



## **Transcript for the CBR202005: Subsequent Nursing Facility Evaluation and Management Services**

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, *CBR202005: Subsequent Nursing Facility Evaluation and Management Services*. My name is Annie Barnaby, and I work for RELI Group, Inc., who is contracted with 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 this CBR topic, the CBR Help Desk can answer those inquiries. So go ahead and submit a ticket, we are here to help!

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 *CBR202005: Subsequent Nursing Facility Evaluation and Management Services*, 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, 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. 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. Then, we will go into a discussion of this CBR, and go through the details of the topic and metrics for *CBR202005*. And finally, I will show you some helpful resources, should you have any questions following the webinar. 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 titles 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. 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. 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 serve several purposes on the provider side as well. The CBR program helps to support the integrity of claims submission, and the adherence to coding guidelines. 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 “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 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 precursor to, an audit.

I am going to now walk through the steps of accessing your report, if you received a CBR, so we can see exactly how that’s done. This page, [cbrfile.cbrpepper.org](http://cbrfile.cbrpepper.org), contains the portal that you’ll use to access your CBR. I’m going to open this page on my screen to show you exactly what it looks like when a CBR is accessed in this way.

The portal does require that you enter some information. First, we’ll indicate the role that we play within the healthcare organization for the physician or physicians who received a CBR. I’ve indicated that I am an administrator 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, I’ve completed these two forms to indicate my 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 for your information, and the provider’s information.

Following these forms, I've indicated how I 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 physicians for their CBR alert.

First on the list indicates that you received an email, a fax, or a letter. This would be an email fax, or letters that were sent to the contact information 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. Confirming this information several times a year allows for the email, the fax, and the physical address to stay up to date, and lessens any issues that may arise otherwise. Next on the list is 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 options, "other," and if that option applies, of course please indicate as such. And, as you can see, I've indicated that I received an email notifying that I have a CBR.

At the bottom of the form, it asks for the provider's NPI number. And, this will be the NPI for the specific provider who received the CBR. And again, I've entered a test NPI number here.

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 are sure that an individual provider was issued a CBR, but you are unsure of the validation code, please submit a Help Desk ticket for this instance, and we can assist.

So, 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 PDF format ready for your review.

This page, [cbrpepper.org](http://cbrpepper.org), is another page that can guide you to the CBR access portal. If you click on the "Access your CBR" button, highlighted here with the purple arrow, you will be directed to the page that we just reviewed, and you can begin the steps we just covered.

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 Subsequent Nursing Facility Evaluation and Management Services 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 sections on your CBR will be consistent with the layout of this sample document. This CBR is formatted into

five sections, as you can see here on this slide, and these help—these sections—help to focus on the process and results of the CBR. I’m going to share my screen here so you can see a sample CBR and we can take a closer look at each section.

Starting, of course, 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 providers that perform established patient subsequent nursing facility evaluation and management services. You can see here, also, information regarding projected improper payments, and information from the Medicare Claims Processing Manual. The introduction also contains the criteria for receiving a CBR, and we’ll go into much more detail and discussion later on about that in the webinar.

Moving on to the Coverage and Documentation Overview. This section identifies the CPT® codes that were analyzed in the report and provides several reports and references from CMS that discusses the CBR topic. You’ll see guidelines from the CPT® reference book regarding the proper assignment of subsequent nursing facility care. Table 1 and Table 2 are listed in this section; Table 1 contains detailed descriptions of the subsequent nursing facility care CPT® codes, as you can see here, and Table 2 contains the information for this sample provider for the allowed charges, allowed units, and beneficiary count during the analysis timeframe.

The metrics of the CBR 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 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 subsequent nursing facility evaluation and management services. 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. And you can see that starting here with Metric 1—we have an explanation, the calculation, and then the results. The same for Metric 2, and again for Metric 3. This section also provides a graph displaying a trend over time for the provider; and again, we’ll discuss this table in a bit more detail later on in the webinar.

Finally, we have the References and Resources section, which lists 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 subsequent nursing facility evaluation and management services, 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 information a little bit more closely. You’ll see here results from the 2019 Medicare Fee for Service Supplemental Improper Payment Data report. In 2019, the CPT® codes 99308, 99309, and 99310, for subsequent nursing facility care, had improper payment rates and projected improper payment amounts listed as 4.8% improper payment rate for CPT® code

99308, representing over \$28 million. CPT® code 99309 had a 7.9% improper payment rate, representing over \$49 million. And CPT® code 99310 had a 25% improper payment rate, representing over \$37 million in projected improper payments. This analysis plays in the Medicare's analysis of clinical procedures and the protection of the Trust Fund, and the information plays into the reasoning behind the CBR analysis.

To look at the level of claims and allowable amounts submitted for subsequent nursing facility evaluation and management services, the *CBR202005* was created. The CBR analysis reviews statistics for providers that perform established patient subsequent nursing facility evaluation and management services.

To create the *CBR202005* and the metrics within the report, we used detailed information for that data during the CBR summary year of January 1, 2019 through December 31, 2019. The results were based on claims extracted for the date range as of April 17, 2020. Those results showed that over 64 thousand providers submitted these claims, which represent over 1.9 billion dollars in allowed charges. When we talk about allowed charges, we're 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 paid amount.

This is a list of the metrics analyzed within this CBR. Each metric was created to take a more detailed look at the submission of evaluation and management services for subsequent nursing facility care. The metrics are average minutes per day, which represents the average minutes per day spent in evaluation and management services for subsequent nursing facility care. Metric 2, the average allowed services per beneficiary billed under a single NPI. And Metric three, the average total services per year rendered to your beneficiaries by all practitioners. We'll break down how each of these metrics is calculated later in the presentation, but first let's take a look at each metric to understand why each analysis was selected and analyzed.

Metric 1 looks at the average minutes per day. This metric tell us the average minutes per day spent in E/M services for subsequent nursing facility care. To calculate the minutes spent in these services, the CBR team performed a simple calculation. Each CPT® code is assigned a value that corresponds to the typical minutes described in the CPT® code descriptions that are listed in Table 1. This value is multiplied by the total allowed services for this code, to arrive at the total weighted services per code.

Metric 2 looks at average allowed services per beneficiary billed under a single National Provider Identifier, NPI. This metric helps us to look at the services performed for each beneficiary during the analysis year. This outcome will tell us if a provider is providing a higher number of subsequent nursing facility evaluation and management services, on average, to individual beneficiaries.

Metric 3 looks at the average Total Services per year rendered to your beneficiaries by all providers. This final metric lets us take a step back to examine the average services that each beneficiary from all providers over the analysis year. So, this let's us take a look at the outcomes from the beneficiary's numbers. And I do want to note that this metric's outcomes are not part of the criteria for receiving a CBR.

Speaking of criteria, the in-depth review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202005*. Using all of the data and research, the CBR team created criteria to select the providers who will receive a *CBR202005*. That criteria is that the provider is significantly higher compared to either state or national averages in Metrics 1 or 2 that would be greater than or equal to the 90th percentile. And, has at least 40 beneficiaries with claims for CPT® codes 99307, 99308, 99309, 99310. And, has at least \$16,000 or more in total allowed charges. Following our discussion of each metric, you can see that the criteria is directly related to the outcomes of Metrics 1 and 2. The criteria states that the provider must be significantly higher in Metrics 1 or 2 outcome. So, what does the term "greater than or equal to the 90th percentile" mean, and what are the other outcomes for the metrics?

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 are significantly higher which means the provider's value is greater than or equal to the 90th percentile from the state or national mean. Higher which means the provider's value is greater than the state or national mean. Does not exceed which means the provider's value is less than or equal to the state or national mean, and not applicable which means the provider does not have sufficient data for comparison.

The outcome of significantly higher does require a little bit more explanation to understand how a provider may fall into that outcome for the metric comparisons. The significantly higher outcome indicates that the provider's value is greater than or equal to the 90th percentile from the peer state or national mean. In order to talk about exactly how we calculate the 90th percentile, 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 percentile. And it is important to fully understand this outcome, as it is a criteria for the receipt of a CBR. In order to identify the providers who were above the 90th percentile, we calculated values for all providers for each of the metrics in each comparison group which would be the peer state and nation. We then order all of the providers' values from highest to lowest. If you use the ladder visual as a reference, imagine that the highest values 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 providers' values fall. This is the 90th percentile mark, represented above on the ladder visual by the black

line. Any outcome for a metric in which the provider's value falls above that point would therefore have the outcome of significantly higher for the metric. Let's look at each metric individually, and the outcomes for the sample provider on our sample CBR.

Let's look first at Metric 1, average minutes per day. To calculate Metric 1, the total weighted services is divided by the total number of days that the services were rendered. As a reminder, the weighted services are calculated by taking the assigned value that corresponds to the typical minutes described in the subsequent nursing facilities evaluation and management CPT® code descriptions. This value is multiplied by the total allowed services for the code to arrive at the total weighted services per code. Let's take a look at the sample figures on the CBR for Metric 1. For that, we go to our sample. And to look at those, we can see the sample figures on the CBR for Metric 1, which are on table three. You can see this provider has an average of 268. The state average was 136, and the national average is at 125. So, the outcome of this metric for this provider is significantly higher for both the state and national comparisons.

Next we have Metric 2, average allowed services per beneficiary billed under a single NPI. Metric 2 is calculated by dividing the total allowed services rendered by your single NPI by the total number of beneficiaries. With that in mind, let's see where the sample provider fell with their results. Those results are here on table four, and we can see that the provider's average is 7.23. The state average is right around five, and national average is 4.49. So, these results produced an outcome of higher for the state comparison, and significantly higher for the national average comparison.

Finally, we arrive at Metric 3, the average total services per year rendered to your beneficiaries by all practitioners. This metric was calculated by dividing the total allowed services rendered by you and all other providers by—dividing that number by the total number of beneficiaries. Let's see the sample figures on the CBR for Metric 3. This provider had an outcome of 19.28 for this metric. The state average is very close at 20.60, and the national average is 19.54, so this brings a result of does not exceed for this provider for the state comparison, and again, also, a does not exceed outcome for the national comparison as well.

As I mentioned before, the CBR includes a graph that represents a billing trend for the provider over the three years, 2017 to 2019. This provider trend graph shows the trend over time analysis of total number of beneficiaries for whom CPT® codes 99307 to 99310 were submitted. After the detail of the metrics and analysis, it is nice to have this graph that takes a step back and reviews an overall analysis for that three-year period of time. And we can see this provider did have a spike in the number for year three.

At this point, I want to review the resources 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 [cbr.cbrpepper.org/Help-Contact-Us](http://cbr.cbrpepper.org/Help-Contact-Us). On this page, you'll find frequently asked questions

link, and a link to submit a new Help Desk request. I always encourage people to review the frequently asked questions before submitting a Help Desk ticket, because those frequently asked questions may be able to answer your inquiry.

Here is a closer look at the frequently asked questions page, which is found at <https://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.

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 Medicare Fee for Service Supplemental Improper Payment Data report, and the guidance regarding evaluation and management code assignment and selection.

This is a screenshot of our homepage, [cbr.cbrpepper.org/Home](https://cbr.cbrpepper.org/Home). There are sections for each of the CBRs that we have released since 2019. For each CBR topic and release, we provide links to a sample CBR, the training materials, the data set, and a link to the portal to access your CBR. This page also contains a link to join our mailing list to stay up to date on any announcements, a link to provide feedback on the CBRs, and a link to submit a CBR success story. We would love to hear how the CBR process has worked for you and your organization. Once again, thank you for joining us today, for our webinar. If you have any questions, please submit them to our Help Desk, at [cbr.cbrpepper.org/Help-Contact-Us](https://cbr.cbrpepper.org/Help-Contact-Us).