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November 17, 2021

Special Edition CBR #: CBR202110
Critical Care Evaluation and Management (E&M) Services
NPI #: 1234567890
Fax #:

First Name Last Name, Title
Address1
Address2
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 Special Edition Comparative Billing Report (CBR) and to support providers with its use.

CMS routinely distributes an educational tool, known as a CBR, to the provider community in a variety of Medicare Fee-for-Service service areas. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns for the same services in his/her state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. The report is not an indication of wrongdoing; rather, it can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication or precursor to an audit, and it requires no response on a provider's part. Selected providers, however, may be referred for additional review and education as a part of CMS' routine CBR Program.

This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation. The report is offered to facilitate an analysis of your billing submissions during a timeframe that includes the Public Health Emergency (PHE). Please consider the changes that took place to your billing practices during the PHE when you review the data within this report.

Periodically, CMS develops and distributes "Special Edition" CBRs, which offer more extensive education and resources to a subset of the provider community. Unlike routine CBRs, Special Edition CBRs include a series of up to four educational letters.

This third educational letter in the Special Edition CBR series is sent to selected providers based on criteria and metrics established through claim data review and research. After receiving this third Special Edition CBR you may receive one additional Special Edition CBR educational letter. Each Special Edition CBR educational letter will include comparison and educational data. Criteria for receiving future Special Edition CBR educational letters is as follows:

- Letter #4 will be sent to any provider who remains an outlier based on the defined criteria. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #4.

We hope that this Special Edition CBR series can help enhance your billing and/or prescribing practices and support internal compliance activities.

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 Special Edition 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: AABB1234.

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org. For each Special Edition CBR release there will be a webinar to follow. According to the criteria described above, you may receive additional Special Edition CBRs. Please be on the lookout for another letter around May 2022.

To request assistance or submit questions: Contact the CBR Help Desk at https://cbr.cbrpepper.org/Help-Contact-Us

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

Comparative Billing Report (CBR) 202110
November 17, 2021

Critical Care Evaluation and Management (E&M) Services

Introduction

CBR202110 focuses on rendering providers that submitted visits for critical care E&M services using Current Procedural Terminology® (CPT®) codes 99291 and 99292.

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on Oct. 5, 2021. The analysis includes claims with dates of service from Jul. 1, 2020, through Jun. 30, 2021. For the trend analysis presented in Figure 1 and Figure 2, claims represent dates of service between Jul. 1, 2018, and Jun. 30, 2021.

The *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects improper payment rates and projected improper Medicare Part B payment amounts for CPT® codes 99291 and 99292. The report shows a 9.7% improper payment rate for Medicare Part B critical care providers, representing over $21 million in projected improper payments. The types of error that comprise the improper payment rate for Medicare Part B critical care services include a 22.9% improper payment rate due to insufficient documentation and a 72.2% improper payment rate due to incorrect coding. Specifically, the CPT® code 99291 holds a projected improper payment rate of 19.7%, representing over $196 million in projected improper payments.

In "Chapter XI: Medicine Evaluation and Management Services" of the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, the following guidance is listed: "Critical care E&M services (CPT® codes 99291 and 99292) and prolonged E&M services (CPT® codes 99354-99357) are reported based on time. Providers shall not include the time devoted to performing separately reportable services when determining the amount of critical care or prolonged provider E&M service time."

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 30 total beneficiaries with claims for either CPT® code 99291 or 99292, and
3. Has at least $20,000 in total allowed charges for critical care E&M CPT® codes, and
4. Is in the top 5% of recipients of CBR202105.

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® 2020 Professional Edition* for critical care services state the following: "Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that 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 failure and/or to prevent further life threatening deterioration of the patient's condition."

According to the *CPT® 2020 Professional Edition,* modifier 25 is used to identify a "significant, separately identifiable Evaluation and Management service by the same physician or other qualified health care professional on the same day of the procedure or other service."

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

Table 1: CPT® Code Descriptions

CPT® Codes	Description
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30 – 74 minutes.
+99292	Critical care, evaluation and management each additional 30 minutes.

See Table 2 for a summary of your utilization of codes for critical care services: CPT® codes 99291 and 99292.

Table 2. Summary of Your Utilization of CPT® Codes for Critical Care Services Between Jul. 1, 2020, and Jun. 30, 2021

CPT® Codes	Allowed Amount	Allowed Services	Visits*	Beneficiary Count**
99291 w/out Modifier 25	$80,531	342	342	46
99291 w/ Modifier 25	$1,652	7	7	6
99292 w/out Modifier 25	$0	0	0	0
99292 w/ Modifier 25	$0	0	0	0
Total	$82,183	349	349	46

*A visit is defined as a unique date of service between a beneficiary and a provider.
**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 services submitted with modifier 25
2. Average number of visits (distinct Dates of Service), per beneficiary
3. Average allowed charges, per beneficiary

The CBR analysis focuses on providers that performed critical care services, excluding providers with an emergency medicine specialty. 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 [XX] and the nation. There are four possible outcomes for the comparisons between the provider and the provider's 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

There are 91,884 rendering providers nationwide who have submitted claims for critical care services. The total allowed charges for these claims were over $1.1 billion during the analysis timeframe.

Metric 1: Percentage of Services Submitted with Modifier 25

Metric 1 is calculated as follows:

- The count of critical care services submitted with modifier 25 (numerator) is divided by the count of critical care services submitted with or without modifier 25 (denominator).

Table 3: Your Percentage of Services Submitted with Modifier 25

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State Percent	National Percent	Comparison with National Percent
7	349	2.01%	9.07%	Does Not Exceed	10.89%	Does Not Exceed

Metric 2: Average Number of Visits (Distinct Dates of Service), per Beneficiary

Metric 2 is calculated as follows:

- The count of unique critical care visits (numerator) is divided by the count of unique beneficiaries who had a critical care service (denominator).

Table 4: Average Number of Visits per Beneficiary

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State Average	National Average	Comparison with National Average
535	84	6.37	1.67	Significantly Higher	2.14	Significantly Higher

Metric 3: Average Allowed Charges, per Beneficiary

Metric 3 is calculated as follows:

- The sum of the total allowed charges for critical care services (numerator) is divided count of unique beneficiaries who had a critical care service (denominator).

Table 5: Average Allowed Charges per Beneficiary

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State Average	National Average	Comparison with National Average
$141,523	84	$1,684.80	$548.35	Significantly Higher	$492.62	Significantly Higher

Figures 1 and 2 illustrate the number of beneficiaries for whom claims with CPT® codes 99291 and 99292 were submitted. Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** Jul. 1, 2018 – Jun. 30, 2019
- **Year 2:** Jul. 1, 2019 – Jun. 30, 2020
- **Year 3:** Jul. 1, 2020 – Jun. 30, 2021

Figure 1: Trend Over Time Analysis of Total Number of Beneficiaries for Whom CPT® Code 99291 Was Submitted

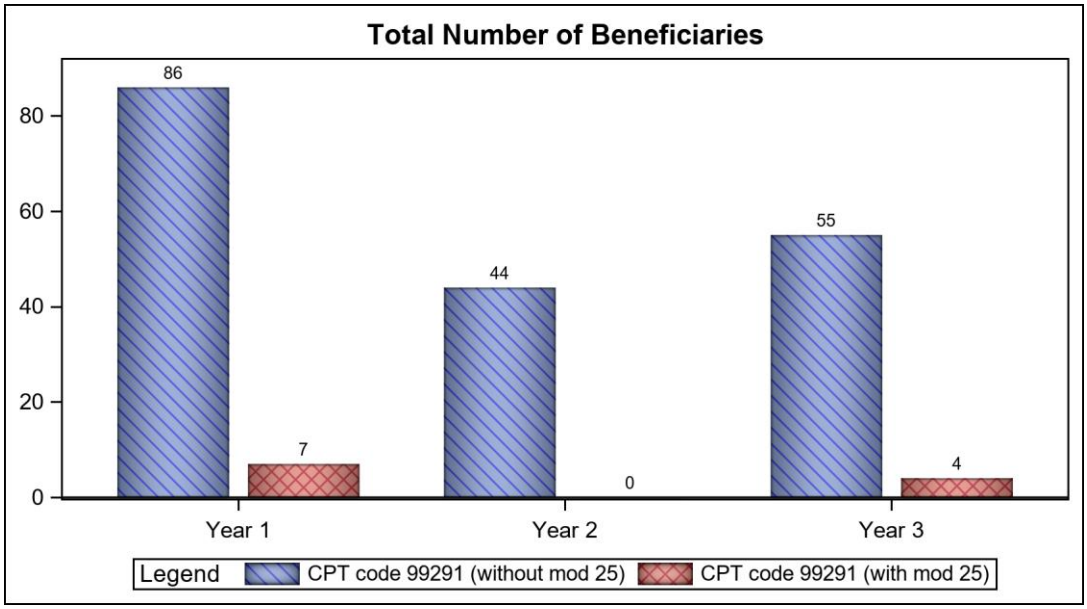
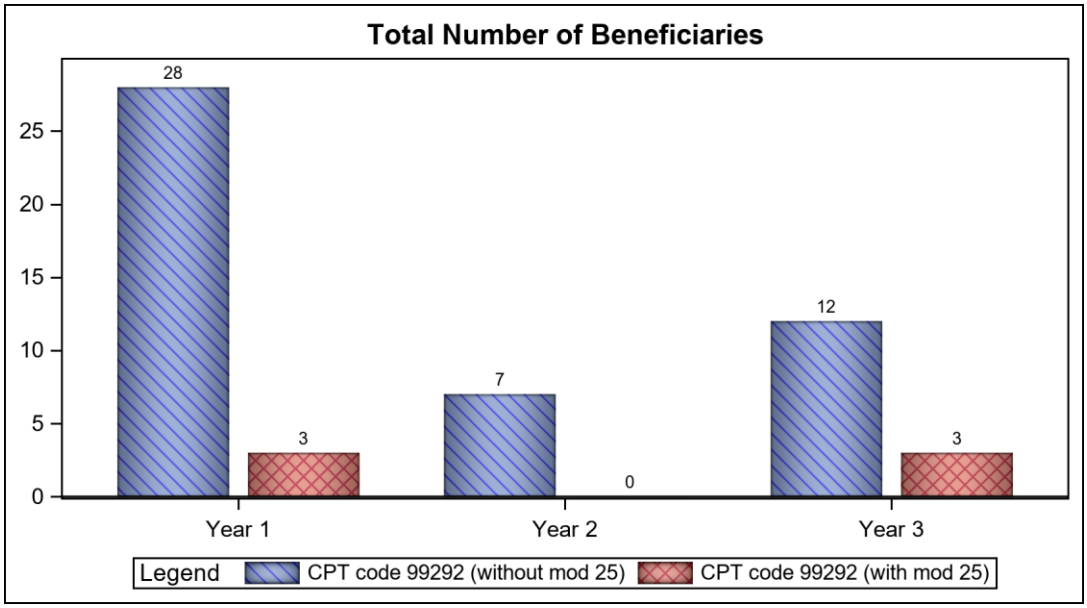


Figure 2: Trend Over Time Analysis of Total Number of Beneficiaries for Whom CPT® Code 99292 Was Submitted



References and Resources

CPT® 2020 Professional Edition. American Medical Association.

2020 Medicare Fee-for-Service Supplemental Improper Payment Data. U.S. Department of Health and Human Services. CMS.gov.

NCCI Policy Manual for Medicare Services, "Chapter XI: Medicine Evaluation and Management Services." CMS. CMS.gov.