EFFECTIVE RISK MANAGEMENT IN MEDICARE COMPLIANCE…HOW TO DETECT, PREVENT AND CORRECT ISSUES.

2019 HCCA COMPLIANCE INSTITUTE

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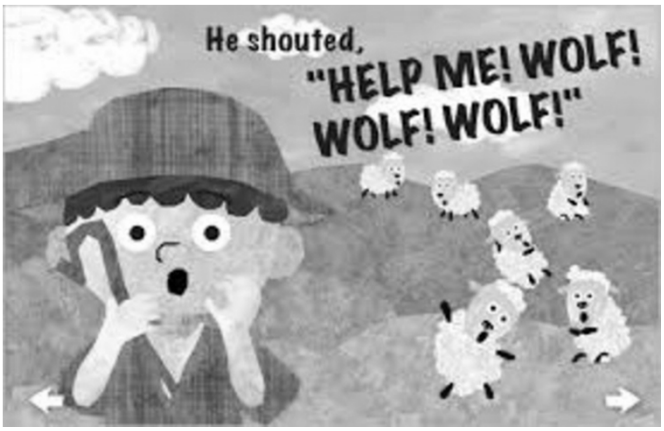
As a Compliance Professional you receive a hot line call indicating that the organization has been billing Medicare for Trauma services provided in the ER trauma unit. The trauma surgeons have been billing 99291 or 99292 every time they are summoned for a trauma. The caller indicates this has been going on for the past several years. The caller further states that the documentation by the trauma surgeons does not support either one of these CPT codes.

You research the two CPT codes and find the following: CPT code **99291**: Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes. CPT code +**99292**: Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes.

You believe this could result in a very large overpayment from Medicare.

WHAT DO WE DO?



INVESTIGATION

Investigation…..careful inquiry or research…**fact finding**….information gathering

INVESTIGATION

- Who
- What
- Where
- When
- Why
- How

WHO

RISK MANAGEMENT

Root Cause Analysis

WHY
U.S. DEPARTMENT OF JUSTICE
EVALUATION OF CORPORATE COMPLIANCE PROGRAMS

- **Analysis and Remediation of Underlying Misconduct**

- **Root Cause Analysis** – What is the company's root cause analysis of the misconduct at issue? What systemic issues were identified? Who in the company was involved in making the analysis?

- **Prior Indications** – Were there prior opportunities to detect the misconduct in question, such as audit reports identifying relevant control failures or allegations, complaints, or investigations involving similar issues? What is the company's analysis of why such opportunities were missed?

- **Remediation** – What specific changes has the company made to reduce the risk that the same or similar issues will not occur in the future? What specific remediation has addressed the issues identified in the root cause and missed opportunity analysis?

WHAT

Root cause analysis (RCA)

is a method of problem solving used for identifying the root causes of faults or problems. A **factor** is considered a root cause if **removal** thereof from the problem-fault-sequence **prevents** the final **undesirable event from recurring**; **whereas a contributing factor is one that affects an event's outcome, but is not a root cause.** Though removing a causal factor can benefit an outcome, it does not prevent its recurrence with certainty.

ROOT CAUSE ANALYSIS

Why

Why

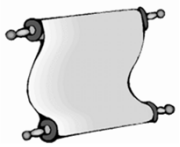
Why

Why

ROOT CAUSE ANALYSIS

RCA STEPS

CHARTER



What is an RCA?

What is the role of the RCA team?

Who is the Base Team?

Process for identifying additional members.

What is the size of the team?

How to determine the facilitator.

BASE TEAM

- Compliance
- Risk Management
- Legal Counsel (attorney client privilege)
- Quality
- Administration Representative

SELECT THE EVENT TO BE INVESTIGATED AND GATHER PRELIMINARY INFORMATION

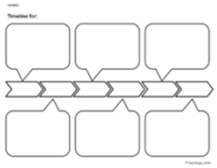
- Gather documents (investigation report, hotline, policies, ect.)
- Start with problem not solution
- What went wrong not why or how
- Focus on process/system

SELECT TEAM MEMBERS AND TEAM FACILITATOR

- Base team
- Charter
  - review with full team
- Identify facilitator
- Members determined by problem (personal knowledge of the problem)

DESCRIBE WHAT HAPPENED

- Time line of events
  - *does time line tell the story*
  - *Is each step pertinent to the event*
  - *Was a step left out*

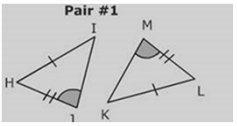


- Resist skipping steps

IDENTIFY THE CAUSUAL FACTORS

- Review each step in the timeline
  - What was going on that increased the likelihood
- Brainstorming an effective tool
- Avoid hindsight
  - Factor present and known

IDENTIFY THE ROOT CAUSES



- All incidents have a direct cause
- Cause versus contributing factor
- Ask
  - would the event have occurred if this cause had not been present
  - Will the problem recur if this cause is corrected or eliminated
- Don't judge individual
- Frank and open discussion of cause and event

DESIGN AND IMPLEMENT CHANGES TO ELIMINATE THE ROOT CAUSES

- Evaluate each root cause
  - choose action to address root cause
    - process/system

- Short term solutions
  - fix contributing factor
  - rarely fix the cause

MEASURE THE SUCCESS OF CHANGES

- Did corrective action get implemented
- Are people complying with changes
- Have changes made a difference
- Measure over time
- Confident change is permanent

CORRECTIVE ACTIONS

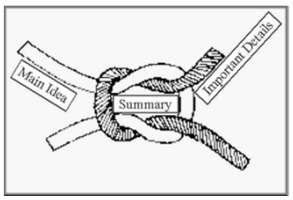
Root Cause	Corrective Action	Responsible Individual/Group	Completion Deadline

MEASURE OF SUCCESS

Corrective Action	Measure of Success (How will we know if this action is successful)	Reporting Schedule

SUMMARY

- Selective in events for RCA
- Base team vs. RCA team
- Timeline of event
- Root causes
- Corrective actions
- Measuring success (auditing/monitoring)
- Why, Why, Why, Why, Why, etc.



QUESTIONS