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When Productivity Targets Aren't Met, Consider wRVU Audit, Which Has Compliance Benefits

By Nina Youngstrom

When the director of operations in a health system sits down with physicians who aren't hitting the productivity targets for their performance-based compensation, the physicians are exasperated. How is that possible? The physicians treat so many patients and are busy in the operating room. "There's no way we aren't meeting productivity goals because we're working so much," they say.

They're probably working as hard as they think, but it may not be paying off in more ways than one. Maybe all those visits and surgeries are not showing up in their work relative value units (wRVUs) because of coding or billing errors, said attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas. To find out, organizations might want to conduct a productivity audit, which is different than a compliance audit but has some of the same benefits, Marting said at a Jan. 23 webinar sponsored by the Health Care Compliance Association.

Provider productivity is affected by missed codes—including evaluation and management (E/M) services, add-on codes, multiple procedure codes during surgery, ancillary services and bedside surgical cases. "All of the ways we capture services could artificially make that provider appear less productive than they are because we are not capturing all the work they are doing," she said.

Hospitals also could run afoul of the Stark Law and Anti-Kickback Statute because they are required to pay employed physicians who are referral sources fair-market value compensation. If the wRVUs credited to providers are low compared to their compensation, "it looks like they are getting paid a lot more money for less work," she notes. The risk, then, is the appearance the hospital is not paying the physician for professional services and that some of the compensation is to encourage patient referrals.

Productivity audits are different from compliance audits. The focus of a billing compliance audit is whether the provider met the payer's requirements and whether they will get paid based on what's in the medical records. A productivity audit looks at the services performed, the codes that describe the services and whether the organization is capturing the codes for the services. If not, something is wrong and should be corrected. "These are not dollars and cents that could be reimbursed from a third-party payer," Marting explains. However, improved charge capture could be a side effect of a productivity audit. The goal is to bring the two types of audits together to assess the codes and associated wRVUs for the work being performed by providers and to reflect the value of their services, which in turn supports their compensation.

It takes a lot of planning to do a meaningful productivity audit, Marting says. The first step is to define the scope of the audit, including:

- **Dates of service to audit.** Decide whether to do a deep dive into one date of service, or audit a month, quarter or year's worth of services.
- **Types of services to audit.** For surgeons, obviously surgical cases will dominate the wRVUs in a productivity

audit. Whether to include E/M codes is a judgment call. "The variation between levels of service in the grand scheme of things won't make a big impact on productivity, but if you want an accurate picture of what the provider is doing, you may want to include E/Ms," Marting said. Another consideration: whether to include E/M services performed by nonphysician practitioners (NPPs) in the physician's productivity data if he or she is the supervising or collaborating physician. "Depending on the particular payer, the NPPs' services may get billed under a doctor's name and number, and that could impact the physician's productivity data favorably or unfavorably," Marting said. If a physician's employment agreement includes a high productivity threshold to achieve bonus compensation because the provider supervises two NPPs and most of the payers require the clinic to bill the NPPs' services under the physician's name, the physician's productivity will be high because it captures her personal work and the work of the NPPs. However, if the NPPs' services weren't billed under the physician's name because the payers won't accept it, "that could significantly impact the physician's productivity and opportunity to reach bonuses under her contract," Marting explained.

- **Coding criteria.** Medicare's National Correct Coding Initiative (NCCI) has hundreds of thousands of code pairs that can't be billed together. Not all payers apply the NCCI edits. "At the outset, you have to decide whether to apply NCCI edits across the board or pick and choose the payers the edits actually apply to," Marting says. "The reason this matters is you get wRVU credit for the services billed." When NCCI edits apply, the comprehensive codes are billed, and the less comprehensive codes are bundled per the NCCI edits and providers don't get credit for the less comprehensive service from a productivity standpoint, she said. If the payer doesn't follow the NCCI edits and pays for the less comprehensive codes separately, providers may get wRVUs assigned to them. Marting also suggests considering internal policies, such as billing for NPPs' services performed incident to the physician's services. Some organizations have abandoned incident-to billing because Medicare compliance is onerous, and they've decided the risk is not worth the 15% bump in reimbursement.

- **Modifier assignment.** With modifiers, different payers may adjust the wRVUs for a code differently for the same modifier. For example, with modifier 55, which is appended to a CPT code when a physician performs only postoperative management and another physician performed the procedure, Medicare pays more of the allowable amount than some commercial payers. If the provider contract is silent on how to adjust wRVUs in those circumstances, you have to decide whether to apply Medicare's rules across the board or adjust them for each payer. "It's not very often the physician compensation contracts specifically address wRVU adjustments for every possible modifier, so we have to set the rules at the outset of a review," she noted. For example, anytime modifier 55 is applied, wRVUs are reduced by 20%. Medicare and other payers also have multiple procedure reduction policies, which means they pay providers or the health system 100% of allowable charges for the most extensive procedure and 50% for subsequent procedures. In turn, the health care organization may have negotiated a reduction in wRVUs when physicians report multiple line items for surgeries, and that's something to establish at the beginning of the review. In some agreements, however, a provider's wRVUs are not adjusted for multiple procedure discounts unless certain modifiers, like modifier 51 for multiple procedures, are applied to a code.

Who Gets Credit for NPPs' Services?

The next step in the productivity audit is to get the data from the billing system. Pull everything billed under the provider's name during the agreed-on dates of service. "Be very careful with the fields you're using when pulling data," she said. Data should include the patient's name or medical record number, units reported, and all of the codes and modifiers reported. It's helpful to include billed charges even though you're not necessarily looking at reimbursement. Finally, obtain wRVUs attributed to the provider for the services and the amount paid by the payer.

"Cull through the data and find only the line item that represents final codes that went out the door that led to wRVU values attributed to the provider," Marting said. Make sure you consider the differences between the billing provider and performing provider, Marting said. For example, the NPP may perform the service, but it's billed under the physician's name. "This leads to good conversations with the organization on how they handle this," she said. Internally, you want to know who gets wRVU credit for NPPs' services. If it's the NPP, is that consistent with the organization's policies? "Sometimes we find it is the intent of the organization to give the physician credit for NPPs' services, but that's not what happens, and it significantly impacts the value of services the physician was credited with," she said.

'Get a Longitudinal Picture'

Marting also recommends checking the accuracy of wRVUs attributed to providers. This can be done by pulling up CMS's resource-based relative value files based on the dates of service. "I pull in the wRVUs associated with each CPT code and see if that matches what the provider was credited with. If there's a discrepancy, we have a conversation on the administration side," she says.

Also, for codes that are considered unlisted in the CPT book, she recommends finding comparable codes for wRVU purposes.

Now that all the prep work is done, the review can begin. Marting recommends giving reviewers access to the patient's entire medical record. "It's incredibly helpful for reviewers to get a longitudinal picture of everything happening with that patient, especially in surgical cases," she said. "We can see the initial consult, sometimes testing, and often in-office services that were never captured in codes that could potentially be reported for productivity and potentially for billing and reimbursement, and you start to get a feel for a provider's practice patterns."

Also look for variances in coding and billing. For example, with a spinal fusion, if five levels were performed, were only two billed? Or was a bone graft also performed, but there's no charge for it? Maybe the coder felt the documentation was incomplete, which could be fixable if the provider is aware of what needs to be recorded. The bottom line: "You miss reimbursement, but the provider misses on productivity," she noted.

When the review is completed, report the results of every record reviewed, with a detailed explanation of why the code accurately described the provider's services, or whether there are variances with the codes reported to payers, Marting said. Look for trends. Maybe bedside procedures, such as twist drill craniostomy or central line replacements, were always overlooked because the provider failed to identify these procedures on charge sheets for the practice, or an outsourced coding company used for a short period of time wasn't familiar enough with the practice's specialty.

Contact Marting at rmarting@forbeslawgroup.com. ✧