Transcript for the CBR202004: Peripheral Vascular Intervention for Claudication

Hello, and thank you for joining us today. Welcome to our webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202004: Peripheral Vascular Intervention for Claudication*. 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'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 in a file that is posted to our website. And if you have a question about the CBR topic, the CBR Help Desk can answer those questions. Submit a ticket to the address shown in that bottom bullet on this slide, and we will respond. We are here to help, so don't be afraid to reach out.

The objectives of today's webinar will be to understand the purpose and use of Comparative Billing Reports, to explain the function of this specific Comparative Billing Report – *CBR202004: Peripheral Vascular Intervention for Claudication* – 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'll show you how to access your CBR, if you received one. I do have a sample CBR that we will review so that we can get a good sense of what we're looking at when we review a CBR document. Then we'll go into a discussion of this CBR and go through the details of the topic and metrics for *CBR202004*. I will show you some helpful resources, should you have any questions following the webinar. 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 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. Now, 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 programs under one contract. And then, beginning in 2019, RELI Group has partnered with TMF and CGS, to create and distribute CBRs and PEPPERs.

So 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 program to be an educational tool that supports their efforts to protect the Trust Fund. CBRs serve several purposes on the provider side as well. The CBR program helps to support the integrity of claims submissions 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 exactly do providers receive CBR reports? Well, a CBR is presented to a provider when the analysis of their billing patterns differ from the provider's peers on a state or specialty and a 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 always important to remember that receiving a CBR is not in any way an indication of or a precursor to an audit.

Next, I'm going to walk you through the steps of accessing a CBR report, if you received one, so we can see exactly how that's done. This page, cbrfile.cbrpepper.org, contains the portal that you'll use to access your CBR. And I'm going to pull that portal up on my screen right now so that we can see exactly how the portal works to access your CBR.

The portal does require that you enter some information that you can see here. And to begin that information, first we'll indicate the role that we play within the health care organization for the physician or physicians who received a CBR. I'm going to indicate that I am an administrator of this 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, we'll complete these two forms that indicate your information and the provider information. To access this test CBR, of course, I'll use test data to complete these forms, but you'll use the correct information here to complete them.

Enter this information here. And then, following those two forms, we're going to indicate how we heard about the CBR that is available for the physician. 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 providers for their CBR alert. So, the first few items on the list indicate that an email, fax, or letter was received. And this would be contact information email, fax, letter that were sent to the account 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, if necessary, so that we can contact the appropriate person regarding CBR information. And confirming this information several times a year allows for the email to stay up to date, along with the fax number and the physical address, and lessens any issues that may arise otherwise. I'm going to indicate that I received an email notifying that I had a CBR.

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 are provider or professional association, and MAC notice. These two 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, indicate as such.

At the bottom of the form, we ask for the provider's NPI number. This will be the NPI for the specific provider who received the CBR. I'm going to put in a false one here.

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 the emails, or the fax, or the mailed alert to confirm your validation code. If you are sure that an individual provider was issued a CBR, but you are unsure for any reason of the validation code, please admit to Help Desk ticket for this instance, and we can assist.

So, I'm going to complete the forum and then 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 that we see here, cbrpepper.org, is another page that you can use to access your CBR and to access 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 you can begin those steps to complete the form for the portal.

So, we've seen how to access the CBR report. Let's now take a look – a closer look at the sample document so we can fully understand the peripheral vascular intervention for

claudication CBR, it's metrics, outcomes, and comparisons. The results shown on the CBR will, of course, differ from those on your CBR, if you received one, but the formatting and sections on your CBR will be consistent with the layout of this sample document.

The CBR is formatted into five sections that you can see here, and each section helps to focus on the process and the results of the CBR. I'm going to share my screen now to share the sample document with you. And you can see, of course, that we start here with the introduction. The introduction is a brief explanation of the specific clinical area addressed in the CBR. In this case, of course, it is peripheral vascular intervention – or PVI – procedures on patients with non-emergency intermittent claudication without first attempting conservative measures.

And you can see here also information regarding projected improper payments, and information from several articles discussing appropriate clinical treatment for peripheral artery disease, and the importance of exercise training and other conservative treatments. The introduction also contains the criteria for receiving a CBR, and we'll go into much more detail about that later on in the webinar.

But first, moving on to the coverage and documentation overview – this section identifies the CPT® and diagnosis codes that were analyzed within the report, and several references and reports from CMS that discuss the CBR topic. You'll see here a Medicare Learning Network article discussing supervised exercise therapy as a treatment for intermittent claudication, and a Medicare National Coverage Determination discussing the research behind supervised exercise therapy and the benefits to patients.

Table one and table two are listed in this section. Table 1 contains the detailed descriptions of the peripheral vascular disease – excuse me – the peripheral vascular intervention CPT® codes and those CPT® codes for peripheral artery disease, and rehabilitation – excuse me – and the ICD codes for intermittent claudication. And following that, in table two, we have information for the sample provider for the allowed charges, allowed units, and beneficiary count during the analysis time frame.

Following that, we have the metrics of the CBR. This 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. The methods and results 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 here of the dates of service included in the report analysis and the total rendering providers who have allowed charges for peripheral vascular intervention procedures. Following that, 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 four. And you can see that here, starting with Metric 1. We have a description of the metric, the calculation, and then

the results here in table three. That's repeated for Metric 2. We have a calculation, a description, and then the results for Metric 2 are in table four. And then, finally, Metric 3 – we do have a description, the calculation, and then the results in table five. This section also provides a graph displaying a trend over time for the provider, and we'll discuss this graph in a little bit more detail later on in the webinar.

But finally, the references and resources section – this section lists reports and documents used for the CBR creation, and those created to help you as you have any questions about the CBR. Go back to our slides. Let's take a look now at the vulnerability of correct payments for vascular surgery 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 that report more closely. You'll see here the results from the 2019 Medicare Fee-for-Service Supplemental Improper Payment Data Report. That stated that, in 2019, vascular surgery had a projected improper payment rate of 10.5%. This rate represented dollar figure of over $45 million in projected improper payments.

The report also showed a particularly high error rate of 64.1 that was due to insufficient documentation. This, of course, means that 64% of the projected improper payments for vascular surgery were due to insufficient documentation. And this data plays into Medicare's analysis of the clinical procedures and the protection of the Trust Fund, and it plays an important role in the reasoning behind the CBR analysis.

To look at the level of claims and allowable amounts submitted for peripheral vascular intervention procedures, the *CBR202004* was created. The CBR analyzes and reviews statistics for rendering providers who performed peripheral vascular intervention procedures on patients with intermittent claudication without first attempting conservative measures. And for the purposes of this webinar and for the purposes of the CBR analysis, "conservative measures" refers to supervised exercise programs and other conservative measures performed during the three-month period preceding the peripheral vascular intervention procedure.

To create the *CBR202004* and the metrics within the report, we use detailed information for that data during the CBR summary year of December 1, 2018 through November 30, 2019. The results were based on claims extracted for the date range as of March 13, 2020. And those results showed that over 9,000 providers submitted these claims, which represent over $922 million in allowed charges.

And when we talk about allowed charges, we are referencing the allowed charges listed in the Medicare Fee Schedule. This lets us compare similar charge figures across all providers and claims submissions regardless of the submitted or the 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 – of peripheral vascular procedures.

The metrics are the percent of claims for peripheral vascular intervention performed on beneficiaries with intermittent claudication without supervised exercise therapy, the average allowed amount per beneficiary with intermittent claudication, and the average number of supervised exercise therapy claims per beneficiary with intermittent claudication with peripheral vascular intervention. We'll break down how each of these metrics is calculated a little bit later, but first, let's take a look at each metric to understand why each analysis was selected and analyzed.

Metric 1 looks at the percent of claims for peripheral vascular intervention performed on beneficiaries with intermittent claudication without supervised exercise therapy. This metric tells us, of all the beneficiaries who have intermittent claudication who received a peripheral vascular intervention procedure, what percentage of those beneficiaries did not first receive conservative measures to treat the intermittent claudication?

This metric truly reflects the information that we saw in the articles from the introduction of the CBR and the MLN Matters and the national coverage determination that we saw in the coverage and documentation overview section of the CBR discussing the benefits of first attempting conservative measures to treat patients with intermittent claudication.

Metric 2 looks at the average allowed amount per beneficiary with intermittent claudication. This metric helps us to put a dollar amount on the treatment for patients with intermittent claudication overall. And taking a look at how the allowed amounts play into the claims submission helps us to see how those claims play into the possible improper payments from the 2019 Medicare Fee-for-Service Supplemental Improper Payment Report that we talked about a little bit earlier.

Metric 3 looks at the average number of supervised exercise therapy claims per beneficiary with intermittent claudication with peripheral vascular interventions. Now, this final metric takes a closer look at the claims for conservative measures and supervised exercise therapies that are submitted for beneficiaries, who have the intermittent claudication, who undergo a peripheral vascular intervention. The outcome of this metric tells us, with the submission of peripheral vascular interventions, what is the average number of claims submitted for conservative treatment prior to the procedure?

The in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202004*. Using all the data and research, the CBR team create the criteria to select the providers who will receive a *CBR202004*. That criteria is that the provider is significantly higher compared to either the state or national percentages for Metric 1, or to the state or national average for Metric 2, which would be greater than or equal to the 90th percentile – or is significantly lower compared to either the state or national average for Metric 3, which would be less than or equal to the 10th percentile.

The provider has at least 15 beneficiaries with peripheral vascular intervention CPT® codes, and the provider has at least $6,000 or more in total allowed charges for peripheral vascular intervention CPT® codes. So, following our discussions 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 must be significantly higher in Metrics 1 or 2, or significantly lower in Metric 3's outcome. So, what are the terms above the 90th percentile and less than or equal to the 10th percentile mean, and what are some of the other metrics for the outcome – or what are some of the other outcomes for the metrics? Excuse me. Well, all four outcomes are 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 significantly lower. That means, again, the provider's value is greater than or equal to the 90th percentile for Metrics 1 or 2, or the provider's value is less than or equal to the 10th percentile for Metric 3. Higher or lower means the provider's value is greater than the state or national mean for Metrics 1 and 2, or the provider's value is less than the state or national mean, which would be lower for Metric 3.

Does not exceed or is not below means that the provider's value is less than or equal to the state or national mean for Metrics 1 or 2 – that would be does not exceed – or the provider's value is greater than or equal to the state or national mean, which would produce an outcome of is not below for Metric 3. And then not applicable means that the provider does not have sufficient data for comparisons.

The outcomes of significantly higher or significantly lower for Metrics 1 or 2 require a little bit more explanation to understand how a provider might fall into that outcome for the metric comparisons. So, let's talk about exactly how we calculate the 90th and 10th percentiles, and to do that, let's go to our next slide.

I think that the visual in this slide can help us to understand the true meaning of the 90th and the 10th percentile. And it is important to fully understand these outcomes, as they are part of the 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 outcomes for all providers for each of the metrics in each comparison group, which would be peer, state, and nation. We then all order all of the providers' values from highest to lowest. And if you use the ladder on the slide as a visual 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 values are at that bottom rung. Next, we identify the value below which 90% of the provider's values fall. This is the 90th percentile mark represented above on this ladder visual by the black line at the top of the ladder. Any outcome for Metrics 1 or 2 in which the provider's outcome or

value falls above or equal to that point would therefore have the outcome of significantly higher for Metrics 1 and 2. The same applies for the 10th percentile. We look at the values and 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, on that bottom rung. And this calculation is used for Metric 3, and the providers who fall in this range are less than or equal to the 10th percentile and have an outcome of significantly lower for Metric 3.

Let's now look at each metric individually and the outcomes for the sample provider on our sample CBR. Looking first at Metric 1 – the percent of claims for peripheral vascular intervention performed on beneficiaries with intermittent claudication without supervised exercise therapy. To calculate Metric 1, the total claims for peripheral vascular intervention performed on beneficiaries with intermittent claudication without supervised exercise therapy is placed in the numerator. And that is divided by the total peripheral vascular intervention claims for beneficiaries with intermittent claudication. That is the denominator. And that result is then multiplied by 100 to get our percent. So, let's look at the sample figures on the CBR for Metric 1. And those are on page three, I believe. Those are down. I apologize. They are in table three on page seven here. You can see that this provider – the outcomes are listed here, again, on table three. And this provider had a percent of 100%, which means that of all of the beneficiaries with intermittent claudication who had a peripheral vascular intervention did not first receive conservative treatment. Now, with the state percentage falling around 86% and the national percentage at 85.85, the outcome for this metric for this provider is significantly higher for both the state and national comparisons.

Go back to our slides and take a look now at Metric 2. Metric 2 is the average allowed amount per beneficiary with intermittent claudication, and Metric 2 is calculated by dividing the sum of the allowed amount for beneficiaries with intermittent claudication by the count of the beneficiaries with intermittent claudication. So, with that calculation in mind, let's see, again, where the sample provider fell with their results. And those results are here on table four on page seven. And we can see that this provider's average was $8,577, the state average is right around $2,100, and the national average is right around $1,300. So these results produced an outcome of, again, significantly higher for this provider for both the state and national comparison.

Go back to our slides to take a look at Metric 3. Metric 3 is the average number of supervised exercise therapy claims per beneficiary with intermittent claudication with peripheral vascular intervention. This metric was calculated by dividing the count of supervised exercise therapy claims for beneficiaries with intermittent claudication with peripheral vascular intervention. That's divided by the total beneficiaries with intermittent claudication with peripheral vascular intervention.

So, let's take a look at the sample figures on the CBR for Metric 3. This provider had an outcome of zero for this metric. So, the state and national averages are both zero, so this brings a result of significantly lower for this provider for both the state and national comparisons.

As I mentioned before, the CBR does include a graph that represents the provider's billing trend over the three years 2016 to 2019 for the trend over time analysis for the number of beneficiaries for whom claims with peripheral vascular intervention procedures were submitted. And after the detail of the metrics and the analysis, it's nice to have this graph that takes a step backwards and reviews an overall analysis for that three-year time period. And we can see that this provider had a slight spike in the number of beneficiaries in year two, but the years three and one are all close in number. Truly, there's not too much of a variance over those three years.

At this point, I want to review the resources that we have available to you if you receive the 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 before submitting a help this ticket, because those frequently asked questions may be able to answer your inquiry. And here is a closer look at the frequently asked questions page, which is 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. And this list really 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. You'll see the CPT® manual, the ICD expert, as well as the articles referenced in the introduction of the CBR that discuss the complications and costs associated with vascular surgery, and the Medicare National Coverage Determination, and some information from the Claims Processing Manual.

Here we have a screenshot of our home page, which is found at cbr.cbrpepper.org/home. There are sections for each of the CBRs that we have released, starting in 2019, coming into 2020. For each CBR topic and release, we provide links to a sample CBR. We have the training materials, the data set, and then a link to access your CBR through the portal.

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. We would love to hear about how the CBR process works for you and your organization. Thank you again so much for joining us today. Again, if you have any questions about this webinar, please submit them to our Help Desk at cbr.cbrpepper.org/help contact us.