Transcript for the CBR201911: Atherectomy November 6, 2019

It is about three o'clock. So let's get started with our webinar for today. I want to welcome you to today's webinar where we will be discussing Comparative Billing Reports or CBRs and more specifically CBR201911 Atherectomy. My name is Annie Barnaby and I work for RELI Group, Inc., who is contracted with the Center for Medicare & Medicaid services (CMS) to develop, produce, and distribute CBR reports.

We have 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 of the slides and of course the Q&A and the CBR help desk are great tools to use if you have any questions. We are here to help so don't hesitate to reach out.

The objectives of today's webinar will be to understand the purpose and the use of Comparative Billing Reports, CBRs, to explain the function of this specific comparative billing report CBR201911 Atherectomy and to help you gather resources that will help answer any further questions and inquiries that you might have.

To accomplish those objectives, our discussion today will cover the following areas: First we will talk about what a comparative billing report is. I will show you how to access a CBR through our portal. I have a sample CBR that we will review so we can get a good sense of what we are looking at when we review the document. Then we will go into a discussion of this CBR and go through the details of the topic and the metrics for CBR201911 Atherectomy. I will show you those helpful resources that we talked about 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 billing report -- excuse me, 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 or 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. A CBR cannot identify improper payments but it can alert providers if their billing statistics look unusual compared to their peers.

Taking a look at the history of the CBR, we can see that this program was spearheaded back in 2010. Then in 2018, CMS combined the CBR program with the PEPPER program. That is the Program for Evaluating Payment Pattern Electronic Reports to put both programs under one contract. And in 2019, RELI Group has partnered with TMF and CGS to create and distribute both the CBR and PEPPER reports.

Now that we have a sense of the history of the CBR, we can discuss why CMS issues the 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. And 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 can help to encourage correct clinical billing. Early detection of any outliers your billing processes can help guide a compliance program that will help to support compliant operations in your own organization. Taking a closer look at specific coding guidelines and billing procedures can increase education and improve future billing practices.

If you received CBR you may be asking why did I receive the CBR? A CBR is presented to a provider when the analysis of their billing patterns differ from the provider's peers on a state or nationwide level. The analysis of a provider's billing patterns is completed through each CBR topic and each CBR is distributed to providers based on individual provider results for specified metrics within the CBR. The metrics for every CBR are created according to the CBR topic and the potential risk to the Trust Fund. And it is important to remember always that receiving a CBR is not in any way an indication of, or a precursor to, an audit.

Here you will see a screen shot of our CBR portal page and this is the page that you will go to access your CBR. I am going to walk through the steps of accessing those reports if you received one, so we can see exactly how that is done. And you can see the title or the site for this page is cbrfile.cbrpepper.org. I am actually going to share my screen.

So here you will see the page, our CBR portal page. And the portal does require that you enter some information and I am going to enter that information onto the portal so you can see exactly how that is done. So first we will indicate the role that we play within the healthcare organization for the physicians or physician who received the CBR. I am going to indicate that I am president of the organization 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. I am just going to click there on the president box.

Next, I will complete these two forms to indicate my information and the provider information. Now, to access this test CBR, I have already filled in some test data to complete the forms but of course you will use the correct information here to complete them using your contact information and the provider's information.

Following these forms, we are going to indicate how we heard about the CBR that is available for the physician or physicians. And this section of the access form is really 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 on the list we can see indicates that the provider received an email or a fax. This would be an email that came to the account that is listed in the NPPES system, that is the National Plan and Provider Enumeration System. We do encourage everyone to confirm the NPPES system information and update as necessary so we can contact the appropriate person regarding CBR information. And we know that oftentimes an employee email might be listed and sometimes those employees leave the organization or something else happens that causes the email address or other information to become incorrect. Confirming this information several times a year allows for the emails and the contact information to stay up-to-date and lessens any issues that may arise otherwise.

Next on the list is an indication that you saw a tweet that 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 like to know that. The next two entries that we see, the provider or professional association or MAC notices are indications of our work alongside the groups and the MACs that are so supportive of proper 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.

Then we do have the Open Door forums led by CMS. If you heard about the CBRs through one of those forums, please let us know. And then we do have the "other" option and if that applies to you, please of course indicate as such.

Then at the bottom of the form, the portal is going to ask for the provider's NPI number. This will be the NPI number for the specific provider who received the CBR. If you are in the position of having several providers who received the CBR, we can help with longer lists of NPI numbers through our help desk ticket system. I am going to put in a place holder NPI for us.

And then finally we have 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 that CBR alert to confirm your validation code. If you are sure that the provider was issued a CBR but you are unsure of the validation code, you can submit a help desk ticket and we can assist with that situation as well.

I am going to complete the form and hit submit. And here we have the sample CBR file that appears. And your CBR will appear in this exact same fashion, in PDF format, ready for your review. So the portal really is very user-friendly. You can access it through this page or by going to cbrpepper.org, which you'll see a screenshot here. This is another page that you can use to access your CBR, if you click on access your CBR button highlighted with the purple arrow, you will be directed to the page we just reviewed and you begin the steps that we just covered.

So we've seen not how to access the CBR report. Let's take a closer look at the sample document so we can fully understand the Atherectomy CBR, it is metrics, outcomes and comparisons. Now, the results shown on the CBR I'm going to bring up in a minute will of course differ from those so your CBR if you received one, but the formatting and the sections on your CBR will be consistent with the layout of this sample document.

I'm just going to bring the sample CBR up here. Okay. The CBR is formatted into five sections, which help us to focus on the process and the results of the CBR analysis. The introduction is a brief explanation of the specific area that is addressed in the CBR. And you can see here information discussing the CBR focus of lower extremity atherectomy procedures, as well as the possible improper payments for the procedures.

Moving on to the coverage and documentation overview, this section identifies the CPT® codes that were analyzed and gives us some definitions regarding some common phrases that we're going to use in the CBR and in our discussion of the report. Table one of the CBR is listed in this section, and that contains the description of the CPT® codes that are used in the CBR. That starts here on page 3 and then continues on page 4. Table two is also contained in this section and it gives an overall summary of the utilization for those CPT® codes.

The next section is the metrics section. And that section lists and explains the metrics used for the CBR, the definitions for the state and national peer group, and the possible outcomes for the CBR metric analyses. You can see all of that information here. And here we have the outcomes.

Which brings us to the methods and results section. This is a review of the results of the CBR analysis, followed by individualized results comparing the CBR recipient to other providers. We have an explanation of the dates of service included in the report analysis, the total rendering providers who had allowed charges for atherectomy procedures, and the criteria for receiving a CBR. Following that information, 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.

As you see here, we will go into each one of these metrics and calculations in detail in just a minute. But here is metric one. We have the explanation. The calculation. And then the sample provider's results. And that format is repeated for metric two. And then finally for metric three. This section also has a graph displaying a trend over time for the provider and again we will discuss this graph in greater detail a little bit later.

And finally, we have the references and resources section which lists reports and documents used for the creation of the CBR and those created to help you as you have questions about the CBR topic.

Let's take a look at the vulnerability of the atherectomy payments and how that plays into CMS's protection of Trust Fund. National claims data shows that, between the dates of July 1, 2016 and June 30th, 2018, over 3,000 providers submitted claims for lower extremely atherectomy services, which brought over $236 million in allowed charges for those services. That is obviously a very large amount of money and allowed charges for these services, so we can see that the lower extremely atherectomy services are performed quite often and represent a high dollar amount in allowed charges submitted to CMS.

A study presented at the 2019 Vascular Annual Meeting of the Society for Vascular Surgery, SVS, referenced a shared initiative goal to avoid interventions for first line treatment, and performed an analysis of Medicare fee-for-service claims to identify providers who may be outliers in utilization of the early application of peripheral vascular interventions. Additionally, an article published in the Wall Street Journal examined the use of atherectomy procedures and contained an analysis of national data from CMS published the journal of vascular surgery. This article reported its own guidelines recommended peripheral vascular interventions only after patients who have leg pain when they walk have failed medical and exercise therapy have lifestyle-limiting symptoms. The article continues, atherectomy is a procedure that many doctors say should be used selectively since there is no conclusive data to support its effectiveness. So these clinical goals and guidelines along with the high allowed charges for atherectomy procedures contributed to the selection of this topic for a CBR analysis.

To tackle the issue, the CBR201911 was created to review statistics for rendering providers who performed lower atherectomy procedures, for which a Medicare Part B claim was submitted. Specific metrics were created, as we saw earlier, to further analyze the issue and evaluate provider results for education and comparative purposes.

And this analysis included CPT® codes for lower atherectomy procedures and arterial studies, which are these CPT® codes we see here. This might look familiar to you; this is table one from the CBR. And this includes the atherectomy codes or the lower extremities but also includes the codes for evaluation and management visits and the codes for arterial studies. All of these

codes will play into the metric analyses and will help us to look at the results according to those specific metrics for providers who perform atherectomy procedures.

To create the CBR201911 and the metrics within the report, we used detailed information again for rendering providers who performed lower extremity atherectomy services during the CBR summary year of June 1 through May 31, 2019. The results were based on claims extracted for the date range as of Sept. 13, 2019. And those results showed that over 3,000 providers performed lower extremity atherectomy procedures and those procedures represented over $244 million in allowed charges. And when we talk about allowed charges, we're referencing the allowed charge listed in the Medicare fee schedule for each code. And this lets us compare similar charge figures across all providers claim submissions regardless of submitted or paid amount.

Here you can see a list of the metrics analyzed within this CBR. Each metric was created to take a more detailed look at the use of atherectomy procedures and the performance of atherectomy procedures in relation for arterial studies and evaluation and management services. The metrics are number one, the percent of lower extremity atherectomies performed without arterial studies by any physician within 90 days prior to the atherectomy. Two, the percent of lower extremity atherectomies performed on the same day as an E&M encounter with any physician. And the third metric, the percent of lower extremity atherectomies performed with an E&M encounter with any physician within 90 days prior to the atherectomy. We will breakdown how each of these metrics is calculated later on in the presentation. But first let's take a look at each metric to understand why each analysis was selected and analyzed.

Metric one again looks at the percent of lower extremity atherectomies performed without arterial studies by any physician within 90 days prior to the atherectomy. Keeping in mind the clinical viewpoint of avoiding performance of atherectomy procedures as a first time intervention, this metric reflects atherectomy procedures in relation to arterial studies. We saw the list of arterial studies CPT® codes that were included in this analysis and this metric was created to see for each provider, the percentage of times an atherectomy was performed without first performing arterial studies. The ideal outcome of this metric would be a lower percentage rate that reflects that arterial studies were performed and analyzed before atherectomy treatment was performed.

Metric two looks at the percent of lower extremity atherectomies performed on the same day as an E&M encounter with any physician. This metric takes a look at the day of an atherectomy procedure to the lower extremities. There may be reasons for an E&M service to take place as an atherectomy procedure but mostly are in relation to a separately identifiable issue or a decision for surgery. For instance, the doctor may bill an E&M code with a modifier 25 to reflect a visit for a separately identifiable issue. This is rather an unlikely situation however as few doctors will see a patient regarding a completely separate issue and then go into surgery for

atherectomy. Or the second situation, the doctor might be billing the E&M code with modifier 57 which is the decision for surgery. While this situation may be a little bit more likely to occur and may occur in instances when the best course of treatment for the patient is immediate intervention, for the purposes of this CBR analysis, we would not want to see this outcome as it might suggest that the provider is deciding to perform the atherectomy before considering other treatment options. Because of the likely -- unlikelihood, excuse me, of these scenarios, the desired result for this metric is a lower percentage.

Metric three takes a little bit of a different look and looks at the percent of lower extremity atherectomies performed with an E&M encounter with any physician within 90 days prior to the atherectomy. This metric also takes into account the role of E&M visits with respect to the time leading up to the atherectomy procedure-E&M visits that took place 90 days prior to. This outcome shows out of all the atherectomy procedures that were performed what percentage had an E&M encounter within 90 days prior to that procedure. Each of the metrics that we have here shows a different side of the atherectomy procedures and the process that surrounds each treatment. And this metric is a reflection of the care that surrounds the atherectomy and gives us a picture of the E&M visits that were given before the procedures.

The in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a CBR201911. Using all of the data and research, the CBR team created criteria to select providers who will receive the CBR. That many criteria is listed here, and it is that the provider is significantly higher compared to either state or national percentages or rates in any of the three metrics. That would be greater than the 90th percentile. And has at least ten beneficiaries with CPT® codes 37229 and 37233. And has at least $7,200 or more in total allowed charges. And following our discussion of each metric, we can see that the criteria is directly related to the outcomes for all three of those metrics.

Now, the criteria states that the provider must be significantly higher or above the 90th percentile in any of the three metrics. What does that term above the 90th percentile mean and what are the outcomes for the other metrics? We have all four outcomes listed here. And these outcomes are the basis of comparisons made regarding the billing patterns and those of the peers for the physician receiving the CBR. The four outcomes, as you can see are significantly higher, higher, does not exceed, and N/A. The outcomes of higher and does not exceed are relatively self-explanatory. And the definitions are provided here for your review as well. And the NA outcome represents that the provider does not have sufficient data for comparison.

However the outcome of significantly higher requires a bit more explanation. The significantly higher outcome indicates that the provider's value is above the 90th percentile from the peer state or national mean. In order to talk exactly about how we calculate that 90th percentile, go to our next slide. So, again, it is important to understand to the true meaning of the 90th percentile and I think that the visual on this slide can help us accomplish that understanding. In

order to identify the providers who were above the 90th percentile, we calculated percentages for all providers for each metric in each comparison group. That would be the peer state and nationwide. We then order all of the providers percent values from highest to lowest. And if you use the ladder visual that is on this slide as a reference, imagine that the highest percentages are listed at the top of the ladder and then in a list in descending order down the length of the ladder, so the smallest percentages are at that bottom rung. Next, we identify the percent value below which 90% of the provider's values fall. This is the 90th percentile mark and it is represented above on the ladder visual by that black line. Any outcome for a metric in which the provider's percentage falls above that point would therefore have the outcome of significantly higher.

So let's take a look now at each of the metrics and how they are calculated so we can understand those outcomes. Looking first at metric one, the percent of lower extremely atherectomies performed without arterial studies by any physician within 90 days prior to the atherectomy. Now, this metric was calculated by dividing the number of times lower extremity atherectomy is performed without lower extremely arterial studies by any physician within 90 days prior to the atherectomy. That number is divided by the total number of lower extremity atherectomies. And then the result is multiplied by 100 to get the percent. Again, when we look at the results of this metric, what we are asking ourselves is: during the analysis year of all the atherectomies performed, what percentage were perform without a lower extremity arterial study performed first. And if we go back to our sample CBR and look at the sample figures for the sample provider, it is the right page here. We can see those sample figures here on table three and we can see it had an outcome result of 3.39 percent. Meaning that the provider performed atherectomy procedures 3.39% of the time during the review year without first performing arterial studies 90 days prior to. The provider's state peer group had a percent of 27.84 and the national percent was 29.4 so this provider had an outcome of does not exceed for both the state and national comparison for this metric.

Next we have metric two, the percent of lower extremity atherectomies performed on the same day as an E&M encounter with any physician. Again, this metric concentrates on the E&M visits performed on the same day as atherectomy procedures, and it is calculated by dividing the number of times lower extremity atherectomy is performed on the same day as an E&M encounter with any physician by the total number of lower extremity atherectomies.
Again the result is multiplied by 100 to get our percentage. So with that in mind, let's go back to our sample CBR and see where our provider fell. Those results are here on table four. This provider had one atherectomy procedure performed on the same day as an E&M visit. And with 59 total lower extremity atherectomies performed in the time frame, this provider has a percentage of 1.59%. The state percent is very low, listed at less than one percent and the

national percent is just slightly above 1%. So these results yielded a significantly higher outcome for this provider for the state comparison and the national level comparison.

Finally, we arrive at metric three, the percent of lower extremity atherectomies performed with an E&M encounter with any physician within 90 days prior to the atherectomy. This metric was calculated by dividing the total number of lower extremity atherectomies performed with an E&M encounter with any physician within 90 days prior to the atherectomy by the total number of lower extremity atherectomies performed. And then as always, the result is multiplied by 100 to get our percentage. So let's see the sample figures on the CBR for metric three. They are found here on table five. This provider had a percentage of 96.61. Which means that 96.61% of the atherectomy procedures had an E&M visit within 90 days prior to that procedure. The state percentage comes in at 94% and the national percentage is about 95%. So this provider has an outcome of higher for both of these metric comparisons.

The CBR includes a graph as I mentioned before that represents the provider's billing trend over the three years of 2016 to 2019 for the number of lower extremity atherectomies. And after the detail of the metrics and analysis, it is nice to have this graph that takes a step back and reviews an overall analysis for that three-year time period. You can see the trend for both atherectomy codes here and with an increase it seems for both procedures although the number of procedures for the 37229 greatly outnumber those for 37223.

At this point, I want to review the resources that we have available to you, if you received a CBR or if you would like further information about the process. We have a helpful resource page which is https://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.

Here is a closer look at that frequently asked question page which is at cbr.cbrpepper.org/FAQ. This page contains the list of frequently asked questions and has links to answers to those questions that you can see here. You simply click on the question and the answer will populate. This list has 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. And you will see the CPT® manual of course as well as a link to an LCD that discusses noninvasive vascular studies.

This is a screen shot of our homepage which is CBR.CBRPEPPER.org/home and there are sections on this homepage for each of the CBRs we have released in 2019. For each CBR topic and release, we provide links to a sample CBR, the training materials, the data set, and a link to access your CBR. This page also contains a link to join our mailing list to stay up-to-date on any

announcements, a link to provide feedback on the CBRs and a link to submit a CBR success story. And we would love to hear how the CBR process works for you and your organization.