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October 31, 2022

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Address
City, State, Zip

CBR #: CBR202209
Initial Nursing Facility Evaluation and Management (E&M) Visits
NPI #: 1234567890
Fax #: 1-XXX-XXX-XXXX

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.

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, and can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication of, 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.

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: (Access_CD).

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org. Register for a live webinar on November 9, 2022, 3 p.m. ET.

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

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Initial Nursing Facility Evaluation and Management (E&M) Visits

Introduction

CBR202209 focuses on rendering providers that submitted Medicare Part B claims for initial nursing facility E&M visits. The report and analysis focus on the Current Procedural Terminology® (CPT®) codes 99304, 99305, and 99306.

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on September 13, 2022. The analysis includes claims with dates of service from June 1, 2021, through May 31, 2022. For the trend analysis presented in Figure 1, claims represent dates of service between June 1, 2019, and May 31, 2022. For the trend analysis presented in Figure 2, claims represent dates of service between June 1, 2021, through May 31, 2022.

The *2021 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 14.1% for nursing home visits, which represents $341,892,648 in improper payments. The types of error that comprise the improper payment rate for Medicare Part B nursing home visits include a 37.1% improper payment rate attributed to insufficient documentation and a 54.9% improper payment rate attributed to incorrect coding.

After review of, and research into, the improper payment rate, this CBR was created to analyze the possible threat to the Medicare Trust Fund associated with initial nursing facility E&M visits. The expectation is that providers that provide these services will maintain proper documentation for patient care and confirm correct coding processes.

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either peer group or national percentages in any of the three metric calculations (i.e., greater than or equal to the 90th percentile), and
2. Has at least 40 total beneficiaries with claims submitted for CPT® codes 99304, 99305, and 99306, and
3. Has at least $7,000 in total allowed charges.

Coverage and Documentation Overview

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

Table 1: CPT® Code Descriptions

CPT® Codes	Description
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: • A detailed or comprehensive history; • A detailed or comprehensive examination; and • Medical decision making that is straightforward or of low complexity. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history;

CPT® Codes	Description
	• A comprehensive examination; and • Medical decision making of moderate complexity. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these three key components: • A comprehensive history; • A comprehensive examination; and • Medical decision making of high complexity. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.

Table 2 provides summaries of your utilization of CPT® codes for initial nursing facility E&M visits.

Table 2: Summary of Your Utilization of CPT® Codes for Initial Nursing Facility E&M Visits Between June 1, 2021, and May 31, 2022

CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count*
99304	$959	11	10
99305	$21,897	174	154
99306	$17,488	108	102
Total	$40,344	293	249

*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 weighted services billed, per day
2. Percentage of beneficiaries with more than one allowed service
3. Percentage of total Medicare Part B allowed amount submitted for initial nursing facility E&M visits

The CBR analysis focuses on providers listed as rendering providers on Medicare Part B claims for initial nursing facility E&M visits. 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 — 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 39,212 providers nationwide that are listed as rendering providers on claims for initial nursing facility E&M visits. The total allowed charges for these claims were over $334 million during the analysis timeframe.

Metric 1: Average Weighted Services Billed, per Day

Metric 1 is calculated as follows:

- Weighted services are calculated as follows: Each CPT® code is assigned a value that corresponds to the time described in the CPT® code for E&M services, as seen in Table 1. This value is multiplied by the allowed services for each E&M CPT® code to arrive at the weighted services, per code. These values are then summed for the weighted service value.
- The weighted services is divided by the number of distinct dates of service for any initial nursing facility E&M visits during the analysis year.

Table 3: Average Weighted Services Billed, per Day

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
11,225	154	72.89	71.61	Higher	79.12	Does Not Exceed

Metric 2: Percentage of Beneficiaries with More Than One Allowed Service

Metric 2 is calculated as follows:

- The number of beneficiaries with more than one allowed service is divided by the total number of unique beneficiaries with at least one allowed service.

Table 4: Percentage of Beneficiaries with More Than One Allowed Service

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
34	249	13.65%	9.18%	Higher	8.27%	Higher

Metric 3: Percentage of Total Medicare Part B Allowed Amount Submitted for Initial Nursing Facility E&M Visits

Metric 3 is calculated as follows:

- The total allowed amount for initial nursing facility E&M visits is divided by the total allowed amount of all Medicare Part B claims.

Table 5: Percentage of Total Medicare Part B Allowed Amount Submitted for Initial Nursing Facility E&M Visits

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
$40,344	$175,718	22.96%	6.09%	Significantly Higher	5.10%	Significantly Higher

Figure 1 illustrates the total number of beneficiaries for whom claims were submitted with CPT® codes 99304, 99305, and 99306.

Figure 2 illustrates the total number of claims for initial nursing facility E&M visits, per month, that were submitted in Year 3.

Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** June 1, 2019 – May 31, 2020
- **Year 2:** June 1, 2020 – May 31, 2021
- **Year 3:** June 1, 2021 – May 31, 2022

Figure 1: Total Number of Beneficiaries for Whom Claims Were Submitted with CPT® Codes 99304, 99305, and 99306

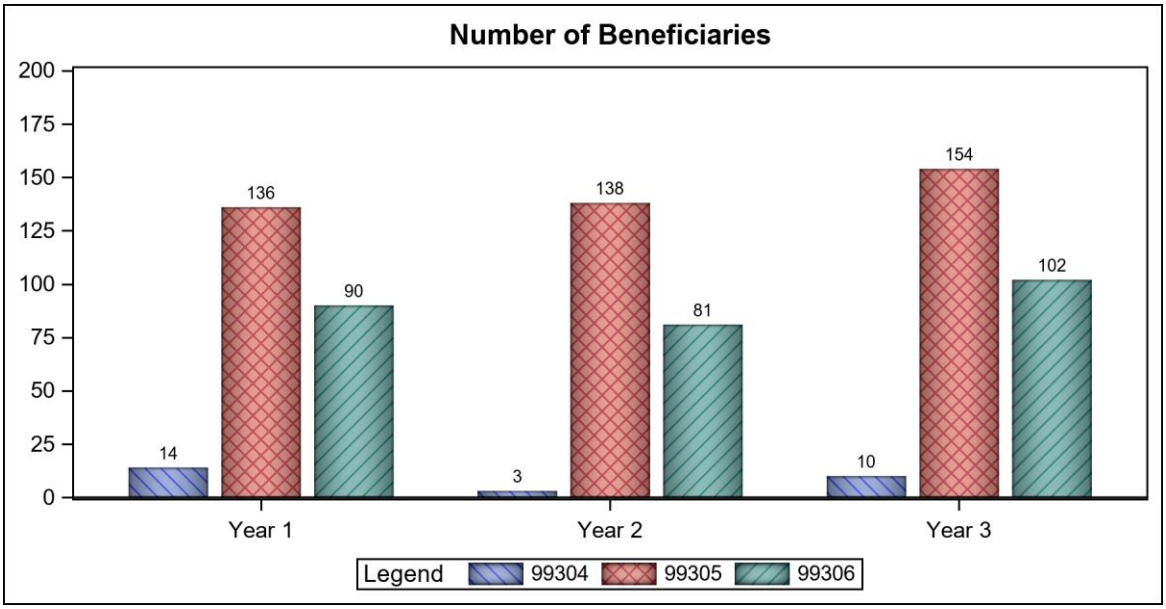
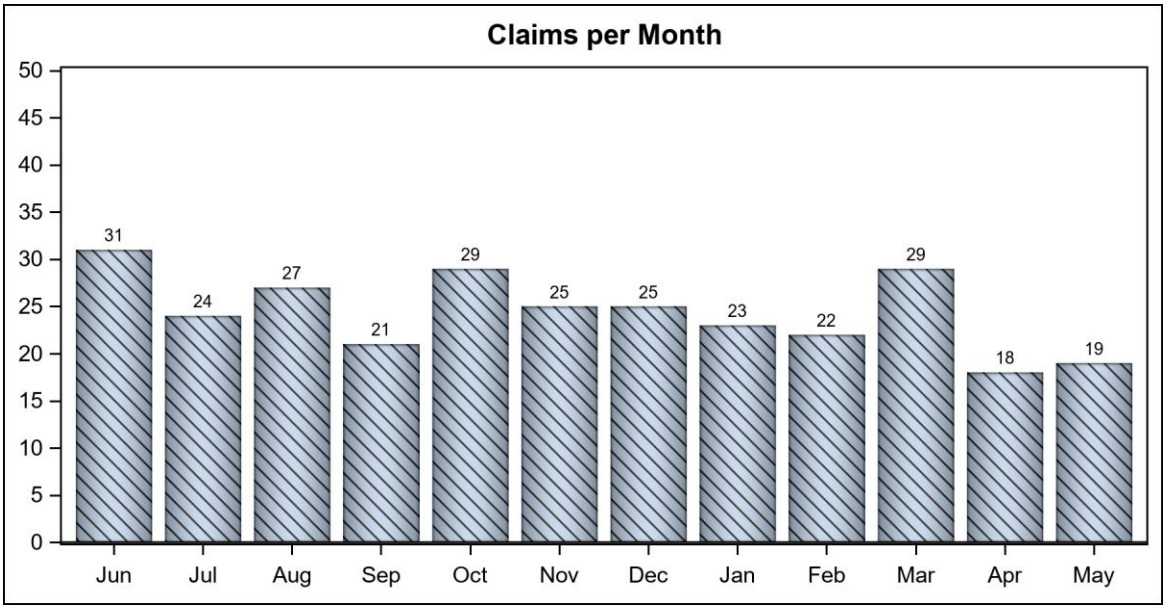


Figure 2: Total Number of Claims Submitted for Initial Nursing Facility E&M Visits, per Month, for Year 3



References and Resources

CPT® 2021 Professional Edition. American Medical Association.

2021 Medicare Fee-for-Service Supplemental Improper Payment Data. U.S. Department of Health and Human Services (HHS). CMS.gov.