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Building a Risk-Based Audit Plan

Bring Your Coding Compliance Into the New Era

By **Frank Cohen**

Building a Risk-Based Audit Plan

At times, being a healthcare provider feels unrewarding and to some extent, burdensome. It is increasingly difficult for hard-working providers to keep the money they earn. For healthcare payers, the primary motivator does not appear to be ensuring the best possible care for their covered patients, but is instead the prevention of improper payments, as shown by their zealous reviews of payments made to nearly every provider both in and out of their networks.

In 2011, a seismic shift in CMS' approach to reduce fraud, waste and abuse began with the introduction of the Fraud Prevention System, or FPS. CMS' Center for Program Integrity has achieved overwhelming success, reporting that prevention of improper payments represented some **70%** of savings year over year.

What is the Fraud Prevention System? It is a predictive analytical model that relies on advanced statistics and specialized algorithms to detect whether a claim should be paid and if it has, whether it should have been paid. According to the CMS, the 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."

The FPS represents a new chapter in CMS' endeavors to fight healthcare fraud and abuse. In its 2012 Report to Congress, CMS stated that they "designed and implemented large-scale innovative improvements to the Medicare and Medicaid program integrity strategy to shift beyond a "pay-and-chase" approach to a more effective strategy that identifies fraud before payments are made." In fact, according to a July 14, 2015 press release from CMS, "After three years of operations … the agency's advanced analytics system, called the Fraud Prevention System, identified or prevented $820 million in inappropriate payments."

And that doesn't even include the billions of dollars in recoupments generated as a result of exception reports generated by the FPS that are made available to the myriad of government-contracted auditors. Some audits now contain annotations where the contractor specifically states that "the provider was identified based on an Alert Summary Report from the Fraud Prevention System, which uses sophisticated algorithms and models to identify suspicious behavior."

And so begins the era of **risk-based auditing** (RBA). In healthcare, RBA can be defined as a method of identifying those claims that would most likely be billed in error and/or subject to an external government or private payer audit. RBA might even be referred to as a "target acquisition system" with the express goal of performing an a priori audit (or chart review) on a target-rich environment of claims with the greatest risk of being audited.

Several years ago, at a national meeting of compliance officers, a CMS representative made it quite clear that the era of random audits and even benchmarking was coming to a close. According to this CMS representative, practices should adopt more advanced analytics because the government was doing so. Today, it's not really an option anymore. With the increase in audits from contractors such as the UPIC, RAC, MAC, OIG, etc. and the introduction of the TPE audits, practices ignore the writing on the wall at their peril.

The target acquisition process goes something like this:

The FPS kicks out some number of claims that are suspected of being billed/coded in error.

a. In essence, the basic classifier algorithm would classify a claim as not appropriate for payment.

The system would also generate an Alert Summary Report (ASR) that summarizes the suspected errors for some number of claims billed under a given NPI.

Contractors have access to these ASRs and they may use them to look at claims from a more retrospective angle.

a. For example, they may pull some limited claim set; perhaps for three or six months, and then review them to determine whether there may a pattern of improper billing (or at least alleged improper billing).

If the contractor finds a pattern, they perform an expected value assessment prior to initiating an audit to ensure that the ROI will meet their organizational goals.

a. In 2016, RACs reported an average ROI of 2.58:1. More recently, it was reported that contractors generally averaged an ROI of over 10:1. Such lopsided ratios certainly a cause of concern with regard to misaligned incentives.

Once the ROI threshold has been met, the provider is sent a request for documentation to support those claims selected for audit.

The goal for any practice is simple: Never be surprised by an audit request. A practice that has been engaged in risk-based auditing should know in advance which providers and which codes/modifiers are most likely to be reviewed. For an inpatient facility, while the data and algorithms may vary, the model is the same; they should know, in advance of the audit, which DRGs are most likely to be reviewed. How is this possible? By having a good RBA program. Knowing these things in advance is the point of such a program.

Here is an illustrative scenario: Say you are driving down the highway and the speed limit is 65 mph. You and the rest of the traffic around you are all moving at 65 mph. Ahead, on the side of the road, is a police officer. What are your chances of getting pulled over? Unless you do something out of the ordinary (an anomaly), like throw something out the window or have a taillight out, the chances are both slim (no reason to pull anyone over) and equal (every driver has the same probability of getting pulled over) because stopping someone at this point would be a random event.

Now, in that 65 mph zone, let's say that you are driving at 85 mph. What are your chances of getting pulled over now? While it's pretty difficult to put an exact number on this scenario, suffice it to say that it is definitely elevated; likely up to 100% if you are the only one speeding in front of the police officer. This is especially likely if the police officer is using advanced technologies such as a radar gun. Finally, let's have everyone driving at 85 mph. In effect, everyone is speeding but the police officer can only pull over one person. What are the chances that you are that person? It goes back to random chance; every driver has the same probability of getting pulled over.

The point here is that the police officer is watching for two things: 1.) The flow of traffic; and 2.) any anomalies (or maybe outliers) that pass by his/her position. Note that the police officer's goal is to monitor the speed of all drivers, but they have limited resources when something out of the ordinary occurs. What are your chances of being audited should the FPS or some other system show you as an outlier or an anomaly? At some point, likely **100%.** It's just a matter of when those resources become available. It is quite difficult to know the exact number of providers audited every year, but some of the best data available puts that figure at nearly 100,000. According to CMS, the number of providers audited is likely to be reduced as more targeting models are established, such as the Target, Probe and Educate (TPE) program, which is "based on data analysis and other findings indicative of a potential vulnerability," CMS says. Data findings come from the FPS, Comprehensive Error Rate Testing (CERT) program, OIG workplan and RACs.

Why not just stick with the legacy audit models? First, CMS has warned providers that they need to adopt better methods to keep up with CMS itself. Secondly, they just don't work.

Random, probe audits miss the mark entirely. For example, a typical internal medicine provider may bill up to 135 different procedures codes in a year. Let's say you pull 10 claims from a universe of 10,000. What are the chances that you will end up with 10 different codes? It's so small that you probably have a better chance of getting struck by lightning right after winning the lottery! And even if you did, what benefit is there to only looking at one of something? Not much. Even if you luckily drew 10 unique codes in your sample, you have 125 more different codes that are not even being reviewed, so in essence, even the most conservative estimate would put your overall efficiency at only **7%**. There is nothing value-based about this.

Volumetrics is another common legacy method. Auditing is based on the largest volume of something; RVUs, payments, frequency, etc. And while this does allow you to assess your greatest exposure in a "all things being equal" setting, the fact is, all things are not equal. And just because you do a lot of something doesn't necessarily make it a risk.

Benchmarking is used quite often by healthcare providers. For example, the practice would look at the rate at which a provider reports some procedure. Maybe your cardiologist performs some specific procedure **4%** of the time, meaning that this procedure accounts for **4%** of the procedural volume they report. To benchmark, you would compare that against some other database; maybe the Physician/Supplier Procedural Summary database that contains **100%** of all Medicare fee-for-service claims. Let's say that the average for all cardiologists is **2%**, so at **4%** your provider bills for this procedure twice as often as his/her peer group. This is certainly better than nothing, but the problem is that risk is not linear. Risk requires more of a non-linear actuarial approach, so while you know the relationship between your provider and the peer group, you can't use that to assess risk.

A more advanced method, and one that produces much better results, involves looking at the CERT study, the OIG workplan, the RAC reports and talking with subject matter experts (SME), such as auditors in the field who conduct audits on a daily basis. This method is a form of predictive modeling in that you are able to "predict" a future risk based on a past risk. For example, if the CERT report shows that procedure code 99233 is billed erroneously 30% of the time, you can likely count on an external audit of those codes happening if you also report "a lot" of them. The same goes for the OIG work plan. In its work plan, which is now updated throughout the year on its website, the OIG is telling us what procedures or categories of procedures are of interest to them. And often times, this comes from the exception reports generated by the FPS.

True predictive analytics is the best of all worlds but requires greater access to relevant data and a more sophisticated approach to analytics. And while some organizations have access to the latter, not many have access to the former. One would need to know either the algorithmic constructs for the FPS (which are black-box protected under confidentiality laws) or have access to a large database of claims identified by the FPS as having been billed in error; both are difficult tasks for most healthcare organizations. Normally, use of these types of predictive models are available from third-party interests, such as researchers and some vendors.

In the end, each organization has to determine which method works best for them. It is a juggling act that requires expected value calculations respecting specific resources, such as personnel and budgeting, as well as one's ability to absorb the risk. Or more specifically, the consequences that the risk of audit brings with it.

CRA

The CRA is a web-based expert system that uses predictive analytics and other advanced statistical models to identify specific procedures, modifiers, and categories that are most at risk for an audit or review for each provider in your practice. Since CRA comes extremely close to mirroring the FPS and can see what CMS sees, you can accurately predict when a provider is putting your practice at risk of an audit.

Through research agreements with claims aggregators, CRA has access to 100% of the claims data for some 250,000 plus physicians. From these tens of millions of claims, CRA uses special advanced sampling methods and to create the "perfect" average provider for each of 60 plus specialties. Through this first-of-its-kind model, CRA can risk-adjust the variance calculations, resulting in meaningful value-based identifiers and compare the "perfect" average physician in that same specialty against the same Medicare benchmark data. To calculate risk, CRA then compares the variance for practice providers against the variance for the cohort and converts the results into a risk-adjusted scalar component that reports the risk on a scale of 1 to 100 - the preferred method for a predictive model.

CRA simplifies a very complex problem into a single value that everyone can understand and use. **Benefits include:**

- Delivering a flexible application that can scale for any size organization
- Conducting a **100%** review rather than a hit-or-miss probe analysis
- Enabling practices to see the same compliance issues as government and private payer auditors
- Providing unmatched precision in identifying chart audits
- Conducting analyses at regular intervals with a lower resource consumption

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About the Frank Cohen Group

The Frank Cohen Group became part of Doctors Management in 2015,specializing in all areas of analytics and business intelligence, including data mining and analysis, applied and computational statistics as well as predictive modeling. While the primary focus is healthcare, the group has worked in other industry settings to provide analytical consulting services to a wide array of clients. Our dynamic team has delivered many diverse solutions including:

- Compliance risk analysis
- Provider performance and compensation
- Fee schedule design and development
- Payer analysis
- Physician compensation modeling

In addition to the development of the CRA and other risk-based software solutions, The Frank Cohen Group also specializes in litigation support and post-audit analyses, working with physicians, healthcare organizations, state's attorneys general and private legal firms to aggressively defend physician's rights against payers and regulatory agencies.

Read more about the coding compliance and auditing solution offered by this division of DoctorsManagement at this link:

https://www.doctorsmanagement.com/services/ compliance-services/compliance-risk-analyzer-2/