



July 29, 2019

RELI Group
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CBR #: CBR201908
Breast Re-Excision

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City, State, ZIP

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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 and/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 Aug. 6 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

Comparative Billing Report (CBR) 201908
July 29, 2019
Breast Re-Excision

Introduction

CBR201908 focuses on rendering providers who performed breast excision or mastectomy services for which a Medicare Part B claim was submitted and paid. Specifically, this CBR focuses on providers who performed a follow-up breast excision procedure (CPT® codes 19120, 19301, 19302, 19303, and 19304; see Table 1) (referred to as a “re-excision” in this document) within 365 days of a previous breast excision procedure. For the purpose of this analysis, “excision codes” are defined as of CPT® codes used to report the excision of cysts, fibroadenomas, or other benign or malignant tumors, aberrant breast tissue, duct lesion, nipple or areolar lesions, and mastectomy procedures (see Table 1).

According to an [April 2019 article in the Journal of American College of Surgeons](#), the physician-level rate of re-excision procedures reached 91.7 percent between 2012 and 2018. Additionally, 17.5 percent of providers had a breast re-excision rate greater than the expert consensus threshold of 30 percent re-excision rate.

A national data analysis found that close to \$5.1 million in charges were allowed over 7,323 claims for re-excision surgery, representing services from almost 9,892 providers.

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, breast excision of cysts, fibroadenomas, or other benign or malignant tumors, aberrant breast tissue, duct lesions, nipple or areolar lesions, and mastectomy services were reviewed. The CPT® codes for these services are 19120, 19301, 19302, 19303, and 19304. The Medicare Part B claims submitted and paid for these services from rendering physicians were analyzed. Specific to this CBR, claims submitted for the following specialty codes were analyzed:

- General Surgery (02)
- Physician Assistant (97)
- Surgical Oncology (91)
- Plastic and Reconstructive Surgery (24)
- Nurse Practitioner (50)

Basic Coding Guidelines

Table 1 identifies CPT® codes that may be reported for breast excision and mastectomy services.

Table 1: CPT® Codes for Breast Excision Procedures

CPT® Code	Descriptor
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesion
19301	Mastectomy, partial
19302	Mastectomy, with axillary lymphadenectomy
19303	Mastectomy, simple, complete
19304	Mastectomy, subcutaneous

CPT® codes and descriptors are copyright 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

**Table 2: Your Utilization – Breast Excision Codes
Mar. 1, 2018 – Feb. 28, 2019**

CPT® Code	Allowed Charges	Allowed Services	Beneficiary Count*
19120	\$800.99	2	2
19301	\$7,194.60	12	8
19302	\$0.00	0	0
19303	\$10,651.64	10	10
19304	\$0.00	0	0
Total	\$18,647.23	24	20

*A beneficiary is counted once per row of CPT® code level. The total “Beneficiary Count” is not the sumtotal; 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 re-excisions
2. Percent allowed amount for re-excisions
3. Percent of beneficiaries receiving a re-excision

The CBR team identified the services for breast excision and mastectomy services submitted with CPT® codes 19120, 19301, 19302, 19303, and 19304. Statistics were calculated for each provider, all providers in the specialty, and all providers in the nation:

- The specialty peer group is defined as all rendering Medicare providers practicing in the individual provider’s specialty 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 specialty peer group values and to the national values. Your metrics were compared to your specialty (General Surgery) 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 excision codes on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims on June 24, 2019. The analysis includes claims with dates of service from Mar. 1, 2017, through Feb. 28, 2019. For the trend analysis (Figure 1), claims represent dates of service between Mar. 1, 2016, and Feb. 28, 2019.

To identify re-excisions:

1. The CBR team identified excisions performed between Mar. 1, 2017, through Feb. 28, 2018 (base time period),
2. For each excision during the base time period, any subsequent excision(s) performed by the same provider through Feb. 28, 2019, were identified, and
3. Any excision that was performed within 365 days of a prior excision is identified as a re-excision. If a provider performed multiple excision procedures on a beneficiary, each is identified as a re-excision if there are less than 366 days between procedure dates.

There are 10,980 rendering providers nationwide with allowed charges for CPT® codes 19120, 19301, 19302, 19303, and 19304 who billed a combined allowed amount of \$73.1 million for 83,366 beneficiaries during the timeframe. The criteria for receiving a CBR is that the provider’s re-excision rate was greater than 30 percent.

Metric 1: Percent of Re-Excisions

Table 3 shows your percent of excisions performed within 365 days of a previous excision. This is calculated as follows:

- The number of excisions performed within 365 days of a previous excision is divided by the total number of excisions and multiplied by 100:

$$\left(\frac{\text{Number of re-excisions}}{\text{Total number of excisions}} \right) \times 100$$

Your comparison with your specialty and in the nation is presented in Table 3.

Table 3: Your Percent of Re-Excisions

Number of re-excisions	Total number of excisions	Your Percent	Your Specialty Percent	Comparison with Your Specialty	National Percent	Comparison with National
3	8	37.5%	17.19%	Significantly Higher	16.69%	Significantly Higher

Metric 2: Percent Allowed Amount for Re-Excisions

Table 4 shows the percent allowed amount for excisions performed within 365 days of a previous excision. This is calculated as follows:

- The allowed amount for excisions performed within 365 days of a previous excision is divided by the total allowed amount for all excisions and multiplied by 100:

$$\left(\frac{\text{Allowed amount for re-excisions}}{\text{Total allowed amount for all}} \right) \times 100$$

Your comparison with your specialty and national is presented in Table 4.

Table 4: Your Percent Allowed Amount for Re-Excisions

Allowed amount for re-excisions	Total allowed amount for all excisions	Your Percent	Your Specialty Percent	Comparison with Your Specialty	National Percent	Comparison with National
\$2,147.56	\$5,623.61	38.19%	16.98%	Significantly Higher	16.49%	Significantly Higher

Metric 3: Percent of Beneficiaries Receiving Re-Excision

Table 5 shows the percent of beneficiaries receiving an excision within 365 days of a previous excision. This is calculated as follows:

- The number of beneficiaries that had at least one re-excision is divided by the total number of beneficiaries that received an excision, multiplied by 100:

$$\left(\frac{\text{Number of beneficiaries with re-excision}}{\text{Total number of beneficiaries with an excision}} \right) \times 100$$

Your comparison with the specialty and nation is presented in Table 5.

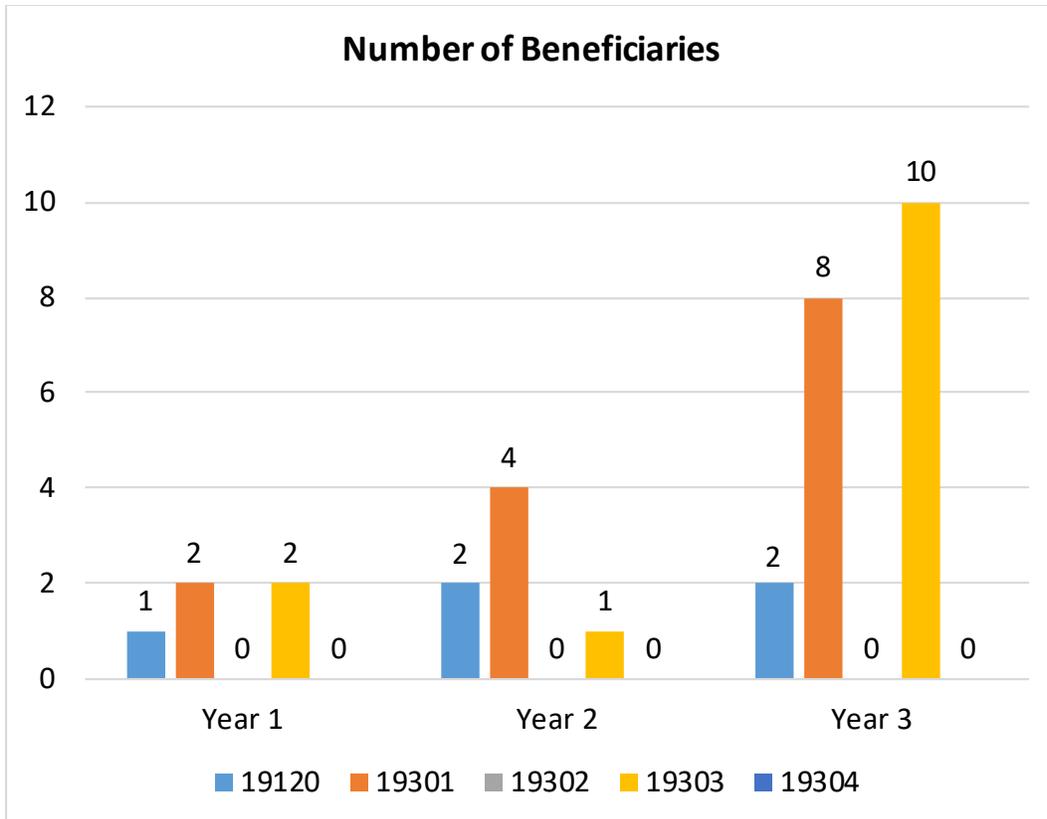
Table 5: Your Percent of Beneficiaries Receiving Re-Excision

Number of Beneficiaries with re-excision	Total Number of Beneficiaries with an excision	Your Percent	Your Specialty Percent	Comparison with Your Specialty	National Percent	Comparison with National
2	5	40%	19.9%	Significantly Higher	19.22%	Significantly Higher

Figure 1 illustrates the trend over time of beneficiaries for CPT® codes 19120, 19301, 19302, 19303, and 19304:

- Year 1: Mar. 1, 2016 – Feb. 28, 2017;
- Year 2: Mar. 1, 2017 – Feb. 28, 2018;
- Year 3: Mar. 1, 2018 – Feb. 28, 2019

Figure 1: Trend Over Time: Number of Beneficiaries for CPT® Codes 19120, 19301, 19302, 19303, and 19304



References and Resources

CPT® 2017 Professional Edition

[”Surgeon Re-Excision Rates After Breast-Conserving Surgery: A Measure of Low-Value Care.”
Journal of the American College of Surgeons, April 2019, Vol. 228, Issue 4](#)