Transcript for the CBR201902: Office Visits, New and Established Patients, Family Practice

February 28, 2019

Welcome to today's webinar where we'll be discussing Comparative Billing Reports or CBRs, and more specifically CBR 201902, new and established patient office visits for family practice.

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

We've developed various resources to accompany this webinar, and those resources are listed here for your convenience. We do have a webinar slides available to you, 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 to use if you have any questions. We are here to help.

The objectives to today's webinar will be to understand the purpose and the use of Comparative Billing Reports or CBRs. To explain the function of this specific comparative billing report CBR 201902, office visits, new and established patients, family practice. And to gather resources to help you answer any further questions or inquiries that you might have. So, let's get started.

Our discussion today will cover the following areas. First, we'll talk about what a comparative billing report is. Then we'll go into a discussion of this CBR and go through the details of the CBR topic.

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 actual CBR. I will show you how to access your CBR. I will show you some helpful resources for yourselves should you have any questions following the webinar. And then finally, I will answer any of those submitted questions as time allows.

So, let's start at the very beginning, what is a comparative billing report? First, we'll see how CMS defines a CBR. CBR stands for, of course, Comparative Billing Reports. And 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

improvements. A CBR is truly what the title says, a report that compares providers on a state and nationwide level and summarizes one provider's Medicare claims, status, statistics, for areas that may be at risk for improper Medicare payment, primarily in terms of whether the claim was correctly coded and billed 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 this program was spearheaded back in 2010. CMS implemented this national program to produce and disseminate CBRs to physicians, suppliers, pharmacies and other health care providers.

In 2018 CMS combined the CBR program with the PEPPER program, which is the Program for Evaluating Payment Pattern Electronic Reports to put both programs under one contract.

And then in 2019, RELI Group has partnered with TMF and CGS to create and distribute these CBRs and PEPPERs.

So why does CMS issue CBRs? Well, CMS is mandated and required by law to protect the tuft fund from any improper payments or anything that would compromise the trust fund.

CMS employs a number of strategies to meet this goal, which include education of providers, early detection through medical review and data analysis.

CMS considers the process to be part of the educational tools that support their efforts to protect the trust fund.

In addition to providing an educational resource, the CBR process supports the integrity of claims submissions and the adherence to coding guidelines.

CBRs also summarize claims data according to specific coding areas which helps to encourage correct clinical billing.

CMS takes advantage of all these benefits of the CBR process to protect the trust fund.

On the provider side, the CBR process can give providers a look into their submission data as compared to other providers. Early detection of any outliers in your billing processes can help to guide a compliance program that will help to support compliant

operations in your own organization. And taking a look at specific coding guidelines and billing procedures can increase education and 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 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 coding guidelines, we're provided with a more detailed description of CPT codes and the correct billing processes.

The metrics of the CBR lists and explains the data used for the CBR and the analysis performed. It usually contains a detailed list of CPT codes and the effect of the billing guidelines have on the CBR results.

The methods and results section is an overall analysis of the CBR results and individualized results comparing CBR recipients to other providers.

And then lastly, the references and resources are simply that, the references and resources used to create the CBR.

And I actually do have a sample CBR as I mentioned before. And before we go into the — too far into the webinar, I would love to just take a look at this sample CBR and take a closer look just at the overview of those distinct sections that we just discussed.

So a CBR starts with this kind of introductory letter that has information about what the CBR is and how it affects you as the provider. And then you can see we start out, it tells you the title of the CBR so you know where you stand with what you're reading. And then we can see here the introduction again gives an overview of the information that was analyzed in the CBR, the coverage and documentation overview can take a look at any — at the — excuse me, the CPT codes that were analyzed and used, and the coding of those CPT codes. In this case they are evaluation and management codes so you can see that we looked at the history, the exam and the plans when you are choosing your code documentation.

And then we have basic coding guidelines. So again, for this sample CBR and for this specific CBR, we're looking at evaluation and management codes. So this table and this section of the CBR is just a refresher on the descriptors of those specific CPT

codes for office visits. So you can see here the new and established patient visit codes and their descriptions and their components.

And again, here's just a little bit more information about the coding guidelines and the selection of codes.

You'll see here in Table 2, this is an overview again of sample data for this provider that shows the allowed units, the allowed charges and the beneficiary count. And we'll get a little bit more into this table in a few more slides, but this just kind of breaks down the data that is for the CPT codes that we just reviewed.

And the metrics section does have a detailed description of the metrics that were analyzed. And again, we'll go through those one by one very soon.

And then it has a list of the outcomes that can come from those metric analytics.

And then finally the numbers — not finally, but then we have the methods and results which shows of the analytics and of the data that the CBR team has analyzed, this shows an overview of those findings.

And then as I promised, here is a little bit more detailed section about each metric. So in this CBR each metric is broken down into several calculations. Again, we'll go over all of this a little bit later.

But just to get a good look at what a CBR looks like.

I apologize, it's at the end of this page here we can see kind of a written calculation of how this metric is calculated. And then here following that we have a table that shows the — this provider's results of those calculations for that metric.

And then that's repeated for the second metric here. You have Metric 2. Again, it's followed by the table with the results. Metric number 3, the calculations are spelled out and then you have the table with the results.

And then there's a nice figure here with a trend over time that's still part of that metrics section. And then we have our references and resources.

So again, we'll probably go over — we'll definitely go over some other sections of that CBR, some specific sections of that CBR, but I think it's a good idea to just take a look at the overall CBR, see what we're looking at.

To begin our specific review of the sections of the CBR, let's discuss the very basis of the topic, evaluation and management, office visits for new and established patients in the family practice setting.

We all know the E and M codes are created to support face to face encounters. The encounters within an office setting are split into new patient visits and established patient visits. The criteria for a new patient states that the patient has not received services from the physician or another physician in the group within the last three years.

The claims processing manual instructs us to select the code for the service based upon the content and the level of service. And in order to do so, five codes are assigned to each group of office visits.

The codes for new patient office visits are represented by 99201, 99202, 99203, 99204 and 99205.

The established patient office visit encounters are recorded with codes 99211, 99212, 99213, 99214 and 99215.

So during this webinar when I reference a new or established patient visit, these are the codes that I will be referencing.

Let's take a closer look at the specific focus of this CBR as it relates to family practice encounters and the specific codes used to report new and established patient office visits that are analyzed within this report.

As you know, the focus of this CBR is a review of statistics for providers who submitted Part B claims for evaluation and management visits for new and established patients in the family practice specialty.

More specifically, the CBR analyzed claims submitted with codes 92204, 99205, 99214 and 99215, so levels four and five of the newly established patient code. And the relationship to those codes as compared to the submission of all new and established patient E and M codes.

As we reviewed earlier the CPT book classifies evaluation and management codes into different sections. The proper code that corresponds with the level of service provided to the patient is complicated and it requires a thorough review of the documentation and classification of the history, exam and medical decision making.

The documentation for each section of the record is classified as problem focused, expanded problem focus, detailed or comprehensive.

So let's take a closer look again at table 1 of the sample CBR and you can see that the table lists the requirements for each office visit and each E and M code.

So you can see here that the codes are selected all the way from a problem focused history in 99201 and 99212, all the way to a comprehensive history and exam and medical decision making in 99205 and 99215.

So again, this is just a review of the E and M codes and how each code selection is made based on the documentation of the history, the exam and the plan for the medical decision making.

The 2018 Medicare Fee-for-Service Supplemental Improper Payment Data Report showed a total of over $1 billion combined, projected improper payments for new and established patient office visits. This report also tells us the reason for these projected incorrect payments. For both new and established patient encounters, the largest percentage of errors were due to incorrect coding.

Looking even closer at the projected improper payments due to incorrect coding for both new and established patient encounters, we can see 86 percent for new patients and 66.4 percent of projected improper payments for established patients were due to incorrect coding.

We all know how difficult it can be to keep up with documentation requirements and coding guidelines, especially with evaluation and management coding.

But we can see here how serious the improper payments can become when documentation does not support patient billing.

Let look at the vulnerability specifically for the family practice specialty.

The same report also shows us specific data to closely look at specifically the family practice encounters.

And the overall improper payment rate for family practice encounters is over 13 percent, which represents a total improper payment of over $727 million.

So obviously that's a very large number, especially when you think about this is only one specialty, this family practice. So that's a portion of the over $1 billion that these codes represent.

And most of these improper payments are due to incorrect coding, but insufficient documentation was also partly to blame. You can see here that 27.5 percent of projected improper payments are due to incorrect coding, while 61.7 percent of the projected improper payments are due to insufficient documentation.

Again, we can see what a huge part of the payment process is contributed to documentation incorrect coding.

After analyzing all this overall data, the CBR team was tasked with looking at the providers who submit claims under the family practice specialty and more specifically the claims for E and M codes under that specialty as well.

In order to get detailed information for these providers who were billing family practice E and M services, the CBR201902 was created. It summarizes a year of services of October 1, 2017 and September 30th, 2018. The statistics and analysis showed 80,636 providers who submitted claims containing the E and M codes for new and established patients. Identifying a specific date range, a specific CPT code range and the family practice specialty helps to get granular detail about the projected improper payment rates and that over $727 million in projected improper payments.

So if we drill down even further from the family practice services to the E and M codes, we can take it one step further by isolating the level 4 and level 5 E and M codes that we talked about before, 99204 and 05 and 99214 and 15.

This can help us to take an even closer look at the improper payment rate and where the outliers might live.

Now that we're familiar with the analysis that was completed within the CBR and before we take another look at the sample CBR, let's also look at why you may have received a CBR.

A CBR is presented to a provider when the analysis of their billing patterns differ from the provider's peers on a statewide or nationwide level.

It is important to always remember that receiving a CBR is not an 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 up that analysis. An outcome of significantly higher indicates that the provider's value is above the 90th percentile from the state peer or national mean.

And we'll talk a little bit more about what that 90th percentile means on our next slide. An outcome of higher shows the provider's value is greater than the state peer or national mean. An outcome of does not exceed indicates that the provider's value is not higher than the state or peer national mean. And an N/A outcome represents that the provider does not have sufficient data for comparison.

Let's discuss what being above 90th percentile actually means because it really is important to idea the true meaning so that you can fully understand the meaning of the outcomes listed in your CBR.

The other outcomes are relatively self-explanatory, but the significantly higher outcome is a bit more involved than the others.

In order to identify the providers who were above the 90th percentile, we calculated percentiles for all providers for each of the metrics in each comparison group, the peer, date and nation.

To calculate the percentiles, we ordered all of the providers' percent values from highest to lowest. And if you can imagine those percentiles being listed on this ladder that you see here on the right of the slide, with the highest value percentiles at the top and then going down in numerical order descending so that the lowest percentile value is down there on that bottom rung.

Next we identify the percent value below which 90 percent of the providers' values fall. And that is the 90th percentile mark. And you can — or excuse me, the 90th percentile mark, which is represented again on the ladder figure with that black line.

Any providers whose percent value is above that point are above the 90th percentile and are identified as being significantly higher for that metric in their CBR as compared to the state and/or nation.

So therefore if you are above that 90th percentile, your results are very different from those of your peers. 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 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.

Again, a CBR is presented to you because your billing patterns differ from your peers patterns on a statewide and nationwide level. However, the criteria listed here also weighs in as to whether or not your data is included in the analysis and the results and whether or not your results qualify for the receipt of a CBR.

To receive a CBR all three of these criteria must be met. The family practice provider must have at least 50 beneficiaries with claims submitted for codes 99201 through 99205, or at least 50 beneficiaries with claims submitted for codes 99211 through 99215. And the provider's results must be significantly higher in any one of the twelve metrics, that's over the 90th percentile that we just discussed. And the provider must

have at least $10,000 in total allowed charges per type of visit for new or established patients.

It is important to identify that your results do not need to have a significantly higher outcome in all twelve metrics or even in more than one metric.

As long as significantly higher is the result of one of the metrics and you meet the other two criteria, you will receive a CBR for review.

Also it is also important to note that the charges that are filed must meet or exceed $10,000 in allowed charges. This dollar amount is drawn not from the billed amount, but from a total of the charges submitted according to the Medicare allowable amount that is assigned to each of those codes. As we all know, the billed amount will exceed the allowable charges so we want to point out that the criteria here is for Medicare allowed charges.

To help us fully understand this CBR, its outcomes and comparisons, let's take one more much closer look at the sample CBR. We'll look at the metrics, the findings, the methods and results, and provider findings for this CBR.

The results of this CBR will of course differ from those on your CBR if you received one, but the formatting and the sections will be consistent with the layout.

As we discussed earlier, the CBR team found over 80,000 rendering providers nationwide with allowed charges for CPT codes for new and established patient office visits with a quantified allowed amount of over three billion dollars during the time frame of service dates October 1st, 2017 through September 30th, 2018.

You'll see here a list of the metrics that were analyzed in the CBR. So the first metrics shows the percentage of allowed units for levels 4 and 5 for new and established patient evaluation and management encounters. The second metric is the percentage of the allowed amount submitted with new and established patient evaluation and management code levels four and five. And finally metric three shows the percentage of beneficiaries that received level four and five service codes for both new and established patients.

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 CBR.

Each of these metrics contain quite a bit of information, so understanding the calculations and analysis of the data is imperative to understanding the information on your CBR.

And at this time I would like to switch back to the sample CBR and take a look again at table 2.

So now that we've had a brief overview of the metric, we can get a little bit of a better understanding as to why these specific data points are listed on this table two of this CBR.

So these are all — these are allowed units. We see allowed charges. And then the beneficiary count for each of the new and established patient code.

So this is an overview for those data points for this provider. And it's good to have an overview and then get down to the nitty-gritty, like I said, with each of the metrics. So let's get back to looking at those specifically.

In order to take a specific look at the findings of the CBR, as I said before in our reviews, the CBR will contain a series of tables as well as the explanation for how each metric is calculated.

So let's start with metric 1, allowed units, which shows the percentage of allowed units for new and established patient visits levels four and five. The allowed units in the context of this metrics refers to the units assigned to an E and M encounter on a date of service. On a claim form the number of units assigned to an E and M visit will be, “one,” used to signify that only one E and M encounter was performed. So for this reason the CBR team does use the term allowed for the unit and in this case that unit equals one.

Because the calculations are made to analyze the submission of each of these four codes, there are several calculations explanations listed. And again, we'll take a moment in a minute to look at the sample CBR table 3, but let's take a look at the metric calculations first.

To begin review of the data analysis, let's look at code 99204 and 99205 first. The CBR team calculated for each provider the units submitted for 99204. That is the number of times the code 99204 appeared on a claims submission for the analyzed time frame.

This total number was then divided by the total of all submissions for all codes for new patient encounters. This calculation shows us out of all new patient encounters, what percentage of those were 99204 level four visits.

And then this calculation is replicated using the claim submission of code 99205 in the numerator, which shows us out of all the new patient encounters what percentage of those were 99205 level five visits.

Still in Metric 1, we can move next to the explanation of the calculations for established patient visits. The same calculations were used as with the new patient encounters. The units submitted for 99214 were divided by the total of all submissions for all established patient encounter codes.

And again, this calculation shows us out of all the submissions for established patients, what percentage of those were 99214 level four visits.

This calculation is again replicated using the claim submissions of 99215 in the numerator, which again shows us the percentage that level five visits represent.

So let's take a look at table 3 of the sample CBR which represents the findings of the calculations for both new and established patient visits that we just looked at.

So let's flip back over to the sample CBR. And we can see here as promised the table with the analysis. So you can see your CPT codes are listed there on the left, and let's take a look at 99204 just as an example.

We have all the data that was used in the calculation written in this table as well as the results.

So for 99204 we have the allowed units for this sample provider and then we have the total units for new patient visits because 99204 is a new patient visit.

And then we have the calculation, this provider's percentage of 99204 visits was 94.7 percent. So compared to that state percent and the national percent, which are right around 33, 36 percent, this provider's comparison was significantly higher.

And if you kind of skip down two rows to the 99214, you can see a similar trend for level four patient visits for established patients as well. The allowed units are listed there and as compared to the total units for established patient visits, this provider submitted 95-point — submitted 99214, 95.6 percent of the time out of all the established patient visits.

So their state percentage as a comparison was 42.3 percent. The national percent was 53 percent. So again, they are significantly higher as compared to state and national for those calculations.

And it's going to come up again, but — so I'll go through 99205, this provider had zero allowed units. They never billed a 99205. So again, the new patient visit total is the same as was above with 99204. And of course, with a zero in the allowed units, their comparison for 99205 does not exceed the national or state average.

And then they do have very low numbers as well for 99215, they only submitted that four times, which comes out to less than one percent, and that does not exceed the state or national percentages again.

It's kind of nice to have the table that spells out the calculation — the results of the calculation that we just went over.

Moving on to metric 2, which is allowed amount. This metric shows the percentage of the allowed amount for levels four and five for new and established patient visits. So first we did units and now we're looking at allowed amounts.

Again, we'll first look at the calculations and then review the table.

The calculations for this metric is very similar to that of Metric 1, the CBR team looked at the allowed amounts submitted for the code 99204 and divided that figure by the total allowed amount for all new patient visits. This shows the percentage of allowed charges for 99204 in relation to all the charges submitted for new patient visits.

As in Metric 1, this calculation is replicated using the claim submission of code 99205 in the numerator.

As we did in Metric 1, we can look again at the calculations for established patient visits as well. The same calculations were used as with the new patient encounters, the allowed amount for 99214 was the allowed the amount for all allowed patient codes submitted during the same time period.

This calculation is replicated again using the claim submission of 99215 in the numerator.

To look at the table for these results let's look at table four of the sample CBR.

So here again we have our CPT code listed on the left-hand side and instead of units now we have that allowed amount. And we saw in the last table that the units for 99204 and 99214 were relatively high, so it stands to reason so is the allowed amount that was submitted.

And as we can see with 99204, the total allowed amount for 99204, the submission for that code was 96.5 percent. So again, compared to the state average of 34 percent and then the national average of 37, those comparisons are going to be again significantly higher. The same with 99214. That percentage of the allowed charges percentage for that vote for this provider is almost 97 percent.

And compared to 54 and 60 percent, those comparisons leave this provider with significantly higher results.

Again, 99205 is going to have a zero dollar amount and the 99215 has a smaller $587, and that does leave him very low in their percentage analysis so they do not exceed the state and national averages here. Or excuse me, comparisons.

Finally, let's look at metric three, which analyzes the number of beneficiaries that received level four and five services within the time frame.

This metric shows the percentage of the beneficiaries who received higher level encounters. Again, we'll first review the calculations and then look at the table.

In metric three, the number of unique beneficiaries that received a level four encounter is divided by the number of unique beneficiaries who received a level of care that was submitted with a new patient encounter.

The calculation is then replicated for level five new patient visits, code 99205.

When we're looking at the analytics and we're discussing metric three and its calculations, it is important to keep in mind that in this calculation we are discussing unique beneficiaries. So the total beneficiaries of the overview in table 2 that we looked at will mostly not match the total for the denominator of this metric, in particular for established visits.

A beneficiary can be counted multiple times in table two. Again, that was an overview of the whole year time frame. If that beneficiary received varying level of care on several dates of service.

In table two the beneficiary is counted for each level of service, but in the calculations for this metric, the beneficiary is treated as a unique number and they're only counted once in the values for the numerator and the denominator.

So just wanted to point out that detail.

And finally, still within metric three, the number of unique beneficiaries that received a level four established patient encounter is divided by the total number of unique beneficiaries who received a level of care that was submitted with an established patient encounter code.

Again, we replicate for level five with the established patient codes, established patient visits with the 99215 in the numerator.

So let's look at table five of the sample CBR so that we can take a look at this specific table.

And again, it's very similar to the other tables as the calculations are rather similar, but we have our CPT codes there on the left.

Let's look at 99204. This provider had 1048 unique beneficiaries who had a code of 99204 submitted. They had a total number of unique beneficiaries of 1107.

So the percentage of unique beneficiaries, and in this case for this provider, ends up being almost 95 percent. Again, significantly higher from the state and national percentages that are hovering right around 30 percent there.

And again, you can see it all kind of adds up. 99205 there were zero number of beneficiaries that received that level of service.

99214 is — they had 1080 unique beneficiaries and then for all established patients they had 1115 unique beneficiaries, which again puts them almost at 97 percent and significantly higher than their initial and state comparisons.

Here we can see the last data graph that is listed in the CBR is figure one, and I just copied it from the CBR so we don't have to go to the sample one to see it. But this is the percentage of beneficiaries at service levels four and five, trending over time.

So you can see here year one, year two, year three, they're all the years October through September from 2015 through 2018. So you can see this specific provider, their trend for 99204 in blue on the left-hand side hovered basically between 30 and 40 percent. And then 99214 on the right-hand side in blue again hovers right around 60 percent.

And as we saw in the data in the calculations and in the tables, 99205 is a much less used, less frequently used code for this provider. So you can see on the left-hand side for new patient visits and for established patient visits actually they're both well under 10 percent for all three years. So they're both under 10 percent for all three years.

So it's kind of nice to take a look at three — two or three years to kind of get an overall view of the trends of the submissions for each code.

We'll talk a little bit about how to access your CBR. You can go to CBRfile.CBR PEPPER.org and we have a screenshot here of what that page looks like. We do ask that you certify the role that you play in your organization, fill out your information and your provider's information. We like to know how you learned about the CBR for our data and our trending. We can — we ask you to enter the provider's NPI number. And if you receive a CBR you will receive a validation code with that information so

you'll enter that validation code, hit submit and a PDF of your file will be available to you.

You can also go to CBRPEPPER.org and click the access your CBR button, which you can see here there's a big purple arrow pointing to it. That takes you to this page again, and again, you're just asked to fill in the same information.

Some helpful resources, we do have the CBR Help Desk. CBR.CBRPEPPER.org/help-contact-us. So that will take you here. Again there's a screenshot. This is the CBR Help Desk support page. You can submit a new help desk request or you can go to — to the Help Desk request or go to frequently asked questions. I tell people to go to the frequently asked questions first because there may be something there that can help you before you have to submit a new Help Desk request and wait for a response.

We are rather quick with our response if I do say so myself, but it's easier if the frequently asked questions can help you.

We do have some more helpful resources listed here. That Medicare Fee-for-Service supplemental improper payment data report, there's a link to that.

The CMS evaluation and management services manual. And then of course the tried and true claims processing manual, chapter 12, section 30.6, discusses office visits.

So going back to CBR.CBRPEPPER.org/home, that has a wealth of resources listed there. That is our homepage. And it has a sample CBR. There's training materials. There are resources and references that are listed in that CBR, the sample CBR that's listed there.

You can join our mailing list so you can get updates. We would love for you to provide any feedback about CBRs. And if you have a success story about how CBR helped you, we would love to hear it. So you have the ability to submit any of that information on that page as well.

And that page looks a little something like this. This is a screenshot. And you can see down there in the corner, the left-hand corner there is this CBR office visits for new and established family practitioners.

This is a screenshot of the frequently asked questions page, CBR.CBRPEPPER.org/FAQ. And just take a look at these FAQs. There might be something here that can help you, I have a question about my claim, I did not receive a CBR or can I request one? Why am I getting this report? What is a CBR? There's a wealth of information here.

All right. Well, thank you all so much.