How to Develop Benchmarking

scorecards

Transitioning to Risk-Based Physician Auditing

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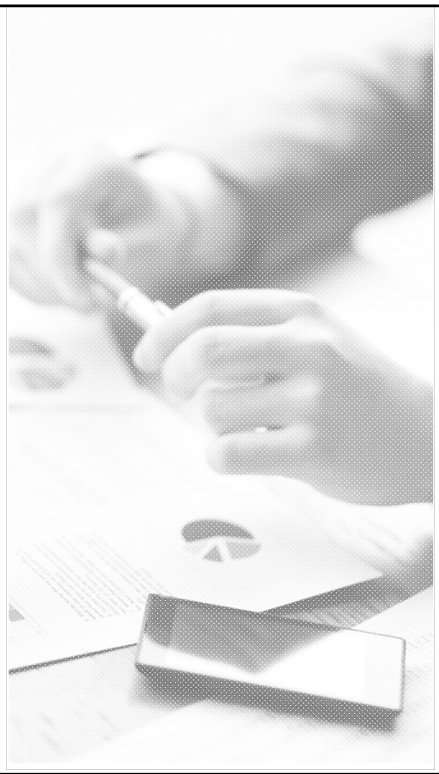

What We Are Going To Cover

1. *The Current Audit Activity*
2. *Reactive vs. Proactive Auditing*
3. *What Metrics to Look at?*
4. *Understanding Peer Group Data*
5. *How to Calculate the Metrics*
6. *Incorporate Risk Thresholds*
7. *Tying Everything into an Audit Plan*

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22 State Diversified Network

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Big Data

Current Audit Activity

- Government has refined their data analytics for "Smarter" Investigations and prosecutions
- More techniques are being developed to target "high-risk physicians" at the federal and state level (cooperation)
- Healthcare investigations are "bipartisan" and will continue no matter who controls congress
- State Medicaid programs are doing more auditing and monitoring (examples)
- 60-day repayment rules (explain) (can't bury your head in the sand)
- Data transparency

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Type	Contractors	Comments
Medicare Administrative Contractors (MACs)	• National Government Services	• Process claims and provider payments • Reduce payment error rates
Zone Program Integrity Contractors (ZPICs)	• Cahaba Safeguard Administrators	• Focus on identifying fraud • All providers • Data mining and analysis
Supplemental Medical Review Contractor (SMRC)	• Strategic Health Solutions	• Nationwide claim review • All providers • Data mining and analysis
Comprehensive Error Rate Testing Contractors (CERT)	• Multiple contractors	• Annual audits to determine FFS error rates • All provider types
Recovery Audit Contractors (RACs)	• CGI Technologies (Medicare) • HMS (Medicaid)	• Identify over and under payment errors
DHHS – Office of Inspector General (OIG)	• N/A	• Audits and investigations • Annual Work Plan published
Department of Justice (DOJ)	• N/A	• Enforcement actions under the False Claims Act
Medicaid Inspector General	• IL Dept. of Healthcare and Family Services	• Aggressively using extrapolation for repayment liabilities

Who is

AUDITING?

Healthcare Providers

An Example: Illinois

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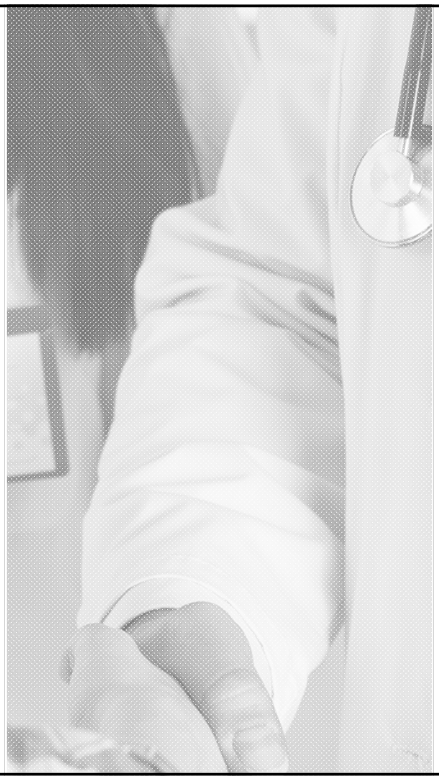
A Typical Trend: Reactive Auditing

- The current reactive approach to auditing and monitoring
  - Just responding to audit requests
  - Conducting documentation reviews entirely in random
  - Benchmarking without a set action plan
- Reasons why this reactive approach is still being used
  - Data issues
  - Understanding benchmarking
  - Restricted FTE and tech resources
  - Fear of knowing



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Becoming Proactive with Provider Benchmarking

- Develop benchmarking and data analytic capabilities that mirror methods being used by the OIG, DOJ, CMS etc.
  - Focus your limited auditing and monitoring resources towards providers based on risk
    - Reduce workload on the auditing team
      - Provide transparency throughout the organization and increase the effectiveness of strategic planning
        - Due diligence of new practices

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What Metrics to Look at?

01 Utilization Benchmarking

- E/M level coding peer comparisons
- Modifier usage
- Top billed procedure analysis

02 Highly Productive Provider Analysis

- Visit per day analysis
- wRVU analysis
- Harvard RUC time study

03 Payments Analysis

- Medicare payments analysis

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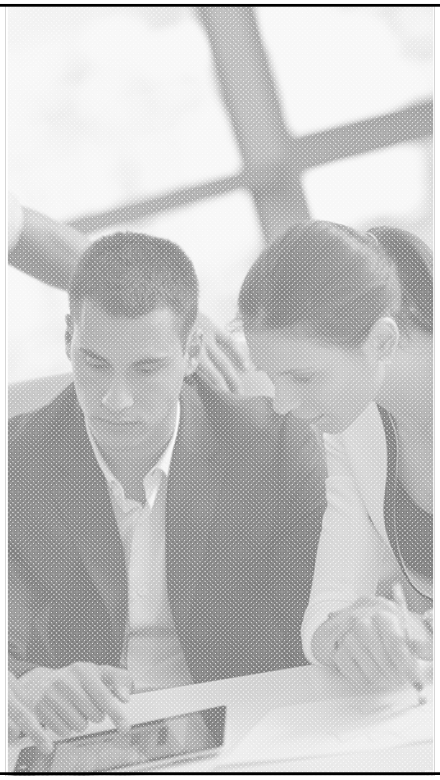
Before You Get Started: Defining Your Peer Group

- CMS Utilization Raw Data
  - Sub-Specialty Bias
  - Payer Mix Bias
- MGMA – Surveys and Benchmarking Data
  - Understand Volume of Data Included (Total / Specialty / Locality)
- CMS Utilization & Payments Data
  - Line Item Data Not Included on Services Performed on Small Number of Patients



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20	Physician/Orthopedic Surgery	207X00000X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery
		207XS0114X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
		207XX0004X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Foot and Ankle Surgery
		207XS0106X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Hand Surgery
		207XS0117X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Orthopaedic Surgery of the Spine
		207XX0801X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Orthopaedic Trauma
		207XP3100X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Pediatric Orthopaedic Surgery
		207XX0005X	Allopathic & Osteopathic Physicians/Orthopaedic Surgery, Sports Medicine

Example of CMS Sub-Specialty Bias

- Understanding the make-up of the peer group data is critical when attempting to make determinations on the results

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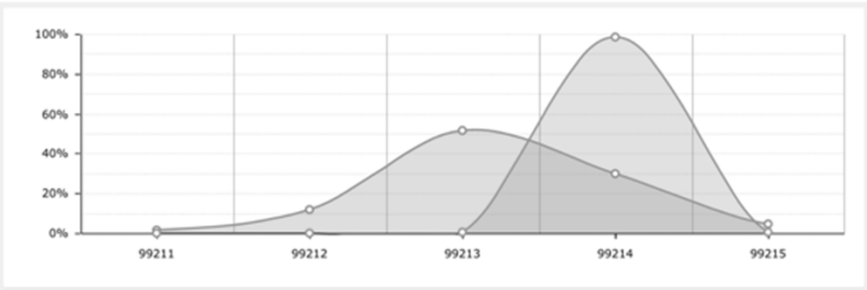
E/M Level Coding Peer Comparisons



	National Peer	1st Quarter 2015					
	Util.	Util.	Vol.	Diff.	Gross $	Adjusted $	Work Rvu
99211	1.79%	0.00%	0	-2%	$0.00	$484.15	0
99212	11.79%	0.22%	3	-12%	$131.04	$6,816.14	1.44
99213	51.42%	0.44%	6	-51%	$440.40	$50,473.94	5.82
99214	**30.14%**	**98.59%**	**1330**	**68%**	**$143,812.90**	**($99,848.47)**	**1995.00**
99215	4.86%	0.74%	10	-4%	$1,457.20	$8,096.41	21.10

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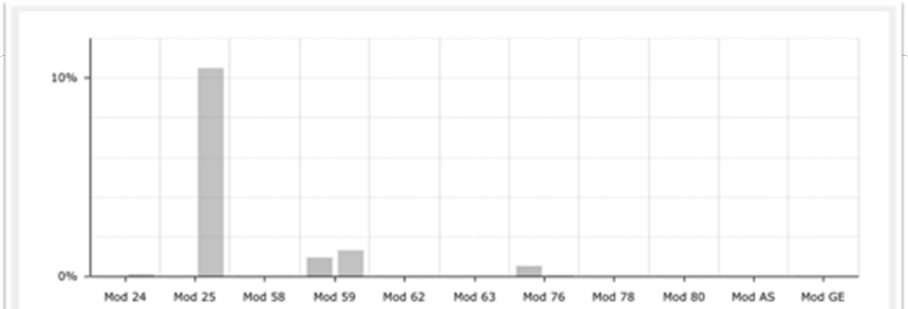

		National Peers	1st Quarter 2015		
	Description	Util.	Util.	Vol.	Diff.
Mod 24	Unrelated E&M in Post-Op Period	0.00%	0.09%	3	0.09%
Mod 25	**Significant, Separate E&M on Same Day**	**0.02%**	**10.50%**	**363**	**10.48%**
Mod 58	Staged/Related Procedure in Post-Op Period	0.00%			
Mod 59	Distinct Procedural Service	0.96%	1.33%	46	0.37%

Modifier Usage

Focus On

- 24
- 25
- 58
- 59
- 62
- 63
- 76
- 78
- 80
- AS

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		1st Quarter 2015					National Peers	
	Fee	Rank	Util.	Vol.	Diff.	Gross $	Rank	Util.
99214	$108.13	1	12.96%	1330	7.60%	$143,812.90	3	5.36%
93306	$230.22	2	9.08%	932	0.00%	$214,565.04		0.00%
36415	-	3	6.23%	639	5.66%	$0	18	0.57%
85610	-	4	4.72%	484	0.00%	$0		0.00%
36416	-	5	3.07%	315	0.00%	$0		0.00%
80048	-	6	2.94%	302	0.00%	$0		0.00%
99223	$204.44	7	2.47%	254	0.00%	$51,927.76		0.00%
93000	$17.19	8	2.28%	234	0.00%	$4,022.46		0.00%
$ 99231	$39.74	9	2.28%	234	0.00%	$9,299.16		0.00%
93351	$273.90	10	2.26%	232	0.00%	$63,544.80		0.00%
78452	$493.02	11	2.21%	227	0.00%	$111,915.54		0.00%
93293	$53.71	12	2.18%	224	0.00%	$12,031.04		0.00%
80061	-	13	2.12%	218	0.00%	$0		0.00%
84450	-	14	2.08%	213	0.00%	$0		0.00%

Top Billed Services Analysis

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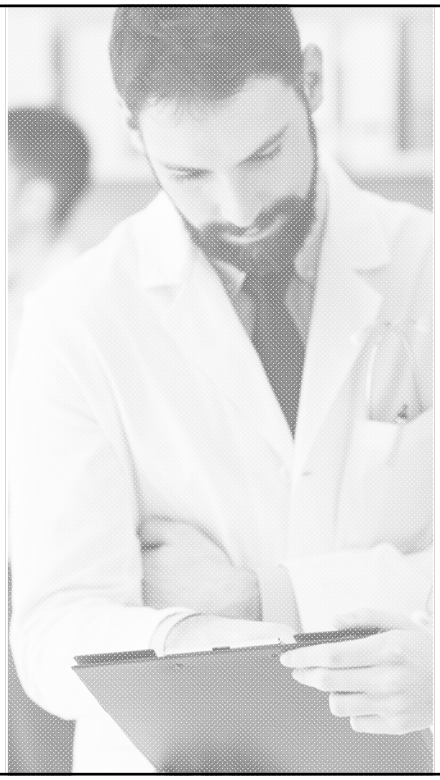
Understanding Medicare Payment Data

- CMS released a data file containing information on Medicare payments made to providers.
- Years Currently Available
  - 2012
  - 2013
  - 2014
- Key Benchmarking Analytics
  - Total Payments
  - Number of Patients
  - Payments Per Patient



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Medicare Payment Analysis

Year	Total Payments	Number of Patients	Payments per Patient
2014	$512,178	882	$581
2013	$488,895	867	$564
2012	$465,721	825	$565

Provider Comparison NATIONALLY STATEWIDE

How [redacted] compares to **82,256** providers specializing in **Family Practice nationally**:

2014	Total Payments: **$512,178**	Number of Patients: **882**	Payments per Patient: **$581**
	100th percentile nationally	98th percentile nationally	97th percentile nationally

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Visit Per Day Analysis

Develop an internal average per day analysis:

- Use MGMA data
- Physician paid claims
- CPT codes, volume, date of service
- MGMA Visit Data 70th, 80th, and 90th
- Outlier?
- How many visits per day?

CPT Code	Typical Time for Code
99212	10 min
99213	15 min
99214	25 min
99215	40 min

Provider Information		MGMA Percentiles		
Criteria	Actual	70th	80th	90th
Total Days Worked	256	240	240	245
Total Encounters	6764	4508	5067	6127
Avg Encounters / Day	26	19	21	25
Total Work RVUs	9439	5672	6279	7390

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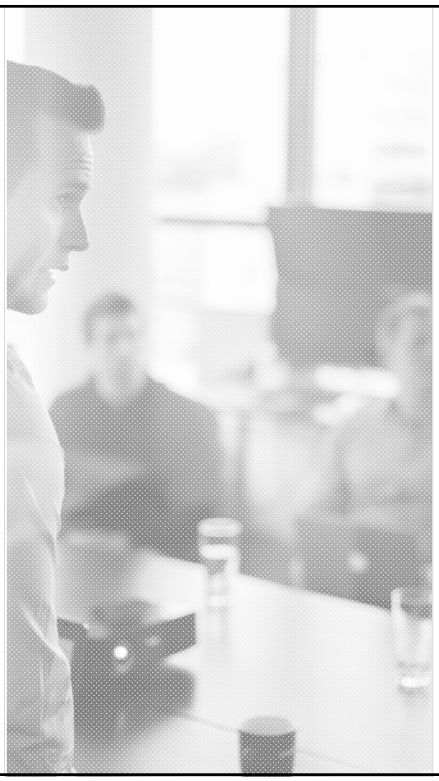

Highly Productive Physicians

- Special care must be taken with "highly productive" physicians
  - *Example:* Physicians with annual wRVUs > 90th% of industry benchmarks
  - *Example:* Physicians that have billed a high number of hours based on Harvard RUC time study
  - Specialties such as cardiology, neurosurgery, orthopedics
- Evaluate need for additional audit procedures to evaluate
  - Medical appropriateness of services
  - Adherence to industry professional standards

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The Importance of Incorporating Risk Thresholds

- Creates a standardized approach to know when a provider is an outlier
  - Streamlines the analysis process by filtering out the providers that are not a risk
    - Scorecards can be created by combing multiple analysis thresholds together

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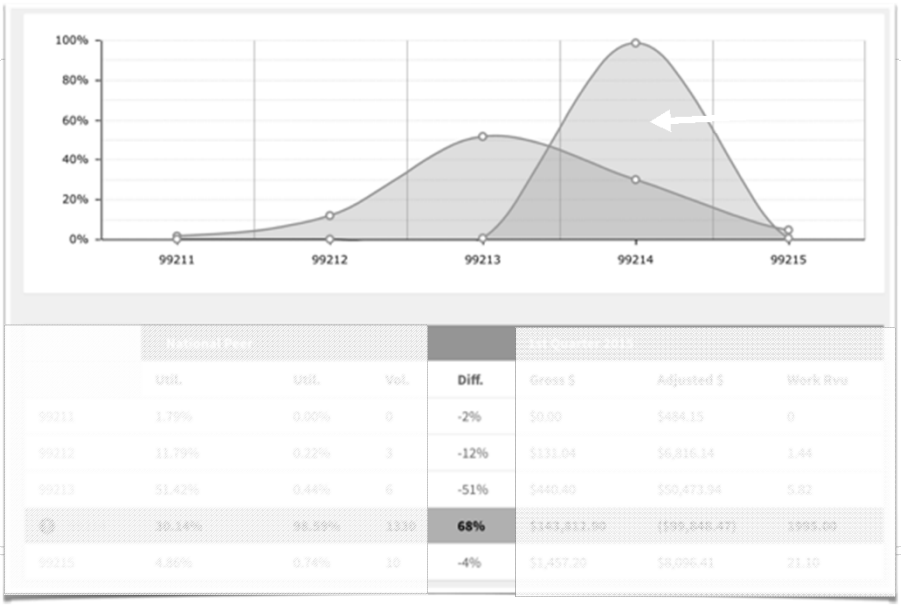

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Example of E/M Threshold

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How Thresholds Help Prioritize

Provider	Specialty	At Risk CPT	CPT Vol	CPT Util.	CPT Diff.
JULIA A MATTSON MD	Obstetrics & Gynecology	99214	1330	98.59%	68.00%
XIANG LIU MD	Diagnostic Radiology	99213	1025	89.75%	54.00%
REZA J DAUGHERTY MD	Diagnostic Radiology	99213	1792	74.14%	38.00%
MINCHUL FRANCIS SHIN MD	Diagnostic Radiology	99213	1991	70.06%	34.00%
TIMOTHY JAMES EDEN CRNP	Nurse Practitioner	99214	1213	67.02%	29.00%
LEONARD ROSENBAUM MD	Diagnostic Radiology	99214	568	64.91%	41.00%
SARA C GAVENONIS MD	Diagnostic Radiology	99213	1875	64.32%	28.00%
KRISTINA SIDDALL MD	Diagnostic Radiology	99213	2048	63.82%	28.00%
RALPH P IERARDI MD	Vascular Surgery	99215	48	32.65%	30.00%

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Category	Cpt	Descriptio	Applicable Util.	Gross $
> 5K Hours			0.00%	$0.00
New Office	99204	OFFICE/OUTPATIENT VISIT NEW	100.00%	$15,616.22
Est Office	99214	OFFICE/OUTPATIENT VISIT EST	98.59%	$143,812.90
Init Hospital	99223	INITIAL HOSPITAL CARE	93.73%	$51,927.76
Subs Hospital	99231	SUBSEQUENT HOSPITAL CARE	50.43%	$9,299.16
New_Est Consults	99244	OFFICE CONSULTATION	90.67%	$12,563.00
Excessive Billing	93351	STRESS TTE COMPLETE	2.26%	$63,544.80

How Benchmarking & Thresholds Work Together

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Benchmarks & Thresholds Incorporated to Build a Complete Risk Assessment for Your All Providers

View Excel Example

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Spike in Data/Outliers..Next Steps

- Ask questions:
  - New hire
  - Software problems
  - New service line
  - Operational issues
- Do a deeper data dive
- Review records – validate (create audit plan)

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Disclaimer

- Disclaimer is very important:
  - The analyses are for benchmarking purposes only and to assist in prioritizing areas for further review by hospital management
  - Coding and billing is dependent upon the services rendered by the hospital as determined to be medically necessary and appropriate based on the patient's presenting medical condition
  - No conclusions regarding the accuracy of coding and billing, nor compliance with government and third-party payer rules and regulations can be made without further review of the provider's underlying medical records documentation

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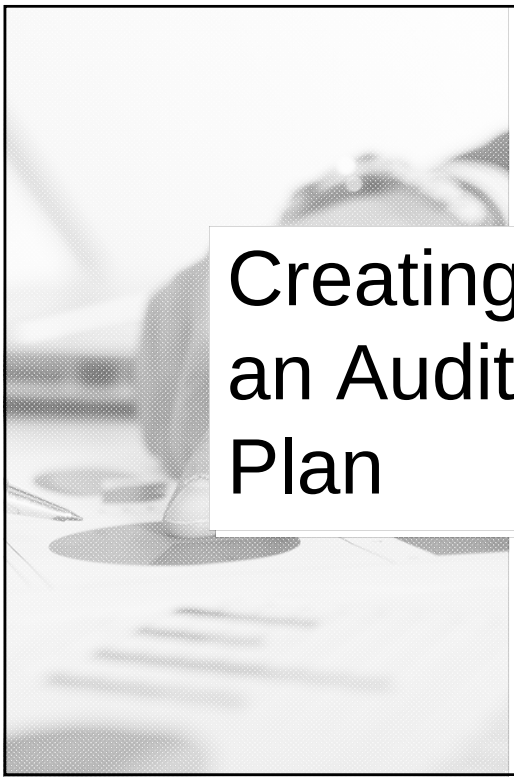

Creating an Audit Plan

- Risk based approach to auditing and monitoring

  - Review benchmarking results to assess outliers

  - Review alternate methods of reducing the scope of the audit based on specialty, volume and revenue. Examples:

    1. Only significant outliers should be considered for audit (Thresholds)
    2. 65% - 80% of primary care revenue is based on established E/M visits
    3. Usually a few services account for 70% - 80% of net revenue for specialty practices
    4. Review the highly productive physicians first

See Handout

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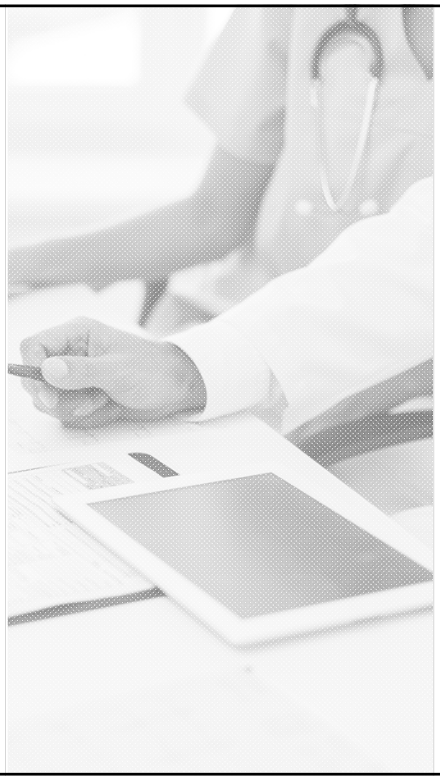

Creating an Audit Plan

- Sampling process/consideration:

  - Retrospective claims (prior 3 months)

  - Non-statistical sampling e.g. judgment sampling

  - Population is stratified (stratums) based on benchmarking

  - Sample size – small samples based on risk

  - Extrapolation – NONE

    1. Since the sample size was controlled by the auditor it cannot be measured

- Analysis of Sample

  - Provider documentation in comparison to CPT codes

  - Accuracy of diagnoses

  - Accuracy of place of service codes

  - Functionality an use of the EMR system

See Handout

Creating an Audit Plan Pt 2

- Error/Accuracy Rate – NONE
- Findings Categories:

  - Observations* – Observations which may affect the accurate assignment of the diagnoses, procedures or compliance with other program requirements and require a management response and corrective action plan.

  - Incidental Matters – Matters noted during the review that do not require a management response.

- Audit Cycle – at risk providers every year all other providers 3-5 year cycle.

* - Observations identified are subject to the following internal Policy, "Correction of Errors in Federal and State Health Care Program Payments"

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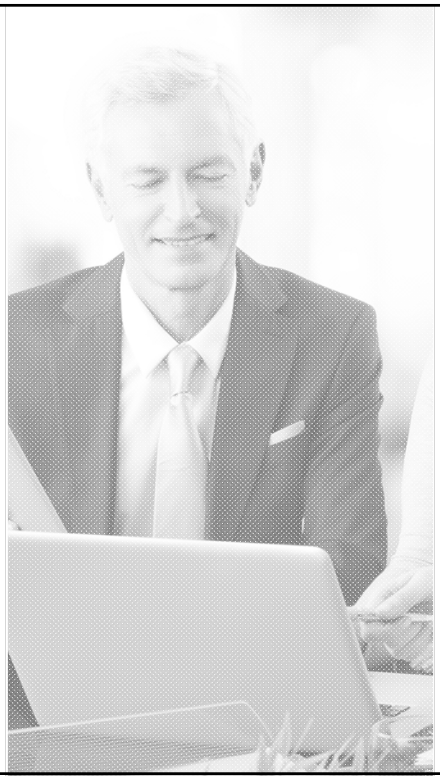

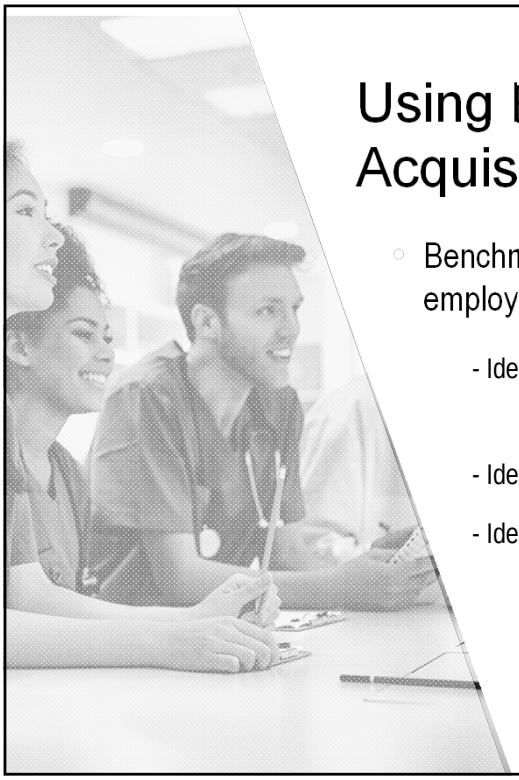

Using Benchmarking for Acquisitions – Due Diligence

- Benchmarking of data is key initial step in due diligence for physician employment or acquisitions

  - Identify potential risks prior to closing

    1. Go or No Go

  - Identify compliance issues

  - Identify opportunities for integration

    1. Education
    2. Coding and Billing Hold

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Current Issues / Challenges

01 Cloning

02 Incident 2 – use NPPs etc

03 Copy Paste

04 Provider Based

05 Medically Necessary

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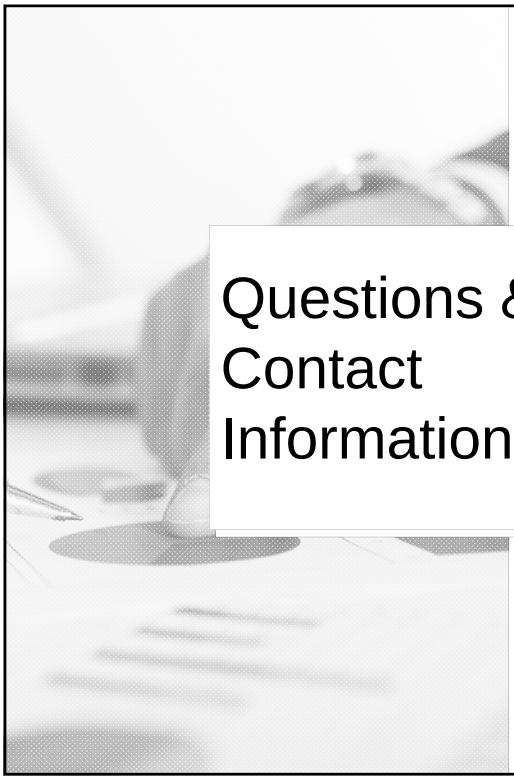

Questions & Contact Information

Please reach out if you have questions or need help starting risk assessment benchmarking and building a proactive audit plans.

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