Auditing Physician Productivity Compensation Arrangements

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Introduction

Bon Secours Health System

New York
- Bon Secours Charity Health System
- Bon Secours New York Health System

Maryland
- Bon Secours Baltimore Health Corporation
- Bon Secours Health System

Virginia
- Bon Secours Virginia — Hampton Roads
- Bon Secours Virginia — Richmond*

Kentucky
- Bon Secours Kentucky Health System

South Carolina
- Bon Secours St. Francis Health System
- Roper St. Francis Healthcare*

Florida
- Bon Secours St. Petersburg Health System

* Joint Venture
Many hospitals have aggressively adopted physician integration strategies.

Within Bon Secours, approximately 900 physicians are either employed by the health system directly or within a joint venture.
Learning Objectives

- Understand the components of relative value units and how they are used in determining productivity based compensation.
- How productivity based compensation aligns the financial interests of employed physicians and hospitals. How can that alignment be broken?
- How do we perform a production compensation audit?
- What are some typical audit findings?
What is Productivity Based Compensation?

- A compensation arrangement whereby physicians (or physician extenders) are compensated based on the volume of work that they produce.

- Productivity measured using Work Relative Value Units (WRVU’s)

- Contracts vary but generally there compensation factor (dollar value per WRVU) applied to WRVU totals for a period (comp factor X WRVU total = compensation for period)
Most physician employment arrangements create financial losses for hospitals (consider employment a long term subsidy of practice losses as opposed to recruitment which is a short term subsidy)

New England Journal of Medicine cites per physician annual losses from $150-$250K for first three years and continued but moderated losses thereafter

“Hospitals are willing to take a loss employing PCPs in order to influence the flow of referrals to specialists who use their facilities.” (NEJM source article linked below)

Why audit productivity comp?

- Complexity: Depending on terms, underlying calculations may be more complex than they first appear.
- Mistakes create many types of risks (financial, compliance, operational, and reputational)
- Financial materiality/importance of success...sheer size and strategic nature of the investment
- Create goodwill among your key physicians...nothing raises employees’ ire more than mistakes involving compensation!
How production is measured...the Relative Value Unit

- Relative Value Units in total are comprised of three components, all three of which may be geographically cost indexed. These are:
  - Physician Work Relative Value Units (WRVU’s): *The relative level of time, skill, training and intensity to provide a given service.*
  - Practice Expense RVU
  - Malpractice RVU
Productivity Compensation Model

- Work relative value units are the most common metric used for compensation calculations
- CMS routinely publishes Medicare Physician Fee Schedule listing WRVU’s by HCPCS code
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html)

2012 Pricing Amount is $34.04 =

\[
(\text{Work RVU} \times \text{Work GPCI}) + \\
(\text{Practice Expense RVU} \times \text{Practice Expense GPCI}) + \\
(\text{Malpractice ins RVU} \times \text{Malpractice ins GPCI})
\]

\[\times \text{Conversion Factor (CF)}\]
WRVU’s are geographically adjusted

**Geographic Practice Cost Indices (GPCI)** - Geographic Practice Cost Indices account for the geographic differences in the cost of practice across the country. CMS calculates an individual GPCI for each of the RVU components -- physician work, practice expense and malpractice. CMS reviews GPCIs are reviewed every three years. **But..**

RVUs are not static! Last years data is no good!
More Work Higher WRVUs

- Greater intensity of service means higher WRVU:
- Ear wax removal (69210): 0.61
- Office/outpatient visit (99213): 0.97
- Heart transplant (33945): 89.50
- Charge code modifiers may either increase or decrease the WRVU value associated with a charge code
- Compensation factor is contracted rate at which each WRVU is reimbursed
Compensation terms may reflect one of several variants:

- **Straight Production:** Compensation is a function of WRVU totals multiplied by a stated compensation factor.

- **Guarantee with a Production Upside:** Physician guaranteed a salary which can increase if production targets are met (comp factor per WRVU can be increased, or stated cash amounts paid, if production thresholds are met).

- **Guaranteed Draw but Reconciled to Productivity with Stated Frequency:** Physician effectively paid a salary but the salary is “trued up” to production which will increase or decrease subsequent draws.
Basic Math…but with lots of nuance

- Base comp (unadjusted for productivity)
- Production comp = Work RVU’s X Comp Factor
- Reconciliation (true up) – compare productivity with base compensation on periodic (e.g. quarterly or annually)
- Important Point…when is WRVU earned by physician? Do contracts require the service to be documented, documented and billed, or documented, billed, and collected prior to granting WRVU credit?
- Some agreements afford sliding scale for comp factors to reward high performance (e.g. Exceed MGMA 75th percentile and comp factor increases by 10%)
Reconciling Production with Base (Draw Amounts)

- True up (production vs. base)
- Production comp $>$ base comp
  - Incentive/Surplus position
  - Full or partial payout?
  - Annual payout of reserve?
- Production comp $<$ base comp
  - Deficit position
  - Adjust base comp (how/when?)

![Diagram showing the relationship between production and compensation, with two possible scenarios: one where production exceeds base compensation and one where it falls short.](attachment:image.png)
True Up Results in Either Surplus or Deficit

- **Surplus:**
  - Pay out at 100%
  - Contracts may reserve a portion of the surplus to offset future shortfalls (e.g. 80% payout and 20% reserved until year end)

- **Deficit:**
  - When are draws reduced to reflect current productivity run rate?
  - How aggressively is draw reduced (how long do contracts allow deficit to linger prior to being refunded?)
  - Do contracts require draw reduction or allow management discretion?
Audit Objectives/Testing Steps

- Recalculate to ensure mathematical accuracy of underlying calculations. Are contractual terms as they relate to the computations clear? Agree WRVU totals to output from the physician billing system.
- Ensure production surpluses or deficits are treated in the manner agreed in the contract.
- Understand the nature of all payments made to physicians during the time period (tie to other agreements beyond employment).
- Understand what review/QA is performed on calculations prior to submitting to payroll.
Testing Steps (cont.)

- Review adjustments to WRVUs for the impact of charge code modifiers (surgical assist, bilateral)
- Evaluate the accuracy and completeness of WRVU and modifier values in the physician billing system
- If data is manipulated in spreadsheets, test formulas, evaluate data archival (read only copy) and review general spreadsheet controls
- Verify compliance with established compensation policies (for example some organizations cap income at 90th percentile MGMA or require advance board approval prior to exceeding the cap)
Watch out for gamesmanship!

- Review physician practice patterns to ensure there is no gamesmanship between those physicians on production and those on a guarantee (e.g. giving the low RVU production volume to docs on a guarantee and the high RVU procedures to those already on production)
- Understand what coding quality assurance is performed on high fliers to validate RVU production
Suggestions for getting started...

- Pick **judgmental** sample with the goal of picking as many different types of compensation models as possible. Often process issues are specific to a model so the more models you pick, the more likely you are to find opportunities.

- Pick some older agreements and some newer agreements.

- Not unusual for any number of different law firms to have been involved in drafting agreements...pick as many disparate agreements as is possible.

- Include some high flyers...>75% percentile MGMA productivity.
CAATS for WRVU Values

- **CAATs:**
  - Join CMS table to the WRVU table loaded in your billing system (key of HCPCS code). Purpose is to verify the system is loaded with the correct WRVU values.
  - Join physician WRVU detail to CMS table (key of HCPCS code). Ensure modifier utilization results in adjustment to accumulated WRVU’s.
Possible Audit Findings

- Physicians are afforded WRVU credit for services that are assigned a WRVU value but are not reimbursed by Medicare or some commercial payors (we identified 127 codes that were unfunded by CMS or Blue Cross but credit accrued to physician, telemedicine is a good example).

- Difficulty in manually reducing WRVU credit for certain modifiers (especially multiple surgeries on same date of service given modifier 51 no longer accepted by many payors...results in physicians receiving full credit for each individual procedure).

- Lack of specific language granting employer the right to reduce WRVU credit for preventable denials (example: insufficient medical record documentation, medical necessity, etc.).
Possible Audit Findings

- Payroll administration: Are there adequate pay codes so that physicians understand what types of incentives have been paid. Are there processes to monitor caps on individual payment types and aggregate compensation caps? Are there provisions that drive physician productivity after reaching annual caps (e.g., approval on a case by case basis to exceed the cap or increase subsequent year cap to reflect current year productivity).

- Administrative duties/meeting attendance: Are there arbitrary WRVU credits that are afforded physicians for performing administrative duties that are not referenced in their contracts (example: doc serves as committee member for meaningful use and insists on being compensated therefore arbitrary credit is granted for the administrative role that is not referenced in the contract).
Possible Audit Findings

- Coding QA: focus on high flyers, monitor outlier production (nursing home visits good example of high RVU production)

- Management discretion in recouping productivity deficits: Some contracts allow management discretion to set subsequent draws to mirror current run rate for productivity or not on a case by case basis.

- Some agreements for coverage are not as specific as they could be regarding whether WRVUs that accrue for providing physician services that are paid an hourly rate (example: coverage for sleep lab at an hourly rate but also paid per WRVU for interpretation of sleep studies during the time the hourly rate is also paid).

- HR involvement in the payment of productivity incentives...they don’t produce the reports but still should monitor payment of all incentives and sample/test calculations to monitor accuracy.
Possible Audit Findings

- Paying physicians for mid-level supervision in instances where mid-level is no longer employed.
- Compensation Factors: does the comp factor tie to the agreement after applying escalators (if any)
- Data repository/data retention (can we replicate results if challenged several years from now?)
- Spreadsheet controls/manual data manipulation CME: Typically CME has an annual not to exceed cap. Must track expenses to ensure cap is not exceeded. Best to approve CME trips and estimated costs in advance. Issues related to excessive travel and accommodations costs, spousal travel, entertainment costs, stays that extend beyond the training dates, general conflict with expense reimbursement policies, etc..
Possible Audit Findings

- Contracts reference different versions of the relative value file but system can only process using a single file.

- Lack of detailed procedure documentation that explains exactly how productivity reports are run (report parameters, date ranges, physician identifiers/etc) and subsequently adjusted to be useful for production compensation calculations. Need adequate detail so the procedure would be useful for training.

- Agreements don’t provide illustrative examples of how production deficits are recouped or provide adequate specificity regarding how deficits are refunded (how subsequent draws are reduced and by what amount, how deficits rolls forward from one period to the next)
Contracts may require physicians to refer within the health system (termed the exclusive right to refer)...how are referral patterns monitored in these instances?
Other types of payments to consider...

- Relocation, signing bonus, retention bonus, tail coverage reimbursement, recruitment expenses, mid level supervision payments, and student loan repayments.

- Legacy credit cards (unrelated but important): make certain all legacy credit card accounts/retail/gas cards are closed and not paid by the practice.
Cost containment will result in close scrutiny of every agreement...especially those that result in absorbing high fixed cost practices that experience declining volumes. It is difficult to use production compensation as a model for those physicians that are sunsetting or who do not work full workweeks.
Important to standardize compensation models!

Variants of the basic production comp model (often result of using various law firms to draft agreements as a result of rapid onboarding) can quickly become difficult to manage.

Standardization is important as it is very difficult to manage many contract variants (and in some cases beyond the ability of the underlying information system...e.g. multiple versions of the RVU table)
Questions?

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Save the Date: August 25-28, 2013

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