Transcript for the CBR202102: Initial Preventive Physical Examinations (IPPEs) and Annual Wellness Visits (AWVs)

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202102: Initial Preventive Physical Examinations and Annual Wellness Visits*. 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.

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 *CBR202102*: *Initial Preventive Physical Examinations and Annual Wellness Visits* 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 (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. Then, we will go into a discussion of this CBR, and go through the details of the topic and metrics for *CBR202102*. And finally, 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 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 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 the 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 PEPPER. 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 for 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 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 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.

We do have some terminology to be familiar with during the presentation. When we're talking about IPPE and AWV, we are referring to HCPCS codes G0402, G0438, and G0439, and "evaluation and management" refers to the new patient and established patient office visit code sets. These terms just make it easier for us to discuss the analysis and outcomes.

Let's take a look now at the vulnerability of correct payments for IPPE and AWV, and how that plays into CMS's protection of the Trust Fund. The *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects possible improper payment rates for specific areas of coding and code sets. That report reflects 29.5% improper payment rate just for the HCPCS code G0439, which represents over 192 million dollars in possible improper payments. So, we can see why this is an area of some interest when we're looking at potential improper payments.

What is the desired behavior for providers who provide IPPE and AWV services? After looking at the projected improper payment and the areas of possible error, providers should be aware that the documentation for the services is sufficient to support the proper use of IPPE and AWV codes, and the billing submissions follow CMS guidance regarding the services that take place during IPPE and AWV encounters

Let's take a closer look now at the sample document, so we can 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 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 IPPE and AWV visits. You can see here information from the *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report, the information from the *Medicare Claims Processing Manual*, and the MLN education tool. The introduction also contains the criterion for receiving a CBR.

Moving on to the Coverage and Documentation Overview. This section identifies the CPT® and HCPCS codes that were used, analyzed in the report. Tables 1 and 2 are listed in this section; Table 1 contains descriptions of the CPT® and HCPCS codes for IPPE, AWV and E/M, and Table 2 contains the summary of the utilization for IPPE and AWV encounters for the analysis time period.

The metrics of the CBR lists and explains the metrics used for the CBR, the provider focus for the CBR, the definitions for the state and national peer groups, 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 providers on claims for IPPE and AWV services. Following that information, the calculation for each metric is described, and then the results for the provider for each metric is shown in table form. This section also contains a graph displaying the trend over time for the provider.

Finally, the References and Resources section lists reports and documents used for the creation of the CBR, and those created to help you as you have questions about this CBR.

CBR202102 focuses on rendering providers that submitted Medicare Part B for IPPEs and AWVs using Healthcare Common Procedure Coding System (HCPCS) codes G0402, G0438, and G0439.

To create the *CBR202102* and the metrics within the report, we used detailed information for that data during the CBR summary year of August 1, 2019 through July 31, 2020. Those results showed that over 142 thousand providers were listed as rendering providers on claims for IPPE and AWV services. The total paid amount for these claims was over one billion dollars.

Let's talk about the metrics for this CBR; 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 claims from providers for IPPE and AWV services. The metrics are percentage of IPPE/AWV services submitted with E/M service on the same date of service, by HCPCS code, and average allowed charge amount for all Medicare Part B services by the same provider on the same date of service, per beneficiary.

The review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202102*. That criteria is that the provider is significantly higher compared to either the state or national averages or percentages in any of the two metrics, and has at least 8 beneficiaries with claims and at least $1,300 in total allowed charges for HCPCS code G0402, or at least 13 beneficiaries with claims and at least $2,000 in total allowed charges for G0438, or at least 94 beneficiaries with claims and at least $10,000 in total allowed charges for G0439.

The four outcomes for the provider's state and national comparisons 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.

In order to talk exactly about how we calculate the 90th percentile listed in the significantly higher outcome, 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 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 at Metric 1, the percentage of IPPE/AWV services submitted with an E/M service on the same date of service, by HCPCS code. To calculate Metric 1, the total number of IPPE/AWV services performed on the same date of service as an E/M visit is divided by the total number of IPPE/AWV services.

Let's look at the sample provider results for Metric 1. These are listed on Table 3, on page 5. We can see the provider has results of around 100% for all three codes; the outcome of G0439 being lower than the other two codes. With the national and state percentages around the 50% for all three codes, the results for this metric for this provider are significantly higher for the national and state comparisons for all three codes.

Next, we have Metric 2, the average Allowed Charge Amount for All Medicare Part B Services by the Same Provider on the Same Date of Service, per Beneficiary. Metric 2 is calculated by dividing the total allowed charges for all Medicare Part B services for a beneficiary performed on the same date of service as an IPPE/AWV service by the same provider by the total number of unique beneficiaries for IPPE/AWV services.

With that in mind, let's see where the sample provider fell with their results. Those are on Table 4, on page 6, and we can see that this provider's average allowed charges are around $400 for codes G0402 and G0438, and $277 for code G0439. The state averages fall close to $100, $150 for all three codes, and the national averages are around $200, $270. These results produced outcomes of significantly higher for both the state and national comparisons for all three codes, for this metric, for the sample provider.

The CBR includes a graph that represents the provider's billing trend, over the three years 2017 to 2020, for Total Number of Beneficiaries Who Received IPPE/AWV Services. After the detail of the metric 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.

CBRs can play a very important role for providers, and as we know from earlier in the webinar, they are meant to be educational and comparative tools for providers. A CBR can help providers to look at their internal claims submissions for areas of coding and billing that have a high possibility for incorrect payments. These reports can guide a self-audit program for compliance and shine a light on correct documentation and medical necessity standards.

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 page 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 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 *HCPCS Manual*, the *Medicare Fee-for-Service Supplemental Improper Payment Data* report, The *Medicare Claims Processing Manual*, the MLN article, and the CPT® Manual.

This is a screenshot of our homepage, 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 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 worked for you and your organization.

Thank you again for joining us today. If you have any questions, please don't hesitate to reach out to us at the Help Desk and we will be happy to assist you.