



Transcript for the CBR201912: Drug Units in Excess of MUE December 4, 2019

I would like to welcome you all to today's webinar where we will be discussing Comparative Billing Reports or CBRs, and more specifically, CBR 201912, Drugs in Excess of Medically Unlikely Edits, which are MUEs.

My name is Annie Barnaby and 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 have developed various resources to accompany this webinar, and those 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 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, to explain the function of this specific Comparative Billing Report, CBR 201912, Drugs in Excess of MUE and to help you gather resources that will help answer further questions and inquiries.

To accomplish those objectives, our discussion today will cover the following areas. First, we'll talk about what a comparative billing report is, I will show you how to access your CBR through our portal. I do have a sample CBR that we will review so we can get a good sense of what we're looking at when we see a CBR document. Then we'll go into a discussion of this CBR and go through the details of topic and metrics for CBR 201912, Drugs in Excess of MUE. 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 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 what the title says, a report that compares providers on a state or specialty and nationwide level and summarizes one provider's Medicare claims status statistics for areas that may be at risk for improper Medicare payment, primarily in terms of whether the claim was correctly coded and billed, and whether the treatment provided to the patient was necessary and in line with Medicare payment policy. A CBR cannot identify improper payments, but it can alert providers if their billing statistics look unusual as compared to their peers.

Taking a look at the history of the CBR program, we can see that the program was spearheaded back in 2010. 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. And then in 2019, RELI Group partnered with TMF and CGS to create and distribute both the CBRs and the PEPPER reports.

Now, that we have a sense of the history of the CBR, we can discuss why CMS issues the documents. 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. And 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 claim submission and the adherence to coding guidelines and this helps to encourage correct clinical billing. 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 can increase education and improve future billing practices.

At this point, if you received a CBR you may be asking, why did I receive a CBR? Well, a CBR is presented to a provider when the analysis of their billing patterns differs from the provider's peers a state specialty and/or nationwide level. The analysis of providers 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. It is important to always remember that receiving a CBR is not in any way an indication of, or a precursor to an audit.

Next, I am going to walk through the steps of accessing your report if you received one so we can see exactly how that is done. This page that you see here is cbrfile.cbrpeper.org. And that page contains the portal that you will use to access your CBR. I am going share my screen here and go to that page. We have that right here. And, the portal does require that you enter some information. So, I am going enter the information as we discuss what is needed. First, we will indicate the role that we play within the organization for the physician or physicians who receive the CBR. I have indicated here that I am the CEO 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.

Next, you will complete two forms to indicate your information and the provider information. So, when we fill out the forms, of course you will use your own information, but I am going to use the test information that you see here to complete these two forms.

Next we are going indicate how we heard about the CBR that is available for those physician or physicians. You can see that list right here. And this section of the access form and the portal form is really most telling to us here at RELI Group and it really helps us to know which form of alert is working best to reach the most physicians for their CBR alert. The first couple of sections on the list indicated the receipt of an email or a fax. Now, this would be an email or a fax that was delivered to the email account or fax number that is listed in the Provider Enrollment Chain and Ownership System that is commonly known as PECOS. We do encourage everyone to confirm their PECOS information and update as necessary so that we can contact the appropriate person regarding CBR information. Confirming this information several times a year allows for the email 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 to you to checkout the CBR program, we would love to know that. The next two entries, the provider or professional association or MAC notice, are indications of our work alongside the groups and the MACs that are so 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 do have the Open Door forums led by CMS. That is the next section down, or—excuse me—the next selection on the list. If you heard about the CBRs through one of those Open Door forums, please let us know. And then we do have that final alternative option, “other,” and if that option applies, of course please indicate as such. I am going to indicate that I saw a tweet about the CBR program. At the bottom of the form we will ask for the provider's NPI. And this will be the NPI number for the specific provider who received the CBR. I'm just going to put in a test NPI number. Of course, you will use the one for the provider who received the CBR. 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 that alert information. So again, check the information on the email alert or the fax alert to confirm your validation code to gain access to this portal. If you are in the position of having several providers who received a CBR, we can help with longer lists of NPI numbers through our help desk ticket system to provide the validation code information. And if you are sure that an individual provider or group of providers again was issued a CBR but you are unsure of the validation code, please submit a help desk ticket for those instances and we can assist.

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

So, we've seen how to access the CBR report. So, let's take a closer look at the sample document so we can fully understand the Drugs in Excess of MUE CBR, its metrics,

outcomes and comparisons. 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 document. The CBR is formatted into five sections, as you can see here. And these sections help to us focus on the process and the results of the CBR. I am going to share that document on my screen. The first page of the CBR and here we are. First of course we start with the introduction. Which is a brief explanation of the specific area and claims submission data that is addressed in the CBR. You can see here information discussing the CBR focus of drugs submitted in excess of MUE and information from the Office of the Inspector General, OIG, regarding the payment volume for outpatient drugs. Also, the criteria for receipt of the CBR is listed in this section as well.

Moving on to the coverage and documentation overview, this section identifies HCPCS codes of the J code, which the drug section, of the HCPCS book, which were analyzed in this report, and gives us information from National Correct Coding Initiative, the NCCI, manual regarding the MUE assignments that were established and what the MUE represents. Table one of the CBR is also listed in this section and table one contains the information for this sample provider for the allowed amounts, the submitted units and the beneficiary count during the analysis time frame.

The metric section is right underneath this next section of the CBR lists and explains the metrics used for the CBR analysis. It contains the definitions for the state and national peer groups, and it lists the possible outcomes for the CBR metric analyses.

And of course, we will go through all of this in greater detail later on in the webinar. The methods and results section is a review of the results of the CBR analysis followed by individual 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 the HCPCS code in the J code series, and then 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. We will scroll through here just to see how it is set up. You can see metric one is listed, here is the description of the calculation and the actual calculation in photo form for you, and then the table with the provider results. And that is repeated here for metric two, as you can see. And then metric three as well. This section also provides a graph, which is figure one, that you can see right here. And this graph displays a trend over time for the provider and again we will discuss this graph in a little bit more detail later on in the webinar.

And then 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.

This page CBRPEPPER.org is another page that you can use to access your CBR through the portal. If you click on the “Access your CBR” button highlighted there with the purple button,

you will be directed to the portal page that we reviewed, and you can begin the steps to complete the information for the portal to access your CBR.

Let's take a look now at the vulnerability of claim submission that contain units for drugs that are above the assigned MUE units, and how that plays into CMS's protection of the trust fund. A study from the OIG released in 2015 stated Medicare contractors nationwide pay providers \$11.5 billion for 26 million claim line items for outpatient drugs. In previous OIG reviews for outpatient services found that Medicare contractors overpaid providers by more than \$122 million for selected outpatient drugs. So, these large amounts of allowed charges for outpatient drugs reflect the high volume of claims and the submission of claims that are over the assigned MUE represent a risk to possible improper payment from the trust fund. So, all of those factors contributed to the selection of this topic for a CBR analysis.

Let's talk a little bit about exactly what an MUE or a medically unlikely unit is. Medically Unlikely Edit — I am so sorry, I said Medical Unlikely Unit, and I apologize — A Medically Unlikely Edit, an MUE, are used by Medicare Administrative Contractors, MACs, including durable medical equipment or DME MACs to reduce the improper payment rate for Part B claims. And an MUE for a HCPCS or a CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. And not all HCPCS and CPT codes have an MUE assigned to them. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS contractor use only. Those confidential MUE values are not releasable. And the public confidential status of MUEs may change overtime. The analysis that we did for this CBR uses only the publicly available MUE values. And you may get returned claims for MUE errors even when an MUE is not published. So that is not uncommon either.

So to tackle the issue of the possible improper payments that we discussed and the threat to the trust fund, the possible threat to the trust fund I should say, the CBR201912 was created to review statistics for rendering providers who consistently submitted claims with units of drugs in excess of an established MUE for those drugs with an assigned MUE that is greater than or equal to one. Specific metrics were created, as we saw earlier to further analyze the issue and evaluate provide results for education and comparative purposes.

To create the CBR201912, and the metrics within the report, we used detailed information for rendering providers again who submitted claims with units of drugs in excess of an established MUE for those drugs within the series J0000 through J9999, the J code series, with an assigned MUE that is greater than or equal to one during the CBR summary year of June 1st, 2018 — excuse me — July 1, 2018 through June 30, 2019. The results were based on claims extracted for the date range as of October 22, 2019. And those results showed that 323,865 providers submitted these claims, which represented over \$21.5 billion in allowed charges. And when we talk about those allowed charges, we are referencing the allowed charges listed in the Medicare

fee schedule. So that lets us compare similar charge figures across all providers and claims submissions regardless of the submitted or paid amount.

Here we see a list of the metrics analyzed within the CBR. Each metric was created to take a more detailed look at the submission of J codes in excess of the assigned MUE. So, the metrics are one, the percentage of submitted units for HCPCS codes within the J series with an MUE greater than or equal to one which were submitted in excess of the assigned MUE. Two, the percent of total allowed amount for HCPCS codes within the J code series with an MUE greater than or equal to one in claims submitted with units in excess of the assigned MUE. And then finally the percent of beneficiaries with claims submitted for the HCPCS codes within the J series with an MUE greater than or equal to one in excess of the assigned MUE. We will break down how each one of these metrics is calculated a little bit later but first let's take a look at each metric, understand why each analysis was selected and analyzed.

We'll start, of course, with Metric 1, which analyses the percent of submitted units for HCPCS codes within the J code section, that were submitted in excess of the assigned MUE. And for this analysis and for all the analyses, we are looking at the drug codes that have an MUE greater than or equal to one. Following the MUE assignments for these drugs, the ideal outcome for this metric would be a lower percentage rate that would reflect that most of the claim submissions for these codes are submitted using the appropriate units according to the assigned MUE.

Metric two looks at the percent of total allowed amount for the HCPCS codes in the J code series with an MUE greater than or equal to one and claims submitted with units in excess of the assigned MUE. This metric helps us put a dollar amount on the claims that were submitted for drugs above the allowed MUE for those specific J codes. Taking a look at how the submitted charges plays into the claims submission helps us see how the claims — how those claims play into the high dollar amount submitted for outpatient drugs that we talked about a few minutes ago in this webinar. Similar to metric one, again, the ideal outcome for this metric would be a lower percentage.

Metric three looks at the percent of beneficiaries that had claims submitted for HCPCS codes within the J series with an MUE greater than or equal to one in excess of the assigned MUE. And this final metric looks at the beneficiaries that are affected by the submission of claims that have a unit submission that is above the assigned MUE. So, this metric shows us the percentage of beneficiaries who have that type of claim submitted. And again, we would ideally see a lower percentage for this metric as well to represent a lower number of beneficiaries that are affected by those claims.

The in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria that you see here for receiving a CBR201912. Using all of the data and research, the CBR

team created this criteria to select the providers who will receive a CBR201912. The criteria is that the provider is significantly higher compared to either the state or national percentages or rates in any of the three metrics. So significantly higher is going to mean greater than the 90th percentile for metrics one and three, and greater than the 95th percentile for metric two. Also, the criteria states that the provider must have at least ten claims submitted with units of the J code series that have an MUE greater than or equal to one and were billed in excess of MUE. Following our discussion of each of the metrics, you can see that the criteria is directly related to the outcomes of all three of those metrics. The criteria states that the provider must be significantly higher in any of the three metrics. So, what does that term “above the 90th or 95th percentile” mean, and what are the other outcomes for the metrics?

Well, all four of those outcomes are listed here. These outcomes are the basis of comparisons made regarding the billing patterns against both of the providers’ peers. The four outcomes that can come of each metric analysis 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. The N/A outcome represents that the provider does not have sufficient data for comparison. However, the outcome of significantly higher requires a little 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. And the significantly higher outcome is greater than the 90th percentile for metrics one and three but greater than the 95th percentile for metric two. So, in order to talk about how exactly we calculate those percentiles, let’s go to the next slide.

And to help us understand the true meaning of the 90th and 95th percentile, I think that the visual that’s used on this slide can really help us out. In order to identify the providers who were above the 90th or 95th percentile, we calculated percentages for all providers for each of the metrics in each comparison group which would be the state — peer state and nation. We then order all of the providers’ percent values, highest to lowest. And if you use again the ladder visual as a reference and as a help, 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 ladder so the smallest percentages are at that bottom rung. Next, we identified the percent value below which 90 percent or 95 percent of the providers values fall. That would be the 90th or the 95th percentile mark, and that is represented above on the ladder visual by that black line. Any outcome for those metrics in which the provider’s percentage falls above that line would therefore have the outcome of significantly higher. And again, we want to remember that for metrics one and three, that black line represents the 90th percentile and for metric two, that black line represents the 95th percentile.

Let’s take a look at the calculation of each of the metrics and looking first at metric one, the percentage of submitted units for the HCPCS codes in the J series with an MUE greater than or

equal to one, which were submitted in excess of the assigned MUE. This metric was calculated by dividing the sum of all submitted units of the J code code set which have an MUE that is greater than or equal to one and were billed in excess of the MUE, that figure is divided by the sum of all submitted units that same J code code set. The result is multiplied by 100 to get the percentage. Again, when we look at the results of this metric, what we are asking ourselves is during the year of all the drug codes submitted from those J codes that have an MUE that is greater than or equal to one, what percentage were submitted with units that were above the assigned MUE? And looking at the sample figures on the CBR for metric one, go back to our sample CBR and go back to page five that contains table two. This has the statistics and the outcomes for the sample provider, and you can see here that the provider had a percentage of 31.53. And with the state percentage falling around five and a half percent and the national percent at 6.37, the outcome for this metric for this provider is significantly higher for the state and national comparisons. And again, that would be the significantly higher than — that is the 90th percentile. That is what gives us that significantly higher outcome for this metric one.

If we go back to our slides, we can discuss the calculation next of metric two. Which is the percent of the total allowed amount for the HCPCS code in the J code set that has a MUE greater than or equal to one, submitted with units in excess of the assigned MUE. Metric two is calculated by dividing the sum of the allowed amount for the J codes with an MUE greater than or equal to one and submitted in excess of the assigned MUE, that figure is divided by the sum of the dollar amount for all of the units of the J codes which have an MUE that is greater than or equal to one. So again, with that in mind, let's go back to our CBR and see where our sample provider fell. These results are on table three. And we with can see here that this provider's percent for this metric was about 15 and a half percent. But the state and national percentages were much lower, both falling under one percent. So, these results then were significantly higher for both the state and national comparison and again for metric two, significantly higher is above the 95th percentile.

So finally, let's take a closer look at metric three, the percent of beneficiaries with claims submitted for HCPCS codes within the J series with an MUE greater than or equal to one in excess of the assigned MUE. Metric three was calculated by dividing the number of beneficiaries with claims submitted with the J codes that have an MUE of greater than or equal to one and were submitted in excess the assigned MUE; that number is divided by the total number of beneficiaries that have claims submitted with the J codes that have an MUE greater than or equal to one. So, let's finally go back one more time to our sample CBR to take a look at the sample figures for metric three, and those are listed on table four. This provider had a lower percentage outcome for this metric, falling just under the ten percent mark. However, this state and national percentages are both very low at 3.27 and 3.59 percent so this provider has a

significantly higher outcome for metric three as well. And again, for metric three, we are looking at the 90th percentile that would trigger that significantly higher outcome.

And we looked before at the graph that the CBR includes that represents the provider's billing trend and that is the graph that you see here that represents three years, 2016 to 2019 for the number of J codes submitted over those three years. After the detail of the metrics and the analysis, it's nice to have this graph takes a step back and reviews an overall analysis for that three-year time period. And it looks like the sample provider had a large growth in submissions in the third year of this analysis as compared to the second year, and of course the first year.

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 resources page, cbr.cbrpepper.org/Help-Contact-Us. On this page you'll find a frequently asked questions link, and the 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 the frequently asked questions page, which is found at cbr.cbrpepper.org/FAQ. This page contains the list of frequently asked questions and has links to answers to various questions that you can see here. 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, and it will most likely have the information that you need or that you are looking for 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 Medicare Part B overpaid millions for selected outpatient drugs — that study from the Office of the Inspector General. You will see the HCPCS Level II Expert book and then you'll see the NCCI manual, the National Correct Coding manual from CMS.

This is a shot of our homepage, which is cbr.cbrpepper.org/home. There are sections for each of the CBRs that we have released in 2019 and 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. And this page also contains a link to join our mailing list to stay up to date on any announcements. It has 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 worked for you and your organization if you would be so kind as to submit that success story on our homepage.