Compliance: Details, Details  
**Dealing with Specific Billing and Operational Issues**  
Lori Laubach, CHC  
Principal

**Agenda**
- Background to government investigations
- Focus on both billing and operational issues the OIG has identified and investigated
- Discuss best practices for reducing error risks, fraud and misconduct
- Corrective action

**Background to Government Investigations**
HHS/DOJ Health Care Fraud Prevention and Enforcement Action Team’s ("HEAT")

- Internal Auditing
- Perform proactive reviews in coding, contracts & quality of care.
- Create an audit plan and re-evaluate it regularly.
- Identify your organization’s risk areas. Use your networking and compliance resources to get ideas and see what others are doing.
- Don’t only focus on the money – also evaluate what caused the problem.
- Create corrective action plans to fix the problem.
- Refer to sampling techniques in OIG’s Self Disclosure Protocol and in CIAs to get ideas.

National Fraud Prevention Program
Two Concurrent Approaches

Take quick administrative action to prevent improper payments.

Provider Screening (Enrollment)
Identify bad actors and prevent them from enrolling in Medicare.

Provider Analytics (Claims)
Take quick action to remove bad actors from Medicare.

Advanced Technology Risk Scores Based On Comprehensive Set Of Models
What Have We Seen?

- Administrative Determination Requests (ADR)
- Recovery Auditors (again)
- Comprehensive Error Rate Testing (CERT)
- OIG Grant Management

CERT

- Random sampling – Stratified
- Report for 2016 issued in July 2017
  - Overall 11% error rate
    - Home health – 42%
- Largest contributor
  - Two midnight rule implementation
- Efforts
  - Health Care Fraud Prevention (HFPP)
  - Medical Review Strategies
  - Provider education
  - Policy clarifications
  - Fraud Prevention System

OIG Medicare Compliance Reviews

- Use computer matching, data mining, and data analysis techniques
- Identify hospital claims potentially at risk for noncompliance with Medicare billing requirements
  - Inpatient rehabilitation
    - Inpatient claims billed with high-severity DRG codes
    - Inpatient claims paid in excess of charges
    - Inpatient same-day discharges and readmissions
    - Outpatient claims billed with modifier -59
- Stratified random samples of inpatient and outpatient claims
- Corrective Action plans advised
<table>
<thead>
<tr>
<th>Items of Focus by Government</th>
<th>OIG WP</th>
<th>CMS Audit</th>
<th>PEPPER</th>
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<td>Inpatient claims with high severity level DRG codes</td>
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<tr>
<td>Readmission – 30 days</td>
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<tr>
<td>Inpatient same-day discharges and readmissions</td>
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<td>Inpatient transfer claims</td>
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<tr>
<td>Inpatient and outpatient claims paid in excess of charges</td>
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<td>Inpatient and outpatient claims involving manufacturer credits for replaced medical devices.</td>
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<td>Cardiac Catheterization and heart biopsies</td>
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<tr>
<td>Inpatient stays billed separately</td>
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<tr>
<td>Outpatient drugs</td>
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<td>●</td>
</tr>
<tr>
<td>72 hour rule</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Outpatient drugs – incorrect HCPCS</td>
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<td>Outpatient claims billed with modifier -91</td>
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<tr>
<td>Outpatient surgeries billed with units greater than one</td>
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<td>Inpatient claims for blood clotting factor drugs</td>
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<td>Inpatient claims with payments greater than $150,000</td>
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<td>Outpatient claims billed with modifier -59</td>
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<th>CMS Audit</th>
<th>PEPPER</th>
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<td>Outpatient drugs – non-covered use of drugs</td>
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<tr>
<td>Minor surgery and other treatment billed as inpatient</td>
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<td>●</td>
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<td>72 hour rule with psych hospitals</td>
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<tr>
<td>Bone marrow or stem cell transplants</td>
<td></td>
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<tr>
<td>DRG Spine procedures</td>
<td></td>
<td></td>
<td>●</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>●</td>
<td>●</td>
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<td>Inpatient claims billed with high-severity DRG codes</td>
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### Pause for an Idea

*What should billing look like?*

- Reduce amount of aging A/R and un-billed days
- Reduce number of claim hand-offs and claim edits requiring manual intervention
- Manage un-billed dollars by prioritizing high dollar claim follow-up
- Expedite cash flow by better managing claim edits and denials
- Identify issues requiring education with action plans and process modifications
- Eliminate repetitive problems by tracking claim edits
- Ensure accurate charge capturing
- Foster continuous improvement of revenue cycle processes through education

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### What We Hear as the Revenue Integrity Program Goal

- Reduce amount of aging A/R and un-billed days
- Reduce number of claim hand-offs and claim edits requiring manual intervention
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- Expedite cash flow by better managing claim edits and denials
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- Eliminate repetitive problems by tracking claim edits
- Ensure accurate charge capturing
- Foster continuous improvement of revenue cycle processes through education
What is a Revenue Integrity and Compliance Program?

• Integration of revenue cycle functions and compliance responsibilities of an organization
• Characteristics of a revenue integrity program include:
  o Consistent actions, values, methods, principles, expectations, and outcomes
  o Achieve operational efficiency, compliance, and legitimate reimbursement
  o Proper processes, tools, and related expertise aimed at effectively pricing, charging and coding for services related to patient care and billing

Monitoring

Monitoring Examples

• Coding work queues
• Denial management
• Claim Scrubber
• Electronic monitoring reports related to work plan focus areas
• Evaluation and management coding distributions
• Excluded provider listing/background checks
Monitoring Examples (cont.)

• Teaching physician supervision requirements
• Modifier usage
• Non-physician practitioner code use
• Clinical quality measures

FUTURE Audit and Monitoring

• Continuous monitoring
• Predictive modeling and data analytic capabilities
  o Leverage data available in internal systems
• Use available industry data (e.g. PEPPER, CMS) for benchmarking
• “Real Time” focus on risks identified by OIG, CMS and other regulators
• Limit performance of retrospective claim audits

Identifying Risks
Risk Assessment Process Flow

- Broad focus on all types of risks

**Risk Profile**

- Build internally
  - Use the same claim data as CMS, FI/MACs, RAC, and ZPICs
  - Consider use of additional non-claim data to provide contextual and background information
- Determine your risk score
  - Overall, Part B, Part A, Other
  - Base on national or state benchmarks when available
  - Develop internal benchmarks when needed
- Update in response to regulatory changes
- Evaluate and explain

**Profiling**

- DRG distribution
- Volume of accounts being stopped by edits to measure productivity and identify patterns causing delays in claims processing and payment
- Edits that are sourced to problems in the charge master
- Edits to identify specific payer requirements and implement changes for continual improvement and to eliminate manual interventions
- Identify pre-bill and post-bill claim edits involving any type of clinical or coding review or required modifier based on services rendered
Profiling

- Identify return-to-provider claims that have issues with revenue code and CPT code/HCPCS combinations
- Track and trend denials by
  - Medical necessity
  - Level of care
  - Provider

Best Practice
Audit Program
Design Thoughts

Thoughts

- Data
- Sampling
- Error rate
- Where is the error?
Universe or Population

- Time period
- Multiple years
- All claims
- All payers
- Only paid claims
  - During period
  - For dates of service
- Data elements
- Completeness
- Charge corrections, etc.

What is Your Sample Size?

- Determine based on review areas and needs
- Retrospective
- Prospective
- How to select?
  - Random
  - Judgmental
  - Stratified
  - Statistically Valid

What is Your Sample Size?

- Examples:
  - Cloning concern – based on day or patient
  - Infusion therapy – by beneficiary
  - Credit balances – base sample on aging categories
  - Overpayment refund – based on timing
Example of Data Analysis

<table>
<thead>
<tr>
<th>Date</th>
<th>Possible</th>
<th>Requested</th>
<th>Possible</th>
<th>Requested</th>
<th>Clinical</th>
<th>Charge</th>
<th>Possible</th>
<th>Requested</th>
<th>Charge</th>
<th>Billed</th>
<th>Tracked</th>
<th>Possible</th>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<td>3</td>
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<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>1/4/2018</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
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<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Where is the Error?

- Clinical Documentation
- Charge master
- Charge capture – Outpatient
- Diagnoses
- Edits / Charge Router
- Work Queues
- Claims scrubber
- Clearinghouse
- Other

Where?

- Outpatient staff / orders
- HIM coding staff
- Chargemaster
- Automated process
- Match to Remittance
Error Calculation/Accuracy

• Count of met and not met for:
  o Claims
  o Lines (services billed)
• Net reimbursement impact
• Weighted points to the total lines
  By line
  By type of CPT code
  Diagnosis errors
  Modifiers
  Teaching physician count

Claim Review Results: December 6, 20XX - December 5, 20XX

<table>
<thead>
<tr>
<th>Provider</th>
<th>Met</th>
<th>Not Met</th>
<th>Total</th>
<th>Accuracy %</th>
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<tbody>
<tr>
<td>A</td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>56%</td>
</tr>
<tr>
<td>B</td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>56%</td>
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## Provider A – Weighted Accuracy Rate

<table>
<thead>
<tr>
<th>Error Description</th>
<th>Error Point</th>
<th>Risk</th>
<th>Count by Line</th>
<th>Weighted Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line Met</td>
<td>0.0</td>
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<td>79</td>
<td>-</td>
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<tr>
<td>CC Missing</td>
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<td>High</td>
<td>-</td>
<td>-</td>
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<tr>
<td>No documentation</td>
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<td>High</td>
<td>-</td>
<td>-</td>
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<tr>
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<td>Low</td>
<td>14</td>
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<tr>
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<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M up coded 3 levels</td>
<td>0.50</td>
<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M up coded 4 levels</td>
<td>1.0</td>
<td>High</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 1 level</td>
<td>0.25</td>
<td>Low</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 2 level</td>
<td>0.50</td>
<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 3 levels</td>
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<td>Medium</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>E/M under coded 4 levels</td>
<td>1.0</td>
<td>High</td>
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<td>-</td>
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<tr>
<td>No authentication</td>
<td>0.10</td>
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<td></td>
<td></td>
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<td></td>
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<td>Accuracy %</td>
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## Provider B – Weighted Accuracy Rate

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<td>70</td>
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<tr>
<td>No documentation</td>
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<td>High</td>
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<td>E/M up coded 1 level</td>
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<td>3.50</td>
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<td>E/M under coded 1 level</td>
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<tr>
<td>Accuracy %</td>
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<td>88.62%</td>
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## Corrective Action Plans
AHLA & OIG Compliance Guidance for Boards

- OIG's expectations for Board oversight are increasing.
  - Note recent CIAs that require board training and signed statements from board members (and executives) as to compliance.

- What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?
- Note collateral consequences of compliance issues, e.g., shareholder derivative actions.

Corrective Action Plans

- Based on root cause of issue
- Collaboration with management to develop appropriate corrective action
  - Specific
  - Actionable
  - Measurable
  - Has a timeline

<table>
<thead>
<tr>
<th>Cause Description</th>
<th>Deficiency Description</th>
<th>Actions to be taken</th>
<th>Indicating Deficiency is Resolved</th>
<th>Status Tracking and Reporting</th>
<th>Resources</th>
<th>Lead</th>
<th>Planned Complete Date</th>
<th>Actual Complete Date</th>
<th>Completion Confirmed</th>
<th>Review Date</th>
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</tbody>
</table>
Corrective Action Plans

- Accountability
- Proof completed
- Monitoring after implemented
- Summary count of CAP items outstanding

Examples

Example – High Producer

- High Producer
  - Rendering versus billing provider
  - Code met/not met based on documentation
  - Appointment schedule time
  - Check in time of patient (roomed) or surgeon arrival time
  - Check out time of patient or surgeon departure time
Examples - Cloning

- Cloning
  - Code met/not met based on documentation
  - Specific template or medical documentation area cloned
  - Code met without cloned area
  - Compared to prior record for:
    - Same patient
    - Prior patient, same day

Examples – Denial Management

- Review revenue integrity monitoring reports and minutes to determine actions
- Obtain denial management reports
- Obtain write off (adjustments) reports
- Select a sample of denials and include:
  - High dollar claims
  - Denial reason not match service
  - Medical necessity
  - Adjustments greater than 50% of expected reimbursement

Examples – Denial Management (cont.)

- Test the sample and obtain the following:
  - Documentation related to action steps
  - Date of posting of denial, first follow up, last follow up and rebill date.
  - Medical necessity follow up and appeal
  - Work flow changes or training due to denials received
  - Denial written off and related approval
Example – Insurance Eligibility

- Review revenue integrity monitoring reports and minutes to determine actions
- Select a sample of admissions and include:
  - Required pre-authorization
  - Insurance
  - Uninsured
- Test the sample for the following:
  - Pre-authorization obtained
  - Insurance checked
  - Uninsured qualifications
  - Duplicate patient

Conclusion

Key Takeaways

- Audit planning and documentation
- Data management
- What are we testing
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