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Quality improvement, patient safety, and the zeal to comply:

What a CPA and a radiologist bring to Compliance leadership

an interview with Don Sinko and Mark Sands

See page 18

by Melissa McCarthy, RHIT, CCS

Billing data: Tools to maximize data mining efforts

» Various resources are available to assist in data mining activities.

» Documentation review is key to support initial findings.

» Make sure you can see the whole picture before you react. If the data does not match up, pieces of the puzzle may be missing, and therefore, exhaust all avenues before you report on the findings.

» CMS data shows that a small percentage of providers account for large portion of Medicare costs.

» Verify that the available data matches your data.

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The volume of available data related to billed claims is staggering today. Learning how to navigate and use the data meaningfully can be challenging. The physician claims data newly released by the Centers for Medicare & Medicaid Services (CMS) opens the door for providers and consumers alike to calculate provider trends and financial gain from Medicare beneficiaries. Already existing resources, such as PEPPER data, allow organizations to compare the performance of their facilities for certain target areas to state and national trends. Keep in mind that the data collections mentioned in this article are just tools to help pinpoint potential problem areas.

McCarthy

CMS physician claims data

On April 9, 2014, the United States Department of Health and Human Services (HHS) and CMS, for the first time, released data related to payment for provider services and procedures provided to Medicare beneficiaries. The purpose behind this historic release is to provide more consumer transparency. The information was met with mixed reviews. Generally, it is believed that transparency is beneficial, but the use of the data should be within the proper context and with appropriate safeguards.

This information is a powerful tool for both Medicare beneficiaries and hospitals. For example, patients can determine how many times a provider has practiced a certain procedure and how much it may cost Medicare, even before patients make an appointment. Hospitals now have the ability to review this data about competing providers as well as reviewing physician billing trends before recruitment.

The CMS data is divided into three sections: Physician and Other Supplier, Inpatient, and Outpatient. In an attempt to maintain Medicare beneficiary privacy, the data from hospitals that have billed fewer than 11 patients per Medicare Severity Diagnosis Related Group (MS-DRG) and/or Ambulatory Payment Classification (APC), has been suppressed and is not searchable within the data.

The Physician and Other Supplier data contains 2012 information on utilization, payment, and submitted charges by individual National Provider Identification (NPI) number. The Inpatient data represents 2011 national hospital-specific charges for the top 100

most-frequently billed discharges to Medicare and is categorized by MS-DRG. The Outpatient data represents the 2011 estimated hospital-specific charges for 30 APCs paid by Medicare.

The New York Times published an article entitled "Sliver of Medicare Doctors Get Big Share of Payouts"[1] that included a link to a search function that concisely aggregated the data from CMS. The information is the same, just arranged differently and easier to navigate in comparison to the HHS Excel files. The *Wall Street Journal* also published an article on the same day, entitled "Small Slice of Doctors Account for Big Chunk of Medicare Costs."[2] Both of these articles explore the fact that a small percentage of providers account for large portion of Medicare costs.

The most common use of this Medicare billing data by healthcare consumers will likely be to view provider reimbursement and the number of times a provider has performed a procedure. The most likely beneficial use of the data for hospitals will be to benchmark provider utilization of services nationally as well as statewide (see Figure 1 below). This graph represents the comparison of established patient and new patient evaluation and management (E&M) levels across the United States and New York State for 2011.

Another way to approach this data would be to look at the same data, but add the element of the average Medicare reimbursed amount across the nation and in New York State (see Figure 2 below).

The addition of individual hospital or provider data on this graph would enable users to detect possible over/under utilization of codes as well as to detect areas to focus on for provider education efforts.

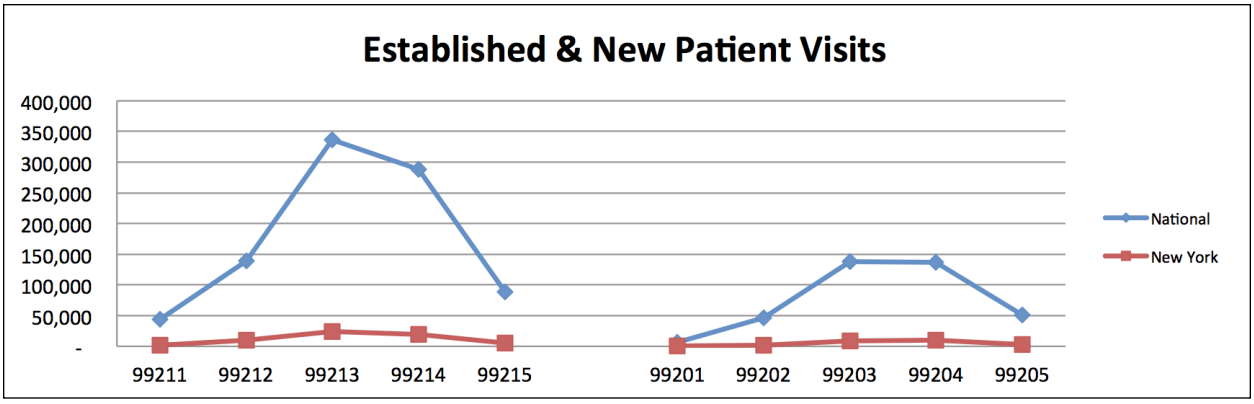

Figure 1: Comparison of national and New York state E&M data

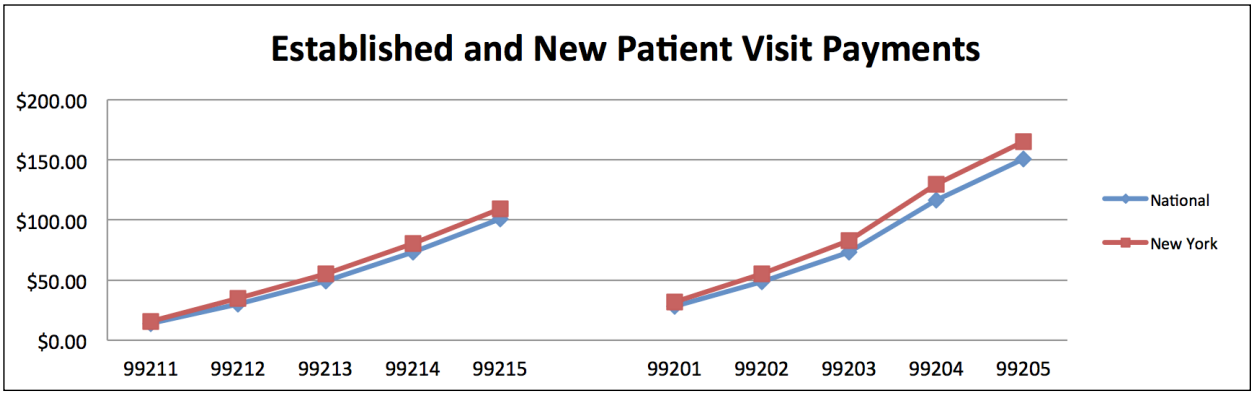

Figure 2: Average national and New York state Medicare reimbursement data

PEPPER data

Other data mining tools are available as well. The Program for Evaluating Payment Patterns Electronic Reports (PEPPER) is available from CMS, containing organization-specific data for target areas identified as high-risk payment areas. This data is available for inpatient hospital, inpatient psychiatric, inpatient rehabilitation facilities, skilled nursing facilities, hospice, and partial hospitalization services.

It is suggested that anything above the 80th percentile or below the 20th percentile, as compared to national, state, and jurisdiction (i.e., regional) benchmarks, should be reviewed. Even though a facility may be red (i.e., at or above 80th percentile for national, state, or jurisdiction) for a certain area, it does not mean the facility's coding is inappropriate. A facility could have a higher ranking because of demographic or other environmental reasons.

CMS dashboards

CMS also recently released a Chronic Conditions Warehouse and Geographic Variation dashboards. These resources give the public a deeper understanding of the chronic conditions among Medicare beneficiaries, disease prevalence, and the implications for our healthcare system. The Chronic Conditions Warehouse dashboard summarizes disease data to national, state, county, and hospital regions for 2008-2012, as well as looking at the differences within Medicare patient populations. The Geographic Variation dashboard is a tool that demonstrates the amount of money spent per capita, by type of service, by year. Users are able to compare and demonstrate trends by national, state, and/or county data.

Other data sources

External vendors can also be used to assist in data mining efforts. These vendors typically have algorithms based upon industry hot topics, such as those that are identified in the Office of Inspector General (OIG) Work Plans or by Recovery Audit Contractor (RAC) targets. Running an organization's billing data through these algorithms can be very helpful in identifying aberrancies in data; however, this is not necessarily indicative of definite issues. The aberrancy should be reviewed carefully, as well as the supporting documentation for the claim, in order to accurately identify whether a problem has been detected.

Organizations also have the ability to mine their own data, without the help of external vendors, through the review of their billing data. For example, an organization can review provider billing by providers' highest volume of charges. It is important to review the supporting documentation for these claims to verify that charges are accurate.

Data mining tips

CMS and your organization's billing provide the data, now what? Here are six suggestions on how to use the data effectively:

- Review the *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* for your organization's providers. Verify that CMS data matches your data.
- Review the *Medicare Provider Utilization and Payment Data: Inpatient* to examine national and state data related to the diagnosis of Kwashiorkor. This topic appears in the 2014 OIG Work Plan. CMS data should be compared to your organization's data for this diagnosis. The review of this data may demonstrate that your organization is using incorrect International Classification Diagnosis – 9th Revision codes related to malnutrition documentation, which may lead to the reporting of a more severe diagnosis than the malnutrition that is common in the United States.
- Review the *Medicare Provider Utilization and Payment Data: Physician and Other Supplier* to trend facility place of service versus office place of service for your organization's providers. The exploration of this area may lead to the discovery that the incorrect place of service is billed for these encounters.

- Review PEPPER data reported for your organization across quarters to identify rising or falling trends related to PEPPER target areas. Target areas that are repeatedly reported higher than the 80th percentile or lower than the 20th percentile should undergo close scrutiny.
- Make sure you can see the whole picture before you react. If the data does not match up, pieces to the puzzle are oftentimes missing, and therefore, exhaust all avenues before you report on the findings. For example, CMS databases only include information on Medicare Fee For Service beneficiaries. A physician or provider's practice typically would include patients with other payment types or insurances. Conclusions about a provider's whole practice should not be drawn from CMS data alone.
- The CMS databases do not take into account incident-to or teaching physician rules. That is, some services may be rendered and documented by a physician extender or resident under the supervision of the billing provider and may not truly represent the volume of services that are rendered by the provider shown in the database. Always verify your findings through the review of medical record documentation.

Conclusion

Data mining is a compass that can guide you to the areas that require more investigation. Data mining can detect aberrancies in billing, but a deeper dive into the supporting documentation behind what was billed is always necessary and sometimes, the discrepancy is explainable.

The views in this article are the author's personal views and do not necessarily represent the views of her employer.

1. Reed Abelson and Sarah Cohen: "Sliver of Medicare Doctors Get Big Share of Payouts." *The New York Times*. April 9, 2014. Available at http://nyti.ms/1CBaOXL
2. Christopher Weaver, , Tom McGinty, and Louise Radnofsky: "Small Slice of Doctors Account for Big Chunk of Medicare Costs." *The Wall Street Journal*. April 9, 2014. Available at http://on.wsj.com/1vrnPjs