



May 31, 2019

RELI Group  
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Catonsville, MD 21228

CBR #: CBR201906  
Emergency Department Services

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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 patterns as compared to your peers' patterns for the same services in your state and/or nationwide. The CBR is intended to enhance accurate billing practices and support providers' internal compliance activities.

**Why did I get a CBR?** We are providing this report because your Medicare billing patterns differ from your peers' patterns within your state 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.**

Attend our free webinar on Jun. 11, 2019, at 3 p.m. ET. Please [Register](#) prior to the event. If you are unable to attend the live event, visit [CBR.CBRPEPPER.org](http://CBR.CBRPEPPER.org) to access the recording and additional resources. Questions may be submitted at any time through the website Help Desk (Help/Contact Us tab) or at 1-800-771-4430 (M – F, 9 a.m. – 5 p.m. ET).

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- [National Plan and Provider Enumeration System](#) (NPPES)
- [Provider Enrollment, Chain, and Ownership System](#) (PECOS)

Sincerely,

The CBR Team

**Comparative Billing Report (CBR) 201906  
May 31, 2019  
Emergency Department Services**

**Introduction**

CBR201906 focuses on rendering providers who submitted claims to Medicare Part B for emergency department visits. According to the “2018 Medicare Fee-for-Service Supplemental Improper Payment Data” report, the overall projected improper payments for “emergency room visits” totaled \$238,537,192, with an error rate of 11.3 percent.

**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, as outlined by the Medicare Administrative Contractors’ (MACs’) Local Coverage Determinations (LCDs).

For the purposes of this CBR, emergency department services were reviewed. The CPT® codes for these services are 99281, 99282, 99283, 99284, and 99285. The codes are part of the Evaluation and Management CPT® code set, and the following information should be included in the documentation of emergency department Evaluation and Management codes:

- History
- Exam
- Medical Decision Making

**Basic Coding Guidelines**

Table 1 identifies CPT® codes that may be reported for Evaluation and Management services for emergency department services, CPT® codes 99281–99285.

**Table 1. CPT® Codes**

CPT® Code	Descriptor
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history, A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family needs. Usually, the presenting problem(s) are of low to moderate severity.

<b>CPT® Code</b>	<b>Descriptor</b>
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

All patient documentation must support the assigned code for the level of patient encounter, using either the 1995 or 1997 guidelines to assign the code level.

Table 2 identifies your utilization of CPT® codes 99281, 99282, 99283, 99284 and 99285.

**Table 2: Your Utilization of the CPT® codes 99281, 99282, 99283, 99284 and 99285**  
Dec. 1, 2017–Nov. 30, 2018

<b>CPT® Code</b>	<b>Allowed Charges</b>	<b>Allowed Services</b>	<b>Visit Count</b>	<b>Beneficiary Count*</b>
99281	\$23.97	1	1	1
99282	\$0.0	0	0	0
99283	\$630.27	9	9	9
99284	\$4,919.72	37	37	37
99285	\$49,778.93	254	254	247
<b>Total</b>	<b>\$55,352.89</b>	<b>301</b>	<b>301</b>	<b>291</b>

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

## **Metrics**

For each rendering physician with submitted claims for emergency department visits using CPT® codes 99281, 99282, 99283, 99284 and 99285, the following metrics were analyzed and compared at the state and national levels:

1. Percentage of Services Billed with CPT® Code 99285
2. Percentage of Services Appended with Modifier 25
3. Average Allowed Charges for all Medicare Part B Services, per Visit

The CBR team identified emergency department services utilizing Part B Claims submitted by rendering providers. Statistics were calculated for each provider, all providers in the state, and all providers in the nation using the following peer group definitions:

- 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 (FL) 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 above the 90<sup>th</sup> 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 not higher than the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

## **Results**

This report is an analysis of rendering providers who submitted CPT® codes 99281, 99282, 99283, 99284, and 99285 on Medicare Part B claims extracted from the Integrated Data Repository, based on the latest version of claims as of Apr. 28, 2019. The analysis includes claims with dates of service billed between Dec. 1, 2017, and Nov. 30, 2018. For the trend analysis (Figure 1), claims represent dates of service between Dec. 1, 2015, through Nov. 30, 2018.

There are 138,687 rendering providers nationwide with allowed charges for CPT® codes 99281, 99282, 99283, 99284 or 99285, billing a combined allowed amount of \$2.86 billion for 10,117,697 beneficiaries during the timeframe. CBRs are generated for providers who:

- Are significantly higher compared to either state or national percentages in any of the three metrics (greater than the 90<sup>th</sup> percentile), and
- Have at least 11 beneficiaries with claims submitted for 99281, 99282, 99283, 99284 or 99285, and
- Have at least \$2,000 or more in total allowed charges.

**Metric 1: Percentage of Services Billed with CPT® Code 99285**

The percentage of services billed with CPT® code 99285 is calculated by dividing the number of services with CPT® code 99285, by the total number of services with CPT® codes 99281–99285:

$$\frac{(\text{Number of Services with CPT® Code 99285}) \times 100}{\text{Total Number of Emergency Department Services}}$$

Your comparison in your state and in the nation is presented in Table 3.

**Table 3: Your Percentage of Services Billed with CPT® Code 99285**

Dec. 1, 2017–Nov. 30, 2018

Your Percent	Your State’s Percent	Comparison with Your State	National Percent	Comparison with National Percent
84.39%	54.63%	Significantly Higher	46.53%	Significantly Higher

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

**Metric 2: Percentage of Services Appended with Modifier 25**

The percentage of services appended with modifier 25 is calculated by dividing the number of services with Modifier 25 by total number of services.

$$\frac{(\text{Number of Services with Modifier 25}) \times 100}{\text{Total Number of Emergency Department Services}}$$

Your comparison in your state and in the nation is presented in Table 4.

**Table 4: Your Percentage of Services Appended with Modifier 25**

Dec. 1, 2017–Nov. 30, 2018

Your Percent	Your State’s Percent	Comparison with Your State	National Percent	Comparison with National Percent
5.65%	9.91%	Does Not Exceed	10.44%	Does Not Exceed

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

**Metric 3: Average Allowed Charges for all Medicare Part B Services, per Visit**

The average allowed charges for all Medicare Part B services, per visit is calculated by dividing the total number of allowed charges of all Medicare Part B emergency department visits by the total number of visits. A visit is defined as a single date of service for a beneficiary.

$$\frac{(\text{Total Allowed Charges of all Medicare Part B at ED})}{\text{Total Number of Emergency Department Visits}}$$

Your comparison in your state and in the nation is presented in Table 5.

**Table 5: Your Average Allowed Charges for all Medicare Part B Services per Visit**  
 Dec. 1, 2017–Nov. 30, 2018

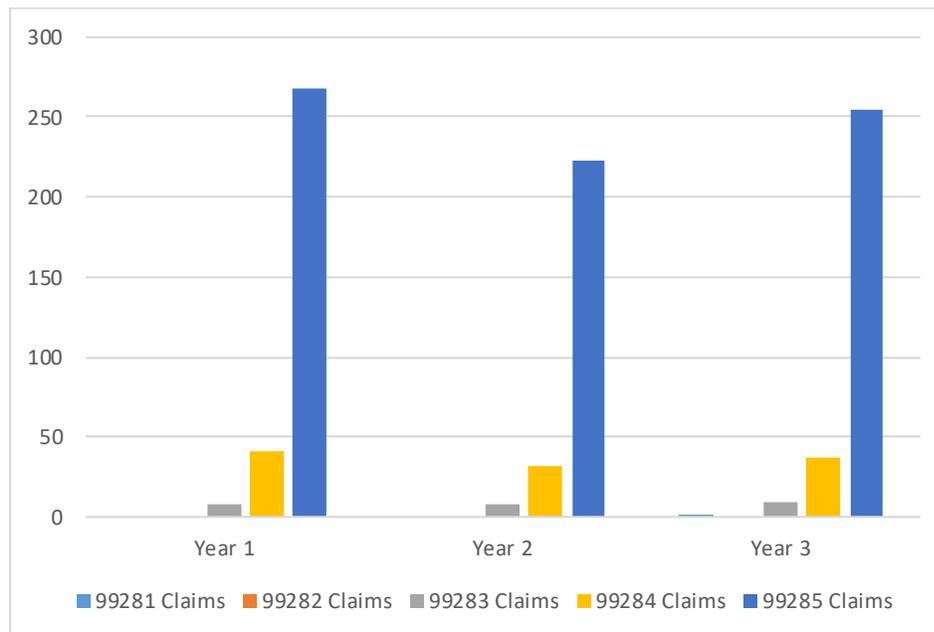
Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
\$183.90	\$135.31	Significantly Higher	\$126.93	Significantly Higher

N/A: Provider does not have sufficient data; State percent is not available when there are fewer than three providers in the state/territory with sufficient data

Figure 1 illustrates Trend Over Time Analysis of Claims for CPT® codes 99281, 99282, 99283, 99284, 99285

- Year 1: Dec. 1, 2015–Nov. 30, 2016;
- Year 2: Dec. 1, 2016–Nov. 30, 2017;
- Year 3: Dec. 1, 2017–Nov. 30, 2018

**Figure 1: Trend Over Time Analysis of Claims for CPT® codes 99281, 99282, 99283, 99284, 99285**



## **References and Resources**

[2018 Medicare Fee-for-Service Supplemental Improper Payment Data](#)

[CMS Evaluation and Management Services Manual](#)