Physician Auditing and Compliance

Compliance Solutions

In today's compliance environment, most physician practices rely on retrospective baseline audits and subsequent annual audits to identify incidents and patterns of compliance risk within their professional services practitioner populations.

This audit methodology relies on the services of an experienced audit team (whether internal or external) to review randomly selected service encounters. However, **the random selection approach often falls short**. The modern healthcare environment and the goals for compliance are just too complex.

Some organizations have addressed this by relying on utilization comparisons to the Medicare database instead. This method of risk analysis compares the utilization for a given practitioner against the utilization for the same specialty reported within the Medicare database.

The challenge with this approach is that **utilization comparisons provide a false sense of security**. By comparing to the limited Medicare specialty database, significant false positives can be created when subspecialties are added—which adds to, rather than mitigates the cost of creating an audit plan.

In contrast, **Panacea has developed a new holistic approach to auditing** using technology, expertise, and education. Panacea's overarching goal and objective with this new approach is to identify incidents and patterns of potential billing and coding risk as well as opportunities where under-coding of services may be taking place.

Professional services have the largest set of codes in use today, so it's no wonder there's significant compliance risk.

Here are just a few examples:

- ☐ 15,000 individual procedure codes in the fee schedule
- ☐ 300 modifiers, including HCPCS (CPT®) Level I and HCPCS Level II

A typical internal medicine practitioner uses:

- ☐ 19 procedure codes for top 50% of cases
- ☐ 77 procedure codes for the top 80% of cases

PANACEA®

A Career Step Company

SOFTWARE. CONSULTING. EDUCATION. RESULTS.

The Solution

The solution is a holistic approach that leverages proprietary technology, predictive analytics, and an expert audit team.

The approach is a four-step process:

Step 1: Deliver a Risk Profile and Analysis

Using the Compliance Risk Analyzer (CRA)—a web-based, predictive analytical application—all claims are quickly processed to identify codes that are known to be high risk for coding and billing errors. A risk analysis is performed for the practice and each practitioner.

Step 2: Select Cases, Capture Results, Report Findings

Cases are targeted for review based on high probability of being under-coded or under-charged, over-coded or overcharged, non-compliance, or quality issues. The analysis findings are captured and summarized using dashboard reporting and detailed bill-level reports. Additional reports can be customized, based on client's unique needs.

Step 3: Conduct Baseline Documentation and Coding Review

The results of the compliance risk analysis are used to target cases for a focused documentation and coding review, designed specifically for each practitioner. The baseline review results are used to develop customized educational programs and best practice coding and documentation policies.

Step 4: Education for Continuous Improvement

Educational courses and tutorials are available to reinforce continuous improvements through an online learning platform or in-person, onsite training. We offer material covering the following topics:

- [ ] General medical record documentation principles (including requirements for scribes)
- [ ] E&M training
- [ ] Preventive care services
- [ ] Modifiers
- [ ] Incident to and split/shared services
- [ ] Teaching practitioners and medical students
- [ ] CPT and ICD-10 coding updates

Talk to a Panacea sales representative today to schedule your compliance review.

1-866-926-5933 | info@panaceainc.com | www.panaceainc.com