Reardon Consulting, Inc.

An Affiliate of The Reardon Group
Healthcare, Financial & Management Consulting

Coding Profile Benchmarking

Are all physicians in your group performing at optimal levels?

One measure of provider productivity can be obtained by analyzing your practice's own coding profile. Such an analysis can supply a unique perspective into a provider's contribution to his/her group practice.

For example, a physician with low new patient volume may have the highest rate of revenue as a result of the intensity of the treatment he/she provides. A coding profile can help to reveal the variations among providers' capabilities, including areas of deviance from the practice overall profile.

Many medical groups under perform financially because of misinformation and bad habits. Uninformed decisions concerning coding, fees as well as the collection process can rob a healthcare practice of tens of thousands of dollars per provider annually.

Having a process to identify areas where improvement may be suggested can not only help the practice to avoid potentially costly coding errors resulting in lost reimbursement but may also serve to stave off the potential of costly fines should overzealous providers fail to adequately document their charts in support of their coding selections.

Why a coding profile to a benchmark?

Some practices are just simply concerned about how they might appear to the governments' or a private insurer's coding reviewers. Others may want to identify variances from within their own practice among their own players and to better understand the drivers that are causing these variances. Still yet some others may be concerned that their coding profile may be too zealous or, perhaps overly conservative when contrasted with some established benchmark, or any combination of the above.

The most widely applicable use for benchmarking your practice to a national coding database such as the MGMA Sourcebook is to determine whether the practice and/or your individual physicians might be undercoding or overcoding procedures, given a patent's diagnosis, age or gender.

Undercoding refers to the practice of recording and seeking reimbursement for less complex procedures than were actually performed. In this scenario, a practice is forgoing revenue it has legitimately earned. Comparing a practice's or physicians coding patterns with those in our database can provide clues as to whether or not under coding exists for particular diagnoses, even by age group and gender.

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Conversely, overcoding is the practice of seeking reimbursement for procedures for which there is insufficient evidence of medical necessity. Overcoding can lead to various sanctions ranging from the return of collected reimbursements with interest to federal criminal prosecution. By comparing physician coding with the benchmarking data in this book, practices can potentially identify and eliminate overcoding and the resulting adverse consequences.

All group practices should hold compliance with the regulations as a prime concern.

The relative frequency that a procedure is performed can indicate whether a practice or provider considers certain procedures "routine" for certain diagnoses. If a practice performs specific procedures for a diagnosis at a rate significantly below peer percentages, it may have the opportunity to provide more thorough care and to generate additional revenue. If a practice performs specific procedures for a certain diagnosis at a rate far above peer percentages, it may have cause to reevaluate treatment.

One application for this data is in comparing national coding profiles to those of a practice or to the patterns of each physician within the practice. It can be an aid in coding evaluations for your practice by bringing attention to specific procedure codes that your practice personnel do not fully understand or have never used. Thus, it can help to identify possible coding inaccuracies.

For example, the evaluation and management (E&M) codes might be profiled for each provider specialty with your practice. This information will demonstrate the relative distribution - from least complex to most complex -with which physicians within the practice perform E&M-specific procedures. Most medical practices devote a great deal of time to and derive a significant portion of patient revenue from E&M office visits. Therefore, understanding how your practice's E&M coding compares with others in your specialty by diagnosis, gender or age group can provide you with valuable insight into patient treatment, as well as your practice's procedure-based revenue streams.

How does it work and what kinds of data might it reveal?

To benchmark your medical practice or your individual physicians, or both we simply need to extract from your billing system a representative sample of your coding for any given period.

Coding Profile Benchmarking

Step 1: We will access selected billing data:

For example, below we have entered the name of the medical practice, and selected its medical specialties. We can then benchmark physicians by either their individual names or IDs, or both, along with their individual specialties. If you do not want to benchmark individual physicians, then we can benchmark just the medical practice alone as whole.

Able Cardiology

Practice Specialties

Cardiology: Invasive
Cardiology: Invasive, Interventional
Cardiology: Noninvasive

Physicians

Name	ID#	Specialty
Peter Jones, MD	121	Cardiology: Invasive
Jillian Peters, MD	332	Cardiology: Invasive
Jacob Shulman, MD	124	Cardiology: Invasive
Mary Fletcher, MD	125	Cardiology: Invasive, Interventional
William Bean, MD	126	Cardiology: Invasive, Interventional
Harold Newbold, MD	127	Cardiology: Invasive, Interventional
George Nichols, MD	128	Cardiology: Invasive, Interventional
Sanders Evenstart, MD	129	Cardiology: Invasive, Interventional
Curtis Ames, MD	130	Cardiology: Invasive, Interventional
Elizabeth MacKnight, MD	131	Cardiology: Invasive, Interventional
Priscilla Davis, MD	140	Cardiology: Noninvasive
Eugene Jones, MD	141	Cardiology: Noninvasive
Allysa Stevens, MD	331	Cardiology: Noninvasive
Sheild Fagan, MD	332	Cardiology: Noninvasive
Herbert Grayford, MD	333	Cardiology: Noninvasive
Appleton Evensworth, MD	334	Cardiology: Noninvasive

Step 2: We Create a Benchmarking Spreadsheet

We will create a Benchmarking Spreadsheet similar to the one presented below (here we are focusing only on the 3 partners selected from among the 16 cardiologic physicians in the Able Cardiology practice, for demonstration purposes):

Table 2.4a Cardiology: Invasive
Evaluation and Management, Office or Other Outpatient Services, New Patient

Code	Description	Peter Jones, MD	Jillian Peters, MD	Jacob Shulman, MD	Total All Physicians
99201	Office/outpatient visit, new, level 1	3	1	4	8
99202	Office/outpatient visit, new, level 2	5	9	4	18
99203	Office/outpatient visit, new, level 3	15	8	49	72
99204	Office/outpatient visit, new, level 4	68	65	6	139
99205	Office/outpatient visit, new, level 5	7	18	9	34
Total E&M Procedures		98	101	72	271

Step 3: We create the Benchmarking data results and supporting Graphs

Our database reports are capable of generating a wide range of comparisons.

We can compare:

- Your entire medical practice to the database result;
- Your Physicians to each other;
- Your Physicians to your entire medical practice, or
- Your physicians to the database results.

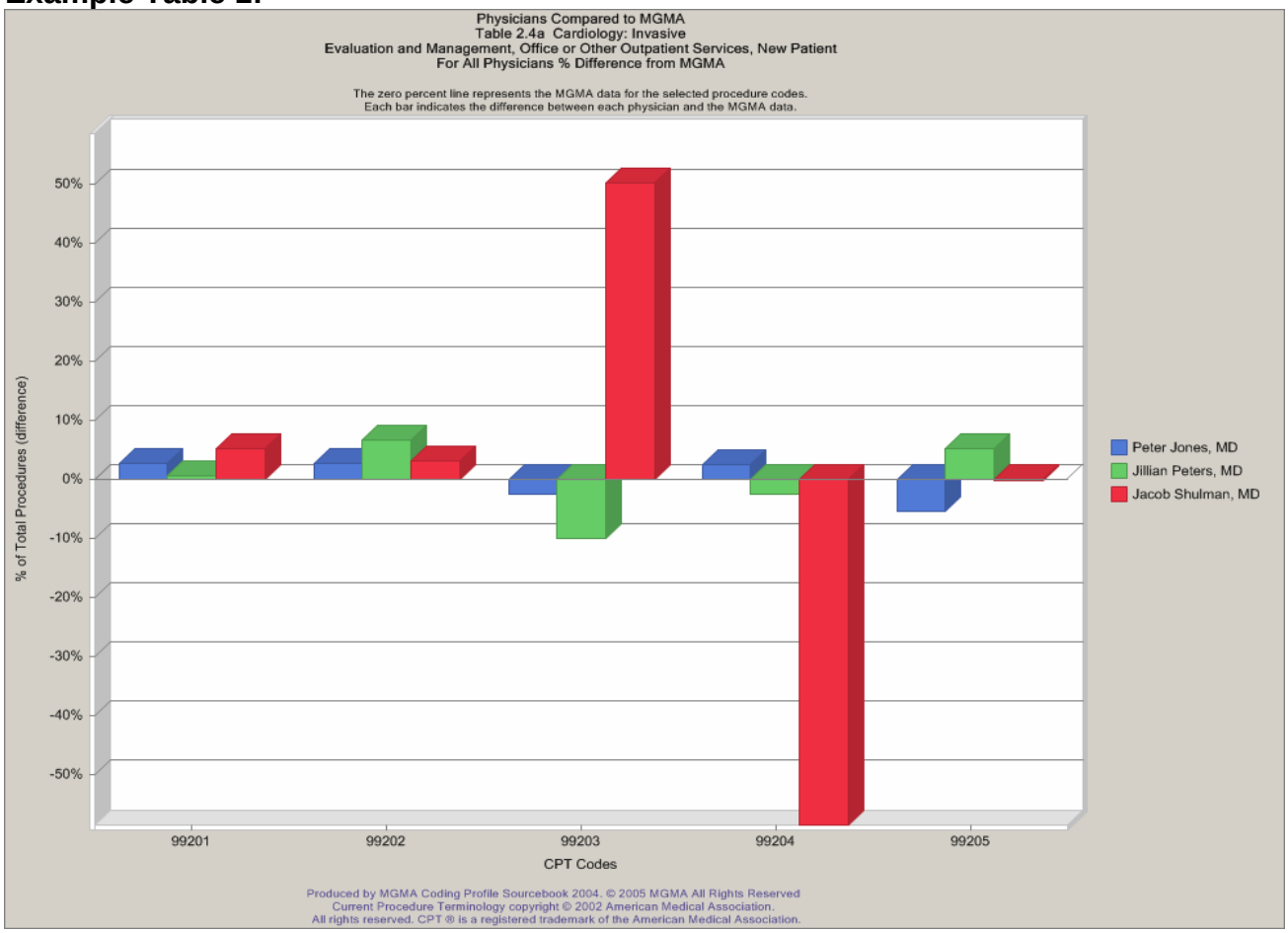
Coding Profile Benchmarking

For Example:

Below, **Table 1**, is a sample of Able Cardiology's Invasive Cardiology Outpatient New E&M coding comparing the 3 physicians Dr. Jones, Dr. Peters and Dr. Shulman to one another as compared to the MGMA national coding data survey medians. Note that the MGMA database forms the midpoint on our graph as the benchmark median (and is reported as 0%). Here, Dr. Shulman appears to exceed the database coding profile for E&M New Patient code 99203 by just under 50% and he is undercoding the database median for E&M New Patient Code 99204 by slightly over 50%.

This data suggests that it may benefit Dr. Shulman to review his coding to determine why it appears that he may be undercoding 99204 levels as compared to his partners, as well as compared to the national database.

Example Table 1:

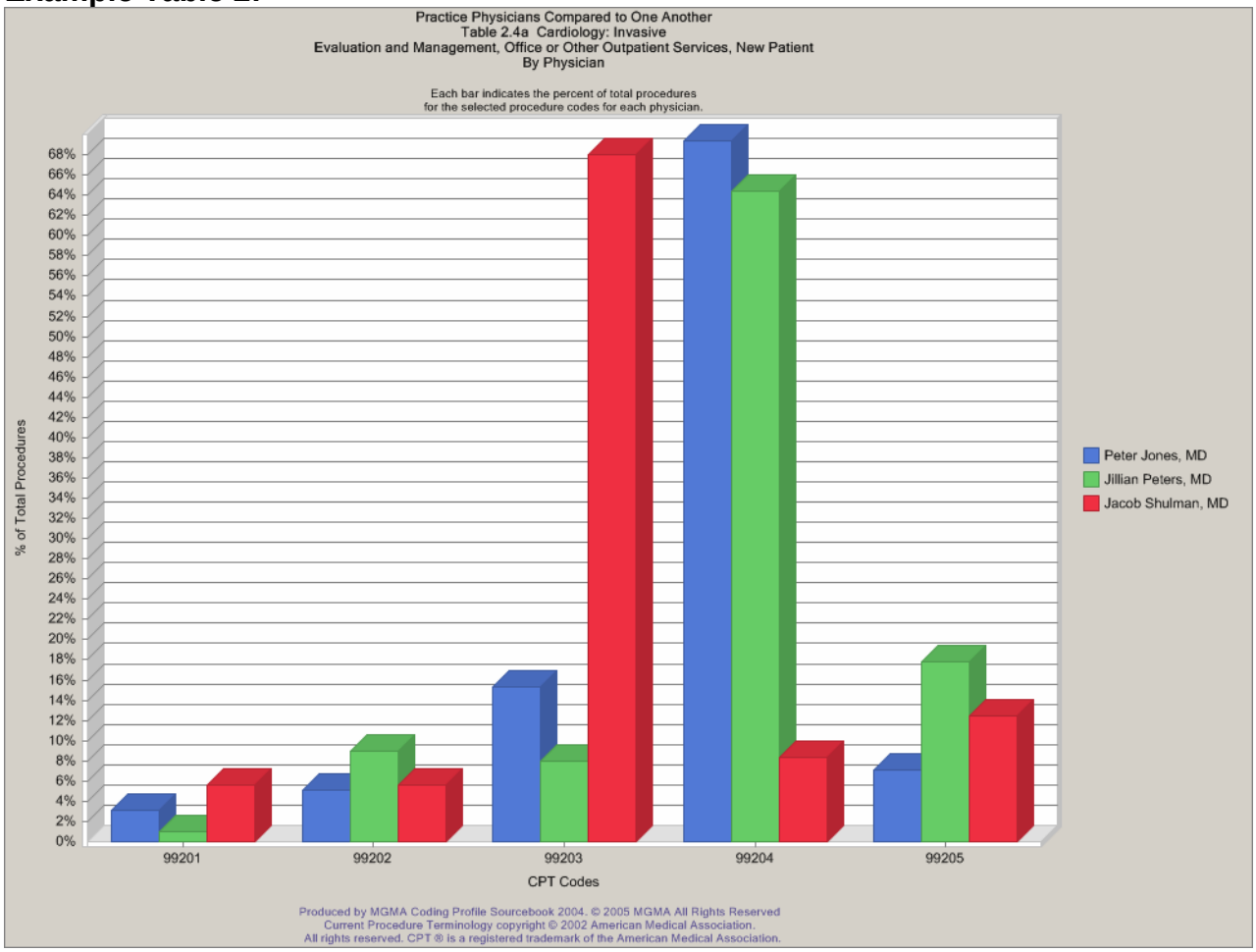


Coding Profile Benchmarking

This graph in **Table 2** depicts the same data (i.e.: Invasive Cardiology Outpatient New E&M coding) comparing all 3 physicians Dr. Jones, Dr. Peters and Dr. Shulman to just one another. Again the disparity between E&M codes 99203 and 99204 level codes for Dr. Shulman is apparent.

Given that his other coding somewhat parallels those of his partners causes one to question why his level 4's are so disparate to his own group's coding.

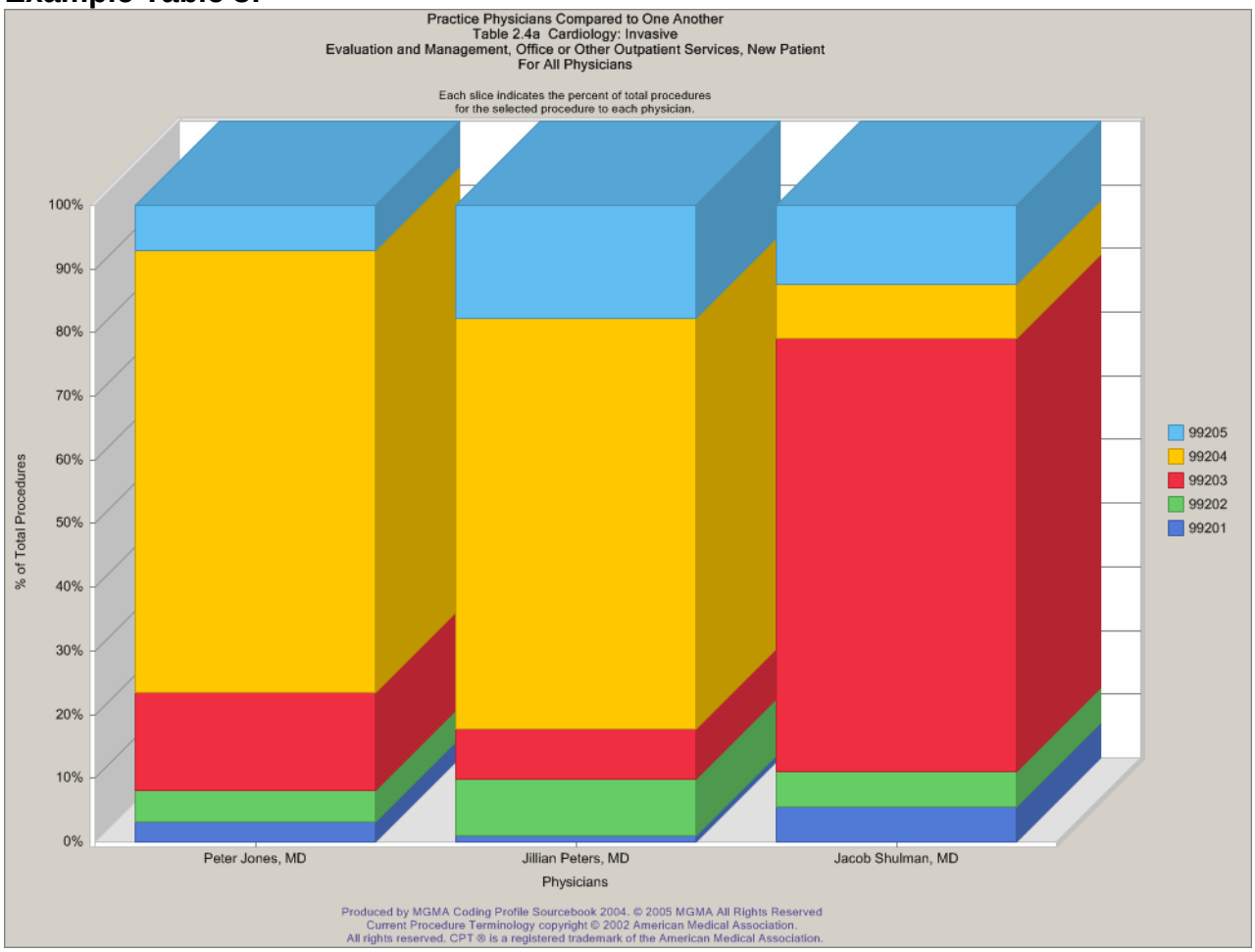
Example Table 2:



Coding Profile Benchmarking

When the same data is presented as it is here in **Table 3** as a staked bar graph, as a percentage mix of each physician's Invasive Cardiology Outpatient New E&M coding, the disparity becomes even more demonstrative (see the red area representing CPT Code 99203).

Example Table 3:

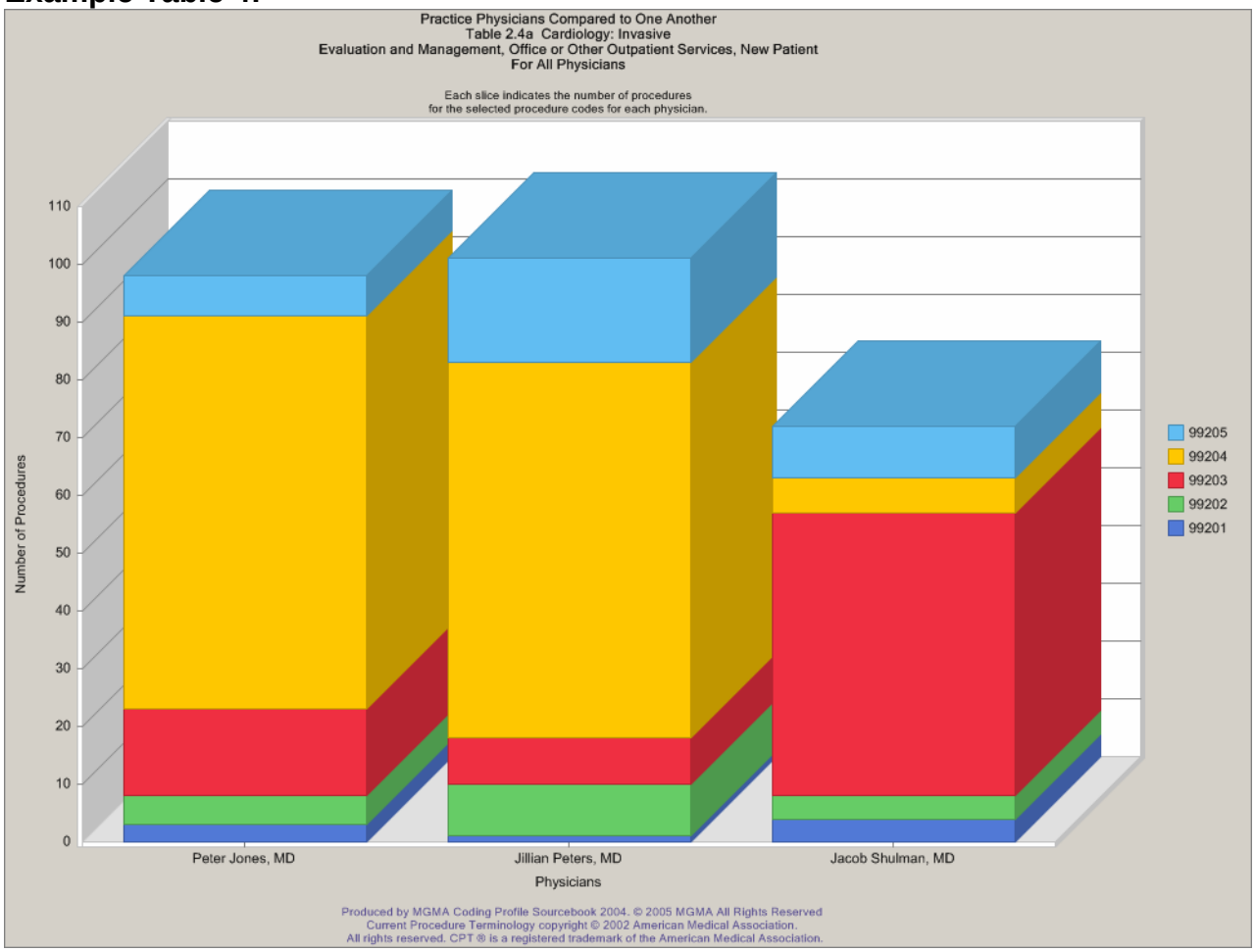


Coding Profile Benchmarking

One more look at the same data here in **Table 4**, but reflecting the total number of procedures performed by each of the 3 physicians reveals that Dr. Shulman's total numbers of E&M procedures for "Invasive Cardiology Outpatient New" are running just under 75% of the volume of his 2 partners for the same time period. Perhaps his practice is not open to new patients or, he may be experiencing some type of adverse selection.

Clearly, the data here reveals that a deeper analysis of this anomaly is warranted.

Example Table 4:



Keep in mind that the above example is just one of an innumerable set of comparisons that are possible. The key is to digest a reasonable sample of data and then for us to report back the significant exceptions for your further consideration.

Coding Profile Benchmarking

Keep in mind that differences do not imply wrongdoing: Unique situational factors not presented here might affect how a specific practice codes for certain diagnoses. The fact that there is a difference between a practices's or physician's coding patterns and those presented in the above example does not necessarily indicate overcoding or undercoding. Any differences noted, however, can provide clues for the focus of internal practice analysis.

The data revealed may simply indicate a need to familiarize certain providers with coding procedures or it may identify a code that another practitioner is unaware of and the circumstances where it may be appropriate.

Either way, your practice, or any practice, can only benefit by better understanding how your overall coding profiles itself, not just to the third party coding reviewers, but to your practicing associates as well.

Our database comparisons are almost limitless. We can contrast just about any combination of procedures by specialty and report back the results to you such as the top 100 Procedure codes for Invasive Cardiology, as reflected below:

Example Table 5:

	Table 2.1: Cardiology: Invasive Top 100 Procedure Codes
1	99213 Office/outpatient visit, est: A
2	99214 Office/outpatient visit, est: A
3	93010 Electrocardiogram report: A
4	93307 Echo exam of heart: A
5	93000 Electrocardiogram, complete: A
6	93325 Doppler color flow add-on: A
7	93320 Doppler echo exam, heart: A
8	99231 Subsequent hospital care: A
9	99232 Subsequent hospital care: A
10	93015 Cardiovascular stress test: A
11	85610 Prothrombin time: X
12	78465 Heart image (3d), multiple: A
13	78480 Heart function add-on: A
14	93733 Telephone analy, pacemaker: A
15	78478 Heart wall motion add-on: A
16	93042 Rhythm ECG, report: A
17	99244 Office consultation: A
18	93545 Inject for coronary x-rays: A
19	99254 Initial inpatient consult: A
20	93543 Injection for heart x-rays: A
21	93018 Cardiovascular stress test: A
22	93736 Telephone analy, pacemaker: A
23	A9500 Technetium TC 99m sestamibi: E
24	93016 Cardiovascular stress test: A

	Table 2.1: Cardiology: Invasive - Continued Top 100 Procedure Codes
25	G0001 Drawing blood for specimen: X
26	93556 Imaging, cardiac cath: A
27	99211 Office/outpatient visit, est: A
28	93510 Left heart catheterization: A
29	99233 Subsequent hospital care: A
30	93555 Imaging, cardiac cath: A
31	A9502 Technetium TC99M tetrofosmin: E
32	93350 Echo transthoracic: A
33	99212 Office/outpatient visit, est: A
34	93880 Extracranial study: A
35	36415 Routine venipuncture: I
36	93731 Analyze pacemaker system: A
37	93230 ECG monitor/report, 24 hrs: A
38	80061 Lipid panel: X
39	99253 Initial inpatient consult: A
40	99215 Office/outpatient visit, est: A
41	G0166 Extrnl counterpulse, per tx: A
42	99238 Hospital discharge day: A
43	99243 Office consultation: A
44	93732 Analyze pacemaker system: A
45	99255 Initial inpatient consult: A
46	J1245 Dipyridamole injection: E
47	82550 Assay of ck (cpk): X
48	99223 Initial hospital care: A
49	80076 Hepatic function panel: X
50	93224 ECG monitor/report, 24 hrs: A
51	99204 Office/outpatient visit, new: A
52	J0280 Aminophyllin 250 MG inj: E
53	93734 Analyze pacemaker system: A
54	99245 Office consultation: A
55	80048 Basic metabolic panel: X
56	J0150 Injection adenosine 6 MG: E
57	82977 Assay of GGT: X
58	92980 Insert intracoronary stent: A
59	93743 Analyze ht pace device dual: A
60	A9505 Thallous chloride TL 201/mci: E
61	99222 Initial hospital care: A
62	83721 Assay of blood lipoprotein: X
63	84460 Alanine amino (ALT) (SGPT): X
64	85025 Complete cbc w/auto diff wbc: X
65	93741 Analyze ht pace device sngl: A
66	93540 Injection, cardiac cath: A

	Table 2.1: Cardiology: Invasive - Continued Top 100 Procedure Codes
67	93539 Injection, cardiac cath: A
68	74185 Mri angio, abdom w or w/o dy: R
69	83615 Lactate (LD) (LDH) enzyme: X
70	99024 Postop follow-up visit: B
71	74183 Mri abdomen w/o&w/dye: A
72	93735 Analyze pacemaker system: A
73	71020 Chest x-ray: A
74	93227 ECG monitor/review, 24 hrs: A
75	93544 Injection for aortography: A
76	93526 Rt & Lt heart catheters: A
77	93971 Extremity study: A
78	84443 Assay thyroid stim hormone: X
79	93270 ECG recording: A
80	76375 3d/holograph reconstr add-on: A
81	85730 Thromboplastin time, partial: X
82	80053 Comprehen metabolic panel: X
83	93272 Ecg/review, interpret only: A
84	93237 ECG monitor/review, 24 hrs: A
85	33208 Insertion of heart pacemaker: A
86	84450 Transferase (AST) (SGOT): X
87	93744 Analyze ht pace device dual: A
88	93922 Extremity study: A
89	93923 Extremity study: A
90	92960 Cardioversion electric, ext: A
91	99203 Office/outpatient visit, new: A
92	93970 Extremity study: A
93	82565 Assay of creatinine: X
94	84520 Assay of urea nitrogen: X
95	80051 Electrolyte panel: X
96	70549 Mr angiograph neck w/o&w dye: A
97	93976 Vascular study: A
98	78472 Gated heart, planar, single: A
99	G0008 Admin influenza virus vac: X
100	93308 Echo exam of heart: A
101	All other
	TOTAL PROCEDURES