RELI Group
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February 15, 2019

CBR #: CBR201902
Office Visits, New and Established Patients, Family Practice
NPI #: 1234567890
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City, State, ZIP

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 and/or prescribing patterns as compared to your peers' patterns for the same services in your state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities.

Why did I get a CBR? We are providing this report because your Medicare billing and/or prescribing patterns differ from your peers' patterns within your state/specialty 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.

To access an electronic copy of your CBR: Visit the secure CBR portal at https://cbrfile.cbrpepper.org.

Please visit the CBR Website at https://cbr.cbrpepper.org, for a recorded webinar and additional resources.

To request assistance or submit questions: Contact the CBR Help Desk at https://cbr.cbrpepper.org/Help-Contact-Us or call 1-800-771-4430 (M–F, 9 a.m.–5 p.m. ET).

Sincerely,

The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

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Comparative Billing Report (CBR) 201902

February 15, 2019

Office Visits, New and Established Patients, Family Practice

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.

The criteria for receiving a CBR is that a provider:

1. Has at least 50 beneficiaries with claims submitted for 99204 or 99205, and has at least 50 beneficiaries with claims submitted for 99214 or 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)

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

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

CPT® Code	Description
99201	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.
99202	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.
99203	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.
99204	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.
99205	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.
99211	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.
99212	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.
99213	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.
99214	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.
99215	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.

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

CPT® Code	Allowed Units	Allowed Charges	Beneficiary Count
99201	0	$0	0
99202	0	$0	0
99203	0	$0	0
99204	32	$5,328	32
99205	0	$0	0

CPT® Code	Allowed Units	Allowed Charges	Beneficiary Count
99211	94	$1,978	12
99212	1	$44	1
99213	127	$9,306	84
99214	1,000	$108,122	251
99215	0	$0	0

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.

Metric 1: Allowed Units

Metric 1 is calculated as follows:

- The number of units allowed for CPT® code 99204 (numerator) is divided by the number of units allowed for combined CPT® codes 99201-99205 (denominator).
- The number of units allowed for CPT® code 99205 (numerator) is divided by the number of units allowed for combined CPT® codes 99201-99205 (denominator).
- The number of units allowed for CPT® code 99214 (numerator) is divided by the number of units allowed for combined CPT® codes 99211-99215 (denominator).

- The number of units allowed for CPT® code 99215 (numerator) is divided by the number of units allowed for combined CPT® codes 99211-99215 (denominator).

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

CPT® Code	Allowed Units	Your Total Allowed Units (new/est.)*	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
99204 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99205 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99214 (est.)	1,000	1,222	81.8%	56.3%	Higher	53.5%	Higher
99215 (est.)	0	1,222	0.0%	3.5%	Does Not Exceed	3.2%	Does Not Exceed

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

Metric 2 is calculated as follows :

- The allowed amount of CPT® code 99204 (numerator) is divided by the allowed amount for all new patient visit Evaluation and Management codes, 99201-99205 (denominator).
- The allowed amount of CPT® code 99205 (numerator) is divided by the allowed amount for all new patient visit Evaluation and Management codes, 99201-99205 (denominator).
- The allowed amount of CPT® code 99214 (numerator) is divided by the allowed amount for all established patient visit Evaluation and Management codes, 99211-99215 (denominator).
- The allowed amount of CPT® code 99215 (numerator) is divided by the allowed amount for all established patient visit Evaluation and Management codes, 99211-99215 (denominator).

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

CPT® code	Allowed Amount	Your Total Allowed Amt. (new/est.)*	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with Nation
99204 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99205 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99214 (est.)	$108,122	$119,449	90.5%	62.6%	Higher	60.2%	Significantly Higher
99215 (est.)	$0	$119,449	0.0%	4.8%	Does Not Exceed	4.4%	Does Not Exceed

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

Metric 3 is calculated as follows:

- The number of beneficiaries with CPT® code 99204 (numerator) is divided by all beneficiaries with all new patient visit Evaluation and Management CPT® codes, 99201-99205 (denominator).
- The number of beneficiaries with CPT® code 99205 (numerator) is divided by all beneficiaries with all new patient visit Evaluation and Management CPT® codes, 99201-99205 (denominator).
- The number of beneficiaries with CPT® code 99214 (numerator) is divided by all beneficiaries with all established patient visit Evaluation and Management CPT® codes, 99211-99215 (denominator).
- The number of beneficiaries with CPT® code 99215 allowed (numerator) is divided by all beneficiaries with all established patient visit Evaluation and Management CPT® codes, 99211-99215 (denominator).

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

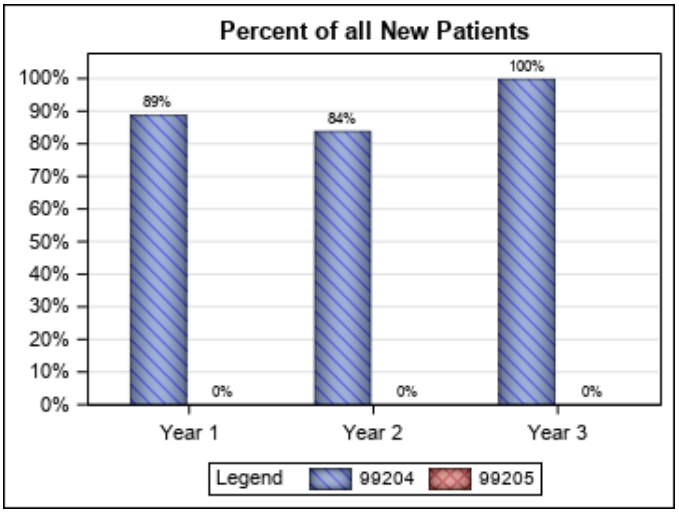
CPT® Code	Your Number of Benefic.	Your Total Benefic. (new/est.)*	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with Nation
99204 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99205 (new)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
99214 (est.)	251	260	96.5%	70.4%	Significantly Higher	66.2%	Significantly Higher
99215 (est.)	0	260	0.0%	7.1%	Does Not Exceed	6.1%	Does Not Exceed

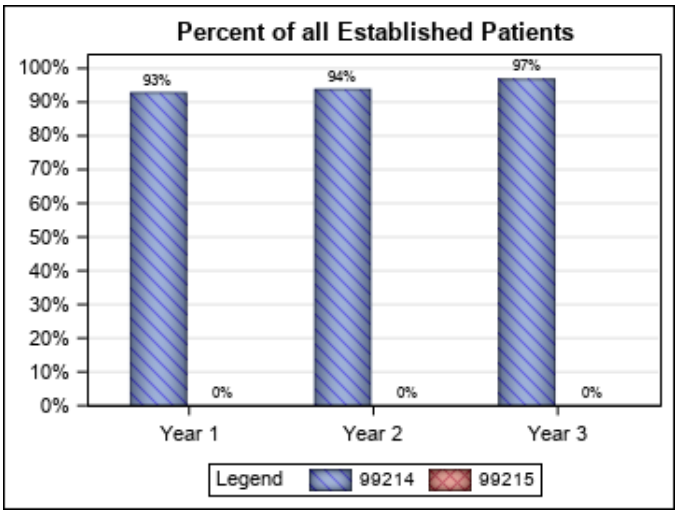
N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data
*Total Beneficiaries for New = 99201-99205; Est. = 99211-99215

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: Oct. 1, 2015-Sept. 30, 2016
- Year 2: Oct. 1, 2016-Sept. 30, 2017
- Year 3: 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