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 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 Apr. 11, 2019, at 3 p.m. EST. 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. EST).

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

CBR201903 focuses on rendering providers in multiple clinical specialties who submitted claims to Medicare Part B for Subsequent Hospital Care (CPT® codes 99231, 99232, 99233). According to the “2018 Medicare Fee-for-Service Supplemental Improper Payment Data” report, the overall projected improper payments for Subsequent Hospital Care totaled $621,652,113. The same report reflected improper payment rates of 21.6 percent for CPT® code 99231, 7.9 percent for CPT® code 99232, and 19.1 percent for CPT® code 99233.

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, Subsequent Hospital Care, Levels I, II, and III were analyzed. The CBR Team identified the clinical specialties in which the highest number of providers submitted claims for CPT® codes 99231, 99232, and 99233 during the time period between Nov. 1, 2017 and Oct. 31, 2018. Those clinical specialties, except Internal Medicine and Psychiatry, were selected (“Top Specialties”). Based on the above criteria, your specialty was determined to be (specialty).

Medicare Part B claims were considered for rendering providers from these specialties for dates of service between Nov. 1, 2017, and Oct. 31, 2018. The Top Specialties are listed below:

- Nurse Practitioner
- Family Practice
- Cardiology
- Physician Assistant
- General Surgery
- Hospitalist
- Gastroenterology
- Orthopedic Surgery
- Neurology
- Pulmonary Disease

The Medicare Program Integrity Manual dictates that Subsequent Hospital Care should follow the documented “Reasonable and Necessary Criteria.” Furthermore, the Medicare Claims Processing Manual states that the following information should be included in the documentation for Subsequent Hospital Care services:

- History
- Exam
- Medical decision making
Basic Coding Guidelines

Table 1 identifies CPT® codes that may be reported for Evaluation and Management services for Subsequent Hospital Care, CPT® codes 99231 – 99233.

Table 1. CPT® Codes

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these three components: A problem focused interval history, A problem focused examination; Medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>99233</td>
<td>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 components: A detailed interval history, A detailed examination, Medical decision making of high complexity. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
</tbody>
</table>

All patient documentation must support the assigned code for the level of patient encounter, as set forth in coding guidelines, and the Medicare Claims Processing Manual, Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.9.1 (Payment for Initial Hospital Care Services (Codes 99221–99233)).

The utilization of the Subsequent Hospital Care codes within the Top Specialties is as follows:

- 99231: 9.95 percent
- 99232: 58.54 percent
- 99233: 31.51 percent
Table 2 identifies a summary of your Medicare statistics for CPT® codes used to report Subsequent Hospital Care, CPT® codes 99231 – 99233.

Table 2: Summary of Your Utilization for Subsequent Hospital Care
Nov. 1, 2017 – Oct. 31, 2018

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>$0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99232</td>
<td>$0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>99233</td>
<td>$30,467</td>
<td>297</td>
<td>114</td>
</tr>
<tr>
<td>Total</td>
<td>$30,467</td>
<td>297</td>
<td>114</td>
</tr>
</tbody>
</table>

**Metrics**

This report is an analysis of the following metrics:

1. Percentage of beneficiaries discharged within one day of a CPT® code 99233 service
2. Average allowed minutes per encounter
3. Percentage of total services billed as CPT® code 99233

The CBR Team identified the services for Subsequent Hospital Care, with Part B Claims submitted by rendering providers from the Top Specialties. Statistics were calculated for each provider, all providers in the specialty, and all providers in the nation for all specialties. Each provider’s values are compared to his/her specialty 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 95th percentile from the peer or national mean.
2. Higher — Provider’s value is greater than the peer or national mean.
3. Does Not Exceed — Provider’s value is not higher than the 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 from the Top Specialties who submitted CPT® codes 99231, 99232 and 99233 on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims as of March 1, 2019. The analysis includes claims with dates of service from Nov. 1, 2017, through Oct. 31, 2018. For the trend analysis, claims represent dates of service between Nov. 1, 2015, and Oct. 31, 2018.

Providers included in the analysis were compared at the national and specialty level:

1) National Comparison = NPI is compared against all specialties in the nation
2) Specialty Comparison= NPI is compared against other NPIs in the same specialty
There are 158,159 rendering providers that submitted claims for Subsequent Hospital Care services using CPT® codes 99231, 99232, and 99233 between Nov. 1, 2017, and Oct. 31, 2018 for the Top Specialties. These providers billed a combined allowed amount of $2.3 billion for 3.9 million beneficiaries during the timeframe. The criteria for receiving a CBR is that the provider:

1. Is significantly higher (greater than the 95th percentile) compared to either the specialty or national percent in at least one of the three metrics
2. Has greater than ten unique beneficiaries with claims submitted for any of these codes: 99231, 99232, 99233
3. Has total allowed charges greater than $2,000 for claims submitted for any of these codes: 99231, 99232, 99233

**Metric 1: Percentage of Beneficiaries Discharged within One Day of a CPT® code 99233 Service**

CPT® codes 99238 and 99239 were used to determine the date of discharge of each beneficiary. If a beneficiary had a CPT® code 99233 service within one day of a discharge code, and the beneficiary did not have a date of death on file, the beneficiary was flagged. Table 3 shows the percentage of unique beneficiaries discharged within one day of a CPT® code 99233 service. This figure is calculated as follows:

- The number of unique beneficiaries flagged is divided by the total number of unique beneficiaries who received services of CPT® code of 99233.

<table>
<thead>
<tr>
<th>Number of Unique Beneficiaries Flagged</th>
<th>All Unique Beneficiaries with CPT® code 99233</th>
</tr>
</thead>
</table>

Your comparison with the level of service per beneficiary amongst providers in your specialty and in the nation is presented in Table 3.

**Table 3: Percentage of Beneficiaries Discharged within One Day of a CPT® code 99233 Service:**

<table>
<thead>
<tr>
<th>Nov. 1, 2017 – Oct. 31, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Percentage of Beneficiaries</td>
</tr>
<tr>
<td>Discharges</td>
</tr>
</tbody>
</table>

**Metric 2: Average Allowed Minutes per Encounter**

Table 4 shows the average allowed minutes per encounter for CPT® codes: 99231, 99232, and 99233, with an “encounter,” which is defined as a single date of service by beneficiary. Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code description, found in Table 1. This value is multiplied by the total allowed services for the code to arrive at the total weighted services. Generally, the total number of encounters is equal to the total number of services by modifier designation. However, if multiple services were allowed for a particular beneficiary and date of service, then these services would be combined in the same encounter. The average minutes allowed per encounter are calculated as follows:
- The sum of all the weighted services is divided by the total number of encounters:
  \[
  \text{Total Weighted Services} \div \text{Total Number of Encounters}
  \]

### Table 4: Your Average Allowed Minutes per Encounter:

**Nov. 1, 2017 – Oct. 31, 2018**

<table>
<thead>
<tr>
<th></th>
<th>Your Average Minutes Per Encounter</th>
<th>Your Specialty’s Average Minutes Per Encounter</th>
<th>Comparison with Your Specialty’s Average</th>
<th>National Average Minutes Per Encounter</th>
<th>Comparison with the National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes</td>
<td>75.9</td>
<td>41.7</td>
<td>Higher</td>
<td>27.1</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

**Metric 3: Percentage of Total Services Billed as CPT® code 99233**

Table 5 shows the percentage of allowed services for CPT® code 99233 service. This is calculated as follows:

- The number of allowed services for CPT® code 99233 is divided by all allowed services for Subsequent Hospital Care CPT® codes 99231 – 99233.

\[
\text{Number of Allowed Services with CPT® code 99233} \div \text{Number of Allowed Services with 99231-99233}
\]

Your comparison amongst providers in your specialty and national percentages is presented in Table 5.

### Table 5: Your Percentage of Total Services Billed as CPT® code 99233

**Nov. 1, 2017 – Oct. 31, 2018**

<table>
<thead>
<tr>
<th></th>
<th>Your Percentage of Services</th>
<th>Your Specialty’s Percentage of Services</th>
<th>Comparison with Your Specialty’s Services</th>
<th>National Percentage of Services</th>
<th>Comparison with the National Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>100%</td>
<td>29.6%</td>
<td>Significantly Higher</td>
<td>30.7%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>
Figure 1 illustrates the Total Number of Beneficiaries with Subsequent Hospital Care CPT® Code 99231, 99232 and 99233.

- **Year 1:** Nov. 1, 2015 – Oct. 31, 2016
- **Year 2:** Nov. 1, 2016 – Oct. 31, 2017
- **Year 3:** Nov. 1, 2017 – Oct. 31, 2018

**Figure 1: Trend Over Time Analysis of Total Number of Beneficiaries (with CPT® codes 99231, 99232, and 99233)**