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CMS Sends Billing Outlier Reports to Part B Providers; Metrics Show How to Identify Them

By Nina Youngstrom

For about a year, a new CMS contractor has been mining data nationally on certain billing outliers, including emergency department services and breast re-excision, and making it available to health care providers—although some of them may be unaware of this. The Comparative Billing Reports (CBRs) are similar to the Program for Evaluating Payment Patterns Electronic Report (PEPPER)—they have free, provider-specific data that can be used to monitor and improve compliance—but there are meaningful differences. A big one: CBRs are only sent to Part B providers who are outliers, and it's up to them to figure out why. PEPPERs, in contrast, are sent to all hospitals and other Part A providers.

"We are looking at all Part B providers nationally," says Kim Hrehor, program director of RELI Group Inc., in Catonsville, Maryland, which generates CBRs for CMS. "Providers have to know where these vulnerable areas are, and they have to understand if it's something that impacts their operations." There's about one monthly release of CBRs, which are distributed through a portal on the CBR website (cbr.cbrpepper.org). To ensure providers know the data is available, RELI Group informs them by fax and email, Hrehor tells *RMC*.

In letters to providers, RELI Group explains the purpose of the CBRs. "A CBR is an educational tool that reflects your billing patterns as compared to your peers' patterns for the same services in your state and nationwide. The CBR is intended to enhance accurate billing practices and support providers' internal compliance activities," the letters state. "We are providing this report because your Medicare billing patterns differ from your peers' patterns within your state and/or across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education."RELI Group asks the providers to review the CBR and check it against their records and Medicare guidelines to ensure compliance.

Medicare administrative contractors (MACs) also have sent CBRs to providers, but they focus on providers in their jurisdictions. "Our CBRs are unrelated to the MAC," Hrehor says. "The CBRs our team produces are more focused on the national level on topics that have the potential to impact Medicare in terms of improper payments that may be due to billing errors and medically unnecessary services," she says.

So far, RELI Group has sent providers CBRs on nine risk areas. Only providers who are outliers or meet specific criteria receive the data. Providers take it from there. "We are not telling them they are doing anything wrong or submitting anything improper. It is comparative data. We are letting them know in one or more metrics, they are outliers," Hrehor says. "Maybe that is what they expect for their patient population for the type of specialty services they offer, but maybe it's not. Maybe that is something they should look at more closely."

Here are the services that are the subject of recent CBRs and the metrics used to identify outliers:

Here Are Metrics for Nine Risk Areas

- Intensity-modulated radiation therapy (IMRT). The metrics are:

    - Average number of IMRT planning services (CPT code 77301) billed, per beneficiary
    - Average allowed charges for the first instance of IMRT planning code 77301, per beneficiary
    - Average number of CT scans for therapy guide (CPT code 77014) billed 0–14 days prior to or up to 60 days after the first instance of CPT code 77301, per beneficiary
    - Average number of intensity-modulated treatment delivery (HCPCS codes G6015 or G6016 [intensity-modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session]) billed 0–14 days prior to or up to 60 days after the first instance of CPT code 77301, per beneficiary
    - Average number of evaluation and management (E/M) CPT codes billed 0–14 days prior to or up to 60 days after the first instance of CPT code 77301, per beneficiary
- Office visits, new/established, family practitioner. The metrics are:
    - Allowed units for new patient visits and for established patient visits, levels 4 and 5 (CPT codes 99204, 99205, 99214, 99215)
    - Allowed charge amount for new patient visits and for established patient visits, levels 4 and 5 (CPT codes 99204, 99205, 99214, 99215)
    - Percentage of beneficiaries per level of service, for new patient visits and for established patient visits, levels 4 and 5 (CPT codes 99204, 99205, 99214, 99215)
- Subsequent hospital visits. The metrics are:
    - Percentage of beneficiaries discharged within one day of a CPT code 99233 service
    - Average allowed minutes per encounter
    - Percentage of total services billed as CPT code 99233
- Vitamin D testing. The metrics are:
    - Ratio of vitamin D testing to office visit
    - Percent of beneficiaries receiving vitamin D testing for other diagnoses
    - Average number of vitamin D tests per beneficiary
- Emergency department services. The metrics are:
    - Percentage of services billed with CPT code 99285
    - Percentage of services appended with modifier 25
    - Average allowed charges for all Medicare Part B services, per visit
- Modifier 25 with dermatology. The metrics are:
    - Percentage of services appended with modifier 25
    - Average minutes per visit for claim lines with modifier 25

    - Average allowed charges per beneficiary summed for one-year period, regardless of the modifiers appended to the claim lines

- Breast re-excision. The metrics are:
    - Percent of re-excisions within 365 days of a previous excision
    - Average allowed amount for re-excisions within 365 days of a previous excision
    - Percent of beneficiaries receiving a re-excision within 365 days of a previous excision
- Venipuncture. The metrics are:
    - Percent of visits with laboratory codes billed with CPT code 36415
    - Percent of total allowed amount for routine venipuncture in conjunction with a laboratory code
    - Percent of visits billed with CPT code 36415 where multiple units of 36415 were billed
- Air ambulance transports. The metrics are:
    - Average number of miles per transport
    - Average allowed amount per transport
    - Average allowed amount per unit

More Audits Are Data Driven

The services were selected for CBRs because they kept popping up in Comprehensive Error Rate Testing (CERT), HHS Office of Inspector General and other audits as "problematic" areas, Hrehor says.

If providers submit a lot of claims that affect any of these areas, "they should have someone on their team who understands these areas—whether it's the correct way to submit the claims, and what the expected treatment patterns and care guidelines are," she says. For some reason, they are an outlier. If so, can it be justified? Answering that question may require coordination between compliance, clinicians and coders. "Each one of the CBR topics is so unique and interesting," she says. For example, when a provider orders lab work, the needle stick (known as venipuncture) shouldn't be unbundled from the lab code, but often the physician bills the venipuncture separately from the lab work. "It's not a lot of money, but if you do it 500 times, it adds up," Hrehor says.

After every CBR release, RELI Group holds a webinar to explain the implications of the data. "You can listen to our webinars even if you don't get the CBR," Hrehor says.

Data mining is playing a more prominent role in compliance programs because audits and investigations are increasingly data driven. Hospitals and other Part A providers have been using PEPPERs for years in their compliance auditing and monitoring programs.

Hospitals also increasingly use data to focus their audits on high-risk areas and avoid wasting time on random reviews ("Hospitals Step Up Data Mining, With Notifications When Risks Cross a 'Threshold,'" *RMC* 28, no. 6).

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