THE RISK BASED APPROACH TO Auditing and Monitoring Employed Physicians

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Trinity Health's Simple 7-Step Audit Process to Proactively Reduce Their Compliance Risk while Maintaining Maximum Resource Efficiency.

Andrei M. Costantino, MHA, CHC, CFE
Vice President of Integrity & Compliance - Trinity Health

Trinity Health
Livonia, MI

nektar Analytics

STEP 1

Identify Potential Risk Via Benchmarking

Benchmark employed physician data to external data sources to determine if the physician is an outlier compared to their peer group.

The following benchmarks should be considered:

A) E/M Bell Curve Analysis

B) High Risk Modifiers

C) High Dollar (Reimbursed) Surgical and Imaging Services

D) Visits per Day

E) wRVUs Analysis

F) Analysis of Ancillary Services

G) Medicare Reimbursement (CMS Utilization & Payments Database)

To conduct these type of analytics you can either:

1) Create the analysis from scratch leveraging CMS reference data and either excel or an in-house BI Solution

2) Investigate the current reporting capabilities of your EMR or Practice Management Software

3) Utilize a third-party analytics tool that specializes in these type of compliance analytics

Discuss alternate methods of reducing the scope of the audit based on specialty, volume and revenue. For example:

- ***65%-80% of primary care revenue is based on established E/M visits***
- ***Usually a few services account for 70% - 80% of net revenue for specialty practices***
- ***Review highly productive physicians first***

STEP 2

Focus On Your Outliers

Significant outliers from the benchmarking analysis should be considered for audit. (Create guidelines regarding what constitutes a significant outlier).

Goal is to audit services that make up 60% to 80% of net revenue.

STEP 3

Sample Process & Considerations

A) Retrospective claims (prior 3 months)

B) Non-statistical sampling – judgment sample. Sample language – "It is important to note that very small samples generate greater sampling risk (i.e. margin for error), therefore, the results cannot be extended or extrapolated to reach any conclusions regarding the population as a whole." Or, "The sample selection was controlled by the auditor and cannot be measured."

Sample Process & Considerations Continued

C) Population is stratified (stratums) based on benchmarking.

D) Sample size – small samples based on risk. For example, the risk assessment identified 99214 as an outlier. The audit should consist of 3-5 claims for E/M code 99214 to determine if the documentation meets the level billed.

F) Extrapolation – NONE, since the sample size was controlled by the auditor it cannot be measured.

STEP 4

The Analysis of the Sample

Assess the nature of the claims to evaluate the medical records documentation in comparison to the billed claims using the following information:

- Provider progress notes
- CMS 1500 claims data
- The Centers for Medicare and Medicaid Services (CMS) 1995 or 1997 Documentation Guidelines for Evaluation and Management (E/M) services http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
- The 2016 International Classification for Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
- Current Procedural Terminology (CPT)

The Analysis of the Sample Continued

- Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §20, Medicare Physicians Fee Schedule (MPFS) http://www.cms.gov/manuals/downloads/clm104c12.pdf
- Medicare Claims Processing Manual, Pub 100-04, Chapter 12, §30.6.1, Selection of Level of Evaluation and Management Services http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf
- Medicare Claims Processing Manual, Pub 100-04, Chapter 12, § 30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
- AHIMA, Guidelines for EHR Documentation to Prevent Fraud http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp?dDoc Name=bok1_033097
- Medicare Program Integrity Manual, Pub 100-08, Chapter 3, §3.3.2.4, Signature Requirements http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf

Review the following:

A) Provider documentation in comparison to CPT codes, place of service and diagnoses reported for claims submission.

B) The accuracy of diagnoses, submitted on claim forms, in sequencing and specificity as documented in the medical record.

C) The accuracy of place of service codes reported on the claim.

D) The functionality and use of the EMR system in relation to 1) authorship integrity; 2) system audit functionality, and 3) documentation integrity.

Functionality and Use of an EMR, review the following risk areas:

A) **Authorship integrity:** The origin of recorded information that is attributed to a specific individual or entity. When there are multiple authors or contributors to a document, all signatures should be retained so that each individual's contribution is unambiguous identified.

B) **Audit Integrity:** Audit trail functionality allows for determination of who created the document, if and when corrections or amendments were made to the documentation, who made the changes, or the nature of the change. EHRs that lack adequate audit trail functionality create uncertainty as to the integrity of health record documentation.

C) **Documentation integrity:** A provider not fully aware of the consequences of defaulting information or templates and/or cut and copy functions may fail to take the time necessary to review al defaulted data for changes and leave incorrect information in the record. This can lead to an inappropriate clinical picture and the accuracy of the entire documented entry may be questioned.

STEP 5

Error/Accuracy Rate

The determination of a pass/fail error rate threshold should be based on the health systems's own internal policies.

STEP 6

Categorizing Your Findings

A) **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.

B) **Incidental Matters** – Matters noted during the review that do not require a management response.

**- Observations identified are subject to the following Trinity Health internal policy, "Correction of Errors in Federal and State Health Care Program Payments"*

STEP 7

The Audit Cycle

The recommended audit cycle is the following:

- At risk providers every year
- All other providers 3-5 year cycle

For Additional Questions:

Andrei M. Costantino, MHA, CHC, CFE

Vice President of Integrity & Compliance - Trinity Health

costanta@trinity-health.org

Jared Krawczyk

Mathematician (Provider Risk Assessments) - Nektar Analytics

jkrawczyk@nektaranalytics.com

Trinity Health Livonia, MI

nektar Analytics