Transcript for the CBR202001: Shoulder Arthroscopy February 5, 2020

I want to welcome you all to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically CBR202001 Shoulder Arthroscopy. My name is Annie Barnaby and I work for RELI Group, Inc., who is contracted with the Centers for Medicare and Medicaid Services, CMS, to develop, produce, and distribute CBR reports.

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. We're 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, CBR202001 Shoulder Arthroscopy, 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 or CBR is. 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 when we review a CBR document. Then we'll go into a discussion of this CBR and go through the details of the topic and the metrics for CBR2020001 Shoulder Arthroscopy. I will show you some helpful resources should you have any questions following the webinar, and finally I'll answer any submitted questions as time allows. So 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 or specialty 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 coded correctly and billed, and whether the treatment provider--provided to the patient was necessary and in line with Medicare payment policy. A CBR cannot identify improper payments, but it can alert providers if their billing statistics look unusual as compared to their peers.

Taking a look at the history of the CBR, we can see that this program was spearheaded back in 2010. 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 of those programs under one contract. Then in 2019, RELI Group has partnered with TMF and CGS to create and distribute CBRs and PEPPERs.

Now that we have a sense of the history of the CBR program, we can discuss why CMS issues those CBRs. Well, CMS is mandated and required by law to protect the Trust Fund from any improper payment or anything else that may compromise the Trust Fund. CMS employs a number of strategies to meet that 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 the effort to protect the Trust Fund. But CBR serves 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 help encourage correct clinical billing. Early detection of any outliers in your billing process can help to guide a compliance program that will support compliant operations in your own organization. Taking a closer look at specific coding guidelines and billing submission procedures can increase education and improve future billing practices.

You may be asking yourself, why do providers receive CBR reports? Well, a CBR is presented to a provider when the analysis of their billing pattern differs from the provider's peers on a state or nationwide--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 to the potential risk to the Trust Fund. It's 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 now walk through the steps of accessing your CBR report, if you received one, so we can see exactly how that's done. This page that you see here, cbrfile.cbrpepper.org contains the portal 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 so you can see exactly how that CBR is processed—or, excuse me--accessed from the portal. And as you can see, as I mentioned, the portal does ask for some information. And first it asks for the role that we play within the health care organization for the physician or physicians who received a CBR. I have indicated that I am the CEO of the organization, and 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. So, next, you see two forms for your information and the provider information. To access this test CBR, I, of course, have used test data to complete these forms, but you'll use the correct information here to complete those two forms. If I can just make my screen a little bit bigger in case you guys are having problems seeing that.

So following those two forms, we're going to indicate how we heard about the CBR that is available for the physician or physicians. This section of the access form is most telling to us here at RELI Group and really helps us to know which form of alert is working best to reach the most physicians for their CBR alert. The first few on the list indicate that you've received an email or a fax or a letter. This would be an email, fax or letter that came to the account or phone number or fax number, or address that is listed in the Provider Enrollment, Chain, and Ownership System, that's commonly known as PECOS. We do encourage everyone to confirm their PECOS information and update that as necessary so we can contact the appropriate person regarding CBR information. Confirming this information several times a year allows for the email most definitely to stay up to date, the other contact information as well. 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 love to know that. The next two entries, 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 one alternative option, "other," and if that option applies, of course, please indicate as such.

At the bottom of the form it asks for the provider's NPI number. This will be the provider's NPI number for the specific provider who received the CBR. And again, I'm just going to put a test one in.

Finally, 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 emailed alert, if you have an email or the mailed alert to confirm your validation code. 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 to provide validation code information.

I'm going to complete this form and then hit submit. Again, using a test validation code. And here we have the CBR in the file as it appears. So your CBR will appear in the same fashion in a PDF format ready for your review.

The portal really is quite user-friendly, and it can also be accessed through this page, cbrpepper.org. If you click on the access your CBR button highlighted here with the purple arrow, you'll be directed to the page that we just reviewed, the portal, and you can begin the steps that we just covered.

So we've seen how to access the CBR report. Let's now take a closer look at the sample document so we can fully understand the shoulder arthroscopy CBR, its metrics, outcomes and comparisons. 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.

I'm going to go and share my screen again, so we can take a look at the sample CBR. The CBR is formatted into five sections which help to focus on the process and results of the CBR. First, we have the introduction which is a brief explanation of the specific clinical area addressed in the CBR. In this case, of course, it is shoulder arthroscopy. You can see here also information regarding studies published, discussing shoulder arthroscopy procedures. And the introduction also contains criteria for receiving a CBR, which we'll go into much more detail in discussion later on in the webinar.

Moving on to the coverage and documentation overview. This section identifies the CPT® and diagnosis codes that were analyzed in the report. Table 1 and Table 2 are listed in this section. Table 1 contains the detailed descriptions of the CPT® and diagnosis codes used in the analysis. And you can see that here. And Table 2 contains the information for the sample provider for the allowed charges, the allowed units and the beneficiary count during the analysis time frame.

The Metrics of the CBR lists and explains the metrics used for the CBR. It contains the definitions for the state and national peer group and the possible outcomes for the CBR metric analyses.

Next, we have the methods and results section. This section 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, and the total rendering providers who have allowed charges for the shoulder arthroscopy, physical therapy, and subacromial injections for diagnoses related to shoulder complaints. Following that information, each metric is explained, the calculation for the metric is described and then the results for the provider for each metric are shown in table form.

So you can see that here with Metric 1. We have a description of the metric, we have the calculation for the metric, and then Table 3 contains the results and the outcomes for this sample provider. Metric 2, again we have the description, the calculation, and then the results in Table 4. And then again for Metric 3, the results, the calculation, and then the results there in Table 5. This section also provide a graph displaying the trend over time for the provider, and we'll discuss this table in a little bit more detail later on in the webinar.

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

Let's take a look now at the vulnerability of the costs and complications for shoulder arthroscopy. We saw in the introduction that the abstracts for several studies were cited to share information regarding the potential costs, the potential complications of shoulder arthroscopy. Let's take a look at each abstract for the information that they provide. First the abstract of a study named the cost—excuse me--*Cost of Shoulder Surgery*, shows results relating to the cost of shoulder surgery. The study evaluated four groups of 50 patients representing four arthroscopy treatment interventions. And found that in group 1, the average length of stay was three days, and the average total cost was about $9,000. For group 2, the average stay was 1.7 days, the average cost was about $8,600. Group 3 had an average stay of zero days and the average cost was about $7,200. And for Group 4 the average day was five days and the average cost was a little over $16,000. So you can see here a summary of those statistics. The length of stay was between 0 and 5 days, and the average cost was as low as about $7,200 and as high as a little bit over $16,000 mark.

Another study, *Costs Associated with the Evaluation of Rotator Cuff Tears before Surgical Repair* looks at data for a group of 92,688 patients. Those results showed a total of over $161 million in charges with an average cost per patient of $1,703. I apologize. I got ahead of myself with the slides. Here you can see the review of that cost associated with the evaluation of rotator cuff tears before surgical repair article.

Finally, a third abstract is referenced in the CBR for a study titled *Complications Associated with Arthroscopic Shoulder Surgery*. The results of this study in the abstract showed potential complications of vascular and neurological injury, fluid extravasation, stiffness, tendon injury and equipment failure. So, these results let us see the risks in patient care and status, and they're a good partner to the cost data we also just saw.

To look at the level of claims and the allowable amount submitted for shoulder arthroscopies for beneficiaries with shoulder complaints, the CBR202001 was created. The CBR analysis reviews statistics for rendering providers who submitted claims for shoulder arthroscopy. These claims were for beneficiaries treated for shoulder complaints who also underwent a shoulder arthroscopy procedure, to determine whether conservative treatment of physical therapy and subacromial injections were performed first for diagnoses that reflected shoulder complaints.

To create the CBR202001 and the metrics within the report, we used detailed information for that data for the CBR summary year of September 1st, 2018, through August 31st, 2019. The results were based on claims extracted for the date range as of January 7th, 2020. Those results showed that 17,154 providers submitted these claims, which represents over $254 million in

allowed charges. And when we talk about allowed charges, we're referencing the allowed charges listed in the Medicare Fee Schedule. So, this lets us compare similar charge figures across all providers and claims submissions regardless of the submitted or paid amount.

Here we have a list of the metrics analyzed within this CBR. Each metric was created to take a more detailed look at the submission of shoulder arthroscopy. The metrics are, one, percent of beneficiaries who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy, Metric 2, the average allowed amount per beneficiary who had shoulder arthroscopy without conservative treatment within 12 weeks prior to shoulder arthroscopy, and Metric 3, the average number of physical rehabilitation claims per beneficiary by any physician within 12 weeks prior to the shoulder arthroscopy. We'll break down 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 1, again, looks at the percent of beneficiaries who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy. So, this metric tells us of all the beneficiaries who had shoulder arthroscopy procedures during the analysis year, what percentage of those beneficiaries did not first receive conservative treatment for their shoulder complaint. The optical—excuse me, the optimal outcomes for this metric would be a low percentage outcome.

Metric 2 looks at the average allowed amount per beneficiary who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy. And again, this metric helps us to put a dollar amount on those claims that were submitted for the shoulder arthroscopy. Taking a look at how the submitted allowed amount plays into the submission of the claims helps us to take a look at that $254 million that were submitted for shoulder arthroscopy that we talked about a few slides ago.

And then finally, metric 3 as we saw looks at the average number of physical rehabilitation claims per beneficiary, by any physician within 12 weeks prior to the shoulder arthroscopy. This final metric tells us about the physical rehabilitation services associated with shoulder arthroscopy. The outcome of this metric tells us for each beneficiary, what's the average number of claims submitted for physical therapy prior to that shoulder arthroscopy. So, we can take a look at the conservative treatments of physical therapy that were attempted prior to the shoulder arthroscopy. So unlike metric 1, the optimal outcome of this metric would be a higher average number.

The in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a CBR202001. Using all of the data and research, the CBR team created criteria to select providers who will receive a CBR. That criteria is that the provider is significantly higher compared to either state or national percentages for metric 1, which would

be greater than or equal to the 90th percentile, or is significantly lower to the state or national percentages for metric 3, which would be less than or equal to the 10th percentile, and has at least five beneficiaries with CPT® codes for shoulder arthroscopy, and has at least $600 or more in total allowed charges for claims with CPT® codes for shoulder arthroscopy.

Following our discussion of each metric, you can see that the criteria is directly related to the outcomes for metrics 1 and 3. Metric 2 was created for the sole purpose of comparison data and the outcomes of metric 2 do not contribute to the receipt of a CBR. The criteria states that the provider must be slightly--significantly higher in metric 1 or significantly lower in metric 3's outcome. So what do the terms above the 90th percentile and less than or equal to the 10th percentile mean, and what are some of the other outcomes for metrics 1 and 3?

Well, all four outcomes are listed here. And these outcomes of the basis of the comparisons made regarding the provider's billing patterns and those of their peers. The four outcomes of this metric are, again, significantly higher or significantly lower. Again, that means that the provider's value is greater or equal to the 90th percentile for metric 1, or the provider's value is less than or equal to the 10th percentile from the state or national mean for metric 3.

The outcome higher or lower means that the provider's value is greater than the state or national mean, which would be higher for metric 1, or less than the state or national mean which would be lower for metric 3.

Does not exceed or is not below, those outcomes mean that the provider's value is less than or equal to the state or national mean. That would be does not exceed for Metric 1 only or is greater or equal to the state or national mean which is not below for Metric 3 only.

Then, of course, we have the outcome of NA which means that the provider did not have sufficient data for comparison.

The outcomes of significantly higher or significantly lower for Metrics 1 and 3 respectively require some more explanation to understand how a provider may fall into that outcome for the metric comparisons. So in order to talk about exactly how we calculate the 90th and 10th percentiles, let's go to our next slide.

I think that the visual on this slide can help us to understand the true meaning of the 90th and 10th percentile. It is important to fully understand these outcomes as they are criteria for the receipt of a CBR. In order to identify the providers who were above the 90th percentile or less than or equal to the 10th percentile, we calculated percentages for metrics 1 and 3 in each comparison group, for all the providers. We then order all of the providers' percent values from highest to lowest. And if you use the ladder as a visual reference, imagine that the highest percentages are listed at the top of the ladder, and then in the list in descending order down the length of the ladder so the smallest percentages are at that bottom rung.

Next, for instance, for Metric 1, we identify the percent value below which 90% of the providers' value falls. This is the 90th percentile mark and it is represented above on the ladder visual by that top black line. Any outcome in which the provider's outcome falls above or equal to that point would, therefore, have the outcome of significantly higher for Metric 1. And the same process applies for the 10th percentile. We look at the percentages and calculate the point below which 10% of the provider's values falls. That point is shown on the ladder by the line, at the bottom of the ladder on the bottom rung. This calculation is used for Metric 3, of course, and the providers who fall in this range that are greater than or equal—or excuse me, lower than or equal to the 10th percentile and have a significantly outcome of significantly lower for Metric 3.

So, let's now take look at each metric individually and the outcomes for the sample provider on our sample CBR. Let's go back to looking at Metric 1, the percent of beneficiaries who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy. Now, this metric was calculated by dividing the beneficiaries with shoulder arthroscopy without conservative treatment, that number is divided by the beneficiaries who received shoulder arthroscopy, and then the result is multiplied by 100. Let's go back to our sample CBR and see where our provider fell. These are on Table 3 as we saw earlier. You can see from these sample provider outcomes that this provider had a percentage of 83.33%, which means that 83.33% of beneficiaries with shoulder arthroscopy procedures performed did not have conservative treatment within 12 weeks prior to the procedure. With the state percentage falling at 68.64, and the national percentage at 88.89, the outcome for this metric for this provider is higher for the state and national comparison.

Next we have Metric 2, the average allowed amount for beneficiary who had shoulder arthroscopy without conservative treatment within 12 weeks prior to the shoulder arthroscopy. Metric 2 is calculated by dividing the sum of the allowed amount for beneficiaries with shoulder arthroscopy without conservative treatment, that number is divided by the count of beneficiaries with shoulder arthroscopy without conservative treatment. So, with that in mind, let's go back to our sample CBR and see where our provider fell for this outcome. These are shown on Table 4, as you can see here. And we can see that this provider's average was over $19,000. The state average was over $80,000. And the national average is over $52,000. So, these results then produced an outcome of does not exceed for this provider for both the state and national comparisons.

And then finally we have Metric 3. The average number of physical rehabilitation claims per beneficiary by any physician within 12 weeks prior to the shoulder arthroscopy. Now, this final metric was calculated by dividing the rehabilitation claims prior to the arthroscopy by the beneficiary—beneficiaries, excuse me, with shoulder arthroscopy procedures. This metric shows us the average number of physical rehabilitation claims that each beneficiary had within

12 weeks prior to a shoulder arthroscopy procedure. So, let's see the sample figures on the CBR for Metric 3. These are on Table 5. This provider had an average outcome of 1.25 for this metric. The state average is a little bit over 11 and a half, and the national average is just under 11. So, this provider had an outcome of significantly lower for the state comparison, and an outcome of lower for the national peer comparison.

As we mentioned before, the CBR does include a graph that represents the provider's billing trend over three years, 2016 to 2019. This specific figure shows us the total number of beneficiaries with submitted claims for shoulder arthroscopy procedures. And after the detail of the metrics and the analysis, it's nice to have the graph that kind of takes a step back and reviews an overall analysis of the claim submission for that three-year time period. As we can see, this sample provider didn't have too much variation for the shoulder arthroscopy procedures submitted the claims over that three-year time period.

At this point I want to review the resources that we have available to you, if you received a CBR, or even if you would just like further information about the process. We have a helpful resources page which is CBR.CBRPEPPER.org/help-contact-us. 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 page before submitting a help desk ticket because those frequently asked questions may be able to answer your inquiry.

And here we have a closer look at those frequently asked questions on the frequently asked questions page, which is CBR.CBRPEPPER.org/faq. And again, this page contains the list of frequently asked questions and has links to answers to various inquiries that you can see here. You can 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 the reporting that the CBR team used in the creation and the analysis of this CBR. You'll see here the CPT®® manual, the ICD expert, as well as those articles that were referenced in the introduction of the CBR that discussed the complications and costs associated with shoulder arthroscopy.

Here we have a shot of our home page, CBR.CBRPEPPER.org/home. There are sections for each of the CBRs that we have released in 2019 and then in 2020. For each CBR topic and release, we provide links to a sample CBR, our training materials, the data set and then the link to the portal to access your CBR. This page also contains a link to join our mailing list to stay up to date for any announcements, a link to provide feedback to the CBRs, and a link to submit a CBR success story. And we always would love to hear how the CBR process worked for you and your organization. So, please don't hesitate to click that link and submit your success story.