# Comparative Billing Report

April 11, 2016

CBR #: CBR201605
Topic: Subsequent Nursing Facility Evaluation and Management Services
NPI #: 1111111111
Fax #: (888)555-5555

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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 eGlobalTech, a professional services firm headquartered in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs provide comparative data on how an individual health care provider's billing and payment patterns for selected topics compare to his/her peers. The CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS' files, and review Medicare guidelines to ensure compliance. CBRs are for educational and comparison purposes and do not indicate the identification of overpayments. **Please note, no reply is necessary**.

Attached is a CBR that reflects your billing or referral patterns compared to peer providers' patterns for the same services in your state and nationwide. We recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed for the CBR. We hope you find this CBR beneficial as an educational tool to assist you in identifying opportunities for improvement. If you have any questions regarding this CBR, or if you want to change the way you receive CBRs in the future, please contact the CBR Support Help Desk.

- Toll Free Number: 1-800-771-4430
- Email: cbrsupport@eglobaltech.com
- Website: http://www.cbrinfo.net

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system.

You can update your National Provider Identifier (NPI) contact information in NPPES at https://nppes.cms.hhs.gov/NPPES. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at 1-800-465-3203 or email customerservice@npienumerator.com.

We hope you find the attached report informative.

Sincerely,

Virna Elly
Acting CBR Program Director
eGlobalTech

Enclosure

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**Comparative Billing Report (CBR): NPI 1111111111**
**Subsequent Nursing Facility Evaluation and Management Services**

## Introduction

This CBR focuses on providers of all specialties who submitted claims for established patient subsequent nursing facility evaluation and management (E/M) services using Current Procedural Terminology (CPT®) codes 99307 to 99310. This report examines the average minutes per date of service based on the typical time assigned by CPT® code, the average number of services per year per beneficiary billed under your National Provider Identifier (NPI), and the average total services per year rendered to your beneficiaries by all practitioners using the CPT® codes in the CBR.

**Table 1: CPT® Codes, Abbreviated Descriptions, and Typical Times**

| CPT® Code | Abbreviated Description | Typical Time |
|---|---|---|
| 99307 | Problem Focused History/Exam | 10 Minutes |
| 99308 | Expanded Problem Focused History/Exam | 15 Minutes |
| 99309 | Detailed Patient History/Exam | 25 Minutes |
| 99310 | Comprehensive Patient History/Exam | 35 Minutes |



According to a May 2012 report published by the Office of Inspector General (OIG) titled, "Coding Trends of Medicare E/M," physicians increased their billing of higher level E/M services from 2001 to 2010. E/M services increased by 48 percent (from $22.7 billion to $33.5 billion), while Medicare payments for all Part B goods and services increased by 43 percent between 2001 and 2010. The OIG reported that the average Medicare payment amount per E/M service increased by 31 percent (from approximately $65 to $85) during the time period under review. The report identified several factors that were involved in the increase, including changes in physicians' billing practices. Billing of higher level E/M services increased in all service types. The OIG's investigation found that physicians who billed consistently for higher level E/M codes and physicians who did not bill consistently for higher level codes treated beneficiaries of similar ages and diagnoses.

As a follow-up to their 2012 report, the OIG conducted a medical review of a sample of Part B claims for services rendered during 2010. The OIG detailed the findings in a May 2014 report titled, "Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010." The OIG found that physicians who routinely billed using high level codes were more likely to have coded incorrectly and documented insufficiently than physicians who did not routinely code their claims at the highest levels. The review revealed that 42 percent of the claims were coded incorrectly, which included downcoding as well as upcoding; and 19 percent lacked documentation.

Comprehensive Error Rate Testing (CERT) data supports a high number of incorrectly coded claims for the two highest CPT® codes in the subsequent nursing facility E/M range, 99309 and 99310. According to the 2014 data, more than 22 percent of claims submitted with CPT® code 99309 were coded incorrectly, while over 67 percent of claims billed with CPT® code 99310 were coded incorrectly.

National Government Services (NGS) conducted a prepayment review of CPT® codes 99309 and 99310 during the months of April through June of 2015. Between 30 and 35 percent of the claims reviewed were reduced or denied during the review period. NGS cited several reasons for

payment denial, including incomplete or illegible documentation, failure to respond to the request for documentation and receiving documentation for the wrong date of service. The majority of claims found to be in error, however, were recoded to a lower E/M level because the record(s) lacked documentation supporting two of the three key components as required by the CPT® code.

## 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 in the Medicare Administrative Contractor (MAC), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

### Basic Coverage Criteria

According to Chapter 12 of the *Medicare Claims Processing Manual (MCPM)*, Section 30.6.13 covering Nursing Facility Services, "Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits." During the initial, federally mandated visit, the physician completes an assessment of the patient and develops a plan of care to be followed during the patient's nursing facility stay. The initial, federally mandated visit is required no later than 30 days after admission. Following the initial, federally mandated visit by the physician, or qualified Non-Physician Practitioner (NPP) where permitted, payment is allowed for federally mandated visits that monitor and evaluate patients at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

In addition to federally mandated visits, "other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits...if all the requirements for collaboration, general physician supervision, licensure and billing are met." Nursing facility codes represent per day services, and E/M documentation guidelines apply.

Per LCD L35068 Evaluation and Management Services Provided in a Nursing Facility, "In the nursing home environment, patients are in a controlled environment in which they are under close supervision and have immediate access to care from trained medical professionals. Under these circumstances, it is customary for physicians to direct nursing home personnel to perform, in the absence of the physician, many of those services that may be necessary but of relatively minor nature. Frequent visits by the physician under these circumstances would be then unnecessary, particularly if the patient is medically stable. However, it would not be unreasonable for the attending physician to make several visits at the time of a new episode of illness or an acute exacerbation of a chronic illness. The medical record should clearly reflect the particular circumstances requiring the increased frequency of services..."

Regarding multiple visits made on the same date of service, Section 30.6.13 of the MCPM states, "The complexity level of an E/M visit and the CPT®code billed must be a covered and medically necessary visit for each patient (refer to §1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits."

Medicare "incident to" services rendered under an employing physician's NPI, such as those by nurses, technicians and therapists, are not covered in the skilled nursing facility (SNF) or nursing facility (NF) setting. If a physician establishes an office in a SNF or NF, his/her services must be confined to the distinct part of facility designated as his/her office and reported using office or other outpatient CPT® codes in the office place of service. Those services would not be reported using the CPT® codes described in this CBR.

According to the Manual, "A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service." A split/shared visit cannot be reported in the SNF or NF setting.

LCD L35068 from Novitas Solutions, Inc. covers evaluation and management services provided in a nursing facility. Under the heading for inpatient consultative or specialist services, the determination states, "Consultative or specialist services are allowed when they address a documented diagnostic or therapeutic question of which the attending physician determines he or she needs the assistance or second opinion of a specialist (by a record review and a physical and/or cognitive examination) to assess the condition. Only one initial specialist service should be reported by each specialist per admission. When ordering specialist services, the following needs to be considered:

- A consulting specialist should possess an additional knowledge base and/or skills clearly outside the skill/knowledge base of that primary care attending physician, unless the consultation is for a second opinion.
- The service requested must be appropriate for the specific individual.
- The service will affect the resident/patient assessment, diagnosis or care planning or treatment."

Information on selecting the proper level of E/M code can be found in Chapter 12, Section 30.6.1 of the MCPM. The Manual states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

## Methods

This report is an analysis of Fee-for-Service Medicare Part B claims with allowed services for the CPT® codes listed in Table 1 with dates of service from October 1, 2014 to September 30, 2015. This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR), as of March 1, 2016. Your averages denoted in Tables 3, 4, and 5 are calculated from the data supplied from your utilization of the CPT® codes in Table 2 using the formulas below. Your values are compared to your state (NV) and national values, using the statistical test (t-test) at the alpha value of 0.05.

### Average Minutes per Day

Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code description in Table 1. This value is multiplied by the total allowed services for this code to arrive at the total weighted services per code. All weighted services are summed, then divided by the total number of days that these codes were rendered. The average minutes per day

that you dedicate to subsequent E/M visits on the days that you visit nursing homes are calculated for you, your state, and the nation, as follows:

$$\frac{\textbf{Total Weighted Services}}{\textbf{Total Number of Days}}$$

### Average Allowed Services per Beneficiary Billed under a Single NPI

The average allowed subsequent nursing facility E/M services per beneficiary that were billed under your single NPI is calculated for the one-year period for you, your state, and the nation, as follows:

$$\frac{\textbf{Total Allowed Services Rendered by Your Single NPI}}{\textbf{Total Number of Your Beneficiaries}}$$

### Average Total Services per Year Rendered to Your Beneficiaries by All Practitioners

The average total allowed subsequent nursing facility E/M services per beneficiary that were billed by you and all other practioners is calculated for all of your beneficiaries for the one-year period. This measure is calculated for you, your state, and the nation, as follows:

$$\frac{\textbf{Total Allowed Services Rendered by You and All Other Providers}}{\textbf{Total Number of Your Beneficiaries}}$$

### Comparison Outcomes

There are four possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** - Provider's value is higher than the peer value and the statistical test confirms a significance
- **Higher** - Provider's value is higher than the peer value but either the statistical test does not confirm a significance or there is insufficient data for comparison
- **Does Not Exceed** - Provider's value is not higher than the peer value
- **N/A** - Provider does not have data for comparison

The t-test used in each analysis gives the provider the benefit of the doubt, as significance is based on the total number of services, beneficiaries, and days, as well as the variability of those values.

## Results

Table 2 provides a summary of your utilization of the CPT® codes included in this CBR. The total allowed charges, allowed services, and distinct beneficiary count are included for each CPT® code. Additionally, the total number of days that you provided these services to your beneficiaries at nursing facilities was **37**.

**Table 2: Summary of Your Utilization**
**October 1, 2014 - September 30, 2015**

| CPT® Codes | Allowed Charges | Allowed Services | Beneficiary Count |
|---|---|---|---|
| 99307 | $0.00 | 0 | 0 |
| 99308 | $8,675.32 | 146 | 61 |
| 99309 | $10,259.60 | 130 | 70 |
| 99310 | $1,999.71 | 17 | 14 |
| **TOTAL** | **$20,934.63** | **293** | **94** |

Please note, the total may not be equal to the sum of the rows. The number of beneficiaries is an unduplicated count for each row and the total. Since it is likely that a beneficiary would have billings for more than one CPT®code, he/she would be counted in the beneficiary count in each applicable row. However, this beneficiary would be counted only once in the total.

Table 3 provides a statistical analysis of the average minutes per day, as described above, and compares those results with others in your state and the nation.

**Table 3: Average Minutes per Day**
**October 1, 2014 - September 30, 2015**

| | Your Average Minutes per Day | Your State's Average Minutes per Day | Comparison with Your State's Average | National Average Minutes per Day | Comparison with the National Average |
|---|---|---|---|---|---|
| Minutes per Day | 163.11 | 148.14 | Significantly Higher | 117.38 | Significantly Higher |

A t-test was used in this analysis, alpha=0.05.

Table 4 provides a statistical analysis of the average services per beneficiary billed under your NPI. Your average is then compared to that of your state and the nation.

**Table 4: Average Allowed Services per Beneficiary Billed under a Single NPI**
**October 1, 2014 - September 30, 2015**

| | Your Average Services per Beneficiary | Your State's Average Services per Beneficiary | Comparison with Your State's Averge | National Average Services per Beneficiary | Comparison with the National Average |
|---|---|---|---|---|---|
| Services | 3.12 | 5.85 | Does Not Exceed | 4.29 | Does Not Exceed |

A t-test was used in this analysis, alpha=0.05.

Table 5 provides a statistical analysis of the average total services per year rendered to your beneficiaries by all practitioners. Your average is then compared to that of your state and the nation.

**Table 5: Average Total Services per Year Rendered to Your Beneficiaries by All Practitioners**
**October 1, 2014 - September 30, 2015**

| | Average Total Services Rendered to Your Beneficiaries | Your State's Average Total Services per Beneficiary | Comparison with Your State's Average | National Average Total Services per Beneficiary | Comparison with the National Average |
|---|---|---|---|---|---|
| Total Services | 29.11 | 23.76 | Higher | 16.39 | Significantly Higher |

A t-test was used in this analysis, alpha=0.05.

## References & Resources

The coverage and documentation guidelines for this CBR are listed below. Please follow the guidelines pertinent to your region. Links to all references and resources can be accessed at http://www.cbrinfo.net/cbr201605-recommended-links.html.

**LCDs-Active on 10/01/15:**

- Novitas Solutions, Inc.: L35068
- First Coast Service Options, Inc.: L36230

**Office of Inspector General:**

- Coding Trends of Medicare Evaluation and Management Services, OEI-04-10-00180, May 8, 2012
- Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010, OEI-04-10-00181, May 28, 2014

**Centers for Medicare & Medicaid Services:**

- Medicare Fee-for-Service 2014 Improper Payments Report
- Comprehensive Error Rate Testing (CERT) Reports: 2012, 2013, 2014

**Medicare Manuals:**

- *Medicare Claims Processing Manual*, Chapter 12, Physician/Nonphysician Practitioners

## The Next Steps

We encourage you to check with your MAC to ensure you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201605 webinar on May 11, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at http://www.cbrinfo.net/cbr201605-webinar.html.

If you are unable to attend, you may access a recording of the CBR201605 webinar five business days following the event at http://www.cbrinfo.net/cbr201605-webinar.html.

For detailed links to information listed in the references and resources section, visit http://www.cbrinfo.net/cbr201605-recommended-links.html.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at CBRSupport@eglobaltech.com or via telephone at (800) 771-4430.

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