CBR202105: Critical Care Evaluation and Management Services
CBR and Webinar Questions and Answers

GENERAL

Q: What is a Comparative Billing Report (CBR)?
A: A CBR is created to compare providers' billing statistics to those of their peers on a state or specialty level and a nationwide level.

Q: Within an organization, who receives the CBR?
A: Each CBR contains specific guidelines as to how a provider is included in the CBR analyses. If a provider meets the criteria to receive a CBR, a notice is sent using the contact information available in the Provider Enrollment, Chain, and Ownership System (PECOS) database. The CBR Team uses providers' listed email addresses or fax numbers to send notifications about CBR releases, along with information about how providers can access their report. Physical copies of the CBR are also mailed to providers' mailing addresses.

Q: Is there a way to receive a list of providers who received CBRs within a group practice or receive information for a large group of providers?
A: The providers who receive a CBR will receive individual notifications via the email address or fax number listed in PECOS. In addition, a physical copy of the CBR will be mailed to each provider's mailing address. If there is a question as to whether or not all notifications were received for a group of providers, our Help Desk can assist with lists of National Provider Identifier (NPI) numbers.

Q: Is the provider who qualified for a CBR the only individual who can obtain the CBR and data?
A: The CBR and validation code information is sent to the contact data listed in PECOS. Those who can access the email or fax receipts will therefore be in a position to view the CBR access information. A physical copy of the CBR is also mailed to the mailing address listed in PECOS.

Q: We did not receive a CBR. Can we request a CBR be sent for our providers or find a CBR on the website, even if our providers were not identified as outliers for this CBR?
A: CBR reports are produced only if a provider meets the criteria for receiving a CBR, and the reports are not produced for providers upon request.

Q: How can I receive emails in regard to the CBR reporting?
A: A link to join our email list can be found on our homepage: cbr.cbrpepper.org/home.

Q: Where would a CBR be sent if our provider was identified as an outlier? How can I change the contact information regarding where the CBR is sent?
A: If a provider is eligible to receive a CBR using the metrics explained in the webinar, an email is sent to the email address available in PECOS. If a valid email address is not available, the notice is sent via fax to the fax number in PECOS. Providers also receive a physical copy of their CBR to the mailing address listed in PECOS. Please ensure your email address and fax number are updated in PECOS. The CBRs are available in the secure CBR Portal at cbrfile.cbrpepper.org by using the unique validation code that can be found in the mailed CBR as well as the email or fax notification.

Q: Where can I obtain the validation code to obtain my CBR report?
A: The validation code is sent upon distribution of the CBR to the provider by email or fax.

Q: Is there a way to submit suggestions for future CBR topics and metrics?
A: Any suggestions or feedback about future CBRs can be submitted through the "Provide your feedback on CBRs" link found on the CBR homepage: cbr.cbrpepper.org/home.

DOCUMENTATION AND CODING GUIDELINES

Q: What is a Special Edition CBR?
A: Periodically, the Centers for Medicare & Medicaid Services (CMS) develops and distributes special editions of CBRs, which offer more extensive education and resources to a subset of the provider community. Unlike routine CBRs, Special Edition CBRs include a series of up to four educational letters.

Q: How can I respond to this CBR?
A: CBRs are educational in nature; they do not require any response from the provider.

Q: What is the definition of critical care?
A: In the *Current Procedural Terminology® (CPT®) 2020 Professional Edition*, critical care is defined as follows: "The direct delivery by a physician(s) 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."

Q: How are the critical care CPT® codes assigned?
A: The critical care CPT® codes are time-based. The first 30 to 74 minutes of critical care are billed with CPT® code 99291. Every additional 30 minutes of service is billed with the add-on CPT® code 99292. As the time spent in care of the patient increases, CPT® code 99291 is used in conjunction with 99292 to represent the time spent in critical care.

Q: The *Medicare Claims Processing Manual* now reflects different information than what is listed in the CBR. Which is correct?
A: Recently, CMS made changes to "Chapter 12, Section 30.6.12" of the *Medical Claims Processing Manual*. The reference to this chapter within the CBR differs from the current entry. However, the information contained within the CBR applied to the claims during the timeframe of the analysis, which was Jan. 1, 2020, through Dec. 31, 2020.

Q: Does the analysis timeframe for this CBR includes dates during the public health emergency (PHE)?
A: This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation. The report is offered to facilitate an analysis of your billing submissions during a timeframe that includes the PHE. Please consider the changes that took place to your billing practices during the PHE when you review the data within this report.

Q: How is modifier 25 defined?
A: The *CPT® 2020 Professional Edition* describes the use of modifier 25 as proper when a "[s]ignificant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service."

Q: Are any services "bundled" with critical care services, meaning the services should not be reported separately?
A: "Chapter 12, Section 30.6.12" of the *Medicare Claims Processing Manual* states that the following services are bundled with critical care services and should not be reported separately:

Service Description	CPT® Codes
Interpretation of Cardiac Output Measurements	93561, 93562
Chest X-Rays, Professional Component	71010, 71015, 71020
Blood Draw for Specimen	36415
Blood Gases, and Information Data Stored in Computers	99090
Gastric Intubation	43752, 91105
Pulse Oximetry	94760, 94761, 94762
Temporary Transcutaneous Pacing	92953
Ventilator Management	94002-94004, 94660, 94662
Vascular Access Procedures	36000, 36410, 36415, 36591, 36600

REPORT SPECIFICS

Q: Am I being compared to only providers in my clinical specialty?
A: This CBR focuses on providers that performed critical care services, though it excludes providers with an emergency medicine specialty.

Q: How are "peers" defined within the CBR?
A: For the purpose of this report, the state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Q: Am I doing something wrong? Should I change my clinical care to lower my metric outcomes?
A: A CBR is not an indication of wrongdoing, and it does not suggest any change in clinical behavior. Provider outcomes can vary for many reasons, including the services provided, the region, and the patient population.

Q: What should I do with the results of my report?
A: CBRs reflect providers' claims billing patterns as compared to their peers for a coding and billing area that is vulnerable to improper payments. Providers are encouraged to use the report as a support to their internal audit and compliance efforts. Since the code set has been identified as vulnerable to improper payments, it is recommended that a separate audit or review of the documentation and code assignment is performed so that providers can confirm that all documentation supports the selection of all codes and modifiers.

Q: Is it possible for us to receive a detailed list of the patients and dates of service that were included in the analysis for this CBR?
A: The CBR Team is not able to provide a listing of claims/patients included in the CBR analysis. Providers may be able to identify those claims/patients by using the same claims inclusion/exclusion criteria that are specified in the CBR.

Q: I work in a specialty that demands more critical care services than my peers in other specialties. Why am I receiving this report if I will always be higher than my peers in critical care services?
A: A CBR is not an indication of wrongdoing. The analysis, metrics, comparisons, and outcomes are education tools and information that can help all providers protect the Medicare Trust Fund. Practice patterns may differ according to specialty, patient population, and location of services, among other factors. The CBR should be used to supplement your internal compliance program;

knowing that you use these codes, which may pose a vulnerability to the Medicare Trust Fund, may prompt a review to ensure that the codes are documented and submitted correctly.

Q: What does the term "allowed amount" represent?
A: The allowed amount refers to the allowed dollar amount that is assigned to each CPT® code in the Medicare Fee Schedule. Due to the variance in billed amounts submitted by providers, the allowed amount creates a dollar amount that is comparable for all providers.

Q: After receipt of a CBR, is there follow-up provided to re-review any changes in claims submission that may have taken place?
A: The CBR Team does not conduct follow-up assessments of claims data to determine whether providers' billing patterns have changed after a CBR release. Please note: The CBR is not intended to suggest wrongdoing or improper activities, and receipt of a CBR does not require response or follow-up from a provider. While it is possible that a CBR topic may be repeated at some point in the future, there are no plans to do so for this CBR topic at this time.

Q: How does RELI Group, Inc., receive the Medicare Part B claims data for the CBR analysis?
A: RELI Group, Inc., has access to the Medicare claims data through its contract with CMS. The CBR Team downloads the claims data from CMS' Integrated Data Repository. The claims data is analyzed during CBR production, and each provider's summarized data is presented in an individualized CBR.

WEBINAR SPECIFICS

Q: I would like to view this webinar again; how can I find the slide handout, recording, and transcript for the webinar?
A: The webinar slide handout, recording, and transcript are posted on the CBR homepage: cbr.cbrpepper.org/home.

Q: I was not able to ask a question during the webinar. Where can I find assistance?
A: To request assistance or submit questions, please contact the CBR Help Desk at cbr.cbrpepper.org/help-contact-us or call 1-800-771-4430, M–F, 9 a.m.–5 p.m. ET (please note the Help Desk line is currently experiencing high call volume; creating a Help Desk ticket for your inquiry is advised).