Transcript for the CBR201906: Emergency Department Services
June 11, 2019

Hello everyone. Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and, more specifically, CBR201906, emergency department services. My name is Annie Barnaby, and I work for RELI Group, Inc., who is contracted with the Centers for Medicare and Medicaid services, or CMS, to develop, produce, and distribute CBR reports.

The objectives of today's webinar will be to understand the purpose and the use of Comparative Billing Reports, CBRs, to comprehend the function of CBR201906 Emergency Department Services, to gather resources for further inquires and questions. So let's get started.

Our discussion today is going to cover the following areas. First we'll talk about what a Comparative Billing Report or CBR is. Then we'll go into a discussion of this CBR and go through the details of the CBR topic, Emergency Department Services. I will show you how to access your CBR. I do have a sample CBR that we will review so we can get a good sense of what we're looking at. I will show you some helpful resources should you have any questions following the webinar. And then finally I will submit any submitted questions as time allows.

So what is a CBR? Well, a 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 and nationwide level and summarizes one provider's Medicare claims data 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.

And 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, and then 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.

Then in 2019, RELI Group has partnered with TMF and CGS to create and distribute those CBR and PEPPER reports.

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 those funds. 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.

And 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. And this helps to encourage correct clinical billing. Because any early detection of any outliers in your billing processes can help 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.

Now that we're familiar with the value of the CBRs, let's take a look at why you may have received a CBR for this analysis of emergency department services.

A CBR is presented to a provider when the analysis of their billing patterns differs from the provider's peers in their state or on a national — nationwide level.

And it's always important to remember that receiving a CBR is not in any way an indication of or a precursor to an audit.

This page cbrfile.cbrpepper.org contains the portal that you'll use to access your CBR if you received one. The portal does require to — excuse me, require that you enter some information and I'm actually going to open this page on my screen to show you exactly what it looks like when a CBR is accessed from the portal.

Let me share this file here.

All right. First we'll indicate the role that we play within the health care organization for the physician or the physicians who received a CBR. I'm going to indicate that I am an administrator of the organization. I'm just going to click here. By doing so I'm indicating that I have the authority to receive the CBR information and that I understand that I am authorized to view this confidential information.

Next I'm going to complete these two forms to indicate my information and the provider information. I'm accessing a test CBR so of course I'll use test data to complete these forms, but you'll use the correct information obviously here to complete your forms.

[Completing form]

They just ask that we enter this information obviously about the provider, where they're located, the state, and then information about you so that we can contact you as needed.

So following these forms, you'll see a list here that indicates how we heard about the CBR that

is available to the physician or physicians. In this section of the access form really is most telling to us at RELI Group and really helps us to know which form of alert is working best to reach the most physicians for their CBR alerts. And we're just going to go down through each one very quickly so we can understand each one. The first two, received an email or fax, this would be an email that came to the account that is listed in the National Plan and Provider Enumeration System, the NPPES system. We do use the email, fax, and address information that is listed there to send CBR information. We first send to the email address and then the fax number and then, if necessary, to the physical address listed there. And we do encourage everyone to confirm that NPPES system information and update it if necessary so we can contact the appropriate person regarding CBR information. We know that often times an employee maybe listed in that system. Sometimes those employees leave the organization or something else happens that causes that email address or other contact information to be to become incorrect. So just logging into that NPPES system and confirming this information several times a year allows for the email to stay up to date and lessens any issues that may arise otherwise. I'm going to say I received an email notifying me that I had a CBR.

Next on the list is an indication that you saw a tweet we sent out about the CBR program. We do tweet about the CBR releases and about these webinars. So if you saw the tweet and that led you to check out the CBR program, we would love to know that.

The next two entries, provider or professional association or MAC notice, these are indications of our work alongside the groups and the MACs that are so supportive of provider billing and information distribution. And we are very appreciative whenever MACs are involved in spreading the word about the CBR program, and similarly when a professional association recognizes the importance of the CBR program and the information that we distribute.

We then have the Open Door forums led by CMS if you heard about the CBRs through one of those forums please let us know.

And we do have two alternative options, other or none of the above. If those — either of those apply to you, of course please indicate as such.

So, we've reached the bottom of the form where it's going to ask for the provider's NPI number. This will be the NPI for the specific practice — excuse me, specific provider that is receiving the CBR. And if you are in a position of having several providers who received a CBR, we can help with longer lists of NPI numbers through our help desk ticket system. You can submit a help desk ticket and a representative will contact you to arrange for access to a longer list of CBRs. So I'm going to put in a dummy one here. Okay.

And then finally we have the validation code. When a provider receives an alert that they have a CBR on full, validation code is included with that alert information. So, again, check the email that may have been sent to the contact information in the NPPES system or check on the

mailed alert or faxed alert to confirm your validation code. If you're sure that the provider was issued a CBR but you're unsure of the validation code, please submit a help desk ticket and we can assist with that as well.

I'm going to complete the form here and hit "submit." And here we have the sample CBR that appears. And your CBR will appear in the same fashion, in a PDF format ready for your review.

This page that is screenshotted here is cbrpepper.org, and this is another page that you can use to access your CBR. If you click on the access your CBR button highlighted 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.

Now, that we've accessed the sample CBR, let's take a closer look at the formatting and information contained inside that report. And I happen to have the sample CBR loaded right here. Now, the results shown on this CBR will of course differ from those on your CBR if you received one, but the formatting and the sections on your CBR will be consistent with the layout of this sample CBR.

Now, a CBR is formatted into six sections, which help to focus on the process and the results of the CBR. The introduction is a brief explanation of the specific billing area and improper payment data addressed in the CBR. And you can see here that the improper payment data for emergency department visits is listed here in the introduction.

The coverage and documentation overview identifies claims data and then it reviews basic CPT code information. And you can see here the emergency department service codes and the history exam and medical decision making are reviewed for selection of these codes.

Moving on to the basic coding guidelines, we're provided with a more detailed description of the CPT codes and the correct billing processes. Taking a look at table 1 of the CBR, we can see the very detailed guidelines of the descriptions for codes 99281 through 99285, the emergency department visit codes.

It continues on the next page.

The next section, the metrics of the CBR, lists and explains the metrics used for the CBR, he definitions for the state and national peer group, and then the possible outcomes for the CBR metric analyses. You can see that here. The state and national group and then the outcomes. We'll discuss those outcomes in a little bit on a different slide.

The results section is a review of the CBR results, and individualized results, comparing the CBR recipient to other providers. As we scroll through you can see each metric is explained, the calculation for the metric is described, and then the results for the provider for each metric is shown in table form. Here we have metric 1. Again, we'll go through all of these in detail a little bit later in the presentation, metric 2, and metric 3. And the table for metric 3 is on this next

page.

Finally we're going to have the references and resources section. This section lists the reports and documents used for the creation of the CBR and those created to help you as you have any questions about this CBR.

So why was this CBR created? We saw the improper payment data briefly on the sample CBR in the introduction, and we will discuss those again shortly. But in order to get detailed information for those providers who were billing emergency department services, the CBR201906 was created. Now, the scope of the CBR summarizes a year of dates of service- that's the year between December 1, 2017, and November 30, 2018. With statistics and analysis showing over 138,000 providers who billed the code set for emergency department services. Now, this figure is based on claims extracted for the date range as of April 28, 2019.

The scope of the CBR dictates the time frame and the provider numbers within the CBR analysis. But now let's talk about those improper payment numbers that we saw in the introduction of the CBR. You'll see here on this slide a review of emergency department services vulnerability regarding Medicare payments and possible improper payments for these services and encounters. The 2018 Medicare Fee-for-Service Supplemental Improper Payment Data Report showed an 11.3 percent projected improper payment rate for emergency department service codes, 99281-99285, and these percentage rates represent over $238 million in projected improper payments. We all know how difficult it can be to keep up with documentation requirements, especially in regards to evaluation and management coding, but we can see here how serious the improper payments can become when codes are potentially assigned incorrectly.

So, identifying that specific date range and the specific CPT codes that isolates these services helps us to get granular detail about that portion of the $238 million in improper payments.

So that's the focus of this CBR. It is a review of statistics for providers who submitted Part B claims for emergency department service encounters. The CBR analyzed claims with these codes 99281, 99282, 99383, 99284, and 99285, and three specific areas of analysis for these codes. The relationship of code 99285 to the total of all submissions for this entire code set, the use of modifier 25 with the claim submission, and the average allowable charges submitted for this code set. We'll take a look at these specific analyses when we discuss each metric that was analyzed in the CBR.

We can see here an overall code information for emergency department services. And these codes are assigned in a similar fashion to almost all evaluation and management codes by reviewing and clarifying the documented history, exam, and medical decision making. These codes are assigned for a patient visit and for this analysis and webinar, a visit is defined as a single date of service for a beneficiary.

Now that we've seen and reviewed quickly the basics of the emergency department service codes, let's take a quick look at the use of modifier 25. The use of modifier 25 is described as when a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. It should be used when the evaluation and management service is above and beyond the usual pre- and post-operative work of a procedure. The emergency department is an area of care in which the modifier 25 is used due to the nature of care. There's often times when an evaluation and management visit finds the patient in need of further care, so the claim and the CPT codes are billed with the modifier 25. And it is very important to understand the use of all modifiers, but because of the prevalence of the use of modifier 25 with the emergency department services codes, this CBR analyzes the use of the modifier in one of its metrics.

As we saw during the CBR review, this CBR does have three metrics that were reviewed. The analysis included the percentage of services billed with CPT code 99285, the percentage of services appended with modifier 25, and the average allowed charges for all Medicare Part B services per visit.

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 the CBR, but first let's discuss the possible outcomes of these metrics.

So there are four potential outcomes that are used — excuse me, that are the result of the metric calculation. And these four outcomes can be an outcome of significantly higher, which indicates that the provider's value is above the 90th percentile from the state, peer or national mean, and we'll talk more about what that 90th percentile means exactly on our next slide. Going down the list here, an outcome of higher shows that a 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 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 90th percentile actually means because it is important to understand that true meaning so you can understand the full 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 first calculated percentages for all providers for each of the metrics in each comparison group, those comparison groups being the state and nationwide level.

So to review these percentiles, we first listed all of the providers' percent values from highest to lowest. If you use the ladder image here that is on the slide, you can imagine that the percentiles are listed starting with the highest at the top rung of that ladder and then in

descending order so that the lowest percentiles are there down by the lowest rung. Next we identify the percent value below which 90% of the providers' values fall. This is the 90th percentile mark. And, again, if you reference this ladder image, that 90th percentile mark is represented by the black line across that top rung of the ladder. Any providers whose percent is above that point, or above the 90th percentile and identified as being significant higher for that specific metric in their CBR as compared to the state or nation. So, therefore, your results are very different from your peers. And we send the reports to allow for the comparison from your peers on a state and nationwide level. And we'll take a look a little bit later on at each of the metrics as promised and then the results that indicate a significantly higher outcome.

The criteria for a provider to receive a CBR for emergency department services are listed here. Now, all three of these criteria must be met for a provider to receive a CBR. First, you'll see listed here your results must be significantly higher as compared to the state or national percentages. In addition, you must have at least 11 beneficiaries with claims submitted for any of the codes for emergency department services. And you must have total allowed charges of $2,000 or more for claims submitted for any of the emergency department codes. And I do want 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.

And also, I do want to note that the charges filed must meet or exceed $2,000 in allowed charges. So 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.

Let's begin our review of the metric calculations for this CBR. We'll start with metric one, the percentage of services billed with CPT code 99285. This metric was calculated by dividing the number of services with CPT code 99285 by the total number of services with CPT codes 99281 through 99285. The result is then multiplied by 100 to get the percentage.

So to take a closer look, let's go back to our sample CBR. And let's look at the table for metric number 1. You can see that listed here in table 3. Now, this provider had an 84.39 percent of their beneficiaries who received a level five emergency service encounter. The provider's state peer group had an overall percentage of 54.63, and the national peer group average is around 46, so this provider had an outcome of significantly higher for this metric in both the state and national peer group. Now, remember that significantly higher only has to be the outcome of one metric to qualify a provider for the receipt of a CBR. So for the sample provider, this metric number 1 was that outcome.

Moving on to metric two, the percentages, sorry — let me get to that slide. Metric two is the percentage of services appended with modifier 25. This metric was calculated by dividing the number of services with modifier 25 by the total number of services with CPT codes 99281

through 99285. The result is multiplied by 100 to get the percentage. So this calculation is very similar to the calculation for metric number 1, but of course the data in the numerator is updated for this metric to review the use of modifier 25. Going back to our sample CBR, let's look at table 4, and you can see here this sample provider's outcomes for metric 2. This provider had 5.65 percent of their submissions for emergency services used with modifier 25. The provider's state peer group had an overall percentage of 9.91 and the national peer group average is 10.44, so this provider had an outcome of does not exceed for this metric for both the state and national peer group comparisons.

Finally, metric 3, the average allowed charges for all Medicare Part B services per visit. This metric was calculated by dividing the allowed charges for all Medicare Part B services by the total number of emergency department visits submitted with codes 99281 through 99285.

Going back to the CBR, to look at the results of this metric, you can see that this sample provider had an average of 183 dollars for emergency service visits. The provider's state peer group had an average of 135 dollars and the national peer group average dollar amount was 126 providers, so this provider ends up with a significantly higher outcome for this metric for both the state and national peer group comparison.

So this provider ended up having significantly higher in the results of two of their metrics.

The CBR, and this slide includes a graph that reviews three years of time from 2015 through 2018 for the submission of emergency service claims. On this analysis, this particular provider, during each year, had a rather large gap between the amount of claims for 99285 as compared to the other two levels for each year. So this graph lets us kind of take a step back and instead of looking at the granular detail for the codes, maybe just take a look at the overall submissions for these three years of review.

So these are some helpful resources that we do have available for you. The page that we're looking at now is cbr.cbrpepper.org/help contact us. And on this page you'll find a frequently asked questions link, and a link to submit a new help desk request. I always encourage people to review the frequently asked questions before submitting a help desk ticket because those frequently asked questions may contain the answer to your inquiry.

And here we do have the frequently asked questions page. It is found at cbr.cbrpepper.org/FAQ, or you can click on the button we just saw on the last slide. So this page contains the list of frequently asked questions and has links to answers to various questions, and you can see that here. You simply click on the question and the answer will populate. And we have gotten a lot of feedback that this list has proven helpful to many people who have questions about the CBR process.

This list of helpful resources is the documentation and reporting that the CBR team used in the creation and the analysis of the CBR. And you can see here the referenced Medicare Fee-for-Services Supplemental Improper Payment Data report, and a link to that report, and the CMS evaluation and management services manual. As well.

Here we have a screenshot of our home page, cbr.cbrpepper.org/home. And there are sections for each of the CBRs that we have released in 2019. For each CBR topic and release you can see links to the sample CBR, the training materials, a link to 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 for your organization.