Dial C for Compliance

HCCA Regional Conference – San Francisco
Friday, December 2, 2016

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1

Introductions

- Judy Waltz
- Lori Laubach

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Today's Topics

- How do you identify issues and flag those that require further review?
- When do you need to bring in an external auditor?
- What is the best way to design an audit, get it done, and succeed in resolution of the issue?
- How do you meet your legal obligations while securing legal protections?

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3

C is for the Case for Monitoring and Auditing

4

Monitoring: One of the Seven Elements

"An **ongoing evaluation** process is critical to a successful compliance program. The OIG believes that an effective program should incorporate thorough monitoring of its implementation and regular reporting to senior hospital or corporate officers. Compliance reports created by this ongoing monitoring, including reports of suspected noncompliance, should be maintained by the compliance officer and shared with the hospital's senior management and the compliance committee"

http://oig.hhs.gov/authorities/docs/cpghosp.pdf

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5

Sentencing Guidelines 8B2.1(b)(5)

The organization shall take reasonable steps to—

- ensure that the organization's compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct;
- evaluate periodically the effectiveness of the organization's compliance and ethics program; and
- have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization's employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation.

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6

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.

https://oig.hhs.gov/compliance/provider-compliance-training/files/OperatinganEffectiveComplianceProgramFinalBR508.pdf

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CMS Stated Expectations for Proactive Compliance Efforts

- **Final Rule for REPORTING AND RETURNING OF OVERPAYMENTS:** 81 Fed. Reg. 7654 (Feb. 12, 2016)
  - [7661] "Reasonable diligence" includes both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.
  - [7661] [C]ompliance with the statutory obligation to report and return received overpayments requires both proactive and reactive activities.
  - [7661] [U]ndertaking no or minimal compliance activities to monitor the accuracy and appropriateness of a provider or supplier's Medicare claims would expose a provider or supplier to liability . . . based on the failure to exercise reasonable diligence if the provider or supplier received an overpayment.

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HHS/DOJ Health Care Fraud Prevention and Enforcement Action Team's ("HEAT")

Enforcement of Policies and Procedures and Prompt Response to Compliance Issues

- Delegate/empower teams closest to the issues to perform reviews, but be careful of possible conflicts or personal relationships that may interfere with getting an objective review.
- Act promptly, and take appropriate corrective action.
- Create a system or process to track resolution of complaints.
- Enforce your policies consistently through appropriate disciplinary action.

https://oig.hhs.gov/compliance/provider-compliance-training/files/OperatinganEffectiveComplianceProgramFinalBR508.pdf

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"Intent" for Purposes of the False Claims Act

The standard for proving a "knowing" violation of the FCA is relatively low.

- Actual knowledge
- Deliberate ignorance
- *Reckless disregard* for the truth or falsity of a claim

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CMS Data Analytics

- Think about your data footprint
- Medicare – each new claim is compared to 9 years of claims data (Integrated Data Repository – A,B & D claim data back to January 2006)
- Other data-driven efforts include the Fraud Prevention System (FPS) – CY 2014
  - 276 New Investigations and Support for 336 existing investigations
  - Administrative Actions – 1,093 providers; CMS took additional actions against 18,113 providers through auto-denial edits implemented directly through FPS.
  - ROI: per CMS - $9.7/$1; per OIG - $2.84/$1

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11

C is for
Competence: Identifying Issues and Flagging for Further Review

12

Audit Plan Development

- Based on risk assessment, interviews, industry knowledge, organization risks, organization's specific issue history, etc.
  - Recent OIG audits (OAS reports), e.g., hospital compliance audits
  - OIG Work plan
  - CMS RAC audits – approved issues
  - Site-specific issues – known challenges
- Taken to Compliance Steering Committee and Audit Committee for final approval.
- Annual audit plan finalized and quarterly plans developed.
- Who is the "stakeholder" driving the audit and will receive the results?

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C is for
Creation of Successful Audit Program

What should I plan for?

14

Legal Involvement?

- There may be advantages to doing an audit under privilege.
  - Even if the information will be disclosed ultimately (i.e., the privilege waived), privilege may allow the entity somewhat more control over that process.
  - Involve Legal at the earliest possible point – privilege will not be retrospective.
  - Consider other potential "collateral" actions that might want the results of these audits – e.g., employment matters.

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Audit Program Design

1. Define the need
2. Establish your compliance goal / accuracy rate
3. Obtain policies and procedures for area of focus
4. Choose an appropriate sample size
5. Determine look-back period (recent 60 day rule establishes a six-year lookback period)
6. Choose who should perform review
7. Request data
8. Prepare the audit report with findings and recommendations
9. Corrective Action Plan (CAP)
10. Ongoing monitoring

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16

Define the Need

- Based identified concerns on reported activity
- Identified from monitoring
- Random or focused
- Document the audit objectives, e.g., define error rate, define total overpayment
- Define the reporting process of results
- How often will the audit be performed?

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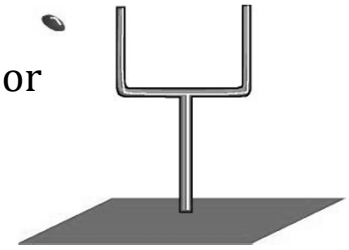
Compliance Goal

- A policy to define expectations
- Define accuracy rate
- Determine what will be measured
- Define need for disclosures, refunds, disciplinary action or education/training, other….



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Who Performs the Audit?

- According the Office of Inspector General 's (OIG) auditing standards, evidence gathered by auditors and compliance officers should be sufficient, competent, and relevant.
  - Sufficiency
  - Competency
  - Relevancy
- Internal vs. external – may be issue-specific or broader based determination

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Lookback Period?

- Final Rule for the 60-Day Refund Requirement sets the lookback period at 60 days for Medicare Part A and Part B – but allows up to 6 months for the investigation/analysis and then 60 days after that for the report and return of an identified overpayment
- Medicaid (no federal rule) – 9/9/2010 CPI Informational Bulletin, indicates that Medicaid Integrity Contractors should use a 5 year lookback period
- Other periods may be appropriate in specific situations

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20

C is for: Corrective Action Plans

21

Reporting and Follow-up

- Draft report with/for stakeholders
  - Verbal
- Rebuttals
  - Tracked
- Final report with recommendations
- Follow-up on status of implementation of recommendations/corrective actions
- Identify monitoring activities for long term compliance
- Establish follow-up reporting timeframes

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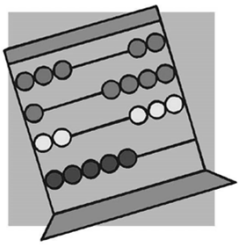
Error Calculation

- Count of met and not met for:
  - Claims
  - 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



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Summary of Issues

			Risk Level	Count	Weighted Errors	Pct of Total Count
A1	Documentation meets all requirements	0	Low	79	-	84.04%
A1.1	Documentation does not meet	NA	High	-		0.00%
A1.2	Documentation exceeds	NA	Medium	-		0.00%
A1.3	CC Missing on IP	0	Low	-	-	0.00%
A2	No documentation for service billed	1	High	-	-	0.00%
A2.1	CC Missing	1	High	-	-	0.00%
A3.1	E&M up-coded by 1 level	0.25	Low	14	3.50	14.89%
A3.2	E&M up-coded by 2 levels	0.5	Medium	-	-	0.00%
A3.3	E&M up-coded by 3 levels	0.5	Medium	-	-	0.00%
A3.4	E&M up-coded by 4 levels	1	High	-	-	0.00%
A3.5	E&M up-coded by 5 levels	1	High	-	-	0.00%
A4.1	E&M under-coded by 1 level	0.25	Low	-	-	0.00%
A4.2	E&M under-coded by 2 levels	0.5	Low	-	-	0.00%
A4.3	E&M under-coded by 3 levels	0.5	Medium	-	-	0.00%
A4.4	E&M under-coded by 4 levels	1	Medium	-	-	0.00%
A4.5	E&M under-coded by 5 levels	1	High	-	-	0.00%
A5	E&M in wrong					
A6						
A9	Hospital discharge criteria not met	0.5	Medium		-	0.00%
A10	Prolonged services criteria not met	0.5	Medium	-	-	0.00%
A11	Insufficient docum of TP participation in patient care	1	High	-	-	0.00%
A12	Wrong provider billed	0.1	Low	-	-	0.00%
A13	Wrong date of service billed	0.1	Low	-	-	0.00%
A14	Documentation not found due to facility	0	Low	-	-	0.00%
A15	Not billable - no doc to support or not separate	0.5	Medium	-	-	0.00%
A20	Performed not coded	0.25	Low	-	-	0.00%
A21	Insufficient documentation of Supervising Physician	0.5	Medium	-	-	0.00%
A22	No authentication	0.1	Low	-	-	0.00%
A23	Findings	0	Low	-	-	0.00%
	Total EM			94	3.75	
				Accuracy %	96.01%	
B1						
B						

24

1st Quarter 2012

E & M Errors			Risk Level	Count	Weighted Errors	Pct of Total Count
	Total professional cases reviewed			25		
	Total IP & ASC cases reviewed			-		
				25		
EM Diagnosis Coding errors						
C1	Diag Documentation meets all requirements	0	Low	61	-	96.83%
C2	Primary diagnosis code error	0.5	Medium	2	1.00	3.17%
C3	Secondary diagnosis code error	0.25	Low	-	-	0.00%
C4	Other diagnosis code error	0.1	Low	-	-	0.00%
C5	Findings	0	Low	-	-	0.00%
C6	Diagnosis error-administrative	0	Low	-	-	0.00%
C7	Additional disgnosis needed	0.1	Low	-	-	0.00%
	Total EM Diagnosis Errors			63	1.00	
				Accuracy %	98.41%	
	Total Diagnosis Met (EM & Procedures)			88		95.65%
	Total Diagnosis Not Met (EM & Procedures)			4		4.35%
				92		100.00%
Modifiers						
	Modifier meets all			33		94.29%
				Accuracy %	97.14%	
Teaching Physician Guidelines						
E1	TP meets all requirements	0	High	-	-	
E2	TP attestation / linking is missing from documentation	1	High	-	-	
E3	TP Attestation for PCE is not correct	1	High	-	-	
E4	The attestation / linking statement is not complete	1	High	-	-	
E5	TP Attestation linked to Med Student	1	High	-	-	
E6	TP Attestation linked to non-ACGME Fellow	1	High	-	-	
E7	TP Attestation not applied by attending	1	High	-	-	
E8	Insufficient TP documentation of Time	1	High	-	-	
	Total Teaching Physician Errors			-	-	
				Accuracy %	0.00%	
	Total Accuracy			161.00	2.50	
				Accuracy %	98.45%	
	Administrative Findings (Not part of weighted errors)					
D5	Modifier meets all requirements-GC	0	Low	-	-	
D8	Modifier error-administrative-GC	0	Low	8	-	
E9	Teaching Physician - Findings	0	Low	8	-	

25

Claim Review Results
December 6, 20XX to December 5, 20XX

Federal Health Care Program Billed	Bene HIC #	Date of Service	Procedure Code Submitted	Procedure Code Reimbursed	Allowed Amount Reimbursed	Correct Procedure Code	Correct Allowed Amount	Dollar Difference
Medicare		3/10/XX	99214	99214	$61.42	99214	$61.42	$0.00
Medicare		3/10/XX	1000F	1000F	$0.00	1000F	$0.00	$0.00
Medicare		3/10/XX	1036F	1036F	$0.00	1036F	$0.00	$0.00
Medicare		3/10/XX	1123F	1123F	$0.00	1123F	$0.00	$0.00
Medicare		3/10/XX	G8421	G8421	$0.00	G8421	$0.00	$0.00
Medicare		3/10/XX	G8427	G8427	$0.00	G8427	$0.00	$0.00
Medicare		3/10/XX	G8445	G8445	$0.00	G8445	$0.00	$0.00
Medicare		3/10/XX	G8457	G8457	$0.00	G8457	$0.00	$0.00
Medicare		3/10/XX	3016F	3016F	$0.00	3016F	$0.00	$0.00
Medicare		9/24/XX	9921[illegible]	99215	$97.71	99215	$97.71	$0.00
Medicare		9/24/XX	100[illegible]	1000F	$0.00	1000F	$0.00	$0.00
Medicare		9/24/XX	10[illegible]	1036F	$0.00	1[illegible]	$0.00	[illegible]0
Medicare		9/[illegible]	112[illegible]	1123F, 8P	$0.00	11[illegible]	$0.00	[illegible]
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[illegible]dicare		8/18/[illegible]	93545		[illegible]	93[illegible]	9[illegible]	[illegible]
[illegible]edicare		8/18/[illegible]	93543	[illegible]	$6.04	9354[illegible]	[illegible].04	$0.00
Medicare		8/19/XX	93320, 26	[illegible], 26	$15.39	NONE	$0.00	$15.39
Medicare		8/19/XX	93325, 26	[illegible]5, 26	$3.01	NONE	$0.00	$3.01
Medicare		12/19/XX	99254	99254	$124.15	99233	$71.98	$52.17
Medicare		12/24/XX	99232	99232	$50.20	99232	$50.20	$0.00
Medicare		12/23/XX	99232	99232	$50.20	NONE	$0.00	$50.20
Medicare		12/22/XX	99232	99232	$50.20	99233	$71.98	-$21.78
					$11,221.60			**$ 610.58**
								5.44%

26

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.

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27

Corrective Action Plans

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

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28

C is for:
Compliantly Reporting Results

29

Reporting Results to Medicare/Medicaid: The 60-day Refund Rule

- Added by the Affordable Care Act
- 42 U.S.C. § 1320a-7k(d)
- Final Rule issued for Parts A/B in 2016 and now in effect; Parts C/D issued in 2015
- *Statute* requires that any person who receives an overpayment from the Medicare or Medicaid programs — and who does not report and return an overpayment within *60 days after identification* — will be subject to potential False Claims Act liability

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30

Identification: The Final Rule – 42 C.F.R. 401.305(a)(2)

A person has identified an overpayment when the person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of the overpayment. A person should have determined that the person received an overpayment and quantified the amount of the overpayment if the person fails to exercise reasonable diligence and the person in fact received an overpayment.

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Identification: Reasonable Diligence!

- CMS requires "reasonable diligence" that includes proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments; and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment. [7661]

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33

Identification: Timing

- When a person obtains credible information concerning a potential overpayment, the person needs to undertake reasonable diligence to determine whether an overpayment has been received and to quantify the amount. [7661]
- Deadline for refund is not "tolled" except for SDP and SRDP disclosures; if no settlement in those processes, the 60-day time line kicks in. [7678-79]

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34

Identification: Timing

- A timely reasonable diligence investigation may take "at most 6 months from receipt of the credible information, absent extraordinary circumstances" [7662]
  - "Extraordinary circumstances" include "unusually complex investigations that the provider or supplier reasonably anticipates will require more than six months to investigate" [7662]
    - Stark investigation expressly referenced as "unusually complex"
    - Other examples: natural disasters or a state of emergency

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Identification: Timing

- The 60-day time period begins when either the reasonable diligence is completed or on the day the person received credible information of a potential overpayment if the person failed to conduct reasonable diligence and the person in fact received an overpayment. [7661]
- To be clear: the 60-day time period starts AFTER the 6-month due diligence.

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Key Takeaways

- Proactively looking at incident for trends and other issues
- Data management
- Utilizing corrective action plans to assist with the 60 day rule

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C is for:

- *Making the **case** for monitoring and auditing*
- ***Competence** in identifying issues for auditing and monitoring*
- ***Creation** of a successful audit program*
- ***Corrective action plans***
- ***Compliantly** reporting results*

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Questions? Now or later…

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