Charlotte Regional
HCCA Conference

Third-party audits & inquiries: leveraging partnerships between compliance and operations for successful outcomes

January 17, 2020
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Executive System Director Hospital Compliance

Objectives for Today’s Session

1. Provide an overview of the current environment of external scrutiny

2. Review the considerations for planning, managing and leading the response effort

3. Discuss how to successfully collaborate with Revenue Cycle and Operational leaders
What type of organization do you represent?

- Hospital/Health Care System
- Private Physician Practice
- Post-Acute/Long Term Care
- Third-Party Vendor/Supplier
- Government Agency
- Other

Are you familiar with Medicare's CERT Program?

- Familiar
- Somewhat
- Unfamiliar
Overview of Current External Scrutiny: CERT

Background: Comprehensive Error Rate Testing (CERT)

- Medicare Fee for Service (FFS) improper payment rate first measured
- Two programs existed for testing error rate: Hospital Payment Monitoring Program (HPMP) and CERT
- CMS reported estimates of $23.8 billion or 14.2% error rate for Fiscal Year 1996
- Office of Inspector General (OIG) became responsible for estimating FFS improper payments
- Sampling method included only paid claims
- Sample size of claims was approximately 6,000 reviewed annually
- OIG recommended an increase in sample size
- CMS took over CERT and began producing a comprehensive Medicare FFS improper payment rate
- Improper Payments Elimination and Recovery Act (IPERA) of 2010
  - IPERA of 2010 updated via
    - Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012
  - IPERIA allows for approximately 50,000 claims to be reviewed for all Part A/B MACs and DMACs
  - Revised program elements, including sample size, allows CMS to determine national error rate
Two CERT contractors provide oversight, administrative logistics and results of improper payments

CERT Review Contractor: AdvanceMed
- Samples claims
- Requests and receives all medical records
- Images medical records
- Performs quality control (QC) of all imaged records
- Furnishes provider customer service and education support
- Reviews medical records
- Compiles the data (using the CERT SC)
- Maintains the CERT Provider Website
- Maintains the CERT Claim Status Website used by the MACs
- Maintains the CERT Management Website used by CMS

CERT Statistical Contractor: The Lewin Group, Inc.
- Calculates improper payment rates and amounts
- Designs sampling strategy
- Maintains the Live Data Dashboard

CMS CERT estimates national decrease from FY2018 to FY2019 of 0.87% or $2.71 billion in improper payments

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Improper Payment Rate</th>
<th>Improper Payment Amount (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall FY2019 (July 1, 2017 – June 30, 2018)</td>
<td>7.26%</td>
<td>$28.91 B</td>
</tr>
<tr>
<td>Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))</td>
<td>8.07%</td>
<td>$13.34 B</td>
</tr>
<tr>
<td>Part B Providers</td>
<td>8.64%</td>
<td>$8.66 B</td>
</tr>
<tr>
<td>Hospital IPPS</td>
<td>3.57%</td>
<td>$4.47 B</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</td>
<td>30.70%</td>
<td>$2.44 B</td>
</tr>
</tbody>
</table>

The improper payment rate is released annually in the Department of Health and Human Services (HHS) Agency Financial Report (AFR), which can be accessed through the HHS AFR link in the Related Links section at the bottom of this page.

1. The national overall and hospital IPPS improper payment rates are adjusted for the impact of Part A to B rebilling of denied inpatient claims.
2. Columns may not sum correctly due to rounding.
Sample CERT request letter and envelope

New policy provides guidelines for responding to external agency communications

New Policy: Contact with External Agencies

CERT communications should be routed to Health Information Management or Denials Management and Audits

- Comprehensive Error Rate Testing (CERT);
- Supplemental Medical Review Contractor (SMRC)

HIM with exceptions noted below:
- UNC MC and REX: Reimbursement sends to unchcsar@unchealth.unc.edu
- Caldwell Physicians, UNC FP, and UNC PN: Practice Management sends to unchcsar@unchealth.unc.edu

Records release to occur through HIM or applicable data release department at the entity.

Compliance to be informed of CERT and SMRC requests in a timely manner.

Coordination to occur, as appropriate, with other departments (e.g., Utilization Management, Denials Management, PFS, Quality/Risk, Administration, etc.)
Audit landscape varies by payer type and audit type

<table>
<thead>
<tr>
<th>Government vs Commercial</th>
<th>Rationale &amp; Insights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial 78%</td>
<td>Audit Process Variation:</td>
</tr>
<tr>
<td>Gov't 22%</td>
<td>• Commercial audit process varies from one payer to the next or one auditor to the next.</td>
</tr>
<tr>
<td></td>
<td>• Commercial audits have very few limitations on what and how many claims can be audited</td>
</tr>
<tr>
<td></td>
<td>• Commercial audits are regulated via payer contracts</td>
</tr>
<tr>
<td></td>
<td>• Governmental audits follow regulations and a defined process</td>
</tr>
<tr>
<td></td>
<td>• Governmental audits have volume limitations</td>
</tr>
</tbody>
</table>

Recovery Audits vs Pre-Payment Audits

<table>
<thead>
<tr>
<th>Recovery Audit 82%</th>
<th>Pre-Pay 18%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit or Denial Workflow Confusion</td>
</tr>
<tr>
<td></td>
<td>• Dollars at Risk/Protected from recoupment versus dollars never received</td>
</tr>
<tr>
<td></td>
<td>• Duplicate workflows between audit created in Cobius versus denials posted in Epic</td>
</tr>
<tr>
<td></td>
<td>• Confusion regarding what is tracked in the specialized audit software</td>
</tr>
</tbody>
</table>

Based on audit volumes FY19 Qtr 4 and FY 20 Qtr 1

Planning, organizing and leading response
Denials Management and Third-Party Audits

Mission Statement:
The Denials Management and Audit Team seeks to prevent denials and protect net revenue for UNC Revenue Cycle Shared Services by leveraging key partnerships, maximizing resources, and improving operational processes.

Denials Management
- Development of denial metrics and reporting
- Denial analytics to identify payer trends and sampling denials to determine root causes
- Collaborating with key clinical stakeholders to champion process improvement projects to reduce future denials and revenue loss

Third-Party Audits
- Timely response to audit requests
- Payor audit tracking in specialized software
- Collaborating with key subject matter experts to respond to audit findings
- Audit tracking of dollars at risk
- Identify process improvements to prevent future audit findings

UNC Health Care Denials Management Evolution

The Denials Management and Audit Team was born out of the Carolina Value initiative as a permanent vehicle for process improvement driven by data and ultimately sustained by appropriate operational owners.
Clinical partners are key for successful revenue cycle improvement projects and compliance at UNC Health Care

Over the past two years, the Denials Management & Audit team has partnered with clinical leadership at the to co-sponsor and facilitate process improvement projects. Issues and fixes identified through these efforts have been implemented at the health care system level benefiting other entities.

Process Improvement Projects

**UNC Pharmacy**
- Medicaid National Drug Code (NDC) Denials
  - Metrics: Dollar Amount of Denials – Reduced 51%
  - Volume of Denials – Reduced 82%
  - Continuous Improvement: Pharmacy continues to work the top ten denials by dollar and volume each month. The Pharmacy team works closely with Rev Cycle Patient Financial Services to address new issues when identified.

**McLendon Labs**
- Lab Medicare and Medicare Advantage Medical Necessity
  - Metrics: Dollar Amt of Adjustments – Reduced 51%
  - Volume of Adjustments – Reduced 40%
  - Continuous Improvement: McLendon Laboratory continues to monitor the top 10 CPT codes adjusted by dollar and volume each month to identify new trends and opportunities

**UNC Registration**
- Inpatient Medicare Coordination of Benefit Denials
  - Metrics: Medicare COB Volume – Reduced 54%
  - Medicare COB Dollars – Reduced 74%
  - Project Completion: Project close is pending registration training updates with Learning, Organizational Development (LOD) to ensure sustainment of denial improvements.

Clinical partnerships working together to drive down hospital billing claims denial rate

Final FY19 denial rate for revenue cycle shared services, hospital billing down 14%; 2 percentage points or 13% from FY18 denial rate; equates to over 41K less denials

Hospital Billing Denial Rate & Total Claim Count

*The denial rate calculation is “remitted claim count with a denial” divided by “total remitted claim count”*
Clinical Partnerships working together to reduce the preventable write-offs (Hospital)

Final FY19 preventable write-offs net savings of $9.2 Million; decrease of $24.2 million since program began in FY17

Hospital Billing (HB) Preventable Write-Off Rate

*The Preventable Write-Off (PWO) rate is preventable loss adjustments divided by total gross charges posted for the same time period.

UNC Hospitals
RAC-C/RAC-A Audit Volume

Cobius Audit Volume by Audit Reason
Facility – UNC Hospitals
Audit Type – RAC-C; RAC-A
Auditor – Cotiviti
Date Range – July 1 – December 31, 2018

Cobius Audit Volume by Audit Reason
Facility – UNC Hospitals
Audit Type – RAC-C; RAC-A
Auditor – Cotiviti
Date Range – July 1, 2017 – June 30, 2018
UNC Hospitals
MAC Prepayment (TPE) Audit Volume FY19 Q1 & Q2

Cobius Audit Volume by Audit Reason
Facility – UNC Hospitals
Audit Type – MAC Prepayment
Auditor – Palmetto GBA
Date Range – July 1 – September 30, 2018

<table>
<thead>
<tr>
<th>Audit Reason</th>
<th># Audits</th>
<th># Open</th>
<th># Suspended</th>
<th># Closed</th>
<th># Denied</th>
<th># Appointed</th>
<th># App. Win</th>
<th># App. Loss</th>
<th>Financial Impact</th>
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<tbody>
<tr>
<td>STIP – Manual</td>
<td>37</td>
<td>31</td>
<td>0</td>
<td>18</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$4,681</td>
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<tr>
<td>EXPIRED – Claim, Claim</td>
<td>13</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAC – APH Non R &amp; D</td>
<td>16</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
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<td>ICFS – CASE, ICFS, PFS</td>
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<td>0</td>
<td>0</td>
<td>$2,483</td>
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<tr>
<td>TOTAL</td>
<td>99</td>
<td>90</td>
<td>0</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$46,510</td>
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FY19
Q1 & Q2

UNC Hospitals
MAC Prepayment (TPE) Audit Volume FY18

Cobius Audit Volume by Audit Reason
Facility – UNC Hospitals
Audit Type – MAC Prepayment
Auditor – Palmetto GBA
Date Range – July 1, 2017 – June 30, 2018

<table>
<thead>
<tr>
<th>Audit Reason</th>
<th># Audits</th>
<th># Open</th>
<th># Suspended</th>
<th># Closed</th>
<th># Denied</th>
<th># Appointed</th>
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<th># App. Loss</th>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>STIP – Manual</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>ICFS – CASE</td>
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<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>ICFS – CASE</td>
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<td>1</td>
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<td>0</td>
<td>$26,196</td>
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<tr>
<td>ICFS – CASE</td>
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<td>0</td>
<td>86</td>
<td>19</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>$0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>97</td>
<td>1</td>
<td>0</td>
<td>95</td>
<td>23</td>
<td>14</td>
<td>7</td>
<td>6</td>
<td>$26,196 $192,667</td>
</tr>
</tbody>
</table>
Has your organization received a Targeted Probe & Educate audit in the past 12 months?

- Yes
- No
- Unsure

What services are being audited, i.e. - therapy, coding, wound. Keep your response to one word.
Successful collaboration with Revenue Cycle and Operations

Elements of an Effective Compliance and Ethics Program provide model structure and guidance for UNCHCS

Program Elements *

1. Policies and procedures
2. High level responsibility
3. Education and training
4. Reporting concerns
5. Enforcement and discipline
6. Auditing and monitoring
7. Response and prevention

* U.S. Sentencing Commission Guidelines, Chapter 8, Section B2.1

Audit work planning and follow through helps identify and reduce organizational risks
Management is responsible for audit action plans which should be completed by due date

Audit Recommendation and Management Action Plan Expectations:

• Management should follow through on action plans by the agreed upon due date
  • If the action plan cannot be completed by the due date then management will communicate with the respective auditing team member

• Audit Team will communicate with management to verify completion of action plan
  • All communication should occur with the Hospital Compliance Analyst conducting the audit or see table below for entity specific contacts

Audit, Compliance and Privacy Services Work Plans are derived from a number of sources

Audit, Compliance and Privacy develops an Audit Work Plan each fiscal year which seeks to mitigate or eliminate risk. This plan covers most network entities and is approved by the Health Care System Board

Consider Topics to Include on Audit Work Plan
• Regulatory Agencies – OIG, DOJ, CMS
• Professional Publications and Conferences
• Compliance Officers and Compliance Committees
• Internal Key Stakeholders and Leaders

Assess Risk for Each Proposed Audit Topic
• Regulatory, Financial, Operational, Reputational

After Approval of Audit Work Plan
• Adjustments for Management Requests, Emerging Issues
• Transparency – Engagement of Key Stakeholders and Publication of Formal Final Reports with Action Plans
Regular updates identifying risk and compliance efforts should be provided to the board

Reporting options could include:

- Risk assessment and audit plans
- Scorecards or dashboards
- Executive summaries of internal and external audits and investigations
- Hotline and other inquiry activity

Resource needs or constraints

Significant code of conduct violations

Executive sessions excluding senior management to encourage open communication with compliance, legal, audit, quality, and others

Mechanisms should be in place for timely reporting to evaluate remedial measures

Discovery of risk areas lead to provider education

Testing Scenario:

A. Important Scenarios

1. APP/Billing Independence and routing for signatures to physicians:

   Testing is the scenario for all providers, ordered that correct billing is critical to the success of the APP. A provider is responsible for the following:
   - Add vendor to the vendor list in the vendor Biller, the change is automatically made.
   - Add vendor to the provider in the vendor Biller, then the change is automatically made.
   - Add vendor to the provider in the vendor Biller, then the change is automatically made.

   The "correct" button ensures the accuracy of the data as being the same as the "add" button, the system's configuration of the APP on the tool as the billing and service provider. If the physician includes a service provider, the service is reviewed reflecting the physician as the service provider.

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TIP SHEET – Inpatient Charging

Advanced Practice Practitioners (APP) Inpatient Charging Workflows

There are two (2) scenarios for which APPs will be required to complete charging within Epic. As a Certified Nurse Midwife (CNM) or PED, you should review the instructions when you are to begin charging for billing purposes. To ensure you receive the correct charge, please log on to the appropriate window, verify you are logged into the correct department. Your clinic is the correct department.

Ensure you log on to the correct department at the hospital. If you are only working on the Revenue Center of the hospital, please log on to the correct department.

1. APP receives the charge (Independent Visit). APP does not send the note (for Cough)
From regulation to audit to collaboration for correction

42 CFR Ch. IV (18-1-14 Edition) 

From regulation to audit to collaboration for correction 

(a) Definitions 

Audit: An independent verification of a process or procedure to determine if it is being done in accordance with policies and procedures. 

Collaboration: Working together with others to achieve a common goal. 

Correction: Taking action to fix a problem or error. 

From regulation to audit to collaboration for correction 

To:
From: 

Subject: 

Audit Report

TO: [To name] 
FROM: [From name] 

DATE: [Date]

SUBJECT: [Subject]

Cooperative efforts on AWV

[Diagram showing cooperative efforts on AWV]

Collaborate with teams to guide and prevent future errors

Credits for Medical Device - Current Process

Epic@UNC Training

Tip Sheet

Device Review for Warranty or Recall Credit

Medicare and other payers require facilities to report specific data elements on claims for patients receiving a replaced medical device explained and the cost is 50% or greater of the purchased medical device. The medical device is to be the manufacturer for analysis for possible credits due to replacement under warranty or known recall. The process begins with flagging the device charge that is under review by the vendor for possible warranty or recall credits.

Flagging the Device Charge

When a device is under review it can be held within a Charge Review WQ by appending the DEY modifier to the charge. The charge will remain with the Department (cost center’s) Charge Review WQ until approved. The DEY modifier can be appended via Unit Charge Entry or with Optimize (OR only) during the charge review process. The screen shot below shows the DEY modifier in the charge line.
Visit the UNC Health Care Compliance Office home page located at unchealthcare.org

UNC Health Care Compliance Office

We are Committed to a Culture of Compliance
Compliance is the obligation to act ethically and in accordance with the Code of Conduct, applicable UNC Health Care and entity-level policies, and relevant laws, rules, and regulations. Everyone working with UNC Health Care (including employees, physicians, contractors, vendors, and volunteers) is accountable for compliance results. Compliant behavior is expected at all times in all UNC Health Care facilities.

You can help foster a culture of compliance by always adhering to applicable policies, laws, and regulations. Your supervisor can help you understand the expectations for your work area. If you have doubts about whether something is compliant, speak up and ask your supervisor, department leader, or Compliance Office for clarification. Promptly report concerns to your supervisor, the Compliance Office, or the Compliance Hotline.

Thank you for your time and attention