What We Are Going To Cover

1. Understand the Audit Landscape
2. The "How-To Guide" to Risk Benchmarking
3. Building Your Analysis Results into a Risk-Based Plan
Trinity Health’s 22-State Diversified System

$17.6 B
In Revenue

$1.3 M
Attributed Loss

$1.1 B
Community Benefit Ministry

$131 K
Colleagues

$7.5 K
Employed Physicians and Clinicians

$25.6 K
Affiliated Physicians

93
Hospitals

22
Clinically Integrated Networks

13
PACE Center Programs

109
Continuing Care Locations

Current Risk Landscape

What is the
- 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

<table>
<thead>
<tr>
<th>Type</th>
<th>Contractors</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Administrative Contractors (MACs)</td>
<td>- National Government Services</td>
<td>- Process claims and provider payments</td>
</tr>
<tr>
<td>Zone Program Integrity Contractors (ZPICs)</td>
<td>- Cahaba Safeguard Administrators</td>
<td>- Focus on identifying fraud</td>
</tr>
<tr>
<td>Supplemental Medical Review Contractor (SMRC)</td>
<td>- Strategic Health Solutions</td>
<td>- Nationwide claim review</td>
</tr>
<tr>
<td>Comprehensive Error Rate Testing Contractors (CERT)</td>
<td>- Multiple contractors</td>
<td>- Annual audits to determine FFS error rates</td>
</tr>
<tr>
<td>Recovery Audit Contractors (RACs)</td>
<td>- CGI Technologies; CMS, Medicare</td>
<td>- Identify over and under payment errors</td>
</tr>
<tr>
<td>DHHS – Office of Inspector General (OIG)</td>
<td>- N/A</td>
<td>- Audits and investigations</td>
</tr>
<tr>
<td>Department of Justice (DOJ)</td>
<td>- N/A</td>
<td>- Enforcement actions under the False Claims Act</td>
</tr>
<tr>
<td>Medicaid Inspector General</td>
<td>- IL Dept. of Health and Family Services</td>
<td>- Aggressively using extrapolation for repayment liabilities</td>
</tr>
</tbody>
</table>
Re-Thinking Risk in APM Programs

### Risks in Fee for Service
- Over-utilization of services
- Lack of medical necessity appropriateness
- Coverage requirements
- Procedural coding
- Billing requirements
- Provider documentation

### Risks in APMs
- Under-utilization of services
- Withholding medically necessary services
- Avoidance of "At-Risk" beneficiaries
- Beneficiary freedom of choice
- Other APM program requirements
- Selection of network providers
- Risk adjusted coding (HCCs, diagnosis)
Don’t Forget About the Advanced Practice Providers

- Scope of practice that may be delegated by physician to APPs
- Physician supervision/collaboration requirements
- Prescriptive authority
- Billing for APP services
- APPs acting as scribes
- "Incident to" physician services
- Split Shared Visits
- Fraud and abuse statues
- Stark Law and Anti-kickbacks Statue under the theory that APP services could be considered remuneration that provides a financial benefit to private physicians.
- Key Questions for Consideration (Handout)

Data Accessibility

- Medicare Provider Utilization and Payment Data
  - CMS Open Payments Look-Up Tool
  - ProPublica Treatment Tracker
  - Access to CMS Raw Data
- Sunshine Act - Open Payments
  - CMS Open Payments Look-Up Tool

URL Links to Sources in Handout
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

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
Which Benchmarking Metrics Should You Use

Basic Benchmarking Recipe
- E/M level coding peer comparisons
- Modifier usage

Advanced Benchmarking Recipe
- Top billed procedure analysis
- Medicare payments analysis
- Harvard RUC time study
- Visits per Day / Work RVUs
- Open Payments
E/M Level Coding Peer Comparisons

Modifier Usage

Focus On

• 24
• 25
• 58
• 59
• 62
• 63
• 76
• 78
• 80
• A
• S
### Top Billed Services Analysis

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Billed</th>
<th>MBR</th>
<th>MBR %</th>
<th>Number of Claims</th>
<th>Total Payments</th>
<th>Total Payments per Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>1,234,567</td>
<td>123</td>
<td>12.3%</td>
<td>456</td>
<td>$789,000</td>
<td>$1,712.00</td>
</tr>
<tr>
<td>2020</td>
<td>1,345,678</td>
<td>134</td>
<td>13.4%</td>
<td>567</td>
<td>$890,123</td>
<td>$1,567.00</td>
</tr>
<tr>
<td>2021</td>
<td>1,456,789</td>
<td>145</td>
<td>14.5%</td>
<td>678</td>
<td>$991,234</td>
<td>$1,485.00</td>
</tr>
</tbody>
</table>

### Medicare Payment Analysis

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Payments</th>
<th>Number of Payments</th>
<th>Payments per Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>$1,234,567</td>
<td>456</td>
<td>$1,712.00</td>
</tr>
<tr>
<td>2020</td>
<td>$1,345,678</td>
<td>567</td>
<td>$1,567.00</td>
</tr>
<tr>
<td>2021</td>
<td>$1,456,789</td>
<td>678</td>
<td>$1,485.00</td>
</tr>
</tbody>
</table>
### Visit Per Day Analysis

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Actual</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Worked</td>
<td>256</td>
<td>240</td>
<td>240</td>
<td>245</td>
<td></td>
</tr>
<tr>
<td>Total Encounters</td>
<td>6764</td>
<td>4506</td>
<td>5067</td>
<td>6127</td>
<td></td>
</tr>
<tr>
<td>Avg Encounters / Day</td>
<td>26</td>
<td>21</td>
<td>22</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Total Work RVUs</td>
<td>5631</td>
<td>5072</td>
<td>6279</td>
<td>7356</td>
<td></td>
</tr>
</tbody>
</table>
Calculate These Metrics

How Do You Actually Understand Peer Group Data

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

Calculation Walk Through

01 Excel Template Tutorial
- E/M level coding peer comparisons
- Modifier usage
- Top billed procedure analysis

02 Methodology Explanation
- Visits per Day / Work RVUs
- Medicare Payments and Utilization
- Open Payments
- HCCs
Excel Template Walk Through
How to calculate E/Ms, Modifiers, and Top Procedure analysis.

Live Example

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
Understanding Medicare Payment Data

First time this data has been available in three decades
These records had been kept secret through legal efforts by theAMA
March 2013 a federal judge vacated the 1979 injunction
What does the data include:
- Medicare payments to doctors, laboratories, ambulance companies and other medical providers under Medicare Part B
- These payments make up approximately 15% of Medicare’s $600 billion in annual expenditures

Datasets Currently Available

Key Benchmarking Analytics
- Total Payments
- Number of Patients
- Payments Per Patient

Links to Data Sources in Handout
Breaking Down the “Physician Payments Sunshine Act”

- Increase transparency and public awareness of financial relationships between pharmaceutical and medical device companies and physician and teaching hospitals
- Most recent data details 12 million payments valued over $8 billion made to 631,000 physicians and 1,146 teaching hospitals
- CMS validated approximately 99% of all records were accurate
- Records not verified were not processed or reported
- Link to source data in Handout

What do you do with this info?
- Review all employed and independent providers
- We established a target of $5,000 or more in payments
- The following detail is provided:
  - Total payments and transactions
  - Total general and research payments
  - Physician ownership information
Excel Analysis Walk Through
Analyzing your Open Payment Data

Live Example

What should you do with Open Payment Analysis

- Share information with Compliance Officer, Medical Director and Chief Medical Officer
- Evaluate the potential impact of the disclosed relationship in relation to various roles or responsibilities the physician may have in your organization including:
  - Participation in clinical research activities, Institutional Review Board, etc.
  - Participation on Pharmacy and Therapeutic committees etc.
  - Department or program leadership roles with influence or decision-making authority for formulary, device or product selection
- Manage any actual or apparent conflicts of interests
What are Risk Adjustment Factors

- CMS uses a risk-adjusted calculation to reimburse private insurers for:
  - Medicare Next Generation Accountable Care Organizations
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Medical Shared Savings Program
  - Medicare Advantage

- A method to predict costs and adjust payment based on the relative risk and health status of a patient.

Hierarchical Condition Categories (HCCs)

- CMS payment model to assign a risk adjustment factor to individuals with chronic illness based upon:
  - HCCs are split into ICD-10 diagnose categories which CMS collects through claims submitted.
  - CMS utilizes these codes to determine how health patients are which in turn predicts patient costs for the following year.
  - HCCs only recognize ICD-10 codes documented on a patient’s record in the past year, which is why it is necessary to document all patient co-morbidities to accurately portray the acuity of the patient population.

- It is crucial to understand the role of patients’ Risk Adjustment Factors to clinical and financial performance under risk.
The Obvious about Hierarchical Condition Categories

- Reimbursement based on outcomes, **diagnostic coding matters**
- Reimbursement based on cost savings, **diagnostic coding matters**
- When a provider or practice is evaluated based upon data specific to case mix and workload, **diagnostic coding matters**
# Diagnosis coding for claims vs. for risk adjustment

<table>
<thead>
<tr>
<th>Diagnoses for Claims</th>
<th>Diagnoses for Clinical Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily: documented on each claim</td>
<td>Primarily: documented on each claim</td>
</tr>
<tr>
<td>Historically used for coverage and reimbursement purposes</td>
<td>For accurate calculation of patient's clinical risk score</td>
</tr>
<tr>
<td>Supports medical necessity</td>
<td>Used to improve clinical care and overall disease management</td>
</tr>
<tr>
<td>Satisfy medical policies for coverage of services (e.g., LCs/HCPCS)</td>
<td>Used to estimate future clinical and financial resource utilization</td>
</tr>
</tbody>
</table>

## The Compliance Risks for HCCs

- Compliance risks:
  - Inflating HCC scores to achieve financial goals
  - Lack of medical record documentation confirming reported diagnoses
  - Claiming current treatment of conditions treated in prior years
  - Overstating the severity of patient medical conditions
  - Performing chart reviews or audits that look only for upward HCC adjustments, while ignoring information that would decrease HCC adjustments
  - Failing to verify provider's diagnoses

- Failure to accurately code diagnosis information can **over/understate the cost and risk associated** with caring for the beneficiary/plan members and result in inaccurate payments from Medicare.
Finding Outliers through using 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 combining multiple analysis thresholds together
### Example of E/M Threshold

<table>
<thead>
<tr>
<th>Service</th>
<th>E/M 1</th>
<th>E/M 2</th>
<th>E/M 3</th>
<th>E/M 4</th>
<th>E/M 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>2.0%</td>
<td>3.5%</td>
<td>5.0%</td>
<td>6.5%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>4.0%</td>
<td>8.0%</td>
<td>12.0%</td>
<td>16.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Other</td>
<td>6.0%</td>
<td>12.0%</td>
<td>18.0%</td>
<td>24.0%</td>
<td>30.0%</td>
</tr>
</tbody>
</table>

### How Thresholds Help Prioritize

<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
<th>As-Billed</th>
<th>E/My</th>
<th>E/Mz</th>
<th>E/Ma</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABCDEF Medical MD</td>
<td>Obstetrics &amp; Gynecology</td>
<td>2000</td>
<td>90.1%</td>
<td>90.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>GHI JKLM MD</td>
<td>Diagnostic Radiology</td>
<td>3000</td>
<td>85.0%</td>
<td>85.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>ABCDEF Medical MD</td>
<td>Diagnostic Radiology</td>
<td>4000</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>GHI JKLM MD</td>
<td>Diagnostic Radiology</td>
<td>5000</td>
<td>75.0%</td>
<td>75.0%</td>
<td>75.0%</td>
</tr>
<tr>
<td>ABCDEF Medical MD</td>
<td>Vascular Surgery</td>
<td>6000</td>
<td>70.0%</td>
<td>70.0%</td>
<td>70.0%</td>
</tr>
</tbody>
</table>
A More Statistical Approach to Outlier Determination

- **E&M Code Groups** – Outliers are determined through a chi-squared distribution analysis against CMS data. A provider is considered an outlier if there is a probability of less than 1% (p < .01) that the variance between the provider data and CMS data is random. If the code group represents less than 5% of the provider’s overall revenue, an outlier is considered low-significance.
- **Modifier Usage** – A provider is considered an outlier if that provider’s modifier usage is more than 3 times the rate of CMS usage.
- **Radiology/Lab/Medicine Charges** – The scorecard contains an analysis of total radiology/lab/medicine charges as a percent of total revenue. A provider is considered an outlier if that percentage is more than 3 times the percentage of CMS.
- **MGMA Metrics** – The scorecard contains an analysis of annual productivity metrics compared to MGMA data, including days worked, encounters, encounters per day, and work RVUs. Any provider above the MGMA 90th percentile is considered an outlier.
- **Medicare Utilization** – A provider is considered an outlier if the provider’s Medicare utilization is greater than the 90th percentile for the provider’s peer group.

Examples of Provider Scorecards

The benchmarking report end deliverable.

*Live Example*
Creating an Audit Plan

• Understanding the Goal of the Audit
  • Yearly Compliance Coding Review
  • Due Diligence Project
  • Highly Compensated Providers
  • Outside Sources

• Build Prioritization Methodology
  1. What is the goal of the audit?
  2. What is your resource capacity?
  3. How do we operationally conduct audits?
    1. By Facility?
    2. Are auditors assigned specific groups of providers?

Examples of Prioritized Audit Plans

How to plan your yearly audits based on risk analysis

Live Example
Building a Due Diligence Audit Plan

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

After the Plan is Made

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 and use of the EMR system
After the Plan is Made cont’d

- Frequency of conducting audits
  - For established providers once a year based on outliers through benchmarking reports
  - For new providers, audit services should occur within the first 30-45 days

- Error / Accuracy Rate = NONE

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

After the Plan is Made

- Findings Categories
  - Observations
    Observations which may affect the accurate assignment of diagnoses, procedures or compliance with other program requirements and require a management response and corrective action plan.
    Observations identified are subject to the following internal Policy, "Correction of Errors in Federal and State Health Care Program Payments".
  - Incidental Matters
    Matters noted during the review that do not require a management response.
After the Plan is Made cont’d

- Holding charges for new providers. The following criteria should be considered:
  - Pre-acquisition audit results
  - Payer credentialing
  - Timely filing limits
  - Qualified coder(s) to review documentation prior to billing

- The following detail is provided:

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
Auditing / Monitoring APPs

- Where to start
  - Create an inventory of APPs – are they employed, contracted, etc.
  - Who controls APPs, what is their scope of work?
  - What collaboration agreements are in place with physicians?
  - What level of supervision is in place?
  - Who bills for APP services?
- Use of an Internal Control Questionnaire
  - See Handout
- Chart review / billing audit
- APP Observations and Recommendations

**HCCs Audit Program**

- Testing Objectives: Review a non-statistical (judgmental) sample of beneficiary services to validate that the medical record documentation supports diagnoses codes submitted on claim forms.
- Population: Participating Medicare beneficiaries (e.g., NGACO Quarterly Participant File, NGACO Benchmark Report, etc.)
- Sampling Unit: Medicare beneficiary. Since the sample will be the beneficiary, the documentation to support the claim may come from both employed and independent providers.
- Sample Size: The sample size will consist of a mix of high, medium, and low clinical risk scoring Medicare beneficiaries to assess both potential risks for high clinical risk scores lacking appropriate supporting clinical documentation as well as opportunities to improve clinical risk scores based on review of supporting clinical documentation.

For example, CMS Risk Adjustment Data Validation (RADV) audits currently use the following sample size: 20 High Scoring Beneficiaries, 20 Medium Scoring Beneficiaries, and 20 Low Scoring Beneficiaries.
HCCs Analysis of Sample

- Provider progress notes
- CMS 1500 claims data
- The most current International Classification for Disease, Tenth Revision, Clinical Modification (ICD-10-CM)
- Current HCCs included in the CMS-HCC risk-adjustment model


- Medicare Program Integrity Manual, Pub 100-08, Chapter 3, §3.3.2.4, Signature Requirements
  www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Auditing HCCs - Analysis of Sample

- It is important to audit to ensure that the diagnosis supports the HCC.
- Examples of common errors include the following:
  - The highest degree of specificity was not assigned the most precise ICD-10 code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
  - Discrepancy between the diagnosis codes being billed versus the actual written description in the medical record. For example, if the record indicates depression (F32.9 Depressive disorder, note elsewhere classified), but the diagnosis code written on the encounter document is major depression affective disorder (F32.1. Major depression affective disorder, single episode, moderate), these codes do not match; with one mapping to an HCC category and the other not having a HCC category. The diagnosis code and the description should mirror each other.
  - Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated during the current plan year.
  - Status of cancer is unclear: Treatment is not documented.
Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic;

- Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).

Questions & Contact Information

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www.nektaranalytics.com

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