Transcript for the CBR202006: Office Visits, New and Established Patients by Nurse Practitioners

Thank you for joining us today. Welcome to our webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202006: Office Visits for New and Established Patients by Nurse Practitioners*. 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. If you have a question about the CBR topic, the CBR Help Desk can answer those inquiries. You can go to the link shown on this slide, and submit a ticket, and we will be happy to respond and help with any inquiries you might have.

The objectives of today's webinar will be to understand the purpose and use of Comparative Billing Reports, CBRs, to explain the function of this specific Comparative Billing Report, and to help you gather resources that will help answer further questions and inquiries. To accomplish those objectives, our discussion today will cover the following areas; first, we'll talk about what a Comparative Billing Report is. I will show you how to access your CBR. 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'll go into a discussion of this CBR, and go through the details of the topic and metrics for *CBR202006*. 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. 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.

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 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 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 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 walk through the steps of accessing your 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. The portal does require that you enter some information; and 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. First, we'll indicate the role that we play within the healthcare organization for the physician or physicians who received a CBR. I'm going to indicate that I am the CEO of the organization, and by doing so, I am indicating that I have the authority to receive the CBR information, and that I understand that I am authorized to view this confidential information. Next, I'll complete 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 to complete them.

Following these 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, and 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. These would be communications that came 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 that contact information to stay up to date, and lessens any issues that may arise otherwise.

Next on this 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'd 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 or professional organizations 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, of course, please 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. And I, of course, am using a standard test code for the NPI number.

Then at the bottom of the form, we finally have the Validation Code. When a provider receives an alert that they have a CBR on file, a validation code is included with that alert information.

So, again, check the information on the emailed alert, the faxed alert, the letter 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 ticket to our Help Desk and we can assist with resolving that issue.

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, is another page that you can use to access your CBR. If you click on the "Access my CBR" button — or "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 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 this CBR, it's 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 this — with the layout of this sample document.

This CBR is formatted into five sections, which help to focus on the process and results of the CBR. Let's go now to the sample document, so we can follow along and look as we talk about each section.

We start 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 nurse practitioners that perform new and established patient evaluation and management services. You can see here, also, information regarding projected improper payments, and information from the Medical Claims Processing Manual. The introduction also contains the criteria for receiving a CBR, and we'll go into much more detail about that later on in the presentation.

Moving on to the coverage and documentation overview. This section identifies the CPT® codes that were analyzed in the report, and several reports and references from CMS that discuss the CBR topic, you can see those here at the top of this page. Tables one, two and three are listed in this section; table one contains detailed descriptions of the evaluation and management CPT® codes, you can see those here. Table two contains the information for this sample provider for the allowed charges, allowed units, and beneficiary count during the analysis timeframe for new patient codes, and table three lists the same information for established patient evaluation and management codes for this provider.

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 for the CBR analysis, followed by individual 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 nurse practitioner evaluation and management services. Following that information, then, 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. This CBR actually has 4 calculations for each metric, because each code 99204, 99205, 99214, and 99215 has its own calculation, and then its own row of data in the following table. So, you can see that here in Metric 1. You can see how each calculation is completed. And then we have the table that has the outcome for those calculations. And that continues with Metric 2. Again, each code has its own calculation. And then the outcomes are in this one table, table five. And then finally, again the same for Metric 3. We have the calculations and then the outcomes for those calculations is shown in table six. This section also has a graph displaying the trend over time for the provider, and we'll discuss this table in a bit more detail later on in the CBR.

Finally, the References and Resources section 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 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 report more closely. You'll see here results from the 2019 Medicare Fee-for-Service Supplemental Improper Payment Data Report. And, in 2019, the CPT® codes for 99204, 99204, 99214, and 99215 had the following improper payment amounts listed. 99204 had a 15.3% improper payment rate, representing over $203 million in projected improper payments. CPT® code 99205 had an 18.8 improper payment rate, representing over $93 million. 99214 had a 5.0 improper payment rate, representing over $423 million in projected improper payments. And then finally, CPT® code 99215 had a 9.9% improper payment rate, representing over $108 million in projected improper payments. So, all of this data plays in the Medicare's analysis of clinical procedures and the protection of the Trust Fund, and this information plays into the reasoning behind the CBR analysis.

To look at the level of claims and allowable amounts submitted by nurse practitioners for evaluation and management services, the *CBR202006* was created. The CBR analysis — excuse me — analyzes and reviews statistics for rendering nurse practitioners that perform new and established patient evaluation and management services.

To create the *CBR202006* and the metrics within the report, we used detailed information for that data during the CBR summary year of February 1, 2019 through January 31, 2020. The results were based on claims extracted for the date range as of May 18, 2020. Those results showed that over 121 thousand providers submitted these claims, which represent over 1.8 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 higher-level CPT® codes, 99204, 99205, 99214, and 99215, for evaluation and management services for nurse practitioners. The metrics are percentage of allowed units for new and established patient E/M levels 4 and 5 CPT® for codes 99204, 05, 99214, 99215. The percentage allowed amount for new and established patient E/M levels 4 and 5 services. And the percentage of beneficiaries that received those high-level CPT® codes 99204, 99205, 99214, and 99215. 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 looks at the percentage of allowed units for new and established patient E/M levels 4 and 5. This metric tell us, of all the evaluation and management services performed through the analysis year, what percentage of those were for these high-level service codes?

Metric 2 looks at the percentage allowed amount — amounts, excuse me — for those high-level new and established patient codes. This metric helps us to look at dollar amount attached to the high-level evaluation and management CPT® codes that were submitted throughout the year, so it is a calculation for the allowed amount for these codes.

And then finally, Metric 3 looks at the percentage of beneficiaries that received these high-level CPT® codes. And this final metric lets us take a step back to examine the beneficiaries who received these high-level services. What percentage of the beneficiaries that the nurse practitioner saw received a high-level evaluation and management code.

Looking at the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202006*. Using all of the data and research, the CBR team created criteria to select the providers who will receive a *CBR202006*. That criteria is that the provider is significantly higher compared to either the state or national averages in any of the three metrics, has at least 10 total beneficiaries with claims submitted for new patient codes or at least 120 total beneficiaries with claims submitted for established patient codes, and has at least $1,200 in total allowed charges for new patient codes or $18,000 in total allowed charges for established patient codes. Following our discussion of each metric, you can see that the criteria is directly related to the outcomes of the metrics. The metrics — or excuse me — the criteria states that the provider must be significantly higher compared to the state or national average in any of the metric outcomes. So, what does the term "significantly higher" and "greater than or equal to the 90th percentile" mean, and what are some of the other outcomes for the metrics?

To answer that question, all four outcomes are listed here. These outcomes are the basis of the comparisons made regarding the provider's billing patterns and those of their peers. The four outcomes that can come of each metric analysis 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 then, not applicable means that the provider does not have sufficient data for comparison. The significantly higher outcome indicates that the provider's value is greater than or equal to the 90th percentile from the state peer — peer state or nation — national mean. In order to talk exactly about 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. It is important to fully understand these outcomes, as they are criteria for 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.

Looking first, again, at Metric 1, the percentage of allowed units for new and established patients E/M Levels 4 and 5. To calculate Metric 1, we performed a calculation and analyzed an outcome for each of the high-level CPT® codes separately. And again, you can see the calculations here. And the outcomes were calculated by dividing the total number of allowed units for CPT® codes — for each of the individual CPT® codes separately, those were divided by the allowed units for CPT® codes 99201-99205. And this slide shows us our new patient codes calculations. And then those results are multiplied by 100 to get our percentage. So, let's take a look at our sample provider, or excuse me — let's look first at the established patient visits for Metric 1. You can see the calculations are the same for the established patient codes, each separated into the 99214 and 99215. So, now let's take a look at the outcomes for Metric 1 for our provider on the sample CBR document. You'll see that we'll go to table four, which we saw in our first review. And we can see, as I said, on table four that this provider had outcomes of 0% for CPT® codes 99204 and 99215, and 100% outcomes for CPT® codes 99205 and 99214. So, these percentages yielded outcomes of does not exceed for CPT® codes 99204 and 99215, and the outcomes of significantly higher for CPT® codes 99205 and 99214. Those are compared to the state and national percentages that you can see here for each of those high-level codes.

Looking at Metric 2, and as with Metric 1, we have separated the calculations for the analyses for Metric 2. To calculate Metric 2, the percentage allowed amount for new patient E/M Levels four and five visits, we divided the total allowed amount for each CPT® code by the total allowed amount for the matching code set. This slide shows the calculations for the new patient evaluation and management codes, 99204 and 99205. And, of course we have the calculations for established patient codes as well for Metric 2. Let's go back to our CBR, our sample CBR to see the outcomes for this metric for our sample provider. Those are in table five. We can see that this provider has similar outcomes; zero percent for CPT® codes 99204 and 99215, and 100% and 99% for CPT® codes 99205 and 99214. So, when we look at the outcomes for the state and national comparisons, we have does not exceed for CPT® codes 99204 and 99215, and significantly higher for CPT® codes 99205 and 99214. And that is of course, again, when compared to those state and national percentages for each of those CPT® codes that you do see here listed in the table.

Finally, we have Metric 3, which looks at the beneficiaries who received the high-level evaluation and management services. This slide shows the calculations for the new patient

evaluation and management codes, which divides the total number of beneficiaries who received services for the individual CPT® codes, that's divided by the number of beneficiaries for each code set.

On this slide we have the details for the established patient evaluation and management codes 99214 and 99215 and the calculations, again, are the same for the — as the new patient evaluation and management code calculations. So, let's go back to our sample CBR, go to table six. We can see that this provider had percentages of 0% for 99204, and 100% for CPT® codes 99205 and 99214, and then 1% of the beneficiaries received 99215. Again, comparing these outcomes to the state and national percentages, we do have the outcomes of does not exceed and significantly higher for the appropriate codes.

As I mentioned before, the CBR includes a graph that represents the provider's billing trend, over three years 2017 to 2019, for total number of beneficiaries at service levels 4 and 5, that's the trend over time. And, 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 time period. And we can see this provider had high beneficiary numbers for 99205, for those new patients on the left, and high beneficiary numbers for 99214 over the three years for the established patient encounters, that's the graph there on the right.

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. 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 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 analysis of the CBR. You'll see the CPT® manual, the Medicare Fee-for-Service Supplemental Improper Payment Data report, and guidance regarding evaluation and management code assignment and selection.

This is a screenshot of our homepage, cbr.cbrpepper.org/Home. There are sections for each of the CBRs that have been released since 2019. For each CBR topic and release, we provide links to a sample CBR, the training materials, the data set, and then, 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 with 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 worked for you and your organization.

I'd like to thank you again for joining us today. Again, if you have any questions, please submit them to our Help Desk at cbr.cbrpepper.org/help-contact-us.