Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) is pleased to provide this Comparative Billing Report (CBR), which can be used to support internal compliance activities. CMS has contracted with the RELI Group to develop and distribute this CBR and to support providers with its use. As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.

What is a CBR? CMS defines a CBR as an educational resource and tool for possible improvement. It reflects your billing patterns compared to your peers’ patterns for the same services in your state or specialty, and nationwide. The CBR is a free, comparative data report intended to educate providers, enhance accurate billing practices, and support providers’ 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.

Action steps: Please carefully review this report. You may wish to check your records against data in CMS’ files and review Medicare guidelines to ensure compliance. If you have specific billing or coding questions, please contact your Medicare Administrative Contractor (MAC).

Training and Support: Register for our free webinar on Feb. 28, 2019, at 3 p.m. EST. The webinar will be recorded for those unable to attend. 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. EST).

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

Sincerely,

The CBR Team
Introduction

CBR201902 focuses on rendering Family Practice providers who submitted claims to Medicare Part B for New and Established patient visits (CPT® codes 99201-99205 and 99211-99215). According to the 2018 Medicare Fee-for-Service Supplemental Improper Payment Data report, the overall improper payment rate for Family Practice visits was 13.6 percent, with over $727 million in projected improper payments. According to the same report, Family Practitioners have an improper payment rate of 5.3 percent for established office visits (CPT® codes 99211-99215), with over $139 million in projected improper payments.

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 as outlined by the Medicare Administrative Contractors’ (MACs’) Local Coverage Determinations (LCDs).

For the purposes of this CBR, new patients are identified as those patients who have not received services from the rendering provider within the last three years. The CPT® codes used to bill for these services are 99201-99205. Established patients, with services for CPT® codes 99211-99215, have received services from the rendering provider within the last three years. The following information should be included in the documentation for Evaluation and Management services:

- History
  - History of Present Illness
  - Review of Systems
  - Past, Family, Social History
- Exam
- Plan
  - Diagnoses
  - Data Reviewed
  - Associated Risks to the patient’s condition

Basic Coding Guidelines

Table 1 identifies CPT® codes that may be reported for Evaluation and Management services to New Patients, CPT® codes 99201-99205 and Established Patients, CPT® codes 99211-99215.
### Table 1. CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; medical decision making of low complexity.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; medical decision making of moderate complexity.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; medical decision making of high complexity.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; medical decision making of low complexity.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: A detailed history; A detailed examination; medical decision making of moderate complexity.</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: A comprehensive history; A comprehensive examination; medical decision making of high complexity.</td>
</tr>
</tbody>
</table>

All patient documentation must support the assigned code for the level of patient encounter, using either the 1995 or 1997 guidelines to assign the code level as set forth in coding guidelines, and the CMS Medicare Learning Network Evaluation and Management Services guide (see References and Resources section).

Table 2 identifies a summary of statistics for CPT® codes used to report Evaluation and Management services to New Patients, CPT® codes 99201-99205 and Established Patients, CPT® codes 99211-99215.
Table 2: Your Allowed Units, Allowed Charges, Beneficiary Count

Oct. 1, 2017-Sept. 30, 2018

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Allowed Units</th>
<th>Allowed Charges</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>2</td>
<td>$91</td>
<td>2</td>
</tr>
<tr>
<td>99202</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99203</td>
<td>57</td>
<td>$6,114</td>
<td>57</td>
</tr>
<tr>
<td>99204</td>
<td>1,048</td>
<td>$172,835</td>
<td>1,048</td>
</tr>
<tr>
<td>99205</td>
<td>0</td>
<td>$0</td>
<td>0</td>
</tr>
<tr>
<td>99211</td>
<td>0</td>
<td>$0</td>
<td>0</td>
</tr>
<tr>
<td>99212</td>
<td>1</td>
<td>$45</td>
<td>1</td>
</tr>
<tr>
<td>99213</td>
<td>90</td>
<td>$6,553</td>
<td>83</td>
</tr>
<tr>
<td>99214</td>
<td>2,079</td>
<td>$225,933</td>
<td>1080</td>
</tr>
<tr>
<td>99215</td>
<td>4</td>
<td>$587</td>
<td>4</td>
</tr>
</tbody>
</table>

**Metrics**

This report is an analysis of the following metrics:

1. Allowed units for new patient visits and for established patient visits, levels 4 and 5 (CPT® codes 99204, 99205, 99214, 99215)
2. Allowed charge amount for new patient visits and for established patient visits, levels 4 and 5 (CPT® codes 99204, 99205, 99214, 99215)
3. Percentage of beneficiaries per level of service, for new patient visits and for established patient visits, levels 4 and 5 (CPT® codes 99204, 99205, 99214, 99215)

The CBR team identified the services for Office Visits for New and Established Patients, with Part B Claims submitted by Family Practitioners. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. Each provider’s values are compared to his/her state peer group values and to the national values. 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 peer or national mean.
2. Higher — Provider’s value is greater than the state peer or national mean.
3. Does Not Exceed — Provider’s value is not higher than the state peer 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 (family practitioner, specialty code 08) who submitted CPT® codes 99201-99205, and 99211-99215 on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims as of February 3, 2019. The analysis includes claims with dates of service from Oct. 1, 2017-Sept. 30, 2018. For the trend analysis (Figure 1), claims represent dates of service between Oct. 1, 2015-Sept. 30, 2018.

There are 80,636 rendering providers nationwide with allowed charges for CPT® codes 99201-99205, and 99211-99215, billing a combined allowed amount of $3,414,683,042 during the timeframe. The criteria for receiving a CBR is that the provider:

1. Has at least 50 beneficiaries with claims submitted for 99201-99205, or has at least 50 beneficiaries with claims submitted for 99211-99215; and
2. Is significantly higher compared to either state or national percent in any one of the twelve metrics (greater than the 90th percentile), and
3. Has at least $10,000 in total allowed charges per type of visit (new or established).

Metric 1: Allowed Units

Table 3 shows the percentage of allowed units for New and Established Patient Evaluation and Management Levels 4 and 5 CPT® codes: 99204, 99205, 99214, and 99215. This is calculated for each code as follows:

- The number of units allowed for CPT® code 99204 is divided by the number of units allowed for combined CPT® codes 99201-99205.
  
  \[
  \frac{\text{Allowed Units for 99204}}{\text{Allowed Units for 99201-99205}}
  \]

- The number of units allowed for CPT® code 99205 is divided by the number of units allowed for combined CPT® codes 99201-99205.
  
  \[
  \frac{\text{Allowed Units for 99205}}{\text{Allowed Units for 99201-99205}}
  \]

- The number of units allowed for CPT® code 99214 is divided by the number of units allowed for combined CPT® codes 99211-99215.
  
  \[
  \frac{\text{Allowed Units for 99214}}{\text{Allowed Units for 99211-99215}}
  \]

- The number of units allowed for CPT® code 99215 is divided by the number of units allowed for combined CPT® codes 99211-99215.
  
  \[
  \frac{\text{Allowed Units for 99215}}{\text{Allowed Units for 99211-99215}}
  \]
Your comparison with the level of service per beneficiary in your state and in the nation is presented in Table 3.

Table 3: Your Allowed Units, New Visits and Established Visits, Levels 4 and 5

Oct. 1, 2017-Sept. 30, 2018

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Your Allowed Units</th>
<th>Your Total Allowed Units (new/est.)*</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204 (new)</td>
<td>1,048</td>
<td>1,107</td>
<td>94.7%</td>
<td>36%</td>
<td>Significantly Higher</td>
<td>33.2%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99205 (new)</td>
<td>0</td>
<td>1,107</td>
<td>0</td>
<td>7.5%</td>
<td>Does Not Exceed</td>
<td>3.4%</td>
<td>Does Not Exceed</td>
</tr>
<tr>
<td>99214 (est.)</td>
<td>2,079</td>
<td>2,174</td>
<td>95.6%</td>
<td>42.3%</td>
<td>Significantly Higher</td>
<td>53.5%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99215 (est.)</td>
<td>4</td>
<td>2,174</td>
<td>0.18%</td>
<td>3.4%</td>
<td>Does not Exceed</td>
<td>3.2%</td>
<td>Does not Exceed</td>
</tr>
</tbody>
</table>

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

*Total Allowed Units for New = 99201-99205; Est. = 99211-99215

**Metric 2: Allowed Amount**

Table 4 shows the percentage of the allowed amount for New and Established Patient Evaluation and Management Levels 4 and 5 CPT® codes: 99204, 99205 and 99214, 99215. This is calculated for each code as follows:

- The allowed amount of CPT® code 99204 is divided by the allowed amount for all new patient visit Evaluation and Management codes, 99201-99205.

\[
\frac{\text{Allowed Amount of 99204}}{\text{Allowed Amount for 99201-99205}}
\]

- The allowed amount of CPT® code 99205 is divided by the allowed amount for all new patient visit Evaluation and Management codes, 99201-99205.

\[
\frac{\text{Allowed Amount of 99205}}{\text{Allowed Amount for 99201-99205}}
\]

- The allowed amount of CPT® code 99214 is divided by the allowed amount for all established patient visit Evaluation and Management codes, 99211-99215.

\[
\frac{\text{Allowed Amount of 99214}}{\text{Allowed Amount for 99211-99215}}
\]

- The allowed amount of CPT® code 99215 is divided by the allowed amount for all established patient visit Evaluation and Management codes, 99211-99215.

\[
\frac{\text{Allowed Amount of 99215}}{\text{Allowed Amount for 99211-99215}}
\]
Table 4: Your Allowed Amount, New Visits and Established Visits, Levels 4 and 5

Oct. 1, 2017-Sept. 30, 2018

<table>
<thead>
<tr>
<th>CPT® code</th>
<th>Allowed Amount</th>
<th>Your Total Allowed Amount (new/est.)*</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204 (new)</td>
<td>$172,835</td>
<td>$179,040</td>
<td>96.5%</td>
<td>34%</td>
<td>Significantly Higher</td>
<td>37.7%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99205 (new)</td>
<td>$0</td>
<td>$179,040</td>
<td>0%</td>
<td>8.6%</td>
<td>Does Not Exceed</td>
<td>4.3%</td>
<td>Does Not Exceed</td>
</tr>
<tr>
<td>99214 (est.)</td>
<td>$225,932</td>
<td>$233,118</td>
<td>96.9%</td>
<td>54.2%</td>
<td>Significantly Higher</td>
<td>60.2%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99215 (est.)</td>
<td>$587</td>
<td>$233,118</td>
<td>0.2%</td>
<td>4.5%</td>
<td>Does Not Exceed</td>
<td>4.4%</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

*Total Allowed Amount for New = 99201-99205; Est. = 99211-99215

Metric 3: Number of Beneficiaries

Table 5 shows the percentage of beneficiaries that received level 4 and 5 service codes, for both new and established patients. This is calculated as follows:

- The number of beneficiaries with CPT® code 99204 is divided by all beneficiaries with all new patient visit Evaluation and Management CPT® codes, 99201-99205.

  Number of Beneficiaries with 99204
  Number of Beneficiaries with 99201-99205

- The number of beneficiaries with CPT® code 99205 is divided by all beneficiaries with all new patient visit Evaluation and Management CPT® codes, 99201-99205.

  Number of Beneficiaries with 99205
  Number of Beneficiaries with 99201-99205

- The number of beneficiaries with CPT® code 99214 is divided by all beneficiaries with all established patient visit Evaluation and Management CPT® codes, 99211-99215.

  Number of Beneficiaries with 99214
  Number of Beneficiaries with 99211-99215

- The number of beneficiaries with CPT® code 99215 allowed is divided by all beneficiaries with all established patient visit Evaluation and Management CPT® codes, 99211-99215.

  Number of Beneficiaries with 99215
  Number of Beneficiaries with 99211-99215

Note: the number of beneficiaries in the denominator (99201-99205, or 99211-99215) represents unique beneficiaries for all CPT code levels; a beneficiary may be identified in multiple CPT code levels for the numerator, but only once in the denominator.
Your comparison with the state and national percentages is presented in Table 5.

**Table 5: Your Number of Beneficiaries, New Visits and Established Visits, Levels 4 and 5**

**Oct. 1, 2017-Sept. 30, 2018**

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Your Number of Benefic.</th>
<th>Your Total Benefic. (new/est.)*</th>
<th>Your Percent</th>
<th>Your State Percent</th>
<th>Comparison with Your State</th>
<th>National Percent</th>
<th>Comparison with Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99204 (new)</td>
<td>1,048</td>
<td>1,107</td>
<td>94.67%</td>
<td>30%</td>
<td>Significantly Higher</td>
<td>33.2%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99205 (new)</td>
<td>0</td>
<td>1,107</td>
<td>0%</td>
<td>7.5%</td>
<td>Does Not Exceed</td>
<td>3.4%</td>
<td>Does Not Exceed</td>
</tr>
<tr>
<td>99214 (est.)</td>
<td>1,080</td>
<td>1,115</td>
<td>96.8%</td>
<td>68.9%</td>
<td>Significantly Higher</td>
<td>66.2%</td>
<td>Significantly Higher</td>
</tr>
<tr>
<td>99215 (est.)</td>
<td>4</td>
<td>1,115</td>
<td>0.4%</td>
<td>7.6%</td>
<td>Does Not Exceed</td>
<td>6.1%</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

*Total Beneficiaries for New = 99201-99205; Est. = 99211-99215

Figure 1 illustrates the percentage of beneficiaries at service levels 4 and 5, for New and Established patients, CPT® codes 99204, 99205, 99214, 99215, trending over the last three years.

- Year 1 represents claims between Oct. 1, 2015-Sept. 30, 2016
- Year 2 represents claims between Oct. 1, 2016-Sept. 30, 2017
- Year 3 represents claims between Oct. 1, 2017-Sept. 30, 2018

**Figure 1: Percentage of Beneficiaries at Service Levels 4 and 5, Trending Over Time**
References and Resources

2018 Medicare Fee-for-Service Supplemental Improper Payment Data
CMS Evaluation and Management Services Manual
Claims Processing Manual: Chapter 12, Section 30.6