

Comparative Billing Reports: A Case Study

A closer look at the validity of the auditing parameters pertaining to general ophthalmological services—the eye codes—and of the findings as pertains to retina practices that use eye codes exclusively.

BY RIVA LEE ASBELL

During the third week of April 2015, many physicians received a fax or email notification that their rating(s) in the ophthalmology comparative billing reports (CBRs) was significantly higher than their peer group's and the national averages in one or more of the areas analyzed in a data-mining utilization report being developed by a subcontractor for the Centers for Medicare and Medicaid Services (CMS), eGlobalTech.¹

According to the notification, the reports are designed to “educate providers on their billing or referral patterns for selected topics through a comparison with other providers across their state and nation.” Those who have watched the “education” patterns over the years recognize the prelude to auditing. In a webinar held April 29, 2015, eGlobalTech stated that the list of providers who received the letters had been shared with the CMS.

SERVICES ASSOCIATED WITH SIGNIFICANTLY HIGHER NOTATIONS

Historically, when a Medicare subcontractor or Medicare Administrative Contractor (MAC) identifies providers who may be outliers, an educational offering ensues, followed by specific audits of those who may be outliers. Be sure you are in compliance with objective standards such as Local Coverage Determinations (LCDs) and CMS guidelines. While you may think you have your medical necessity issues and chart documentation in place, it is always best to confirm this with an external audit. Providers identified in data-mining audits generally are the fish that have been captured in the net and are most likely to be audited.

Three ophthalmology services were addressed in the mailings. A physician may have been cited for high use of any one or all three. If the physician was not an outlier, no report was issued. The issues analyzed were:

1. The percentage of complex extracapsular cataract surgeries (66982) versus routine extracapsular cataract surgeries (66984).
2. The percentage of services for comprehensive versus intermediate level general ophthalmological services for new and established patients (92002-92014).
3. The average number of minutes for new and established patients (evaluation and management [E/M] services, 99204-99215).

This article questions the validity of the auditing parameters pertaining to general ophthalmological services—the eye codes—and the validity of the findings as pertains to retina practices that use eye codes exclusively.

METHODOLOGY

eGlobalTech analyzed Medicare Part B claims with allowed services for the above-listed CPT codes with dates of service from July 1, 2013, to June 30, 2014, and included only claims in which the rendering National Provider Identifier (NPI) specialty is denoted as ophthalmology (Code Specialty 18). The lack of ophthalmic subspecialty taxonomy codes caused many retina specialists to receive notification of being outliers.

The following formula was used independently for patient types defined as new versus established:

$$\left(\frac{\text{Number of Comprehensive General Ophthalmological Services by Patient Type}}{\text{Total Number of General Ophthalmological Services by Patient Type}} \right) \times 100$$

The physician's percentage was then compared with the percentage in his or her state and the national percentage using a chi-square test at an alpha value of .05.

TABLE 1. PERCENTAGE OF COMPREHENSIVE GENERAL OPHTHALMOLOGICAL SERVICE BY PATIENT TYPE

Patient Type	Your Percentage of Comprehensive Services	Your State's Percentage of Comprehensive Services	Comparison With Your State's Percentage	National Percentage of Comprehensive Services	Comparison With the National Average
New	N/A	90%	N/A	91%	N/A
Established	82%	73%	Significantly Higher	61%	Significantly Higher

A chi square test was used in this analysis, alpha = .05.

TABLE 2. HYPOTHETICAL EXAMPLE OF A REPORT RECEIVED BY A RETINA SPECIALIST WHOSE PRACTICE USES ONLY THE EYE CODES

Patient Type	Your Percentage of Comprehensive Services	Your State's Percentage of Comprehensive Services	Comparison With Your State's Percentage	National Percentage of Comprehensive Services	Comparison With the National Average
New	99%	91%	Significantly Higher	91%	Significantly Higher
Established	15%	58%	N/A	61%	N/A

The CBR letter from eGlobalTech states:

“Comparison Outcomes. There were four possible outcomes for the comparisons between the provider and the peer groups:

1. Significantly Higher – Provider’s value is higher than the peer value and the statistical test confirms a significance
2. Higher – Provider’s value is higher than the peer value but the statistical test does not confirm a significance
3. Does Not Succeed – Provider’s value is not higher than the peer value
4. N/A – Provider does not have sufficient data for comparison.”

Only those in the “significantly higher” category received letters.

Table 1 shows the sample given for comparing the percentage of Provider X’s established visits for follow-up comprehensive general ophthalmological services (92014). In this hypothetical example, the provider has been identified as having a significantly higher percentage use of code 92014 (comprehensive service, established patient) than the state and national averages.

Problems With the Methodology

Table 2 shows another example, this time from one of my clients who received a report. Some retina practices use only the eye codes; my client, a physician in a practice of less than seven retina specialists, is one of them. Only one provider received a report. There are actually 10 states that have the same percentage of comprehensive services at 91%.

eGlobalTech Issues

Auditing subcontractors do not have an in-depth familiarity with ophthalmology practices in general or with vitreoretinal practices specifically. If a retina practice elects to use only the eye codes, I would expect to see

that provider’s percentage of comprehensive new services (92004) at or near 100%. New retina patients are referred patients with problems that almost always merit a comprehensive examination. Seldom will a patient present with a less severe problem, as occurs in comprehensive ophthalmology, wherein the initial encounter would be coded as new, intermediate (92002).

Providers’ Issues

The CPT codes for comprehensive ophthalmological services (92004/92014) have specific requirements: history, general medical observation, external (ie, lids/adnexa + slit lamp exam), gross visual fields, basic sensorimotor examination, and dilated ophthalmoscopy examination. There must be medical necessity for the examination as well as the individual elements of the exam. This is true for eye codes as well as E/M codes. Furthermore, any examination element being counted toward fulfilling the requirements of a given examination code must be performed by the physician. Thus, there seldom would be a medical necessity to use CPT established patient comprehensive code 92014 when billing an office visit in addition to an intravitreal injection because there would be limited medical necessity to perform sensorimotor evaluation and confrontation visual fields at every injection visit in the absence of new symptoms. The packaging of the office visit with the minor procedure as part of the Medicare global surgery fee is the other principal factor.

Taxonomy Code Issues

The Healthcare Provider Taxonomy Code Set is designed to categorize the type, classification, or specialization of health care providers. Whereas other specialties, such as internal medicine or even cardiology within internal medicine, have numerous taxonomy codes that provide subspecialty identification, ophthalmology has just one

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taxonomy code, Code Specialty 18. Ophthalmology, as a specialty, has been resistant to giving different subspecialties (eg, retina, neuro-ophthalmology, oculoplastics) their own taxonomy codes.

Subspecialists are being penalized when it comes to any type of utilization audit of which the CBR is a variation. Anyone subject to one of these audits knows he or she is compared with all ophthalmologists on use of a given service, such as extended ophthalmoscopy, optical coherence tomography, or fluorescein angiography. If a retina specialist, for example, was compared only with other retina specialists on utilization of a given service per 100 beneficiaries, most physicians would fare much better on the data-mining results.

LESSONS TO BE LEARNED

Code Selection

Consider not using all eye codes in your practice. Ophthalmology electronic health record (EHR) systems are all based on the E/M code format. If you learn the rules for E/M coding, with a little bit of tweaking you can access CPT code 99204 for many new patients, which generally pays about \$20.00 more than 92004 and has the added benefit of distributing your utilization of codes. Another thing to watch out for is the possible reduction in pricing for CPT code 92002 in 2016, followed by possible reimbursement reduction, or even elimination, of all the eye codes in 2017 and the following years.

EHR Compliance

When I am not writing, I am generally auditing. Unfortunately, I have yet to come across a system that is in compliance with the 1997 E/M guidelines. There have not been public offerings for training in E/M coding by the ophthalmic societies for several years, which is a serious issue that must be addressed. For those interested, please email me and I will send you some links to articles that will help you.

Complex Cataract Code (66982)

If you are considering using this code, it is best to do your research. It is one of the codes physicians are being “educated” on and, like repair of complex retinal detachment, it has definitive guidelines. In both cases, complexity does not equal complication. ■

Riva Lee Asbell is the principal of Riva Lee Asbell Associates, an ophthalmic reimbursement consulting firm located in Fort Lauderdale, Florida. Ms. Asbell may be reached at rivalee@rivaleeasbell.com.



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1. www.cbinfo.net. Accessed July 20, 2015.