Economic Profiling

Provider Selection and Evaluation Process

The MPN uses the following tools and procedures for, retaining, selecting, terminating, and evaluating providers in its MPN:

1. A process for tracking, reviewing and analyzing provider performance. This process is driven by the completion of automated "Provider Incident Reports" which allows for the capture of provider performance issues such as:
    a. Patterns of untimely submission of medical reports;
    b. Difficulties in communicating effectively with provider office staff;
    c. Patterns of referral of care to providers outside of the MPN;
    d. Failure to contact the Utilization Management unit for pre-certification of treatment;
    e. Lack of compliance with CA State Labor Code and regulations.

2. A process and procedure for gathering and organizing data from internal claims, medical management, and medical director staff which relates to their day to day interactions and experiences with providers in the MPN.

3. A process for comparing claim volume and frequency by geographic area to the supply of providers in defined geographic areas, to create an optimum balance between need for medical services and supply of medical services.

4. Review of provider billing, treatment and service data from Liberty Mutual data systems. These may include summaries or tabulations of clinical activity for a given time period, as well as metrics designed to compare provider performance with peer groups or against state and national benchmarks. These metrics will only be applied to providers or practices with a sufficient volume of services that statistically meaningful comparisons can be made; where reasonably possible, case-mix adjustments will be attempted. Metrics used by the MPN will be in the following categories:

    a. Clinical outcome metrics – These may include the following measurements of clinical outcomes: Frequency, timing, and reasons for re-operations, post-surgical treatment referrals, post–surgical events, surgical outcomes and clinical complications. Non-surgical outcomes and events, return to work parameters, Temporary Total Disability rates, musculoskeletal recovery times, rates of treatment referral, and referral patterns, other industry-standard outcome measurements.
    b. Process metrics – These will measure provider patterns of care compared with the CA MTUS and other evidence-based medicine guidelines, and will include: patterns and rates of interventions, drug therapies, diagnostic testing, physical therapy or other treatments for particular diagnoses; adherence to best practices as recommended by the CA MTUS; patterns of care metrics as benchmarked against nationally recommended standards (such as those from the NCQA or NQF) or scientifically based, nationally recognized, and peer-reviewed guidelines.
    c. Utilization metrics – These will include: analyses of prescription drug patterns; utilization of diagnostic tests and therapeutic services such as physical therapy; referrals to surgical vs. non-surgical treatments; rate of utilization review denials; composite provider efficiency ratings; metrics comparing severity-adjusted costs and rates of services to benchmark values; hospital metrics such as average length of stay, readmission rates; and other industry-standard benchmarks.

d. Billing and Coding metrics – These will include: reports and measures of new patient visits, duplicate billing, office visit coding, prolonged services, out of network referrals, use of miscellaneous and complex service codes, and analysis of providers' CPT coding.

Selected analytic metrics as enumerated in Section 4 above may be used to either identify or support concerns that are also addressed by evaluations and reports described in Sections 1-3, but individual metrics are never used independently or in lieu of a complete review of all components of a provider or provider group's performance.

These tools and procedures may be employed, in whole or in part, when changing vendor provider networks.

As providers have expressed an interest in participating in the MPN, the above-described process has been used to assist staff in making decisions as to whether to remove or add a provider to the MPN. The process ensures that the MPN views the performance of providers in the broadest context that is reasonable. Final recommendations on provider participation in the MPN are reviewed and approved by the CA Medical Director and by the MPN Coordinator.

The results of Economic Profiling may be used to evaluate, on a provider-by provider basis, the need for a provider to undergo the Utilization Review and Peer Review process. The MPN does not use economic profiling or any of the provider evaluation procedures described in this document to evaluate providers performing utilization review or peer review functions for the MPN.

A copy of this Provider Selection and Evaluation Process is provided to MPN providers through the Provider Support Website, at:
https://www.libertymutualprovidersupport.com/PSC/public/californiaMPN.faces