Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

What is a CBR? A CBR is an educational tool that reflects your billing patterns as compared to your peers’ patterns for the same services in your state or specialty or nationwide. The CBR is intended to enhance accurate billing practices and support providers’ internal compliance activities.

Why did I get a CBR? We are providing this report because your Medicare billing patterns differ from your peers’ patterns within your state and/or across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education.

Please carefully review this report. You may wish to check your records against data in CMS’ files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.

Attend our free webinar on Sep. 24 at 3 p.m. ET. Please register prior to the event. If you are unable to attend the live event, visit CBR.CBRPEPPER.org to access the recording and additional resources. Questions may be submitted at any time through the website Help Desk (Help/Contact Us tab) or at 1-800-771-4430 (M – F, 9 a.m. – 5 p.m. ET).

REMINDER: Please ensure your email address and fax number are updated in the following systems:
National Plan and Provider Enumeration System (NPPES)
Provider Enrollment, Chain, and Ownership System (PECOS)

Sincerely,

The CBR Team
Introduction

CBR201910 focuses on rendering providers who submit claims for upper and lower endoscopy services performed within 90 days on different dates of service.

According to the “2018 Comprehensive Error Rate Testing (CERT)” report, an estimated $6,485,888 was potentially paid improperly for upper endoscopy services. Additionally, an article published for the National Center for Biotechnology Information revealed that 30% of bidirectional endoscopy procedures were performed on different dates of service.

Coverage and Documentation Overview

This portion of the CBR offers a broad 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 outlined by the Medicare Administrative Contractors’ (MACs’) Local Coverage Determinations (LCDs).

For the purposes of this CBR, upper and lower endoscopy procedures were reviewed. The CPT® codes for these services are included in Table 1, below. The Medicare Part B claims submitted and paid for these services from rendering physicians were analyzed. For the purposes of this document and analysis, “upper endoscopy,” “lower endoscopy,” and “upper/lower endoscopy” procedures refer to these CPT® code sets. Additionally, for the purposes of this document, the term “different dates of service” refers to different dates of service within 90 days of each other. The phrase “date(s) of service” will be referred to with the acronym “DOS.”

The CPT® and HCPCS codes selected for claim submission should correctly represent the procedure and service provided to the patient and adhere to the guidelines, as dictated within the CPT® Manual.

Basic Coding Guidelines

Table 1 identifies CPT® and HCPCS codes that may be reported for upper/lower endoscopy services.

Table 1: CPT® and HCPCS Codes for Upper/Lower Endoscopy Procedures

<table>
<thead>
<tr>
<th>CPT® Code/HCPCS Code Set</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>43235-43259, 43210, 43233, 43270</td>
<td>Endoscopic Procedures: Esophagogastroduodenoscopy (Upper)</td>
</tr>
<tr>
<td>43191-43229, 43211-43214</td>
<td>Endoscopic Procedures: Esophagus (Upper)</td>
</tr>
<tr>
<td>45300-45350, 45346</td>
<td>Flexible Sigmoidoscopy Procedures (Lower)</td>
</tr>
<tr>
<td>45378-45398, 45388, 45390, 45398</td>
<td>Flexible and Rigid Colonoscopy Procedures (Lower)</td>
</tr>
<tr>
<td>G0105</td>
<td>Colorectal Cancer Screening; Individual at High Risk (Lower)</td>
</tr>
</tbody>
</table>
Table 2 identifies a summary of your utilization for upper/lower endoscopy procedures.

**Table 2: Summary of Your Utilization for Upper/Lower Endoscopy Codes between May 1, 2018, and April 30, 2019**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lower Endoscopy Codes</strong></td>
<td>$59,482.44</td>
<td>345</td>
<td>227</td>
</tr>
<tr>
<td><strong>Upper Endoscopy Codes</strong></td>
<td>$30,289.40</td>
<td>219</td>
<td>185</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$89,771.84</td>
<td>564</td>
<td>412</td>
</tr>
</tbody>
</table>

*A beneficiary is counted once per row of CPT® code level. The total “Beneficiary Count” is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.*

**Metrics**

This report is an analysis of the following metrics:

1. Percent of claims billed for upper/lower endoscopies performed on different dates of service
2. Percent of allowed dollars for upper/lower endoscopies performed on different dates of service
3. Rate of upper/lower endoscopies performed on different dates of service per beneficiary
4. Percent of beneficiaries with upper/lower endoscopies performed on different dates of service

The CBR team identified the services for upper/lower endoscopy services submitted with the CPT® and HCPCS codes included in Table 1. Statistics were calculated for each provider, all providers in the state, and all providers in the nation:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider’s state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider’s values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state (state code) and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:
1. Significantly Higher — Provider’s value is above the 90th percentile from the state or national mean.
2. Higher — Provider’s value is greater than the state or national mean.
3. Does Not Exceed — Provider’s value is not higher than the state or national mean.
4. N/A — Provider does not have sufficient data for comparison.

**Methods and Results**

This report is an analysis of rendering providers who submitted upper and lower endoscopy codes on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims on Aug. 22, 2019. The analysis includes claims with dates of service from May 1, 2018, through Apr. 30, 2019. For the trend analysis (Figure 1), claims represent dates of service between May 1, 2016, and Apr. 30, 2019.

There are 13,403 rendering providers nationwide with allowed charges for upper and lower endoscopy procedures, with total allowed charges of $51.76 million during the timeframe.

The criteria for a provider to receive a CBR are:

1. Is significantly higher compared to either state or national percentages or rates in any of the four metrics (greater than the 90th percentile), and
2. Has at least 30 beneficiaries with both Upper and Lower (U/L) endoscopies performed on the same day or within 90 days, and
3. Has at least $10,000 or more in total allowed charges.

**Metric 1: Percent of Claims Billed for Upper/Lower Endoscopies Performed on Different Dates of Service**

Table 3 shows your percent of claims billed for upper/lower endoscopies performed on different dates of service. This is calculated as follows:

- The number of claims for upper/lower endoscopies performed on different dates of service is divided by the total number of claims for upper/lower endoscopies performed on the same or different dates of service. The result is multiplied by 100.

\[
\left( \frac{\text{Claims for upper/lower endoscopies performed on different dates of service}}{\text{Claims for upper/lower endoscopies performed on the same or different dates of service}} \right) \times 100
\]

Your comparison in your state and in the nation is presented in Table 3.
### Table 3: Percent of Claims Billed for Upper/Lower Endoscopies Performed on Different Dates of Service

<table>
<thead>
<tr>
<th>Number of claims for U/L endoscopies performed on different DOS</th>
<th>Number of claims for U/L endoscopies performed on the same or different DOS</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>147</td>
<td>66.67%</td>
<td>14.83%</td>
<td>Significantly Higher</td>
<td>16.26%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

### Metric 2: Percent of Allowed Dollars for Upper/Lower Endoscopies Performed on Different Dates of Service:

Table 4 shows the percent of total allowed dollars for upper/lower endoscopies performed on different dates of service. This is calculated as follows:

- The total allowed amount for upper/lower endoscopies performed on different dates of service is divided by the total allowed amount for upper/lower endoscopies performed on the same or different dates of service. The result is multiplied by 100.

\[
\left( \frac{\text{Total allowed amount for upper/lower endoscopy performed on different dates of service}}{\text{Total allowed amount for upper/lower endoscopy performed on the same or different dates of service}} \right) \times 100
\]

Your comparison in your state and in the nation is presented in Table 4.

### Table 4: Percent of Total Allowed Dollars for Upper/Lower Endoscopies Performed on Different Dates of Service

<table>
<thead>
<tr>
<th>Allowed amount for U/L endoscopies performed on different DOS</th>
<th>Allowed amount for U/L endoscopies performed on the same or different DOS</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,801.04</td>
<td>$21,953.80</td>
<td>71.97%</td>
<td>16.52%</td>
<td>Significantly Higher</td>
<td>18.02%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>
Metric 3: Rate of Upper/Lower Endoscopies Performed on Different Dates of Service per Beneficiary

Table 5 shows the rate of upper/lower endoscopies performed on different dates of service per beneficiary. This is calculated as follows:

- The number of claims for upper/lower endoscopies performed on different dates of service is divided by the number of beneficiaries with upper/lower endoscopies performed on different dates of service.

\[
\text{Claims for upper/lower endoscopies performed on different dates of service} \bigg/ \text{Beneficiaries with upper/lower endoscopies performed on different dates of service}
\]

Your comparison in your state and in the nation is presented in Table 5.

Table 5: Your Rate of Upper/Lower Endoscopies Performed on Different Dates of Service per Beneficiary

<table>
<thead>
<tr>
<th>Number of U/L endoscopies performed on different DOS</th>
<th>Number of beneficiaries with U/L endoscopies performed on the same or different DOS</th>
<th>Your Rate</th>
<th>Your State Rate</th>
<th>Comparison with Your State</th>
<th>National Rate</th>
<th>Comparison with National Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>37</td>
<td>2.65</td>
<td>1.82</td>
<td>Higher</td>
<td>1.60</td>
<td>Higher</td>
</tr>
</tbody>
</table>

Metric 4: Percent of Beneficiaries with Upper/Lower Endoscopies Performed on Different Dates of Service

Table 6 shows the percentage of beneficiaries with upper/lower endoscopies performed on different dates of service. This is calculated as follows:

- The number of beneficiaries with upper/lower endoscopies performed on different dates of service is divided by the number of beneficiaries with upper/lower endoscopies performed on the same day or different dates of service. The result is multiplied by 100.

\[
\left( \frac{\text{Beneficiaries with upper/lower endoscopies performed on different dates of service}}{\text{Beneficiaries with upper/lower endoscopies performed on the same or different dates of service}} \right) \times 100
\]

Your comparison in your state and in the nation is presented in Table 6.
Table 6: Your Percent of Beneficiaries with Upper/Lower Endoscopies Performed on Different Dates of Service

<table>
<thead>
<tr>
<th>Number of beneficiaries with U/L endoscopies performed on different DOS</th>
<th>Number of beneficiaries with U/L endoscopies performed on the same or different DOS</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>55</td>
<td>67.00%</td>
<td>14.41%</td>
<td>Significantly Higher</td>
<td>15.99%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

Figure 1 illustrates the trend over time of the number of allowed services for upper/lower endoscopy:

- Year 1: May 1, 2016 – Apr. 30, 2017
- Year 2: May 1, 2017 – Apr. 30, 2018
- Year 3: May 1, 2018 – Apr. 30, 2019

Figure 1: Trend Over Time of the Number of Allowed Services for Upper/Lower Endoscopy

References and Resources

*CPT® 2017 Professional Edition*

*2018 Medicare Fee-for-Service Supplemental Improper Payment Data*

*“Bundling in Medicare Patients Undergoing Bidirectional Endoscopy, How Often Does it Happen?”*