It Takes a Village

HCCA Compliance Institute – Virtual Conference

1

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

2

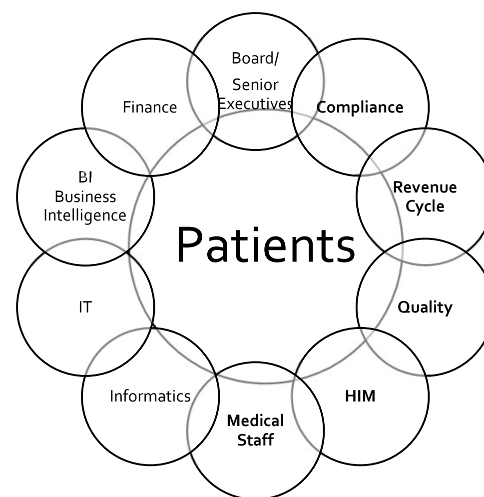
Objectives

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

3

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

4

Self Awareness/Functional Awareness - Does each area have an understanding of potential functional intersections?

Does your compliance program:

- Operate parallel but apart from the fundamental activities of your health system?
- Or as a strategic partner?
- Contribute to the clinical processes of care for the patients served?

- Is your compliance team aware of denials, up-coding or other possible billing errors discovered outside of compliance reviews?
- Is your compliance team viewed as a resource for questions and concerns?
  - Before or after an issue bubbles to the surface?
- Is your compliance team part of on-going monitoring?
- Is your compliance team viewed as an objective voice for investigations?

Does Quality:

- Include compliance in discussions about quality measures?
- Include Compliance at Root Cause Analysis meetings?
- Look to Compliance to assist in validating coding reviews of HACs? PSIs?
- Request compliance assistance in coding validation of increases or decreases in reported diagnosis; i.e. sepsis? CAUTI? CLABSI?
- Make compliance aware when an external quality report or audit is received?
- Inform compliance about a potential provider quality concern and ask for documentation review assistance?

Does Revenue Cycle:

- Discuss new services/CDM codes with Compliance to ensure CCI?
- Provide Denial Reports to Compliance or access to denial work queues?
- **Track all payer additional documentation and audit requests received *either* through Patient Accounts &/or HIM and share that data with Compliance?**
- When does Compliance get involved?
  - Early on in a RAC committee type format?
  - Later when there are potential repayments?

5

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?

6

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

7

DRUG DIVERSION

8

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

9

9

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

10

10

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……….

11

REPORTED QUALITY DATA

12

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

13

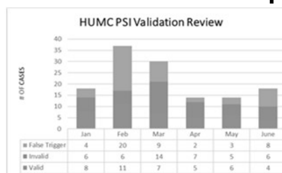
Quality Metrics are being Reported

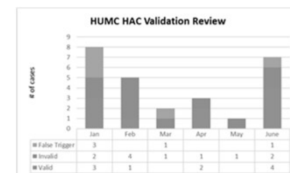
Opportunities for Collaboration

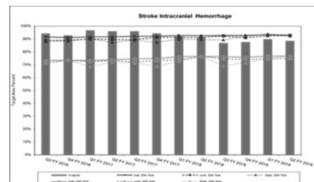
The Quality Dashboard

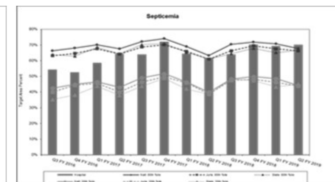
- How is the data being collected?
- Examples of what might be reported on a Quality Dashboard:
  - PSI and HACs:
    - What are the documentation and coding requirements?
    - Have they been cascaded?
    - Have they been validated
  - Readmissions – Hmm, some of these look familiar. PEPPER!
    - 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

14

Example: Payer Quality Coding Guide

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

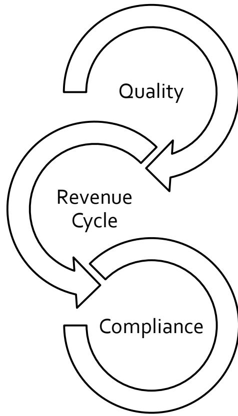
Payer Quality Coding Guide

Quality Measure	*Payer Program*	*Measure Description*	*Steward*	*Data Type Accepted*	*Requirements*	*Link to Value Set Codes*
What is the measure?	**Which Program(s)?**	**Describe**		**What can you submit? Which CPT codes? What format? Is other data accepted; i.e. a signed report from a provider other than the submitting provider?**	**What is required to meet the measure?**	**Links to the payer guides/instructions for that measure**
Example: Breast Cancer Screening		The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. ***Exclusions:*** • Bilateral mastectomy • Two unilateral mastectomies • Hospice services • Frailty & Advanced Illness	HEDIS	Claims coding; EMR-to-Excel Flat File uploads CPT: 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067 HCPS: G0202, G0204, G0206; –	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 (2019). The following types and methods of mammograms will satisfy the numerator for Payer X: • Screening • Diagnostic • Film • Digital • Digital breast tomosynthesis	Guide link

15

REVENUE CYCLE

16



- 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?

17

Denial Avoidance: Build the Foundation

- **New Technology/ Procedure or Service?**
  - Credentialing requirements?
  - 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?
    - Who is responsible for developing the MCA
  - Is there a device involved?
    - Is it a device that is provided at no cost as part of a research study?
  - Will a new procedure pre-bill hold be put in place?
    - 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 QUESTIONAIRRE

Will augmentation of privileges be required? ☐ YES ☐ NO If yes, list privilege and attach any clinical white papers to be used in completion of FPPE plan: ______

What other resources will be required (e.g. radiology, surgical backup, ICU bed requirement, respiratory therapy, pharmacy, etc)? ______

Section II -- Product/Equipment Use:

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

Procedure Code/DRG	Description	Est. Volume - Inpatient per Procedure	Est. Volume - Outpatient per Procedure

Are the procedures listed above reimbursed by Medicare? ☐ YES ☐ NO ☐ N/A

- If yes, is there a Medicare NCD or LCD for the procedure/use of equipment? ☐ YES #______ ☐ NO
  (Please attach NCD or LCD)

Are the procedures listed above reimbursed by Commercial Insurance? ☐ YES ☐ NO ☐ N/A

- If yes, confirmed by______
- If yes, is there a clinical use policy for the procedure/use of equipment? ☐ YES ☐ NO
  (Please attach clinical use policy)

Specify the estimated impact on Length of Stay, if any:______ ☐ N/A

Other factors to consider in deliberations: ______

Section III – The following information must be completed by the requesting physician, if applicable:

Do you or a member 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 a member 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 will you receive any discounts, business courtesies or free goods or services from the manufacturer, distributor and/or seller of the requested new product or equipment in consideration of your use and/or promotion of this new product or equipment? If yes, please explain:

Physician's signature: ______ Date: ______

18

MITRACLIP (TMVr)

Transcatheter mitral valve repair (TMVr):

MitraClip 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 portion 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 MR on Inpatient Hospital Claims:

1. **MitraClip is Inpatient only procedure**
2. Inpatient hospitals shall bill for TMVR for MR on a 11X Type of Bill (TOB)
3. ICD-10-CM diagnosis code I34.0 OR I34.1;
4. ICD-10-PCS procedure code 02UG3JZ (MitraClip) & B24S224 (ultrasound)
   a. Usually reimbursed under MS-DRG 228 or MS-DRG 229
5. Secondary ICD-10 diagnosis code Z00.6 (**should be listed after identified MCC**
6. Condition Code 30; and
7. Value Code FD with An 8-digit NCT Number 02245763

Claims Processing Requirements for TMVR for MR on Professional 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 I34.0 OR I34.1;
3. CPT procedure codes 33418 (33419 for additional prosthesis) with Modifier Q0
4. Secondary ICD-10 diagnosis code Z00.6;
5. An 8-digit NCT Number 02245763

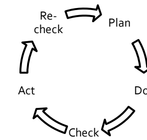
Reference:

1. NCD 20.33
2. Abbott MitraClip

New Procedure [name] Dashboard - potential items for inclusion	Base Year	Goal	Month	Month
Number of Procedures performed	#	Not Applicable		
Number Medicare	#			
Number Other Payers	#			
Percentage of Performed Procedures reviewed	%	100%	100%	
Correct Patient Status (IP only procedures)	%	100%	95%	
NCD/LCD [insert #] requirements met - FFS Medicare	%	100%	75%	
Other payer requirements met	%	100%	100%	
Research - Clinical trial or other registry form completed	%	100%	88%	
Joint decision making tool completed (if applicable)	%	100%	100%	
Requests for additional information (reports not complete at time of review)	#	TBD	5	
Number of Remediation activities per claim (average)	#	TBD		
Coding - HIM				
Correct Procedure Code	%	100%	85%	
Correct Diagnosis Codes (except clinical trial diagnosis codes)	%	100%	100%	
Correct Clinical Trial Diagnosis Code (Z00.6)	%	100%	50%	
Correct DRG	%	100%	90%	
Correct Discharge Disposition Code	%	100%	100%	
Number of Remediation Activities per Claim	#			
Patient Accounts - Billing				
Correct Bill Type (IP only)	%	100%	95%	
Clinical Trial Condition Code & Value Code (added by billing)	%	100%	68%	
Number of Remediation Activities (Charges, NCT number errors) Total for month	#			
Incorrect DRG (pre-bill review prevention of overpayment)	$			
Incorrect DRG (pre-bill review prevention of underpayment)	$		$10,000	
Pre bill Denial related loss (i.e. patient status; NCD not met)	$		($25,000)	
Device Implants	#			

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

Payer	Medical Necessity #	Medical Necessity $	No Authorization #	No Authorization $	Documents Req. #	Documents Req. $	Coding Issue #	Coding Issue $	Coding - Modifier #	Coding - Modifier $
Federal Emergency Fee For Service	1323	$3.620.060	17	$274.180	6	$224.357	1	$1.224		

Bundling/ Unbundling #	Bundling/ Unbundling $	Service Not Covered #	Service Not Covered $	Claim Form Denial #	Claim Form Denial $	Does Not Meet Care Criteria #	Does Not Meet Care Criteria $	All Others #	All Others $	Total #	Total $
		31	245803	50	$59.186	245	$304.934	697	$2.658.416	2.370	$7.388.16

hfma | 2019 Annual Conference

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

21

CYBERSECURITY

PASSWORDS

22

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

23

Typical U.S Hospital

100,000,000,000,000 Lines of Code

400+ Systems
750+ Business Associates
Thousands of Devices

24

An Ounce of Prevention….
Passphrase Instead of Password!

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

Passphrases Crack Time

A passphrase is several random words combined together, like xkcd's famous correcthorsebatterystaple suggestion.

The below chart assumes the attacker knows what dictionary you used and the dictionary has around 8000 words.

Number of Words	Time to Crack
3 words	3 seconds
4 words	7 hours
5 words	8 years

Passwords Crack Time

Alphanumeric means the password is made up of uppercase and lowe
numbers. Basically *A-Z, a-z, 0-9.*

Password Length	Time to Crack	... with special character
9 characters	2 minutes	2 hours
10 characters	2 hours	1 week
11 characters	6 days	2 years
12 characters	1 year	2 centuries
13 characters	64 years	—

Password Length	Time to Crack	... with special character
9 characters	2 minutes	2 hours

Password Length	Time to Crack	... with special character
13 characters	64 years	—

25

IN CLOSING:

26

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

27

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

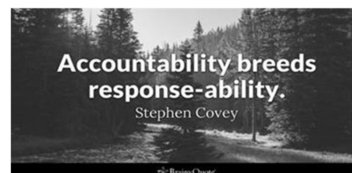
- ✓ ***Participate in positive change and***
- ✓ ***Be recognized as a strategic partner?***

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!

28

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

29