

The logo for the Faculty Practice Solutions Center features a blue arc above the text. The text is arranged in three lines: "faculty practice" in white, "solutions center" in yellow, and "powered by UHC & AAMC" in a smaller white font below.

faculty practice
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Using FPSC Benchmark Data to Understand Academic Radiation Oncology

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The FPSC in Brief



Participating Institutions

- Began as UHC CPT Database in 1995
- FPSC Advisory Group created in 2000
- FPSC created in 2001
- 87 participating institutions nationwide
- 65,000+ participating physicians
- 100+ unique subspecialties
- 200+ million records, 40 gigabytes of data
- Hundreds of performance measures



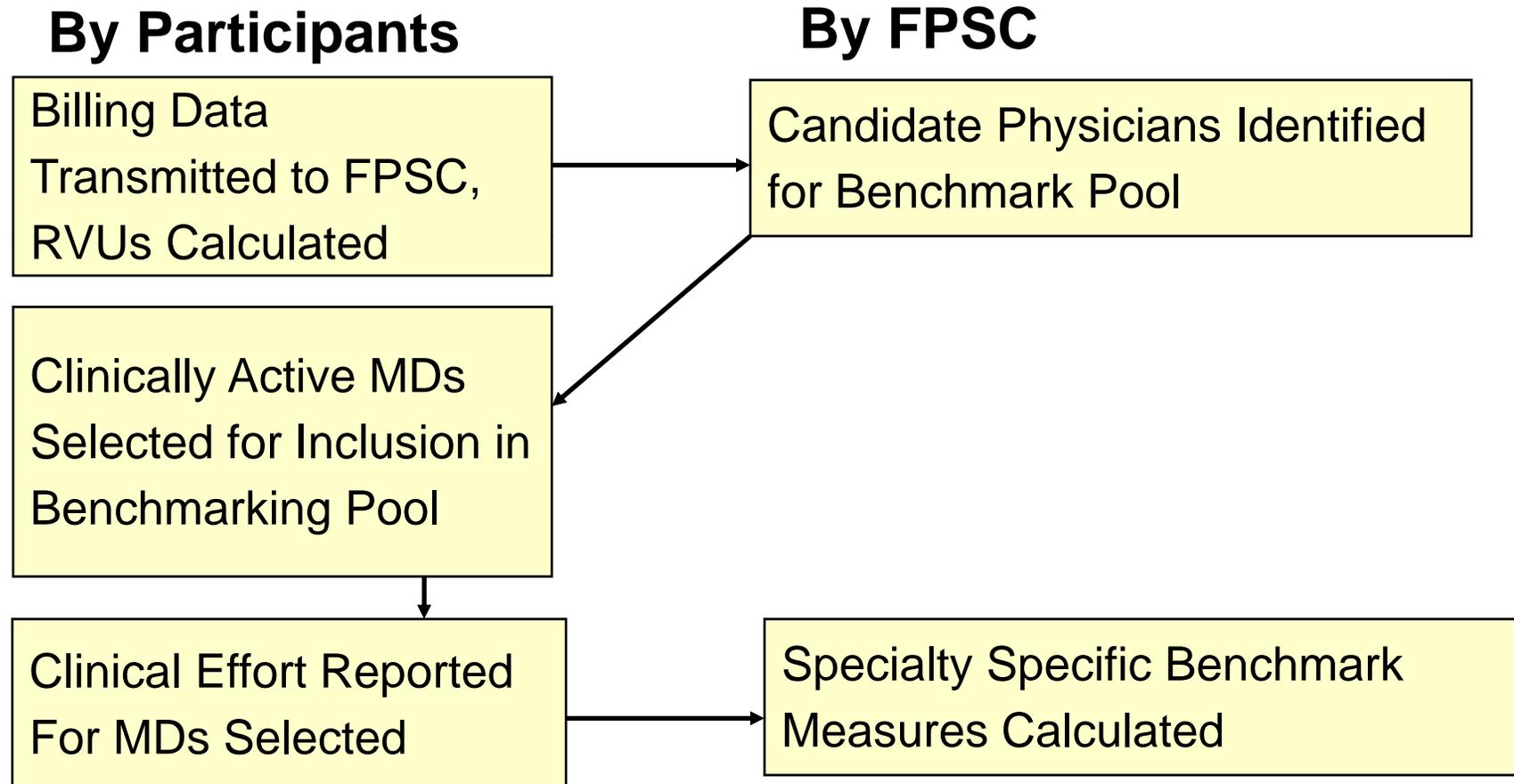
UHC-AAMC FPSC Participants

- Albany Medical Center
- Baystate Health System
- Beth Israel-Deaconess
- Brigham & Women's
- Cedars-Sinai Medical Center
- Clarian Health Partners
- Columbia University
- Denver Health
- Duke University
- East Carolina University
- Georgetown University
- Howard University
- Indiana University
- Johns Hopkins University
- Kansas University Physicians
- LifeBridge Health
- Loyola University
- LSU Healthcare Network
- Massachusetts General
- Medical College of Georgia
- Medical College of Wisconsin
- Medical University of South Carolina
- Montefiore Medical Center
- Morehouse Medical Associates
- Mt. Sinai Faculty Practice Associates
- NLSU Health System
- Northwestern University
- Oregon Health and Science University
- Rush Medical College
- Saint Louis University
- Stanford University
- SUNY at Stony Brook
- SUNY Downstate
- SUNY Upstate
- The Emory Clinic
- The Methodist Hospital Physician Organization
- The Ohio State University
- Thomas Jefferson University
- Tufts Medical Center
- Tulane University Medical Group
- University of Alabama
- University of Arizona
- University of Arkansas
- University of California-Davis
- University of California-Irvine
- University of California-Los Angeles
- University of California-San Diego
- University of California-San Francisco
- University of Chicago
- University of Cincinnati
- University of Colorado
- University of Connecticut
- University of Florida
- University of Illinois
- University of Iowa
- University of Kentucky
- University of Louisville
- University of Maryland
- University of Massachusetts
- University of Miami
- University of Michigan
- University of Minnesota
- University of Mississippi
- University of Missouri – Columbia
- University of Missouri – KC
- University of Nebraska
- University of New Mexico
- University of North Carolina
- University of Oklahoma, OU Physicians
- University of Pennsylvania
- University of Rochester
- University of South Florida
- UTMB, Galveston
- University of Tennessee
- University of Texas San Antonio
- University of Toledo Physicians
- University of Utah
- University of Vermont
- University of Virginia
- University of Washington
- University of Wisconsin
- Vanderbilt University
- VCU School of Medicine/MCV Physicians
- Wake Forest University Physicians
- West Virginia University
- Weill Cornell Physician Organization
- Yale University

FPSC Benchmark Development Process – Key Goals

- Maximize sample size (both number of MDs and number of institutions represented)
- Ensure that sample reflects a population of clinically active faculty
- Generate a stable distribution (i.e., eliminate outliers)
- Identify relevant subpopulations

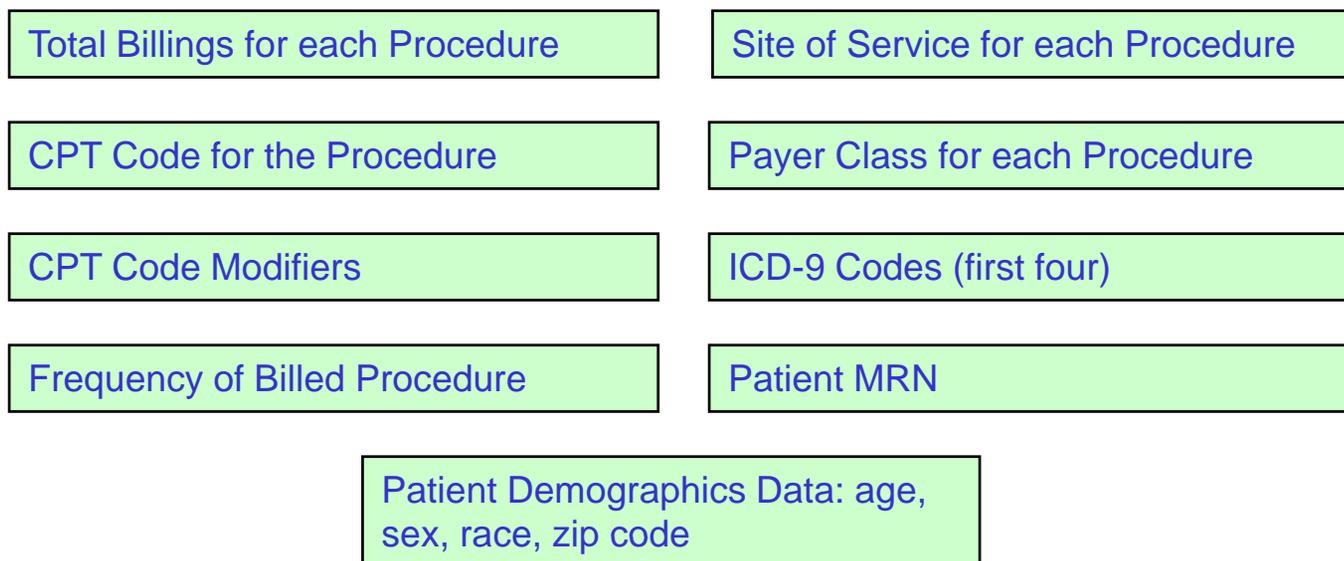
FPSC Benchmark Process Overview



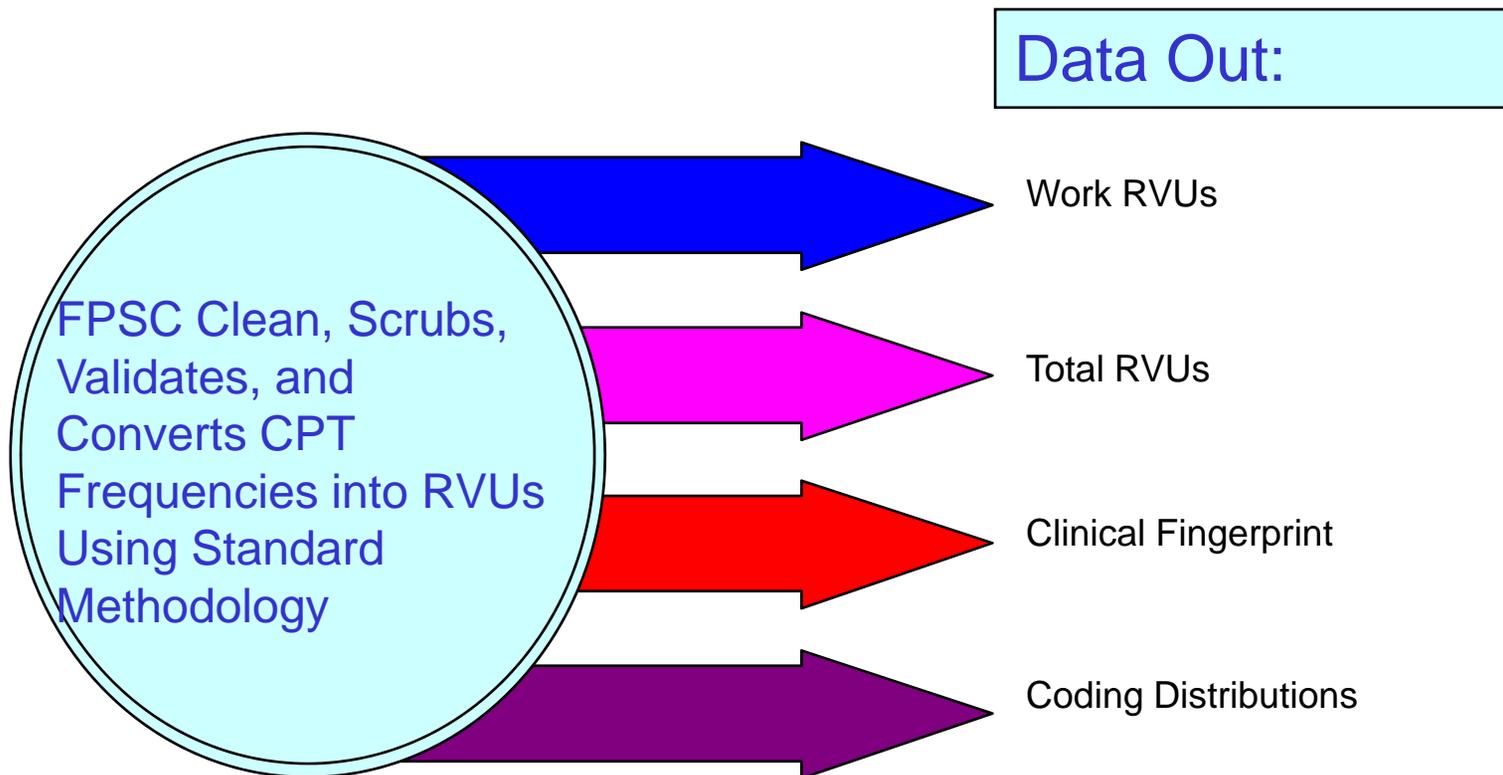
Automated Electronic Transfer Allows Efficient Data Capture

Participants send physician-level billing data to the FPSC. Data is electronically extracted and sent from the billing office.

Data In (at the procedure-level):



FPSC Applies Multi-Stage Validation and Standard Approach to Calculating RVUs



RVU Source Data

- Data Sources:
 - Medicare RBRVS Fee Schedule (period specific)
 - The Complete RBRVS, Relative Value Studies, Inc.
- Gap Filling:
 - Local charge:RVU ratio at specialty level – *gives RVU credit to physicians performing unlisted procedures*

What does CFTE Mean to You?

Clinical **F**ull-**T**ime **E**quivalent

OR

Constantly **F**ighting about **T**ime and **E**ffort

The Academic Conundrum:

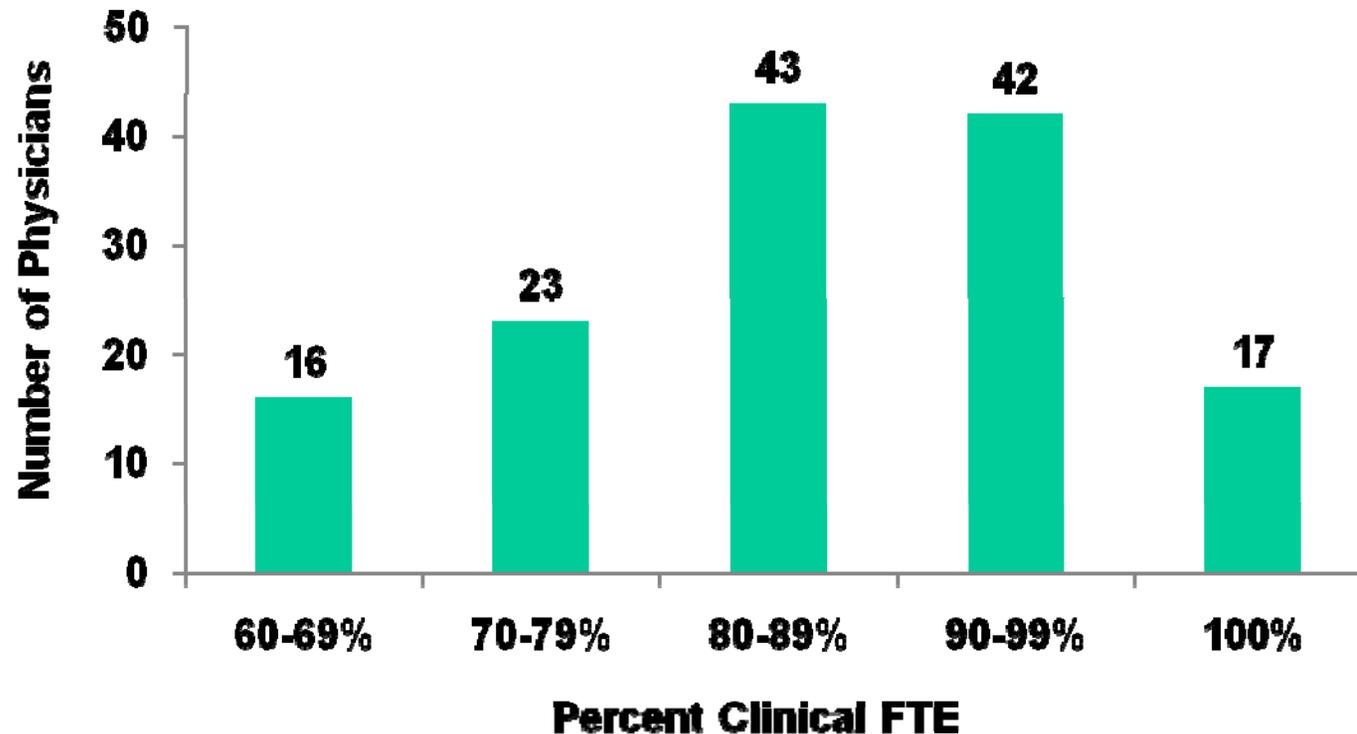
Since faculty time is spread among clinical, research, teaching, and administrative activities, time and effort (T&E) must be normalized when benchmarking.

Among Approaches to Account for Faculty T&E, 3 Methodologies Most Common

- Time/schedule-based
- Self-reported via survey
- Salary-based

MDs in 2009 FPSC Radiation Oncology Benchmark Have Average CFTE of 82%

Distribution of Benchmark MDs by %CFTE



FPSC Designed to Address Common Pitfalls in Benchmarking Data

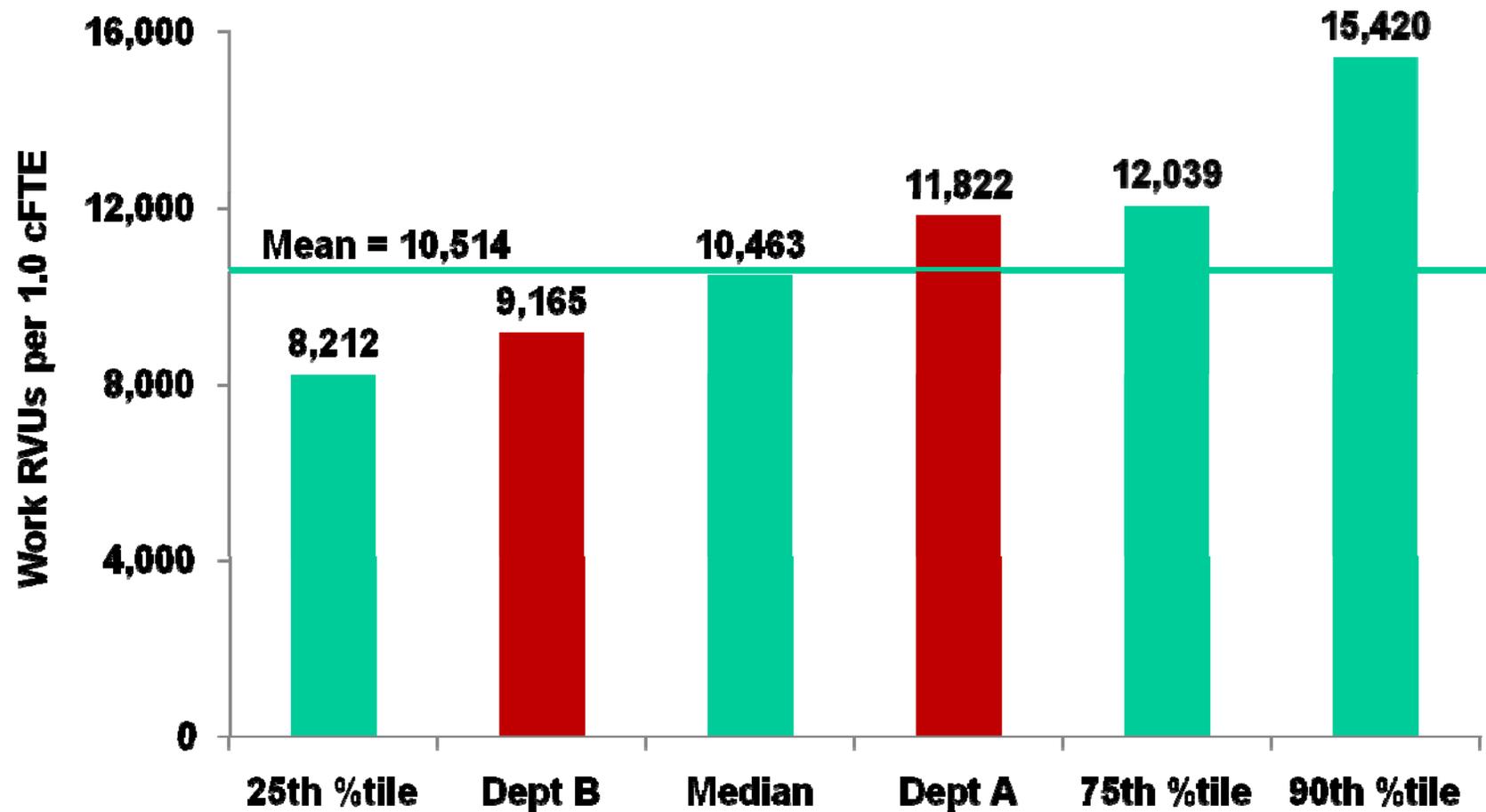
Common Pitfalls:	FPSC Approach:
<ul style="list-style-type: none"> existing comparative data not reflective of AHC faculty groups 	<ul style="list-style-type: none"> → numerous faculty groups participating → broad scope of specialties → continuous feedback and refinement through member involvement
<ul style="list-style-type: none"> inaccuracies of “survey” data missing or misclassified data 	<ul style="list-style-type: none"> → data submitted electronically → consistent methodology in RVU calculation
<ul style="list-style-type: none"> significant year to year variability in existing comparative data 	<ul style="list-style-type: none"> → individual MD detail allows exclusion of outliers and analysis of coding behaviors

What Benchmark Measures Does the FPSC Provide?

- Work RVUs, Total RVUs, Billed Charges per 1.0 CFTE
- Evaluation and Management (E&M) Coding Distributions
- Scope and Mix of Services (Clinical Fingerprint)
- Charge Lag Analysis
- Charge Summary Statistics
- Revenue Cycle Performance—Collections, Denials, AR
- Payment Forecasting
- Custom Peer Cohort Benchmarking
- Others

Clinical Activity Highly Variable

Sample Departments vs. 2009 FPSC Benchmarks

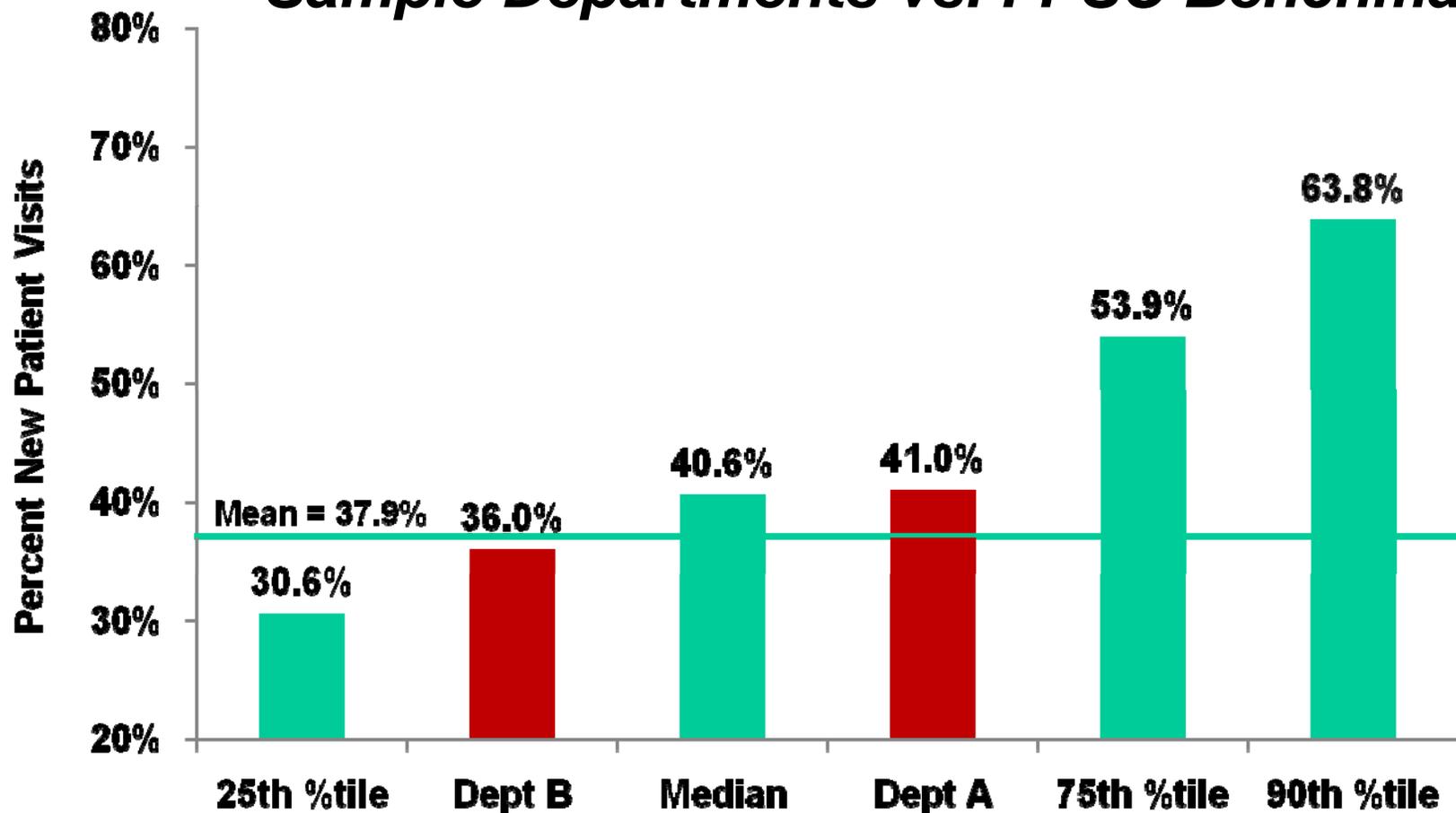


Differential Diagnosis for Variable Clinical Activity

- **Operational barriers**
 - Lack of space, aging infrastructure
 - Variable operational support and resources
 - Clinical and non-clinical support staff shortages
 - New practice ramp-up
 - Patient no-shows
- **Visit mix and practice composition**
 - New vs. established patients
 - Procedures vs. E&M work
 - Faculty with part-time practices
- **Inconsistent coding and billing**
 - Under-coding
 - Incorrect modifier use
 - Unbilled services and procedures
- **Inefficiencies**
 - Training
 - Clinical processes

Percent New Patient Visits* Can Impact Productivity and Access

Sample Departments vs. FPSC Benchmarks



* Percent New Patients = (Count of 99201-205 + 99241-245) / (Count of 99201-205 + 211-215 + 241-245)

Key Benefits Of Focusing On Access For New Specialty Patients

- Improvement in payer mix and collections per unit of service by reducing access barriers that alienate favorably insured patients
- More work RVUs and total RVUs per unit of specialist time expended → increased revenue
- Greater volume of procedures per patient encounter through successful screening work-up of new patients
- Greater downstream professional fee and facility revenues from broadening patient base served

Practice Composition—Distribution of Services by CPT Code—Key Driver of Variability

Faculty Practice Solutions Center Clinical Fingerprint--Work RVUs per 1.0 CFTE

CPT Code Family	Dept A Mean	Dept B Mean	FPSC Mean
Surgery	49	27	66
Radiology	10,931	7,811	9,189
Pathology & Laboratory	5	-	0
Medicine	-	109	16
Evaluation & Management	838	1,217	1,243
All CPT Ranges/Codes	11,822	9,165	10,514

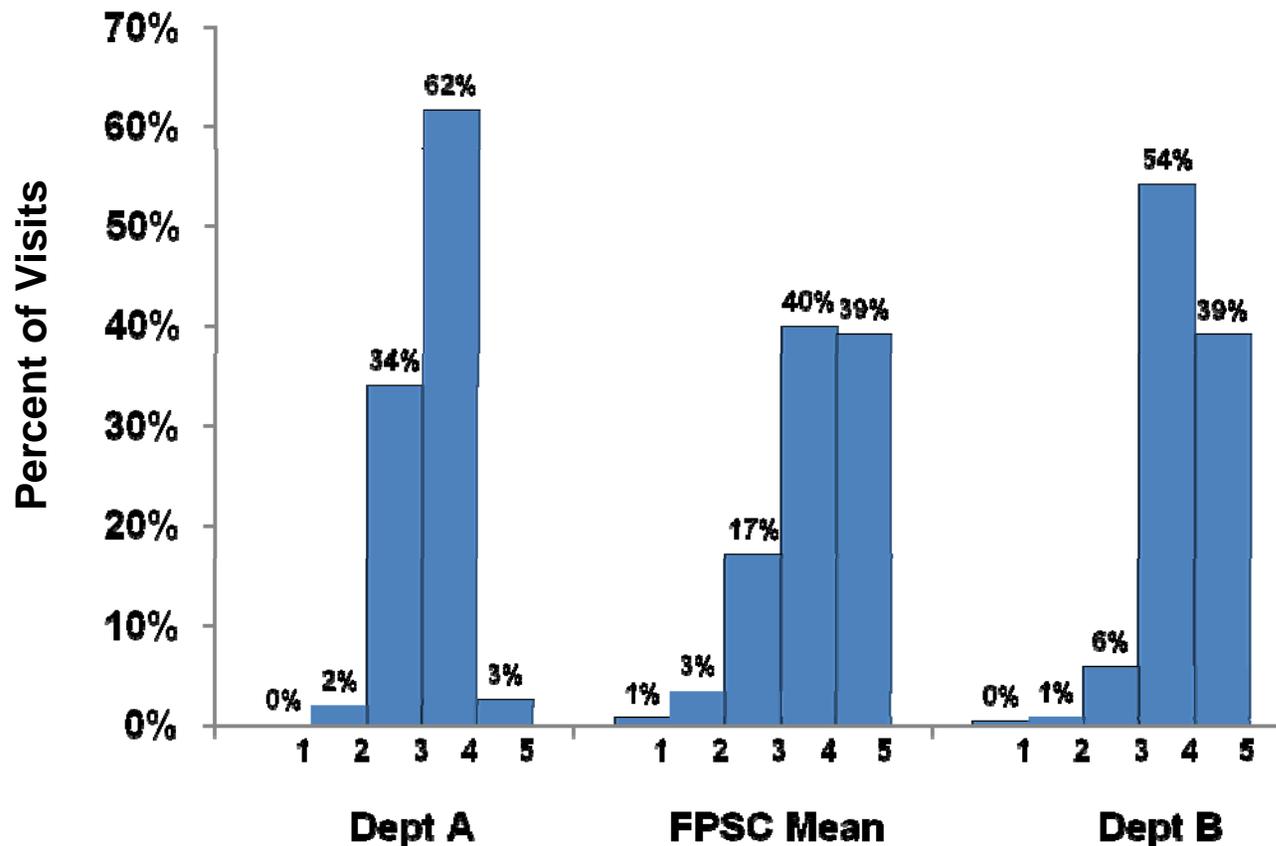
Distribution of Services by CPT Code

Work RVUs per 1.0 cFTE, Radiation Oncology Codes

Radiation Oncology CPT Codes	Dept A Mean	Dept B Mean	FPSC Mean
77261-77263 -- Radation therpay planning	831	610	694
77280 - Set radiation therapy field -- simple	196	113	102
77285 - Set radiation therapy field -- intermediate	-	-	4
77290 - Set radiation therapy field -- complex	318	322	350
77295 - Set radiation therapy field -- 3 dimensional	702	182	590
77300 - Radiation therapy dose plan	1,204	658	790
77301 - Radiotherapy dose plan, imrt	389	593	447
77305-77321 -- Teletx isodose	202	156	116
77326-77331 -- Other special services	25	52	186
77332 - Radiation treatment aid(s) -- simple	32	20	20
77333 - Radiation treatment aid(s) -- intermediate	1	7	8
77334 - Radiation treatment aid(s) -- complex	2,142	1,305	1,317
77421 - Stereoscopic x-ray guidance	84	674	89
77427 - Radiation tx management, x5	4,169	2,518	3,727
77431-77470 -- Other treatment management	488	310	440
77600-77790 -- Other	143	208	126
77261 - 77799 Radiation Oncology	10,926	7,729	9,006

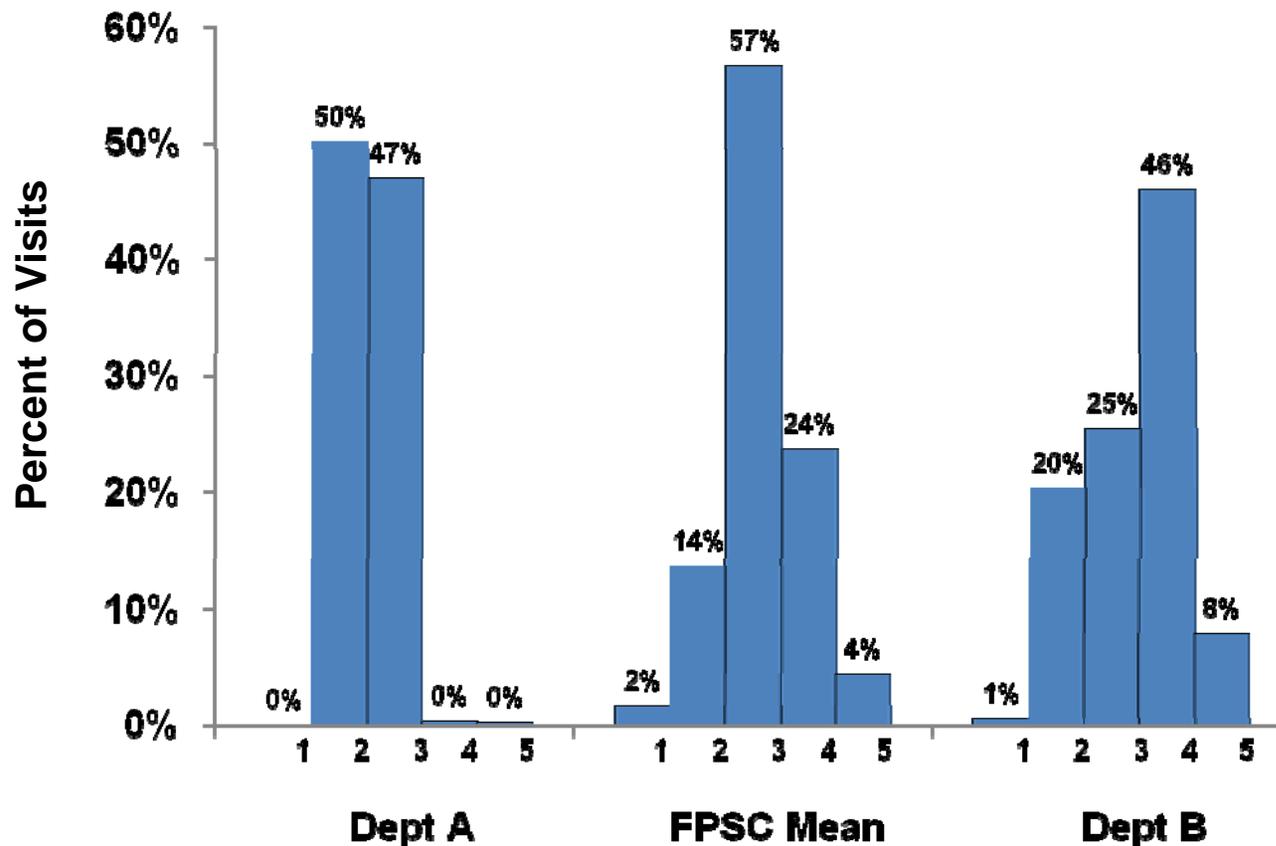
Variable E&M Service Coding Can Translate Into Lost RVUs and Payment

Outpatient Consultations—99241-245



Variable E&M Service Coding Can Translate Into Lost RVUs and Payment

Established Patient Visits—99211-215



Reducing Coding Variance Can Increase Productivity and Revenue

	99211	99212	99213	99214	99215	Total Visits/Payment
2010 NF Total RVU	0.53	1.08	1.82	2.73	3.68	
2010 Medicare NF Rate	\$19.12	\$38.97	\$65.67	\$98.51	\$132.79	
Dept A Distribution	0.0%	50.1%	46.9%	2.8%	0.2%	2,000
Payment	\$0	\$39,042	\$61,655	\$5,517	\$478	\$106,691
FPSC Mean Distribution	1.7%	13.6%	56.6%	23.8%	4.3%	2,000
Payment	\$631	\$10,616	\$74,343	\$46,950	\$11,420	\$143,960
Payment Increase at FPSC Mean Distribution						\$37,269
						34.9%

- Under-coding and over-coding are of equal concern
- Appropriate documentation and coding are key

Optimizing Efficiency

- What role do part-time physicians play in your practice?
- What is the mix of new patient visits, consultations, and established patient visits?
- How is return visit frequency determined and managed?
- How do generalists assist in the management of chronic, stable patients?
- Are there services being rendered but not billed for?
- What impact do residents have on faculty productivity and volumes?
- What are the barriers to productivity in the academic radiation oncology practice setting?

Questions? Comments?

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