# Transcript for the CBR201907: Modifier 25: Dermatology July 10, 2019

Comparative billing reports or CBRs and more specifically CBR201907, Modifier 25: Dermatology. I work for RELI Group, Inc., who is contracted with the centers for Medicare & Medicaid services (CMS) 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 the 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&A, and CBR Help Desk are great tools to use if you have any questions. Just reach out; we're here to help.

The objectives of today's webinar will be to understand the purpose and use comparative billing reports, or CBRs, to explain the function of this specific comparative billing report, CBR201907 Modifier 25: Dermatology, and to help you gather resources that will help you answer further questions and inquiries.

First today we're going to talk about what a comparative billing report is. I will show you how to access your CBR. 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 a CBR document. Then we'll go into a discussion of this CBR and go through the details of the topic, Modifier 25: Dermatology. I will show you some of those helpful resources, should you have any questions following the webinar, and then finally, I will answer any submitted questions as time allows.

Let's get started.

Let's start at the very beginning. What is a CBR? Well, 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 just 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 was necessary and in line with Medicare payment policy.

A CBR cannot identify improper payments, but it can alert providers if their billing statistics looks 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 to put both programs under one contract. And then, in 2019, RELI Group has partnered with TMF Health Quality Institute and CGS to create and distribute CBRs and PEPPERs.

Now that we have a little bit of a sense of the history of the CBR, we can take a look at why CMS issues CBRs. CMS is mandated and required by law to protect the trust fund from my improper payments or anything else that might compromise the trust fund. They have a number of strategies to meet this goal, which include education of providers, early detection through medical review and data analysis. And CMS considers the CBR process to be an educational tool that supports their effort to protect the trust fund.

CBRs serve several purposes on the provider side as well. The CBR program helps to support the integrity of claim submission and the adherence to coding guidelines, and this helps to encourage correct clinical billing. Any early detection of outliers in your billing processes can help to guide a compliance program that will help to support compliant operations in your own organization. Taking a closer look at the specific coding guidelines and billing procedures can increase education and improve future billing practices.

We've seen how CMS defines a CBR, the history of the process, why CMS issues CBR. Let's now look at why you may receive a CBR for this or any other CBR analysis. A CBR is presented to a provider when the analysis of their billing patterns differs from the provider's peers on a state or specialty level or on a nationwide level. It is important to always remember that receiving a CBR is not in any way an indication of, or a precursor to an audit.

I'm going to walk through the steps of accessing your CBR report if you received one so we can see exactly how this is done. This page that we see here, cbrfile.cbrpepper.org, contains the portal that you'll use to access your CBR. The portal does require that you enter some information, and I'm going to open this page on my screen to show you exactly what it looks like when a CBR is accessed in this way.

First, we'll indicate the role that we play within the health care organization for the physician or physicians who received a CBR. I'm going to indicate that I am an administrator of the organization. I clicked that right there. And by doing so, I am 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'll complete these two forms to indicate my information as the person accessing the CBR and the provider information. To access this test CBR, I'll, of course, use test data to complete these forms, but you'll use the correct information here to complete them for your CBR access.

Following these forms, we're going to indicate how we heard about the CBR that is available to

the physician or physicians. This section of the access form is truly most telling to us and really helps us to know which form of alert is working best to reach the most physicians for their CBR alert.

First two listed here are "Received an e-mail or a fax." This would be an e-mail or a fax that came to the account or fax number that is listed in the N-P-P-S, or NPPES system. That's the National Plan and Provider Enumeration System. We use the e-mail, fax, and can address information that is listed in that NPPES system to send the CBR information. We do encourage everyone to confirm their NPPES information and update it, if necessary, so that we can contact the appropriate person regarding CBR information. We know that oftentimes an employee e-mail may be used and sometimes those employees leave the organization or change departments or something else happens that causes the contact information to become incorrect. So confirming this information several times a year allows for the e-mails to stay up-to-date and lessens any other issues that may arise otherwise.

Next on the list is the indication you saw a tweet that we sent out about the CBR program. We use Twitter and tweet about these CBR releases and about these webinars. So if you saw that tweet and that led to you check out the CBR program, we would love to know that. The next two entries are provider or professional association or MAC notice, are indications of work alongside the groups and the MACs that are supportive of provider billing and information distribution. 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 forum 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 either of those apply, of course, please indicate as such.

I'm going to say that I received an e-mail. At the bottom of the form, we ask for the provider's NPI number. This will be the NPI for the specific provider that received the CBR. If you are in the position of trying to check for 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 that longer list of CBRs.

Finally, the validation code. When a provider receives an alert that they have a CBR on file, a validation code is included with the alert information. So, again, check the information on the e-mailed alert to confirm your validation code. If you are 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 in that situation as well.

I'm going to complete the form and click submit. Oh, dear. Well…sorry about that. Please hold. Well, this is poor timing. I apologize. It seems the system is undergoing a little bit of

maintenance, and I apologize for that poor timing. What you will see when you click the "Access Your CBR" button or the "Submit" button, I should say, is a PDF file of your CBR, and it will be there to access for you to download and for your review.

This page here, CRBPEPPER.org, is another page that you can use 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 we just reviewed and you can begin the steps that we just covered.

So we've seen the process to access your CBR report. Let's take a closer look at the sample CBR so we can fully understand the Modifier 25: Dermatology CBR, its outcomes, and comparisons. The results shown on the CBR will differ from those on your CBR if you received one, but the formatting and the section will be consistent with the layout of this sample CBR.

A CBR is formatted into six sections which help to focus on the process and results of the CBR. I do have a sample CBR, as I said, to pull up here.

The introduction is a brief explanation of the specific billing area and improper payment data addressed in the CBR. And you can see here information including projected improper payments which we will discuss, in more detail, a little bit later. The coverage and documentation overview identifies claims data and reviews CPT® code information. You can see here coding information for established office visit service codes and that the history, exam, and medical decision making are reviewed for these codes. Then we also have some information about Modifier 25 and its use. That Modifier 25 information carries over on to this next page.

The following section is basic coding guidelines. And in this section, we are provided with a more detailed description of the CPT® codes and the correct billing processes. Table One of the CBR, as you can see here, lists the more detailed descriptions of the codes for 99211 through 99215.

The metrics section of the CBR lists and explains the metrics used for the CBR. The definitions for the state and national peer group, and the possible outcomes for the metric analyses. At the bottom here, you can see the outcomes listed, and we'll go over those a little bit later.

The methods and results section is a review of the CBR results and individualized results comparing the CBR recipient to other providers. As we scroll through, 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. So as I scroll through here, you can see this metric one. It has a description and the calculation and then the results. Metric two, we have the same thing, a description of the metric, a visual of the calculation, and then the results for that metric in table form. Then finally, metric three, the description, the calculation, and then the table with the results for this particular provider.

Then finally, we have the references and resources section, which is a list of reports and documents used for the creation of the CBR and any documents created to help you as you have questions about this or other CBRs.

What exactly is the analysis that is contained in the CBR that we just reviewed? Well, the CBR201907 was created using detailed information for those providers who billed dermatology services for established patient office visits. The CBR summarizes a year of dates of service, the year between February 1st, 2018, and January 31st, 2019. The statistics and analysis showed over 12,000 providers who billed charges for dermatology services for established patient visit codes, and this figure is based on claims extracted for the date range as of May 24th, 2019.

The time frame and the provider numbers within the CBR analysis give us important information about the analysis and the statistics. But now let's talk some different numbers, payment numbers. You'll see here a review of dermatology office visit claims 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 increase in improper payments for dermatology visits from 3.4 percent in 2017 to 15.7 percent in 2018, which is a very considerable increase. The increase in improper payments for overall dermatology services also increased from 2.4 percent in 2017 to 7.2 percent in 2018. Now, these increases represent a dollar amount increase from $68 million in 2017 to $181 million in 2018.

The focus of this CBR, as you know, is a review of statistics for providers to submit Part B claims for dermatology services for established office visits. Specifically, this means the CBR analyzed claims submitted with codes 99211, 99212, 99213, 99214, and 99215. We'll take a look at all the specific analyses as we discuss each metric that was analyzed in the CBR. As we saw in the introduction of the CBR and in our last slide, we have listed here the codes used to bill for established patient office visits. These codes are of course assigned in a similar fashion to almost all evaluation and management codes by reviewing and classifying the documented history, exam, and medical decision making. These codes are assigned for a patient visit, and for this analysis and webinar, a visit defined as a single date of service for a beneficiary.

Now that we have reviewed the basics of the E/M codes, take a quick look at the use of Modifier 25. The use of Modifier 25 is described according to the CPT® 2017 Professional Edition as a, quote, 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 E/M service is above and beyond the usual pre- and post-operative work of a procedure. According to chapter one of the National Correct Coding Initiative, the NCCI policy manual, the use of Modifier 25 applies to evaluation and management services performed on the same day as minor procedures with global periods of 10 days or less. The modifier may also be appended to E/M services performed on the same

date of services such as mole removal, for instance.

There is further advice regarding Modifier 25 from the NCCI policy manual and that advice reads that in general, E/M services on the same date of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with Modifier 25.

The NCCI manual also states that services related to the decision to perform the procedure include assessing the patient before, during, or after the procedure, informing the patient of possible risks, and giving the patient instructions for post-operative care.

Continuing on with the NCCI policy manual information regarding Modifier 25, chapter one states the following regarding codes: A modifier should not be appended to a HCPCS or CPT® code solely to bypass an NCCI PTP, procedure to procedure edit if these clinical circumstances do not justify its use. And finally, the Medicare Claims Processing Manual addresses the selection of CPT® codes in chapter 12, section 30. The advice there is, of course, that medical necessity is a service that is the overarching criteria for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation certainly is an integral part of CPT® code selection and it plays an important part in the support for the use of Modifier 25 as well.

As we mentioned before, the CBR process is used to help providers compare their billing patterns to those of their peers. And when we talk about comparing your billing pattern to those of your peers, there are four outcomes that can come of this analysis. An outcome of significantly higher indicates that the provider's value is above the 90th percentile from the state, peer, or national mean. We'll talk more about what that 90$^{th}$ percentile means exactly in a few more slides. An outcome of higher shows that a provider's value is greater than the state peer and national means. An outcome of does not exceed indicates that the provider's value is not higher than the state peer or national mean. And an NA outcome represents that the provider does not have sufficient data for comparison.

The outcomes we saw are results of the analysis for each metric within the CBR. We saw those briefly in our review of the sample CBR and we'll get more into the detail of them very soon. At least one of these criteria for a provider to receive a CBR involves the outcomes that we just discussed. All three of the criteria for a provider to receive a CBR are listed here on this slide.

First, your results must be significantly higher, just as we saw in the outcome, as compared to

the state or national outcomes in any one of the metrics. In addition, you have at least 50 beneficiaries with claims submitted for any of the codes for established office visit services. And you have total allowed charges of $43,000 or more. It is 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 we see here, you will receive a CBR for review.

Also, it's important to note that the charges that are filed must meet or exceed $43,000 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.

Going back to that 90th percentile, let's discuss what being above that 90th percentile actually means. As we saw in the last few slides discussing the outcomes of the metrics and the criteria for receiving a CBR, it is important to understand the true meaning of this outcome so that you can understand the meaning of the outcomes listed in your CBR. The other outcomes are truly self-explanatory, but the significantly higher outcome is a bit more involved.

In order to identify the providers who were above the 90th percentile, we calculated percentages for all providers for each of the metrics in each comparison group, which is the peer, state, and nation. To calculate the percentages—the percentiles, excuse me-we first order all of the providers' percent values from highest to lowest. If you use this ladder visual that is on this slide as a reference and think of the percent values being listed from the highest at the top rung and then in descending order so the lowest percent values are listed at the bottom rung, it can help you to visualize what we're talking about with the 90th percentile. Next we identify the percent value below which 90 percent of the providers' values falls, and this is the 90$^{th}$ percentile mark, represented, above, on the ladder visual by that black line on the top rung. Any providers whose percent value is above that point are above the 90th percentile and as such identified as being significantly higher for that metric, in their CBR as compared to the state and nation. We send the reports to allow for comparison for your peers and offer an opportunity to see that your results in one of the metrics of the CBR varied greatly from those of your peers.

You'll see here a list of the metrics analyzed within this CBR. The CBR reviewed the percentage of services appended with Modifier 25, the average minutes per visit for claim lines with Modifier 25 and without Modifier 25, and the average allowed charges per beneficiary summed for a one-year period regardless of the modifiers appended to the claim lines. We'll break down how each of these metrics is calculated in the following slides so we can have a deeper understanding of the statistics that are listed on each CBR.

So starting out first with metric one, the percentage of services appended with Modifier 25. Now, this metric was calculated by dividing the number of evaluation and management services

with Modifier 25 by the total number of evaluation and management services with the same CPT® codes, 99211 through 99215. You can see the calculation of that metric listed here. Just as we saw it listed in the CBR, going back to the CBR document, here is metric one as we just can discussed, and table three lists the results for this sample provider for this metric. You can see here that this provider had 62 percent of their services appended with the Modifier 25. Moving to the right, the provider's state peer group had an overall percentage of 55 for services appended with Modifier 25. The national peer group percentage was around 55 percent. So, this provider had an outcome of higher for this metric for both the state and national peer group comparisons.

Now, remember the significantly higher outcome only has to be the outcome of one metric to qualify a provider for the receipt of a CBR.

Going back to our slides, we can move next to metric two, which is the average minutes per visit with Modifier 25 and without Modifier 25. This metric was analyzed in a little bit of a different way, using the average allowed minutes for the CPT® code submitted. Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code description that we saw in table one on the CBR. This value is multiplied by the total allowed services for the code to arrive at total minutes. Generally, the number of visits is equal to the total number of services provided by modifier designation. However, if multiple services were allowed for a particular beneficiary and date of service, then these services were counted as one visit for this analysis.

So, with that in mind, this metric has two calculations and outcomes; one with Modifier 25 and one without Modifier 25. To look at the first calculation, the total minutes with Modifier 25 was divided by the total number of visits billed with a Modifier 25. And here we can see the total minutes billed without a Modifier 25 addition to the office visit code divided by the total number of visits without a Modifier 25. Though the calculations within this metric are very similar but, of course, we're looking at with and without that Modifier 25 addition.

So, let's take a look at the sample figures on the CBR for metric two. You can see here in this table that this provider had an average of about 16 minutes for codes billed with Modifier 25. The provider's state peer group had an overall average of about 17, almost 18 minutes. And the national peer group average is also around 16 to 17 minutes. So, this provider had an outcome of does not exceed for this metric for both the state and national peer group comparisons for claims submitted with the Modifier 25 appended to those established patient office visit codes.

Looking on that second line down at the outcomes for office visits submitted without the 25 modifier, we see that this provider had an average of 13 minutes per visit. The state peer group has an average of 16, almost 17 minutes, and the national average was, again, almost 16 minutes. So the provider ends up with an outcome of does not exceed for this calculation as

well.

Finally, we'll move on to metric three, the average allowed charges per beneficiary. This metric was calculated by dividing the allowed charges for all evaluation and management dermatology services by the total number of beneficiaries who received care. Going back to our CBR, we can take a look at the results in the table for metric three. This provider had an average of $211 and this provider's state peer group had an average of $126. The national peer group average dollar amount was 123. So, this provider ends up with an outcome of significantly higher for this metric and state and national comparison.

The CBR analysis includes, in this case, two graphs that review three years of time from 2016 to 2019 for the submission of office visit codes with Modifier 25 and then without Modifier 25. On this analysis, as you can see here, this particular provider, during each year, had a higher level of submissions for code 99213 as opposed to the submissions for the other office visit codes. This graph is, again, for the E/M services submitted with Modifier 25.

Moving on to the same analysis, except with claims with E/M services without the appended Modifier 25, this graph shows the same three years, again, for the same office visit codes, and you can see, again, a little bit of variation for this particular provider according to the level three codes; those do seem to be a bit higher for each year. After the granular detail of the metrics, it's kind of nice to take a step back and look at three years over time of all the submissions for all claims for each of these evaluation and management codes with and without the E/M modifier.

Looking at the resources that are available to you regarding this CBR and the CBR process, we do have a helpful resources page, which is cbr.cbrpepper.org/help-contact-us. On this page, you'll find the 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 be able to answer your inquiry.

The frequently asked questions page that I just referenced is here at cbr.cbrpepper.org/faq. This contains a list of frequently asked questions and has links to answers to those various questions, as you can see here. You 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.

These helpful resources are the documentation and reporting that the CBR team used in the creation and the analysis of the CBR. You can see here a link to the Medicare Fee-for-Services Supplemental Improper Payment Data Report, a link to the NCCI policy manual, and then the CPT® Professional Edition is referenced as well.

This is a shot of our home page, cbr.cbrpepper.org/home. There are sections for each of the CBRs that we've released in 2019. For each CBR topic and release, you can see the links to a sample CBR, 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.