Transcript for the *CBR202209: Initial Nursing Facility Evaluation and Management (E&M) Visits*

Welcome to today's webinar, where we'll be discussing Comparative Billing Reports, or CBRs, and more specifically, *CBR202209: Initial Nursing Facility 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, 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 Comparative Billing Report, 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 this CBR. 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.

We now know a bit about why CMS issues CBRs, 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.

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.

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 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, 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'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.

As we mentioned earlier, CMS is required to protect the Trust Fund. To that end, the *CBR202209* 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.

Let's take a look now at the vulnerability of correct payments for nursing home visits, and how that plays into CMS's protection of the Trust Fund. The *2021 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects a 14.1% improper payment rate these services, which represents over $341 million in projected improper payments. This improper payment rate is attributed to insufficient documentation, and incorrect coding. These statistics give us a great look into why this is an area of interest for CMS in their protection of the Trust Fund.

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. You can see here the timeframe for the analysis, information from the *2021 Medicare Fee-for-Service Supplemental Improper Payment Data* report, and the criteria for receiving the report.

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 CPT® codes used in the data analysis; you can see those here. Table 2 contains the summary of utilization of the CPT® codes for this sample provider. The table lists the allowed charges, allowed units, and beneficiary count for the codes.

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. We also have a list of the possible outcomes for each of the metric comparisons.

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 total providers and allowed charges for the analysis. 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.

To create the CBR22—*CBR202209* and the metrics within the report, we used detailed information for that data during the CBR summary year of June 1, 2021, through May 31, 2022. The results showed that over 39 thousand providers submitted claims, which represent over 334 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.

What is the desired behavior for providers who perform initial nursing facility evaluation and management 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 carefully reviewing CPT® code assignments and confirming proper documentation.

Let's talk about the metrics for this CBR; each metric was created to take a more detailed look at the submission of claims for nursing facility visits. The metrics are percent of average weighted services billed, per day, percentage of beneficiaries with more than one allowed service, and percentage of total Medicare Part B allowed amount submitted for initial nursing facility E&M visits.

Using the data and research, the CBR team created criteria to select the providers who will receive a *CBR202209*. That criteria is that the provider is significantly higher compared to either peer group or national outcomes for any of the three metric calculations (i.e., greater than or

equal to the 90th percentile), and has at least 40 total beneficiaries with claims submitted for CPT® codes 99304, 99305, and 99306, and has at least $7,000 in total allowed charges.

The four possible outcomes for the metric analyses are listed here. These outcomes are the basis of the comparisons made regarding the provider's billing patterns and those of their peers. The 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 the 90th percentile from the peer state or national mean. 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. In order to identify the providers who were above the 90th percentile, we calculated payment 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' payment 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, average weighted services billed, per day. To calculate Metric 1, we begin by calculating the weighted services: each CPT® code is assigned a value that corresponds to the time described in the CPT® code for E&M services, as seen in Table 1. This value is multiplied by the allowed services for each E&M CPT® code to arrive at the weighted services, per code. These values are then summed for the weighted service value. To calculate the outcome for the provider, the weighted services is divided by the number of distinct dates of service for any initial nursing facility E&M visits during the analysis year. Looking at the sample CBR, we can see that this provider has an outcome of 71.61 for this metric. Or, excuse me, 72.89 for this metric. The state average is 71.61 and the national average is 79.12, so the outcome for the results for this provider for this metric are higher for the state and does not exceed for the nation.

Next, we have Metric 2, percentage of beneficiaries with more than one allowed service. To calculate Metric 2, number of beneficiaries with more than one allowed service is divided by the total number of unique beneficiaries with at least on allowed service. With that in mind, let's see where the sample provider fell with their results. This provider has a percent outcome of 13.65 so with the state percent at 9.18 and the nation at 8.27 the comparison outcomes are higher for this metric for the sample provider.

Next is Metric 3, percentage of Medicare part b allowed amount submitted for initial nursing facility E&M visits. To calculate the outcome for this metric, the total allowed amount for initial nursing facility E&M visits is divided by the total allowed amount of all Medicare Part B claims. Let's see the sample figures on the CBR for Metric 3. This provider has an outcome of 22.96%. The state outcome is 6.09% and national outcome is 5.10%. Therefore, the outcomes are significantly higher for this provider.

The CBR includes graphs that represent the provider's billing trend, over the three years 2019-2022, for an analysis of total number of beneficiaries for whom claims were submitted with CPT® codes 99304, 99305, and 99306. Figure 1 shows the results of this data for the sample provider, so let's look on the sample CBR. 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 you can see the numbers for this provider for those codes for the three years.

Figure 2 takes a closer look at initial nursing facility E&M visits for year 3, the analysis year. This detailed graph shows the services submitted for each month during the analysis year. This is a great way to see the breakdown for these services for each month of one specific year.

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 a 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, and the Medicare Fee-for-Service Supplemental Improper Payment Data report.

This is a screenshot of our homepage, cbr.cbrpepper.org/Home. On our homepage, among many other resources, you'll find links and information for the most recent nine CBR releases. 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 for this webinar. I hope you found it to be beneficial. If you have any questions about this or any other CBR, please reach out to us through our Help Desk.