Cloning, Tagging and How to Avoid Orange Pajamas

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Conflicts of Interest
None relevant to this presentation.

DISCLOSURE STATEMENT
Keeping you out of jail increases the likelihood you will keep doing good for patients in your community!
And supporting SkinPac.

INSURANCE
n. An ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the man who keeps the table.
–Ambrose Bierce
–THE DEVIL’S DICTIONARY
THREATS: “Is your EMR fueling risky record keeping?”

by Cheryl Toth

  Link now dead.
- Customize templates to ensure accurate documentation.
- Customize common conditions first.
- Avoid creating “cloned” notes.

--- Original Document ---

THREATS: “Is your EMR fueling risky record keeping?”

... what happens if the notes from the previous visit do not get reviewed? According to E&M documentation guidelines, each record must be allowed to stand on its own.

"Letting the system pull the previous history into an autogenerated form without reviewing it is risky."

... “Many ... surgeons get busy and forget to review the ‘cloned’ HPI from the previous visit. But paying close attention to what is being pulled forward is critical because the patient’s current problem could be completely different from the previous one.”

A good example, she says, is the three-pack-a-day spine patient who enters into a nonsmoking agreement prior to a laminectomy.

"If the patient sticks with it and the orthopaedic surgeon doesn’t review and update the social history while the patient is being managed conservatively in preparation for spinal surgery, the note will ‘pull forward’ as if the patient is still smoking three packs a day, thus creating inconsistencies in the current HPI and the review of systems (ROS). “
THREAT: Is your EMR fueling risky record keeping?
- Another common issue associated with the cloning process is that it creates a verbose chart note...
- ...not reader-friendly and contains rote responses that don’t necessarily call out pertinent positives.
- As referring physicians often complain about getting "canned" EMR chart notes from consulting specialists.
- Because the note has so much extraneous material, the referring physician may skip to the bottom and skip something important.

Is your EMR fueling risky record keeping?
- ...an EMR note should essentially mirror handwritten notes—except that it is legible.
- If normal documentation into the paper chart is about a half-page long, the documentation in the EMR system should be about the same length.

THREAT: Thought Experiment
- At the Brooklyn VA I copied two notes into Word documents for comparison and deleted them both without copying them so I would not get into trouble.
- I will demo how to DIY using published non-medical documents as examples.

THREATS: Thought Experiment
- In presidential campaigns the same speech is given often and tweaked for the audience.
- Similar but not the same.
- Not cloned,
- Different audience, slightly different message.
- And public domain, not HIPAA protected.
THREATS: Thought Experiment

- 8:58am GA: Well, we'll have a health care system with the efficiency of the motor vehicles if we do that, the motor vehicles division, and also the KGB, the same compassion.
- 12:31pm JAX: Frankly, I think we need, Americans deserve a better health care system than one that's run with the efficiency of the department of motor vehicles and the compassion of the KGB. We do not want to go to a nationalized or a socialized plan.
- Similar but not the same.
THREATS: “Send in the Clones” with apologies to Steven Sondheim

THREATS: Where are the clones?

Compare two versions of a document

1. Open one of the two versions of the document that you want to compare.
2. On the Tools menu, point to Track Changes, and then click Compare Documents.
3. On the Original document pop-up menu, select the original document.
4. On the Revised document pop-up menu, browse to the other version of the document, and then click OK.

Changes from the revised copy are merged into a new copy that is based on the original copy of the document.
The original copy remains untouched. Revision marks show any differences introduced by the revised copy of the document.

Tip: To change document comparison settings or the level of detail shown, on the Tools menu, point to Track Changes, click Compare Documents, and then click Options.

But where are the clones?

THREATS: Quick, send in the clones.
THREATS: There ought to be clones!

President Bush varied his speech enough to make each one sort of novel.
In contrast, a typical derm note in the VA has few deletions or insertions.
Many heme onc and primary care notes only differ in vital sign or lab results.
Very little markup on the comparison.
Curiously.

THREATS: Are there no clones?

THREATS: Quick, send in the clones. Don't bother, they're here.
THREATS: Clone Groans
- Too much fluff.
- If they had med reconciliation with the primary doc yesterday, why are you copying and pasting it in to your note. It is not medically necessary.
- Surgical notes often have every possible surgical procedure embedded creating long lists of unchecked boxes as you search for what was actually done.

THREATS: Clone Groans
- I can see you used 5-0 vicryl and 6-0 nylon and know the diagnosis was BCC but I have no idea what you did.
- Mohs? Excision?
- Did you play cats cradle with the suture or make a lanyard?
- Documentation should follow a few basic premises.

The World According To McCaffree
- Document what you did.
- Do what you documented.
- Report that which you did which was medically necessary with appropriate CPT codes linked to appropriate ICD 10 codes.

- Medicare B Update, third quarter 2006 (vol. 4, no. 3) states “Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries.
- Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary.
It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.

All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter.

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Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

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Threats: TAGGING

- Many newer EHR systems tag information copied from a previous note (from the same or a different provider).
- The information is pasted into the documentation with a tag at the end of the dictation, noting the authorship of the entry.
- This tagging could be viewed ill one of two ways:
  1. As a "reference" to another author's work; or
  2. As plagiarism, if used as their own account of that day’s encounter.
In medical coding, the content of the documentation supports an (E/M) code level, which determines the provider's reimbursement. The reimbursement for a given E/M level is meant to compensate the provider for their effort to examine, evaluate, and treat the patient.

There is no problem with tagging information from a previous encounter, or even from another physician’s note, if it is used only as a reference or for past med hx and NOT to support a level of service for reimbursement purposes.

Per Medicare Administrative Contractor First Coast Service Options’ 2006 Medicare Part B Update! (directed at Connecticut and Florida Medicare Part B providers):

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

The November/December 1999 Medicare Bulletin further instructs:

Cloned notes are notes that have little or no change from day to day and patient to patient. These types of notes do not support the medical necessity of a visit. More importantly, in some cases, they may not actually support that a visit occurred. Cloned notes may be construed as an attempt to defraud the Medicare program.

A 2013 Congressional white paper stated:

There is a growing body of evidence that indicates some physicians may simply copy and paste information in medical records, which represents a significant increase in the risk of medical errors by potentially including inaccurate, old, or out-of-date patient information in a patient record that can jeopardize patient safety and increase costs.
Threats: TAGGING

- Is tagging simply cloning with a new moniker?
- Yes.

There Are Many Ways To Game The System

- We will look at some examples from the bedside to the cloud.
  - Blatantly make things up. Lying.
  - Fudge your coding.
  - Be a major outlier.

Flipping on Flaps

- ATT(14000-14350)
- Codes 14000-14302 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap).

Flipping on Flaps

- They do not apply to direct closure or rearrangement of traumatic wounds incidentally resulting in these configurations.
- Undermining alone of adjacent tissues to achieve closure, without additional incisions, does not constitute adjacent tissue transfer, see complex repair codes 13100-13160.
If the suture line looks like this, these are not flaps!

Flipping on Flaps
- The excision of a benign lesion (11400-11446) or a malignant lesion (11600-11646) is not separately reportable with codes 14000-14302.
- "Getting around this" with modifier 59 or any other modifier is fraud

I would report this as 1731Xs &
- A. 13132 CR, cheeks, 2.6 to 7.5 cm AND 13151 CR, nose, 1.2-2.5 cm
- B. 14041 – ATT, 10.1-30 sq cm AND 13151 CR, nose, 1.2-2.5 cm
- C. 14041 – ATT, 30-50 sq cm AND 13132 CR, cheeks, 2.6 - 7.5 cm
- D. 13132 CR, cheeks, 2.6 cm to 7.5 cm
I would report this as 1731Xs &
A. 13132 CR, cheeks, 2.6 to 7.5 cm AND 13151 CR, nose, 1.2-2.5 cm
Two complex repairs from different anatomic regions.

Intermediate vs Complex Repairs

Repair—Complex
Reconstructive procedures, complicated wound closure.
Sum of lengths of repairs for each group of anatomic sites.

13131  Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
(CPT Assistant Fall 92:7, Sep 97:11, Dec 98:5, Nov 99:10, Feb 00:10, Apr 00:8, Feb 10:3
(For 1.0 cm or less, see simple or intermediate repairs)
13132  2.6 cm to 7.5 cm
13150  Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
(CPT Assistant Sep 97:11, Dec 98:5, Nov 99:10, Feb 00:10, Apr 00:8, Feb 10:3
(See also 40650-40654, 67961-67975)
13151  1.1 cm to 2.5 cm
(CPT Assistant Dec 98:5, Nov 99:10, Feb 00:10, Feb 10:3

Simple repair is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
Intermediate repair includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

Complex repair includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.

Don’t be Stupid

- Not every wound needs stenting sutures or drains.
- Not every wound needs extensive undermining.

What is wide or extensive undermining?

- It is undermining beyond that which is typically included in a simple or intermediate repair....
- That you have documented....
- That is medically necessary.
Lets play auditor and let common sense prevail!

- Small punch biopsy.

- Droopy eyelid from which you have excised a teeney lesion.

Lets play auditor and let common sense prevail!

- Turkey gullets.

Instructions for listing services at time of wound repair:
1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.
These are still not flaps!
Nor necessarily complex repairs.

2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same code descriptor. For example, add together the lengths of intermediate repairs to the trunk and extremities. Do not add lengths of repairs from different groupings of anatomic sites (e.g., face and extremities). Also, do not add together lengths of different classifications (e.g., intermediate and complex repairs).

3. Decontamination and/or debridement: Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.

(For extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s) resulting from penetrating and/or blunt trauma, see 11042-11047.)

(For extensive debridement of subcutaneous tissue, muscle, fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s), see 11010-11012.)
Remove Tumor Today, Repair In One or a Few Days

- Likely not a separately reportable debridement.

4. Involvement of nerves, blood vessels and tendons: Report under appropriate system (Nervous, Cardiovascular, Musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure unless it qualifies as a complex repair, in which case modifier 59 applies.

Simple ligation of vessels in an open wound is considered as part of any wound closure.

Simple “exploration” of nerves, blood vessels or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required. If the wound requires enlargement, extension of dissection (to determine penetration), debridement, removal of foreign body(s), ligation or coagulation of minor subcutaneous and/or muscular blood vessel(s) of the subcutaneous tissue, muscle fascia, and/or muscle, not requiring thoracotomy or laparotomy, use codes 20100-20103, as appropriate.

“Dog ear” or “standing cone” removal does not make a repair complex despite what you were told one, two, five, fifteen or twenty five years ago.
Complex Repairs

- Changes are coming.
- New definitions.
- Not public yet.

I would report this as:

- A. 15260 FTSG, free, nose,...; <20 sq cm
- B. 15260 and 15004 Surgical preparation or creation of recipient site by excision of open wounds
- C. 15260 and 13132 CR, cheeks, 2.6 to 7.5 cm
- D. 15260 and 12032 Int Repair, 2.6-7.5 cm

15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

* CPT Assistant Fall 91:7, Fall 93:7, Apr 97:4, Aug 97:6, Sep 97:3, Jul 99:3, Feb 08:3, Mar 08:14; CPT Changes: An Insider’s View 2002
I would report this as:

A. 15260 FTSG, free, nose....;
<20 sq cm

B. 15260 and 15004
Surgical preparation or creation of recipient site by excision of open wounds.

This repair would be reported as:

A. 15740 Flap; island pedicle
B. 15750 Flap; neurovascular pedicle
C. 14040 ATT or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
D. 15756 Free muscle or myocutaneous flap with microvascular anastomosis

If a repair of the donor site requiring skin grafting or local flaps is necessary, it should be reported separately with a separate code.
No man is an Island, entire of itself

- John Donne

Codes 14000-14302 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap).

“And an island never cries.”

- Simon & Garfunkel

Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an axial vessel into its design.

The flap is typically transferred through a tunnel underneath the skin and sutured into its new position.

The donor site is closed directly.

This repair would be reported as:

C. 14040 ATT or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
**Headliners**

- Those who have made the national news.
- Outlier Hall of Fame.
- Most exposed by someone close.
- “Qui tam pro domino rege quam pro se ipso in hac parte sequitur”
- “[He] who sues in this matter for the king as well as for himself.”

**Qui Tam: For the king**

- “The allegations resolved by today’s settlement were initiated by a lawsuit originally filed ... by Alan Freedman, M.D., a pathologist who formerly worked at TPL.
- Dr. Freedman filed the lawsuit under the *qui tam*, or whistleblower provisions of the False Claims Act.
- Under the False Claims Act, a private party may file suit on behalf of the United States for false claims and share in any recovery.
- The United States has the right to intervene in the action, which it did in this case, filing its own complaint in October 2010.
- Dr. Freedman will receive $4,046,000 of today’s settlement.”

**What is an outlier?**

- Reports more frequently than others do.
- 11100 reported with EM 65%
- 17000 similar.
- Modifier 25 use by a derm ~75%
- Use 100% of the time has gotten some folks audited in NY.
- 17311/17313 w EM 5% of the time.
What is an outlier?

- RT has become more popular in recent year.
- RT using sub-megavoltage therapy uses one code, 77401 for each day of treatment.

Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200 kV) may be generated by a variety of technologies and should not be reported with megavoltage (77402, 77407, 77412) for surface application. Do not report clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiography treatment management (77427, 77431, 77432, 77435, 77469, 77470, 77499) with 77401, 0394T, or 0395T. When reporting 77401 alone, evaluation and management, when performed, may be reported with the appropriate E/M codes.

What is an outlier?

77401  Radiation treatment delivery, superficial and/or orthovoltage, per day

- CPT Changes: An Insider's View 2015
- CPT Assistant Apr 03:14, Aug 03:10, Oct 07:1, Oct 10:3, Dec 15:14, Feb 16:3
- Clinical Examples in Radiology Summer 08:12, Summer 09:7

(Do not report 77401 in conjunction with 77373)
What is an outlier?

**77402**
Radiation treatment delivery, >1 MeV; simple

- CPT Changes: An Insider’s View 2015
- CPT Assistant Apr 03:14, Aug 03:10, Oct 07:1, Oct 10:3, Dec 15:14, Feb 16:3, Mar 16:7
- Clinical Examples in Radiology Spring 07:7-9, 12, Summer 08:12, Summer 09:7

(Do not report 77402 in conjunction with 77373)
(77403, 77404, 77406 have been deleted. To report, use 77402)

Data Diving?

- CMS releases granular data for the first time for 2012.
- Searchable by CPT code – Doctor name - NPI – ZIP and many other parameters.
- Year by year aggregate data.
- More later.

Digression

- The CMS site is techie heaven but not everyone does spreadsheets and databases,
- There are other ways for the technophobes.

### What is an Outlier?

At data.cms.gov, one can look up granular billing data.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MARKER</th>
<th>%</th>
<th>NORMAN</th>
<th>ABBOTT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>24604</td>
<td>63%</td>
<td>270</td>
<td>8335</td>
</tr>
<tr>
<td>2013</td>
<td>16170</td>
<td>36%</td>
<td>1975</td>
<td>7811</td>
</tr>
<tr>
<td>2014</td>
<td>14874</td>
<td>33%</td>
<td>2222</td>
<td>7036</td>
</tr>
</tbody>
</table>
### Provider Comparison

How GARY L. MARDER D.O. compares to 327 other providers in Florida specializing in Radiation Oncology:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Payments</th>
<th>Number of Patients</th>
<th>Payments per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$2,363,074</td>
<td>486</td>
<td>$4,862</td>
</tr>
<tr>
<td>2013</td>
<td>$2,368,547</td>
<td>486</td>
<td>$4,862</td>
</tr>
<tr>
<td>2012</td>
<td>$3,713,812</td>
<td>486</td>
<td>$7,705</td>
</tr>
</tbody>
</table>

**Provider's Services at a Glance, 2014**

Types of services provided by GARY L. MARDER D.O.:

<table>
<thead>
<tr>
<th>Category</th>
<th>Total reimbursed by Medicare</th>
<th>Percent of total reimbursements by Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation oncology</td>
<td>$1,605,871</td>
<td>66.0%</td>
</tr>
<tr>
<td>Surgeries and procedures</td>
<td>$380,966</td>
<td>14.9%</td>
</tr>
<tr>
<td>Lab tests</td>
<td>$283,005</td>
<td>12.2%</td>
</tr>
<tr>
<td>Evaluation and management</td>
<td>$64,640</td>
<td>2.7%</td>
</tr>
<tr>
<td>Exams and medical services</td>
<td>$11,526</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Note: Category totals may not add up to a provider's total payments because information about a provider's specific services to fewer than 11 Medicare patients is suppressed by Medicare.

### Provider’s Services in Detail, 2014

Services GARY L. MARDER D.O. performed on more than 10 patients:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number performed</th>
<th>Number of Medicare patients</th>
<th>Average Medicare reimbursement per procedure</th>
<th>Total Medicare payments for procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation treatment delivery, three or more treatment areas</td>
<td>4,100</td>
<td>96</td>
<td>$187.25</td>
<td>$763,725</td>
</tr>
<tr>
<td>Radiation treatment delivery, single treatment area</td>
<td>4,602</td>
<td>57</td>
<td>$188.82</td>
<td>$890,790</td>
</tr>
<tr>
<td>Pathology, examination, tissue using microscopy</td>
<td>3,752</td>
<td></td>
<td>$16.08</td>
<td>$60,188</td>
</tr>
<tr>
<td>Radiation therapy consultation per week</td>
<td>1,277</td>
<td>114</td>
<td>$18.31</td>
<td>$2,355</td>
</tr>
<tr>
<td>Surgery: removal of growth of skin and/or tissue</td>
<td>2,850</td>
<td>337</td>
<td>$25.00</td>
<td>$73,529</td>
</tr>
<tr>
<td>Radiation therapy consultation, simple</td>
<td>1,070</td>
<td>114</td>
<td>$18.18</td>
<td>$19,253</td>
</tr>
<tr>
<td>Management of radiation therapy simulation, simple</td>
<td>277</td>
<td>102</td>
<td>$210.63</td>
<td>$58,345</td>
</tr>
</tbody>
</table>
New York Times

Old resource now links to CMS site.


Which has links to data.cms.gov.

Data.cms.gov

This tool is a part of the CMS Open Data initiative and is updated daily. It provides detailed information about Medicare providers and services, including the amount they billed for services and the payment they received from Medicare.

- **How Much Medicare Pays For Your Doctor’s Care**

This tool allows you to search for a specific provider or browse by specialty, state, or city. You can also filter results by payment status, which is calculated based on the amount paid to the provider compared to the total charges.

- **Healthcare Costs Across the United States**

This section provides an overview of healthcare costs in the United States, including average charges, Medicare payment rates, and the number of providers.

- **Physician and Other Supplier Charges**

This tool allows you to search for charges by provider, specialty, or state. You can also see how Medicare payment rates compare to the average charges.

- **Medicare Payment Transparency**

This tool provides a comprehensive overview of Medicare payments, including the amount paid to providers, the number of payments, and the average payment per claim.

- **Data Validation**

This section provides information about the validation process used to ensure the accuracy of the data.

- **Contact Us**

If you have any questions about the data or the tool itself, you can contact the CMS via email or phone.

- **Disclaimer**

This tool provides an overview of Medicare payments, but it is not intended to be a complete guide to all Medicare payments. For more information, visit the CMS website or contact them directly.

New York Times

http://www.nytimes.com/interactive/2014/0
4/09/health/medicare-doctor-database.htm

Old resource now links to CMS site.


Which has links to data.cms.gov.
Medicare Provider Utilization and Payment Data: Physician and Other Supplier Look-Up Tool

This look-up tool is a searchable database that allows you to look up a provider by National Provider Identifier (NPI), or by name and location. The look-up tool will return information on services and procedures provided to Medicare beneficiaries, including utilization information, payment amounts (allowed amount and Medicare payment), and submitted charges organized by Healthcare Common Procedure Coding System (HCPCS) code. The data cover calendar year 2015 and contains 100% final action physicians/suppliers Part B non-institutional items for the Medicare fee-for-service population (information is redacted where necessary to protect beneficiary privacy).

The database is populated from the Physician and Other Supplier Use File (PUF). While the Physician and Other Supplier PUF has a wealth of information on services and utilization for Medicare Part B services, the database has a number of limitations. Of particular importance is the fact that the data may not be representative of a provider’s entire practice as it only includes information on Medicare fee-for-service beneficiaries. In addition, the data are not intended to indicate the quality of care provided and are not risk-adjusted to account for differences in underlying severity of disease of patient populations. To review more information about the Physician and Other Supplier PUF, please refer to the Methodology document.

When populating any field in the look-up tool, you need to enter content exactly. You may choose to populate only one field, but content will yield exact matches.
Curious?
- 2.0 GB uncompressed.
- > 10 million records.
- Too big for Microsoft Excel.
- Use of database or statistical software is required; a SAS® read-in statement is supplied.
- Sounds like a dead end………..

CMS to the rescue
- Visit data.cms.gov
- Use anonymously or get a free account.
- Account lets you save searches.
### Table

<table>
<thead>
<tr>
<th>National Provider Identifier</th>
<th>Name of the Provider</th>
<th>State Code of the Provider</th>
<th>HGPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1696493228</td>
<td>SANCHEZ WALTER D</td>
<td>FL</td>
<td>17311</td>
</tr>
<tr>
<td>1696493229</td>
<td>SANCHEZ WALTER D</td>
<td>FL</td>
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<td>FL</td>
<td>17311</td>
</tr>
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<td>1696493231</td>
<td>SANCHEZ WALTER D</td>
<td>FL</td>
<td>17312</td>
</tr>
<tr>
<td>1696493232</td>
<td>SANCHEZ WALTER D</td>
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<td>17311</td>
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<tr>
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<td>SANCHEZ WALTER D</td>
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<td>1696493234</td>
<td>SANCHEZ WALTER D</td>
<td>FL</td>
<td>17311</td>
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<td>1696493235</td>
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<td>17312</td>
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</tbody>
</table>

### Diagram

The diagram shows a filter interface with options to select State Code of the Provider and HGPCS Code. The user can add filter conditions and apply them to the dataset.
Outlier Practice Patterns in Mohs Micrographic Surgery: Defining the Problem and a Proposed Solution.


Outlier practice patterns in Mohs micrographic surgery: defining the problem and a proposed solution.

Objectives: To study outlier physician practices in Mohs micrographic surgery (MMS) and the associated factors.

Design, setting, and participants: This retrospective analysis of publicly available Medicare Part B claims data from January 2012 to December 2014 includes all physicians who received Medicare payments for MMS at the head and neck, genitalia, hands, and feet regions of Medicare Part B patients.

Main outcomes and measures: Characteristics of outlier physicians, defined as those whose mean number of stages for MMS was 2 standard deviations greater than the mean number for all physicians billing MMS. Logistic regression was used to study the physician characteristics associated with outlier status.

Results: Our analysis included 22,000 individual billing physicians performing MMS. The mean number of stages per MMS case for all physicians practicing from January 2012 to December 2014 was 1.74, the median was 1.59, and the range was 1.00 to 2.11. Overall, 13% physicians who perform MMS surgery were greater than 2 standard deviations above the mean in 2.41 stages per case) in at least 1 of the 3 examined years, and 49 physicians (23.6%) were persistent outliers in all 3 years. Persistent high outlier status was associated with performing MMS surgery in a solo practice (odds ratio, 2.36; 95% CI, 1.25-4.45). Volume of cases per year, practice experience, and geographic location were not associated with persistent high outlier status.

Conclusions and relevance: Marked variation exists in the number of stages per case for MMS for head and neck, genitalia, hands, and feet regions, which may represent an additional financial burden and unnecessary surgery on individual patients. Providing feedback to physicians may reduce unexplained variation on this metric of quality.

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You can do it on yourself and colleagues.
They can research you.
The government, always here to help can do it.
Others payers have always had their data.
Now they can merge it with CMS.
Be afraid. Be careful!

You only can see, for the most part, aggregate data.
"They" can see you in real time.
Think US Customs: If you took out $9500 a week for three weeks just before going to the Caribbean and don’t declare a Rolex.
You will likely be taken apart.

You stop at 7-11, gas station, Amazon and use a credit card.
A rapid analysis looks a the likelihood you are you.
Was the last purchase with that card made at a "bricks ans mortar" show 2000 miles away?
The algorithms are good.
Research

- Bx rate and college tuition.
- New car purchase and more destructions.
- You get the idea.
- All discoverable in real time.

SNAFU & FUBAR

- Yes, there has been a consolidation of some Federal agencies.
- Soon all will be running under one of these two overriding acronyms.
- Remember, there is treatment, another acronym:

If You Have Claim Denials or Other ICD 10 Issues, contact our excellent AAD staff:
- Faith McNicholas FMcNicholas@aad.org
- Peggy Eiden PEiden@aad.org
- Cynthia Stewart cstewart@aad.org
They are all great and are all here to help you.
Summary

- You should be paid fairly for what you do.
- Document what you do.
  - Do what you document.
- Report that which you have done which is medically necessary.
- Don’t be overly creative.