

Comparative Billing Report



Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

May 7, 2018

CBR#: CBR201804
Critical Care Services
NPI#: 1111111111
Fax#: (888)555-5555

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

Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430
M-F 9:00 a.m. – 5:00 p.m. ET
cbrsupport@eglobaltech.com
Write to the return address above

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, to develop Comparative Billing Reports (CBRs).

What is a CBR?

A CBR is an educational tool that reflects your billing patterns compared to your peers' patterns for the same services in your state and nationwide. No reply is necessary as this report is for educational purposes.

Why did I get a CBR?

You received this CBR because your billing patterns differ from your peers' patterns within your state and/or across the nation. Receiving this CBR is not an indication of, or precursor to, an audit. We hope the report assists you in identifying opportunities for improvement and helps you validate your current billing patterns.

Optional - Next Steps

- Contact your MAC for specific billing or coding questions
- Visit www.cbrinfo.net for additional resources
- Attend our free webinar June 6, 2018 from 3:00 p.m. – 4:00 p.m. ET. Space is limited so register early at www.cbrinfo.net/cbr201804-webinar
- If you are unable to attend the live webinar, a recording will be available within 5 business days following the event at www.cbrinfo.net/cbr201804-webinar

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Enclosure

Comparative Billing Report (CBR): NPI 1111111111 Critical Care Evaluation and Management (E/M) Services

Introduction

CBR201804 focuses on providers who submitted claims for critical care E/M services using Current Procedural Terminology (CPT®) codes 99291 and 99292.

According to the *2017 Medicare Fee-for-Service Supplemental Data* report, services for hospital visit-critical care are in the top 20 service types with an improper payment rate of 19.1 percent and a projected improper payment amount of \$184 million. CPT® code 99291 is in the top 20 service-specific overpayment rates with an overpayment rate of 18.9 percent and projected dollars overpaid amount of \$174 million.

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) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

MACs follow the guidance given in the *Medicare Program Integrity Manual* (Chapter 3, Section 3.6.2.2), which states a service 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.”

Basic Coverage Criteria

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. 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*, which 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 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.” Critical care services must be reasonable and medically necessary.

According to the *CPT® Professional Edition* codebook, “Critical care is defined as urgent medical care that is delivered directly by a physician(s) where the nature of the patient’s condition is critical due to illness or injury. A critical illness or injury is one that acutely impairs one or more vital organ systems in such a way there is a high probability of imminent or life threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system and/or to prevent further life threatening deterioration of the patient’s condition.” As long as the nature of the patient’s condition for care meets the definition of critical care, Medicare payment may be made for any location.

Critical care is a time-based code. Physician time spent evaluating, providing care, and managing critically ill/injured patients requires the full attention of the physician. Additionally, no other services may be provided to any other patient(s) concurrently during that same time period. The time may be continuous, intermittent, or aggregated. Physicians of the same specialty within the same group practice may bill and are paid as though they are a single physician; however, more than one physician can provide critical care at another time and be paid if the service meets the criteria of critical care, is medically necessary, and is not duplicative care. Concurrent care by more than one physician (generally representing different physician specialties) is payable if these requirements are met.

According to the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.9), “When a hospital inpatient or office/outpatient evaluation and management (E/M) are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical care services (CPT® codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same

physician to the same patient.” During critical care management of a patient, those services that do not meet the level of critical care shall be reported using inpatient hospital care service CPT® codes 99221-99223.

Critical Care E/M codes may be appended with the same modifiers as other E/M codes. Per the *National Correct Coding Initiative Policy Manual* (Chapter 1, Section E), modifier 25 should only be appended to the claim when the E/M performed is over and above what would normally be required for the procedure. The service should be significant and separately identifiable, and should be performed by the same provider on the same day of the procedure or other service.

Methods & Results

This report is an analysis of providers submitted as the “Rendering NPI” on Medicare Part B claims extracted from the Integrated Data Repository based on the latest version of claims as of April 12, 2018. The analysis includes claims with dates of service from January 1, 2017 to December 31, 2017 and excludes all claims submitted with the rendering provider’s specialty denoted as Emergency Medicine (93).

There are over 86,000 providers nationwide with allowed charges for the CPT® codes included in this study. Criteria for receiving the CBR are:

- Provider is significantly higher than at least one of the peer groups on at least one of the measurements studied
- Provider is near or above the 75th percentile in allowed charges (\$10,000)
- Provider had at least 25 beneficiaries

Table 1 provides a summary of your utilization for the CPT® codes included in this CBR.

Table 1: Mock Data Summary of Your Utilization for Critical Care E/M Services
Dates of Service: January 1, 2017 – December 31, 2017

CPT® Code	Type	Allowed Charges	Allowed Services	Visits*	Beneficiary Count
99291	Without Mod 25	\$75,911	322	318	167
99291	With Mod 25	\$12,258	52	51	49
99292	Without Mod 25	\$3,495	29	22	22
99292	With Mod 25	\$2,047	16	13	13
Total		\$93,711	419	369	183

* A visit is defined as a unique date of service between a beneficiary and a provider.

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the visit and beneficiary counts are unduplicated counts for each row and the total. For example, a beneficiary receiving multiple services with different CPT® codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

Statistics were calculated for each provider and the two peer groups, all providers in the nation and all providers in your state (e.g., California). Each provider's values are compared to his/her peer group values. 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 the statistical test does not confirm significance
- Does Not Exceed – Provider's value is not higher than the peer value
- N/A - Provider does not have sufficient data for comparison

Table 2 presents the percentage of critical care E/M allowed services submitted with modifier 25.

Table 2: Mock Percentage of Services Submitted with Modifier 25
Dates of Service: January 1, 2017 – December 31, 2017

Number of Services with Modifier 25	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
68	419	16%	9%	Significantly Higher	11%	Significantly Higher

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

Table 3 shows the average number of critical care service dates, or visits per beneficiary for the one-year period.

Table 3: Mock Average Number of Visits per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Number of Visits	Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
369	183	2.02	2.47	Does Not Exceed	1.98	Higher

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

Table 4 shows the average allowed charges per beneficiary for the one-year period.

Table 4: Mock Average Allowed Charges per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Total Charges	Total Number Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
\$93,711.14	183	\$512.08	\$593.42	Does Not Exceed	\$464.00	Significantly Higher

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

References & Resources

The coverage and documentation guidelines for critical care E/M services are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201804-recommended-links>.

Centers for Medicare & Medicaid Services

- *2017 Medicare Fee-for-Service Supplemental Improper Payment Data*

Social Security Act

- Title XVIII, Sections 1833 (e), 1862 (a) (1) (A)

Medicare Manuals:

- *Medicare Claims Processing Manual* (Chapter 12, Section 30)
- *Medicare Program Integrity Manual* (Chapter 3, Section 3.6.2.2)
- *National Correct Coding Initiative Policy Manual* (Chapter 1, Section E)

American Medical Association

- *CPT® 2017 Professional Edition*