Transcript for the CBR202110: Critical Care Evaluation and Management (E/M) Services

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and, more specifically *CBR202110: Critical Care Evaluation and Management Services*. 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, as I mentioned before, we are recording this session, and that recording will be made available to you 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'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 *CBR202110: Critical Care Evaluation and Management (E/M) Services*, 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 *CBR202110*. 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 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.

In the Current Procedural Terminology, CPT® book, critical care services are included in the evaluation and management services section. The CPT® book defines critical care services as "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. So, when we're talking about critical care, about these codes, we are talking about patients who are very ill and in need of 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 30 minutes of critical care services are provided, we start using the critical care codes, starting with 99291. As the time spent in care of the patient increases, we use 99291 in conjunction with 99292 to represent the time spent in critical care. If under 30 minutes is spent in care, you would use the other evaluation and management codes to submit the services.

Here we see an expanded definition and description of Modifier 25 and its definition according to the CPT® 2021 Professional edition. The first part of the definition does indicate use of the Modifier 25 with a significant, separately identifiable evaluation and management service, and 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.

Let's take a closer look at the sample 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 this—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 critical care services. You can see here information from the 2020 Medicare Fee-for-Service Supplemental Improper Data Report, the Medicare Claims Processing Manual, and the National Correct Coding Initiative Policy Manual for Medicare Services. 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 critical care CPT® codes, you can see those here. Table 2 contains the information for this sample provider for the allowed amount, allowed services, visits, and beneficiary count during the analysis timeframe for the critical care codes.

The Metrics of the CBR lists and explains the metrics used for the CBR, the list of specialties included in the CBR analysis, the definitions for the specialty 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 rendering providers who had

allowed charges for critical care services. 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 we want you to be aware of that as you review your analysis and review the outcome 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 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. 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 99291 alone carries an improper payment rate of 19.7%, which represents over $196 million in project improper payments just for that code. So, this information tells us that this is an area of interest for CMS in their protection of the Trust Fund.

What is the desired behavior for providers who provide critical care services? After looking at the projected improper payment and the areas of possible error, providers should be aware that the documentation for the critical care service is complete; including medical necessity, a 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 significant, separately identifiable evaluation and management service that is documented correctly, that calls for the use of the modifier 25? We want to be sure that all of these documentation and service guidelines are met when we're using critical care codes and modifier 25.

To look at the rendering providers who submitted claims for critical care services, the *CBR202110* was created. The CBR analyzes and reviews statistics for rendering providers who performed critical care services. After seeing the possible error rate for critical care services, the CBRs are distributed to providers who perform CBR services, 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 *CBR202110* and the metrics within the report, we used detailed information for that data during the CBR summary year of July 1, 2020 through June 30, 2021. Those results showed that over 91 thousand providers submitted these claims, which represent over 1.1 billion 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 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 were submitted with a modifier 25? Metric 2 looks at the average number of critical care services per beneficiary for the provider, and Metric 3 looks at the average allowed charges for critical care, per beneficiary, during the analysis year. We'll break down how each of these metrics is calculated later in the presentation.

The review of the metrics and their role in the CBR topic helps us to understand the criteria for receiving a *CBR202110*. Using all of the data and research, the CBR team created criteria to select the providers who will receive a *CBR202110*. 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 the provider has at least 30 beneficiaries with claims for CPT® codes 99291 and 99292, the provider has at least $20,000 or more in total allowed charges, and the provider was in the top 5% of recipients of *CBR202110*. 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 *CBR202110*. In order to talk exactly about how 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 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.

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 modifier 25. Looking at the sample figures on the CBR for Metric 1, which are in Table 3, on page 5. You can see that this provider has a percentage of 2.01. With the specialty percentage falling at 9.07, and the national percentage at 10.89, the outcome of this metric for this provider is does not exceed for both the state and national comparisons

Next, we have Metric 2, the average number of visits per beneficiary. For this metric, 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.

With that in mind, let's see where the sample provider fell with their results. Those results are on Table 4, on page 5, and we can see that this provider's average is 6.37. The state average is 1.67 and national average is 2.14. These results produced an outcome of significantly higher for both comparisons for this metric for the sample provider.

Finally, we arrive at Metric 3, the average allowed charges per beneficiary. This metric was calculated by dividing the count of unique critical care visits by the count of unique beneficiaries who had a critical care service

Let's see the sample figures on the CBR for Metric 3 in Table 5 on page 7. This provider had an outcome of $1,684.80 for this metric. The state average is $548.35, and the national average is $492.62 so this brings a result of significantly higher for this provider for the state and national comparisons.

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 critical care services, and use of modifier 25.

The CBR includes a graph that represents the provider's billing trend, over the three years 2018 to 2020, for trend over time analysis of total number of beneficiaries for whom CPT® code 99291 was submitted. We can see the beneficiaries over the years for this provider for code 99291, and Figure 2 looks at code 99292. After the detail of the metrics and analysis, it is nice to have this graph that takes a step back and reviews an overall analysis for that three-year period.

And here we have Figure 2 that reflects the beneficiary count over the time period for code 99292.

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 Medicare Fee-for-Service Supplemental Improper Payment Data report, and the NCCI Policy Manual

This is a screenshot of our homepage, cbr.cbrpepper.org/Home. There are sections for each of the past nine CBRs that have been released. 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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