

# IS YOUR PRACTICE A GOVERNMENT TARGET?

BY

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# WHAT IS AN AUDIT?

An audit is a review of medical claims submitted to a government or private payer.

External audits can be conducted due to:

A random event

A Qui Tam event

Benchmarking event

At times, it may be impossible to determine what triggered an audit, but you must always be prepared



## RECOVERY AUDITS

- Health care fraud is a persistent and costly problem both for commercial and government payors (sic). The Centers for Medicare & Medicaid Services (CMS) estimates that a significant amount of fee-for-service payments are misspent on improper payments every year. To address health care fraud, Congress and CMS have developed a variety of approaches over the past several years to audit Medicare and Medicaid claims. [*CMS.gov*]



## THE COMPLIANCE PLAN

- A document that, when properly designed, lays out the policies and procedures that help to optimize reimbursement while reducing the risk of conflicts and recoupments
- Every practice should have one, and that's according to OIG, not me!
- The benefits [*CMS Self Audit Toolkit*]
  - Reducing and preventing improper payments;
  - Ensuring that claims submitted are true and accurate;
  - Enhancing patient care;
  - Speeding up and optimizing proper claim payment;
  - Minimizing billing mistakes;
  - **Reducing the chances of an external audit;** (emphasis added)

## NEW FRAUD DETECTION TECHNOLOGIES

### Executive Summary

The Fraud Prevention System (FPS) is the state-of-the-art predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA). Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment. For the first time in the history of the program, CMS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis as part of its comprehensive program integrity strategy.

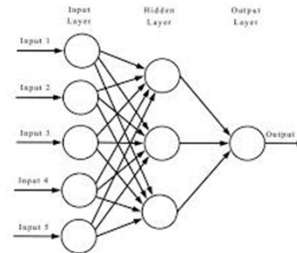
- *CMS REPORT TO CONGRESS; FRAUD PREVENTION SYSTEM  
SECOND IMPLEMENTATION YEAR, JUNE 2014*

### THE FRAUD PREVENTION SYSTEM (FPS)

- “After three years of operations, the Centers for Medicare & Medicaid Services (CMS) today reported that the agency’s advanced analytics system, called the Fraud Prevention System, identified or prevented \$820 million in inappropriate payments in the program’s first three years. The Fraud Prevention System uses predictive analytics to identify troublesome billing patterns and outlier claims for action, similar to systems used by credit card companies.” [*CMS Press Release, July 14, 2015*]
- These are moneys you *didn't* get, not moneys that were recouped after the fact!



## WHAT IS PREDICTIVE ANALYTICS?

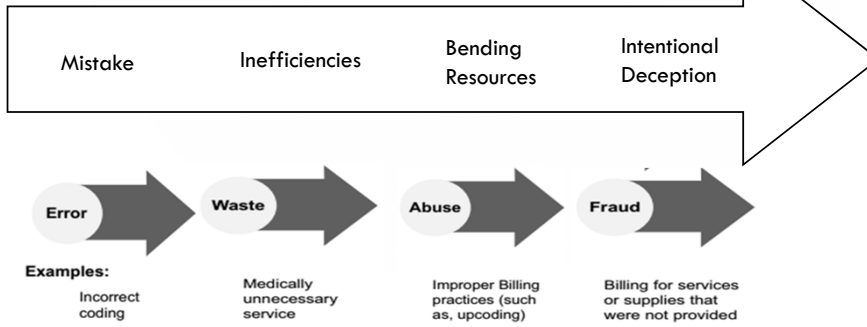


## PREDICTIVE ANALYTICS

- A branch of advanced statistics that uses historical data to make predictions about future events
- For our purposes, it is used by CMS to identify fraud using detection methods such as coding rules, anomaly detection, link analytics, etc.
- Uses specific algorithms to associate scores to likely matches
  - Regression
  - $K_{th}$  nearest neighbor
  - Neural networks
  - Support Vector Machines

# WHAT ARE (ALL)PAYERS LOOKING FOR?

**Program Integrity** encompasses a range of activities to target the various causes of improper payments



The National Health Care Anti-Fraud Association estimates that health care fraud accounts for approximately 3 percent of the nation's \$2.26 trillion in health care spending.

## Government Auditing Entities



- RAC - Recovery Audit Contractor (including Medicaid)
- ZPIC - Zone Program Integrity Contractor
- UPIC - Unified Program Integrity Contractor
- MIC - Medicaid Integrity Contractor
- MAC - Medicare Administrative Carrier
- CERT - Comprehensive Error Rate Testing
- HEAT - Health Care Fraud Prevention and Enforcement Action Team
- PERM - Payment Error Rate Measurement
- PSC - Program Safeguard Contractor (MIP)
- OIG - Office of the Inspector General
- DOJ - Department of Justice

## Private Payer Audits

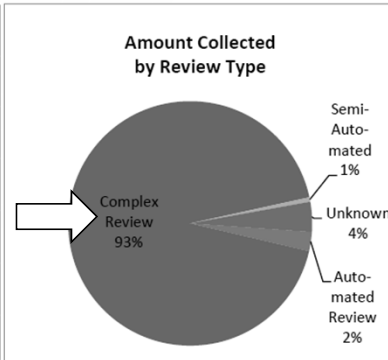
- |   |  |   |   |
|---|--|---|---|
| 1 | Avoid improper payments (over and under payments) and              | 4 | Rules are a bit nebulous (depends on economy) |
| 2 | Recoup what they say are improper payments at a (much) later date. | 5 | There is often no limit on number of records  |
| 3 | Time and Frequency based on contract language                      | 6 | Review criteria most often based on CMS rules |

## The Big Five

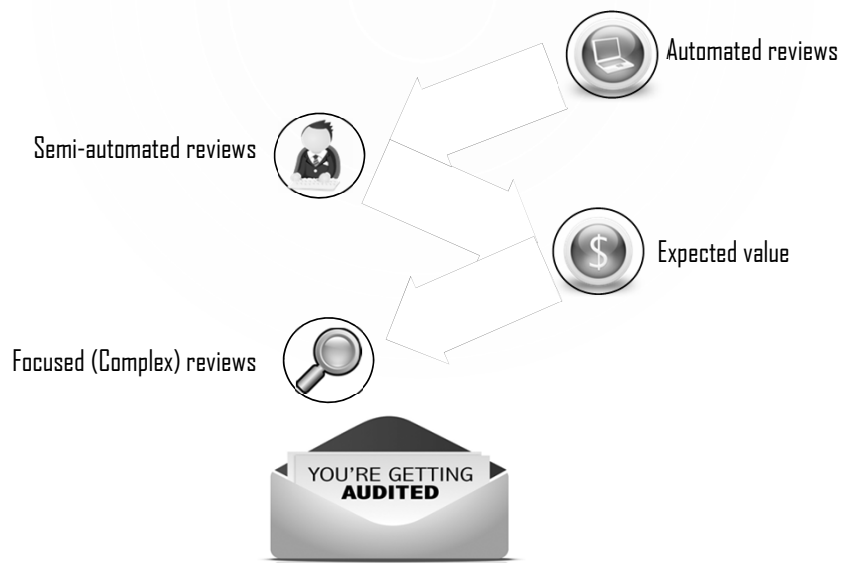
- 1 Evaluation and Management codes
- 2 Procedure code utilization by frequency
- 3 Procedure code utilization by RVU
- 4 Modifier Utilization
- 5 Time

# Audit Results by Review Type

Review Type	Overpayments Collected		Underpayments Restored		Total Corrected	
	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Automated	477,123	\$60,573,148	22,193	\$35,790,603	499,316	\$96,363,752
Complex	506,715	\$2,225,700,473	30,429	\$100,209,498	537,144	\$2,325,909,972
Semi-Automated	29,147	\$14,134,248	44	\$117,112	29,191	\$14,251,360
Unknown <sup>20</sup>	26,312	\$94,438,280	25,094	\$36,979,690	51,406	\$131,417,971
<b>Total</b>	<b>1,039,297</b>	<b>\$2,394,846,149</b>	<b>77,760</b>	<b>\$173,096,903</b>	<b>1,117,057</b>	<b>\$2,567,943,055</b>



# The Auditor's approach



## CONDUCTING A SELF-AUDIT

- CMS AND PRIVATE PAYERS *EXPECT*, AND OFTEN *REQUIRE* THAT YOU CONDUCT YOUR OWN INTERNAL SELF-AUDITS ON A REGULAR BASIS.

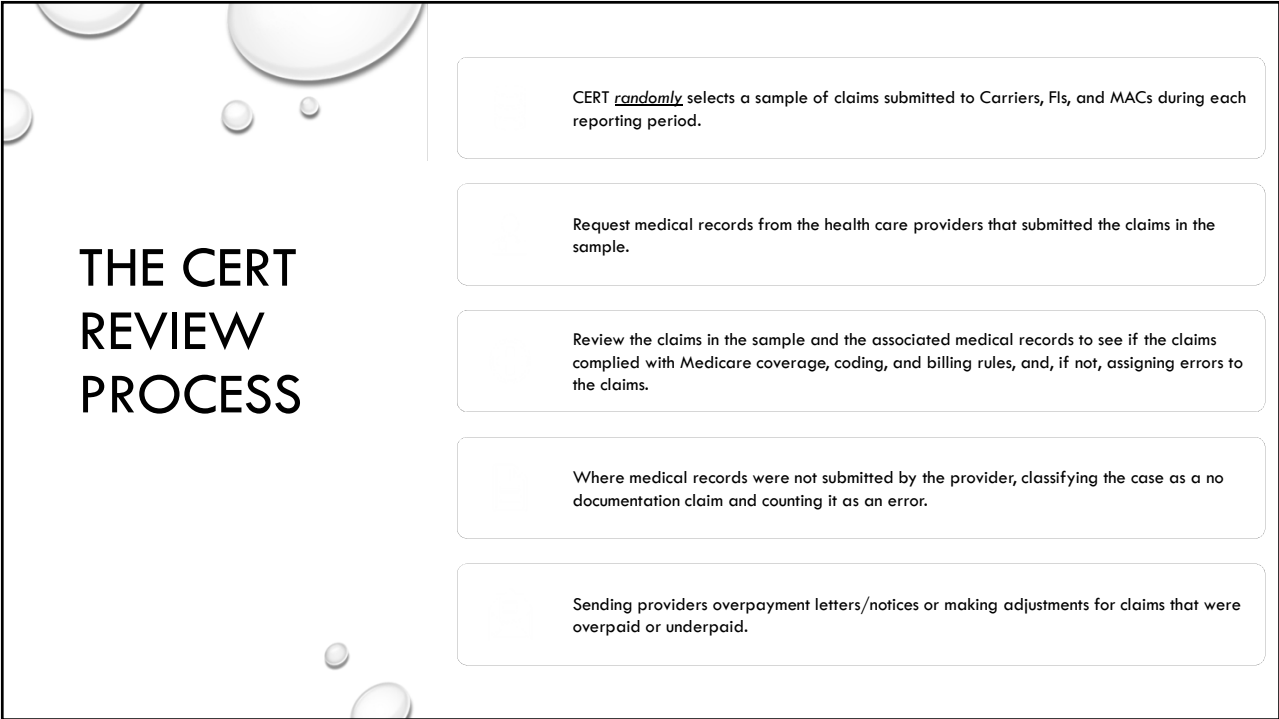
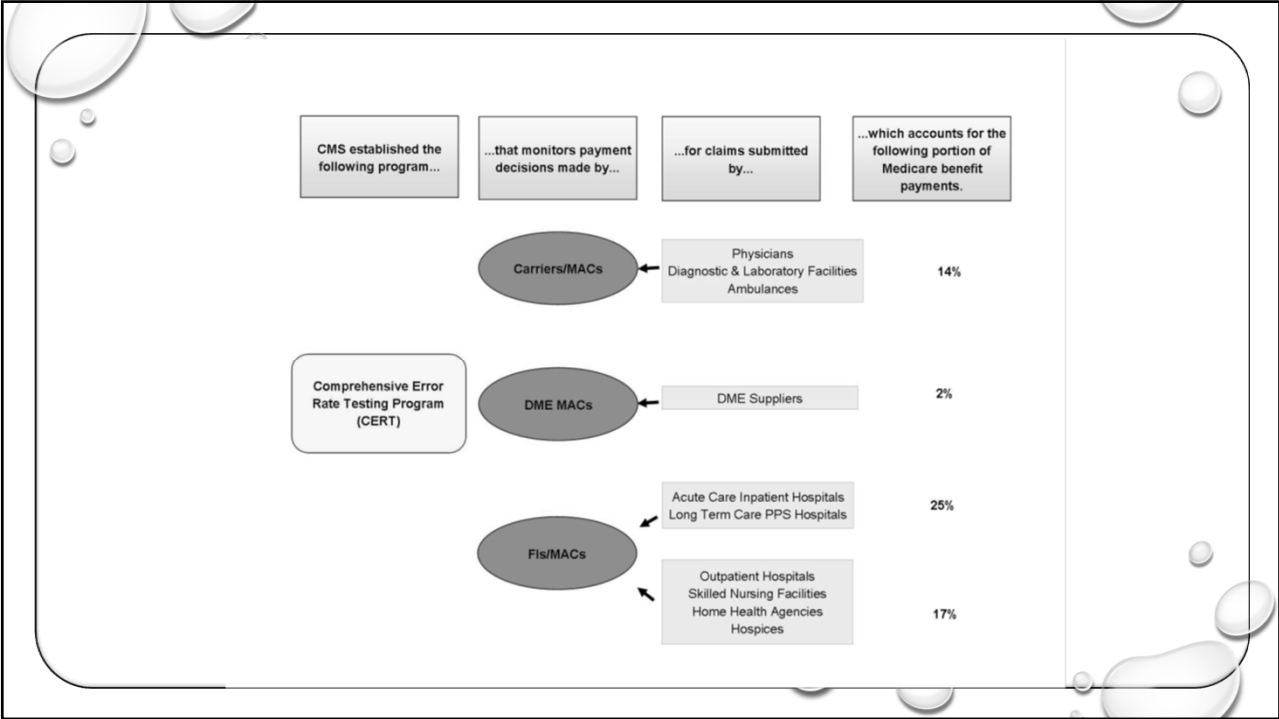
From April 2009 to May 2010, Evaluation and Management (E/M) professional services accounted for an estimated \$28 billion in Part B payments on a national level. Based on the most recent data from the Comprehensive Error Rate Testing (CERT) Program, 8.4% of those E/M payments were identified as being billed at the wrong code level – either too high or too low. Providers are responsible for ensuring that the codes they submit accurately reflect the services they provide.

The billing data in this report is reflective of your practice and can assist you in performing a self-audit in assessing your conformity with Medicare guidelines for rendering evaluation and management services. The report also provides an opportunity for comparing your billing practices to other [REDACTED] billing for these services. We encourage you to conduct an audit on your own claims and refund any overpayments to the appropriate Medicare Administrative Contractor (MAC). To access the contact information for your MAC as well as CMS' other review contractors, please access the Provider Compliance Interactive Map at <http://go.cms.gov/IMap>. Your MAC can explain how to submit a voluntary refund. We hope you find this information helpful and that it will provide insights into your current and future billing practices. Listed below are website references pertinent to this CBR:

## WHAT IS CERT

COMPREHENSIVE ERROR RATE TESTING





# HIGH-LEVEL SUMMARY

Figure 1: Payment Accuracy

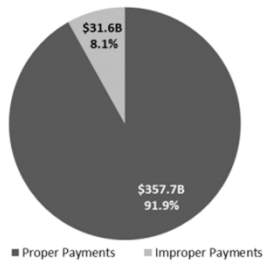
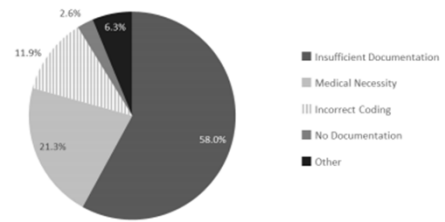


Figure 2: Improper Payment Rate Error Categories by Percentage of 2018 National Improper Payments



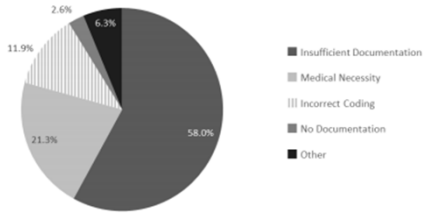
## 2018 IMPROPER PAYMENT RATES AND PROJECTED IMPROPER PAYMENTS BY CLAIM TYPE (DOLLARS IN BILLIONS)

Claim Type	Claims Sampled	Claims Reviewed	Total Payment	Projected Improper Payment	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
<b>Part A (Total)</b>	29,556	21,979	\$284.0	\$18.6	6.5%	6.1% - 7.0%	58.7%
Part A (Excluding Hospital IPPS)	9,768	8,480	\$168.5	\$13.6	8.1%	7.3% - 8.8%	43.0%
Part A (Hospital IPPS)	19,788	13,499	\$115.5	\$5.0	4.3%	3.9% - 4.7%	15.7%
<b>Part B</b>	17,879	17,037	\$98.0	\$10.5	10.7%	9.3% - 12.0%	33.1%
<b>DMEPOS</b>	11,345	10,981	\$7.3	\$2.6	35.5%	33.7% - 37.3%	8.2%
<b>Total</b>	<b>58,780</b>	<b>49,997</b>	<b>\$389.3</b>	<b>\$31.6</b>	<b>8.1%</b>	<b>7.6% - 8.6%</b>	<b>100.0%</b>

Table A1: 2018 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions) (Adjusted for Impact of A/B Rebilling)

# 2018 NATIONAL IMPROPER PAYMENT RATES BY ERROR CATEGORY

## COMMON CAUSES OF IMPROPER PAYMENTS



## COMMON CAUSES OF IMPROPER PAYMENT BY TYPE

Error Category	2017	2018				
	Overall	Overall	Part A Excluding Hospital IPPS	Part A Hospital IPPS	Part B	DMEPOS
No Documentation	0.2%	0.2%	0.1%	0.0%	0.1%	0.0%
Insufficient Documentation	6.1%	4.7%	2.1%	0.3%	1.8%	0.5%
Medical Necessity	1.7%	1.7%	1.0%	0.7%	0.1%	0.0%
Incorrect Coding	1.2%	1.0%	0.1%	0.2%	0.6%	0.0%
Other	0.3%	0.5%	0.2%	0.0%	0.1%	0.1%
<b>Total</b>	<b>9.5%</b>	<b>8.1%</b>	<b>3.5%</b>	<b>1.3%</b>	<b>2.7%</b>	<b>0.7%</b>

## TABLE L1: SERVICE-SPECIFIC OVERPAYMENT RATES

Part B Services (HCPCS Codes)	Claims Reviewed	Lines Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	4,634	8,307	\$110,885	\$1,016,059	\$3,603,631,278	8.7%	5.9% - 11.7%
Initial hospital care (99223)	686	687	\$35,232	\$127,886	\$456,023,354	27.2%	24.8% - 29.6%
Subsequent hospital care (99233)	672	988	\$19,154	\$97,952	\$364,115,497	19.0%	16.8% - 21.4%
Office/outpatient visit est (99214)	512	514	\$2,365	\$50,209	\$356,102,902	4.4%	3.4% - 6.3%
Therapeutic exercises (97110)	371	395	\$3,960	\$18,459	\$244,967,061	21.0%	16.5% - 26.3%
Emergency dept visit (99285)	299	299	\$6,585	\$47,548	\$219,283,364	14.0%	12.0% - 16.3%
Chiropract manj 3-4 regions (98941)	245	331	\$5,129	\$11,193	\$202,601,504	46.0%	37.9% - 54.1%
Subsequent hospital care (99232)	568	998	\$5,687	\$65,984	\$201,046,796	7.9%	5.2% - 10.6%
BLS (A0428)	273	285	\$11,545	\$53,601	\$193,759,971	21.5%	16.0% - 26.9%
Critical care first hour (99291)	302	361	\$12,929	\$72,776	\$183,468,482	19.0%	14.5% - 23.6%
Office/outpatient visit new (99204)	225	225	\$4,740	\$31,924	\$179,902,093	15.0%	11.9% - 18.2%
Drug test def 22+ classes (G0483)	382	382	\$57,304	\$72,185	\$169,605,093	71.7%	58.7% - 84.7%
Office/outpatient visit est (99213)	550	551	\$1,170	\$36,116	\$152,535,443	2.9%	5.0% - 8.5%
BLS-emergency (A0429)	180	180	\$6,513	\$53,618	\$150,581,127	18.7%	9.6% - 27.9%
Office/outpatient visit est (99215)	174	181	\$2,863	\$21,769	\$133,110,410	13.0%	10.2% - 15.9%

**TABLE M1: SERVICE-SPECIFIC UNDERPAYMENT RATES**

Part B Services (BETOS Codes)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
Office/outpatient visit est (99213)	550	551	\$1,352	\$36,116	\$202,061,624	3.8%	5.0% - 8.5%
Office/outpatient visit est (99212)	134	134	\$1,117	\$4,701	\$87,837,376	22.2%	20.6% - 40.5%
Subsequent hospital care (99231)	140	226	\$1,334	\$7,694	\$45,562,985	18.3%	13.9% - 29.3%
All Codes With Less Than 30 Claims	4,634	8,307	\$637	\$1,016,059	\$41,543,029	0.1%	5.9% - 11.7%
Office/outpatient visit est (99214)	512	514	\$214	\$50,209	\$33,368,468	0.4%	3.4% - 6.3%
Initial hospital care (99222)	226	226	\$411	\$27,783	\$10,057,971	1.4%	14.5% - 22.9%
Emergency dept visit (99283)	35	35	\$116	\$1,696	\$8,132,555	6.3%	(1.2%) - 16.5%
Nursing fac care subseq (99308)	105	118	\$86	\$6,543	\$6,536,496	1.3%	3.1% - 13.8%
Ranibizumab injection (J2778)	102	106	\$1,521	\$193,918	\$5,853,974	0.8%	(0.7%) - 4.4%
Unlisted molecular pathology (81479)	295	484	\$2,184	\$206,887	\$5,519,149	5.5%	17.9% - 52.5%
Nursing fac care subseq (99307)	32	36	\$79	\$1,305	\$5,036,623	4.4%	3.8% - 26.8%
Office/outpatient visit new (99203)	132	132	\$217	\$11,869	\$4,855,265	0.5%	4.6% - 12.4%
Therapeutic exercises (97110)	371	395	\$64	\$18,459	\$4,606,837	0.4%	16.5% - 26.3%

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES ★ OFFICE OF INSPECTOR GENERAL

**OIG  
Work Plan  
2019**



## FROM THE 2019 OIG WORK PLAN

- PHYSICIANS BILLING FOR CRITICAL CARE EVALUATION AND MANAGEMENT SERVICES
- REVIEW OF POST-OPERATIVE SERVICES PROVIDED IN THE GLOBAL SURGERY PERIOD
- MEDICARE PART B PAYMENTS FOR END-STAGE RENAL DISEASE DIALYSIS SERVICES
- ACO'S STRATEGIES AIMED AT REDUCING SPENDING AND IMPROVING QUALITY
- MEDICARE PAYMENTS MADE OUTSIDE OF THE HOSPICE BENEFIT
- QUESTIONABLE BILLING FOR OFF-THE-SHELF ORTHOTIC DEVICES
- MEDICARE PART B PAYMENTS FOR PSYCHOTHERAPY SERVICES
- PHYSICIAN-ADMINISTERED DRUGS FOR DUAL ELIGIBLE ENROLLEES
- PROLONGED SERVICES - REASONABLENESS OF SERVICES

## AUDITORS LOOK AT MORE THAN JUST E&M

### Modifier 25

AdvanceMed opened an investigation on [REDACTED] on [REDACTED] 2013 based on data analysis that indicated Modifier 25 is routinely billed with CPT Code 96413 Chemotherapy Administration. This pattern of billing can be indicative that the provider is inappropriately appending modifier 25 to claims when a separately identifiable service was not actually performed. A review of the Medicare billing for year of service 2012 by [REDACTED] indicated that [REDACTED] providers billing under this group billed an Evaluation & Management (E&M) service on the same date of service as 96413 on an average of 76.7% of submitted claims. [REDACTED]

### Time

On [REDACTED], AdvanceMed opened an investigation based on data analysis which identified the provider as ranking in the top ten billers of E & M procedure codes in [REDACTED]. The provider's daily billing time per filed E & M claims from 2006 to 2009 was 13.5 hours. AdvanceMed conducted data analysis in June 2011 and found this provider was ranked # [REDACTED] in the State of [REDACTED] and ranked # [REDACTED] as the top biller of E & M procedure codes in 2009 through 2010. Data analysis also revealed this provider billed for services totaling over 15 hours per day. The table illustrates the number of hours per day and the percentages.

## THE AUDIT PLAN

- Ultimately, the goal of any compliance plan is the creation of the audit plan
- The audit plan is a concise document or worksheet that details, at the service level, those procedures codes and modifiers subject to an internal review
- CMS and private payers expect that you are going to self-monitor your coding and billing and report when you have found an error
- Without the audit plan, the compliance plan is nothing more than a policy and procedural binder stuck on a shelf somewhere

## TRADITIONAL APPROACHES



- Probe Audits (unstable, unpredictable, very poor ROI)
- Compare rank positions (inadequate without variance)
- Establish variance (inadequate without frequency)
- Factoring frequency by variance (huge scalar differences)
- CMS has made it clear that practices need to do more to identify aberrant coding behavior



# THE PRE-AUDIT ANALYSIS

## QUANTITATIVE METHODS

### TOP 25 FREQUENCY COMPARISON

CPT Code	Description	Total RVUs	National		Provider_1		Count	Variance
			Rank	Percent	Rank	Percent		
99213	Office/outpatient visit est	2.07	1	13.42%	1	16.06%	439	19.67%
99232	Subsequent hospital care	2.05	2	11.13%	24	0.59%	16	(94.70%)
99214	Office/outpatient visit est	3.06	3	9.94%	5	7.28%	199	(26.76%)
43239	Upper gi endoscopy biopsy	10.33	4	8.47%	3	7.76%	212	(8.38%)
45380	Colonoscopy and biopsy	14.12	5	4.58%	6	6.00%	164	31.00%
99231	Subsequent hospital care	1.12	6	4.38%				
99204	Office/outpatient visit new	4.72	7	3.95%	31	0.37%	10	(90.63%)
99222	Initial hospital care	3.91	8	3.64%				
45378	Diagnostic colonoscopy	11.83	9	3.57%	4	7.32%	200	105.04%
45385	Lesion removal colonoscopy	15.89	10	3.10%	10	3.95%	108	27.42%
99203	Office/outpatient visit new	3.09	11	2.89%	35	0.29%	8	(89.97%)
99223	Initial hospital care	5.74	12	2.82%				
99233	Subsequent hospital care	2.94	13	2.64%				
43235	Uppr gi endoscopy diagnosis	8.95	14	2.27%	7	5.71%	156	151.54%
88305	Tissue exam by pathologist	3.11	15	2.06%				
99212	Office/outpatient visit est	1.25	16	2.05%	37	0.29%	8	(85.85%)
99215	Office/outpatient visit est	4.11	17	1.30%	42	0.22%	6	(83.08%)
G0105	Colorectal scrm; hi risk ind	11.83	18	1.22%	16	0.95%	26	(22.13%)
G0121	Colon ca scrm not hi risk ind	11.83	19	1.09%	17	0.95%	26	(12.84%)
99221	Initial hospital care	2.89	20	1.01%				
99205	Office/outpatient visit new	5.86	21	0.73%				
45384	Lesion remove colonoscopy	14.01	22	0.71%	11	3.62%	99	409.86%
43248	Uppr gi endoscopy/guide wire	5.63	23	0.65%	50	0.15%	4	(76.92%)
43246	Place gastrostomy tube	7.52	24	0.58%	33	0.29%	8	(50.00%)
43249	Esoph endoscopy dilation	5.19	25	0.55%	18	0.77%	21	40.00%

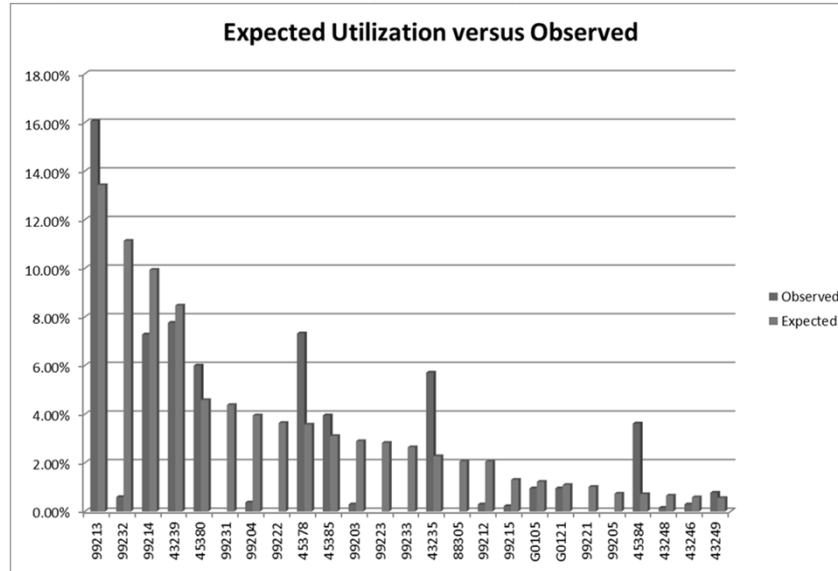
439 \* .1967 = 86

200 \* 1.0504 = 210

156 \* 1.5154 = 236

99 \* 4.0986 = 406

## EXPECTED V. OBSERVED ANALYSIS



## TOP 25 RVU COMPARISON

CPT Code	Description	Total RVUs	National		Provider_1		Variance
			Rank	Percent	Rank	Percent	
43239	Upper gi endoscopy biopsy	10.33	1	14.66%	3	10.38%	1,982.28 (29.20%)
45380	Colonoscopy and biopsy	14.12	2	11.81%	2	11.60%	2,216.46 (1.78%)
45385	Lesion removal colonoscopy	15.89	3	9.02%	4	8.98%	1,716.12 (0.44%)
45378	Diagnostic colonoscopy	11.83	4	7.54%	1	12.20%	2,331.79 61.80%
99214	Office/outpatient visit est	3.06	5	5.59%	11	3.19%	608.94 (42.93%)
99213	Office/outpatient visit est	2.07	6	5.10%	8	4.76%	908.73 (6.67%)
99232	Subsequent hospital care	2.05	7	4.19%	43	0.17%	32.80 (95.94%)
43235	Uppr gi endoscopy diagnosis	8.95	8	3.50%	5	6.81%	1,300.26 94.57%
99204	Office/outpatient visit new	4.72	9	3.42%	35	0.25%	47.20 (92.69%)
99223	Initial hospital care	5.74	10	2.97%			
G0105	Colorectal scrn; hi risk ind	11.83	11	2.63%	15	1.61%	307.58 (38.78%)
99222	Initial hospital care	3.91	12	2.62%			
G0121	Colon ca scrn not hi rsk ind	11.83	13	2.32%	16	1.57%	299.95 (32.33%)
45384	Lesion remove colonoscopy	14.01	14	1.81%	6	6.41%	1,223.78 254.14%
99203	Office/outpatient visit new	3.09	15	1.64%	46	0.13%	24.72 (92.07%)
99233	Subsequent hospital care	2.94	16	1.42%			
91110	Gi tract capsule endoscopy	27.62	17	1.33%	9	4.12%	786.38 209.77%
99215	Office/outpatient visit est	4.11	18	0.98%	47	0.13%	24.66 (86.73%)
99231	Subsequent hospital care	1.12	19	0.90%			
43264	Endo cholangiopancreatograph	15.31	20	0.83%	17	1.52%	290.89 83.13%
43262	Endo cholangiopancreatograph	12.76	21	0.80%	14	1.69%	323.07 111.25%
88305	Tissue exam by pathologist	3.11	22	0.79%			
43246	Place gastrostomy tube	7.52	23	0.79%	30	0.31%	60.16 (60.76%)
99205	Office/outpatient visit new	5.86	24	0.79%			
45383	Lesion removal colonoscopy	17.01	25	0.77%	34	0.27%	51.03 (64.94%)



## MODIFIER UTILIZATION - SUMMARY

Provider_3	Modifier Utilization Analysis			
Modifier	National Utilization	Provider Count	Provider Utilization	Variance
22	0.14%	0	0.00%	(100.00%)
24!	2.59%	1	0.05%	(98.07%)
25!	3.93%	1,831	84.65%	2053.94%
26	34.10%	8	1.55%	(95.45%)
50!	0.18%	185	8.25%	4483.33%
51!	3.32%	468	20.87%	528.61%
52	0.03%	7	0.31%	933.33%
53	0.03%	0	0.00%	(100.00%)
57	1.86%	5	0.23%	(87.63%)
58!	0.89%	208	9.28%	942.70%
59!	3.17%	85	3.79%	19.56%
62!	0.11%	0	0.00%	(100.00%)
76!	0.12%	2	0.09%	(25.00%)
78!	0.46%	47	2.10%	356.52%
79	0.89%	12	0.54%	(39.33%)
80!	0.00%	1	0.04%	0.00%

$$1,831 * 20.5394 = 37,608$$

$$185 * 44.8333 = 8,294$$

$$468 * 5.2861 = 2,474$$

$$208 * 9.4270 = 1,961$$

## ASSESSED TIME ANALYSIS

- HARVARD/RUC TIME ASSESSMENTS ARE ASSIGNED TO EACH CODE IN ORDER TO ASSESS BELIEVABILITY OF REPORTED PROVIDER WORK LOAD IS HOURS
- VISIBLE RISK IS BASED ON OIG STANDARD OF 2.5 TIMES FMV
  - 5,000 HOURS
- LATENT RISK IS A FACTOR OF FTE RATIO AND OBSERVED TIME
  - ESTABLISHES WHAT TIME WOULD LOOK LIKE IF

## EXAMPLE TIME COMPARISON

Provider Name	Provider ID	Specialty	E/M Time	Non-E/M Time	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time	FTE-Factored Time
Provider 1	1	OS	584	2,433	421	1,127	298	3,017	3,079
Provider 10	10	OS	1,088	3,259	613	1,686	535	4,348	4,437
Provider 11	11	FP	9	7	1	9	2	17	87
Provider 12	12	FP	735	171	11	591	161	906	2,311
Provider 13	13	PO	867	2,786	582	1,472	541	3,653	3,728
Provider 14	14	OS	1,048	4,521	978	1,952	704	5,569	5,683
Provider 15	15	PH	570	2,129	551	1,470	585	2,699	2,754
Provider 16	16	RH	2,170	1,484	184	2,404	677	3,654	3,729
Provider 17	17	RH	1,878	1,341	201	2,101	601	3,219	3,285
Provider 18	18	OS	986	3,514	810	1,641	608	4,501	4,593
Provider 19	19	OS	338	3,601	743	1,213	393	3,939	4,019

## E/M INTRA-CATEGORY CALCULATIONS

Table 1 - New Office Visits

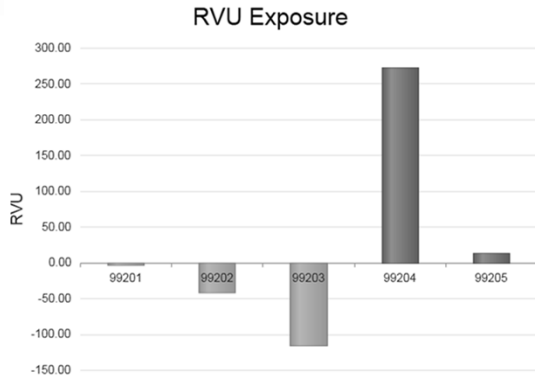
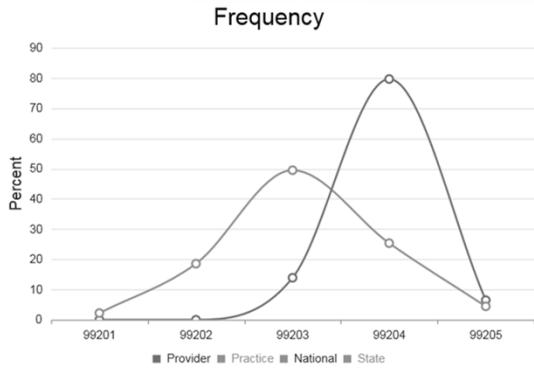
Code	Current Frequency	Current RVU	Current Total RVUs	Current Practice Dist. %	National Dist. %	Variance Practice v. Control	Redistributed Frequency	RedistRVUs	RVU Differential
99201	2	1.25	2.50	0.88%	0.71%	24.95%	2	2.00	0.50
99202	3	2.13	6.39	1.32%	5.63%	-76.51%	13	27.21	(20.82)
99203	13	3.09	40.17	5.73%	28.49%	-79.90%	65	199.83	(159.66)
99204	147	4.72	693.84	64.76%	44.42%	45.78%	101	475.96	217.88
99205	62	5.86	363.32	27.31%	20.76%	31.58%	47	276.12	87.20
<b>Totals</b>	<b>227</b>		<b>1,106.22</b>	<b>100.00%</b>			<b>227</b>	<b>981.11</b>	<b>125.11</b>

New Office Visits

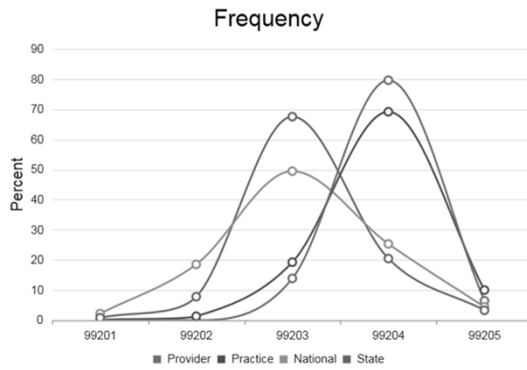
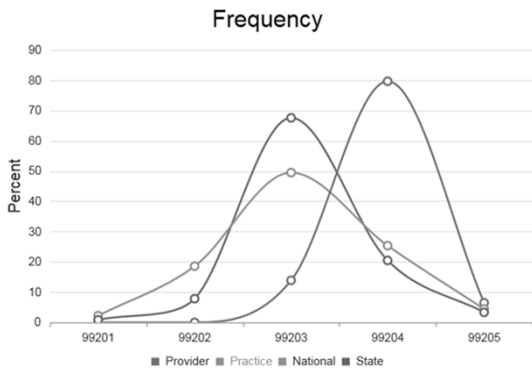
Code	Current Annual Frequency	Current / calculated Fee	Current Gross Charges	Current Practice Dist. %	National Dist. %	Variance Practice v. National	ReDist Annual Frequency	Redist Gross Charges	Charge Differential
99201	5	55	\$275	0.43%	2.07%	-79.25%	24	\$1,325	\$1,050
99202	64	99	\$6,336	5.49%	10.84%	-49.35%	126	\$12,510	\$6,174
99203	702	148	\$103,896	60.21%	30.08%	100.15%	351	\$51,910	(\$51,986)
99204	348	211	\$73,428	29.85%	34.78%	-14.18%	406	\$85,563	\$12,135
99205	47	269	\$12,643	4.03%	22.24%	-81.87%	259	\$69,749	\$57,106
<b>Totals</b>	<b>1,166</b>		<b>\$196,578</b>	<b>100.00%</b>	<b>100.00%</b>		<b>1,166</b>	<b>\$221,057</b>	<b>\$24,479</b>

1. Record frequency and current RVU (\$) value
2. Multiply to calculated total RVUs (\$)
3. Create frequency distribution calculation
4. Compare to national distribution
5. Calculate difference (variance)
6. Redistribute the frequency
7. Calculate differences
8. Positive tends towards under-utilization comparison while negative trends towards over-utilization comparison

# CONTROL ANALYSIS AND RVU EXPOSURE

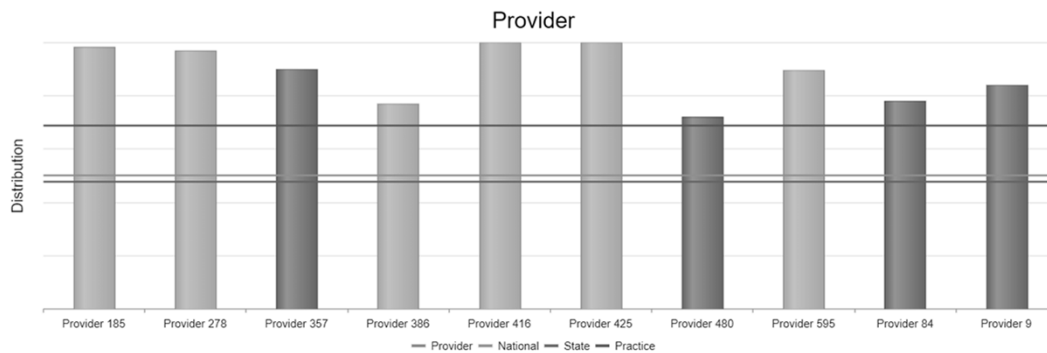


# SIMULTANEOUS ANALYSIS OF UTILIZATION



## COMPARISON ACROSS SIMILAR PROVIDERS

New Office Visits



## WHAT CAN WE EXPECT IN THE NEAR FUTURE?

- More aggressive audits using extrapolation
- Forensic auditing techniques
- Private payers adopting more advanced target acquisition systems
- More scrutiny on CDI engagements (e.g. Providence Whistleblower Case)
- More funding for compliance audits and investigations
- Recommended burden reduction strategies will not affect audit progress

# QUESTIONS?

(NOW IS YOUR CHANCE!)

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