Transcript for the CBR202111: Orthoses Referring Providers

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202111: Orthoses Referring Providers*. 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, a recorded webinar session and transcript, a coding guidance document focused on this topic, 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 *CBR202111: Orthoses Referring Providers*, 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 *CBR202111*. 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 communications are distributed 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.

Near 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.

CBR202111 focuses on providers listed as referring providers on claims for off-the-shelf and custom-fitted prefabricated orthoses products. The 15 Healthcare Common Procedure Coding System (HCPCS) codes that you see here are included in this analysis, and for the purposes of the analysis and this presentation, these 15 L-codes will be referred to as "target codes."

Let's now take a closer look at the sample document, so we can fully understand this CBR, and the 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 orthoses referring providers. You can see here information from the *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report, an Office of Inspector General, OIG, report, and a media release calling attention to the vulnerability of improper payments for durable medical equipment. The introduction also contains the criteria for receiving a CBR.

Moving on to the Coverage and Documentation Overview. This section identifies the HCPCS codes that were analyzed in the report. Tables 1 and 2 are listed in this section; Table 1 contains descriptions of the HCPCS codes for off-the-shelf and prefabricated orthoses, you can see those here. Table 2 contains the summary of referrals for the target codes for this sample provider. The paid amount from your referrals refers to the amount that was paid for the orthoses for which you made a referral. The number of paid orthoses is the actual number of orthoses that were paid, so this will be a number while the previous column will be a dollar amount. The beneficiary count lists the number of beneficiaries for which you had an orthoses referral, and the count of beneficiary state codes lists the number of states where those beneficiaries were located.

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 the CBR recipient to other providers. We have an explanation of the dates of service included in the report analysis, and the total referring providers on claims for the target codes. 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 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

Let's take a look now at the vulnerability of correct payments for orthoses products, 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 a 31.8% improper payment rate for durable medical equipment, prosthetics, orthotics, and supplies. Within that error rate, there is a 65% improper payment rate due to insufficient documentation, and a 5.9% improper

payment rate due to medical necessity errors. So you can see, with these statistics, why this area is of interest to CMS for their protection of the Trust Fund.

To look at referring providers on claims for off-the-shelf and custom-fitted prefabricated orthoses products using the identified HCPCS target codes, the *CBR202111* was created. The CBR analyzes and reviews statistics for referring providers on claims for off-the-shelf and custom-fitted prefabricated orthoses products, again for those 15 target codes. The CBRs are distributed to providers for use as an education and comparative tool, and to aid in internal compliance. Because there is a known possibility of improper payments for the DME products, and specifically the listed target codes, providers can use the CBR to encourage a review of these specific codes when performing an internal compliance review.

To create the *CBR202111* 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 120 thousand providers were listed as referring providers on claims that listed the target codes. The total paid amount for these claims was over 344 million dollars.

We are aware that the public health emergency played a role in providers' services, claims data, and therefore, the claims submission. The timeframe of this CBR analysis does include dates that fall within the public health emergency and we urge you to take the public health emergency and the changes it caused into account as you review your analysis and 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.

What is the desired behavior for providers who make referrals for these target code orthoses? After looking at the projected improper payment and the areas of possible error, providers should be aware that the documentation for the orthosis is complete; including medical necessity. Also, providers should be sure that they are referring a responsible number of orthoses for each patient, and that those referrals go to a reasonable number of suppliers.

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 referring providers for the target codes. The metrics are percentage of beneficiaries referred for target codes, percentage of paid amounts for target codes, and percentage of suppliers for target codes.

Metric 1 analyzes, of all the beneficiaries who had claims submitted with a HCPCS L-code, what percentage of those beneficiaries had claims submitted with a target code? Metric 2 looks at the paid amounts for the target codes as opposed to all HCPCS L-codes, and Metric 3 looks at the suppliers that the provider referred orthoses. 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 *CBR202111*. The criteria are that the provider is listed as a referring provider on claims with at least $50,000 or more in total paid charges for the target L-codes, the provider is a recipient of Letter 2, and the provider is in the top 50% of providers meeting criteria 1 & 2. Again, those paid charges are paid charges as a result of the provider being listed as the referring provider for the orthoses.

Each metric analysis results in a comparison of the provider to their peers. The four outcomes for the provider's state and national comparisons are listed here for each metric analysis. 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 80th 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 80th percentile from the peer state or national mean. In order to talk exactly about how we calculate the 80th 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 80th percentile. In order to identify the providers who were above the 80th 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' outcome 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 80% of the providers' values fall. This is the 80th percentile mark, represented 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 percentage of beneficiaries referred for target codes. To calculate Metric 1, the number of unique beneficiaries with claims submitted for any of the target codes is divided by the number of unique beneficiaries with claims submitted with any L-code. 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 99.71 %, which means that almost all of the beneficiaries that this provider referred for L-codes were referred for a target code. With the

state percentage falling at 33.12, and the national percentage at 37.56, the outcome of this metric for this provider is significantly higher for both the state and national comparisons.

Next, we have Metric 2, the percentage of paid amount for target codes. For this metric calculation, the total paid amount for claims with any of the target codes is divided by the total paid amount for claims submitted with any L-codes.

With that in mind, let's see where the sample provider fell with their results. Those results are on Table 4, on page 6, and we can see that this provider's percentage is 99.26. The state percentage is 28.17 and national percentage is 29.90. 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 percentage of suppliers for target codes. This metric was calculated by dividing the number of unique suppliers who submitted claims with any of the target codes by the unique suppliers who submitted claims with any of the L-codes.

Let's see the sample figures on the CBR for Metric 3 in Table 5 on page 6. This provider had an outcome of 100% for this metric. The state percentage is 38.13 and the national percentage is 38.11 so this brings a result of significantly higher for this provider for the state and national comparisons.

The CBR includes a graph that represents the provider's billing trend, over the three years 2018 to 2021, for trend over time analysis of the number of beneficiaries referred for target codes. 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. Let's take a look at the sample provider CBR. Here we can see the trend over time for this provider went drastically up in years two and three as compared to year one.

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 HCPCS manual, the Medicare Fee-for-Service Supplemental Improper Payment Data report, and the two articles referenced regarding the OIG studies of possible incorrect payments for orthoses.

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. Thank you again for joining us today, if you have any questions, please feel free to submit your inquiry to our Help Desk.