Transcript for the CBR202103: Comprehensive Eye Examinations

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202103: Comprehensive Eye Examinations*. 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, of course the recording, and we have handouts, and of course the Q&A and CBR Help Desk are great tools to use if you have any questions. We're here to help, so don't be shy about reaching out to us!

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 *CBR202103: Comprehensive Eye Examinations* 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 will go into a discussion of this CBR, and go through the details of the topic and metrics for *CBR202103*. And then 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 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 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 reference "eye examinations' within the document and presentation, we are referring to CPT® codes 92002, 92004, 92012, 92014. 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 eye examinations, 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 2.3% improper payment rate for the ophthalmology provider type, which represents over $162 million 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 eye examination 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 proper use of eye examination codes and medical necessity, and the correct code assignment for the services included in the intermediate and comprehensive code descriptions.

Let's now take a closer look at the sample CBR document, so we can fully understand this 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, 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 eye examination visits, and you can see here information from the 2020 Medicare Fee-for-Service Supplemental Improper Data Report. The introduction also contains the criteria for receiving a CBR.

Moving on to the Coverage and Documentation Overview. This section identifies the CPT® codes that were analyzed in the report. Tables 1 and 2 are listed in this section; Table 1 contains descriptions of the CPT® eye examinations, and Table 2 contains the summary of the utilization for codes during 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 the ophthalmol—ophthalmological 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 provides graphs 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.

CBR202103 focuses on rendering providers that submitted claims for eye examinations for new established—new and established patients, CPT® codes 92002, 92004, 92012, 92014.

To create the *CBR202103* and the metrics within the report, we used detailed information for that data during the CBR summary year of Nov. 1, 2019 through Oct. 31, 2020. Those results showed that over 48 thousand providers have submitted claims for these services for new and established patients.

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 eye examinations. The metrics are percentage of comprehensive eye examinations, average allowed amount per claim, and average number of comprehensive eye examinations per beneficiary.

The review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a CBR202103. That criteria is that the provider is significantly higher compared to either state or national averages or percentages in any of the three metrics, i.e., greater than or equal to the 90th percentile, and has at least 130 beneficiaries with claims submitted for the comprehensive eye examination codes, and at least $17,200 in total allowed charges for the comprehensive eye examination codes.

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 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.

Looking first at Metric 1, percentage of comprehensive eye examinations. To calculate Metric 1, the count of unique claims for comprehensive eye examinations is divided by the count of unique claims for comprehensive and intermediate eye examinations.

Let's look at the sample provider results for Metric 1. Those are listed on Table 3, on page 5. We can see the provider has results of 94.95% for this metric. With the national percentage is around 69% and state percentage is around 66%, so the results are significantly higher for the national comparison and the state comparison for this metric.

Next, we have Metric 2, the average allowed amount per claim. Metric 2 is calculated by dividing by the total number of unique claims—the total allowed charge amount for comprehensive and intermediate eye exams is divided by the total number of unique claims for comprehensive and intermediate eye examinations.

With that in mind, let's see where the sample provider fell with their results. Those are listed on Table 4, on page 5. We can see the provider has results of $106 for this metric. The national average is $117 and state average is $114, so the results for this metric for this provider are does not exceed for the national comparison and for the state comparison.

Finally, we arrive at Metric 3, average number of comprehensive eye examinations per beneficiary. This metric was calculated by dividing the total number of un—excuse me—the total number of unique claims for comprehensive eye examinations by the total number of unique beneficiaries for comprehensive eye examinations.

Let's see the sample figures on the CBR for Metric 3 in Table 5. This provider had an outcome of 1.44 for this metric. The state average is around 1.36 and the national average is 1.28 so this brings a result of significantly higher for this provider for the state and national comparisons.

The CBR includes two graphs that represent the provider's billing trend, over the three years 2017 to 2020, for total number of beneficiaries who had claims submitted for CPT® codes 92002, 92004, 92012, 92014. After the detail of the metrics and analysis, it is nice to have these graphs that takes a step back and reviews an overall analysis for that three-year period. Here we can see Figure 1, which concentrates on the billing trend for CPT® codes 92002 and 92004.

And then Figure 2 looks at the CPT® code 92012 and 92014 over those three years.

CBRs can play a very important role for providers, and as we knew 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 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 CPT® manual and the Medicare Fee-for-Service Supplemental Improper Payment Data report.

This is a screenshot of our homepage, cbr.cbrpepper.org/Home. There are sections for each of the CBRs that we have released in 2019 and 2020. 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, 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.

Again, thank you for joining us today. If you have any questions about the CBR or this webinar, please submit a Help Desk ticket on our homepage.