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CBR #: CBR202006
Office Visits, New and Established Patients
by Nurse Practitioners
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June 29, 2020

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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/. Populate the fields, and in the "validation code" field, enter your unique validation code: A7A2CE.

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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Comparative Billing Report (CBR) 202006
June 29, 2020

Office Visits, New and Established Patients by Nurse Practitioners

Introduction

CBR202006 focuses on rendering nurse practitioner providers that perform new and established evaluation and management (E/M) services. The CBR analysis reflects the submission of claims by nurse practitioners for Current Procedural Terminology® (CPT®) codes for E/M services, which includes CPT® codes 99201-99205 (new patients) and 99211-99215 (established patients).

The *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 8.2% for nurse practitioners, including errors involving insufficient documentation, medical necessity, and incorrect coding, which represents $255,741,122 in possible improper payments. In addition, the report reflects the following projected improper payment rates for high-level E/M services, CPT® codes 99204, 99205, 99214, and 99215:

- A 15.3% improper payment rate for CPT® code 99204, representing over $203 million in projected improper payments
- An 18.8% improper payment rate for CPT® code 99205, representing over $93 million in projected improper payments
- A 5.0% improper payment rate for CPT® code 99214, representing over $423 million in projected improper payments
- A 9.9% improper payment rate for CPT® code 99215, representing over $108 million in projected improper payments

In "Chapter 12, Section 30" of the *Medicare Claims Processing Manual*, the Centers for Medicare & Medicaid Services (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 are that a provider:

1. Is significantly higher compared to either state or national averages in any of the three metrics (i.e., greater than or equal to the 90th percentile), and
2. Has at least 10 total beneficiaries with claims submitted for new patient CPT® codes or at least 120 total beneficiaries with claims submitted for established patient CPT® codes, and
3. Has at least $1,200 in total allowed charges for new patient CPT® codes or $18,000 in total allowed charges for established patient CPT® codes.

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.

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®	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. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with patient and/or family
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. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with patient and/or family
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. Usually, the presenting problem(s) are moderate severity. Typically, 30 minutes are spent face-to-face with patient and/or family.
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. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with patient and/or family.
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. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with patient and/or family
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. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with patient and/or family
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem

CPT®	Description
	focused history; An expanded problem focused examination; Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with patient and/or family
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with patient and/or family
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with patient and/or family

See Tables 2 and 3 for summaries of your utilization of codes for new and established patient E/M care: CPT® codes 99201-99205 and 99211-99215.

Table 2. Summary of Your Utilization of CPT® Codes for New Patient E/M Services Between Feb. 1, 2019, and Jan. 31, 2020

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
99201	$0	0	0
99202	$0	0	0
99203	$0	0	0
99204	$1,064	8	8
99205	$0	0	0
Total 99201-99205	$1,064	8	8

*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.

Table 3. Summary of Your Utilization of CPT® Codes for Established Patient E/M Services Between Feb. 1, 2019, and Jan. 31, 2020

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
99211	$0	0	0
99212	$0	0	0
99213	$900	15	14
99214	$21,824	248	148
99215	$0	0	0
Total 99211-99215	$22,724	263	153

*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. Percentage of allowed units for new and established patient E/M levels 4 and 5 CPT® codes 99204, 99205, 99214, 99215

2. Percentage allowed amount for new and established patient E/M levels 4 and 5 CPT® codes 99204, 99205, 99214, 99215
3. Percentage of beneficiaries that received CPT® codes 99204, 99205, 99214, 99215

The CBR analysis focuses on providers that performed new and established patient 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 [KY] 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 — Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — 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 May 18, 2020. The analysis includes claims with dates of service from Feb. 1, 2019, through Jan. 31, 2020. For the trend analysis presented in Figure 1, claims represent dates of service between Feb. 1, 2017, and Jan. 31, 2020.

There are 121,484 rendering providers nationwide who have submitted claims for new and established patient E/M services. The total allowed charges for these claims were over $1.8 billion during the analysis timeframe.

Metric 1: Percentage of Allowed Units for New and Established Patient E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

Metric 1 is calculated for each code as follows:

- The total number of allowed units for CPT® code 99204 (numerator) is divided by the allowed units for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total number of allowed units for CPT® code 99205 (numerator) is divided by the allowed units for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total number of allowed units for CPT® code 99214 (numerator) is divided by the allowed units for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.
- The total number of allowed units for CPT® code 99215 (numerator) is divided by the allowed units for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.

Table 4: Your Percentage of Allowed Units for New and Established Patient E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

CPT® Codes	Your Percentage	Your State Percentage	Comparison with Your State	National Percentage	Comparison with National Percentage
99204	100.00%	32.90%	Significantly Higher	33.48%	Significantly Higher
99205	0.00%	2.12%	Does Not Exceed	5.08%	Does Not Exceed
99214	94.00%	44.37%	Significantly Higher	48.95%	Higher
99215	0.00%	1.58%	Does Not Exceed	3.62%	Does Not Exceed

Metric 2: Percentage Allowed Amount for New and Established Patient E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

Metric 2 is calculated for each code as follows:

- The total allowed amount for CPT® code 99204 (numerator) is divided by the total allowed amount for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total allowed amount for CPT® code 99205 (numerator) is divided by the total allowed amount for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total allowed amount for CPT® code 99214 (numerator) is divided by the total allowed amount for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.
- The total allowed amount for CPT® code 99215 (numerator) is divided by the total allowed amount for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.

Table 5: Your Percentage Allowed Amount for New and Established Patient E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

CPT® Codes	Your Percentage	Your State Percentage	Comparison with Your State	National Percentage	Comparison with National Percentage
99204	100.00%	43.79%	Significantly Higher	43.23%	Significantly Higher
99205	0.00%	3.47%	Does Not Exceed	8.18%	Does Not Exceed
99214	96.00%	54.68%	Significantly Higher	58.03%	Higher
99215	0.00%	2.50%	Does Not Exceed	5.62%	Does Not Exceed

Metric 3: Percentage of Beneficiaries that Received E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

Metric 3 is calculated for each code as follows:

- The total number of beneficiaries for CPT® code 99204 (numerator) is divided by the total number of beneficiaries for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total number of beneficiaries for CPT® code 99205 (numerator) is divided by the total number of beneficiaries for CPT® codes 99201-99205 (denominator). The result is multiplied by 100.
- The total number of beneficiaries for CPT® code 99214 (numerator) is divided by the total number of beneficiaries for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.

- The total number of beneficiaries for CPT® code 99215 (numerator) is divided by the total number of beneficiaries for CPT® codes 99211-99215 (denominator). The result is multiplied by 100.

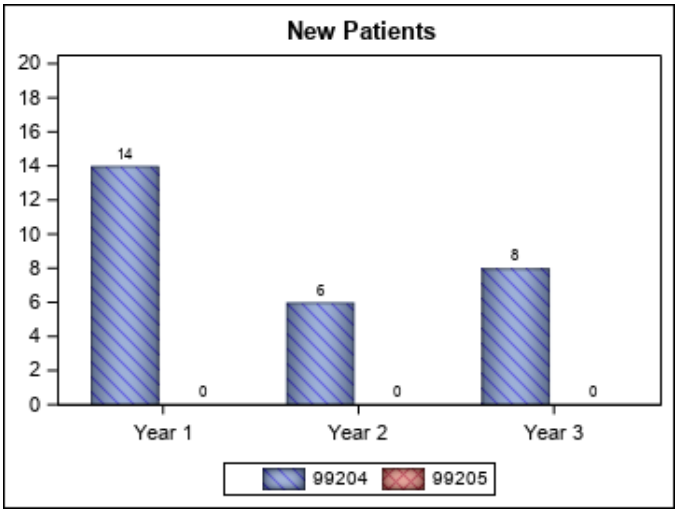
Table 6: Your Percentage of Beneficiaries Who Received E/M Levels 4 and 5 CPT® Codes: 99204, 99205, 99214, and 99215

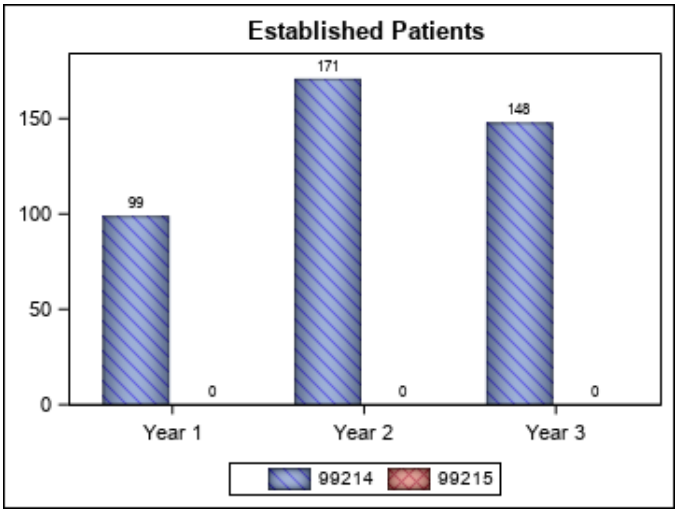
CPT® Codes	Your Percentage	Your State Percentage	Comparison with Your State	National Percentage	Comparison with National Percentage
99204	100.00%	33.92%	Significantly Higher	34.54%	Significantly Higher
99205	0.00%	2.22%	Does Not Exceed	5.32%	Does Not Exceed
99214	97.00%	61.12%	Significantly Higher	61.89%	Higher
99215	0.00%	3.46%	Does Not Exceed	6.32%	Does Not Exceed

Figure 1 illustrates number of beneficiaries at service levels 4 and 5. Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** Feb. 1, 2017 – Jan. 31, 2018
- **Year 2:** Feb. 1, 2018 – Jan. 31, 2019
- **Year 3:** Feb. 1, 2019 – Jan. 31, 2020

Figure 1: Total Number of Beneficiaries at Service Levels 4 and 5, Trend Over Time





References and Resources

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