topic, methods used to produce the report, source references, and additional resources available to you. At the conclusion of the Question and Answer (Q&A) session, we will provide you with a brief survey to complete. We do welcome and value your feedback. When available, the Q&A can be accessed at the following web link: **CBR201709 Webinar** (http://www.cbrinfo.net/cbr201709-webinar).

Now that we have gone over the agenda for today's webinar, we would like to get your response to a poll question. During today's presentation, we will be asking five poll questions, and we will give you about 30 seconds to respond to each question. We are now ready for our first poll question.

POLL QUESTION

What is your role in the Medicare program for your facility?

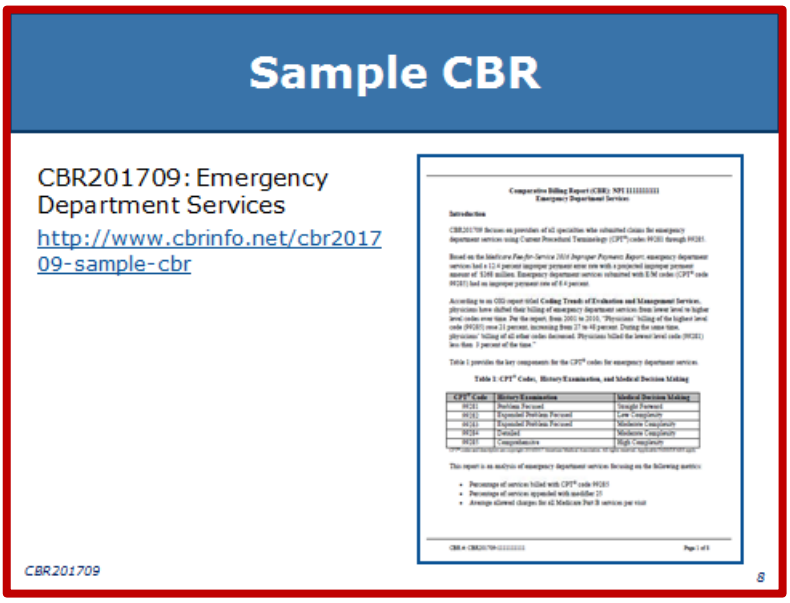
- *Clinician*
- *Biller*
- *Compliance*
- *Administrator*
- *Other*

Now that we have all of your answers, we will continue with our presentation. Thank you for your participation.

Please note that during the webinar, all attendee lines will be muted; however, all webinar related questions can be submitted at any time during the presentation via the chat function, which is currently open. We will provide responses at the end of the presentation during our Q&A session; but please keep in mind that we may not be able to answer all of the questions submitted today, so please take note of our email address which is cbrsupport@eglobaltech.com. Questions about individual claims should be addressed to your MAC. To locate your MAC's contact information, select this website link: **Review Contractor Directory-Interactive Map** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

By the end of this webinar, you should have a general understanding of this CBR and how the data was analyzed. You should also be able to locate policy references and resources.

If you did not receive a CBR and you would like to reference one during this webinar, please log on to our website at **CBR201709 Sample CBR** (http://www.cbrinfo.net/cbr201709-sample-cbr). A sample CBR is produced for each topic, and you may find it beneficial to have a copy available to reference during the webinar.



CBR PURPOSE & FOCUS

The purpose of the CBR is to provide comparative data on how an individual health care provider's billing and payment patterns compare to those of his/her peers. CBRs are solely for provider and supplier information, and they give providers an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance.

CBR201709 focuses on Medicare providers of all specialties who submitted claims for emergency department services using CPT® codes 99281 - 99285. The metrics included in this report are the:

- Percentage of services billed with CPT® code 99285
- Percentage of services appended with modifier 25
- Average allowed charges for all Medicare Part B services per visit

The reports were sent to approximately 16,000 providers who had different billing patterns for these services as compared to their peers.

Links to all of the references and resources provided in the CBR and discussed today are currently available on the CBR website page at **CBR201709 Recommended Links** (http://www.cbrinfo.net/cbr201709-recommended-links). The webinar slides are currently available on our website, but do not contain any speaker's notes. Within five business days of the webinar, we will post the video recording and handout of the entire webinar.

Any questions answered today, as well as questions that we are not able to address this afternoon, will be posted in a detailed Q&A document within 14 days of today. The webinar slides, recording, handout, and Q&A will be available on the CBR webinar page at the link, **CBR201709 Webinar** (http://www.cbrinfo.net/cbr201709-webinar).

ACRONYMS

Please note some of the acronyms that we will be using today:

Acronyms

Code	Description
CBR	Comparative Billing Report
CERT	Comprehensive Error Rate Testing
CPT®	Current Procedural Terminology
ED	Emergency Department
E/M	Evaluation and Management
HPI	History of Present Illness
IDR	Integrated Data Repository
LCA	Local Coverage Article
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MPFS	Medicare Physician Fee Schedule
NCCI	National Correct Coding Initiative
OIG	Office of Inspector General
PFSH	Past, Family, and Social History
Q&A	Questions & Answers
ROS	Review of Systems
ZPIC	Zone Program Integrity Contractor

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Now that you have some information on the purpose, objective, and focus of this CBR, we would like to get your response to our second poll question.

POLL QUESTION

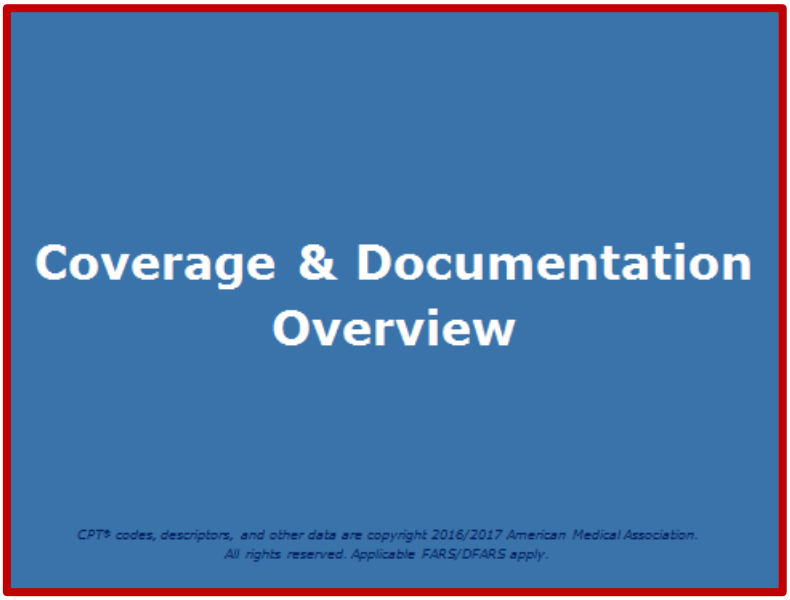
How do you plan to use the information in the CBR and the information presented today?

- *To better understand Medicare guidelines for Emergency Department Services*
- *To educate our billing staff*
- *To locate references and resources*
- *To better comprehend CBR201709*
- *All of the above*

Okay, it looks like we have all of your answers. Thank you for your participation. Now, I will turn it over to Tamara who will provide a coverage and documentation overview.

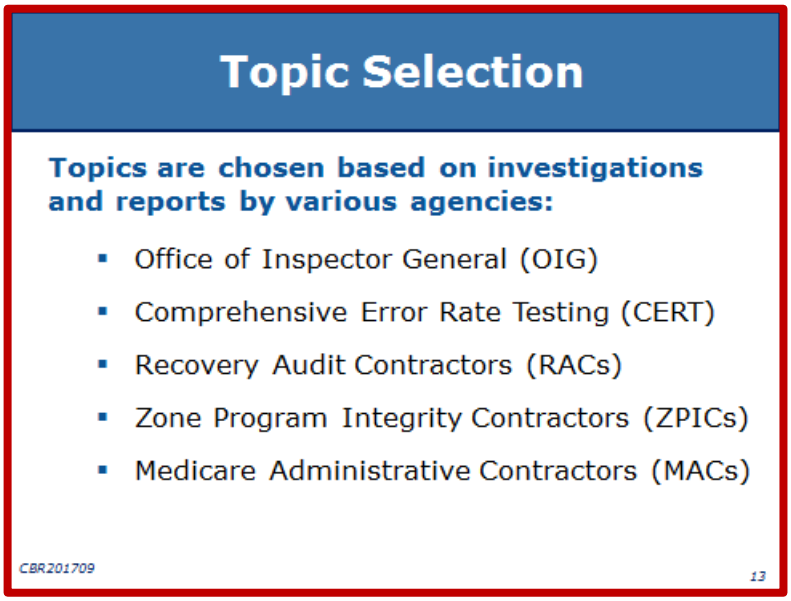
COVERAGE & DOCUMENTATION OVERVIEW

Thank you, Nick. My name is Tamara Canipe. I am a Registered Nurse with Palmetto GBA. My primary responsibility is to research policies and guidelines for our CBR letters and webinar presentations. I will be providing an overview of the coverage criteria, billing and documentation requirements for emergency department services.



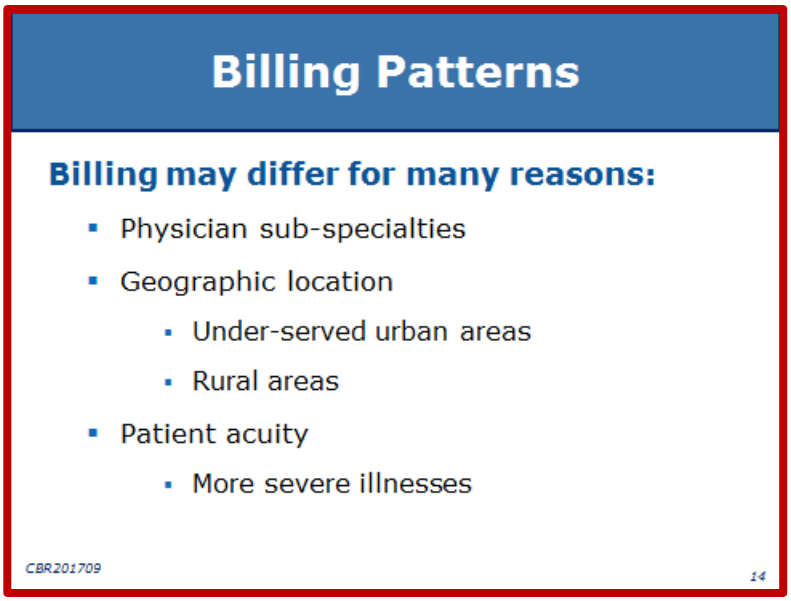
TOPIC SELECTION

This is a list of agencies and reports that we review to stay on top of the latest trends and topics. We also research articles which pertain to private payers and other government payers such as Medicaid and Tricare; because when one payer group reports a problem in billing, it could be found across other payer types.



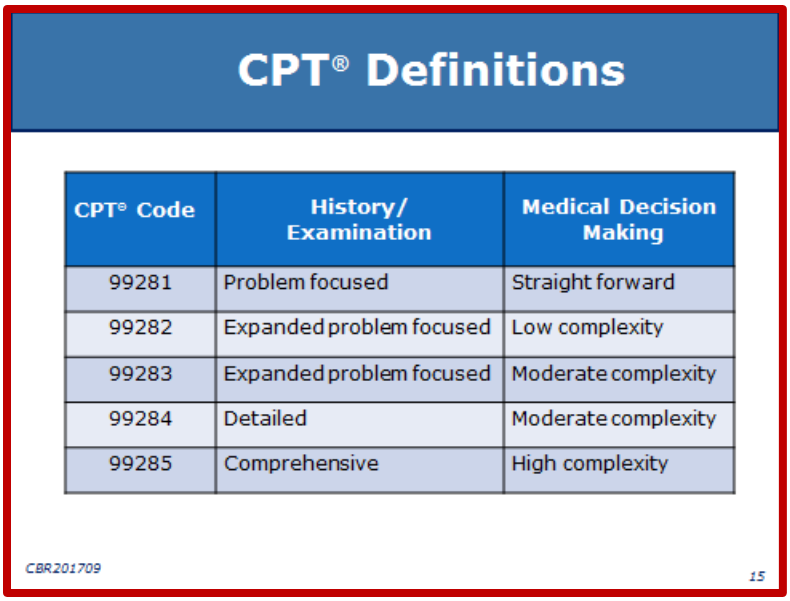
BILLING PATTERNS

The CBR team is aware that practice patterns may differ for various reasons. Some practitioners have sub-specialties or distinctive focuses that are not apparent in claims data. Other providers may practice in under-served urban or rural areas, or in areas with a higher proportion of sicker Medicare beneficiaries. Your office may have a complete understanding of how to code and bill the emergency codes that we will discuss today, and the results of your report may not come as any surprise. If, on the other hand, the report that your office received supports that your billing patterns differ significantly from your peers, and you are not confident of the reason why you are different, then you may want to perform a self-audit using guidance from today's presentation. For guidelines on conducting an audit, select the following link: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).



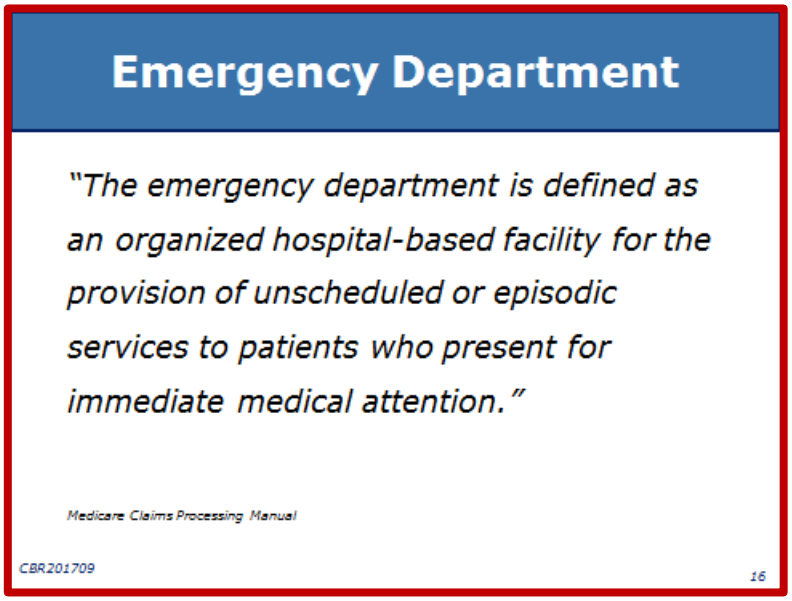
CPT® DEFINITIONS

The history, examination, and medical decision making are the key components in selecting the level of services. As noted on the slide, the history and exam can be problem focused, expanded problem focused, detailed, or comprehensive. The medical decision making can be straight forward, low complexity, moderate complexity, or high complexity.

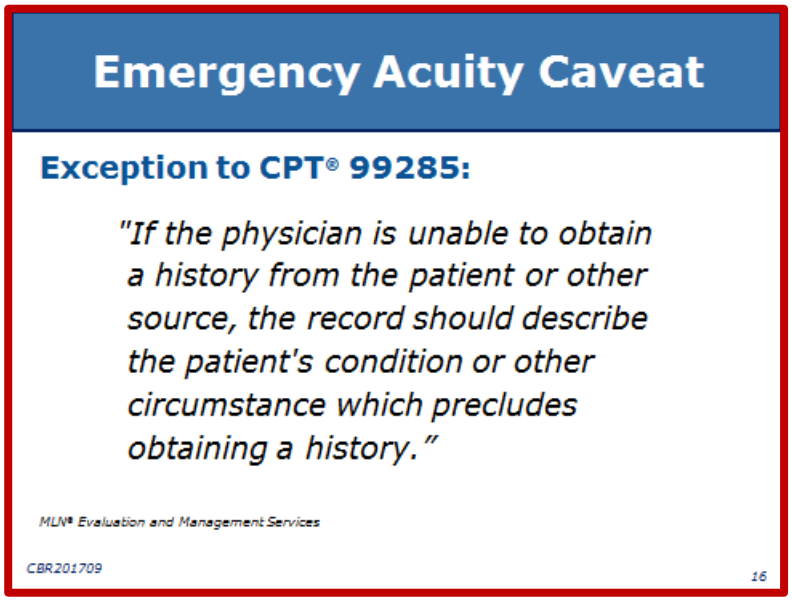


EMERGENCY DEPARTMENT

According to Chapter 12 of the *Medicare Claims Processing Manual*, "The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention." Any physician may treat a patient in the emergency department (room) setting and bill utilizing emergency services CPT® codes. The physician does not have to be assigned to the emergency department. Emergency services CPT® codes should **only** be billed when the patient is treated in the emergency department. Detailed information can be found at the following link: ***Medicare Claims Processing Manual*** **, Chapter 12, Section 30.6.11** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

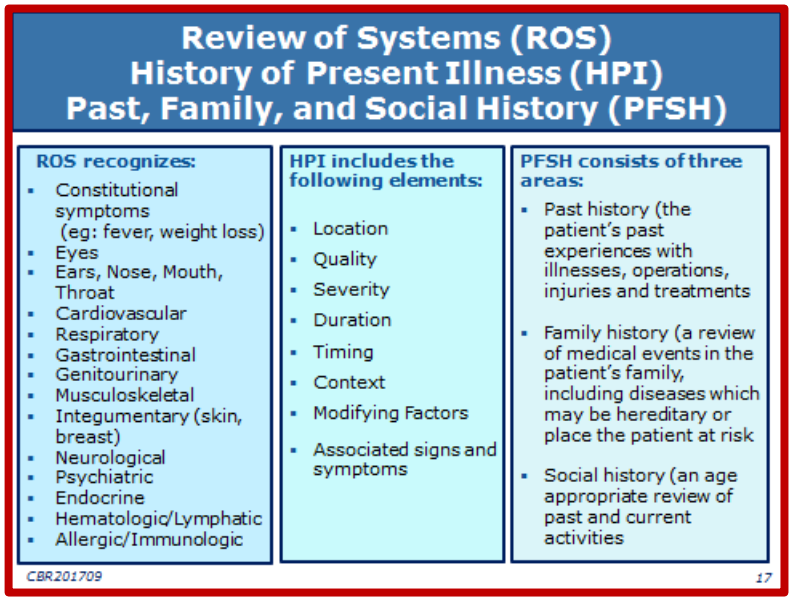


EMERGENCY ACUITY CAVEAT



Emergency department services must be met "within the constraints imposed by the urgency of the patient's clinical condition and/or mental status." This concept is known as the acuity caveat or the emergency medicine caveat. This caveat is exclusive to CPT® code 99285, the highest level emergency department services, and provides an exception if the provider is unable to obtain the patient's history. When this is the case, the documentation should include differential diagnoses, procedures, diagnostic studies, interventions and risk factors. For more information, select the following *Medicare Learning Network (MLN®)* publication: **Evaluation and Management Services** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf).

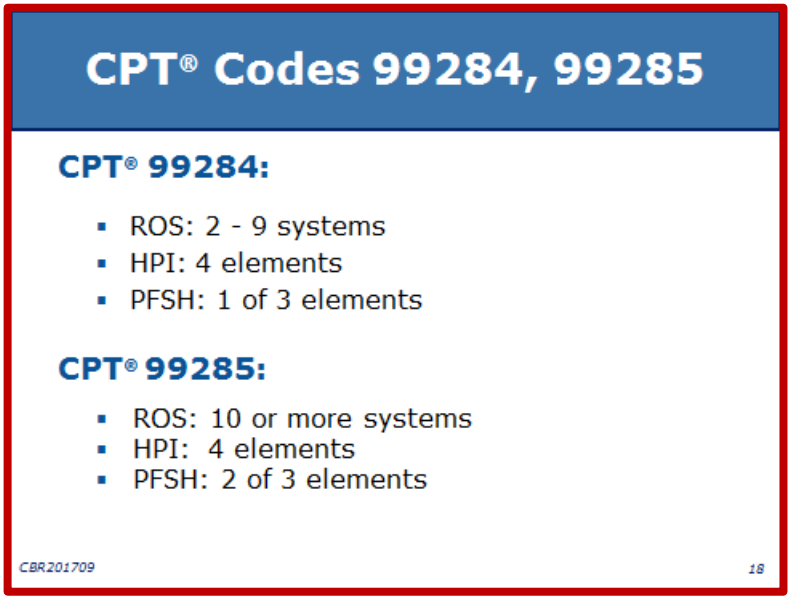
REVIEW OF SYSTEMS (ROS), HISTORY OF PRESENT ILLNESS (HPI), AND PAST, FAMILY, AND SOCIAL HISTORY (PFSH))



This slide shows a list of requirements for the **Review of Systems**, the elements for the **History of Present Illness**, and the three areas for the **Past, Family, and Social History**. All of these can be found in the *MLN®* publication, which is available at this web link: **Evaluation and Management Services** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf).

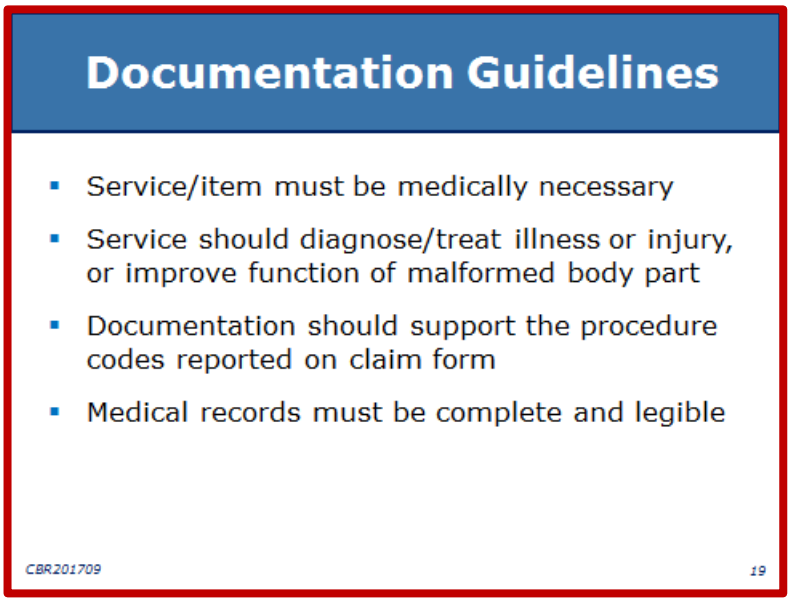
CPT® CODES 99284, 99285

CPT® code 99284 requires providers to document a review of two to nine systems in the **Review of Systems (ROS)**, while CPT® code 99285 requires the recording of 10 or more. Listing of pertinent positives and/or negatives with the statement "all other systems are negative" meets CPT® 99285 requirements. The **History of Present Illness (HPI)** and **Past, Family, and Social History (PFSH)** must also be documented in order to support medical necessity of the services. For the HPI, CPT ® codes 99284 and 99285 both require documentation of four HPI elements. For the PFSH, CPT® 99284 requires recording of one of the three PFSH elements and CPT® 99285 requires recording of two of the three PFSH elements. For details, select this link: **Evaluation and Management Services** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf).



DOCUMENTATION GUIDELINES

Chapter 12 of the *Medicare Claims Processing Manual* contains information about selecting the correct level of evaluation and management (E/M) services. Those instructions state "medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code.

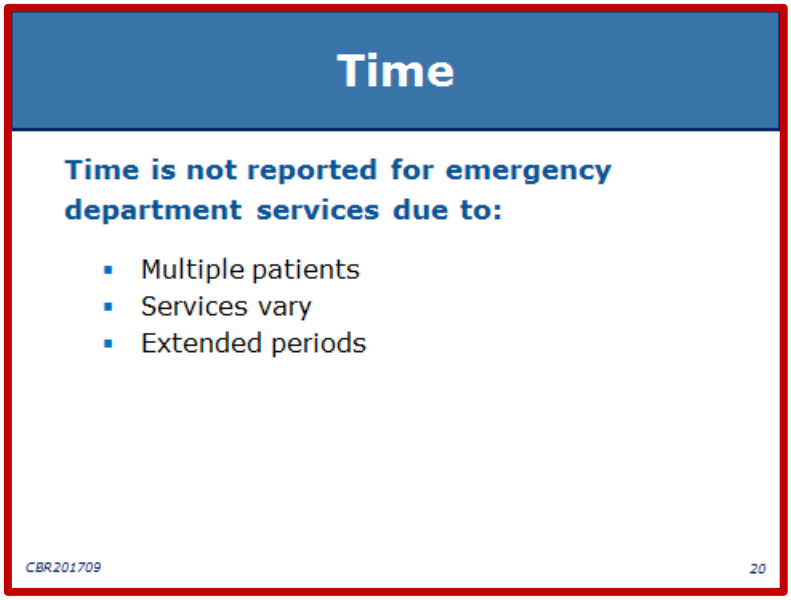


It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record." For complete details, select the following web link: ***Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

Title XVIII of the Social Security Act also states that "no payment may be made for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of injury or to improve the functioning of a malformed body member." This information can be accessed by selecting this link: **Social Security Act, Section 1862 (a)(1)(A)** (https://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

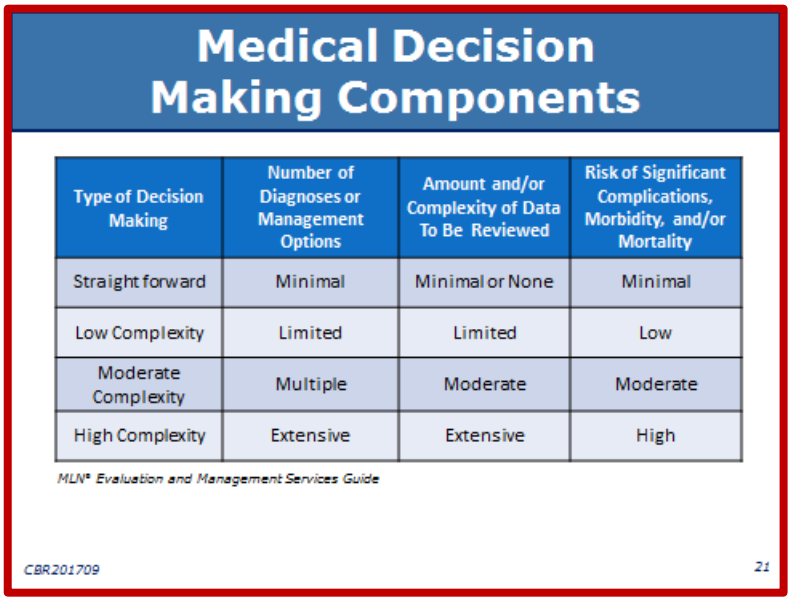
TIME

Time is not used in the descriptive CPT® definition of emergency department E/M services. These services typically have varying intensity. The providers usually have multiple encounters with a number of patients over an extended period of time. This makes it difficult for providers to give an accurate account of face-to-face time with the patient.



MEDICAL DECISION MAKING COMPONENTS

Medical decision making is the driver of E/M CPT® codes. There are three components included in the medical decision making component. They are diagnoses or management options (which can be minimal, limited, multiple or extensive); the amount of data (which can be minimal or none, limited, moderate, or extensive); and the level of risk (which can be minimal, low, moderate or high). More detailed information is available at the following link: **Evaluation and Management Services** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf).



Medical Decision Making Components

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data To Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straight forward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

MLN® Evaluation and Management Services Guide

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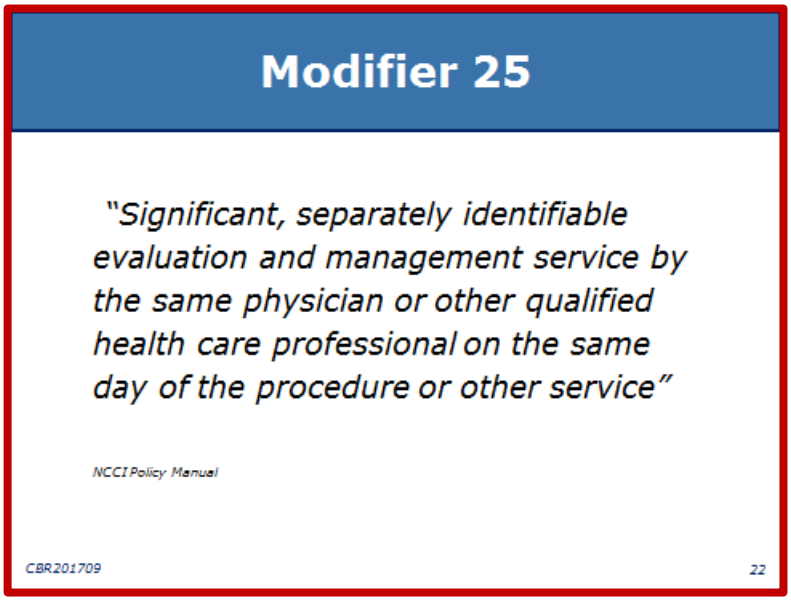
MODIFIER 25

There may be circumstances when it is appropriate to report modifier 25 with emergency department E/M codes; however, documentation must show that the service was significant and separately identifiable, and that the work performed was above and beyond the other service provided.



Modifier 25

"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"

NCCI Policy Manual

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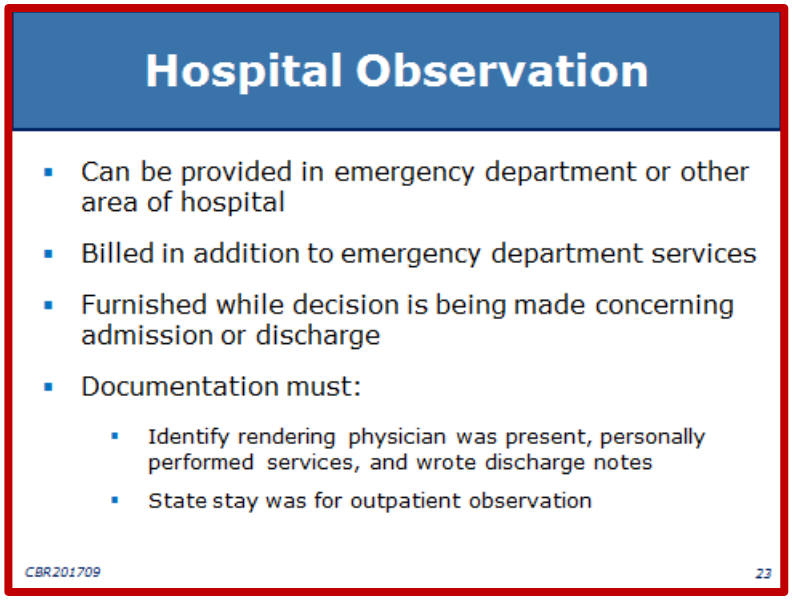
Modifier 25 is a global surgery modifier. This means that it will bypass the edits that bundle the E/M service into the minor procedure performed on the same date of service by the same physician. According to the *National Correct Coding Initiative (NCCI) Policy Manual*, "An E/M service is separately reportable on the same date of service as a procedure with a global period of 000, 010 or 090 days **under limited circumstances**. If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure."

So, if a physician performs a minor surgical procedure in the emergency department, and provides the care immediately required for the procedure, all of these services would be included in the payment for the minor surgical procedure, and would **not** be reported separately as an E/M service with modifier 25. For additional information, select this web link: ***NCCI Policy Manual* (Chapters 1, 11)** (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html).

HOSPITAL OBSERVATION

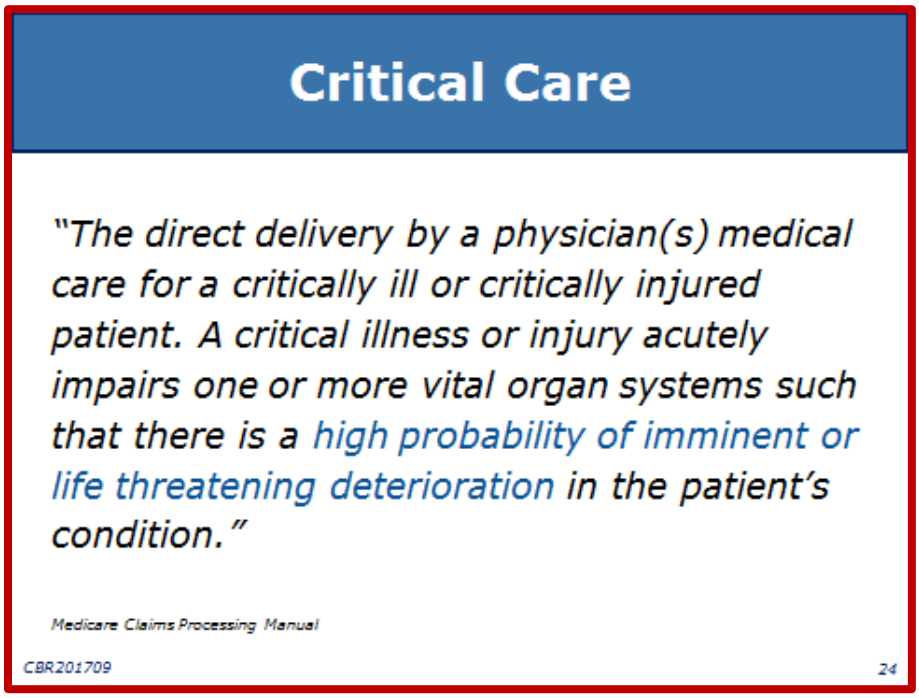


According to Chapter 12 of the *Medicare Claims Processing Manual*, physicians may order observation services for patients who are being treated in the emergency department or in any other area of the hospital. Observation care services can be billed "for patients who present to the emergency department, and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge…There must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient encounter."

Only the ordering physician will receive payment for initial observation care. All other physicians who evaluate or consult during observation must bill the appropriate new or established office, or outpatient service codes. The documentation must identify the physician who performed the services, and must state that the stay was for observation. For more information, select the following web link: ***Medicare Claims Processing Manual,* Chapter 12, Sections 30.6.8, 30.6.11** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

CRITICAL CARE

If the level of service provided meets the criteria for an emergency department CPT® code, then the emergency department CPT® codes should be utilized; however, if the patient's condition and care meets the definition of critical care, then only the critical care code should be billed. CPT® codes 99291 and 99292 should be billed for critical care service.

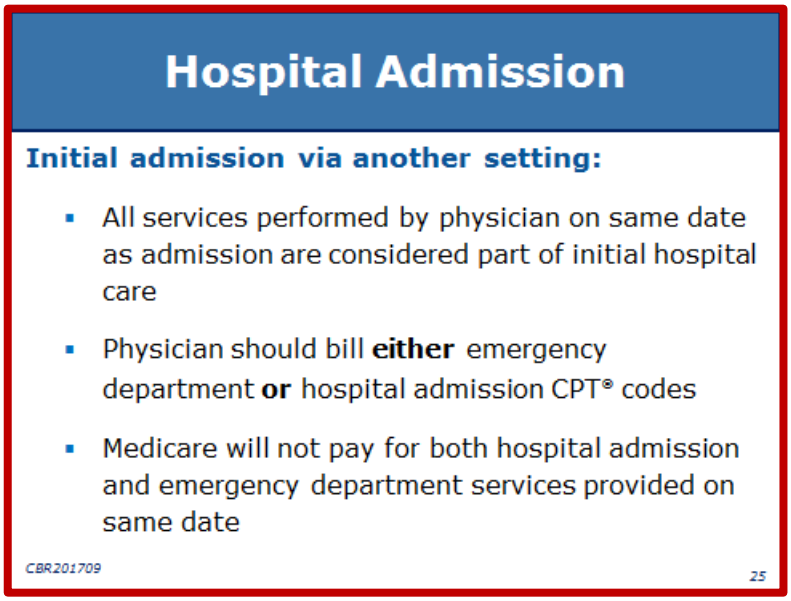


According to the *Medicare Claims Processing Manual*, "Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." Critical care involves high complexity decision making.

Medicare will pay for critical care services provided in any location as long as the services meet the definition of critical care. More details about critical care are available from the following web link: ***Medicare Claims Processing Manual,* Chapter 12, Section 30.6.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

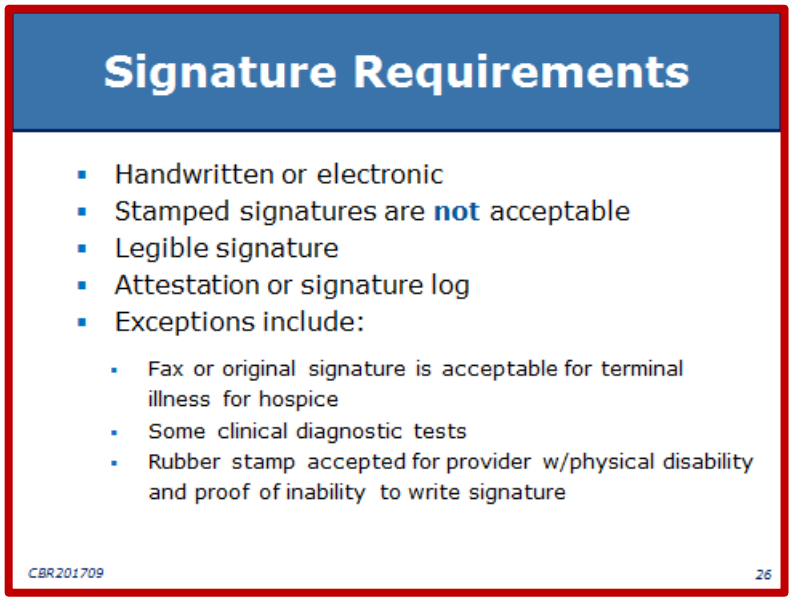
HOSPITAL ADMISSION

If a patient is admitted during an encounter from another setting such as a physician's office, nursing home or emergency department, all E/M services provided by that physician combined with the hospital admission are considered part of the initial hospital care. The rendering physician should bill either the emergency department code or the hospital admission code. Medicare will not pay for both the initial hospital care and the emergency department service by the same physician on the same date of service.



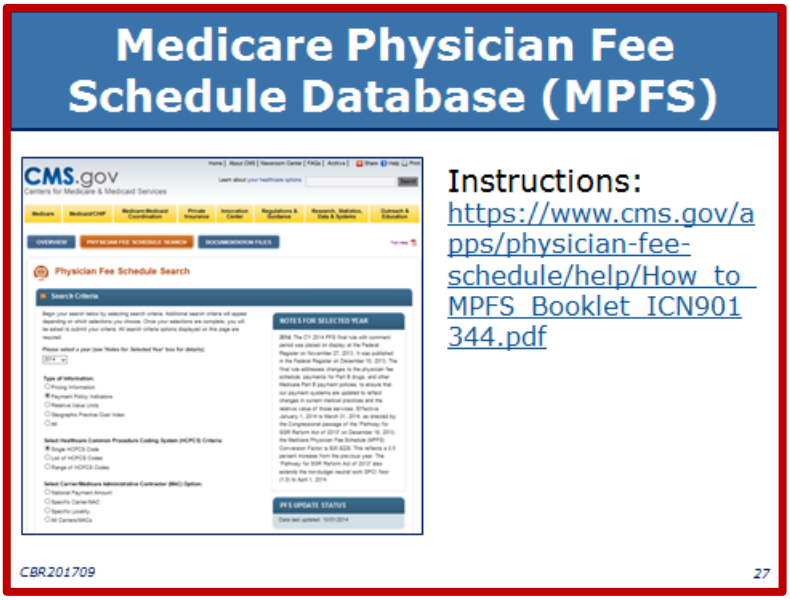
SIGNATURE REQUIREMENTS

Medicare requires that providers authenticate any services they provide or order. This must be a handwritten or electronic signature. Stamped signatures are not acceptable. The signature must be legible. A signature log or attestation statement may be utilized in order to meet the guidelines. There are some exceptions to these rules as outlined on this slide. For detailed information, see the following web link: ***Medicare Program Integrity Manual,* Chapter 3, Section 3.3.2.4** (https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).



MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFS)

To determine the payment policy indicator, you would need to search the **Medicare Physician Fee Schedule Database**, also known as the MPFS. Instructions for searching this database may be found at this link: **How to Use the Searchable Medicare Physician Fee Schedule Database (MPFS)** (http://www.cms.gov/apps/physician-fee-schedule/help/Medicare-Physician-Fee-Schedule-Search-Help.pdf).



That concludes the coverage and documentation portion of our webinar and it's time for our third poll question.

POLL QUESTION

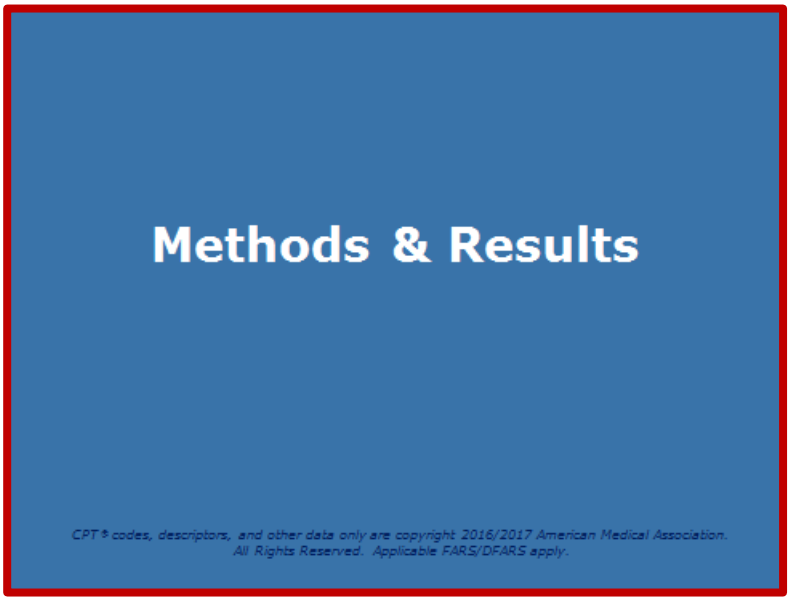
From the information presented today, do you have a better understanding of the documentation and coverage requirements for emergency department services?

- *Yes*
- *Neutral*
- *No*

Now, I will turn the presentation over to Cheryl Bolchoz, who will go over the Methods and Results portion of our webinar.

METHODS & RESULTS

Good afternoon. My name is Cheryl Bolchoz. I am with Palmetto GBA and I am the Lead Data Analyst on the CBR contract. I will be explaining the data, statistical analysis, and tables provided in this CBR. I will be using the data of a mock provider that is supplied in the sample CBR that you can locate from the CBR website, **www.cbrinfo.net** under CBR201709.



REPORT DATA

As mentioned earlier in this presentation, we selected about 16,000 fee-for-service Medicare Part B providers. These providers were identified by **Rendering NPI.** Claims for CPT® codes 99281 through 99285 were pulled on September 12, 2017 from the Integrated Data Repository (IDR). The claim lines used in this analysis cover dates of service between July 1, 2016 and June 30, 2017. If you would like more information on the IDR, please visit the following website: **CMS Integrated Data Repository** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/).

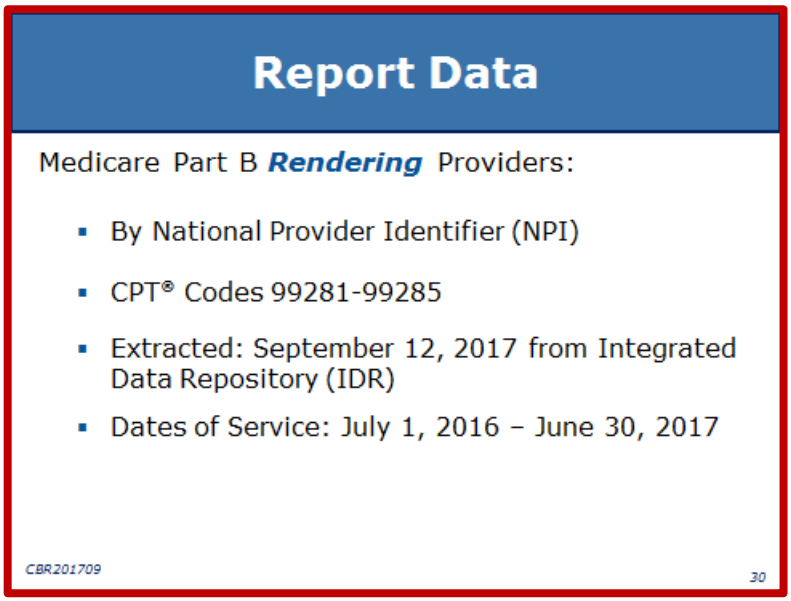


TABLE 1

Table 1 is a list of the **CPT® Codes**, **History/Examination, and Medical Decision Making.** A complete description of these codes can be found in the *CPT® Manual*, which can be accessed from the following website: **American Medical Association** (https://commerce.ama-assn.org/store/).

Table 1

Table 1: CPT® Codes, History/Examination, and Medical Decision Making

CPT® Code	History/Examination	Medical Decision Making
99281	Problem Focused	Straight Forward
99282	Expanded Problem Focused	Low Complexity
99283	Expanded Problem Focused	Moderate Complexity
99284	Detailed	Moderate Complexity
99285	Comprehensive	High Complexity

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TABLE 2

Table 2 is titled **Summary of Your Utilization of Emergency Department Services.** The Table details an individual provider's utilization of the procedure codes for dates of service, July 1, 2016 through June 30, 2017. The Table provides the **CPT® Codes**, **Allowed Charges**, **Allowed Services,** distinct **Visit Count,** and distinct **Beneficiary Count** for each code. In addition, an overall **Total** row is included. A visit is defined as a single date of service for each beneficiary.

Table 2

Table 2: Summary of Your Utilization of Emergency Department Services
Dates of Service: July 1, 2016 – June 30, 2017

CPT® Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
99281	$0	0	0	0
99282	$0	0	0	0
99283	$5,536	92	92	86
99284	$15,418	135	135	129
99285	$60,271	358	358	358
Total	**$81,225**	**585**	**585**	**529**

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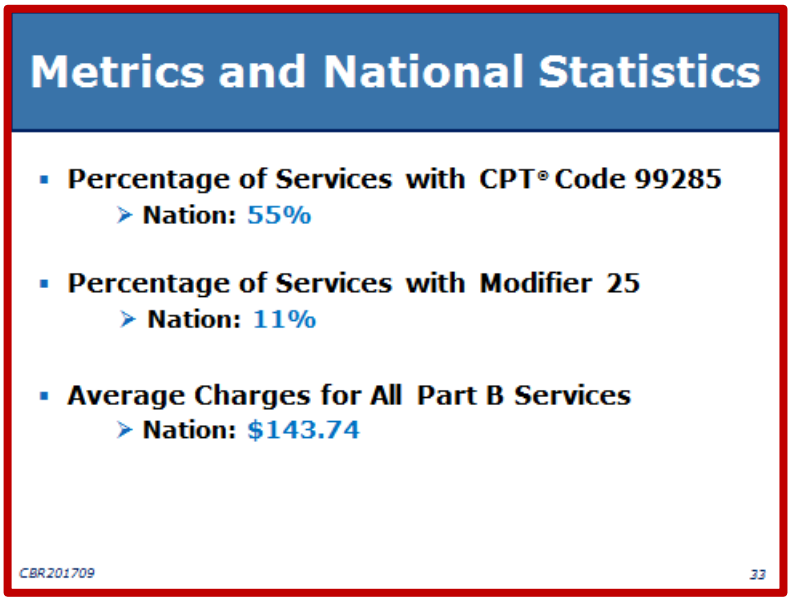
Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the beneficiary and visit counts are unduplicated counts for each row and the total. For example, a beneficiary with multiple visits to the emergency department with different CPT® codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

METRICS AND NATIONAL STATISTICS

This CBR addresses three metrics. The first metric is the **Percentage of Emergency Department Services Submitted with CPT® Code 99285.** Our analysis of claims revealed that the national percentage was 55 percent. The second metric is the **Percentage of Emergency Department Services Appended with Modifier 25**. The national percentage for this metric was 11 percent. The final metric is the **Average Allowed Charges for All Part B Services** per visit that were submitted by the same provider on the same date of service as the emergency department service. The national average was $143.74.



PEER GROUPS

For each measure in the CBR, the provider's billing history and patterns are compared to his/her peers. These comparisons are given so that providers are aware of where they stand among their peers and to allow them to see how their billing is different than their peers on the key measurements. For this CBR, each provider is compared to **two peer groups**:

- **STATE** peer group is defined as all rendering Medicare providers practicing in the provider's state, with allowed charges for emergency department services
- **NATIONAL** peer group is defined as **all** rendering Medicare providers in the nation with allowed charges for emergency department services

We found a total of over 130,000 providers with allowed charges for these codes with dates of service from July 1, 2016 – June 30, 2017.

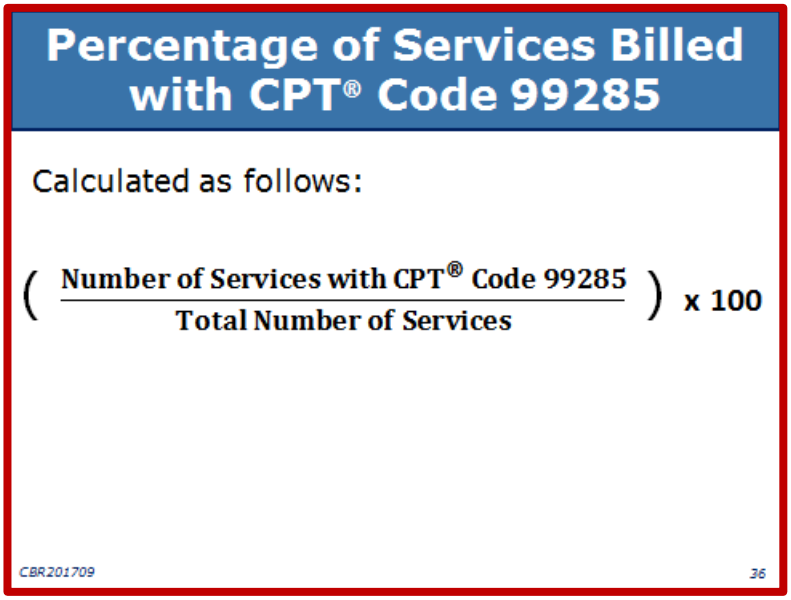
COMPARISON OUTCOMES

In each analysis, there are four possible outcomes for the comparisons between the provider and the peer groups:

- ***Significantly Higher*** is displayed if the provider's value is higher than the peer value and the statistical test confirms significance
- ***Higher*** is displayed if the provider's value is higher than the peer value, but the statistical test does not confirm significance
- ***Does Not Exceed*** is displayed if the provider's value is not higher than the peer value
- ***N/A*** is displayed if the provider did not have sufficient data for comparison

PERCENTAGE OF SERVICES BILLED WITH CPT® CODE 99285

The first analysis in this CBR is the **Percentage of Services Billed with CPT® Code 99285.** It is calculated as the **Number of Services with CPT® Code 99285** divided by the **Total Number of Services**, and then multiplied by **100**.



Each provider's percentage is compared to his/her state and the nation, using the chi-square test at the alpha value of 0.05. These results are shown in Table 3 of this CBR.

TABLE 3

Here is an example of Table 3 and the results of this analysis. In this example, the mock provider has 358 services that were billed with CPT® code 99285, out of a total of 585 services. Dividing the 358 by 585, and multiplying by 100, you should get this provider's percentage of 61 percent. The state's percentage is also 61 percent, and the national percentage is 55 percent.

The statistical test used in this analysis, chi-square test, shows that this provider's percentage ***Does Not Exceed*** the state's average, but is ***Significantly Higher*** than the national percentage. To view the percentages of services billed with CPT® code 99285 for all states and the nation, please select the following link: **CBR201709 Statistical Debriefing** (https://www.cbrinfo.net/cbr201709-statistical-debriefing).

It is important to note that the significance, determined by the statistical test, is based on not only the differences in the values, but also the number of observations and the variability of those observations. Generally, the higher the number of observations, the better the statistical test is able to detect significance.

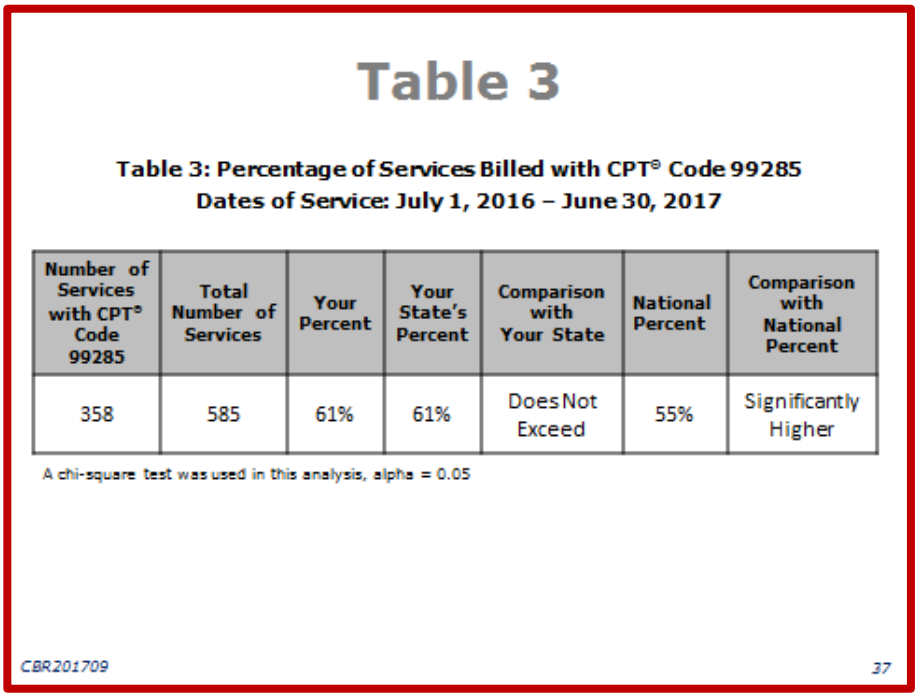


Table 3

Table 3: Percentage of Services Billed with CPT® Code 99285
Dates of Service: July 1, 2016 – June 30, 2017

Number of Services with CPT® Code 99285	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
358	585	61%	61%	Does Not Exceed	55%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05

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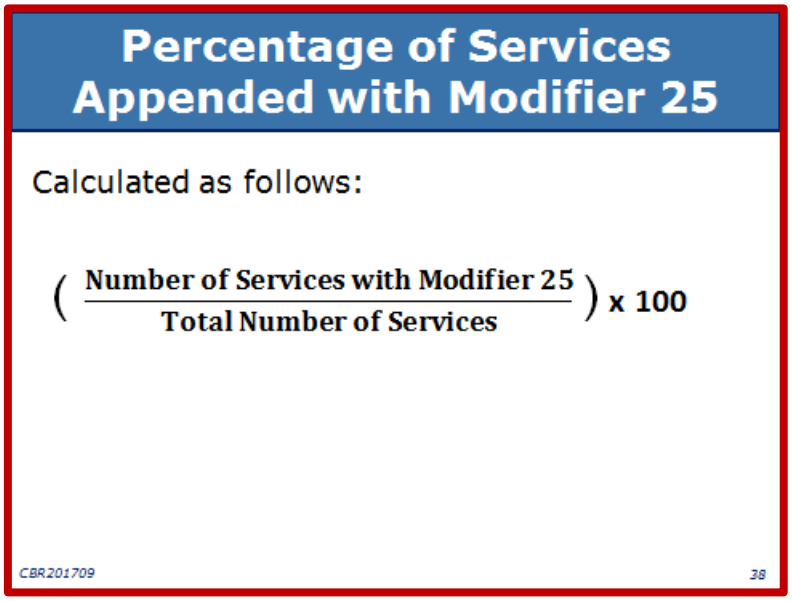
PERCENTAGE OF SERVICES APPENDED WITH MODIFIER 25

The second analysis in this CBR is the **Percentage of Services Appended with Modifier 25.** It is calculated as the **Number of Services with Modifier 25** divided by the **Total Number of Services**, and then multiplied by **100.**



Each provider's percentage is compared to his/her state and the nation, using the chi-square test at the alpha value of 0.05. These results are shown in Table 4 of this CBR.

TABLE 4

Table 4 is an example of the results of this analysis. In this example, the mock provider has 221 services that were appended with modifier 25, out of a total of 585 services. Dividing the 221 by 585, and multiplying by 100, you should get his percentage of 38 percent. In this case, the provider is ***Significantly Higher*** than both the state and the national percentages based on the results of the chi-square test. The averages for all states and the nation can be viewed at the following web link: **CBR201709 Statistical Debriefing** (https://www.cbrinfo.net/cbr201709-statistical-debriefing).

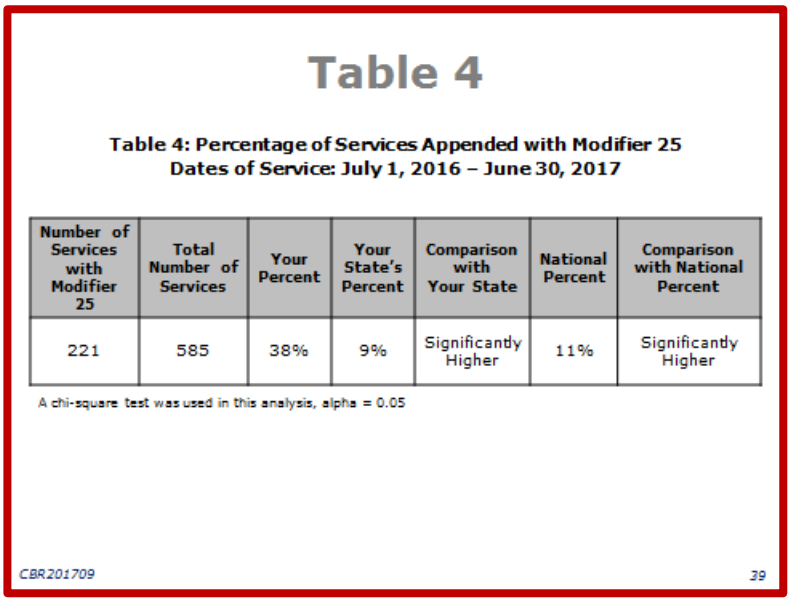


Table 4

Table 4: Percentage of Services Appended with Modifier 25
Dates of Service: July 1, 2016 – June 30, 2017

Number of Services with Modifier 25	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
221	585	38%	9%	Significantly Higher	11%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05

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AVERAGE ALLOWED CHARGES ALL PART B SERVICES PER VISIT

The next analysis in this CBR is the **Average Allowed Charges of All Medicare Part B Services per Visit** submitted by the same provider on the same date of service as the emergency department service. It is calculated as the **Total Charges Allowed for All Part B Services at ED** divided by the **Total Number of Visits**. Each provider's average is compared to his/her state and the nation, using the t-test at the alpha value of 0.05. These results are shown in Table 5.

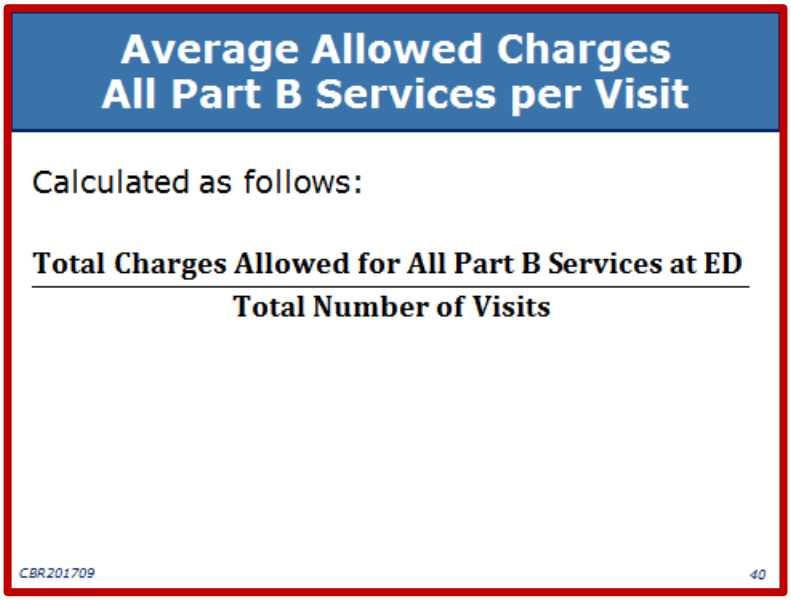
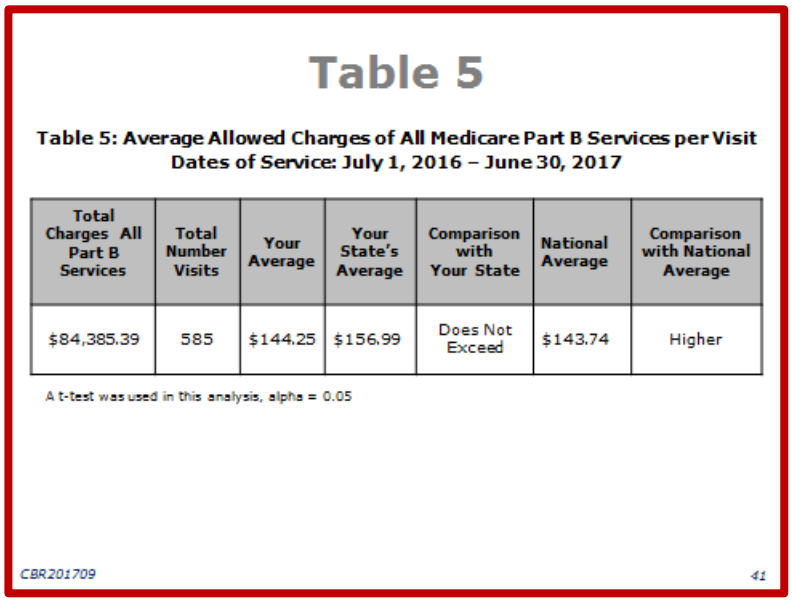


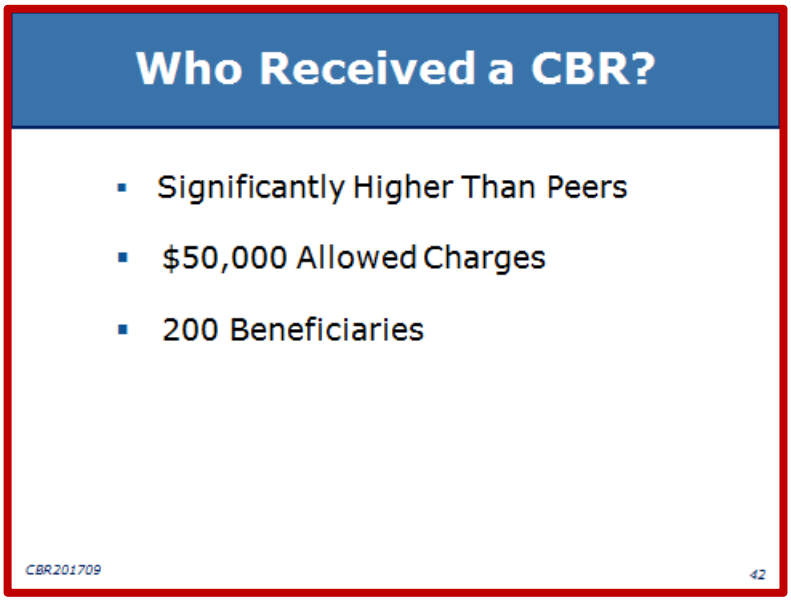
TABLE 5

Table 5 shows the results of this analysis. This provider has total allowed charges of $84,385.39 for **ALL** Medicare Part B services that were submitted at the time of the emergency department service. This covers 585 visits. Dividing $84,385.39 by 585 visits will give you the average per visit of $144.25. This provider's average ***Does Not Exceed*** the state's average, but is ***Higher***, although not *significantly higher* than the national average. Please note that this total charges amount is not comparable to the total charges displayed in Table 2. The total charges on Table 5 represent all Part B services submitted at the time of the emergency department service. The totals on Table 2 represent only the five emergency department codes. To view average allowed charges for all states and the nation, select this web link: **CBR201709 Statistical Debriefing** (https://www.cbrinfo.net/cbr201709-statistical-debriefing).



WHO RECEIVED A CBR?

So you are probably asking now, "Why did I receive this CBR?" After analyzing all of the data for each individual provider, we chose those providers that were ***Significantly Higher*** than their peers in at least one of the three measures that I just described. Additionally, each of these providers met certain thresholds of allowed charges and beneficiary counts. For this CBR, recipients had at least **$50,000 in allowed charges** and at least **200 beneficiaries**. These thresholds are at or near the 80th percentile of all emergency department providers, and were chosen to ensure that the providers had sufficient information to compare to the peer groups, and that they could benefit from the educational material supplied in this letter.



Again, please note that the CBR letter does not indicate any wrong-doing. This report is meant for educational purposes based on the literature included in the references and resources section of the CBR. Also, all statistics supplied in this analysis are based only on the information obtained from the claims. No additional documentation was reviewed, nor special circumstances considered when making these calculations. We encourage you to keep sufficient documentation to justify your billings, especially in the areas where you are different than your peers.
This brings us to our next poll question.

POLL QUESTION

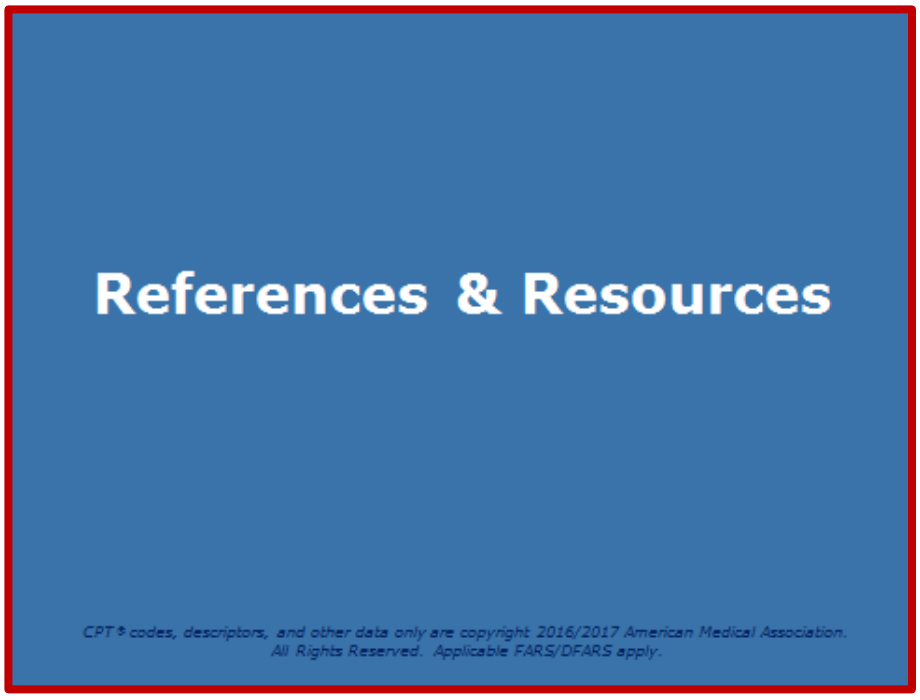
Did the calculations help with understanding the CBR measures?

- *Yes*
- *Neutral*
- *No*

It seems all your answers are in. Thank you for your responses. This concludes the Methods & Results portion of the webinar. As a reminder, the chat function is open for you to send any questions that you may have so far. We will respond to as many as we can at the conclusion of the presentation. Now, back to Nick Grant for the References & Resources.

REFERENCES & RESOURCES

Thank you, Cheryl. As I mentioned previously, we provide links to all of the resources referenced in this webinar on our website page at the link, **CBR201709 Recommended Links** (http://www.cbrinfo.net/cbr201709-recommended-links).



CBR WEBSITE

Again, our website is located at the link, **Comparative Billing Reports** (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
- All CBR releases
- Education information and outreach events
- Recommended Links
- Frequently Asked Questions (FAQs)
- CBR support material
- Contact information for our help desk

CBR201709 WEB PAGE

Please be sure to visit the **CBR201709: Emergency Department Services** web page. Here, you will find the webinar materials for today's presentation. You will also find the Sample CBR, the Statistical Debriefing, which shows comparison data for state and national analysis, and you will find Recommended Links, and Frequently Asked questions. To visit this web page, select the following web link: **CBR201709: Emergency Department Services** (https://www.cbrinfo.net/cbr201709).

PROVIDER SELF-AUDIT

After receiving a CBR, there are some additional steps that you may choose to take. 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 that you use the Coverage & Documentation Overview and References discussed earlier and supplied in each CBR as a guide. We also have a Self-Audit Help page with links to high-level instruction and advice on how to begin the self-audit process. Please select the following web link for more information: **Self-Audit Help** (http://www.cbrinfo.net/self-audit-help.html).

CBR SUPPORT HELP DESK

If you have any questions regarding the CBR program, we encourage you to contact us. The CBR Support Help Desk is available from 9:00 a.m. to 5:00 p.m. ET Monday through Friday. The toll-free number is 1-800-771-4430, and our email address is **cbrsupport@eglobaltech.com**. Both the telephone number and the email address are on the actual CBR letter. The contact information is also on the CBR website page at **Comparative Billing Reports** (http://www.cbrinfo.net/).

CONTACTING MACS

Providers should contact the Medicare Administrative Contractor, or MAC, for their geographic area for assistance with questions about specific claims, documentation requirements, and/or billing and coding questions. We encourage you to check with your MAC to ensure you are meeting the standards for all services that you are providing. MAC contact information is easily accessible from the CMS website at the link, **Review Contractor Directory – Interactive Map** (https://www.cms.gov/Research-Statistics-Data-and- Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

PECOS AND NPPES

eGlobalTech receives all contact information used in producing and disseminating CBRs from the information providers and suppliers add to the Provider Enrollment, Chain, and Ownership System, or PECOS. If no fax number is found in PECOS, fax numbers are pulled from the National Plan and Provider Enumeration System (NPPES). Fax is the default dissemination method, but if a provider does not have a fax number listed in either system, or if more than five CBRs are scheduled to go to the same fax number, we mail the reports instead. If your CBR lists an incorrect address or was sent to an incorrect fax number, you are advised to update this information in PECOS and NPPES. The links are provided here for your convenience:

- **PECOS** (https://pecos.cms.hhs.gov/pecos/login.do)
- **NPPES** (https://nppes.cms.hhs.gov/NPPES/Welcome.do)

This concludes the References and Resources portion. Before we move on to the Q&A session, we have one last poll question:

POLL QUESTION

Do you feel the CBR provided educational benefit?

- *Yes*
- *Neutral*
- *No*
- *Did not receive a CBR*

It looks like we have gotten everyone's responses. Thank you all for your participation.

QUESTIONS & ANSWERS

In a few moments, we are going to start responding to some of the questions we received throughout the presentation. If you joined late or have a question you want to ask, the chat function is still open. We may not be able to answer every question submitted today; however, we will respond to all webinar related questions that were submitted at registration and via chat this afternoon in a detailed Q&A document. The Q&A will be posted to the CBR201709 webinar page within 14 days of the webinar.

Within five days of today, a recording and a handout of today's webinar will be available. For those who registered for today's webinar, you will get a reminder email when the documents are ready. If you did not register, you can still access the documents from the CBR website page titled, **CBR201709 Webinar** (http://www.cbrinfo.net/cbr201709-webinar). In the meantime, please feel free to email us with any questions and/or concerns you may have at **cbrsupport@eglobaltech.com**.

Lastly, please note that we make every effort to address all questions submitted during our webinars; however, we cannot provide responses related to coding issues or specific claims and scenarios. Since your MAC makes the determination to pay or deny a claim based on the procedure 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. Contact information for your MAC can be accessed from the CMS website link at **Review Contractor Directory – Interactive Map** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Now, I will turn it over to Debra who will facilitate the Q&A session. Thank you all for your time.

RECOMMENDED LINKS

The below reference and resource website links have been added to the webinar transcript of **CBR201709: Emergency Department Services** to optimize your browsing experience while reading and/or listening to the webinar. All web links are accurate as of the date of the webinar, but may change due to frequent changes in Medicare policy or movement of online content by external publishers.

Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

Review Contractor Directory-Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)

CBR201709 Webinar (http://www.cbrinfo.net/cbr201709-webinar)

CBR201709 Sample CBR (http://www.cbrinfo.net/cbr201709-sample-cbr)

CBR201709 Recommended Links (http://www.cbrinfo.net/cbr201709-recommended-links)

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

Evaluation and Management Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf)

***Medicare Claims Processing Manual*, Chapter 12, Sections 30.6.1, 30.6.8, 30.6.11** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Social Security Act, Section 1862 (a)(1)(A) (https://www.ssa.gov/OP_Home/ssact/title18/1862.htm)

***NCCI Policy Manual*, Chapters 1, 11** (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html)

***Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4** (https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)

How to Use the Searchable Medicare Physician Fee Schedule Database (MPFS) (http://www.cms.gov/apps/physician-fee-schedule/help/Medicare-Physician-Fee-Schedule-Search-Help.pdf)

CMS Integrated Data Repository (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/)

American Medical Association (AMA Store) (https://commerce.ama-assn.org/store/)

CBR201709 Statistical Debriefing (https://www.cbrinfo.net/cbr201709-statistical-debriefing)

Comparative Billing Reports (http://www.cbrinfo.net/)

CBR201709: Emergency Department Services (https://www.cbrinfo.net/cbr201709)

PECOS (https://pecos.cms.hhs.gov/pecos/login.do)

NPPES (https://nppes.cms.hhs.gov/NPPES/Welcome.do)