



## **Transcript for the CBR202003: Lower Extremity Joint Replacement**

Hello and thank you for joining us today. Welcome to our webinar where we will be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202003: Lower Extremity Joint Replacement*. 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 resources are listed here for your convenience. We do have the webinar slides available to you in a file that is posted to our website. And, if you have a question about the CBR topic, the CBR Help Desk, which is the last bullet there, can answer those inquiries. Don't be afraid to submit a ticket; we are here to help.

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 the specific Comparative Billing Report *CBR202003: Lower Extremity Joint Replacement*, 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 a 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 metrics. I'll show you some helpful resources should you have any questions following the webinar. You can, again, submit those to our Help Desk that is found on our website. 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 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, we can see that this program was spearheaded 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 of those programs under one contract. And then beginning in 2019, RELI Group partnered with TMF and CGS to create and distribute CBRs and PEPPERS.

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

You may be asking yourself, why do providers receive CBR reports? A CBR is presented to a provider when the analysis of their billing patterns differs from the provider's peers on a state, specialty, and/or nationwide level. The analysis of the 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. It is important to remember that receiving a CBR is not, in any way, an indication of, or a precursor to an audit.

I'm going to walk you through now the steps of accessing your report if you received one so we can see exactly how it's done. This page, [cbrfile.cbrpepper.org](http://cbrfile.cbrpepper.org), contains the portal that you'll use to access your CBR. The portal does, of course, require that you enter some information. And I'm going to open this page on my screen now to show you exactly what it looks like when a CBR is accessed through the portal. So, to fill out the form for the portal access, first we'll indicate the role that we play within the health care organization for the physician or physicians who received a CBR. I've indicated that I am an administration — administrator 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'm authorized to view this confidential data.

Next, these two forms are completed to indicate my information and the provider information. To access this sample CBR, of course, I'll use test data to complete these forms, but you'll use the correct information here to complete each of these forms.

Following that, 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 most telling to us and really helps us

to know which form of alert is working best to reach the most physicians for the CBR alert. So, the first several options on the list is to indicate that you received an email, a fax, or a letter. These would be sent to the contact information that is listed on the account 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 if necessary so that we can contact the appropriate person regarding CBR information. And confirming this information several times a year allows for that contact information to stay up-to-date and lessens any issues that may arise otherwise. So, 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 one alternative option, other. And if that option applies to you, of course, please indicate as such.

The very bottom of the form, you can see that the portal asks for the provider's NPI number. This would be the NPI for the specific individual provider who received the CBR. Of course, I've entered a placeholder NPI number for this test. And then 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 emailed, faxed, or mailed alert to confirm your validation code. If you're sure that an individual provider was issued a CBR but you're unsure of the validation code, please submit a ticket to our Help Desk for this instance, and we can assist you. So, I'm going to complete the form. I'm going to say that I received an email. And then I'm going to 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.

This page, [cbrpepper.org](http://cbrpepper.org), is another page that you can use to access your CBR from the portal. If you click on the Access Your CBR button highlighted here with the purple arrow, you'll be directed to the portal page that we just reviewed, and then 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 lower extremity joint replacement 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 the sample document.

This CBR is formatted into five sections, as you can see here, which help to focus on the process and the results of the CBR. I'm going to share a sample CBR here with you on my screen and we can see each of those sections as we review the sample document.

First, of course, we have the introduction. The introduction is a brief explanation of the specific clinical area addressed in the CBR, in this case of course it is lower extremity joint replacement procedures that were on patients with osteoarthritis without first attempting conservative measures. You can see also here in the introduction information regarding projected improper payments, and information from several articles discussing appropriate clinical treatment for osteoarthritis. The introduction also contains the criteria for receiving a CBR. We'll go into more detail about that criteria later on in the webinar.

But first, moving on to the...the coverage and documentation overview — this section identifies the CPT® and diagnosis codes that were analyzed in the report. Table one and table two are listed in this section; table one contains the detailed descriptions of the lower extremity joint replacement, physical and occupational therapy, therapeutic injections, and then the diagnosis codes for osteoarthritis. And then you can see table two contains the information for this sample provider for the allowed charges, allowed units, and beneficiary count during the analysis timeframe.

Moving on to the metrics of the CBR. 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 is the methods and results section, which is a review 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, and the total rendering providers who had allowed charges for lower extremity joint replacement procedures. 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. So, you can see here, starting with Metric 1, we have a description of the metric, the calculation, and then the results. And that's repeated, of course, in Metric 2. An explanation of the metric, the calculation, and then the results here in table four. And then finally Metric 3 contains, of course, the explanation of the metric, the calculation, and the results for the provider. This section also provides a graph displaying the trend over—a trend over time for the provider; and we'll discuss this graph and table in a bit more detail later on in the webinar.

But finally, in the sample CBR, we have the references and resources section which lists the reports and documents used for the creation CBR, and those created to help you as you have questions about this CBR

Let's take a look now at the vulnerability of correct payments for lower extremity joint replacement procedures and how that plays into CMS's protection of the trust fund. We saw in the introduction information regarding projected improper payment rates. So, let's review those reports for the information that they provide.

You'll see here the results from the 2019 Medicare Fee-for-Service Supplemental Improper Data Report. These results that we see here are for Part A data, but they are relevant to our analysis. If a physician initiates an admission for a procedure that may not be medically necessary, then the admission and the charges related to the procedure would therefore — therefore be medically unnecessary. And those data figures help us to see the scope of the possible improper payments for hip and knee replacement procedures in that context. So, looking at the figures, in 2019, major hip and knee replacement procedures fell within two projected improper payment top 20 lists — the list for insufficient documentation errors and the list for medical necessity errors. And you can see here what those results mean in terms of percentage of improper payment rates for major hip and knee replacement procedures.

In terms of insufficient documentation, these procedures had a 3.6% projected improper payment rate representing over \$245 million. And then in terms of medical necessity errors, the projected improper payment rate is 6.4%, which represents over \$439 million. So, this data plays into Medicare's analysis of the clinical procedures and the protection of the trust fund. And it plays into the reasoning behind the CBR analysis.

To look at the level of claims and allowable amounts submitted for lower extremity joint replacement procedures, the *CBR202003* was created. The CBR analysis reviews statistics for rendering providers who submitted claims for lower extremity joint replacement procedures on patients with osteoarthritis without first attempting conservative measures.

To create the *CBR202003* and the metrics within the report, we used detailed information for that data during the CBR summary year of November 1, 2018 through October 31, 2019. The results were based on claims extracted for that date range as of February 17, 2020. And those results show that over 20,000 providers submitted these claims, which represents over \$720 million in allowed charges. And when we talk about allow — allowed charges, we are referencing the allowed charges that are listed in the Medicare fee schedule. This lets us compare similar charge figures across all providers and claim 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 lower extremity joint replacement procedures. The metrics are the percent of beneficiaries with osteoarthritis who received a lower extremity joint replacement without prior conservative treatment; the average allowed amount per beneficiary with osteoarthritis who received lower extremity joint replacement without

conservative treatment—and then the average number of physical rehabilitation claims per beneficiary with osteoarthritis with a lower extremity joint replacement.

We'll break down how each of these metrics is calculated a little bit 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 with osteoarthritis who received lower extremity joint replacement without prior conservative treatment. So, this metric tells us, of all the beneficiaries diagnosed with osteoarthritis who received a lower extremity joint replacement, what percentage of those patients did not first receive conservative treatments prior to the procedure? This metric is truly where those articles from the introduction of the CBR come into play and looks at the provider's use of conservative treatments for patients who have osteoarthritis.

Metric 2 looks at the average allowed amount per beneficiary with osteoarthritis who received a lower extremity joint replacement without conservative treatment. And this metric helps us to put a dollar amount on the claims for lower extremity joint replacement procedures. Taking a look at how the allowed amounts play into the claim submissions helps us to see how the submissions play into that possible improper payment from that 2019 Medicare Fee-for-Service Supplemental Improper Payment Report that we talked about a little bit earlier in the webinar.

And then finally, Metric 3, again, looks at the average number of physical rehabilitation claims per beneficiary with osteoarthritis with lower extremity joint replacement. And this final metric takes a closer look at those physical rehabilitation claims that were submitted for beneficiaries who have osteoarthritis who undergo a lower extremity joint replacement. The outcome of this metric tells us, with the submission of the joint replacement, what's the average number of claims submitted for physical therapy one year prior to the surgery.

The in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202003*. Using all of the data and research, the CBR team created criteria to select the providers who will receive a *CBR202003*. The criteria is that the provider is significantly higher compared to either the state or national averages or percentages in metrics 1 or 2, that would be greater than or equal to the 90<sup>th</sup> percentile, or is significantly lower compared to either the state or national percentages for metric 3, which is less than or equal to the 10<sup>th</sup> percentile. And, has at least 10 beneficiaries with CPT® codes 27130 or 27447, and has at least \$15,000 or more in allowed charges for CPT® codes 27130 or 27447.

Following our discussion of each metric, you can see that the criteria is directly related to the outcomes for all three of those metrics. The criteria states that the provider outcomes must be significantly higher in metrics one or two or significantly lower in metric three. So, what do the

terms “above the 90<sup>th</sup> percentile” and “less than or equal to the 10<sup>th</sup> percentile” mean, and what are some of the other outcomes for the metrics?

We have all four outcomes listed here. These outcomes are the basis of the comparisons made regarding your billing patterns and those of your peers. The four outcomes that can come of each metric analysis are significantly higher or lower; this means the provider’s value is greater than or equal to the 90<sup>th</sup> percentile from the state or national mean, or the provider’s value is less than or equal to 10<sup>th</sup> percentile from the state or national mean. The higher or lower outcome means the provider’s value is greater than the state or national mean for Metrics 1 or 2, or the provider’s value is less than the state or national mean, for Metric 3. Does not exceed or is not below would represent that the provider’s value is less than or equal to the state or national mean. Does not exceed for Metrics 1 and 2, or the provider’s value is greater than or equal to the state or national mean, for — is not below, for Metric 3. And then not applicable or N/A outcome would mean that the provider does not have sufficient data for comparison.

The outcomes of significantly higher for Metrics 1 and 2 require a little bit more explanation to understand how a provider may fall into that outcome for the metric comparison. Also, the significantly lower outcome for Metric 3. And we saw that the — we see that the significantly higher outcome indicates the provider’s value is above the 90<sup>th</sup> percentile, and the significantly lower outcome indicates that the provider’s value is less than or equal to the 10<sup>th</sup> percentile. So, let’s talk about how exactly we calculate that 90<sup>th</sup> and the 10<sup>th</sup> percentile, and to do that let’s go to our next slide.

Because I think the visual on this slide can help us to understand the true meaning of that 90<sup>th</sup> and the 10<sup>th</sup> percentiles. 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 90<sup>th</sup> percentile or less than or equal to the 10<sup>th</sup> percentile, we calculated outcomes for all providers for each of the metrics in each comparison group, that would be the peer state or the nation. We then order all of those outcomes from highest to lowest for each metric. And if you use the ladder visual as a reference, imagine that the highest outcomes 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 outcomes are at that bottom rung. Next, we identify the value below—below which 90% of the provider’s values fall. This is the 90<sup>th</sup> percentile mark represented on the ladder visual here on this slide by the black line at that top of the ladder. Any outcome for a metric in which the provider’s outcome falls above or equal to that point would therefore have the outcome of significantly higher because they would be above that 90<sup>th</sup> percentile point. The same applies for the 10<sup>th</sup> percentile. We look at the percentages calculate the point below which 10% of the provider’s values fall. That point is shown on the ladder by the line at the bottom of the ladder on that bottom rung. This calculation is used for Metric 3, and the providers who fall in this range are lower than the 10<sup>th</sup> percentile and have an outcome of significantly lower for Metric 3.

So, let's look at each metric individually now and the outcomes for the sample provider on our sample CBR. Looking first at Metric 1, the percent of beneficiaries with osteoarthritis who received lower extremity joint replacement without prior conservative treatment. The total number of beneficiaries with osteoarthritis who underwent a lower extremity joint replacement without first receiving conservative treatment is placed in the numerator. And that number is divided by the total number of beneficiaries with osteoarthritis who underwent a lower extremity joint replacement, that's in the denominator. The result is multiplied by 100 to get our percent value.

So, going back to our sample CBR to take a look and see where the sample provider fell with the outcomes for Metric 1. Those are found on table three here on page six. You can see this provider had a percentage of 83.33%, which means that 83% of the beneficiaries who had a joint replacement did not first receive conservative treatment. With the state percentage falling a little around the 63% mark and the national percentage at 51.36, the outcome of this metric for this provider is higher for the state comparison and significantly higher for the national comparison.

Going back to our slides to take a look at Metric 2, which is the average allowed amount per beneficiary with osteoarthritis who received lower extremity joint replacement without conservative treatment. And Metric 2 is calculated by dividing the total allowed amount for beneficiaries with osteoarthritis with a lower extremity joint replacement who did not first receive conservative treatment, that number is divided by the beneficiaries with osteoarthritis with a lower extremity joint replacement but did not receive conservative treatment. So again, let's keep that in mind where we see where the provider — excuse me, the sample provider fell with their results. And those results are here in table four. And you can see that the provider's average was around \$2,000. The state average is \$888, and the national average is very close, around \$840. So these results, produced an outcome of significantly higher for this provider for both the state and the national comparisons.

And then finally, back to the slides to take a look at Metric 3. And again, you'll remember that Metric 3 is the average number of physical rehabilitation claims per beneficiary with osteoarthritis who underwent a lower extremity joint replacement. This final metric was calculated by dividing the total number of rehabilitation claims for each beneficiary with osteoarthritis performed prior to a lower extremity joint replacement, and then, in the denominator, we have the beneficiaries with osteoarthritis who also underwent a lower extremity joint replacement.

So, let's see the sample figures for Metric 3. And you can see that this provider had an average of 0.17. The state average was 0.38, and the national average was 0.50. So, with these comparisons, this provider had an outcome of lower for both the state and the national average.



As I mentioned, before that the CBR includes a graph that represents the provider's billing trend. over the three years, 2016 to 2019, And, this graph represents the trend over time analysis, of number of beneficiaries for whom claims with lower extremity joint procedures were submitted. So, after the details of the metrics and the analysis, it's nice to have this graph that takes a step back and reviews an overall analysis for that three-year time period. So, we can see here that this provider had beneficiaries with claims for both the hip and knee replacement, and that in year three there were fewer claims submitted than years one and two.

At this point, I do want to review the resources we have available to you if you received a CBR or even if you would just like information about the process. We have a helpful resources page, which is [cbr.cbrpepper.org/help-contact-us](https://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 again if you have any questions about today's webinar, please submit those to the Help Desk request system.

Here's a closer look at that frequently asked questions page, which is [cbr.cbrpepper.org/faq](https://cbr.cbrpepper.org/faq). And this page, of course, contains the list of the frequently asked questions and has links and answers to various questions that you can see here. You simply click on the question, and the answer will populate. And this list truly has served very useful to many people who have questions about the CBR process.

These helpful resources that you see here are the documentation and reporting that the CBR team used in the creation of the CBR. You can see CPT® manual, the ICD-10 Expert, as well as the articles referenced in the introduction of the CBR that discuss the complications and costs associated with lower extremity joint replacement services. And you can also see the 2019 Medicare Fee-for-Service Supplemental Improper Payment Data Report that we discussed within the webinar.

Here we have a screenshot of our home page, which is [cbr.cbrpepper.org/home](https://cbr.cbrpepper.org/home). There are sections for each of the CBRs that we released in 2019. For each CBR topic and release, we provide links to a sample CBR, the training materials, the dataset, 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 and a link to provide feedback on the CBRs, and a link to submit a CBR success story. We would love to hear how the CBR process work for you and for your organization.

Thank you so much for joining us today. I hope you found this webinar to be beneficial. If you do have any questions, again, please submit them to our Help Desk at [cbr.cbrpepper.org/help-contact-us](https://cbr.cbrpepper.org/help-contact-us).