



COMPREHENSIVE MEDICAL PRACTICE ANALYSIS

SERVICE PROSPECTUS

Medical Practices

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Comprehensive Medical Practice Analysis

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INTRODUCTION

Physician practices account for about a quarter of the total dollars spent on healthcare in this country, yet 80% of the regulatory focus has rested squarely in the lap of the provider. Since 1992, the net revenue for physicians has steadily declined and many medical practices have become unprofitable affecting small and large practices alike.

E/M guidelines are administratively complex, medically unnecessary and overly elastic. In national studies, only 50% of professional coders can agree on the proper code, making utilization studies critical for risk assessment. More and more payers are relying on RBRVS as a foundation for establishing their fee schedules and as such, practices need to be expertly versed in its use and application. Over the past few years, payers have engaged in such unscrupulous practices as unauthorized rental networks and silent PPOs, stealing millions of dollars directly from the providers' pockets. Being able to analyze multiple allowable schedules is the only way to identify and prevent this practice from occurring. The OIG has made it very clear that they are looking harder at the use of modifiers for potential violations of fraud and abuse statutes and coding utilization has moved up several notches in their toolbox for profiling practices. To counter this attack, it is necessary to have access to benchmark data and comparative analytical tools designed to identify potential problems. Many practices have proven that it is possible to negotiating fees within managed care contracts but only if they have substantiated cost data and RBRVS is an inexpensive yet effective tool for this type of business process. The recent popularity of using RBRVS to develop productivity-based physician compensation plans contrasts with the government's move to examine these models against fair market value benchmarks. And the list of challenges goes on and on and on.

Many experts in our industry estimate that the medical practice is some 20 years behind the curve with respect to understanding and implementing contemporary business models, widening the gap between where they are now and where they need to be in order to thrive. The fact is the difference between surviving and thriving in any business is tied to metrics; the ability to measure performance in every area, and this only comes from data driven organizations. Remember, if you can't measure it, you can't manage it.

WHAT IS A COMPREHENSIVE MEDICAL PRACTICE ANALYSIS?

For many practices, particularly those involved in process improvement and ongoing strategic planning, a significant portion of their time and money is spent in data mining; that is, searching for the information needed to identify areas of both risk and opportunity.

The Comprehensive Medical Practice Analysis, or CMPA, is a cutting edge approach designed to provide you with the data and information you need to make the right business decisions for your practice. Based on expert system technology, the CMPA provides a complete and comprehensive financial, utilization and compliance toolbox for your practice, saving you time and money in the process.

Understanding data is absolutely necessary for success in a highly competitive and regulated market and for every practice, a CMPA supplies the type of complex work product that is otherwise unaffordable. Over the past 15 years, we have conducted analyses on nearly 50,000 physicians in 2200 medical practices and the results were always the same; increased profitability and reduced risk.

A CMPA provides solutions in the following areas:

- Fee Schedule Analysis
- Reimbursement Validation Analysis

- Procedural Cost Accounting Analysis
- Procedure Code and Modifier Compliance Analysis
- Evaluation and Management Code Utilization Review
- Managed Care Profitability Analysis
- Physician Productivity / Compensation Analysis
- Resource Allocation and Statistical Modeling by Location by Physician

Whether used in its entirety as individual components, the CMPA will prove to be the most valuable and affordable toolbox available.

ANALYTICAL COMPONENTS

CMPA, because of its compartmentalized development properties, can be performed in whole or in part. Some of the analytical components are inclusive with respect to the basic data set and others are separated by either additional data or disparate relationships. Of significance is the level of research that goes into CMPA. We incorporate advanced statistics and quality control techniques to insure that every analysis provides the tools the practice needs to make the right decisions at the right time. In addition to performing analyses based on traditional and accepted industry standards, we incorporate Six Sigma, Lean and Kaizen techniques.

ACUITY FACTORING

The most significant challenge with respect to comparative analyses is defining what constitutes a valid sample. This is particularly true when comparing by specialty by location as this requires a larger universe of data that is commercially available. The CMS database, called the Physician/Supplier Payment System (P/SPS) Master file, contains every Medicare claim filed within a calendar year. For CY 2004, this equates to nearly 5 billion claims, the most significant database of its type. Imagine having access to a database of claims that represents nearly every physician in every specialty in every zip code in the United States submitted from over 40 million patients. The only problem is that this database is almost exclusive to adults aged 65 and over.

The Acuity Factor, when applied through CMPA, normalizes this database so that any practice, irrespective of their Medicare payer mix, can use this data for important comparative analyses. From E/M to coding to modifier utilization, the acuity factor takes a large database and turns it into a useful database; certainly an advantage for any medical practice.

When applied to E/M coding and utilization, acuity factoring can be used to adjust the national distribution for any patient population, rendering the national Medicare data set useful for compliance as well as financial analyses. When applied to physician productivity, the acuity factor can be used to demystify the 'my patients are sicker than others' dilemma that faces most administrators and consultants engaged in physician compensation efforts.

In general, acuity factoring helps to prevent the practice from becoming compartmentalized with respect to relational databases and standard comparative methodologies and is proprietary to the CMPA system.

The following describes each of the analytical components as they stand individually and in relation to the entire process.

PROVIDER PRODUCTIVITY ANALYSIS

In this module, CMPA uses actual revenues and calculated gross charges by provider to measure a myriad of metrics used to identify overall provider productivity. It will automatically calculate the upper and lower quartiles, median, mean and standard deviation for each provider based on the specific metrics represented. The primary worksheet is broken into eight major components, as follows:

FINANCIAL ANALYSIS

This component analyzes basic financial information. Using the calculated charges and requested revenue by provider, this component analyzes expense distribution and collection ratios to calculate profitability; a key marker for many performance-based compensation programs

RVU ANALYSIS

The RVU component uses special factoring edits and logic to create the most accurate representation of RVU consumption available. Considering the use of specific modifiers, each provider's RVU values are calculated for work, practice expense and total components. Considering the number of practices that pay providers based on work RVUs, we also calculate the work-to-total RVU ratio and compare it to national averages by specialty.

COMPENSATION ANALYSIS

The compensation analysis is the most comprehensive of its kind in that we consider data that are often missed in other similar types of analyses. For example, we calculate a metric for minutes-per-work-RVU based on the national Harvard/RUC time study. This allows for an accurate assignment of work RVUs to define 1 FTE for every specialty. Using inferential statistics, we calculate a 95% confidence interval; far more important than point estimates when assessing a provider's relative performance. Other metrics include comparative compensation, including our proprietary Effort Adjusted Compensation value and, a Fair Market Value assessment.

PRODUCTIVITY AND PERFORMANCE ANALYSIS

This component uses both RVUs and expenses to calculate the relative productivity of each medical provider. The basic concept centers around the ratio of what the provider puts into the practice as a percent of total compared to what the provider takes out of the practice as a percent of total. This is a great tool for assisting providers with understanding and improving their overall financial productivity.

TIME-BASED ANALYSIS

Using the Harvard/RUC assessed time study, this component looks at the component (pre-, intra- and post-) and total time assessed to each provider. This is a great way to rapidly identify potential compliance risks based on the OIG audit standard of 5,000 hours. It also compares charges per hour and collection per hour for each provider against the national average for their specialty.

VOLUMETRIC ANALYSIS

This component combines the volume of procedure reported by provider with the time study to obtain such metrics as time per procedure and procedures per hour and then compares these against national averages by specialty. When studying ratios of E/M to non-E/M procedure, the raw data is also useful in identifying potentially high-risk trends.

DHS ANALYSIS

Fairly clear-cut, DHS procedures are of concern when providers are compensated using procedural or RVU-based productivity models. DHS procedures need to be considered in order to avoid legal issues under Stark II and other self-referral rules and regulations. This component calculates the greatest risk by reporting the total potential DHS procedures and charges by provider.

ACUITY ANALYSIS

Using our proprietary Acuity Factor calculation, this component analyzes the relative complexity level of services and procedures reported by each provider and then compares this to the national average acuity factor by specialty. Our Acuity factors are now widely used by practices to justify higher fees, normalize national and comparative databases and justify provider compensation based on more than just assessed work effort.

PROCEDURE CODE COMPLIANCE/UTILIZATION ANALYSIS

During this component, each procedure code is checked to insure it is valid for the current year and represented by the correct description. Then, it is compared with Medicare and other government regulations to insure that it is being used properly. CMPA identifies codes subject to the National Correct Coding Policy, fraud exclusionary areas and reasonableness of use. In addition to basics such as status and validity, this module reports important regulations such as those covering the use of assistants at surgery, co-surgeons, multiple surgeons, multiple procedures, etc. These types of details are often overlooked, particularly by larger practices, because of the difficulty in obtaining all of the data from one source. Other reports show such specifics as the financial impact and deletion dates for codes that are no longer valid for the current year and also for codes that have never been valid HCPCS codes. In essence, this component replaces the need to be a coding expert with experiential knowledge.

After the qualitative assessment, CMPA then performs a quantitative analysis by comparing the top 50 procedures for the practice against its specialty peer group nationally. This provides information useful in identifying areas of financial opportunity as well as compliance risk. This analysis is customarily conducted by specialty and a drill-down worksheet conducts the same analysis, only by individual provider.

MODIFIER COMPLIANCE/UTILIZATION ANALYSIS

After the global codes have been analyzed, the system performs a specific examination of the use of modifiers in relation to their counterpart codes. For example, it will identify code/modifier combinations that are inappropriate and that may result in denials and even violations of the law. It looks at all E/M codes to insure that they are used only with appropriate E/M modifiers and then examines the rest of the codes to insure that they are not used with E/M-only modifiers. If the frequency data is available by provider, this analysis will report the frequency of violations for each specific provider in addition to the total frequency and global charges, making it easy to identify both the source and the pattern of potential violations. And because the process of analyzing what can be a nearly infinite number of possible modifier iterations, most practices lack the resources to achieve this level of compliance.

As with the procedure code analysis, after the quantitative portion is complete, CMPA will also look at the quantitative use of modifiers, analyzing the utilization of each modifier against all procedures and comparing the results against the national data for each specialty reported. This analysis is customarily conducted by specialty and a drill-down worksheet conducts the same analysis, only by individual provider.

EVALUATION AND MANAGEMENT CODE UTILIZATION REVIEW

The only thing more important than E/M coding is the patient! Responsible for more reviews, audits and overpayment demands than any other single element, E/M code utilization is the most important compliance issue in the medical practice. Improper E/M coding will result in one of two outcomes; cost the practice money through unrealized revenues in cases of under coding or cost the practice money in as the result of overpayment demands due to over utilization. Providing the most complete and comprehensive E/M utilization analysis in the industry, CMPA employs three degrees of analysis, going well beyond what most practices and consultants even consider. In addition to looking at intra-category utilization, CMPA also analyzes inter-category and global relationships to more specifically identify aberrant behavior. These relational areas are monitored by carriers and outside reviewers to profile practices for audits and reviews.

For large practices with many providers, the CMPA produces a flat-file matrix that can be used to instantly identify anomalies by individual code or coding category for each provider or aggregate specialty. This matrix can be used for more in depth investigational analyses, such as scatter graphing for cluster analysis, rapid data modeling for compliance reviews and resource allocation. In addition, for multi-specialty groups, a separate worksheet is generated that catalogs all critical E/M utilization statistics by specialty for eight different metrics.

UTILIZATION DIFFERENTIAL

While standard E/M utilization techniques can define potential over and under utilization tendencies, they do not quantify that differential as a value relative to the control group. Using a proprietary mathematical algorithm to assign a total distributed resource value for each E/M category and by comparing that to national values, CMPA can actually assess the level of under or over coding for that specific group as a percent variance of the control.

ACUITY ADJUSTED CHARGE DIFFERENTIAL

In the E/M analysis, CMPA takes the acuity model one step further; it separates acuity based upon E/M and non-E/M codes. Using the assumption that non-E/M procedures are coded more accurately than E/M codes, the CMPA is able to develop a variance differential based upon patient-specific characteristics to calculate what we refer to as an acuity-adjusted charge differential. This resultant value defines for the practice the level of revenue that the practice should be generating by E/M category if the level of E/M coding was commensurate with the level of complexity assigned to their patient population. The CMPA is the only system in the country that can accurately assess the financial potential or liability based upon E/M specific coding practices.

CORRECT CODE INITIATIVE COMPLIANCE ANALYSIS

The Correct Coding Initiative (CCI) was developed for the purpose of eliminating the practice of unbundling procedures by establishing an exhaustive set of restricted coding pairs. Currently, the database contains nearly half a million records, each representing a pair of procedure codes that if billed together will either be rejected outright or paid at an amount equal to the lowest reimbursement of the two codes in the edit pair. If a practice has noticed a seemingly unexplained increase in rejections and denials from all payers over the past year or so, they can be relatively certain that it is due to the CCI restrictions.

CMPA is the only integrated system that produces a set of cross-referenced reports for the practice that are filtered by the practice's fee schedule. By making the reports far more user-friendly and manageable, it all but guarantees the practice will use this as a reference to increase Medicare collections and cash flow. In addition, CMPA offers a free-standing CCI search engine that can be used real-time by the practice to check the presence of restricted pairs prior to submitting the claim.

FEE ANALYSIS

The practices' fee schedule should be based on the value of its services, the cost to deliver those services and market dynamics, not held hostage to what payers are willing to reimburse. The fee schedule is the most important financial tool within the medical practice. It is from here that the entire billing and collection process begins. And while EOBs are required in order to validate reimbursement, much can be done in their absence to establish a fee schedule that is quiet, consistent and passes muster in relation to several important internal and external benchmarks. This process of balancing the fee schedule is referred to as profiling and it is designed to assist the practice with the development and maintenance of a fee schedule that optimizes revenue and minimizes exposure. First, and most importantly, fees are compared against the Medicare Fee Schedule amount to insure that no procedures are being charged below that benchmark. Next, fees are compared against the cost of delivering the service to insure that what is being collected at least exceeds the cost. Then, fees are compared against the Minimum Charge Threshold (MinCT), a factor established by the practice as a relational minimum amount above which the procedure should be billed, and the Maximum charge Threshold (MaxCT), a value above which might be considered at risk. The final benchmark is to compare the practice's fees against national fee statistics and against the mean fee amount for that specific geographic locality. This also includes comparison of the practices conversion factors by category to that of its peers within the same geographic market.

The importance of establishing a defensible and reasonable fee schedule cannot be overstated. The benefits of such are perhaps the most notable in any medical practice. The ability to defend fees against potential payers, patients and local industry is a matter of survival and the increased ability to negotiate more meaningful and profitable contracts is essential to thrive in a highly competitive market.

REIMBURSEMENT VALIDATION/CONTRACT ANALYSIS

This is an EOB driven model designed to validate reimbursement and assess contract value for virtually any payer or payer type. The industry is rife with all sorts of payer schemes and shenanigans, such as silent PPOs, rental networks, broker contacts, etc. Each of these has a single purpose; to subvert the process of paying the provider their contracted amount for the services they provide to the patient. In this analysis, CMPA imports EOBs to develop a financial and statistical picture of payer compliance. To establish contract amounts, the actual fee schedules can be imported or, better yet, calculated by using a number of different possible calculations, including percent of usual fees, ratio of Medicare or RBRVS, a fixed conversion factor or even a procedure-by-procedure entry. This analysis has two purposes; to ensure that the practice is being reimbursed the appropriate amount based on each payer contract and to assess the value of a contract outside of traditional models. We allow the practice to enter such metrics as A/R days and hassle factor to create a unique rating of each payer contract so when the time comes to start culling, the practice will have the information they need to dump the worst contracts to make way for better contracts.

There are two worksheets for this component. The first is a simple flat file that compares the contract fee amount by payer. The second is a more complex matrix that summarized critical financial metrics by payer, such as total payments, ratios to allowable and usual fees, RVU values and our unique ranking system. Each payer is then represented on a separate tab, reporting more detailed data by procedure code, including metrics for allowable, payment, utilization frequency, statistical metrics and other very useful information.

PROCEDURAL COST ACCOUNTING/BREAK-EVEN ANALYSIS

Cost accounting techniques take on a number of different forms. In fact, entire books have been written about the topic. In the CMPA, the focus is on the relationship of costs to the revenue base of the practice, including line item procedural relationships and overall costing of procedures and services. Using the RBRVS as the basis to this relational model, CMPA compares utilization levels, resource allocation, profit and loss levels, common costing and other bits of critical information for the practice. The analysis is conducted on both a macro level (global amounts such as total billing, collections, cost per RVU, etc.) and on a micro level (per procedure and per unit comparisons, such as break-even amounts).

This analytical component will show most practices (many for the very first time) what it costs in real dollars to perform a procedure or deliver a service. It also develops line-item P&L and break-even values that are critical for analyzing the profitability of managed care contracts. It will also calculate both the cost and collection per RVU; perhaps the most important metrics available for measuring effectiveness of revenue generation and cost containment efforts in a dynamic system. Then, using the component structure of RBRVS, CMPA compares the cost relationship between operational issues and provider expense, granting the practice that ability to design methodologies for improving profitability without affecting quality.

PRACTICE UTILIZATION/COST ANALYSIS

Without question, managed care has become the driving force behind commercial health care. And while there continues to be opposing opinions as to the life cycle of capitation plans, they also remain a market force in some regions of the country. The CMPA includes a managed care/capitation cost analysis component that will identify the profitability of virtually any managed care contract, including PCP full risk contracts, specialty shared risk or just total contract rate proposals. Too many practices blindly sign managed care contracts without having the slightest idea as to what the cost of the contract will be or whether it will be profitable for the practice. In a substantial contract, one that accounts for more than 10% of revenue, a bad contract can financially destroy a practice. Using the practice's own expense amounts and number of active patients, the system calculates utilization per thousand by procedure and then both the variable and fixed cost per unit, per member and per member per month (PMPM), the most common payment methodology under capitation models. Then, by obtaining the number of insured lives under a proposed contract, the practice can calculate the projected number of visits, diagnostic and therapeutic procedures and total and variable cost expected.

RELATIVE VALUE SCALE STUDIES

Relative value scales (RVS), particularly the RBRVS, have been embraced for years by the health care industry as a way to statistically benchmark the medical practice and the individual physician. Relative value scales are used in almost every aspect of costing, revenue, compensation, utilization and resource allocation studies performed. As part of the total package, CMPA will perform a complete Relative Value Scale analysis to prepare the practice for further, more complex analyses. Information obtained includes component RVU data, conversion factors and Geographic Adjustment Factors (GAF) broken out by major HCPCS coding categories. In addition, CMPA is the only system that automatically adjusts RVU values by the mathematical factors assigned to specific modifiers in relation to their reimbursement potential. Without this step, an RBRVS analysis would very well result in a skew of all related analytical components.

STATISTICAL MODELING BY LOCATION BY PHYSICIAN

For single-specialty practices, the default analyses are based on global practice data. That is, cumulative data for the entire practice or organization. This is referred to as an **aggregate** analysis. For multi-specialty practices or single-specialty multi-provider practices, CMPA has the ability to capture frequency information

by location, by physician, by department or any combination as long as this data is available from the practice management system. This is referred to as a **segregated** analysis. This is a very powerful tool for looking at different profit centers within the organization. For example, the practice can look at the E/M analysis using the aggregate data (all physicians and locations as one group) or they can use the segregated frequency data to select different physicians within the E/M analysis to compare E/M utilization for aberrant behaviors. Remember, **it only takes one physician with poor coding practices to trigger a review for the entire group.** The practice may also want to compare cost accounting data by location to identify the profit generated by one location using the segregated frequency set and compare that to the overall aggregate cost analysis. The CMPA can also produce a resource allocation study segregated by physician that will compare the revenues generated by resource expenditure (costs) for each physician selected against any control group chosen. This is invaluable for building revenue/cost relationships for compensation and bonus determination.

REPORTS AND WORK PRODUCT

One of the greatest benefits of the CMPA is the comprehensive work product that is produced from the analysis. The work product consists of detailed MS Excel spreadsheets for each analysis component, individual E/M utilization worksheets for each provider/specialty, a full analysis summary and a complete interpretation guide that defines and explains each field in each report/spreadsheet. Through specific organization and categorization of worksheets, the work product is optimized for Six Sigma, Lean Six Sigma, Kaizen and other process improvement techniques.

Reports and worksheets are broken down into four categories:

- Financial
- Fee Scheduling
- Coding
- Productivity

Possibly the most important report is the analysis summary report. This ten-page report contains hundreds of summary statistics which, used properly, can reveal an enormous amount of critical information about the practice in just a matter of moments. And used in conjunction with the associated worksheets, provides detailed drill-down data unique within our industry.

CMPA OPPORTUNITIES

The medical practice is the desired end-user for the CMPA analysis. To what extent you wish to take advantage of the analysis will be based upon your needs and available resources. With respect to entry points, you can choose to contract a certified Medical Practice Analyst (MPA) to have the analysis conducted or you may choose to license the system for the practice.

Opportunities to license the software are restricted to those medical practices that have professional staff capable of working with the level of detail provided by the CMPA analysis. The majority of our licensed practices employ CPAs or other highly qualified professionals that have a keen understanding of operational and financial processes within a medical practice.

Some practices have professional-level staff capable of understanding and interpreting the results of the CMPA and implementing the processes necessary to remediate those issues defined by the analysis. For these practices, all that may be required is the work product. This consists of a summary analysis report and a

series of worksheets that contain data organized by analytical component. This includes a detailed interpretation document that is used as a key to understand each of the fields in the component spreadsheets.

For smaller practices or those that may not have access to these types of resources, the MPA can provide more involved assistance, including a detailed executive summary report that includes specific conclusions and recommendations based upon the results of the analysis. The MPA can also provide remediation services, such as coding reviews and chart audits, assistance with A/R, billing and collections, development of compliance programs and other needed consulting services.

FOR MORE INFORMATION

If you would more information about having the CMPA performed for your practice, or if you are a consultant and would like more information about licensing the CMPA software for use with your medical clients, please visit our web site at www.mitsi.org, email us at info@mitsi.org or call our offices at 800.616.CMPA (2672).