# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>GENERAL</td>
<td>3</td>
</tr>
<tr>
<td>CLINICAL AND BILLING</td>
<td>5</td>
</tr>
<tr>
<td>REPORT SPECIFICS</td>
<td>7</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>8</td>
</tr>
</tbody>
</table>
INTRODUCTION

These questions are excerpted from the CBR201613: Modifier 25 – Obstetrics/Gynecology (OB/GYN) webinar presented on Wednesday, October 5, 2016. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version, or open a PDF of the slides only. All of these options are available from the CBR website page titled, CBR201613 Webinar [http://www.cbrinfo.net/cbr201613-webinar].

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

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

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

GENERAL

Q. We entered the webinar because it was for OB/GYN. What happened?
A. The CBR201613 webinar focusing on obstetricians and gynecologists was created to inform Medicare providers (specialty 16) about their billing and payment patterns on evaluation and management (E/M) claims appended with modifier 25. Prior to the webinar, our team mailed
comparative billing reports (CBRs) to approximately 5,000 OB/GYN providers who were identified as having different billing patterns than their peers. According to research, modifier 25 costs Medicare millions in improper payments, and is an area vulnerable to fraud, waste and abuse. For more information on this topic and an explanation of the analyses performed in the report, please visit the CBR website at the following web link: CBR201613: Modifier 25-OB/GYN (http://www.cbrinfo.net/cbr201613).

Q. Why would we receive an invite to this webinar if we did not receive a CBR letter? My concern is that I received the webinar invite because there was an associated CBR sent that we may not have received.
A. Many providers who have not received CBR letters find out about our webinars from announcements on the CMS website and on social media. All of the CBR201613 reports have been disseminated to the providers selected to receive them; however, if you think you should have received a report, please contact the CBR Support Help Desk at 1-800-771-4430 or by email at cbrsupport@eglobaltech.com.

Q. If I did not receive CBR letters for our providers, how can I get a copy of them?
A. CBRs have been mailed to all Medicare providers who were selected to receive CBR201613. To ensure privacy, information in each CBR letter is shared only with each provider. Reports are not produced by the CBR team on an ad-hoc basis by request; however, a sample report of a mock provider allows providers who did not receive a CBR the opportunity to read the CBR content and to review the data presented. To view a copy of the Sample CBR, select the following web link titled, CBR201613 Sample CBR (http://www.cbrinfo.net/cbr201613-sample-cbr).

Q. Our carrier is Wisconsin Physician Service (WPS). Does this mean our providers are excluded from eGlobalTech CBR Reports?
A. CBR201613 letters were mailed to approximately 5,000 Medicare OB/GYN (16) providers across the nation, regardless of their MAC affiliation. These providers were selected based on their billing of claims with modifier 25. Located on our CBR website are results for providers in each state and the nation. To view the percentage of services with modifier 25, average charges and average minutes for providers in all states and the nation, please select the following link: CBR201613 Statistical Debriefing (http://www.cbrinfo.net/cbr201613-statistical-debriefing). If you have questions and/or concerns about CBR201613, please contact our CBR Support Help Desk at 1-800-771-4430 or by email at cbrsupport@eglobaltech.com.

Q. Is the CBR part of an audit or an indication I’m going to be audited?
A. No. The purpose of CBRs is to allow providers to compare their billing patterns to those of their peers. Since the CBR team does not have access to the medical documentation necessary for audit purposes, providers will not be audited by the CBR team. If you need resources about
audits, please review the material available at the following web link: Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html).

**Q. How can I get a copy of the recording and slides for this webinar?**

A. A recording of the presentation is available within five business days of the webinar. Providers have the option to view the entire recording, listen to the audio-only version or open a PDF of the slides only. Additionally, the Q&A document and a detailed handout of the webinar will be available on the CBR website within 14 days of the webinar held on October 5, 2016. All of these options are available from the CBR website page located at the web link titled, CBR201613 Webinar (http://www.cbrinfo.net/cbr201613-webinar).

**CLINICAL AND BILLING**

**Q. Can you explain further on the modifier 25 with a procedure that has an XXX?**

A. Modifier 25 is required when the E/M code is billed on the same day as a minor procedure and when the service is above and beyond what would normally be required for the procedure. If an E/M service is billed on the same day as a minor procedure carrying a 000 or 010 global period without modifier 25, the E/M service will deny as bundled into the procedure. Per the National Correct Coding Initiative (NCCI) Policy Manual, (Chapter I, Section E):

> “Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.”

For minor procedures, modifier 25 should only be appended to the claim when the E/M performed was over and above what would normally be required for the procedure. The NCCI Policy Manual can be accessed from the CMS website at the web link titled, NCCI Policy Manual, Chapter I, Section E (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

**Q. Can an endometrial biopsy (CPT® 58100) and CPT® 99214 be billed for a patient who receives treatment for post-menopausal bleeding (PMB) as long as the provider details the exam, medical decision making (MDM) and history for the patient (who has not been seen for over a year)?**

A. According to the Medicare Physician Fee Schedule Database (MPFSDB), CPT® 58100 has a global surgery period of 000 days. In addition, the NCCI Policy Manual states,
“If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.”

Per the NCCI Policy Manual, it doesn’t matter if the patient is new or established, as “Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure.” To find more information about global surgery, please select the following web link: NCCI Policy Manual, Chapter I, Section D, E (https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html).

Appendix A of the CPT® 2015 Professional Edition (known as CPT® Manual) also provides guidelines for use of modifier 25: “A significant separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service. Modifier 25 is required when the E/M code is billed on the same day as a minor procedure and when the service is above and beyond what would normally be required for the procedure.” A complete list of Level I modifier descriptions is found in the Appendix of the CPT® Manual, which can be accessed from the American Medical Association website at the following link: AMA Store (https://commerce.ama-assn.org/store/).

Q. Is an E/M billable with a colposcopy (colpos)? What If the patient needs one and it’s her first?
A. The example you describe supports a significant, separately identifiable E/M service, in addition to the preventive service. Modifier 25 should be appended to the problem oriented E/M service. According to the CPT® Manual, modifier 25 describes 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.” To review this information, see the CPT® 2015 Professional Edition, available for purchase from the American Medical Association (AMA) website at the link titled, AMA Store (https://commerce.ama-assn.org/store/).

Q. If a physician assistant finds a problem while performing an annual GYN, follows up with labs, and does medical decision making, can he/she bill a problem visit with modifier 25 - or is that included in the preventive visit?
A. The example you describe appears to support a significant, separately identifiable E/M service, in addition to the preventive service; however, please contact your MAC if you’re inquiring about a specific claim and need a more definitive answer. As a reminder, modifier 25 should be appended to the problem oriented E/M service, and according to the CPT® 2015 Professional Edition, modifier 25 describes 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.” To review this information, see the CPT® 2015 Professional Edition, available from the American Medical Association (AMA) website at the link titled, AMA Store (https://commerce.ama-assn.org/store/).

REPORT SPECIFICS

Q. Can you explain Table 5 in lay terms?
A. Table 5 provides a comparison of the mock provider’s Average Allowed Charges per Beneficiary to those of the provider’s peers. It is calculated as the Total Allowed Charges divided by the Total Number of Beneficiaries. For illustration, please refer to the example at the web link, CBR201613 Sample CBR (http://www.cbrinfo.net/cbr201613-sample-cbr.html). In this example, the provider’s average allowed charges per beneficiary were $149.06, which is significantly higher than the state’s average of $105.80 and higher than the nation’s percentage of $127.04. The results of the analysis for each state and the nation can be reviewed at the following link: CBR201613 Statistical Debriefing (http://www.cbrinfo.net/cbr201613-statistical-debriefing).

Q. How were claims data obtained for this report?
A. Claims with CPT® codes covered in this CBR with dates of service from January 1, 2015 to December 31, 2015 were downloaded from the CMS Integrated Data Repository (IDR) and loaded into the Palmetto GBA Medicare Data Warehouse. The providers’ data (as identified by NPPES) was compared to peers located in their states and the nation. For more information about the IDR, see the following link: CMS Integrated Data Repository (IDR) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html).

Q. How were allowed charges calculated in this CBR?
A. Allowed charges for this CBR were calculated based on the Medicare Physician Fee Schedule (MPFS). Payment can vary depending on the carrier locality, the type of facility where the service was rendered, the number of units billed, and the use of a modifier. In most instances, Medicare pays the provider 80 percent of the fee schedule allowed amount, and the patient is responsible for the balance of the payment; however, there are some exceptions to this rule. To search for payment rates in the MPFS, see the web link, Physician Fee Schedule Search (https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx).
REFERENCES

CBR201613 Webinar [http://www.cbrinfo.net/cbr201613-webinar]

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


CBR201613: Modifier 25-OB/GYN [http://www.cbrinfo.net/cbr201613]

CBR201613 Sample CBR [http://www.cbrinfo.net/cbr201613-sample-cbr]

CBR201613 Statistical Debriefing [http://www.cbrinfo.net/cbr201613-statistical-debriefing]

Self-Audit Help [http://www.cbrinfo.net/self-audit-help.html]

NCCI Policy Manual, Chapter I, Section E [https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html]

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