It Takes a Village
HCCA Compliance Institute – Virtual Conference

Disclaimer

• The opinions expressed are those of the presenters and are not intended to be statements or reflections of the opinions or positions of an organization/employer

• This presentation is general in scope, seeks to provide relevant background and hopes to assist in the identification of pertinent issues and concerns. The speakers are not rendering billing or legal advice

• Unless otherwise noted data/examples do not represent a specific facility or health system
Objectives

1. Demonstrate how successful engagement of revenue cycle and quality in the compliance journey can maximize the effectiveness of all three areas.

2. Identify real world examples of risk based data analytics impacting all three areas.

3. Improve understanding of regulatory and data requirements for each area.

Connect Patient Care to Quality, Cost, Compliance

- Communication and coordination across functions is critical to quality care and patient safety and it is also critical to capturing all the risks and reporting that occur in today’s healthcare environment.

- Remember when:
  - Compliance was defined by check the box policies, education, basic coding audits and laws and regulations;
  - Joint Commission Quality reviews were binders of policies and basic checklist reviews meeting Medicare CoPs; and
  - Your hospital bill was a bill not an audit tool.

- Those days are long gone → today’s innovative payment programs, laws and ever increasing regulatory focus requires that the compliance function must extend to clinical, financial and quality areas and vise versa.

Any many others - space limitations
Self Awareness/Functional Awareness - Does each area have an understanding of potential functional intersections?

<table>
<thead>
<tr>
<th>Does your compliance program:</th>
<th>Does Quality:</th>
<th>Does Revenue Cycle:</th>
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</thead>
<tbody>
<tr>
<td>• Operate parallel but apart from the fundamental activities of your health system?</td>
<td>• Include compliance in discussions about quality measures?</td>
<td>• Discuss new services/CDM codes with Compliance to ensure CCI?</td>
</tr>
<tr>
<td>• Or as a strategic partner?</td>
<td>• Include Compliance at Root Cause Analysis meetings?</td>
<td>• Provide Denial Reports to Compliance or access to denial work queues?</td>
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<tr>
<td>• Contribute to the clinical processes of care for the patients served?</td>
<td>• Look to Compliance to assist in validating coding reviews of HACs? PSIs?</td>
<td>• Track all payer additional documentation and audit requests received either through Patient Accounts &amp;/or HIM and share that data with Compliance?</td>
</tr>
<tr>
<td>• Is your compliance team aware of denials, up-coding or other possible billing errors discovered outside of compliance reviews?</td>
<td>• Request compliance assistance in coding validation of increases or decreases in reported diagnosis; i.e. sepsis? CAUTI? CLABSI?</td>
<td>• When does Compliance get involved?</td>
</tr>
<tr>
<td>• Is your compliance team viewed as a resource for questions and concerns?</td>
<td>• Make compliance aware when an external quality report or audit is received?</td>
<td>• Early on in a RAC committee type format?</td>
</tr>
<tr>
<td>• Before or after an issue bubbles to the surface?</td>
<td>• Inform compliance about a potential provider quality concern and ask for documentation review assistance?</td>
<td>• Later when there are potential repayments?</td>
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<td>• Is your compliance team part of ongoing monitoring?</td>
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<tr>
<td>• Is your compliance team viewed as an objective voice for investigations?</td>
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To Eliminate Silos: You have to be at the table

Board Quality Committee &/or Hospital Quality and Patient Safety Committee:
Finance/Revenue Cycle Committees:
Compliance Committees:

• Who has a seat at the table?
  • Compliance?
  • Revenue Cycle?
  • Informatics?
• Does Compliance know what data is being reported to p4p payers? CMS?
• Does Compliance know if algorithms are being used to data mine quality workflows?
• Does Compliance participate in the determination of quality metrics and incorporate into the work plan how compliance will audit those reported metrics for validity
  • How do you find out who is reporting what, to whom and when?
• Does compliance or internal audit monitor these reports for accuracy, completeness or indicators of risk?

*Have you sat at a meeting and watched statistics being presented that don’t match the statistics in your report to a different committee?*
Building Your Village

Where to start

- Institutional knowledge verses Industry Hot Topics
  - Risk assessments
  - Dashboards
  - On the National Radar Screen

- Common problem(s)
  - high cost?
  - high risk?
  - high visibility?
  - High probability of success?
    - Quick hits verses long term gains

- Know the team you are building
- Provider Involvement

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DRUG DIVERSION
Financial Impact of Controlled Substance Abuse & Diversion

- Estimated cost of controlled prescription drug diversion and abuse to public and private medical insurers is approximately $72.5 billion a year (2016)

- Economic costs overall are $193 billion, including $120 billion in lost productivity due to labor participation costs, drug abuse treatment, incarceration and premature deaths

- Federal and state governments bore about $45.1 billion of the total in drug abuse costs

- Approximately 100 individuals die from drug overdoses daily with opioids accounting for 75% of these overdoses

Health System Statistics

- For a typical 500 bed hospital, expect 25-75 diversions at any point in time

- Most diversion is not detected, investigated or reported
  - 84% of hospitals investigated less than 10 cases in 2018
  - 65% of hospitals investigated less than 5 cases in 2018

- 18 months = average time individuals were involved in drug diversion before detection

- 12 years = longest period of time drug diversion incident went undetected

  • Source: National Association of Drug Diversion Investigators conference, April 1-2, 2019, St. Petersburg, FL
Drug Diversion – Example of a Village

• Who is on your Pharmacy Steering Committee?

• What type of controls do you have in place?

• Organization wide Education?

• HR/Nursing/Compliance/Pharmacy/Revenue Cycle and the list goes on.........

REPORTED QUALITY DATA
Compliance 101- Trust but Verify!!!

What data is being collected?

Do you know what data is being reported & to whom?
- Is the reported data available to the general public?
- How is the data being used?
- What is the data source?
- Where is it housed?
- Can it be replicated/produced upon request by audit?
- Who is validating the data?

Do you know what is being distributed to your employed providers?
- HCC Reports?
- Coding Reports?

Are results of state report cards or other rating systems shared with you?

Do you know your organization’s value-based purchasing penalties and incentives?

What data is distributed to the Board?
- Do Board Committees receive reports with different data reported for the same issue?
- Data Timing Issue or Lack of Validation/Single Source of Truth

Where’s the Data?

Quality Metrics are being Reported

Opportunities for Collaboration

The Quality Dashboard

- How is the data being collected?
- Examples of what might be reported on a Quality Dashboard:
  - PSM and HACs:
    - What are the documentation and coding requirements?
    - Have they been cascaded?
    - Have they been validated
  - Readmissions – Hmm, some of these look familiar. PEPPER!
    - Acute Myocardial Infarction,
    - Heart Failure,
    - Pneumonia,
    - Total Hip/Total Knee,
    - COPD,
    - CABG,
    - Stroke
- Does Compliance validate/audit or receive reports from those areas that may perform validations/audits?
  - Are these department reviews recognized as contributing to compliance/risk mitigation?
- How do you integrate physician practices?
- Application of FCA to quality of care – *FCA is never waived*

Start with the Simple

Move to the more complex:

Innovative Payment Programs
Example: Payer Quality Coding Guide

- Guide in Shared Folder
- Education and Audit Plan
- Ambulatory Protocol Committee
- Feedback Loop

<table>
<thead>
<tr>
<th>Measure</th>
<th>Patient Program(s)</th>
<th>Measure Description</th>
<th>Data Type Accepted</th>
<th>Requirements</th>
<th>Link to Value Set Codes</th>
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<tbody>
<tr>
<td>Example: Breast Cancer Screening</td>
<td></td>
<td>The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.</td>
<td></td>
<td></td>
<td>Links to the payer guides/instructions for that measure</td>
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<td>One or more mammograms any time on or between October 1, two years prior to the measurement year (2017) and by December 31 of the measurement year (2018). The following ages and methods of mammograms will satisfy the numerator for Payer:</td>
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<td></td>
<td></td>
<td></td>
<td>• Screening</td>
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<td>• Diagnostic</td>
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<td>• Film</td>
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<td>• Digital</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Digital breast tomosynthesis</td>
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Revenue Cycle is well positioned as a bridge between quality and compliance

- Understand the financial implications of:
  - Value Based Purchasing Penalties & Incentives
  - HACs and adverse safety events
  - Billing requirements of HACs and adverse safety events

- Denials Tracking:
  - Patient Status – where does UM report?
  - DRG shifts

- Does compliance see the results of, or sit on the committee where, medical record reviews, tracer exercises, conditions of participation assessments and emergency preparedness reviews are reported?

- How are revenue cycle and quality team members integrated into compliance meetings/reporting?

### Denial Avoidance: Build the Foundation

- **New Technology/Procedure or Service?**
  - What are the CPT codes? Is this an IP only procedure?
  - Are there overlaps to other departments coding? Resource requirements?
  - Are there any conflicts of interest that will need to be addressed?

- **How is the technology/procedure or new service reimbursed?**
  - Is it covered by Medicare?
  - Is there an NCD/LCD?
  - Is it covered by other payers?
  - Is it a research study?
  - Is there a device involved?
  - Who is responsible for developing the MCA?
  - Who will audit?

- **EMR – will templates need to be created or revised**
  - Documentation templates
  - Build the NCD/LCD/research database requirements into the template
  - Security templates

- **Who will be responsible for:**
  - Coding education
  - Billing education
  - Research protocol and billing education
  - Staff education

- **Patient education**
  - Is a special consent required?
  - Is a joint decision making tool required?

### NEW TECHNOLOGY QUESTIONNAIRE

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</table>

- Is there a device involved?
- Who is responsible for developing the MCA?
- Who will audit?

### Section II – Product/Equipment Use:

- Please specify the procedures in which the new product or equipment will be used:

### Section III – Following information must be completed by the requesting physician, if applicable:

- Do you or any of your immediate family, have any ownership or investment interest in the manufacturer, distributor and/or seller of the requested new product or equipment? If yes, please explain.
- Do you or any of your immediate family receive any type of compensation from the manufacturer, distributor and/or seller of the requested new product or equipment? If yes, please explain.
- Do you or any of your immediate family receive any discounts, business courtesies or free goods or services from the manufacturer, distributor and/or seller of the requested new product or equipment? If yes, please explain.
**MITRAL CLIP (TMVR)**
Transcatheter mitral valve repair (TMVR):

MitralClip is used in the treatment of percutaneous reduction of significant symptomatic mitral regurgitation (MR 3+) due to primary abnormality of the mitral apparatus (degenerative MR). A TMVR device involves clipping together a porition of the mitral valve leaflets as treatment for reducing mitral regurgitation (MR).

Currently, Abbott Vascular's MitraClip® is the only one with Food and Drug Administration (FDA) approval.

**Claims Processing Requirements for TMVR for Inpatient Hospital Claims:**
1. MitralClip is Inpatient only procedure
2. Inpatient hospitals shall be for TMVR for MR on a 11X Type of Bill (TOB)
3. ICD-10-CM diagnosis code 134.0 or 134.1
4. ICD-10-PCS procedure code 02U03Z (MitralClip) & B045224 (ultrasound)
5. Secondary ICD-10-coding code 200.6 (should be listed after identified MCC)
6. Condition Code 30, and
7. Value Code PD with An 8-digit NCT Number 02245763

**Claims Processing Requirements for TMVR for Inpatient Hospital Claims:**
1. Place of service (POS) code 21 is valid for use for TMVR for MR services (inpatient only procedure)
2. Primary ICD-10-CM diagnosis code 134.0 or 134.1
3. CPT procedure code 33418 (33419 for additional prosthesis) with Modifier QQ
4. Secondary ICD-10-coding code 200.6
5. An 8-digit NCT Number 02245763

**Reference:**
1. ICD-10-33
2. Abbott MitraClip

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**Denials Reporting**

- Assist in tracking and trending for patterns and audit risk
- Analyze root cause of denials for prevention
- Provide reports
  - Breakout reports in a format/language that is both meaningful & understandable to your audience;
  i.e. - medical necessity denials from documentation concerns verses administrative issues -pre-authorizations
- Monitor corrective actions for long term sustainability
- Monitor for changes in coding, NCDs/LCDs

**Sample Denial Data**

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<table>
<thead>
<tr>
<th>Procedure Name</th>
<th>Potential Denial Causes</th>
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</thead>
<tbody>
<tr>
<td>Abnormal Heart</td>
<td>Heart rate, rhythm</td>
</tr>
<tr>
<td>Bacterial Infection</td>
<td>Infection site</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Blood clot</td>
</tr>
<tr>
<td>Cardiac Failure</td>
<td>Cardiac failure</td>
</tr>
<tr>
<td>Device Implant</td>
<td>Implantation failure</td>
</tr>
</tbody>
</table>

**Notes:**
- Inappropriate | Incorrect diagnosis |
- Incomplete Documentation | Incorrect billing |
- Incorrect Procedure Code | Incorrect DRG |

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**Source:** Managing and Preventing Denials in a Clinically Driven Revenue Cycle
Additional Opportunities for Collaboration

- Value of Cost Report Data
  - Teaching Hospitals – Special Considerations
- Variance Analysis
- Managed Care Agreements
  - RADV Audits
  - HCC Reviews and Reports
- CDI/HIM Queries
  - Are queries audited?
  - Are CDI Specialists held to a 95% accuracy rate?
- Third party coding and/or billing contracts
  - Benchmarks
  - Quality Reviews
  - Accuracy Reviews

CYBERSECURITY
PASSWORDS
IT Security and Compliance – Close Neighbors

#1 on everyone’s list of current Issues in healthcare
OCR Audit
Security Breach = Privacy Breach
Education – a partnership
Bigger and Bigger problem

Typical U.S Hospital

100,000,000,000,000 Lines of Code
400+ Systems
750+ Business Associates
Thousands of Devices
An Ounce of Prevention…
Passphrase Instead of Password!

<table>
<thead>
<tr>
<th>Number of Words</th>
<th>Time to Crack</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 words</td>
<td>1 second</td>
</tr>
<tr>
<td>2 words</td>
<td>2 seconds</td>
</tr>
<tr>
<td>3 words</td>
<td>3 seconds</td>
</tr>
<tr>
<td>4 words</td>
<td>4 seconds</td>
</tr>
<tr>
<td>5 words</td>
<td>5 seconds</td>
</tr>
</tbody>
</table>

Password Length | Time to Crack | ... with special character
-----------------|---------------|--------------------------
9 characters      | 2 minutes     | 2 hours                  
10 characters     | 2 minutes     | 2 hours                  
11 characters     | 6 days        | 2 years                  
12 characters     | 1 hour        | 2 months                 
13 characters     | 64 years      | —                        

"The sticky note? Oh, to save time and hassle, we just all use the same user name and password."

IN CLOSING:
The Role of the Medical Staff

Cannot underestimate the importance and role of the medical staff in quality and compliance

- The Medical Staff is key to Quality Patient Care
- Physicians drive Compliance – Physician champions
- Physician exposure – innovative payment programs; i.e. Pay-for-Performance; MIPS

- Exposure Common areas of exposure
  - Malpractice exposure/ Billing FCA
    - Inadequate medical record documentation
    - Lack of Medical Necessity for patient encounter
    - Inadequate supervision of residents/PAs/NPs and other extenders
    - Medical misadventures
    - Incomplete orders
    - Poor Physician-Patient communications
    - Poorly executed patient Informed Consent
    - Inadequate patient education

- Providers are busy – they are scientists; they are fact driven – don't waste precious meeting time

How are you & your department perceived?

Are you the Toll Collector or Did you help build bridge?

Start with the end in mind - What do you hope to accomplish?
✓ Check the box for the regulators? Auditors?
OR
✓ Participate in positive change and
✓ Be recognized as a strategic partner?

Silos or silo mentality still exists despite efforts at silo busting
- Hard to break silos in large groups – how many are really managing system risk from a centralized location?
- Successful P4P organization recognized that the typical role silos would not result in innovative payment method success
- Management by walking around – does your organization recognize the compliance needs to be seen to be heard? Or is the department off-site?

Understand each other's languages and goals
- Does your compliance team think in terms of continuous quality improvement or are they still living in a bell shaped curve? Does quality understand compliance as an asset? Does Revenue Cycle?
- How does compliance or a culture of compliance blend into a HRO culture? Other than “mandatory education” – what is your role – what could it be?
- Survey readiness – How can compliance be a resource?

How Can I Help?
- Don't attempt to eat the elephant in one bite
  - Smaller group – the folks that do the work
- Start with an easy lift
  - Where to start – common problems
    - high cost/ high risk/ high visibility
- Recognize limitations – it's ok to say I don't know but I'll help you research & together we'll figure it out
- Celebrate success!
Contact Information

- Barbara J. Piascik, FHFMA, CHC
  Chief Compliance Officer
  Bergen New Bridge Medical Center
  E-mail: bpiascik@newbridgehealth.org

- Kerri McCutchin, MBA, CHC, CHRC
  Compliance Manager
  Cooper University Health Care
  E-mail: McCutchin-Kerri@cooperhealth.edu