Provider Profiling Methodology for CA MPN

Profiling for the GENEX CA MPN will follow a Case-Mix adjustment methodology. Case-mix adjustment allows for creation of provider to provider or provider to peer-group comparisons that are more equitable and better received by providers than unadjusted comparisons.

Case mix refers to the mix of illness and severity of cases for a provider. Case mix may be measured by looking at patient diagnosis, the severity of a patient’s illness or the services utilized. This methodology focuses on the severity or complexity of patient illness. An advantage of this approach is that users can separate patient illness burden from service utilization. For instance, users could look at both simple back injuries and those that involved surgery and/or underlying comorbidities and compare utilization separately for the two providers.

For this analysis, GENEX has drawn upon five years’ worth of provider bill review data on bills reviewed by GENEX. ALL data will be looked at, not just for those providers identified as being in-network.

Following the methodology, a primary provider will be identified at a case/claim level. Primary provider being defined as the one whom provided the most services on the claim. Also noted will be the specialty of the provider.

Diagnoses for claimants will be grouped at the 3 digit code category level for like comparisons (e.g. 847.2 and 847.3 will be grouped under 847). The 3 digit category ICD-9 will be used as the primary diagnosis. Presence of multiple diagnoses will also be identified in order to look at treatment patterns for a category (e.g. back injuries) and also those with surgery and without surgery. The actual treatment is compared by ICD-9 to the guideline to identify those treating outside of accepted guidelines. The treatment is also looked at in conjunction with the diagnosis to ensure that all treatment relates to that diagnosis.

Items to be considered for comparison and profiling to compare appropriateness of care and the potential for overutilization:

- Diagnostic group – primary diagnosis
- Multiple diagnoses
- Did the claimant have surgery?
- Was the claimant admitted to a hospital?
- Number of office visits to the primary provider. Number of procedures done.
- What was the duration of treatment?
- Were there multiple providers on the claim?
- What is the overall medical cost for duration of care – this will be compared after fee schedule reduction only for a fairer cost comparison.
- Provider specialty, in order to compare against same provider type. Primary specialties included in the economic profiling are General Practice, Orthopedics, Family Practice, Internal Medicine, Occupational Clinics, Physical Therapy and Chiropractic.
- Adjustments will be made for claimants’ gender and age.

Comparison will be done on providers of same specialty with similar cases/like set of injuries based on the above items. Metrics for comparison are total medical cost, number of office visits, number of services provided, duration of treatment. Providers will then be ranked and scored based on where they fall in line on the comparison.

Providers will receive a score in each category and then be assigned an aggregate score.

Economic Profiling information will not be taken into consideration in the performance of Utilization Review or Peer Review services.

Profiling information will not be utilized to assess any incentives or penalties nor in provider retention and termination decisions.