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Director, Organizational integrity & Audit Services

Compliance Institute
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Orland, FL

Agenda / Overview

• Trinity Health – Background (Who, What, Where)
• Current Regulatory Environment
• Data Resources for Benchmarking
• Physician Benchmarking Report
• Provider Scorecard Assessment Grid
• Sampling Approach
• Reporting
• Challenges
  – Potential Payback Issues
  – Education
  – Electronic Health Record
• Questions
Trinity Health: Unified Enterprise Ministry

Serving Nine States Nationwide

- Fourth-largest Catholic health system in the United States (based on Net Patient Revenue)
- 46,000 full-time equivalent employees
- More than 8,000 active staff physicians (over 1,400 employed)
- 19 Ministry Organizations, encompassing 46 hospitals 34 owned, 12 managed
- 379 outpatient centers
- Revenues of $7 billion
- Over $455 million in Community Benefit Ministry

Medicare/Medicaid Improper Payments

- CMS implemented new audit standards to calculate Medicare fee-for-service error rates for 2010.
- **2010 Medicare rate** – 10.5% ($34.3 Billion)
- **2010 Medicaid rate** – 9.4% ($22.5 Billion)
- **2010 Medicare Advantage rate** – 14.1% ($13.6 Billion)

Source: Department of Health and Human Services
Who’s Who in Health Care Enforcement

- Recovery Audit Contractors (RACs)
- Medicaid Integrity Contractors (MICs)
- Medicare Administrative Contractors (MACs)
  - Replacing Fiscal Intermediaries and Carriers
  - Responsible for both Part A and Part B claims
  - Accountable by CMS for reducing payment errors to providers on front-end
- Zone Program Integrity Contractors (ZPICs)
  - Data mining and analytics
- Health Care Fraud Prevention and Enforcement Action Team (“HEAT”)
- Medicare Fraud Strike Teams
- HHS - Office of Inspector General (OIG)
- Department of Justice (DOJ)

Quote from the Movie Armageddon:

“You know we’re sitting on four million pounds of fuel, one nuclear weapon and a thing that has 270,000 moving parts built by the lowest bidder. Makes you feel good, doesn’t it?”
ZPICs

- ZPICs Focus – Detecting, Deterring and Preventing Medicare Fraud & Abuse
- Immediate referral to CMS, OIG and/or Law Enforcement
- What triggers a ZPIC audit?
  - High utilization of services or items
  - High costs services or items
  - Submitting insufficient documentation
- ZPICs use of statistical sampling and extrapolation

What’s Being Audited?

Professional Services with Highest Rates of Improper Payments
Source: CERT Report May 2008

What “Errors” Are Reported?
- No Documentation
- Insufficient Documentation
- Medically Unnecessary Services
- Incorrect Coding
- Other
### Medicare/Medicaid Improper Payments

**Top Services with Incorrect Coding Errors: Carriers**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Paid Claims Error Rate</th>
<th>Projected Improper Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/outpatient visit, est (99214)</td>
<td>5.5%</td>
<td>$244,047,384</td>
</tr>
<tr>
<td>Subsequent Hospital Care (99233)</td>
<td>16.8%</td>
<td>$220,483,945</td>
</tr>
<tr>
<td>Office/outpatient visit, est (99215)</td>
<td>18.6%</td>
<td>$128,689,331</td>
</tr>
<tr>
<td>Office Consultation (99244)</td>
<td>19.6%</td>
<td>$120,585,360</td>
</tr>
<tr>
<td>Office/outpatient visit, est (99213)</td>
<td>1.7%</td>
<td>$75,715,227</td>
</tr>
<tr>
<td>Office/outpatient visit, new (99204)</td>
<td>20.8%</td>
<td>$66,046,693</td>
</tr>
<tr>
<td>Office Consultation (99245)</td>
<td>19.1%</td>
<td>$69,300,754</td>
</tr>
<tr>
<td>Office/outpatient visit, new (99203)</td>
<td>10.4%</td>
<td>$42,348,998</td>
</tr>
</tbody>
</table>


### Example ZPIC Letter

**E&M Services Audited**

$127,366 Medicare Overpayment
Benchmarking – Physician Practice

- Use of Benchmark Data
  - Analysis of physician practice/physicians by specialty
  - Establish goals/targets
  - Prioritize providers for auditing and monitoring
  - Make your case for additional resources
  - Develop audit plans
  - Identify Outliers / Target risk areas
  - Develop compliance scoring system
  - Acquisition Due Diligence
Data Resources for Benchmarking

CMS:
- Raw data
- Requires intermediate/advance database skills to manipulate
- Cost - $250.00
- Open zip file containing an Excel spreadsheet titled "PUF_REQUEST_WORKSHEET"
- Under the PUF REQUEST tab starting on 53 “PSPS Data Request” enter your start year and end year
- Fill out payment and shipping
- Approximately two weeks to receive file

CMS Data
- 100% summary of all Part B Carrier claims processed through the Common Working File and stored in the National Claims History Repository
- One year in arrears
- The file is arrayed by
  - Carrier
  - Pricing locality
  - HCPCS
  - Modifier
  - Specialty
  - Type of service
  - Place of service
Data Resources for Benchmarking

MGMA:
- Organized data on CD
- Beginning / Intermediate database skills
- Cost - $435.00 member $695.00 non-member
- Primary use for benchmarking is wRVU and visits per day data

What To Do With It

- Develop Physician Snapshot that includes the following:
  - E/M level coding distribution peer analysis
  - Visit per day analysis
  - Modifier use
  - Work RVU analysis
  - Revenue analysis
- Analyze data to develop risk and audit strategies
- Use data for physician scorecard
Note: Just because a physician benchmarks outside of peer group does not mean there is a compliance issue.
Excessive Visit Settlement

FALSE CLAIMS ACT

Louisville Physician, Dr. Julio Melo, Agrees to Pay $984,705 to Settle Federal False Claims Act and Civil Fraud Claims.

According to the settlement agreement, the United States maintains that Dr. Melo improperly submitted claims for payment to federally-funded health care programs for E/M services which, based on the AMA CPT recommended times, resulted in numerous days in which the CPT’s E/M time guidelines exceeded 24 hours in duration.

Along with the fine Dr. Melo also received a five year Corporate Integrity Agreement ("CIA").
Visit Per Day Analysis

- Use MGMA data
- Develop an internal average per day analysis:
  - 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>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

Source: AAPC 6/09

### MGMA Percentiles

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Actual</th>
<th>70th</th>
<th>80th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Worked</td>
<td>199</td>
<td>240</td>
<td>240</td>
<td>245</td>
</tr>
<tr>
<td>Total Visits All Levels</td>
<td>3275</td>
<td>5163</td>
<td>5795</td>
<td>6985</td>
</tr>
<tr>
<td>Average Visits Per Day</td>
<td>16</td>
<td>22</td>
<td>24</td>
<td>29</td>
</tr>
</tbody>
</table>

Visit Per Day Analysis

(A) Total Visits (240 days) Average Visits Per Day

<table>
<thead>
<tr>
<th>Levels</th>
<th>Per Day</th>
<th>Total</th>
<th>Per Day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>49</td>
<td>11,677</td>
<td>25</td>
<td>9,724</td>
</tr>
<tr>
<td>99214 &amp; 99215</td>
<td>41</td>
<td>1,252</td>
<td>24</td>
<td>1,021</td>
</tr>
<tr>
<td>99214 &amp; 99215 90th %</td>
<td>24</td>
<td>1,021</td>
<td>24</td>
<td>1,021</td>
</tr>
</tbody>
</table>

Average Visits Per Day

<table>
<thead>
<tr>
<th>Levels</th>
<th>Per Day</th>
<th>Total</th>
<th>Per Day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>99214 &amp; 99215 90th %</td>
<td>24</td>
<td>1,021</td>
<td>24</td>
<td>1,021</td>
</tr>
</tbody>
</table>

Physician Group Practice Analysis

Family Practice - Dr. High Volume

Average Visits Per Day

Graph showing average visits per day for different levels and groups.
Modifier Use

- Modifier -25 appended to an E/M service, identifies the service as significant and separately identifiable from a procedure or other service provided on the same date of the service.
- Modifier -59 under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.
- Use CMS data.
- Develop a utilization table and compare provider use with peer group.

Highly Productive Physicians

- Special care must be taken with “highly productive” physicians.
  - Example: Physicians with annual wRVUs > 90th% of industry benchmarks.
  - Specialties such as cardiology, neurosurgery, orthopedics.
- Evaluate need for additional audit procedures to evaluate.
  - Medical appropriateness of services.
  - Adherence to industry professional standards.
St. Joseph Medical Center – Towson, Md

- $22 Million settlement to the DOJ, alleged violations of Anti-Kickback Act and Stark Law
- Cardiologist Mark Midei – unnecessary cardiac stenting
  - According to press, many patients with less than 50% blockage and some as low as 10% blockage
- Hospital stripped physician of privileges
- Accused of 585 unnecessary stent procedures in his last two years of practice
- Hospital sent letters to 369 patients and more may be forthcoming

Total Work RVUs

- MGMA – Physician Compensation and Production Survey: 2010 Report Based on 2009 Data:
  - Physician Work RVUs by specialty
  - 25th, Median, 75th and 90th percentile data
- Compare physician’s actual Work RVUs vs. MGMA data

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Total RVUs</th>
<th>75th Physician Work RVU</th>
<th>90th Physician Work RVU</th>
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</thead>
<tbody>
<tr>
<td>Dr. Howard</td>
<td>Cardiology</td>
<td>13,586</td>
<td>14,984</td>
<td>21,230</td>
</tr>
<tr>
<td>Dr. Fine</td>
<td>Cardiology</td>
<td>31,322</td>
<td>14,984</td>
<td>21,230</td>
</tr>
<tr>
<td>Dr. Holliday</td>
<td>Cardiology</td>
<td>20,589</td>
<td>14,984</td>
<td>21,230</td>
</tr>
</tbody>
</table>
Top 10 CPT Codes by Charges

- Comparison by Specialty vs. CMS Data
  - Top ten procedures usually make up approximately 65% to 90%
  - Analyze top ten data compared to CMS data for any potential outliers
  - Identifies potential areas of risk for audit

<table>
<thead>
<tr>
<th>Provider</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>$35,736</td>
</tr>
<tr>
<td>99295</td>
<td>$92232</td>
</tr>
<tr>
<td>99285</td>
<td>$92232</td>
</tr>
<tr>
<td>99275</td>
<td>$5,716</td>
</tr>
<tr>
<td>99260</td>
<td>$2,004</td>
</tr>
<tr>
<td>99250</td>
<td>$4,500</td>
</tr>
<tr>
<td>99249</td>
<td>$3,177,755</td>
</tr>
<tr>
<td>Total / % of Row</td>
<td>$3,177,755</td>
</tr>
</tbody>
</table>

Charges by Diagnostic Services

- Comparison of Provider diagnostic services vs. CMS data
  - Review diagnostic services by CPT section (e.g. Radiology, Laboratory, and Medicine)
  - Compare the CPT sections vs. CMS data by CPT section
  - Identify outliers

<table>
<thead>
<tr>
<th>CPT Section</th>
<th>Charges Provider</th>
<th>Percentage Provider</th>
<th>Charges CMS</th>
<th>Percentage CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology</td>
<td>$28,125.00</td>
<td>3.3%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td>PathLab</td>
<td>$26,418.00</td>
<td>3.5%</td>
<td>3.8%</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>$110,242.50</td>
<td>14.7%</td>
<td>10.9%</td>
<td></td>
</tr>
</tbody>
</table>

*Not including HM codes
Benchmark - Reporting

• Disclaimer is very important:
  – The analyses are for benchmarking purposes only and to assist in prioritizing areas for further review by Practice management
  – Coding and billing is dependent upon the services rendered by the provider 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.
Benchmark - Reporting

- Summary of Benchmarking Analyses:
  - E/M Coding Distribution
  - Average Daily Visits
  - Modifier -25 / -59 Utilization

- Recommended Actions
  - Discussion with providers
  - Medical record documentation coding and review
  - Validate modifier usage
  - Follow-up

Provider Scorecard Assessment

- The purpose is to see at-a-glance how an individual provider, or practice is progressing with their E/M coding and documentation. This tool offers several benefits including:
  - Specific areas of coding and documentation that need attention
  - Assistance with knowing where to focus limited audit and coding resources
  - Method for scheduling future provider audits and coding education

Provider Scorecard Assessment

- Used in Trinity Health physician network audits since 2007
- Evaluates providers in following three areas:
  - Net Reimbursement Results (based on audit)
    - The net reimbursement results compares the actual billed reimbursement amount for E/M services to the derived reimbursement amount from the audit.
  - E/M Bell Curve Analysis (based on benchmarking)
    - A comparison of each provider’s utilization of the CPT E/M codes in comparison to a peer group in the same specialty and region.
  - Overall Documentation Quality (based on audit)
    - 13 point scoring system to evaluate documentation quality

Category I: Net Reimbursement Results

- Points are assigned based on the net reimbursement results on E/M code assignment.
- The net reimbursement results compares the actual billed reimbursement amount for E/M services to the derived reimbursement amount from the audit.
- By using net reimbursement it takes into account overcoding, undercoding, unbilled services, unbillable services, and wrong category.
  - 6 points = 90% or greater accuracy
  - 4 points = 80% or greater accuracy
  - 2 points = 70% or greater accuracy
  - 0 points = less than 69% accuracy
  - The net reimbursement result analysis has a 50% weight.
# Category I: Net Reimbursement Results

<table>
<thead>
<tr>
<th>Provider</th>
<th>Billed Reimbursement</th>
<th>Derived Reimbursement</th>
<th>Difference</th>
<th>Net Reimbursement Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABC Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Fine</td>
<td>794.77</td>
<td>212.46</td>
<td>582.31</td>
<td>26.73%</td>
</tr>
<tr>
<td>Dr. Howard</td>
<td>595.33</td>
<td>573.61</td>
<td>21.72</td>
<td>96.35%</td>
</tr>
<tr>
<td>Dr. Weby</td>
<td>258.13</td>
<td>258.13</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Dr. Carter</td>
<td>191.44</td>
<td>191.44</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Practice Subtotal</td>
<td>1,819.67</td>
<td>1,215.64</td>
<td>604.03</td>
<td>66.81%</td>
</tr>
<tr>
<td><strong>DEF Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Burns</td>
<td>595.33</td>
<td>546.96</td>
<td>48.37</td>
<td>91.88%</td>
</tr>
<tr>
<td>Dr. Seuss</td>
<td>646.68</td>
<td>408.54</td>
<td>238.14</td>
<td>63.17%</td>
</tr>
<tr>
<td>Practice Subtotal</td>
<td>1,242.01</td>
<td>955.5</td>
<td>286.51</td>
<td>76.93%</td>
</tr>
<tr>
<td><strong>GHI Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Hibert</td>
<td>1,733.36</td>
<td>957.39</td>
<td>775.97</td>
<td>55.23%</td>
</tr>
<tr>
<td>Dr. House</td>
<td>1,868.02</td>
<td>1,343.52</td>
<td>524.5</td>
<td>71.92%</td>
</tr>
<tr>
<td>Practice Subtotal</td>
<td>3,601.38</td>
<td>2,300.91</td>
<td>1,300.47</td>
<td>63.89%</td>
</tr>
<tr>
<td><strong>JKL Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Doctor</td>
<td>595.33</td>
<td>549.92</td>
<td>45.41</td>
<td>92.37%</td>
</tr>
<tr>
<td>Dr. Howser</td>
<td>646.68</td>
<td>623.97</td>
<td>22.71</td>
<td>96.49%</td>
</tr>
<tr>
<td>Dr. King</td>
<td>646.68</td>
<td>501.94</td>
<td>144.74</td>
<td>77.62%</td>
</tr>
<tr>
<td>Practice Subtotal</td>
<td>1,888.69</td>
<td>1,675.83</td>
<td>212.86</td>
<td>88.73%</td>
</tr>
</tbody>
</table>

# Category II: E/M Bell Curve Analysis

- A comparison of each provider’s utilization of the CPT E/M codes in comparison to a peer group in the same specialty and region. Points are assigned based on how far a provider deviates on a percentage basis from the peer group’s norms that they are being measured against.
  - 3 points = Less than a 15% deviation
  - 2 points = between 16% - 25% deviation
  - 1 point = between 26% - 44% deviation
  - 0 points = greater than a 45% deviation
  - The E/M bell curve analysis has a 25% weight.
Percentage deviation calculation is:
64% - 41% = 23%
23% / 64% = 35.94%

Category III: Overall Documentation Quality

13 point scoring system
1. Correct date-of-service (1pt)
2. Legible (1pt)
3. Correct diagnosis(es) reported on encounter form to documented diagnosis(es) in medical record (1pt)
4. Proper use of student and/or scribe documentation (2pts)
5. Documentation present for a consult (2pts)
6. Percentage time spent documented for time based code or counseling visit (2pts)
7. Documentation authenticated by signature (2 pts)
8. Documentation present for ordered diagnostics or ancillaries (2pts)

– The overall documentation quality analysis has a 25% weight.
After the provider scorecard assessment grid is performed a summary form is completed to provide an overall score. The scoring is as follows:

- **Outstanding 11-12 points:** Routine follow-up
- **Good 8 – 10 points:** Internal follow-up audit
- **Fair 4 – 7 points:** Focused audit in 6-9 months
- **Poor < 4 points:** 100% pre-bill review or the review will be placed under attorney client privilege (ACP)
Provider Scorecard Assessment Grid – Reporting

- Overall results for the Provider Network
  - Network scorecard in the executive summary
- Provider Network detailed findings with corrective actions
- Practice scorecards
- Individual provider scorecards with analysis

<table>
<thead>
<tr>
<th>Practice Scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Reimbursement Results</strong></td>
</tr>
<tr>
<td>Provider:</td>
</tr>
<tr>
<td>Dr. Fine</td>
</tr>
<tr>
<td>Dr. Howard</td>
</tr>
<tr>
<td>Dr. Welby</td>
</tr>
<tr>
<td>Dr. Howser</td>
</tr>
<tr>
<td>Practice</td>
</tr>
</tbody>
</table>

**SCORING**
- Outstanding 11-12 points
- Good 8 - 10 points
- Fair 4 - 7 points
- Poor < 4 points
- Routine Follow-up
- Internal follow-up audit
- Focused audit in 6-9 months
- 100% review/ACP

**CATEGORY I: Net Reimbursement Results**
- 6 points = 90% or > accuracy
- 4 points = 80% - 89% accuracy
- 2 points = 70% - 78% accuracy
- 0 points = < 69% accuracy

**CATEGORY II: E/M Bell Curve Analysis**
- 3 points = < 15% deviation
- 2 points = 16% - 25% deviation
- 1 point = 26% - 44% deviation
- 0 points = > 45% deviation

**CATEGORY III: Overall Documentation Quality**
- 3 points = 90% or > accuracy
- 2 points = 80% - 89% accuracy
- 1 point = 70% - 78% accuracy
- 0 points = < 69% accuracy
The overall results were fair/good. Dr. Fine is an outlier compared to his peers with regards to billing CPT 99214 in comparison to CPT code 99213, but the results of the record review showed that the documentation supports the E/M level billed. This is a good example of when a physician is considered an outlier in the eyes of CMS and will come under scrutiny by the MAC but the audit results support the level of coding.

Opportunities exist for improvement in the reporting of the diagnosis code on the encounter form to the documented diagnosis in the medical record.

We recommend periodic internal reviews of CPT code 99214 and education on the appropriate use of ICD-9 codes.

E/M Bell Curve Analysis

- If the provider is considered an outlier in comparison to his/her peers and the documentation supports the deviation from the norm then the provider will receive the full three points.
The overall results were good. Dr. Fine is an outlier compared to his peers with regards to billing CPT 99214 in comparison to CPT code 99213, but the results of the record review showed that the documentation supports the E/M level billed. This is a good example of when a physician is considered an outlier in the eyes of CMS and will come under scrutiny by the MAC but the audit results support the level of coding.

Opportunities exist for improvement in the reporting of the diagnosis code on the encounter form to the documented diagnosis in the medical record.

We recommend periodic internal reviews of CPT code 99214 and education on the appropriate use of ICD-9 codes.

Net Reimbursement Results: 96.35% 6 points
E/M Bell Curve Analysis: 50% (supported) 3 points
Overall Chart Documentation Quality: 74% 1 point

The overall results are poor. Dr. Howard is an outlier based on her usage of E/M code 99214 in comparison to her peers. The results of our review show that the documentation supports the E/M code 99214. Therefore, Dr. Howard received the full three points in the E/M Bell Curve Analysis category. This is a good example of when a physician is considered an outlier in the eyes of CMS and will come under scrutiny by the MAC but the audit results support the level of coding.

The poor results are attributed to an intern or student primarily documenting services without the appropriate supervision and documentation from Dr. Howard.

We recommend education on the correct way to document and supervise students and interns when a physician is acting as a teaching physician and education regarding the appropriate use of ICD-9 codes.
The overall results are fair to poor. Dr. Welby is an outlier based on his usage of E/M code 99214 in comparison to his peers. The results of our review show that the documentation does not support the E/M code 99214 in most cases. Since Dr. Welby is an outlier he will be under the scrutiny by the MAC and since the audit results do not support the level of coding the Carriers could perform a provider-specific probe review. Our results also showed that when a consultation was billed the documentation supported a subsequent hospital care E/M service.

We recommend internal periodic reviews of E/M codes 99214 and consultation E/M codes, education regarding the definition and requirements that must be documented to support billing consultations and education regarding the appropriate use of ICD-9 codes.

The overall results are poor. We focused our audit on CPT code 99215 and 99213 because of the unusually high volume in these codes. We reviewed five charts that were billed with CPT code 99215 and discovered that all five charts should have been billed using the preventive medicine CPT codes and in particular CPT code 99397 (Preventive Medicine 65 years and older). Three out of the five charts reviewed billed with CPT code 99213 should have been billed with CPT code 99214.

We recommend a 100% internal review of CPT code 99215 and 99213.
Overall results are outstanding. From our bell-curve analysis, Dr. No is billing a significantly higher number of 99213s and fewer 99214s. We recommend periodic review and discussion with Dr. No to determine if this is a matter of under documentation when the acuity of his patients do indeed warrant the billing of more 99214s.

The Process: Gathering and Manipulating Data

- Gathering and manipulating data
  - We receive physician data from all of the Trinity Physician Network practices
    - Current 12-month period of billed professional services
    - Sort by physician and specialty, CPT codes
    - Subtotal by reimbursement and count
  - Compare Trinity data with CMS data
  - Develop a normal distribution graph (bell curve) by practice and physician
  - Analyze data to develop risk and audit strategies
Sampling……

Before and After…

• Prospective vs. Retrospective audit
• Random vs. Judgmental sample
  – Focus on Government payers
  – OIG Work Plan
  – Issues identified by Ministry Organization
  – Noted findings at other Organizations
  – Previous audit findings
  – **Usually a few services account for 70% - 80% of charges**
  – **Goal is to review services that make up 60% to 80% of charges**
• Ten records per provider vs. Limited sample sizes
• There is a chance that not all physicians will be reviewed
• Three year cycle review vs. Yearly follow-up

---

The Process: Sampling Method

<table>
<thead>
<tr>
<th>Sample Selection</th>
<th>Number of Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>Total Charge</td>
</tr>
<tr>
<td>Family Practice - Happy Valley</td>
<td>$155,386</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Doogie Howser</td>
<td>$128,170</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Derek Pain</td>
<td>$8,873</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Marcus Welby</td>
<td>$8,873</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Larry Fine</td>
<td>$60,343</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>$352,772</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total Audit %</td>
<td>78.65%</td>
</tr>
</tbody>
</table>
### The Process: Risk Assessment/Sampling

#### Specialty Cardiology

#### Carrier Ranking / Pct of Charges

<table>
<thead>
<tr>
<th>CPT</th>
<th>Rank</th>
<th>PctOfTotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>78485</td>
<td>1</td>
<td>9.95%</td>
</tr>
<tr>
<td>93307</td>
<td>2</td>
<td>8.75%</td>
</tr>
<tr>
<td>93320</td>
<td>3</td>
<td>5.69%</td>
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<tr>
<td>92960</td>
<td>4</td>
<td>4.45%</td>
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<tr>
<td>93325</td>
<td>5</td>
<td>4.24%</td>
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<tr>
<td>93510</td>
<td>6</td>
<td>3.43%</td>
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<tr>
<td>99214</td>
<td>7</td>
<td>3.19%</td>
</tr>
<tr>
<td>99213</td>
<td>8</td>
<td>3.18%</td>
</tr>
<tr>
<td>99232</td>
<td>9</td>
<td>2.98%</td>
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<tr>
<td>93015</td>
<td>10</td>
<td>2.93%</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>48.79%</strong></td>
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</table>

#### Provider Ranking / Pct of Charges

<table>
<thead>
<tr>
<th>CPT</th>
<th>Rank</th>
<th>PctOfTotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>92940</td>
<td>1</td>
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<tr>
<td>93306</td>
<td>2</td>
<td>12.15%</td>
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<td>93151</td>
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<td>11.53%</td>
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<td>92444</td>
<td>4</td>
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<tr>
<td>99231</td>
<td>5</td>
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<td>99214</td>
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<tr>
<td>99213</td>
<td>9</td>
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<tr>
<td>93000</td>
<td>10</td>
<td>3.45%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>70.81%</strong></td>
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</table>

### The Process: Audit Database
# The Process: Audit Database

## Summary of Review Findings

<table>
<thead>
<tr>
<th>Case No.</th>
<th>Date of Service</th>
<th>Insurance Type</th>
<th>Diagnosis Code</th>
<th>CPT Code</th>
<th>Amount</th>
<th>CPT Amount</th>
<th>Difference</th>
<th>CPT Reason</th>
<th>CPT Session</th>
<th>ICD9 Reason</th>
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<tbody>
<tr>
<td>04-02-340</td>
<td>MEDICARE</td>
<td>9463</td>
<td></td>
<td></td>
<td>$59.53</td>
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<tr>
<td>01-09-351</td>
<td>MEDICARE</td>
<td>9613</td>
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<td>$95.90</td>
<td>95.13</td>
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</tr>
<tr>
<td>02-02-357</td>
<td>MEDICARE</td>
<td>9224</td>
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<td></td>
<td>$75.00</td>
<td>74.24</td>
<td>$0.76</td>
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**Comments:**
- Case No. 04-02-340: NO CHARGE, LACK OF MEDICAL NECESSITY, PROVIDER AT 65, CODE TO HIGHER LEVEL OR SPECIFY DOCUMENTED IN PROGRESS NOTE.
- Case No. 01-09-351: CODE ALL DIAGNOSIS EXAMINATIONS DOCUMENTED IN PROGRESS NOTE WITH APPROPRIATE CODES.
- Case No. 02-02-357: CODE ALL DIAGNOSIS EXAMINATIONS DOCUMENTED IN PROGRESS NOTE WITH APPROPRIATE CODES.
Reporting: Format

- Sections
  - Executive Summary
  - Table of Contents
  - Background
  - Findings/Corrective Action
  - Sampling Techniques
  - Analysis of Sample

Reporting: Follow-up

- Follow-up
  - Outstanding Results
    • Follow-up audit every other year
  - Good Results
    • Internal follow-up
  - Fair Results
    • Focused audit in 6-9 months
  - Poor Results
    • 100% pre-billed review

- Yellow and red we'll see again!

SCORING

- Outstanding 11-12 points
- Good 8 - 10 points
- Fair 4 - 7 points
- Poor < 4 points
Challenges: Potential Payback Issues

- 60-day deadline for providers to repay and report overpayments of federal funds
- Inappropriate use of NPPs
  - Billing “incident to” at a provider-based clinic
  - Billing services provided by NPPs as “incident to” for new patient visits or new conditions
- Wrong POS on claims – provider-based clinic vs. freestanding office
- Inappropriate or no documentation for supervision of residents when acting as a TP
- Inappropriate use of student documentation
- Billing services for one physician under another physician’s billing number
- Insufficient or no documentation
- Billing a global service when a professional service was performed.

Challenges: Follow-up Education

- Providing cost-effective education
  - Trinity Health provides pre-recorded audio-conferences on the Trinity Health intranet website
- Other education
  - Who performs
    - Internal vs External
    - One-on-one education
EHR: OIG Oversight

- Medicare paid $25 billion for E/M services in 2009, representing 19% of all Medicare Part B payments. (Modern Medicine, April 3, 2009, "The Problem with EHRs and Coding")
- Recent CMS study of four practices using EHRs, resulted in a 20% - 90% error rate.
- Medicare contractors have noted an increased frequency of medical records with identical documentation across services (cloning). OIG FY11 workplan includes an audit of EHR documentation practices.

Challenges: EHR

- Primary E/M documentation pitfalls to avoid:
  - Templates and billing driving care and charting
  - Point-and-click mentality vs. accurate and ethical documentation
  - Copy and past forward
  - Charting for services that were not performed: use of default entries
  - Documentation cloning
  - Negatives listed vs. positives – hard to discern what is wrong with the patient
  - Failure to review available information
  - Inaccurate charting
  - Addendums for increased reimbursement vs. patient care
  - Relative value unit (RVU) – driven care
  - Signing of notes without reading them
  - EHR revealing bad practice patterns

Source: AAPC Coding Edge, February 2011
Physician Networks and Clinics – Compliance Program (Refresh)

- Establishes standards for operation of Organizational Integrity Program in Trinity Health physician practices and clinics
- Scope
  - All employed provider networks and clinics
  - Both provider-based and free-standing
  - Professional billing central business offices (CBO)
  - All associates, physicians, and NPPs working in Trinity Health physician networks and clinics

Reality
Questions/Discussion

• Thank-You for Your Attendance and Participation!
• Follow-up questions can be directed to:

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Director, Organizational Integrity
Trinity Health
(248) 324-8479
Costanta@trinity-health.org