Benchmarking For Coding Outliers

How to Transition to a Risk Focused Audit Plan

What We Are Going To Cover

1. The Current Audit Landscape
2. Reactive vs. Proactive Auditing
3. What to Benchmark
4. Understanding Peer Group Data
5. How to Calculate the Metrics
6. Incorporating Risk Thresholds
7. Constructing Your Audit Plan
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

<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>• CSI Technologies (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>• Annual Work Plan published</td>
</tr>
<tr>
<td>Medicaid Inspector General</td>
<td>• IL Dept. of Healthcare and Family Services</td>
<td>• Enforcement actions under the False Claims Act</td>
</tr>
</tbody>
</table>

Who is AUDITING Healthcare Providers

An Example: Illinois

Data transparency
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

Understanding Peer Group Data

- 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
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

Benchmarking Recipes

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

02 Advanced Benchmarking Recipe
- Top billed procedure analysis
- Medicare payments analysis
- Harvard RUC time study
E/M Level Coding Peer Comparisons

<table>
<thead>
<tr>
<th>National Peer</th>
<th>1st Quarter 2015</th>
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<tbody>
<tr>
<td>99211</td>
<td>1.75%</td>
</tr>
<tr>
<td>99212</td>
<td>12.73%</td>
</tr>
<tr>
<td>99213</td>
<td>52.43%</td>
</tr>
<tr>
<td>99214</td>
<td>20.14%</td>
</tr>
<tr>
<td>99215</td>
<td>4.86%</td>
</tr>
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</table>

Modifier Usage

Focus On
- 24
- 25
- 58
- 59
- 62
- 63
- 76
- 78
- 80
- AS
CMS released a data file containing information on Medicare payments made to providers.

- **Years Currently Available**
  - 2012
  - 2013
  - 2014
  - 2015
  - 2016

- **Key Benchmarking Analytics**
  - Total Payments
  - Number of Patients
  - Payments Per Patient
**Medicare Payment Analysis**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Payments</th>
<th>Number of Patients</th>
<th>Payments per Patient</th>
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</thead>
<tbody>
<tr>
<td>2014</td>
<td>$912,178</td>
<td>882</td>
<td>$581</td>
</tr>
<tr>
<td>2013</td>
<td>$480,895</td>
<td>867</td>
<td>$564</td>
</tr>
<tr>
<td>2012</td>
<td>$465,721</td>
<td>825</td>
<td>$565</td>
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</table>

**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
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 combing multiple analysis thresholds together

Example of E/M Threshold

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>1.75%</td>
<td>0.00%</td>
<td>0</td>
<td>-2%</td>
<td>$10.00</td>
<td>$90.15</td>
<td>0</td>
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<tr>
<td>99212</td>
<td>11.75%</td>
<td>0.22%</td>
<td>3</td>
<td>-12%</td>
<td>$133.04</td>
<td>16,816.14</td>
<td>1.44</td>
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<tr>
<td>99213</td>
<td>31.42%</td>
<td>0.40%</td>
<td>0</td>
<td>-51%</td>
<td>$440.40</td>
<td>10,473.04</td>
<td>5.62</td>
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<tr>
<td>99214</td>
<td>30.14%</td>
<td>98.53%</td>
<td>1216</td>
<td>68%</td>
<td>$143,832.80</td>
<td>(509,648.47)</td>
<td>1390.00</td>
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<tr>
<td>99215</td>
<td>4.84%</td>
<td>0.78%</td>
<td>10</td>
<td>-4%</td>
<td>$1,467.20</td>
<td>18,996.41</td>
<td>21.10</td>
</tr>
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How Thresholds Help Prioritize

How Benchmarking & Thresholds Work Together

<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
<th>At Risk CPT</th>
<th>CPT Vol</th>
<th>CPT UTIL</th>
<th>CPT Diff.</th>
</tr>
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<tbody>
<tr>
<td>JULIA A MATTSON MD</td>
<td>Obstetrics &amp; Gynecology</td>
<td>99214</td>
<td>1330</td>
<td>98.59%</td>
<td>68.00%</td>
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<tr>
<td>XIANG LIU MD</td>
<td>Diagnostic Radiology</td>
<td>99213</td>
<td>1025</td>
<td>89.75%</td>
<td>54.00%</td>
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<tr>
<td>REZA J DAUGHERTY MD</td>
<td>Diagnostic Radiology</td>
<td>99213</td>
<td>1792</td>
<td>74.34%</td>
<td>38.00%</td>
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<tr>
<td>MINCHUL FRANCIS SHIN MD</td>
<td>Diagnostic Radiology</td>
<td>99213</td>
<td>1991</td>
<td>70.06%</td>
<td>34.00%</td>
</tr>
<tr>
<td>TIMOTHY JAMES EDEN CRNP</td>
<td>Nurse Practitioner</td>
<td>99214</td>
<td>1213</td>
<td>67.02%</td>
<td>29.00%</td>
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<tr>
<td>LEONARD ROSENBAUM MD</td>
<td>Diagnostic Radiology</td>
<td>99214</td>
<td>568</td>
<td>64.91%</td>
<td>41.00%</td>
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<td>SARA C GAVENONIS MD</td>
<td>Diagnostic Radiology</td>
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<td>1875</td>
<td>64.32%</td>
<td>28.00%</td>
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<tr>
<td>KRISTINA SIDDALL MD</td>
<td>Diagnostic Radiology</td>
<td>99213</td>
<td>2048</td>
<td>63.82%</td>
<td>28.00%</td>
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<tr>
<td>RALPH P IERARDI MD</td>
<td>Vascular Surgery</td>
<td>99215</td>
<td>48</td>
<td>32.65%</td>
<td>30.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Cpt</th>
<th>Description</th>
<th>Applicable Util.</th>
<th>Gross $</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 5K Hours</td>
<td>99204</td>
<td>OFFICE/OUTPATIENT VISIT NEW</td>
<td>100.00%</td>
<td>$15,616.22</td>
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<tr>
<td>New Office</td>
<td>99214</td>
<td>OFFICE/OUTPATIENT VISIT EST</td>
<td>98.59%</td>
<td>$143,812.90</td>
</tr>
<tr>
<td>Ext Office</td>
<td>99223</td>
<td>INITIAL HOSPITAL CARE</td>
<td>93.73%</td>
<td>$51,027.76</td>
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<tr>
<td>Init Hospital</td>
<td>99231</td>
<td>SUBSEQUENT HOSPITAL CARE</td>
<td>50.43%</td>
<td>$9,299.16</td>
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<tr>
<td>Subs Hospital</td>
<td>99244</td>
<td>OFFICE CONSULTATION</td>
<td>90.67%</td>
<td>$12,563.00</td>
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<tr>
<td>Excessive Billing</td>
<td>93351</td>
<td>STRESS TTE COMPLETE</td>
<td>2.26%</td>
<td>$63,544.80</td>
</tr>
</tbody>
</table>
Constructing a ProviderBenchmarking Scorecard

View Excel 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 are assigned specific groups of providers?
Actual Audit Plan Examples Utilized by Health Systems

View Excel Example

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
Audit Odds & Ends

- 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

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

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