RELI Group
5520 Research Park Dr. #105
Catonsville, MD 21228

May 22, 2020

CBR #: CBR202005
Subsequent Nursing Facility Evaluation and
Management Services

Organization Name 1
Address 1
Address 2
City, State, Zip

NPI #:
Fax #:
Email:

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/. Populate the fields, and in the "validation code" field, enter your unique validation code: (code here).

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org.

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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Introduction

CBR202005 focuses on rendering providers that perform established patient subsequent nursing facility evaluation and management (E/M) services. The CBR analysis reflects the submission of claims for Current Procedural Terminology® (CPT®) codes for subsequent nursing facility care, which includes CPT® codes 99307, 99308, 99309, and 99310.

The *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects improper payment rates and projected improper payment amounts for CPT® codes 99308, 99309, and 99310 as follows:

- 4.8% improper payment rate for CPT® code 99308, representing over $28 million in projected improper payments
- 7.9% improper payment rate for CPT® code 99309, representing over $49 million in projected improper payments
- 25% improper payment rate for CPT® code 99310, representing over $37 million in projected improper payments

In "*Chapter 12, Section 30*" of the Medicare Claims Processing Manual, CMS provides the following guidance for the use of CPT® codes: "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. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

The criteria for receiving a CBR is that a provider:

1. Is significantly higher compared to either state or national averages for Metric 1 or Metric 2 (i.e., greater than or equal to the 90th percentile), and

2. Has at least 40 beneficiaries with claims for CPT® codes 99307, 99308, 99309, 99310, and

3. Has at least $16,000 or more in total allowed charges.

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 any coverage and documentation policies outlined by the Medicare Administrative Contractors' (MACs') Local Coverage Determinations.

The guidelines within the CPT® Professional Edition for subsequent nursing facility care codes state the following: "All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status,

(i.e., changes in history, physical condition, and response to management) since the last assessment by the physician or other qualified health care professional."

Additional instruction about the guidelines for the assignment of the proper E/M code according to the service provided to the patient is provided in CMS' *Evaluation and Management Services Guide*.

Table 1 identifies the CPT® codes used in the CBR analysis.

Table 1: CPT® Code Descriptions

CPT® Code	Description
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 key components: • A problem focused interval history; • A problem focused examination; • Straightforward medical decision making. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 key components: • An expanded problem focused interval history; • An expanded problem focused examination; • Medical decision making of low complexity. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 key components: • A detailed interval history; • A detailed examination; • Medical decision making of moderate complexity. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires 2 of these 3 key components: • A comprehensive interval history; • A comprehensive examination; • Medical decision making of high complexity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

See Table 2 for a summary of your utilization of codes for subsequent nursing facility care: CPT® codes 99307, 99308, 99309, and 99310.

Table 2. Summary of Your Utilization of CPT® Codes for Subsequent Nursing Facility Care Between Jan. 1, 2019 – Dec. 31, 2019.

CPT® Code	Allowed Charges	Allowed Units	Beneficiary Count*
99307	$288.84	6	6
99308	$31,751.82	421	130
99309	$231,585.31	2,311	389
99310	$31,409.92	212	130
Total	$295,035.89	2,950	408

*A beneficiary is counted once per row of CPT® code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the CPT® codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Average minutes per day
2. Average allowed services per beneficiary billed under a single National Provider Identifier (NPI)
3. Average total services per year rendered to your beneficiaries by all practitioners

The CBR analysis focuses on providers that performed subsequent nursing facility E/M services. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider's values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state (state code) and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider's value is greater than or equal to the 90th percentile from the state or national mean.
2. Higher — Provider's value is greater than the state or national mean..
3. Does Not Exceed — The Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — The provider does not have sufficient data for comparison.

Methods and Results

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on April 17, 2020. The analysis includes claims with dates of service from Jan. 1, 2019, through Dec. 31, 2019. For the trend analysis presented in Figure 1, claims represent dates of service between Jan. 1, 2017, and Dec. 31, 2019.

There are 64,604 rendering providers nationwide who have submitted claims for subsequent nursing facility care E/M services. The total allowed charges for these claims were over $1.9 billion during the analysis timeframe.

Metric 1: Average Minutes Per Day

Metric 1 is calculated as follows:

Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code descriptions 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 and 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 as follows:

- The total weighted services (numerator) is divided by the total number of days that the services were rendered (denominator).

$$\frac{\text{Total weighted services}}{\text{Total number of days}}$$

Table 3: Your Average Minutes per Day

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
71,570	267	268.05	136.21	Significantly Higher	125.87	Significantly Higher

Metric 2: Average Allowed Services per Beneficiary Billed Under a Single NPI

Metric 2 is calculated as follows:

- The total allowed services rendered by your single NPI (numerator) is divided by the total number of beneficiaries (denominator).

$$\frac{\text{Total allowed services rendered by your single NPI}}{\text{Total number of beneficiaries}}$$

Table 4: Average Allowed Services per Beneficiary Billed Under Your Single NPI

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
2,950	408	7.23	4.94	Higher	4.49	Significantly Higher

Metric 3: Average Total Services per Year Rendered to Your Beneficiaries by All Practitioners

Metric 3 is calculated as follows:

- The total allowed services rendered by you and all other providers (numerator) is divided by the total number of beneficiaries (denominator).

$$\frac{\text{Total allowed services rendered by you and all other providers}}{\text{Total number of beneficiaries}}$$

Table 5: Average Total Services per Year Rendered to Your Beneficiaries by All Practitioners

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
7,866	408	19.28	20.60	Does Not Exceed	19.54	Does Not Exceed

Figure 1 illustrates the number of beneficiaries for Whom CPT® codes 99307 – 99310 were submitted. Year 1, Year 2, and Year 3 are defined as follows:

- Year 1: Jan. 1, 2017 – Dec. 31, 2017
- Year 2: Jan. 1, 2018 – Dec. 31, 2018
- Year 3: Jan. 1, 2019 – Dec. 31, 2019

Figure 1: Trend Over Time Analysis of Total Number of Beneficiaries for Whom CPT® Codes 99307 – 99310 were Submitted

Total Number of Beneficiaries
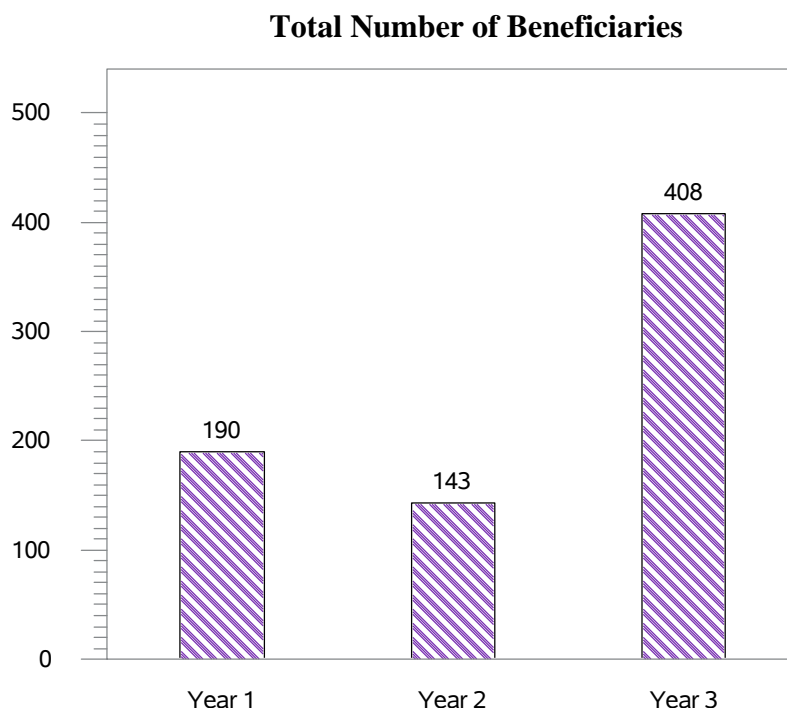
References and Resources

CPT® Professional Edition, American Medical Association

2019 Medicare Fee-for-Service Supplemental Improper Payment Data, CMS. CMS. gov.

Evaluation and Management Services Guide, CMS. CMS. gov.

Medicare Claims Processing Manual, "Chapter 30, Section 6.1.", CMS. CMS. gov.