CBIZ
KA Consulting
Services, LLC

Identifying Outliers to Improve Physician Billing and Coding

HIGHLIGHTS

- Comparing hospital baseline metrics to national standards can identify coding irregularities and outliers.
- Face-to-face interviews can uncover the problematic practices and processes that need to be addressed.
- Physician coding accuracy improved from 58% to 91% after physician education and hospital process enhancements.

The Steps

As part of its ongoing compliance review, a New Jersey acute care hospital engaged CBIZ KA Consulting Services, LLC (CBIZ) to evaluate the billing and coding of their oncologists.

The hospital's compliance department was concerned that its existing oncology coding and billing exposed the facility to compliance risk. The hospital engaged CBIZ to provide an independent, third-party assessment of their oncologists' Evaluation and Management (E&M) coding, which would include data analytics.

If any irregularities were identified in respect to E&M coding, CBIZ would inform the hospital and the two parties would work together to help craft an educational program.

The engagement consisted of the following steps:

PART I
Data Analytics

- Using data analytics, establish a baseline E&M assessment for each physician
- Compare the baseline metrics of all the oncologists at the hospital
- Determine if there were any outliers within the specialty by using national standards

PART II
Clinical Reviews

- If an outlier was identified in Part I, perform a clinical review of that specific physician's E&M coding
- Determine if the physician's E&M coding and billing present compliance risks for the hospital

PART III
Education, Process Improvement and Monitoring

- Work with the hospital to help develop and administer an education plan
- Monitor progress of the physician

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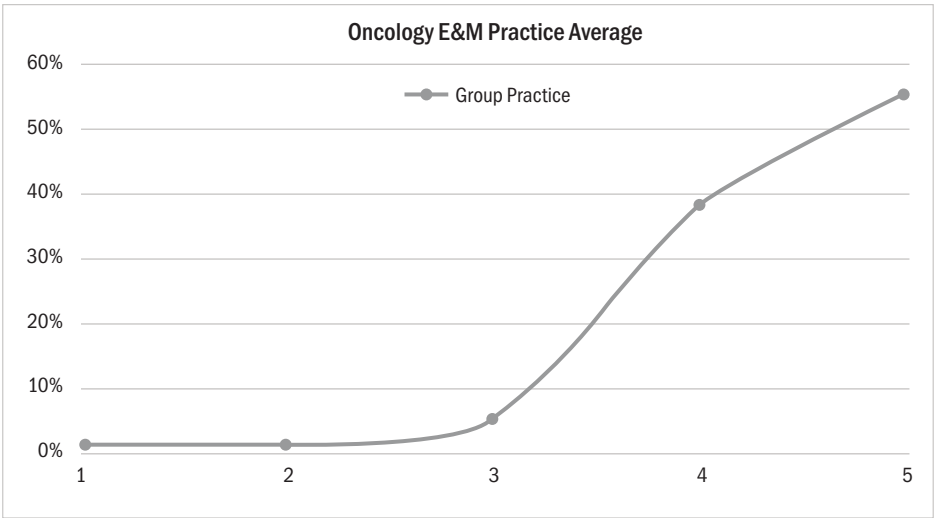
PART I – Data Analytics

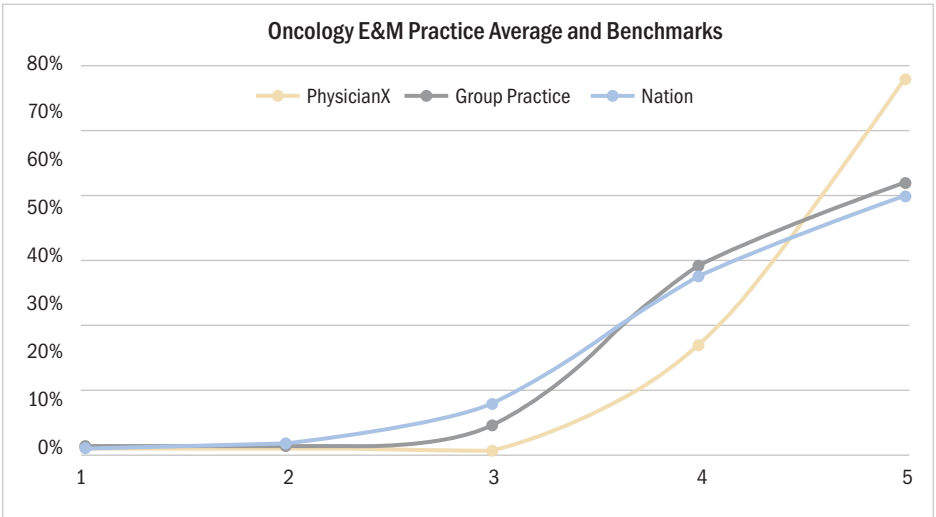
EXHIBIT 1

CBIZ received a 12-month sample of data from the hospital. Analyzing the data, CBIZ created an E&M distribution for the physicians over the 12-month period.



CBIZ then compared these findings to national standards. The comparison highlighted a specific physician who coded significantly more Level 4 (cases coded as 99214) and Level 5 (cases coded as 99215 or 99245) than the other physicians within his specialty [Exhibit 2]. The physician also appeared to be an outlier when compared to the national standard.

EXHIBIT 2



After conferring with the hospital, both parties agreed that a clinical chart review was needed to gain more understanding about the physician's coding and billing practices, with a specific emphasis on cases billed at Level 4 or Level 5.

PART II – Clinical Reviews

CBIZ conducted its initial chart review, selecting 24 cases from patient visits from 2/12/18 through 2/15/18. All 24 of the cases were coded as Level 4 or Level 5. CBIZ's proprietary data analytics assisted with the case selection. Of the 24 accounts reviewed, CBIZ agreed with the physician's coding for 16 of them (66.7%); however, it disagreed with eight of them (33.3%) [Exhibit 3].

EXHIBIT 3

SUMMARY OF FIRST E&M REVIEW		
Period: 2/12/18 to 2/15/18		
	Cases	%
TOTAL NUMBER OF LEVEL 4/5 CASES REVIEWED	24	
Number of cases where CBIZ agreed	16	67%
Number of cases where CBIZ DID NOT agree	8	33%

In all eight of the cases where CBIZ disagreed with the physician's coding, CBIZ's coders advocated that a lower coding level should have been assigned based on the information in the chart. Of the eight cases where CBIZ disagreed with the physician's assessment, six of them were Level 5 cases that we believed should have been coded as a Level 4 and two were Level 4 cases that should have been coded as a Level 3.

We presented our findings to the client and they decided to expand the sample size before undertaking provider education. The hospital engaged CBIZ to review additional charts.

CBIZ's second case review consisted of 24 Level 3, Level 4 or Level 5 cases from patient visits from 2/26/18 through 3/3/18. After reviewing the charts, CBIZ agreed with the findings for only 12 of the 24 cases (50%) [Exhibit 4]. In the 12 cases where CBIZ disagreed with the physician's coding, eight Level 5 cases should have been coded as Level 4 cases and four Level 4 cases should have been coded as Level 3 cases.

EXHIBIT 4

SUMMARY OF SECOND E&M REVIEW		
Period: 2/26/18 to 3/3/18		
	Cases	%
TOTAL NUMBER OF LEVEL 3/4/5 CASES REVIEWED	24	
Number of cases where CBIZ agreed	12	50%
Number of cases where CBIZ DID NOT agree	12	50%

PART II – Clinical Reviews (cont.)

CBIZ then combined the results of its two reviews into one deliverable for the client. In total, of the 48 cases in our review sample, CBIZ agreed with the coding for 28 of them (58.3%) and disagreed with the coding for 20 cases (41.7%). CBIZ found 14 Level 5 cases that should have been coded as Level 4 cases and six Level 4 cases that should have been coded as Level 3 cases.

Following the presentation of our findings, the hospital determined that an extensive root cause analysis of the billing and coding issues should be undertaken. For this part of the engagement, CBIZ utilized its E&M coding director and an executive director in charge of clinical services to craft an education plan, with additional input from our client.

CBIZ conducted two face-to-face interviews with the physician, reviewing each case that featured a difference of opinion in coding levels. From the results of our interviews, CBIZ was able to identify a number of problematic practices and processes with the physician and the hospital's electronic medical record (EMR) that were leading to the inaccurate coding.

Major Findings

- *There was a lengthy delay from when the physician saw patients until the visit documentation was entered into the EMR. This situation led to incomplete physician notes in the EMR and a delay in generating a bill. Often times the physician would not enter cases into the EMR until notified by hospital staff. Consequently, the physician hastily entered notes and codes so that the delay would cease.*
- *The hospital had recently upgraded its physician billing system. Initially, default settings were set up that led to simple cutting-and-pasting of records for each subsequent visit from the same patient. In the rush to code records, the physician cut-and-pasted certain notes from previous office visits, generating codes at higher levels than cases necessitated.*
- *Compared to the general population, cancer patients often require higher levels of utilization when receiving medical treatment. However, not every routine follow-up visit from these patients necessitates a Level 4 or Level 5 code. Even when follow-up visits from these patients are routine and require no acute level of services or utilization for a particular visit, the physician would still code many of these cases as a Level 4 or Level 5 when a lower level would have been more appropriate.*

PART III – Education, Process Improvement and Monitoring

CBIZ presented its findings to the client and the following action steps were taken.

- Agreeing with the results of CBIZ's clinical reviews, the hospital rebilled the cases where a lower level E&M code was appropriate.
- An education session was conducted with the physician that included CBIZ and hospital staff. This education included a refresher on the differences between Levels 3, 4 and 5, and what constituted a "routine follow-up visit."
- As part of this education session, the hospital reiterated its recommended guidelines regarding the need to code cases contemporaneously. The hospital also offered additional assistance to ensure that the physician's cases and codes were billed in a more timely manner.
- Based on CBIZ's recommendations, the hospital changed a number of the screens in its EMR system where the physicians document, ultimately leading to a more deliberate process for cutting-and-pasting.
- The hospital recommended that CBIZ conduct a third clinical chart review to see if the education process was successful.

CBIZ performed its third chart review of the physician for patient visits from 5/28/18 through 5/31/2018. CBIZ selected 22 Level 3, Level 4 or Level 5 cases. Once again, data analytics were used as part of the case selection. Of the 22 cases, CBIZ agreed with the coding in 20 of the cases (90.9%). In the two cases where CBIZ disagreed with the physician, CBIZ determined that Level 5 cases should have been coded as Level 4 [Exhibit 5].

EXHIBIT 5

SUMMARY OF THIRD E&M REVIEW		
Period: 5/28/18 to 5/31/18		
	Cases	%
TOTAL NUMBER OF LEVEL 3/4/5 CASES REVIEWED	22	
Number of cases where CBIZ agreed	20	91%
Number of cases where CBIZ DID NOT agree	2	9%

PART III – Education, Process Improvement and Monitoring (cont.)

For the two reviews conducted before the education session and process improvements by the hospital, CBIZ agreed with the physician in 28/48 cases (58.3%). After the physician education and process improvement implementation by the hospital, CBIZ agreed with 20/22 cases reviewed (90.9%) [Exhibit 6].

EXHIBIT 6

REVIEW SUMMARY		
Before Education Session/Process Improvements		
	Cases	%
TOTAL NUMBER OF LEVEL 3/4/5 CASES REVIEWED	48	
Number of cases where CBIZ agreed	28	58%
Number of cases where CBIZ DID NOT agree	20	42%
After Education Session/Process Improvements		
	Cases	%
TOTAL NUMBER OF LEVEL 3/4/5 CASES REVIEWED	22	
Number of cases where CBIZ agreed	20	91%
Number of cases where CBIZ DID NOT agree	2	9%

CBIZ presented the findings of its third review to the client. The hospital was satisfied with the coding improvement demonstrated by the physician. In addition, the hospital noted that there no longer were coding and billing delays for the physician. Also, they indicated that they were satisfied with the changes made to the EMR, believing that the changes significantly reduced the prospect of future compliance risks and external audits. The hospital also wanted CBIZ to review the physician again in 2019 to ensure that the educational gains continued to hold up over time.

Summary

As part of its ongoing compliance review, a hospital engaged CBIZ to provide a third-party evaluation of oncology coding and billing. The client wanted to know if its oncologists were exposing the hospital to compliance risk.

Through an evaluation of 12 months of data, CBIZ was able to create a distribution of the Oncology Department's E&M coding. CBIZ then compared that distribution to national standards. Through its data analysis, CBIZ determined that a specific physician appeared to be an outlier.

The hospital then engaged CBIZ to perform a clinical chart review. CBIZ performed two chart reviews consisting of 48 total accounts. CBIZ's proprietary data analytics assisted with the case selection. The physician only had a 58.3% coding accuracy rate.

CBIZ uncovered a number of areas of concern during its follow-up interviews with the physician. The physician used full-scale cut-and-pasting of patient records; the hospital's EMR had several default settings and screens that enabled physicians to cut-and-paste with ease. The physician also did not code cases contemporaneously. Relatedly, the physician had significant coding and billing delays.

When prompted by the hospital regarding the delays, the physician entered patient notes in a rushed or haphazard fashion. Finally, the physician needed additional education regarding what constituted a "routine office visit."

CBIZ and the hospital crafted an education session. The hospital reiterated its policies and procedures regarding the timeliness of coding and billing. In addition, the hospital made several adjustments to its default EMR screens for physician coding. Also, significant education was given regarding the differences between E&M coding levels 3, 4 and 5, and what constituted a routine office visit.

After the education session was given and the hospital had implemented its process changes, CBIZ performed a third review of the physician. The physician had a 91% accuracy rate (20 out of 22 cases). The hospital also reported that the delays for the physician's coding and billing had ceased. The hospital was pleased with the physician's progress and wanted CBIZ to perform a follow up review during the next calendar year.