Transcript for the CBR202105: Critical Care Evaluation and Management (E/M) Services

I want to thank you all for joining us today for this webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202105: Critical Care Evaluation and Management Services*. My name is Annie Barnaby and I work for RELI Group, Inc., contracted with Centers of 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. As I mentioned, before you are muted, because we are recording this session, and a recording is available to you on the website as well. We have handouts and of course, the Q&A and CBR Help Desk are great tools to use if you have any questions. We are 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, *CBR202105: Critical Care Evaluation and Management Services* and to help you to gather resources that will help to 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'll review so that we can get a good sense of what we are looking at when we review a CBR. Then, we will go into a discussion of this CBR and go through the details of the topics and the metrics for *CBR202105*. 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 title says, a report that compares providers on a state or a specialty, and nationwide level, and summarizes one provider's Medicare claim 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 correctly and if it was necessary and in line with Medicare payment policy. A CBR cannot identify improper payments but it can alert providers if their 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 CBRs, we can discuss why CMS issue CBRs. They are 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 for medical review and data analysis. CMS considers the CBR process to be an educational tool that supports their efforts to protect the trust fund. CBR serve several purposes on the provider side as well. The CBR program helps to support the integrity of claim submission and the adherence to coding guidelines. This helps to encourage correct medical 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 provider's 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 to remember that receiving a CBR is not in any way an indication of or a precursor to an audit.

I am going to walk through the steps of accessing your report if you received one, so that we can see exactly how that's done. This page, cbrfile.cbrpepper.org contains the portal that you will use to access your CBR. The portal does require that you enter some information, and I am going to open this page on my screen to show you exactly what it looks like when a CBR is accessed this way. First, we are going to indicate the role that we play within the health care organization for the physician or physicians who received a CBR. I have indicated 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 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 will use the correct information here to complete that. Following these forms, we are 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 have received an email, a fax, or a letter. These will be communications that came to the contact information that is listed in the Provider Enrollment Chain and Ownership System, that is commonly known as PECOS. We do encourage everyone to confirm their PECOS information and update if necessary so we can contact the appropriate person regarding CBR information. Confirming this information several times are year allows for the contact information to stay up

to date and lessen any issues that may arise otherwise. Next on this 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, 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 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. Towards 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 that NPI number. Then at the bottom of the form, we finally have the validation code. When a provider receives an alert, 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, and 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 am going to complete the form and hit "submit."

Here we have the sample CBR files that appear and your CBR will appear in the same fashion in PDF format ready for your review. This page, cbrpepper.org is another page you can use to access your CBR. If you click on "access your CBR" button, highlighted with the purple arrow, you will be directed to the page we just reviewed the portal, and you can begin the steps that we just covered. In the Current Procedural Terminology, the CPT® book, Critical Care Services are included in the evaluation and the management section. The CPT® book defines Critical Care Services as "The direct delivery by a physician or other qualified health care professional of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition." So, when we are talking about critical care about these codes and about this report and their outcomes, we are talking about patients and services to patients who are very ill and in need of that advanced care. This chart spells out the code assignment for the submission of Critical Care Services. As you can see these are strictly time-based codes so as soon as the 30 minutes of Critical Care Services are provided, we start using these critical care codes, starting with 99291. As time spent in care of the patient increases, we use 99292 in conjunction with 99291 to represent the time spent in critical care. Now if under 30 minutes is spent in care, you would use the other evaluation and management codes to submit the services accordingly.

This slide reflects the critical care guidelines according to the *Medicare Claims Processing Manual*, "Chapter 12, Section 30.6.12." This excerpt and this item give us some insight into some more detail about the decision making for critical care, the requirements for patient medical care, and of course, the important piece that the services must be medically necessary and reasonable. Now I do want to say that recently the Center for Medicare and Medicaid Services (CMS) made changes to this chapter of the *Medicare Claims Processing Manual*. The reference to this chapter within the CBR and as you see on this slide differs from the current entry due to that change, however, the information contained within the CBR and on this slide applied to the claims during the timeframe of this analysis. So, we just want to call attention to the fact that we do know that there has been a change to this section of the claims processing manual, however, again the claims timeframe that we used for this analysis, that timeframe included these guidelines that you see here. Here we see an expanded definition and description of "modifier 25" and its definition, according to the CPT® book, the first part of the definition does indicate use of the modifier 25 with a significant, separately identifiable evaluation and management service. It goes on to state that the evaluation and management service must be documented as such. So, when we use modifier 25, we have to remember that this is what we are indicating with the use of that modifier, and we must be sure that the patient's medical record is updated accordingly, so that the documentation is compliant. Again, according to that claims processing manual during the timeframe of this analysis, the services listed here when performed on the day a physician bills for critical care, are included in the critical care service and should not be reported separately. This does relate back to that use of modifier 25, and we see these procedures knowing that these are included in the Critical Care E/M Services and if modifier 25 is used with these services at the same time as Critical Care Services, the documentation would have to support that the services were significant and separately identifiable.

We have seen how to access the CBR report and we've taken a look at the CPT® and the claims manual guidelines and definitions. Let's take a closer look now at the sample document so that 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 the 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 that we can follow along and to 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 Critical Care Services. You can see here the information from the *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report. That section out of the *Medicare Claims Processing Manual*, again, that did apply

to this timeframe within the report and the National Correct Coding Initiative, the *NCCI Policy Manual for Medicare Services*. In the introduction, also contain the criteria for receiving a CBR. Moving onto the coverage and documentation overview, this section identifies the CPT® codes that were analyzed within the report. Tables one and two are listed in this section. Table 1 contains just the descriptions of the critical care CPT® codes as you can see here and Table 2 contains the information for this sample provider for the allowed amount, allowed services, visits and beneficiary count during the analysis timeframe for Critical Care codes. The metric section of the CBR lists and explains the metrics used for the CBR, the list of specialties included in the definition of the state peer group and the CBR analysis, and the possible outcomes for the CBR metric analyses. Next, the methods and results section is a review of the results for the CBR analysis, followed by individualized results comparing the CBR recipient to other providers. We have an explanation of the dates for service, included in the report's analysis, and the total rendering providers who had allowed charges for Critical Care 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 4. You can see those three metrics there. This section also provides two graphs displaying a trend over time for the provider, and we will take a look at those in more detail later on. Finally, the references and resources section list reports and documents used for the creation of the CBR, and those created to help you as you have questions about the CBR. We are aware of the outcome and the role that the public health emergency played within all providers, claims data and your claims submission. This CBR does provide data regarding the submission of your claims during a timeframe that did occur during the public health emergency. So, we are aware of that, and we want you to be aware of that as you review your analysis, and you review your outcomes and comparisons. Please consider that, consider how your billing practices have changed during the public health emergency when you review that data within this report, because as I said we are aware that they are going to affect the outcomes and we want you to be aware that you need to take that into consideration as you review your report.

Let's take a look now at the vulnerability of correct payments for Critical Care Services and how that plays into CMS's protection of the trust fund. We saw in the introduction information from the *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report. That report reflects a 9.7% improper payment rate for part B critical care providers which represents $21 million in projected improper payments. Now within that error rate there is a 22.9% improper payment rate due to insufficient documentation and a 72.2% improper payment rate due to incorrect coding. Code 99921 alone has an improper rate of 19.7%, which represents over $196 million in projected improper payments, just for that code. This information does tell us that this is an area of interest, of course, for CMS in their protection of the trust fund. What is the desired behavior for providers who provide Critical Care Services? After looking at those projected improper payments and the area of possible error. Providers should be aware that

the documentation for the Critical Care Services is complete including medical necessity of critically ill patient, high complexity medical decision making, and the time spent in critical care so, that the assigned codes can be supported. Also, the use of modifier 25 should be reviewed and confirmed. Is there a significantly separately identifiable E/M service that is documented correctly that calls for that use of the modifier 25? We want to be sure that all of these documentation and services guidelines are met, when we are using critical care codes and modifier 25. To look at the rendering providers who had submitted claims for Critical Care Services, the *CBR202105* was created. The CBR analyzes and reviews statistics for rendering providers who performed Critical Care Services. The CBRs are distributed to providers who perform these services so, that they may use the CBR as an educational and a comparative tool and to aid in internal compliance. The providers can use the CBR to encourage a review of these specific codes when performing an internal compliance review. To create the *CBR202105* and the metrics within the report, we use detailed information for that data during the CBR summary year of January 1, 2020, through December 31st, 2020. Basically, the entire calendar year of 2020. The results were based on claims that were extracted for that time period, and the results showed that over 93,000 providers submitted these claims which represent over $1.1 billion in allowed charges. When we talk about allowed charges, we are referencing the allowed charges listed in the Medicare fee schedule. This lets us compare similar charged figures across all providers and claim submissions, regardless of the submitted or the paid amount.

Let's talk about the metrics for this CBR. This is the list of the metrics analyzed within the CBR. Each metric was created to take a more detailed look at the submissions of claims for Critical Care Services. The metrics are percentage of services submitted with modifier 25, average number of visits per beneficiary, and average allowed charges per beneficiary. Metric 1 analyzes of all the Critical Care Services provided by the provider over the analysis year, what percentage of those were submitted with a modifier 25? Metric 2, looks at the average number of Critical Care Services that each beneficiary received from the provider and then metrics three looks at the average allowed charges for each beneficiary on average during the analysis year for this specific individual provider. We will break down how each of these metrics is calculated later on in the presentation. The review of these metrics can help to us understand the criteria for receiving a *CBR202105*. Using all the data and research, the CBR team created criteria to select the providers who will receive this CBR. That criteria is that the provider is significantly higher compared to either state or national averages or percentages in any of the three metrics, which would be greater than or equal to the 90th percentile. and that the provider had at least 30 beneficiaries with claims for CPT® code 99291 or 999292 and the provider has at least $20,000 or more in total allowed charges. Let’s look now at the outcomes that could come from each of the comparisons for the metrics. 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 is means that the provider's value is greater than or equal to the 90th percentile from the state or national mean. Higher, which means that the provider's value is greater than the state or national mean. Does not exceed, which means that the provider's value is less than or equal to the state or national mean. Then Not Applicable, means that the provider does not have sufficient data for comparison for that specific metric. 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 and it is part of the criteria for receiving a CBR.

In order to talk about how exactly 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 the outcome as I said it is a criteria for receipt of the CBR. So, in order to identify the providers who were above the 90th percentile, we calculate values for all of the providers for each of the metrics for each comparison group, which would be the peer, state, and nation. We then order all those providers' values outcomes from highest to lowest and if you use the latter as a reference, imagine that the highest outcomes for each individual provider are listed at the top of the ladder, and then in the list in descending order down the length of the ladder, so that 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 that 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. So, imagine that all of those individual providers results are listed down that ladder. We draw that line, and we look at everybody, all of those individual provider results that came above that line.

Let's look now at each metric individually and the outcomes for the sample provider on our CBR. Looking first at Metric 1, the percent of services submitted with modifier 25. To calculate Metric 1, the count of Critical Care Services submitted with modifier 25 is divided by the count of Critical Care Services submitted with or without a modifier 25. Looking at the sample figures on our CBR for Metric 1, which are on Tables 3, we can see that this provider had a result of 99%. So, 99% of their claims for Critical Care Services were submitted with a modifier 25. Now their state percent was 9.18 and the national percent was a little higher 11% mark but, as you can imagine a 99% outcome for this provider did yield a significantly higher comparison for this provider, for this metric. Next, of course, we have Metric 2, the average number of visits per beneficiary. For this metric, the number of visits means a distinct date of service. Metric 2 is calculated by dividing the count of unique critical care visits by the count of unique beneficiaries who had a critical care service. So, with that in mind, let's see where our sample provider fell with their results. This provider's average is 6.20 so, that means that their unique beneficiary each had an average of about six visits for the Critical Care Services. Now the state

average and the national average are two, and then about one and a half, and so this did yield an outcome of significantly higher for their state comparison and the national comparison. Finally, we arrive at Metric 3, the average allowed charges per beneficiary. Now this metric was calculated by dividing the total allowed charges for Critical Care Services by the count of unique beneficiaries who had a critical care service. Remember, this is all for this one individual provider who is receiving these results. Let's see the sample figures on the CBR for Metric 3. So, this provider had an outcome of about $1,600, an average charge per beneficiary, for their Critical Care Services. Their state average is about $630, and the national average is right around $500. Again, these comparisons, each of the comparisons to the provider's outcome did yield that significantly higher outcome.

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 claim 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 coding for Critical Care Services, and the use of modifier 25. This CBR does include two graphs. You can see those here. They show the trend over time analysis for the total number of beneficiaries, for CPT® code 99291, and then the next figure is 99292. After the details of the metrics and analysis, it's nice to have the graphs to take a step back and to review an overall analysis for that three year time period. Here as I said we have figure 2 that reflects the beneficiary count over the time period for that code, 99292. At this point, I want to review the resources that 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 will 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 FAQs may be able to answer your inquiry. Here's 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 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 the reporting that the CBR team used in the creation and analysis of the CBR. You will see the CPT® manual, the Medicare fee for service improper data report, the *Medicare Claims Processing Manual*, again, that has been updated since, but the items found in the reference that is included in this CBR did apply during the analysis timeframe and the NCCI policy manual. This is a screenshot of our home page. cbr.cbrpepper.org/home. There are sections for each of the CBRs that we have released in 2020 and into 2021. For each CBR topic and release we provide links to a sample CBR, the training materials, the dataset, and the 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 for your organization. At this point I am going to just pause for just a moment to get a drink of water, but then I will happily answer any of the questions that you have submitted as time allows.