Transcript for the CBR201901: Intensity-Modulated Radiation Therapy Webinar

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Barnaby: Today's webinar, where we will be discussing Comparative Billing Reports or CBRs, and more specifically, CBR201901, Intensity-Modulated Radiation Therapy.

My name is Annie Barnaby and I work for RELI Group, Inc. who is contracted with the Centers for Medicare & Medicaid Services, CMS, to develop, produce, and distribute these CBR reports.

Before we move on to the content of today's webinar, let's review a couple of housekeeping items to ensure that the session runs smoothly. If you would like to utilize the live captioning for today's presentation, you can access that captioning by clicking the link that's listed in the Q and A panel. That will bring up a separate Web page for you to move around however you would like so that the captions can show. Your lines will be muted during this presentation, so that the recording is not interrupted or compromised, and so that the audio can flow smoothly for our recording. If you have any questions, please submit them at any time using the Q and A panel on your computer screen. I will answer those questions verbally at the end of the session as time allows.

And a Q and A document will be created and then posted for your review as well.

If you have any questions about the statistics in your individual CBR, I encourage you to submit those questions through our help desk, instead of addressing those questions during this webinar. The Help Desk can answer specific questions and we can be sure we're looking at the same report and the same statistics in your CBR, when we answer your specific inquiry.

Sorry about that. So to ask the question in split screen, again, you do have the Q and A chat screen on the side of your screen. Be sure to submit your question to all panelists so that everyone on the call can be involved in the inquiry and the answer as we discuss it. If you would like to use it in full screen mode, if you are listening to the webinar in full screen mode, excuse me, you can click on the Q and A button that is the little question mark icon, type in your question just as we discussed to all panelists, and then hit the send button. And then if you would like to close that Q and A window, again, you can use the minimize button and you will be back in full screen.

We've developed various resources to accompany this webinar, and those resources are listed here for your convenience. We do have the webinar slides available to you, and as I mentioned before, we are recording this session. And that recording will be made available to you as well.

We have handouts and of course the Q and A and CBR Help Desk are great tools for you to use

if you have any questions. We are here to help.

The objectives of today's webinar will be to understand the purpose and the use of Comparative Billing Reports or CBRs, to help explain the function of this specific Comparative Billing Report, CBR201901, Intensity-Modulated Radiation Therapy, and to help you gather resources that will help answer further questions and inquiries, so let's get started.

Our discussion today will cover the following areas: First, we'll talk about what a Comparative Billing Report, CBR, is, then we'll go a discussion of this CBR and we'll go through the details of the CBR topic, Intensity-Modulated Radiation Therapy, or IMRT. I do have a sample CBR that we will review so that we can get a good sense of what we're looking at when we review an IMRT CBR. I'll show you how to access your CBR and then I will show you some helpful resources should you have any questions following the webinar, and finally, as I said, I will answer any submitted questions as time allows.

Let's start at the very beginning. What is a Comparative Billing Report? First, let's take a look at how CMS defines a CBR. According to the CMS definition, a CBR is a free comparative data report that can be used as an educational resource and a tool that providers can use for possible improvement measures. A CBR is truly just what the title says: A report that compares providers on a state or specialty and nationwide level and summarizes one provider's Medicare claim status statistics for areas that may be at risk for improper Medicare payment, primarily in terms of whether the claim was correctly coded and whether the treatment provided to the patient was necessary and in line with Medicare payment policy.

A CBR cannot identify improper payments, but it can alert providers if their billing statistics look unusual as compared to their peers.

Taking a look at the history of the CBR, we can see that the program was spearheaded in 2010. CMS implemented a national program to produce and disseminate the CBRs to physicians, suppliers, pharmacies, other healthcare providers, and then in 2018, CMS combined the CBR program with the PEPPER program, which is the program for Program for Evaluating Payment Pattern Electronic Reports to put both programs under one contract, and then RELI Group has partnered with TMF and CGS to create and distribute the CBRs and the PEPPERs.

CMS is mandated and required by law to protect the trust fund against any improper payments or anything that would compromise that trust fund.

CMS employs a number of strategies to meet that goal, which include education of providers, early detection through medical review and data analysis. CMS considers the CBR process to be an educational tool that supports their effort to protect the trust fund.

Let's take a look at how CBRs can help providers. And they do serve several purposes on the provider side. The CBR program helps to support the integrity of claims submission and the

adherence to coding guidelines. This helps to protect the trust fund and helps to encourage correct clinical billing. Early detection of any outliers in your billing process can help to guide a compliance program that will help to support compliant operations in your own organization.

Taking a look at the -- a closer look at the specific coding guidelines and billing procedures can increase education and can help improve future billing practices. A CBR is formatted into six sections, which helps to focus on the process and the results of the CBR. The introduction is a brief explanation of the specific billing area addressed in the CBR and it's a description of the findings of the CBR. The coverage and documentation overview identifies claims data and reviews basic CPT code information. In the section covering basic guidelines, we're provided with a more detailed description of CPT codes and the correct billing processes.

The metrics to a CBR lists and explains the values for the CBR and the analysis performed and it usually contains a detailed list of CPT codes and the effect the billing guidelines have on the CBR results. The message and results section is an overall analysis of the CBR results and individualized results comparing the CBR recipient to other providers.

And then we'll also take a brief look today at the resource -- excuse me, the references and resources used with CBR, those created to help you as you have any questions about this or other CBRs. To begin our review of the sections of this CBR, let's discuss the very basis of the topic. What is Intensity-Modulated Radiation Therapy, or IMRT?

IMRT is used for the delivery of generally narrow, patient-specific, spatially and often temporally modulated radiation to solid tumors within a patient. So again, let's take a closer look at the specific findings of this CBR as it relates to IMRT around the specific codes used to report IMRT that are analyzed within this CBR report.

As you know, the focus of this CBR is a review of the statistics for providers who submitted Part B claims for IMRT. More specifically, the CBR analyzed claims billed with codes 77301, which is the IMRT planning code. 77301 is typically reported only once per course of IMRT treatment, which stands to reason, because the code 77301 truly does encompass all of the planning for each course of IMRT. This CBR addresses the billing guidelines for that code and other codes as they relate to it.

As we mentioned, in the last slide, 77301 is reported once per course of therapy. A second unit can be billed only if there are changes in patient anatomy during treatment that requires a repeat CT Scan.

So if the tumor changes, or if there is another treatment that needs to be planned, at that time, you would be able to bill that second 77301 code.

And then looking at code 77014. This code is used to report the computed tomography, CT Scan, for placement of radiation therapy deals. Codes G6015 and G6016 are used to report

IMRT treatment, and these codes are used on a per treatment session sequence. There is a table here that lists the Evaluation and Management codes. And this is just a basic list of the evaluation and management code groupings, and of course when you assign an E and M code, you will choose the correct level from the code group seen here. E and M codes should not be billed along with 7301. Because the services of 77301 are considered the face-to-face encounter, duplicate the billing for those services rendered.

The 2018 Medicare fee-for-service supplemental improper payment data report showed a 10.3% improper payment rate for oncology radiation therapy.

IMRT is included in that oncology radiation therapy section of the analysis. So knowledge of the codes that we just reviewed is important when looking at the improper payments. The code knowledge can help us to understand what was paid incorrectly.

This 10.3% payment rate represents over $112 million in improper payments, the cause of which is insufficient documentation. And we all know how difficult it can be to keep up with documentation requirements, but we can see here how serious the improper payments can become when documentation does not support patient billing.

In order to get detailed information for those providers who were billing for IMRT services, the CBR, 201901 analyzing IMRT was created. The CBR summarizes one year of service, and that year is between September 1, 2017, and August 31, 2018.

The statistics and analysis showed 4,158 providers who billed the code 77301. Identifying this specific date range and a specific CPT code that isolates the IMRT service, helps to get granular detail about the portion of the 10.3% improper rate and the over $112 million in improper payments.

So if we drill down even further, from the oncology/radiation therapy to IMRT services, to the specific code of 77301, we can also narrow down the diagnoses that are usually treated with the IMRT CPT service code. And you'll see here the list of diagnosis codes that were used for the focus of this IMRT CBR.

Now that we're familiar with the analysis that was completed within the IMRT CBR, let's take a look at why you may have received a CBR. A CBR is presented to a provider when the analysis of their billing pattern differs from the provider's peers on a state or specialty and nationwide level. It's always important to remember receiving a CBR is not in any way an indication of, or a precursor to an audit.

When we talk about comparing your billing patterns to those of your peers, there are four outcomes that can come of that analysis. An outcome of significantly higher indicates that the provider's value is above the 95th percentile from the state peer or national mean, and we'll talk a little bit more about what that 95th percentile means exactly on our next slide. The other

outcome, an outcome of higher, shows that the provider's value is greater than the state peer and national mean. An outcome does not exceed indicates the provider's value is not higher than that state peer or national mean, and a NA outcome represents that the provider does not have sufficient data for comparison.

Let's discuss what being above the 95th percentile actually means, because it is important to understand the true meaning so that we can understand fully the meaning of the outcomes listed in the CBR.

The other outcomes are relatively self-explanatory, but the significantly higher outcome is a little bit more involved than the others. In order to identify the providers who were above the 95th percentile, we calculated percentiles for all providers for each of the metrics in each comparison group.

The comparison groups being the statewide and nationwide.

To calculate the percentiles, we first ordered all of the providers' percent values from highest-to-lowest, and if you look at the ladder on the right-hand side of this slide, it can give you a visual representation, if you can imagine the higher percent values being listed at the very top of that ladder, and then the provider -- the percent value listed as it decreases going down so that the lowest percentile -- excuse me, are on that bottom rung. Next, we identify the percent value below which 95% of the providers' values fall, so that is the 95th percentile mark, and that is represented -- excuse me, represented above by the black line. Any providers whose percent value is above that point, are above the 95th percentile, and are identified as being significantly higher for that metric in their CBR as compared to the statewide or nationwide result.

Therefore, when you are in that group, your results are very different from your peers. And we send the reports to allow for comparison among your peers and to offer an opportunity to see that your results in one of those five metrics vary greatly from those of your peers.

We'll take a look later on at each of the metrics and the results that indicate a significantly higher outcome.

A CBR is presented because your billing pattern differ from your peer pattern on a statewide specialty or nationwide level; however, the above criteria also weighs in as to whether or not your billing was included in the analysis and whether or not your results qualify for the receipt of the CBR.

So to receive a CBR, all three of the top -- of the criteria above here, on this slide must be met. At least ten beneficiaries must have claims submitted with the code 77301, and your results must be significantly higher in any one of the five metrics, and you have to have at least $18,000 in total allowed IMRT charges.

And it is important to just drive the point home and identify that your results do not need to have a significantly higher outcome in all five metrics, or even more than one metric, as long as significantly higher is the result of one of the five metrics, and you meet the other two criteria listed here, you will receive a CBR for review.

Also, it is important to note that the charges that are filed must meet or exceed $18,000 in allowed charges. This dollar amount is not drawn from the billed amount, but from the total of the charges submitted according to the Medicare allowable amount that is assigned to those codes.

And as we all know, the billed amount will exceed the allowed charges, so I do want to point out that the criteria here is for the Medicare allowed charges. To help us fully understand the IMRT CBR, its outcomes and comparisons, let's take a look and review a sample IMRT CBR. We'll look at the metrics, the findings, the methods and results, and the provider findings for this CBR. The results of this CBR that we're about to review will of course differ from those on your CBR if you received one, but the formatting in the sections will be consistent with the layout of this sample CBR. You will see here a list of the metrics that were analyzed in the CBR. You'll note reading through metric 1-3 listed here that these metrics deal with averages per beneficiary. The first metric, metric number one is the average number of IMRT planning services, CPT code, 77301, that were billed per beneficiary. Metric number 2 is the allowed -- excuse me, the average allowed charges for the first instance of IMRT planning code 77301, per beneficiary. And metric number 3 is the average number of CT Scans therapy guide, CPT code 77014, billed zero to 14 days prior to or up to 60 days after the first instance of CPT code 77301 per beneficiary.

We'll break down how each of these metrics is calculated so we can have a deeper understanding of the statistics that are listed on each of the CBR, and we'll continue with those metrics. We have two more.

All right. Sorry, got ahead of myself there. I think. I apologize. I think I might be missing a slide here.

There are two more metrics that we are going to discuss. I'll explain them verbally for you here. The average number intensity modulated treatment delivery, and -- I'm sorry, I'm getting a little mixed up with my slides here.

Yes, I'm missing it. I apologize. So we are going to take a look at the intensity modulated treatment delivery, codes G6015 or G6016, that were billed zero to fourteen days prior to or up to 60 days after the first instance of CPT code 77301, per beneficiary, and then the fifth metric is an average number of the Evaluation and Management codes billed zero to fourteen days prior to or up to 60 days following the first instance of CPT code 77301 per beneficiary. So please note the wording to the billing timing of the codes that we just discussed in metrics

three, four and five, for codes 77014 and then G6015 and G6016. And the evaluation management codes.

The specific billing timing is zero to fourteen days prior to or up to 60 days after the first instance of CPT code 77301.

This is a bit wordy and very specific, so when we talk later in the presentation about the billing of these codes in regards to each metric, please note that we are referring to the timing of zero to fourteen days prior to or up to 60 days following the first instance of CPT code 77301.

So let's take a look at the exact method of calculating the statistics for each of the metrics. Each metric is an average of a set of data, and therefore the calculations are relatively straightforward. Metric 1, as we discussed, average number of IMRT planning services, billed per beneficiary, is calculated by dividing the number of IMRT planning services, billed during the period by the number of beneficiaries with at least one IMRT planning code billed during the period.

This time period is the span of dates we discussed earlier, September 1, 2017 through August 31, 2018.

So each time we reference that billing period for this metric, we are talking about that year-long time frame.

The average allowed charges for the first instance of IMRT planning code 77301, per beneficiary, metric two, is calculated by dividing the sum of allowed charges for IMRT planning services by the number of IMRT planning services billed during the period.

Moving on to the calculations of metrics three, four and five. We're still looking at the same billing period for our analysis, that one-year time period, and as we pointed out earlier, these metrics address the timing of the billing and these codes relative to the billing of code 77301.

Metric 3, the average number of CT Scans per therapy guide, code 77014 billed, we take the number of CT Scans billed and divide by the number of beneficiaries who had at least one CT Scan billed.

For metric 4, the number of G6015 or G0616 codes billed is divided by the number of beneficiaries with at least one of the codes billed. That gives us the average number of IMRT treatment delivery code 6015 or 6016 per beneficiary.

And then finally for metric 5, we can take a look back at our table of E and M codes, take the number of E and M visits billed, divide that number by the number of beneficiaries who had at least one E and M visit billed. So now for the question of the afternoon: What were our findings? Well, the CBR quantifies the number of instances during which the codes which we just discussed in metrics 3 and 4, 77014, and the G codes, were billed within the fourteen days prior to or up to 60 days following the first instance of billing code 77301.

The results of those findings are on this slide here. So we can see that code 77014 was billed in 61.7% of claims, while the G codes, 6015 and 6016 were billed at a lower rate of 35.4% of claims.

And then Evaluation and Management codes were billed in 40% of claims.

These percentages are rather high, especially when we take a look at the coding that doesn't allow for those codes to be billed with the 77301. So what does that mean to you?

The statistics above that we see here are an overall value of the percentage of claims that were billed with these code combinations; however, as we talked about earlier in a presentation, the CBR is all about comparing your billing practices to your peers on a state or specialty and nationwide level. So the following table will break down the statistics as compared to your peer group.

In order to take a specific -- excuse me, to look at the specific findings of this CBR, moving on from the overall findings of the claims billing, the CBR will contain a series of tables. These tables detail the billings of the provider receiving the CBR.

This sample CBR holds sample data, but when we look at the tables and the metrics that the table represents, we can get a good idea of what you'll see on your individual CBR.

On table 3, we can look at the details of the calculations that we discussed earlier for metric 1, the average number of IMRT planning services per beneficiary. You will see here the table lists the number of beneficiaries who had at least one IMRT planning service code billed. The total number of IMRT planning services billed and the average of those two numbers, which in this sample case was 1.00.

The statewide average for this calculation was 1.03, and the national average is 1.06, which of course is slightly higher than the average for the sample provider. You'll see then on the right-hand side of the table that the comparison for statewide and nationwide as well are marked does not exceed. As we learned earlier, the provider does not have to score significantly higher for every metric measure in the CBR. Only one metric needs to have the significantly higher outcome. In this case, for this metric, the provider was actually under the state and national average.

Moving on to table 4, which displays the calculations and data for metric 2, the average allowed charges during an IMRT treatment period per beneficiary. The calculation is done by dividing the sum of allowed charges for the first instance of 77301, by the total number of beneficiaries billed during the time period.

This metric explores the numeric value of charges billed using the Medicare allowable rate for 77301. The table and the metric allow us to see a provider's total number of allowed charges for the time period, and the average dollar amount that was billed per beneficiary using that

allowable charge. You'll see here that the provider's total allowed charges totaled $162,185.17, with beneficiaries having that code billed, the provider average was $2,002.29. The state average totaling 774.20, and the national average coming in 921.01, we can see this provider does have a higher average comparatively, and that higher outcome is noted here on the right-hand side of the table again.

Moving forward to look at the specifics for code 77014 and G codes 6015 and 6016. Table 5 details the average number of CT Scans billed by codes 77014 per beneficiary. The sample provider had 80 beneficiaries who had at least one CT Scan billed within the examined time period, and 2,698 CT Scans billed within that time frame for an average of 33.73. A state average of 15.51 and a national average of 17.25 show that this provider had a significantly higher average number of CT Scans billed as compared to the state average, and a higher outcome as compared to the national average. This significantly higher outcome was the outcome that prompted the CBR for this provider. And as we can see, that outcome was for the statewide comparison only.

So this again drives home the fact this the provider does not need to have significantly higher outcomes across the board for these metrics or even across the board for one metric. The significantly higher outcome for the statewide comparison was what prompted the CBR here.

Finally, table 6, looking at the submission of code G6015 or G6016, this table shows the provider who had 80 beneficiaries who had at least one intensity modulated treatment delivery billed. In 2,697 total treatment delivery instances billed.

This brings an average of 33.71. The state average is 20.32, and the national average is a little bit closer to that, with 21.67. This provider, therefore, has a higher outcome for those two statistic comparisons.

And finally, the Evaluation and management code, table 7 explores metric 5, the average number of E and M visits billed. As we saw in the list of E and M code, there are several sections of E and M codes that qualify for this data collection. The numbers reflected here are for all E and M codes submitted in the time frame. We can see that the provider had -- this provider has 13 beneficiaries who showed E and M codes submitted surrounding the first instance of 77301, with a total number of E and M visits totaling 13 as well. The average for this provider brings him below the state and national average for this metric which is noted here with the does not exceed outcome. The metrics and the tables that we've just reviewed cover a very specific time period, and the CBR also includes data that ranges over a yearly time period, so let's take a look at some sample data for that information now.

Here we can see the provider trends for this sample provider for a trend over three-year period of time, and each year is September through -- September 1, through August 31. So you can see here that this provider had a small uptick in year two, September 1, 2016, through August 31,

2017, and then year three kind of lines up a little bit more with year 1. So this, again, is another section of the CBR that instead of getting to that granular specific level can show you a trend for your claim submission over the last three most recent years.

So now that we've taken a look at the CBR, the sample CBR, let's discuss how you can access your CBR. We do have several resources that we can use to access your CBR. Here you will see a screen shot of the website.

We do ask that you certify the role that you play in the organization that is receiving the CBR. On the left you can enter your information, on the right is the provider's information. We do ask that you let us know how you learned about your CBR, so you can keep track of those statistics and those trends and then you'll enter the provider NPI number, and then at the very bottom, there's a space for the validation code that you'll receive when you receive your CBR.

There's another way to get to your CBR, it's the website CBRPEPPER.org. You can see the arrow there pointing to the button that says access your CBR. If you click on that button, it will take you to the home screen that we -- excuse me, this screen that we just reviewed on the last slide, and you will be asked to enter the same information. That's just a different site to go to, and this one also has the PEPPER information as well. So your CBR access button is on this page as well.

Some helpful resources here: The biggest one obviously would be our Help Desk, https://cbr.cbrpepper.org/Help-Contact-Us.

And that is our CBR Help Desk. We are here to help as I said before. On this page you can submit a new Help Desk request. There's obviously the button right there, and you can submit a written request with any inquiry that you might have and we will respond to your specific inquiry. And then there is a frequently asked questions button that can help you to maybe see if your question is asked in that list, you know, before you submit a specific inquiry, take a look at those frequently asked questions, something might be answered there instead.

We do have a link here for the 2018 Medicare fee-for-service supplemental improper payment data page, and that's the report that we talked about at the very beginning of this presentation, and then the CMS publication which is the coding guidelines for radiology services, and other diagnostic procedures.

There are some local coverage determinations that are related to IMRT. There's some LCDs that you might want to look at. If you are involved with one of the MACs that is listed here. First Coast Services, Novita or Noridian, you might want to take a look at the MAC home page or contact your Mack to see what the LCDs that are related to IMRT.

If you go to CBR.CBRpepper.org/home, there's training materials, part of the sample CBR lists three sources and references that were used for that CBR. You can join an e-mail list so you can

stay up to date with any announcements. You can provide feedback which we would greatly appreciate. We would love to hear a CBR success story, something that you were helped with when you looked at your sample CBR -- excuse me, your CBR, not a sample one.

And here you can see a screen shot of that page that I just described. Down there on the bottom left hand corner is the CBR201901 for IMRT, and you can see there that there are links for the sample CBR, the statistical briefing, the link that I just discussed. So go to that home page -- excuse me, go to that page, CBR.CBRpepper.org/home, check out those links and you can get a wealth of information. Again, I mentioned frequently asked questions, those can be found at CBR.CBRpepper.org/FAQ, a list of your frequently asked questions. What is a CBR?

Why am I getting this report?

I have a question about my claims. Is there a sample CBR I can view. Take a look at these frequently asked questions before you submit to the Help Desk. That can save yourself time without having to wait for us to respond specifically to your inquiry. Some of your questions may be answered here.