RELI Group
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March 29, 2019

CBR #: CBR201903
Subsequent Hospital Care

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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 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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**Subsequent Hospital Care**

## Introduction

*CBR201903* focuses on 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.

The criteria for receiving a CBR is that a provider:

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

Medicare Part B claims were considered for rendering providers from these specialties for dates of service during the time period 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

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**

| CPT® Code | Description |
|---|---|
| 99231 | 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 |
| 99232 | 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 |
| 99233 | 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. |

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**

| CPT® Code | Allowed Charges | Allowed Services | Beneficiary Count |
|---|---|---|---|
| 99231 | $0 | 0 | 0 |
| 99232 | $229 | 3 | 1 |
| 99233 | $20,277 | 186 | 124 |
| Total | $20,506 | 189 | 125 |

## 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 their Specialty's values and to the national values:

- National Comparison = NPI is compared against all specialties in the Nation
- Specialty Comparison= NPI is compared against other NPIs in the same Specialty.

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 95$^{th}$ percentile from the specialty or national mean.
2. Higher — Provider's value is greater than the specialty or national mean.
3. Does Not Exceed — Provider's value is not higher than the specialty 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 through Oct. 31, 2018.

There are 158,159 rendering providers that submitted claims for Subsequent Hospital Care services using CPT® codes 99231, 99232, 99233 between Nov. 1, 2017, and Oct. 31, 2018 for the Top Specialties, billing a combined allowed amount of $2.3 billion for 3.9 million beneficiaries during the timeframe.

### 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.

Metric 1 is calculated as follows:

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

**Table 3: Your Percentage of Beneficiaries Discharged within One Day of a CPT® Code 99233 Service Nov. 1, 2017-Oct. 31, 2018**

| Your Percentage | Your Specialty's Percentage | Comparison with Your Specialty | National Percentage | Comparison with National Percentage |
|---|---|---|---|---|
| 0.0% | 2.8% | Does Not Exceed | 26.1% | Does Not Exceed |

**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 counted as one encounter.

Metric 2 is calculated as follows:

- The sum of all the weighted services (numerator) is divided by the total number of encounters (denominator).

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

| Your Average | Your Specialty's Average | Comparison with Your Specialty | National Average | Comparison with National Average |
|---|---|---|---|---|
| 34.8 | 27.1 | Higher | 27.1 | Significantly Higher |

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

Metric 3 is calculated as follows:

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

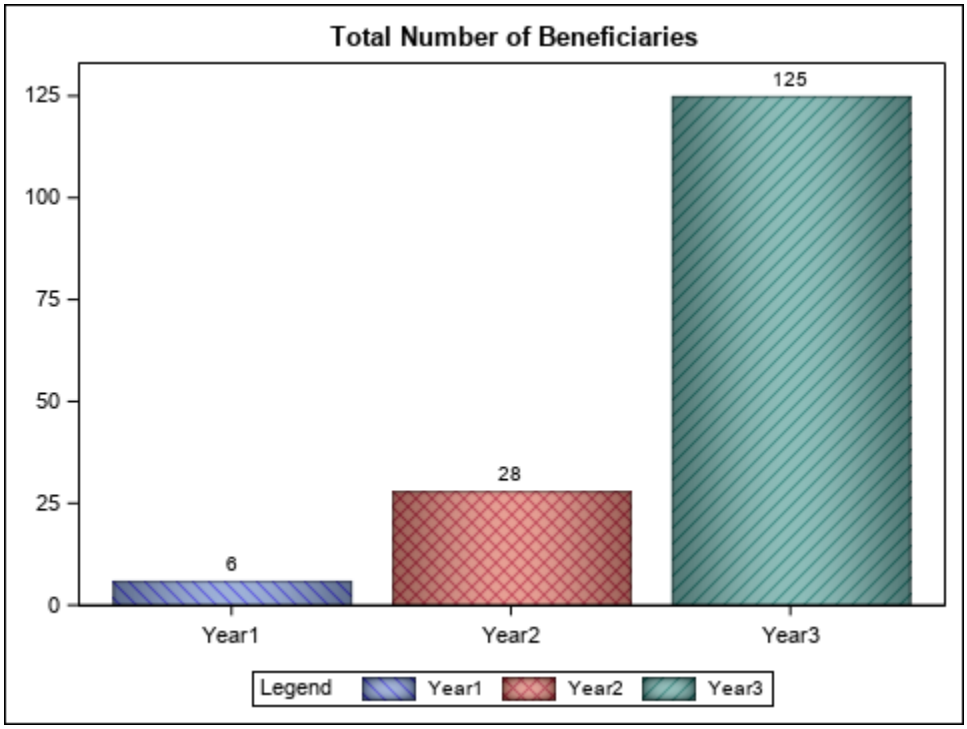
**Table 5: Your Percentage of Total Services Billed as CPT® code 99233**

| Your Percentage | Your Specialty's Percentage | Comparison with Your Specialty | National Percentage | Comparison with National Percentage |
|---|---|---|---|---|
| 98.4% | 32.4% | Higher | 30.7% | Significantly Higher |

Figure 1 illustrates the Total Number of Beneficiaries with Subsequent Hospital Care CPT® Codes 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)**




## References and Resources

2018 Medicare Fee-for-Service Supplemental Improper Payment Data

Claims Processing Manual: Chapter 12, Section 30.6

Medicare Program Integrity Manual, Section 3.6.2.2