Transcript for the CBR201903: Subsequent Hospital Care
April 11, 2019

Welcome to today's Webinar where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, CBR 201903 Subsequent Hospital Care. My name is Annie Barnaby and I work for RELI Group Inc., who is contracted with the Centers for Medicare and Medicaid Services, CMS, to develop, produce and distribute CBR reports.

The objectives of today's Webinar will be to understand the purpose and use of Comparative Billing Reports or CBRs, to explain the function of this specific Comparative Billing Report CBR 201903, subsequent hospital care, 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 is. Then we'll go into a discussion of this CBR and the details of the CBR topic, subsequent hospital care. I do have a sample CBR that we will review so that we can get a good sense of what you're looking at when we review a CBR. I will show you how to access your CBR. I will show you some helpful resources, should you have any questions following the webinar, and then finally I will answer any submitted questions as time allows. 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 Comparative Billing Report. 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 improvement. A CBR is truly what the title says, a report that compares providers on a state or specialty and nationwide level and summarizes one provider's Medicare claim data statistics for areas that may be at risk for improper Medicare payments, 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. In 2018 CMS combined the CBR program with the PEPPER program, which is the Program for Evaluating Payment Pattern Electronic Reports, and they put both of those programs under one contract. And then in 2019, RELI Group has partnered with TMF and CGS to create and distribute CBRs and PEPPERs.

So why does CMS issue CBRs? Well, CMS is mandated and required by law to protect the trust fund from any improper payments or anything else that may 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 CBR process to be an educational tool that supports their efforts to protect the trust fund.

CBRs serve several purposes on the provider side as well: The CBR program helps to support the integrity of claims submission and the adherence to coding guidelines. This helps to encourage correct clinical billing. 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 closer look at specific coding guidelines and billing procedures can increase education and improve future billing practices.

A CBR is formatted into six sections, which help to focus on the process and the results of the CBR. Let's take a look at the sample CBR that I have loaded as we review each of these sections.

The introduction of the CBR is a brief explanation of the specific billing area addressed in the CBR, and a description of the findings of the CBR. You can see that right here, right at the top where it belongs. The coverage and documentation overview identifies claims data and reviews basic CPT code information. You can see here that the subsequent hospital visits were analyzed in this CBR, and this section discusses the specific specialties and CPT codes that the CBR team looked at. So that continues -- that section continues down until we reach the section covering Basic Coding Guidelines. In this section we're provided with a more detailed description of the CPT codes and the correct billing processes. And the table that you see here, table 1, shows detailed descriptions of the CPT codes for subsequent hospital care.

The metrics section of the CBR, as you can see here, lists and explains the metrics that were identified for the CBR analysis and the explanation of the outcomes for the comparison data.

Moving along to the methods and results section, this section details the number of providers identified, the date range, and the criteria that must be met for a provider to receive the CBR. And this section also goes into detail about each metric, the calculations, and the provider results. You can see that section starts on this page and continues. Here you can see Metric 1. There's an explanation, and we'll go into this in a little bit more detail as we move through the presentation. But there is the description here, the calculation, and then a table with the specific provider's information and results. And that continues for Metric 2. And then finally with Metric 3. Description, calculation and results.

And then finally the references and resources section lists any reports or documents used for the creation of the CBR, and those created to help you as you have any questions about the specific report.

To begin our more in-depth review of the sections of the CBR let's discuss the very basis of the topic, subsequent hospital care. Let's take a closer look at the specific focus of this CBR as it relates to subsequent hospital care and the specific codes that are analyzed within this CBR report.

As you know, the focus of this CBR is a review of statistics for providers who submitted part B claims for subsequent hospital care encounters. More specifically, the CBR analyzed claims submitted with codes 99231, 99232, and 99233, the relationship of each of these individual codes to the total of all submissions for this entire code set, and the relationship of code 99233 services in relationship to the date of discharge for those patients who did receive a 99233 service.

The CBR team identified the clinical specialties in which the highest number of providers submitted claims for CPT codes 99231, 99232, and 99233 between November 1, 2017 and October 31, 2018.

These clinical specialties, except internal medicine and psychiatry, were selected. The internal medicine and psychiatry specialties were removed from this data analysis due to recent CBRs that focused on these specific specialties -- excuse me -- and we really do our best to review and analyze as wide a range of specialties as possible.

The clinical specialties that remain, the top specialties for the purposes of this CBR, are listed here.

As we discussed earlier, subsequent hospital care is reported with codes 99231, 99232 and 99233, and those codes are assigned in a similar fashion to almost all E&M codes, by reviewing and classifying the documented history, exam and medical decision-making. I would like to go back to the CBR really quickly to take a look at the codes and the code descriptions that are listed here, because what's unique about the subsequent hospital care codes, as you can see in the code description, is the inclusion of the patient's response to therapy and the typical amount of time spent with the patient or on the floor or unit dedicated to the patient. These added descriptions can help providers and coders to get a sense of the status of the patient according to each level of care per code.

Now that we've reviewed the code set for subsequent hospital care, let's talk numbers. Payment numbers, to be exact. The 2018 Medicare Fee-for-Service supplemental improper payment data report, showed projected improper payment rates of 21.6 percent for code 99231, a 7.9 percent for code 99232, and 19.1 percent for code 99233. We can use the knowledge of the code set that we just reviewed to get a sense of what we're looking at with the improper payments, that code knowledge can help us to understand what was paid incorrectly.

These payments -- excuse me, these percentage rates represent over $621 million in projected improper payments, 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 codes are potentially assigned incorrectly.

In order to get detailed information for those providers who were billing subsequent hospital

care services, the CBR 201903 was created. Again the CBR summarizes a year of dates of service, the year between November 1, 2017 and October 1 -- 31st, excuse me, 2018.

The statistics and analysis showed over 158,000 providers who billed the subsequent hospital care code set. Identifying a specific date range and a specific CPT code that isolates these services helps to get granular detail about that portion of those over $621 million in improper payments.

So we have drilled down to identify the top specialties that we reviewed and a specific date range of claims data. The CBR 201903 analyzes that data based on the version of claims as of March 1, 2019.

Now that we're familiar with the analysis that was completed within the CBR let's take a look at why you may have received the CBR or this analysis of subsequent hospital care.

A CBR is presented to a provider when the analysis of their billing patterns differs from the provider's peers in their specific specialty or on a nationwide level. And it is important to always remember that 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 out 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.

An outcome of higher shows that the provider's value is greater than the specialty peer national mean.

An outcome of does not exceed indicates that the provider's value is not higher than the specialty peer or national mean.

And an N/A outcome represents that the provider does not have sufficient data for comparison.

Let's discuss what being above that 95th percentile actually means because it's important to understand the true meaning so that you can understand fully 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 95th percentiles we calculated percentiles for all the providers for each of the metrics in each comparison group. To calculate the percentiles we first ordered all of the providers' percent values from the highest to lowest, and if you use this picture of a ladder here and imagine that we listed the percentiles with the highest percentile up at the top of the ladder and then listing them in a descending order so that the lowest values are down near that bottom rung it can give you a visual picture of the

percentile. Next we identified the percent mark below which 95 percent of the providers' values fall. This is the 95th percentile mark represented above on that ladder picture with 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 their specialty and/or the nation.

We send these reports to allow for comparison among your peers and to offer an opportunity to see that your results, in one of the metrics, varied greatly from those of your peers.

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

Why did I receive a CBR? Well, the criteria here determines your qualification for inclusion in the analysis and whether or not your results qualify for the receipt of a CBR. To receive a CBR all three of the criteria listed here must be met. Your results must be significantly higher in any one of the metrics, and you have at least ten beneficiaries with claims submitted for any of the codes, 99231, 99232, or 99233, and you have a total allowed charges of $2,000 or more for claims submitted for any of those codes: 99231, 99232, 99233. It's important to identify that your results do not need to have a significantly higher outcome in all of the 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 important to note that the charges that are filed must meet or exceed $2,000 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 those codes. As we all know, the billed amount can exceed the allowable charges, so I just want to point out here that the criteria is for Medicare allowed charges.

To help us fully understand the subsequent hospital care CBR, its outcomes and comparisons, let's take a closer look at the sample 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 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 of this sample CBR.

You'll see here a list of the metrics that were analyzed in the CBR. The CBR reviewed: First, the percentage of beneficiaries that were discharged within one day of a CPT code 99233 service.

Second, the average allowed minutes per encounter.

And third, the percentage of total services billed as CPT code 99233.

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.

Beginning with Metric 1, the percentage of beneficiaries discharged within one day of a 99233

service. This metric was calculated in two steps. First, the CBR team identified any beneficiary who received a Level 3 subsequent hospital care service, 99233, within one day of a discharge. Those discharge codes are submitted with codes 99238 or 99239, and if a patient had a date of death on file, then the beneficiary was not included in the analysis. Those beneficiaries who did receive a Level 3 subsequent hospital care service within one day of a discharge were flagged.

Next, the CBR team completed the calculation shown here. We divided the number of unique flagged beneficiaries by the number of all unique beneficiaries who received CPT code 99233. When we use the word "unique" in the description of CBR calculations we mean that a beneficiary is counted just once, regardless of how many services the patient received during the data pull.

This calculation has such a widespread effect on patient care and how providers perceive their level of care. If you'll remember, CPT code 99233 lists the patient condition that is, quote, "unstable or has developed a significant complication or a significant new problem." The CPT code descriptions are not exact, of course, but that wording gives us a suggestion as to the health and the status of the patient, and it can be helpful to see how the discharge data plays into the assignment of this code 99233.

Going back to the sample CBR, take a look at Metric 1. You can see here that this provider had -- excuse me. Sorry, let me scroll on down so that you guys can see the table, Table 3. You can see here that this provider had 21.1 of their beneficiaries who received a Level 3 subsequent hospital care code within one day of a discharge code. The provider's specialty had an overall percentage of 22.5, and the national average is around 26.1, so this provider had an outcome of does not exceed for this metric. And remember that significantly higher only has to be the outcome of one metric to qualify a provider for the receipt of a CBR. So even though this provider did not have a significantly higher outcome for this metric, he did in one of the other two.

Moving on to Metric 2, the average allowed minutes per encounter. Metric 2 also requires two calculations to arrive at the final figure. Metric 2 examines the typical minutes spent with a patient. Again, going back to the CPT code description, a suggestion for the amount of time spent with a patient is listed for each code. The CBR team multiplied the listed minutes by the total allowed services for the code. This gave us the total weighted services, which was in turn divided by the total number of encounters.

This metric is really fascinating that we can get down to this level of specificity to take a look at provider care. It's really amazing. And the results of this metric are also valuable as a provider looks back at the time spent with patients, when that provider is giving subsequent hospital care.

To take a look at the sample CBR. Here we see Table 4 for this sample provider for the second

metric, and the calculations show that the provider spent an average of 75.9 minutes per encounter. The specialty outcome is 41.7 minutes, while the national average is 39.6 minutes. We can see that this provider does have a significantly higher outcome for this metric as compared to the national average but only a higher outcome within the specialty comparison.

Finally we arrive at Metric 3, the percentage of total services billed as CPT code 99233. Now, this metric's calculation is performed by dividing the number of allowed services with CPT code 99233 by the number of services with CPT codes 99231, 99232 and 99233. This calculation is rather straightforward compared to the other two metrics.

And if we go back to the sample CBR, we can see on Table 5, the providers' results for this final metric, and we can see here that this provider billed 100 percent of their subsequent hospital care as a Level 3, Code 99233. So compared with the specialty percentage of 29.6 and a national percentage of 30.7, this provider of course has a significantly higher outcome for both comparisons of this metric. Again, this provider can look at these results and see this very high percentage of encounters that were submitted with the highest level of care available for subsequent hospital care. And this information can allow for review from not only their -- the provider, but from their billing and coding staff.

Let's take a step back to look at the big picture for each of the subsequent hospital care codes. You can see here that code 99231 was billed on 9.95 percent of claims, code 99232 was billed in 58.54 percent of claims, and code 99233 was billed in 31.51 percent of claims. Using the specific results of your CBR in conjunction with these figures here can offer another valuable comparison regarding this code set.

This provider trend graph that's listed here is also listed in the CBR, and you can see here that it displays the trend over time of total number of beneficiaries with subsequent hospital care codes. This particular provider had a jump in beneficiaries in year 2, as you can see, and then in years 1 and 3 this provider remained right around the 110 beneficiary mark.

Let's take a look at how you can access your CBR if you received one. You can go to the page listed here, which is cbrfile.cbrpepper.org; you'll see a screenshot of the page on this slide. You'll be asked to input some information when you arrive at this page, and we do ask that you certify your role in the organization, input your information and the provider's information, answer how you learned about your CBR, and your provider's NPI number. When you receive notification that you have a CBR on file, a validation code is given to you. You'll input that validation code there at the bottom of the page, and when you click “submit,” a file of your CBR will come up for your review.

This page, cbrpepper.org, is another page that you can go to to access your CBR. If you click on the access your CBR button, highlighted here with the purple arrow, you'll be directed to the page that we just reviewed and you can begin the steps that we just covered. This page is just

another way for you to navigate to the CBR access page.

We have a helpful resources page located at cbr.cbrpepper.org/help-contact-us. On this page you'll find frequently asked questions link and a link to submit a new help desk request. I always encourage people to review the frequently asked questions page before submitting a help desk ticket because those frequently asked questions may be able to answer your inquiry without having to submit a help desk request.

These helpful resources are the documentation and reporting that the CBR team used in the creation and the analysis of the CBR. You'll see here the link for the Medicare Fee-for-Service supplemental improper payment data report link, a link to the claims processing manual, and a link to the Medicare program integrity manual as well.

Our home page, cbr.cbrpepper.org/home, has a wealth of resources and links that can help with you any CBR inquiries that you may have. We have a sample CBR listed there, training materials, the resources and references that are within the sample CBR. You can join our mailing list to stay up-to-date on any announcements. The page has a link to provide feedback on the CBRs, and we would love for you to submit a CBR success story so that we can hear how the CBR process worked for you and your organization.

This is a screenshot of the home page that we just reviewed, and you can see the links here on the page. Some of them are on the bottom left-hand side. This has the links for our first CBR of the year, but you can see there that there is a link for the sample CBR, the statistical debriefing, the register for this Webinar. The data that was included, and then the access your CBR link.

The frequently asked questions page, cbr.cbrpepper.org/FAQ, contains the frequently asked questions that I mentioned a few slides ago. And this page has links to answers to various questions that you can see here: What is a CBR? Why am I getting this report? I have a question about my claims. Who should I contact? How will I know if I have a CBR available? And you can just simply click on the question and the answer will populate. This list has really proven helpful to many people who have questions about the CBR process, and I think it can help all of you with any questions that you might have.