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112520 NEWS BLAST

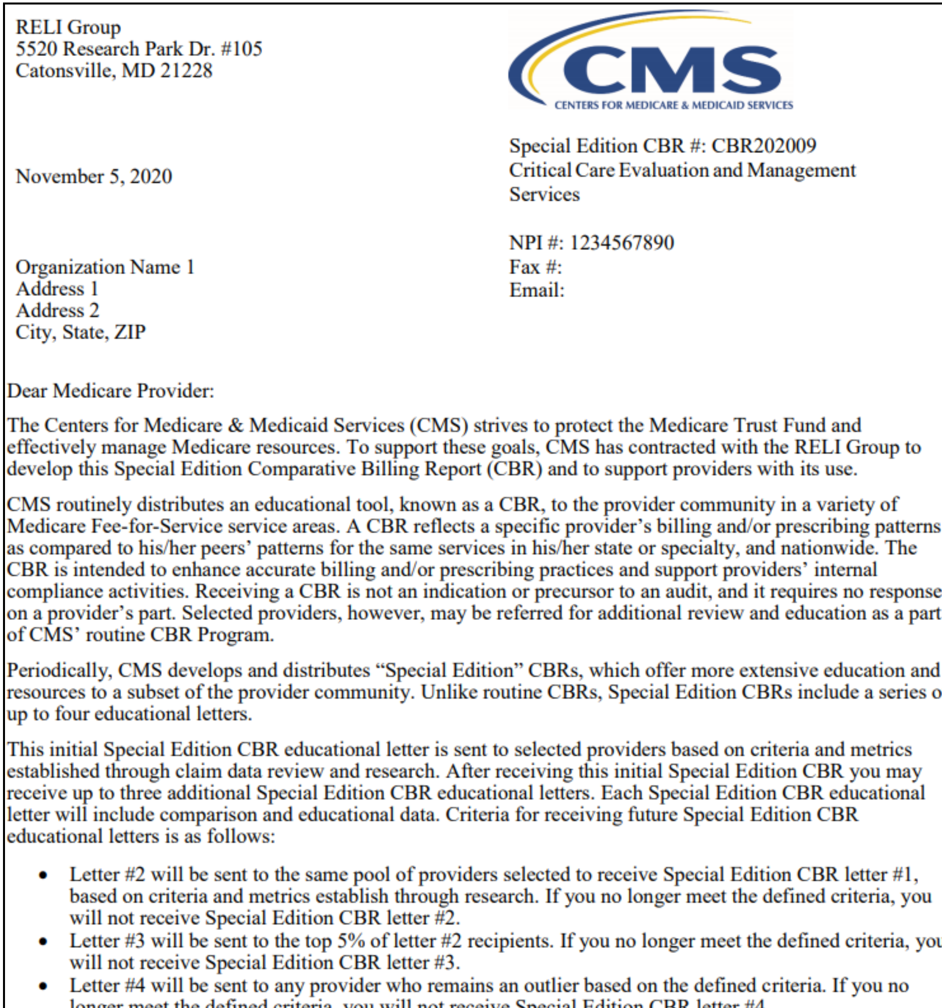
ATTN: ALL PROVIDERS

Review of Critical Care Services (99291-99292)

The RELI Group (along with its partners TMF Health Quality Institute and CGS) is an auditing body that highlights potential problem areas related to Medicare billing via Comparative Billing Reports (CBR) which are disseminated to the Medicare provider community to provide insight into Medicare policy and regional billing trends. The RELI Group was contracted by CMS in 2019 to begin producing CBRs. (see RESOURCES *section* below for link to obtain CBR)

On November 5, 2020, the RELI Group announced that it would be sending “Special Edition CBR educational letters” to selected providers based on criteria and metrics established through claim data review and research concerning the providers use of the Critical Care Evaluation and Management (E&M) codes 99291 and 99292.

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.



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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

November 5, 2020

Special Edition CBR #: CBR202009
Critical Care Evaluation and Management Services

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

NPI #: 1234567890
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 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. 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.

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 initial Special Edition CBR educational letter is sent to selected providers based on criteria and metrics established through claim data review and research. After receiving this initial Special Edition CBR you may receive up to three additional Special Edition CBR educational letters. 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 #2 will be sent to the same pool of providers selected to receive Special Edition CBR letter #1, based on criteria and metrics establish through research. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #2.
- Letter #3 will be sent to the top 5% of letter #2 recipients. If you no longer meet the defined criteria, you will not receive Special Edition CBR letter #3.
- 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.

The Special Edition CBR educational letters gives providers examples of national averages, and outlier results which would be of concern to CBR, i.e., when the provider totals are much higher than the national averages.

Table 3: Your Percentage of Services Submitted with Modifier 25

Numerator	Denominator	Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
421	421	100.00%	8.85%	Significantly Higher	11.90%	Significantly Higher

Table 4: Average Number of Visits per Beneficiary

Numerator	Denominator	Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
421	96	4.39	1.64	Significantly Higher	1.49	Significantly Higher

Though the RELI Group assures recipients the letter is not an indication of or precursor to an audit, these sweeps tend to be issued in conjunction with other CMS oversight efforts on the same topic. For example, last year the auditors looked at family practice providers' use of established patient office E&M codes 99211-99215 a year after a Medicare Fee-for-Service Supplemental Improper Payment Data report investigated the same codes (PBN 7/17/19).

A CBR webinar for providers walks through the proper use of Critical Care codes and the time requirements for Critical Care, i.e., can't be reported for encounters less than 30 minutes, and units of 99292 are billed after 99291 in increments after the first 74 minutes, as well as the **23 codes** bundled in Critical Care, i.e., 36415 (Blood draw for specimen).

This Critical Care audit comes as OIG works on the results of its announced 2018 investigation of Critical Care code use, expected to be issued in 2021. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000316.asp

Physicians Billing for Critical Care Evaluation and Management Services

Critical care is defined as the direct delivery of medical care by a physician(s) for a critically ill or critically injured patient. Critical care is usually given in a critical care area such as a coronary, respiratory, or intensive care unit, or the emergency department. Payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care. Critical care is exclusively a time-based code. Medicare pays physicians based on the number of minutes they spend with critical care patients. The physician must spend this time evaluating, providing care and managing the patient's care and must be immediately available to the patient. This review will determine whether Medicare payments for critical care are appropriate and paid in accordance with Medicare requirements.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
August 2018	Centers for Medicare & Medicaid Services	Physicians Billing for Critical Care Evaluation and Management Services	Office of Audit Services	W-00-18-35816; various reviews	2021

MEDDATA offers a Critical Care section in the MDS Evaluation & Management General Information Packet, see link below.

RESOURCES:
RELI Group help desk: https://cbr.cbrpepper.org/HelpContact-Us

Sample CBR letter, "Special Edition CBR#: CBR202009 Critical Care Evaluation and Management Services," Nov. 5: https://cbr.cbrpepper.org/Portals/0/Documents/CBR_202009/cbr202009-critical-care-cbr-sample%20for%20website.pdf?ver=2020-11-02-144145-043

CBR critical care webinar: https://cbr.cbrpepper.org/About-CBR/CBR-202009

Access Providers CBR: https://cbrfile.cbrpepper.org/

OIG Workplan: https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

MDS Evaluation & Management General Information Packet: https://www.medtronsoftware.com/User Guides/E&M_Resources/E&M_Information_Packet_General.pdf

For assistance or any questions, contact MDS/MSI via:
From **MED**PM or **MED**EHR Sign On screens, double click on **'helpdesk@medtronsoftware.com**' to compose an email which will automatically create a ticket in our ticketing system. The ticketing system will then send an automated reply with your ticket # for all future correspondence related to your question/concern.