Transcript for the CBR202109: Drugs of Abuse Testing

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202109: Drugs of Abuse Testing*. 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'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, a recording of this webinar is available, 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 202109*, 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, CBR 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 *CBR202109*. 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 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.

As we mentioned earlier, CMS is required to protect the Trust Fund. To that end, the *CBR202109* was created and distributed. This CBR offers an analysis of providers' billing patterns for use by providers in their compliance processes. The topic selection is completed through research and collaboration with CMS, with the goal of drawing attention to areas of coding and billing that pose a threat to the Trust Fund. The metrics for every CBR are created according to the CBR topic and the potential risk to the Trust Fund, and the CBRs are distributed to providers based on individual provider results for specified metrics within the CBR.

The CBR is an educational tool that can be used for internal provider compliance. CBRs can draw providers' attention to their individual utilization of specific clinical services, and how that utilization plays into the protection of the Trust Fund. The supporting resources for each CBR release provide reminders of proper code selection and can be valuable additions to your internal annual compliance review.

We now know a bit about the purpose of the CBR, but let's look at what a CBR isn't. A CBR is not, in any way, an indication of or a precursor to an audit. It also is not an indication of wrongdoing. Again, the CBR is educational in nature, and should be reviewed as such. Some Medicare Administrative Contactors, or MACs, release medical review CBRs. This CBR is not a medical review CBR; internal medical records are not reviewed. Instead, the report provides education and a summary of your claims submissions as compared to your peers. Receipt of a CBR is not in any way a prompt to make changes to your clinical care. We sometimes have providers contact us and say "does this mean I have to stop providing these services?" The answer to that question is, of course, no. The report is a comparison tool; we do not in any way want to tell you how to provide services to your patients. And finally, you do not need to respond to a CBR, they are meant for internal use. We do encourage everyone to download your report so that the data is saved to your internal online files for use during those annual compliance reviews.

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. Again, the report is not an indication of wrongdoing, and the hope is that providers will use the data analysis to support their internal compliance. Also, providers can confirm that their billing practices are compliant with the guidelines for these difficult code sets, and those services that may pose a risk to the Trust Fund, to ensure that their piece of the billing process is appropriate and correct.

As always, and as we mentioned earlier, it is important to always remember that receiving a CBR is not in any way an indication of, or precursor to, an audit.

Downloading and saving your CBR internally guarantees availability of the report to any department or employee tasked with reviewing the CBR. We talk to providers who have noted that the saved CBR also helps with future compliance reviews; saving an electronic copy helps to ensure that the file doesn't get lost in the shuffle. With all that in mind, let's look at how to access your CBR through the portal.

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 not require—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.

And here we have the list of the CPT® codes that were included in this analysis and the description for each of the codes. This chart spells out the code descriptions for each of the CPT® codes used in the CBR, and as you can see, these are the codes for the presumptive drug testing.

Next is the list of the HCPCS codes that were included in this analysis, and these HCPCS codes are the definitive drug testing codes.

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 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 drug testing services using those specific CPT® and HCPCS codes. 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 and the timeline for the analysis.

Moving on to the Coverage and Documentation Overview. This section identifies the CPT® and HCPCS codes that were analyzed in the report. Tables 1 and 2 are listed in this section; Table 1 contains descriptions of the codes, you can see those here. Table 2 contains the information for this sample provider for the allowed charges, allowed units, and beneficiary count during the analysis timeframe.

The Metrics of the CBR lists and explains the metrics used 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. Following that information, the calculation for the metric is described, and then the results for the provider for each metric is shown in table form. This section also provides a graph displaying the trend over time for the provider.

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.

During the creation of the CBR, we took into account many factors, including the public health emergency that began in 2020. We are aware of the role that the public health emergency played for all providers, their services, claims data, and therefore, the claims submission. The timeframe of this CBR analysis does include dates that fall within the public health emergency. We are aware of that and took that into account when we created the analysis and CBR, and we want you to be aware of that as you review your analysis, and review the outcomes and comparisons in the report. Please consider how your billing practices have changed during the public health emergency when you review that data within this report.

Let's take a look now at the vulnerability of correct payments for drug abuse testing, 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 42.7% improper payment rate just for the one HCPCS code G0483, which represents $104 million in projected improper payments. With this high percentage of possible improper payments just for one code, these statistics give us a great look into why this is an area of interest for CMS in their protection of the Trust Fund.

What is the desired behavior for providers who provide drugs of abuse testing, and refer patients for these services? After looking at the projected improper payment rate, we aim to have providers realize their role in the protection of the Trust Fund and offer an analysis that

can support internal reviews to confirm proper coding and documentation. Providers can help by performing drug testing only when appropriate, referring patients responsibly, and reviewing all code assignments and internal compliance.

To create the appropriate distribution of *CBR202109*, we analyzed referring and rendering providers that submitted claims to Medicare Part B for drug testing or referred patients for drug testing. The CBRs are distributed to providers so that they may use the CBR as an education and 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 *CBR202109* and the metrics within the report, we used detailed information for that data during the CBR summary year of March 1, 2020 through February 28, 2021. The results showed that over 85 thousand providers submitted claims for testing, or referred patients for testing, which represent over 629 million 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.

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 for drugs of abuse testing. The metrics are Metric 1, average number of presumptive and definitive drug tests, per unique beneficiary. This metric is split into two parts; Metric 1a is the average number of presumptive drug tests, and Metric 1b looks at the definitive drug testing. Metric 2 analyzes the percentage of definitive drug tests using HCPCS code G0483.

The list of the metrics helps us to understand the criteria for receiving a *CBR202109*. Using the data and research, the CBR team created criteria to select the providers who will receive a *CBR202109*. That criteria is that the provider is significantly higher compared to either the state or national averages or percentages in any of the three metrics, which would be greater than or equal to the 90th percentile, and the provider has at least 31 beneficiaries with claims and at least two hundred and for—excuse me—$24,240 in total allowed charges for Metric 1a, at least 30 beneficiaries with claims and at least $31,000 in total allowed charges for Metric 1b, or at least 16 beneficiaries with claims and at least $6,000 in total allowed charges for Metric 2. Let's look now at the outcomes that could come from each comparison 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 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 peer state or national mean and is part of the criteria for receiving a CBR. In order to talk exactly about how we calculate the 90th percentile, lets 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.

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Looking first at Metric 1, average number of presumptive and definitive drug tests, per unique beneficiary. To calculate Metric 1a, total number of units for presumptive drug testing is divided by the total number of beneficiaries who received at least one presumptive drug test. Let's look at the sample figures on the CBR for Metric 1a. And we can see here, the numerator and denominator counts for this metric. The provider's average was 3.87, the state and national average were both around 2, so the comparison for this provider for this metric was significantly higher for both of those state and national comparisons.

Next, we have Metric 1b, the average number of definitive drug tests, per beneficiary. Metric 1b is calculated by dividing the total number of units for definitive drug testing by the total number of beneficiaries who received at least one definitive drug test. With that in mind, let's see where the sample provider fell with their results. You can see here their average for this metric was 3.88, again the state and national average are both around 2, so their comparison for this metric was significantly higher for both comparisons.

Finally, we arrive at Metric 2, percentage of definitive drug tests using HCPCS code G0483. This metric was calculated by dividing the number of allowed units of HCPCS code G0483 by the total number of allowed units for all definitive drug tests. Let's see the sample figures on the CBR for Metric 2. We can see this outcome is at about 83.5%, the state percent is about 34% the national percent is about 33%, so the comparison for this provider for this metric was higher for both the state and national comparisons.

The CBR includes graphs that represent the provider's billing trend, over the three years 2018 to 2021, for an analysis of total beneficiaries who had claims submitted for, or who were referred for presumptive and definitive drug testings. The graphs are split by the type of testing; Figure 1 shows presumptive testing codes and Figure 2 shows the definitive drug testing. Let's see the sample of data on the sample CBR. We can see here the outcomes for this provider, for beneficiaries for the presumptive drug testing, and then the definitive drug testing. After the detail of the metrics and analysis, it is nice to have these graphs that take a step back and reviews an overall analysis for that three-year period.

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 coding for the CBR topic.

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 FAQs 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, the HCPCS 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 since RELI began distributing the CBRs in 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, 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.

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