Use a Productivity Analysis to Drive Your Audit Plan

Auditing providers without data on their utilization trends is like shooting at targets while blindfolded. You know which direction to face, but whether you hit anything - let alone the bullseye - is largely up to chance.

You don't have to go in blind. Running a provider-level productivity analysis before you begin auditing can reveal valuable information about which codes or providers are more vulnerable, and thus require more attention.

The term "productivity analysis" may seem intimidating, so let's demystify it. Physician productivity refers to the amount of work a provider has performed, and is usually measured using work RVUs (relative value units) or even code-level utilization (i.e. the number of times each CPT code has been billed).

Depending on your practice management system or electronic health record system, you can run provider-level reports that reveal productivity either through RVUs or code-level utilization (or both). Once you have this information, let's look at how you can use it to focus your audits and make them more meaningful.

Now, if you're performing a baseline audit, you won't need to focus as much on specific services or providers. The productivity analysis is most useful when you want to perform a targeted audit and you already have some idea of the baseline.

Focusing audits on high-RVU services
Depending on your providers' specialties and service mix, you may find the majority of their RVUs come from E/M services or procedures. If it's not an even mix, you may want to focus on services that have the higher overall RVU value. There are variables to consider as well, such as the denial rate for those services. If you find that 70% of provider RVUs come from a series of surgical procedures which have an average denial rate of less than 5%, it may not be necessary to focus on those services. Look to focus audits on:

- Services with high denial rates that represent significant chunks of your total RVUs.
- Any code with a denial rate that approaches or exceeds 10% should receive immediate attention.
- If no codes have a denial rate near 10%, take a relative view - that is, look at codes that have the highest denial rate *relative* to all the other codes.

Focusing audits on high or abnormal utilization
Looking at provider-level utilization is another way of using productivity to direct your audits. Utilization analyses are most commonly associated with E/M services, because

they specific code levels that make them easier to benchmark (either within your group or against national Medicare data). Non-E/M services can also be analyzed for unusually high or low utilization compared to other providers in your group.

Tip: You can use a variety of tools to perform an E/M utilization analysis, including a simple self-made spreadsheet where you can input provider utilization by E/M code.Look to focus audits on:

- E/M services with an unusual distribution when compared to benchmark data or even your other providers (e.g., one provider bills level 5 codes significantly more than everyone else).
- Providers who have high utilization for any procedure relative to other providers with a similar patient mix.
- High-utilization codes with a high error rate. Again, if none of your high-utilization codes have a high error rate, use a *relative* error rate to single out codes for audit.

This week's tip provided by:

Grant Huang, CPC, CPMA

Grant is director of content at our parent company, DoctorsManagement, LLC. He has worked for years as a healthcare regulatory analyst and producer of educational content. He is also a certified coder and auditor.