How to Develop Benchmarking scorecards
Transitioning to Risk-Based Physician Auditing

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
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</td>
<td>National Government</td>
<td></td>
</tr>
<tr>
<td>contractors</td>
<td></td>
<td>focus claims and provider scrutiny</td>
</tr>
<tr>
<td>Drug Program Integrity</td>
<td>CalPERS</td>
<td>focus on identifying fraud</td>
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<tr>
<td>Compliance/Investigations</td>
<td></td>
<td>all providers</td>
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<td>(CPI)</td>
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<td>data mining and analytics</td>
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<td>Compliance (Insurance</td>
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<td>Oversight (COI)</td>
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<td>Reviewer (RO)</td>
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<td></td>
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<tr>
<td>Recovery Audit</td>
<td>OIG</td>
<td></td>
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<tr>
<td>Contractors (OIG)</td>
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<td></td>
</tr>
<tr>
<td>(OIG) – Office of Inspector</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>General (OIG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Justice (DOJ)</td>
<td>NA</td>
<td></td>
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<tr>
<td>Medical investigator general</td>
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Who is AUDITING Healthcare Providers: An Example: Illinois

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

What Metrics to Look at?

<table>
<thead>
<tr>
<th>01</th>
<th>Utilization Benchmarking</th>
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<tr>
<td></td>
<td>E/M level coding peer comparisons</td>
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<tr>
<td></td>
<td>Modifier usage</td>
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<td>Top billed procedure analysis</td>
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<table>
<thead>
<tr>
<th>02</th>
<th>Highly Productive Provider Analysis</th>
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<tr>
<td></td>
<td>Visit per day analysis</td>
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<tr>
<td></td>
<td>wRVU analysis</td>
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<td>Harvard RUC time study</td>
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<th>03</th>
<th>Payments Analysis</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Medicare payments analysis</td>
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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
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.

E/M Level Coding Peer Comparisons

Modifier Usage

Focus On
- 24
- 25
- 38
- 59
- 62
- 63
- 70
- 71
- 73
- AS
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

Medicare Payment Analysis

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Payments</th>
<th>Number of Patients</th>
<th>Payments per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$192,789</td>
<td>802</td>
<td>$239</td>
</tr>
<tr>
<td>2013</td>
<td>$300,275</td>
<td>807</td>
<td>$373</td>
</tr>
<tr>
<td>2012</td>
<td>$301,275</td>
<td>807</td>
<td>$373</td>
</tr>
</tbody>
</table>

Provider Comparison:

Here, the provider is compared to 62,256 providers specializing in Family Practice nationwide:

- 2014 Total Payments: $192,789
- Number of Patients: 802
- Payments per Patient: $239

Compared to 2014:
- 100th percentile nationally
- 90th percentile nationally
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?

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Typical Time for Code</th>
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<tbody>
<tr>
<td>99212</td>
<td>10 min</td>
</tr>
<tr>
<td>99213</td>
<td>15 min</td>
</tr>
<tr>
<td>99214</td>
<td>25 min</td>
</tr>
<tr>
<td>99215</td>
<td>40 min</td>
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</table>

<table>
<thead>
<tr>
<th>Provider Information</th>
<th>MGMA Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Actual</td>
</tr>
<tr>
<td>Total Days Worked</td>
<td>756</td>
</tr>
<tr>
<td>Total Encounters</td>
<td>6254</td>
</tr>
<tr>
<td>Avg Encounters/day</td>
<td>36</td>
</tr>
<tr>
<td>Total Work RVUs</td>
<td>24488</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

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 who are not a risk
- Scorecards can be created by combing multiple analysis thresholds together
Example of E/M Threshold

How Thresholds Help Prioritize

<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty</th>
<th>MIN CPT</th>
<th>CPT Tot</th>
<th>CPT UCL</th>
<th>CPT LCL</th>
</tr>
</thead>
<tbody>
<tr>
<td>JULIA MATTHEWS</td>
<td>OBGYN &amp; GYNECOLOGY</td>
<td>99241</td>
<td>1300</td>
<td>88.09%</td>
<td>80.68%</td>
</tr>
<tr>
<td>FARRIS, MD</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>1905</td>
<td>89.13%</td>
<td>98.00%</td>
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<tr>
<td>RICHARDson, MD</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>1763</td>
<td>72.45%</td>
<td>90.00%</td>
</tr>
<tr>
<td>NICK M. SAVAGE, MD</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>1691</td>
<td>76.09%</td>
<td>90.05%</td>
</tr>
<tr>
<td>TIMOTHY JAMES, MD</td>
<td>Nurse Practitioner</td>
<td>99241</td>
<td>1223</td>
<td>67.02%</td>
<td>90.59%</td>
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<tr>
<td>LEONARDO RODRIGUEZ</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>166</td>
<td>84.61%</td>
<td>91.05%</td>
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<tr>
<td>EMMA L. GARCIA, MD</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>1878</td>
<td>81.26%</td>
<td>90.80%</td>
</tr>
<tr>
<td>KRYSTAL A. MOORE, MD</td>
<td>Diagnostic Radiology</td>
<td>99203</td>
<td>1688</td>
<td>83.65%</td>
<td>90.60%</td>
</tr>
<tr>
<td>RALPH L. ROGERS, MD</td>
<td>Vascular Surgery</td>
<td>99231</td>
<td>48</td>
<td>98.05%</td>
<td>98.06%</td>
</tr>
</tbody>
</table>

How Benchmarking & Thresholds Work Together

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT</th>
<th>Description</th>
<th>Applicable UCL</th>
<th>Score E</th>
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<tbody>
<tr>
<td>Lab Fees</td>
<td>99204</td>
<td>Office supplies</td>
<td>$26,000</td>
<td>0.00</td>
</tr>
<tr>
<td>Exam Fee</td>
<td>99201</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
</tr>
<tr>
<td>Lab Test</td>
<td>99202</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
</tr>
<tr>
<td>Hospital</td>
<td>99203</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
</tr>
<tr>
<td>Subsequent</td>
<td>99204</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
</tr>
<tr>
<td>New Patient Consult</td>
<td>99205</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
</tr>
<tr>
<td>Emergency Billing</td>
<td>99206</td>
<td>Office supplies</td>
<td>$20,000</td>
<td>0.00</td>
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</tbody>
</table>
Benchmarks & Thresholds Incorporated to Build a Complete Risk Assessment for Your All Providers

View Excel Example

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)

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
Creating an Audit Plan

- Risk based approach to auditing and monitoring
  - Review benchmarking results to assess outliers
  - Review alternative 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

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 and 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”
Using Benchmarking for Acquisitions – Due Diligence

- Benchmarking 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

01 Cloning
02 Incident 2 – use NPPs etc
03 Copy Paste
04 Provider Based
05 Medically Necessary

Current Issues / Challenges

Questions & Contact Information

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

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