Part B Insider (Multispecialty) Coding Alert

Self-Audits: Know What Benchmarking Against 'Bell Curves' Can Do For You -- And What It Can't

Remember: Chart audits are still your most powerful weapon in the war against miscoding allegations.

Medicare's utilization statistics can be an important tool when benchmarking your practice against the general Medicare population \" as long as you don't rely too heavily on these numbers.

In the past, practices were strongly advised to compare their code utilization stats against Medicare's to determine whether auditors considered them to be an "outlier." If, for example, the average practice billed 99215 about 100 times a week but your practice billed the same code 500 times weekly, auditors would probably consider you an outlier and want to audit your records.

That can still be the case, in that auditors do look at outliers to determine how a practice looks in reference to others, says **Frank D. Cohen, MPA, MBB,** senior analyst with MIT Solutions, Inc. "If a physician's coding statistics are significantly different than others in their peer group, that doctor's risk is higher for review by a RAC, but it doesn't necessarily mean they're coding incorrectly," Cohen says.

Plus: Even though auditors are looking at your utilization data, they aren't using it as the basis for random audits. In August 2000, CMS announced that "the decision to conduct medical review should be data-driven," and should only take place after probe reviews reveal errors (www.cms.gov/transmittals/downloads/ab0072.pdf).

Know Why the Statistics Matter

There are a few reasons why you should keep Medicare's utilization statistics handy at your practice. "I only use the benchmarking data as a very macroscopic assessment of where there might be issues for a particular doctor -- I'm talking about the view from 10,000 feet," says **Joan Gilhooly, CPC, PCS, CHCC,** president of Medical Business Resources, a physician consulting firm based in Cincinnati.

"For example," Gilhooly says, "Suppose I am going to a dermatologist's office to do a chart audit and let's say I don't know dermatology coding off the top of my head. In this case, I could look at the Medicare data to see what the collective distribution is for that specialty and I can look to see if there is a shift to the left or right in the practice that I'm auditing and investigate further whether that doctor might be billing for procedures when he shouldn't be." In many cases, the physician's utilization does not match Medicare's, but he is still coding accurately based on the documentation.

Why: Some practices may simply be seeing sicker patients than others, Cohen says. "And keep in mind that your practice may not be 100 percent Medicare, whereas the CMS statistics are," he says. "The majority of Medicare patients are over the age of 65, and age is the most critical cohort for determining variability of diagnosis and treatment -- older patients for the most part have different problems and more problems, so an older person new to a doctor may warrant a higher E/M level."

CMS May Take Data Review Further

Although it's good for your practice to have utilization statistics to review for reference, additional permutations often take place beyond the basic raw data. "When I review a practice, I'll create an acuity factor for that practice to see how complex the patient population is compared to other doctors in his specialty," Cohen says. Medicare reviewers also use sophisticated algorithms to perform data mining beyond the basic utilization numbers. "I worked with one practice that was told they were an outlier and CMS had looked at multiple variables to see that the doctors were falling outside of a given profile," Gilhooly says.

Audit Charts for Best Results

For an idea of what Medicare's general utilization statistics look like, see our sidebar on page 211. You can use the link on that page to find specialty-specific benchmarking data for comparison to your practice.

Once you determine whether your practice is considered an "outlier," your next step should be to find the reason. If your trend is to bill more lower-level codes than most practices, maybe you are seeing generally healthy patients -- or perhaps your physicians are downcoding. If you tend to bill higher level codes than the norm, you could be seeing sicker patients than most physicians, or you could have a physician who upcodes.

The only way to know for sure why your practice is falling outside the average is to perform a chart audit -- chart audits remain the single most important tool in knowing whether your practitioners are coding correctly.