
How to Develop Benchmarking
scorecards
Transitioning to Risk-Based Physician Auditing
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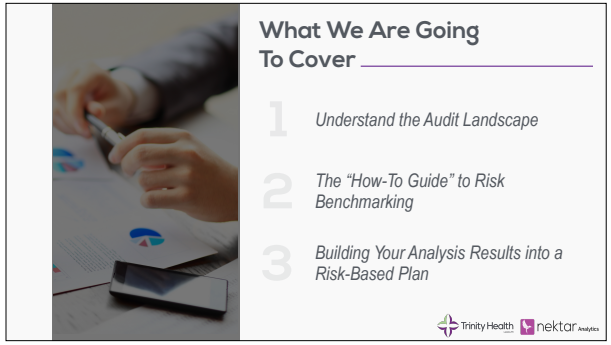
What We Are Going To Cover
1 Understand the Audit Landscape
2 The "How-To Guide" to Risk Benchmarking
3 Building Your Analysis Results into a Risk-Based Plan
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Trinity Health's 22-State Diversified System

$17.6 B
In Revenue

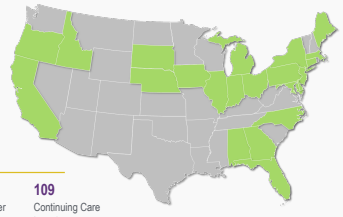
$1.3 M
Attributed Lives

$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

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What is the

Current Risk Landscape

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- 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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Comprehensive Error Rate Testing Program

Table D1: Top 20 Service Types with Highest Improper Payments: Part B

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Lab tests - other (non-Medicare fee schedule)	$1,121,237,359	32.4%	27.0% - 37.8%	0.5%	98.9%	0.6%	0.0%	0.0%	3.1%
Office visits - established	$832,300,002	5.5%	4.5% - 6.5%	2.6%	29.8%	0.0%	67.6%	0.0%	2.3%
Hospital visit - subsequent	$830,470,464	15.2%	13.5% - 16.8%	5.8%	47.1%	0.1%	46.6%	0.4%	2.3%
Hospital visit - initial	$765,933,412	26.1%	24.0% - 28.1%	3.2%	21.9%	0.2%	74.5%	0.3%	2.1%
Other drugs	$744,482,041	7.6%	2.5% - 12.6%	0.6%	91.4%	1.0%	7.0%	0.0%	2.0%
Ambulance	$687,458,438	15.5%	12.6% - 18.4%	2.7%	57.3%	36.9%	2.3%	1.0%	1.9%
Minor procedures - other (Medicare fee schedule)	$560,063,138	17.4%	13.4% - 21.4%	1.1%	88.2%	1.1%	9.1%	0.4%	1.5%
Office visits - new	$524,625,770	18.4%	15.7% - 21.1%	3.6%	15.8%	0.0%	72.6%	8.0%	1.4%
Nursing home visit	$349,210,260	17.3%	13.9% - 20.6%	11.2%	35.9%	0.0%	52.9%	0.0%	1.0%
Specialist - psychiatry	$310,744,929	25.7%	17.1% - 34.3%	1.7%	91.9%	0.0%	6.5%	0.0%	0.8%
Emergency room visit	$282,298,975	12.6%	10.4% - 14.8%	4.4%	11.0%	0.0%	84.6%	0.0%	0.8%

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)

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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
- 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)***
- "Incident to" physician services
- Split Shared Visits
- Fraud and abuse statues

01 **Medicare Provider Utilization and Payment Data**

- WSJ Medicare Unmasked
- ProPublica Treatment Tracker
- Access to CMS Raw Data

02 **Sunshine Act - Open Payments**

- CMS Open Payments Look-Up Tool

URL Links to Sources in Handout

Data Accessibility

Anyone Can Look You Up

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Availability of Provider Data Online

Finding Outliers on the Internet

Live Example

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Transforming the

Auditing Mindset

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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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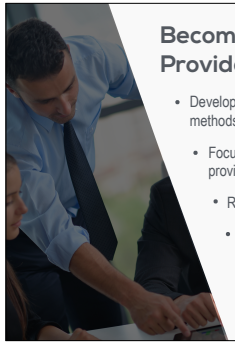

Becoming Proactive with Provider Benchmarking

- 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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Which Benchmarking

Metrics Should You Use

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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
- Visits per Day / Work RVUs
- Open Payments

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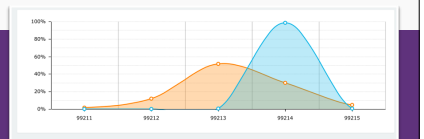
E/M Level Coding Peer Comparisons



	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	-31%	$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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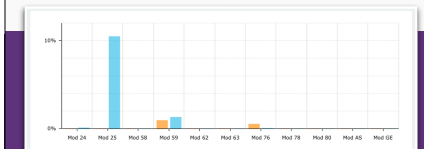
Modifier Usage



		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%

Focus On

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

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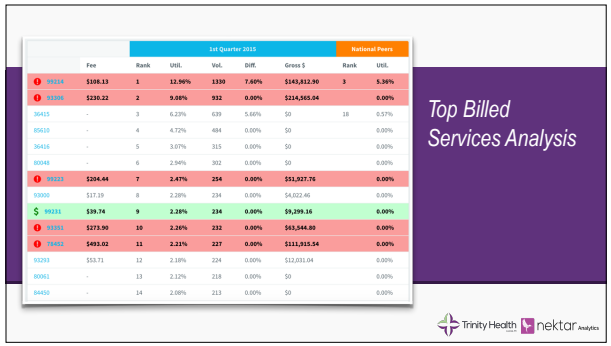

Top Billed Services Analysis

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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** 100th percentile nationally	Number of Patients: **882** 98th percentile nationally	Payments per Patient: **$581** 97th percentile nationally

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Visit Per Day Analysis

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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Open Payments Analysis

ABC Hospital

Open Payment Summary - Teaching Hospital

Total Payments: $283,438.58

Saint Francis Hospital: $272,670.09

St. Marys Hospital: $10,768.49

	Teaching Hospital	Total_Payments
1	**ABC Hospital**	**$272,670.09**
	GeneralPay	**$180,815.72**
	Haemonetics Corporation	$68,912.00
	Sanofi and Genzyme US Companies	$53,800.00
	Zimmer Biomet Holdings, Inc.	$10,762.00
	Novartis Pharmaceuticals Corporation	$7,500.00
	OMNIlife science, Inc	$6,165.00
	Merck Sharp & Dohme Corporation	$4,300.00
	Mazor Robotics Inc.	$4,051.16
	Gilead Sciences Inc	$4,000.00
	AstraZeneca Pharmaceuticals LP	$3,800.00
	Lantheus Medical Imaging, Inc.	$3,500.00
	Boehringer Ingelheim Pharmaceuticals, Inc.	$2,500.00
	Stryker Corporation	$2,427.34
	Abbott Laboratories	$2,000.00
	St. Jude Medical, Inc.	$1,500.00
	Olympus America Inc.	$1,377.00
	Janssen Pharmaceuticals, Inc	$1,300.00

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How Do You Actually

Calculate These Metrics

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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

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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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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

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Excel Template Walk Through

How to calculate E/Ms, Modifiers, and Top Procedure analysis.

Live Example

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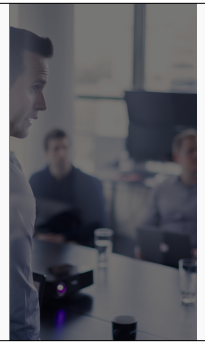

Highly Productive Physicians

- 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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Understanding Medicare Payment Data

- First time this data has been available in three decades
- These records had been kept secret through legal efforts by the AMA
- 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

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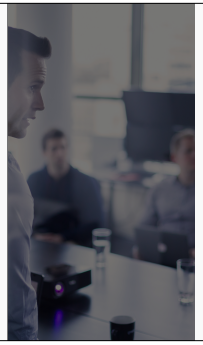

Understanding Medicare Payment Data cont'd

- Datasets Currently Available
  - 2012, 2013, 2014, 2015
- Key Benchmarking Analytics
  - Total Payments
  - Number of Patients
  - Payments Per Patient
- Links to Data Sources in Handout

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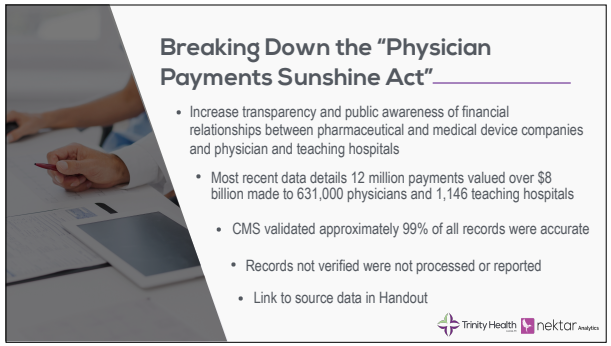

Breaking Down the "Physician Payments Sunshine Act"

- 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

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Breaking Down the "Physician Payments Sunshine Act" cont'd

- 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

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Excel Analysis Walk Through

Analyzing your Open Payment Data

Live Example

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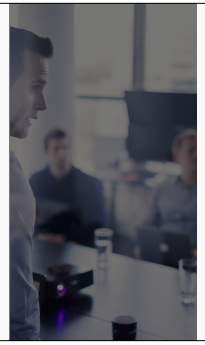

What should you do with Open Payment Analysis

- 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

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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

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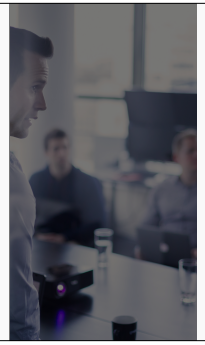

Hierarchical Condition Categories (HCCs)

- 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 patients' 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

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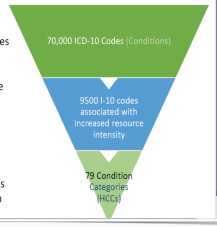
Hierarchical Condition Categories

- 70,000 ICD-10-CM codes (Conditions)
  - Of these, 9500 ICD-10 codes have been shown to represent serious conditions that will require substantial CMS $ to manage
  - Conditions grouped into Condition Categories:
    - Similar conditions
    - Similar recourse needs
    - 79 different Condition Categories



HCCs

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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**

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Diagnosis coding for claims vs. for risk adjustment

Diagnoses for Claims	Diagnoses for Clinical Risk Adjustment
• Prospective – submitted on each claim	• Retrospective – reviewed periodically (e.g. annually)
• Historically used for coverage and reimbursement purposes	• For accurate calculation of patient's clinical risk score
• Supports medical necessity	• Used to improve clinical care and overall disease management
• Satisfy medical policies for coverage of services (e.g., LCDs/NCDs)	• Used to estimate future clinical and financial resource utilization

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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.

How to incorporate the results into a

Risk-Based Auditing Plan

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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

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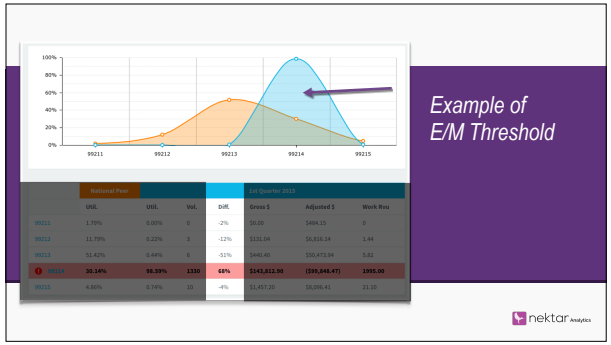
Example of
E/M Threshold
100%
80%
60%
40%
20%
0%
99211
99212
99213
99214
99215
National Peer
1st Quarter 2015
Util.
Util.
Vol.
Diff.
Gross $
Adjusted $
Work Rvu
99211 1.79% 0.00% 0 -2% $0.00 $494.15 0
99212 11.79% 0.22% 3 -12% $331.04 $6,816.14 1.44
99213 51.42% 0.44% 6 -51% $840.40 $50,473.94 5.82
99214 30.14% 98.59% 1330 68% $143,812.90 ($99,848.47) 1955.00
99215 4.86% 0.74% 10 -4% $1,457.20 $8,096.41 21.10
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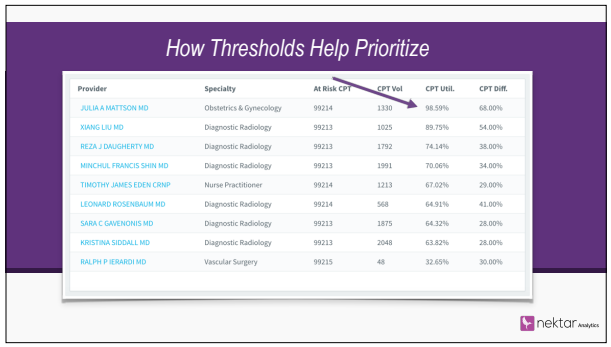
How Thresholds Help Prioritize
Provider
Specialty
At Risk CPT
CPT Vol
CPT Util.
CPT Diff.
JULIA A MATTSON MD Obstetrics & Gynecology 99214 1330 98.59% 68.00%
XIANG LIU MD Diagnostic Radiology 99213 1025 89.75% 54.00%
REZA J DAUGHERTY MD Diagnostic Radiology 99213 1792 74.14% 38.00%
MINCHUL FRANCIS SHIN 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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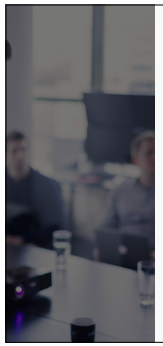

A More Statistical Approach to Outlier Determination

- **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 2 times the rate of CM 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 2 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 90- percentile is considered an outlier.
- **Medicare Utilization** – A provider is considered an outlier if the provider's Medicare utilization is greater than the 90- percentile for the provider's peer group.

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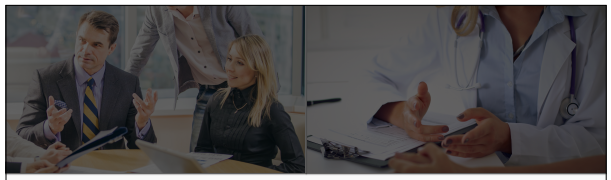

Examples of Provider Scorecards

The benchmarking report end deliverable.

Live Example

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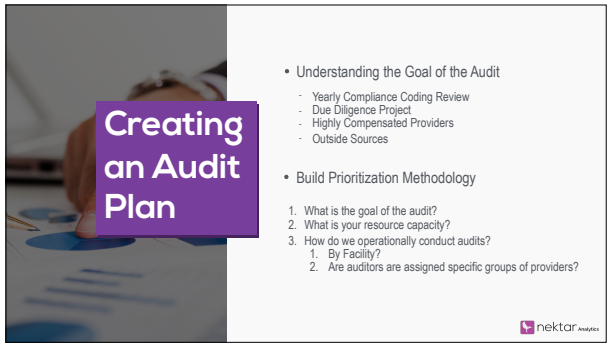
Creating an Audit Plan
• Understanding the Goal of the Audit
- Yearly Compliance Coding Review
- Due Diligence Project
- Highly Compensated Providers
- Outside Sources
• Build Prioritization Methodology
1. What is the goal of the audit?
2. What is your resource capacity?
3. How do we operationally conduct audits?
1. By Facility?
2. Are auditors are assigned specific groups of providers?
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Examples of Prioritized Audit Plans
How to plan your yearly audits based on risk analysis
Live Example
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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

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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 an use of the EMR system

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After the Plan is Made cont'd

- Frequency of conducting audits
  - For established providers once a year based on outliers through the 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 the 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**

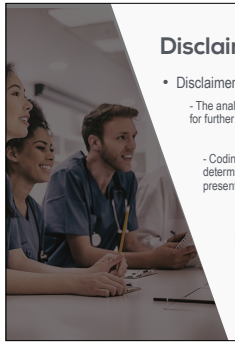
    Matters noted during the review that do not require a management response.

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 coders(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 APP's, 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

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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 unit 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 sizes: 20 High Scoring Beneficiaries, 20 Medium Scoring Beneficiaries, and 20 Low Scoring Beneficiaries.**

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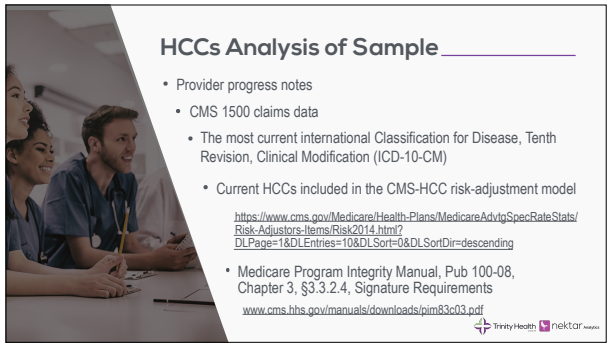

HCCs Analysis of Sample

- 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

https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2014.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

- Medicare Program Integrity Manual, Pub 100-08, Chapter 3, §3.3.2.4, Signature Requirements

www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

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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, moderate severity, (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;

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Auditing HCCs - Analysis of Sample cont'd

- 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).

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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.

Andrei M. Costantino, MHA, CHC, CFE
Vice President of Integrity & Compliance
costanta@trinity-health.org
Trinity Health

Jared Krawczyk
Director of Analytics
jkrawczyk@nektaranalytics.com
www.nektaranalytics.com

nektar Analytics