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Comparative Billing Reports: Tools to support Medicare Part B providers

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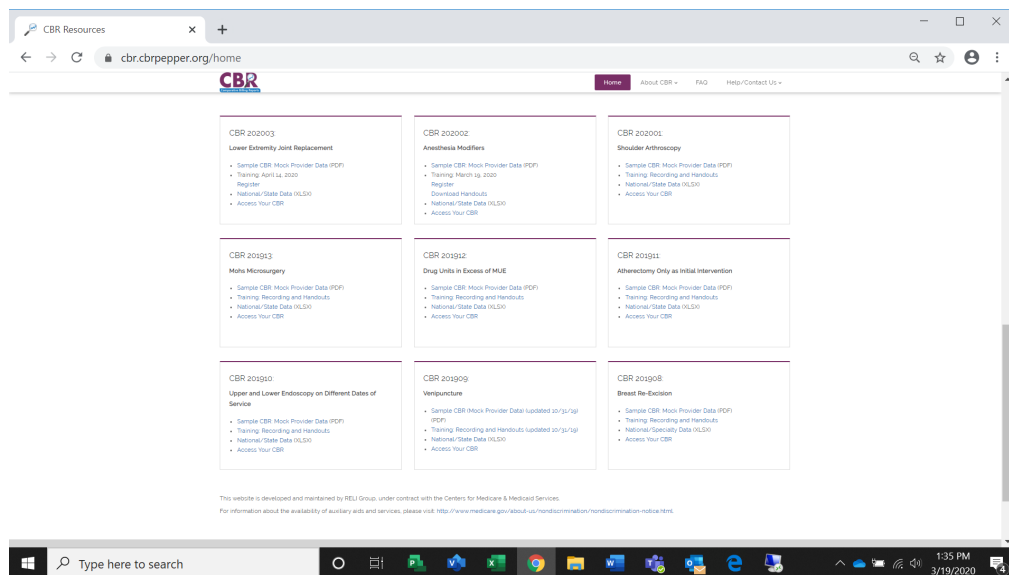
How do your billing and/or prescribing submissions compare to those of your peers? Even the most compliant process can benefit from comparisons and analyses of claims, billing, and/or prescribing data. To evaluate these data, develop provider education, and raise awareness of peer claim submission patterns, the Centers for Medicare & Medicaid Services (CMS) initiated the Comparative Billing Report (CBR) program in 2010.

More generally, CMS designed CBRs to protect the Medicare Trust Fund by focusing on areas that may be vulnerable to compliance, billing, and/or prescribing issues.^[1] To this end, the CBR team identifies clinical areas with the potential to significantly affect the Medicare Trust Fund, analyzes claims data associated with those areas, and generates individualized CBRs for providers. Each CBR summarizes one provider's Medicare claims data statistics and offers peer comparison data, making it an educational resource and tool that the provider can use for possible improvement.

What are CBRs?

CBRs are free, educational resources for providers that offer complex data in a format that allows providers to compare themselves against their peers on a specialty or state level, as well as on a national level. Each CBR release takes into consideration all providers at a national level to bring attention to potential coding, billing, and/or prescribing vulnerabilities. A CBR summarizes one provider's Medicare claims data statistics for areas that may be at risk for improper Medicare payments, which may be the result of incorrect coding, incorrect billing, incorrect prescribing, the provision of unnecessary care, and/or nonadherence to Medicare payment policy. Though CBRs cannot identify improper payments, they can alert providers when their claims statistics appear unusual when compared to their peers. After they are released, recent CBRs and their associated resources can be accessed from the homepage of the CBR website (Figure 1) at cbr.cbrpepper.org.

Figure 1: The CBR website homepage



CBRs are designed to be used as educational resources and tools to help providers identify areas for possible improvement in their billing and/or prescribing procedures and compliance plans. The delivery of CBRs supports the integrity of claims submission by summarizing and displaying detailed claims data. The claims data provided in the CBR analyses identify coding, billing, and/or prescribing areas that may be at risk for improper Medicare payments. These analyses and comparisons can detect any outliers in a provider's billing and/or prescribing processes, which can guide review and verification of compliant claims submission. To help providers with this process, CBRs include information about billing and/or prescribing submissions data and peer comparisons. In addition, CBRs also include information about specific coding guidelines, billing and/or prescribing information, and the connection between compliance and proper billing and/or prescribing.

How are CBR topics selected?

The CBR team identifies CBR topics by assessing the vulnerability of claims for errors, as well as the potential educational value to providers and administrative billing and/or prescribing staff. The selection of each topic for analysis is a detailed process involving resource research and data analytics. This process begins with an analysis of nationwide claims submissions, after which the CBR team examines the results in conjunction with relevant coding guidelines and Medicare payment policies. The CBR team uses these shared analyses to confirm that the topic will provide useful information and education.

To clarify areas of claims submission that are vulnerable to improper payments, the CBR team employs data and statistics from published coding guidelines, as well as documents sourced from government organizations. For example, Medicare National Correct Coding Initiative policy; the American Medical Association's Current Procedural Terminology (CPT) manual; and reports originating with CMS, the Office of Inspector General, or the Comprehensive Error Rate Testing contractor may contribute to the knowledge and analysis used for the topic selection and creation of CBRs.

The CBR team does not set policies, nor does it interpret CMS or Medicare Administrative Contractor guidelines. Rather, the CBR team coordinates with CMS for discussion and interpretation of the necessary information for each CBR topic. The CBR topics and analytics, when combined with the CBR outcomes, produce a reflection of correct coding initiatives and guidelines, provider claims submission, and comparative analytics on a state or specialty level, as well as on a nationwide level.

How are CBRs created?

Using the analytic results generated during the topic selection phase, the CBR team creates unique criteria to identify outliers in the data analysis comparisons, which are then used to generate valuable comparative data for

providers. This is the heart of the CBR process. The results of the data outcomes and comparisons provide value to the CBR recipient. The criteria for each CBR vary according to data analytics, results, and statistical inquiries, and they are the basis for identifying the providers that will receive a CBR.

After the CBR team selects a topic and analyzes the data to identify outliers, the process of creating the CBR content begins. CBRs include five detailed sections that explain all facets of the CBR topic:

1. **Introduction** identifies the specific clinical area addressed in the CBR, as well as the criteria that must be met in order for a provider to receive a CBR.
2. **Coverage and documentation overview** identifies the CPT; International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM); and/or Healthcare Common Procedure Coding System (HCPCS) codes used in the report analyses. This section also includes a summary of the provider's use related to charges, units, and beneficiary count pertaining to the topic.
3. **Metrics** describe the metrics included within the report, as well as the peer group definitions (usually the nation and the provider's state), which are used to identify outliers for CBR receipt using metric comparisons.
4. **Methods and results** present a national-level summary of the number of providers and the overall claims submission volume for the topic. In addition, this section includes the individual provider's results for each of the metrics.
5. **References and resources** include the references and resources used to create the CBR.

Who receives a CBR?

The CBR team determines the criteria for receiving a CBR specifically for each CBR release. To be considered at all, providers must meet minimum thresholds related to the number of beneficiaries treated and the dollar amount assigned to the specified CPT code in the Medicare Fee Schedule. Generally, providers will receive a CBR if their results for at least one metric indicate that they are above the 90th percentile as compared to the national or state/specialty peer group.

Receiving a CBR is not an indication of any wrongdoing on the provider's part, nor is it an indication or a precursor to an audit. The receipt of a CBR requires no response on the provider's part. If providers feel their billing is correct and in accordance with Medicare payment policy, they should not be concerned about receiving a CBR. Selected providers, however, may be referred for additional review and education. Please note, the CBR analyses do not consider practice type or patient population; CBR recipients are selected using the metric outcomes and recipient criteria.

How are the CBRs distributed?

The CBR team notifies providers that a CBR is available electronically via email or fax, and providers also receive a hard copy of their CBR through the mail. The email and fax notifications are sent to the contact listed within the Provider Enrollment, Chain, and Ownership System or to the contact listed in the National Plan and Provider Enumeration System.

The CBR team creates CBRs electronically in a portable document format (PDF) and houses them in a secure portal for online access through the CBR website. Due to the confidential information contained within CBRs, only the provider that has been issued the CBR, including any authorized personnel, may access the report. The portal provides a secure way to access CBRs, which may then be saved as PDF files for future reference and review.

CBR example review: Office visits for new and established patients

In the February 2019 CBR, the CBR team examined the CPT codes assigned to office visits for new and established patient visits for family practitioners (CPT code sets 99201–99205 and 99211–99215, respectively) within family practice patient encounter claims submissions.^[2] The CBR team presented this analysis to encourage providers to review their internal coding and billing systems for the proper assignment of these high-level codes, which have been identified as at risk for improper payments due to their higher rate of reimbursement. If a provider received this CBR, the provider could use this information to identify outliers within its internal coding and billing processes. The provider could review the documentation for patient encounters to ensure the compliant use of code selection procedures. The data and comparisons available in this CBR are indicative of the value offered to providers with each CBR release.

To help providers better understand the information communicated in CBRs, each section of a given CBR includes an explanation of every component of its analyses. In this particular CBR, the “Introduction” section stated that the improper payment rate for evaluation and management (E/M) codes in family practices was more than 13%, with more than \$727 million in projected improper payments.^[3] The “Coverage and Documentation” and “Basic Coding Guidelines” sections of this CBR described the required elements for the assignment of every level of E/M codes. By grouping the possible improper payments for E/M codes with a reminder about the proper process for assigning the appropriate level to each code selection, this CBR supported the idea that noncompliant coding and billing may lead to improper payments from Medicare for Part B beneficiaries.

As with every CBR release, the CBR team developed the criteria to specify the provider population that would be considered in this particular CBR analysis and to identify outliers, as indicated by the CBR’s analyses, outcomes, and comparisons. The criteria to receive this CBR were as follows:

1. The provider “had at least 50 beneficiaries with claims submitted for 99204 or 99205,”
2. The provider “had at least 50 beneficiaries with claims submitted for 99214 or 99215,” and
3. The provider was significantly higher (i.e., greater than the 90th percentile) compared to either the state or national percent in any of the metrics.

The criteria for every CBR is created by examining the claims data through the metric analyses for each specific CBR topic. The metrics for this CBR focused on the following:

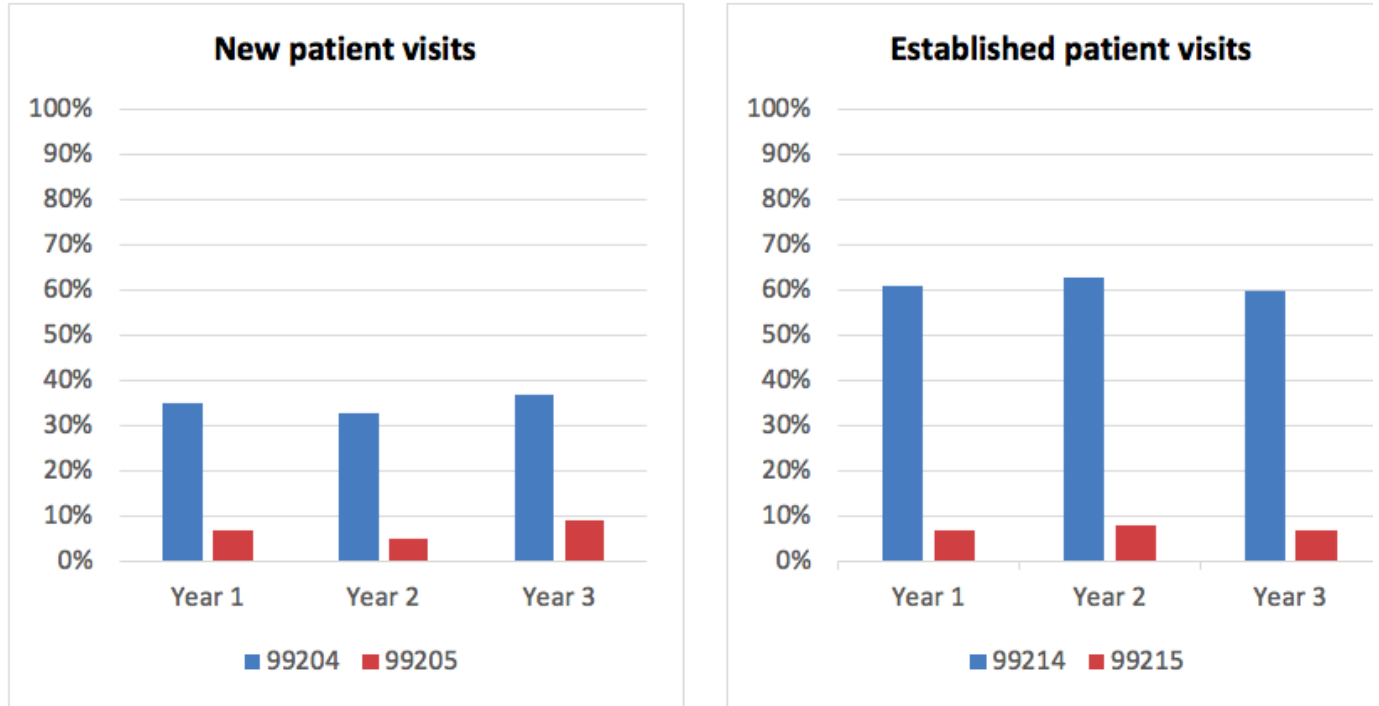
1. The percentage of level four and level five E/M codes (CPT codes 99204, 99205, 99214, and 99215) submitted;
2. The average dollar amount involved in the E/M charges for the provider for level four and level five E/M codes; and
3. The percentage of beneficiaries that received services submitted with level four and level five E/M codes.

Correct coding and compliance with E/M guidelines can be difficult to maintain, and some providers are not aware of the levels of E/M codes that are assigned to their patient encounters. This specific CBR allowed providers to compare their E/M claim submissions to those of their peers. This valuable information supports internal comparisons of provider documentation and patient care to ensure correct code assignment according to patient encounter documentation.

In addition to the detailed information included for each specific metric, CBRs also include providers’ trend data over a three-year time period. The detail of each metric, when combined with these trend data, offers a comprehensive examination of the claims data presented for the given CBR topic. As constructed for this CBR, the trend analysis for the family practice E/M data (Figure 2) shows a sample provider’s trend for the percentage of beneficiaries who received level four and level five E/M services that were reported with CPT codes 99204, 99205, 99214, and 99215, all of which have been identified as at risk for improper payments due to their higher level of reimbursement.^[4] These graphs indicate that the sample provider has a high percentage of beneficiaries who received a level four E/M service for both new and established patients. If this were true for an actual provider,

the analysis and resulting graph presentation could prompt the provider to evaluate its billing procedures and examine the code selection for each patient’s level of care.

Figure 2: Sample percentages of beneficiaries at E/M service levels four and five



Educational resources

After the release of each report, the CBR team hosts a live webinar to discuss what CBRs are, the specific CBR topic, and the specific metrics used in the CBR. During the webinar, participants can observe the CBR retrieval process and review a report with sample data. Each metric, outcome, and CBR criterion is explained in detail, and participants may submit questions about the CBR directly to the CBR team and receive answers during the webinar. Shortly after the live event ends, the CBR team posts a recording of the webinar content, a transcript of the presentation, and a questions and answers document to the CBR website for future reference.

The CBR website includes a number of other resources that are specific to each CBR release, including a sample CBR and a document that includes aggregate national and state/specialty data. Should they have any questions or need assistance obtaining their report, CBR recipients may access a virtual help desk from the CBR website. To stay up to date, a provider can subscribe to a news and releases email Listserv directly from the CBR website and receive news about CBR topics, release dates, and educational resources.

Conclusion

Compliance is constantly evolving and expanding to every area of patient care administration. More than ever, correct coding, billing, and/or prescribing plays a key role in claims submission and in the protection of the Medicare Trust Fund. CBRs support compliance and education by raising awareness and offering tailored knowledge for recipients. All providers can take advantage of the wealth of education, analyses, and resources that accompany each CBR topic to support compliance in their organizations.

Takeaways

- The Centers for Medicare & Medicaid Services created the Comparative Billing Report (CBR) program to provide education to Medicare providers.

- CBRs offer providers peer-to-peer comparison data for Medicare Part B claims submissions.
- CBRs reflect coding, billing, and/or prescribing patterns and analysis results for specific clinical topics.
- CBRs support the auditing component of an effective compliance program.
- CBRs are distributed to individual providers using contact information in the Medicare Provider Enrollment, Chain, and Ownership System, as well as through an online portal.

1 “About CBR Page,” CBR PEPPER, last accessed June 11, 2020, <https://bit.ly/2UAJeXr>.

2 RELI Group, “Comparative Billing Report (CBR) 201902: Office Visits, New and Established Patients, Family Practice,” February 15, 2019, <https://bit.ly/3dZo9BC>.

3 U.S. Department of Health & Human Services, *2018 Medicare Fee-for-Service Supplemental Improper Payment Data*, November 30, 2018, <https://go.cms.gov/2TCCn3O>.

4 U.S. Department of Health & Human Services, *2018 Medicare Fee-for-Service Supplemental Improper Payment Data*.

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