



Comparative Billing Report

October 3, 2016

CBR #: CBR201615
Topic: Subsequent Hospital Care
NPI #: 1111111111
Fax #: (888)555-5555

ORGANIZATION NAME
FULL NAME
123 STREET LANE
SUITE 4000
ANYTOWN, XX 55555-4444

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
CBR Program Director
eGlobalTech
Enclosure

7127 Ambassador Road, Suite 150, Baltimore, MD 21244

Comparative Billing Report (CBR): NPI 1111111111 Subsequent Hospital Care

Introduction

This CBR focuses on physicians with a specialty of internal medicine, specialty 11, who submitted claims for subsequent hospital care services using Current Procedural Terminology (CPT®) codes 99231 through 99233. According to a May 2012 report by the Office of Inspector General (OIG) titled, *Coding Trends of Medicare Evaluation and Management Services*, billing of hospital services by physicians has shifted from lower level to higher level codes. From 2001 to 2010, billing of the lowest level code (CPT® code 99231) decreased by 16 percent, while billing of the two higher level codes (CPT® codes 99232 and 99233) increased by six and nine percent, respectively.

According to the Executive Summary of “The Supplementary Appendices for the Medicare Fee-For-Service 2014 Improper Payments Report”, subsequent hospital care evaluation and management (E/M) services had a 20.7 percent error rate, accounting for 2.4 percent of the overall Medicare Fee-for-Service (FFS) improper payment rate, with a projected improper payment amount during the 2014 reporting period of \$1.2 billion. The report detailed that the majority of improper payments were due to insufficient documentation.

The CBR team focused on claims for subsequent hospital services billed to Part B Medicare based on the 2014 CERT Claims Data available from the Additional Data page on the CMS website. The team found that only 17 percent of the services billed with CPT® code 99231 were paid in error; however, nearly 59 percent of the services billed with CPT® code 99233 were paid incorrectly, with 48 percent of the services being coded incorrectly. Out of a total of 1,309 dates of service for CPT® code 99233, 769 of those were paid in error, with 629 being denied or reduced because they were coded incorrectly.

Palmetto GBA Railroad Medicare is currently conducting a widespread review of CPT® code 99232. The overall error rate percent by dollar amount for Third Quarter, Fiscal Year 2016 was 47.5 percent. The top reasons for denial were missing, illegible, or incomplete documentation; the date of service was not documented clearly; medical necessity was not supported; and/or the signature was illegible, missing, or in an unacceptable format.

The metrics reviewed in this report are:

- Percentage of beneficiaries discharged within one day of a CPT® code 99233 service
- Average allowed minutes per visit
- Percentage of total services billed as 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 supercede or alter the coverage and documentation policies, as outlined by the Medicare Administrative Contractors (MACs), in Local Coverage Determinations (LCDs), or in Local Coverage Articles (LCAs). Please refer any specific questions you may have to the MAC of your region.** MACs follow the guidance given in the *Medicare Program Integrity Manual*, Chapter 3, Section 3.6.2.2 - Reasonable and Necessary Criteria, which states a service or item is “reasonable and necessary if the item or service meets the following criteria:

- It is safe and effective;
- It is not experimental or investigational; and
- It is appropriate, including the duration and frequency in terms of whether the service or item is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary’s condition or to improve the function of a malformed body member;
 - Furnished in a setting appropriate to the beneficiary’s medical needs and condition;
 - Ordered and furnished by qualified personnel; and,
 - One that meets, but does not exceed, the beneficiary’s medical need.”

Title XVIII of the Social Security Act, Section 1862 (a)(1)(A) excludes expenses incurred for items or services which are “not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Basic Coverage Criteria

Medicare payment for any claim which lacks the necessary information to process the claim is also prohibited, according to Title XVIII of the Social Security Act, Section 1833 (e). Information on selecting the proper level of E/M code can be found in Chapter 12, Section 30.6.1 of the *Medicare Claims Processing Manual*. 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.”

According to the CPT® definitions of the codes in our CBR, all levels of subsequent hospital care include the medical record and reviewing the results of diagnostic studies and changes in the patient’s status since the last assessment. They are defined as subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of the following three components; patient history, examination, and medical decision making (MDM).

Table 1 provides a presenting problem and key components for CPT® codes 99231 through 99233, as well as the typical time assigned by the *CPT® Manual*.

Table 1: CPT® Codes, Presenting Problem, and Key Components

CPT®	Presenting Problem	Patient History	Examination	MDM
99231	Stable, recovering, or improving; typically 15 minutes	Problem focused interval history	Problem focused examination	Straightforward or low complexity
99232	Responding inadequately to therapy or has developed a minor complication; typically 25 minutes	Expanded problem focused interval history	Expanded problem focused examination	Moderate complexity
99233	Unstable or has developed a significant complication or a significant new problem; typically 35 minutes	Detailed interval history	Detailed examination	High complexity

Typical times assigned are inclusive of time spent at the bedside and on the patient’s hospital floor or unit. Patients are more likely to be discharged to home without assistance from home health care when they are stable or recovering and billed CPT® code 99231. It is not expected that the

patient be discharged within a day of significant complications or new problems and billed CPT® code 99233.

Physicians in the same group practice and specialty bill and are paid as though they are a single physician. A subsequent hospital visit represents the services provided during an entire day, and only one subsequent visit per day should be billed. If two physicians from different specialties see the patient for different reasons (i.e., different diagnosis), then both may bill a subsequent hospital visit based on the physicians notes with the medical necessity of the service.

Methods

This report is an analysis of Medicare Part B claims with allowed services for the CPT® codes listed in Table 1, with dates of service from January 1, 2015 to December 31, 2015, and includes only those claims where the rendering NPI specialty is denoted as Internal Medicine (11). This analysis was based on the latest version of claims available from the Integrated Data Repository (IDR), as of September 7, 2016. Your percentages and averages, denoted in Tables 4 and 5, are calculated from the the data supplied from your utilization of the CPT® codes in Table 2, using the formulas below. However, calculations for the percentages in Table 3 cannot be calculated from this table, as the calculation requires additional information on the billing of hospital discharge CPT® codes 99238 and 99239. Your values are compared to your state (CA) and national values, using either the chi-squared or t-test at the alpha value of 0.05.

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 the discharge code and the beneficiary did not have a death date on file with the IDR, the beneficiary was flagged. The percentage is calculated, as follows:

$$\left(\frac{\text{Number of Beneficiaries Flagged}}{\text{Total Number of Beneficiaries}} \right) \times 100$$

Average Allowed Minutes per Visit

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. The sum of all the weighted services is divided by the total number of visits. A visit is defined as a single date of service by beneficiary. Generally, the total number of visits is equal to the total number of services by modifier designation. However, if multiple services are allowed for a particular beneficiary and date of service, then these services would be combined in the same visit. The average minutes allowed per visit are calculated, as follows:

$$\frac{\text{Total Weighted Services}}{\text{Total Number of Visits}}$$

Percentage of Total Services Billed as CPT® Code 99233

The percentage of total services billed as CPT® code 99233 is calculated, as follows:

$$\frac{\text{Number of Services for CPT}^{\text{®}} \text{ Code 99233}}{\text{Total Number of Services}} \times 100$$

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 significance
- **Higher** - Provider's value is higher than the peer value, but either the statistical test does not confirm 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 sufficient data for comparison

It is important to note that significance is based on the total number of services, visits, or beneficiaries and 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.

**Table 2: Summary of Your Utilization for Codes
January 1, 2015 - December 31, 2015**

CPT [®]	Allowed Charges	Allowed Services	Beneficiary Count
99231	\$243.04	6	6
99232	\$21,908.76	292	200
99233	\$29,425.50	234	212
Total	\$51,577.30	532	412

Please note that the totals 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 possible 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 comparison of your percentage of beneficiaries discharged within one day of a CPT[®] code 99233 service to that of your state and the nation.

**Table 3: Percentage of Beneficiaries Discharged within One Day of a CPT[®] Code
99233 Service
January 1, 2015 - December 31, 2015**

	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Percentage	National Percentage of Beneficiaries	Comparison with the National Percentage
Discharges	15%	7%	Significantly Higher	4%	Significantly Higher

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

Table 4 provides a comparison of your average allowed minutes per visit. Your averages are compared to that of your state and the nation.

**Table 4: Average Allowed Minutes per Visit
January 1, 2015 - December 31, 2015**

	Your Average Minutes Per Visit	Your State's Average Minutes Per Visit	Comparison with Your State's Average	National Average Minutes Per Visit	Comparison with the National Average
Minutes	29.29	28.95	Higher	27.54	Significantly Higher

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

Table 5 provides a comparison of your percentage of total services billed as CPT[®] code 99233 to that of your state and the nation.

**Table 5: Percentage of Total Services Billed as CPT[®] Code 99233
January 1, 2015 - December 31, 2015**

	Your Percentage of Services	Your State's Percentage of Services	Comparison with Your State's Percentage	National Percentage of Services	Comparison with the National Percentage
Services	44%	44%	Does Not Exceed	32%	Significantly Higher

A chi-square 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. A complete list of web links is located at <http://www.cbrinfo.net/cbr201615-recommended-links.html>.

Office of Inspector General (OIG):

- Coding Trends of Medicare Evaluation and Management Services, OEI-04-10-00180, May 8, 2012

Social Security Administration (SSA):

- Title XVIII of the Social Security Act: Section 1815 (a), Section 1862 (a)(1)(A), Section 1833 (e)

Centers for Medicare & Medicaid Services (CMS):

- *Medicare Fee-For-Service 2014 Improper Payments Report*
- Comprehensive Error Rate Testing (CERT): Additional Data and 2014 Claims Data

Medicare Manuals:

- *Medicare Claims Processing Manual*, Chapter 12 - Physician/Nonphysician Practitioners
 - Section 30.6.1 - Selection of Level of Evaluation and Management Service
- *Medicare Program Integrity Manual*, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions
 - Section 3.6.2.2 - Reasonable and Necessary Criteria

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 CBR201615 webinar on November 2, 2016 from 3:00 - 4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201615-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201615 webinar five business days following the event at <http://www.cbrinfo.net/cbr201615-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201615-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.

For written correspondence, postal mail can be sent to the following address:

CBR Program
eGlobalTech
7127 Ambassador Road, Suite 150
Baltimore, MD 21244

SAMPLE