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Crowe Healthcare Summit 2019

Nurture Your Network
Upskill. Connect. Grow.

Top Compliance Risks That Could Jeopardize Your Organization

September 17

Presented by:
Delena Howard
Jill Sell-Kruse

Introducing Healthcare's Trusted Community:

The Crowe Hive Network

Being successful in your role today looks different than it did even a few years ago. **Engage with a network of those who have been there before you:**

- Ask and answer community questions
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- Earn rewards for your engagement and shop the Hive store

Simplify your busy workday. Register today to continue the Healthcare Summit conversations: **crowehive.com.**

Agenda

- Physician Practice Coding & Compliance Risks
- OIG Focus Areas
- Data Analytics – How your Organization looks from the Outside

Your presenters

Delena Howard

Is the Senior Manager leader of the Coding Compliance Team for Crowe. Delena has over 20 years of experience in the healthcare industry.

Jill Sell-Kruse

is a coding compliance Manager for Crowe. Jill has over 30 years of experience in the healthcare industry.

Physician Practice Coding & Compliance Risks

Physician Practice Coding & Compliance Risks

“Hot Topics” for Coding & Compliance within Physician Practices

- Physician Compensation Arrangements
- Provider Based Clinics
- Non-Physician Practitioners (‘Incident to’)
- Evaluation and Management Coding (Critical Care Services)
- Modifier Utilization
- Copy & Paste/Cloning

Physician Arrangement Concerns

Inherent Risks of Physician Compensation Arrangements:

- Physician Self-Referral Law (“Stark Law”)
- The Anti-Kickback Statute (“AKS”)
- The Civil False Claims Act (“FCA”)
- June 9, 2015 OIG Fraud Alert – Physician Compensation Arrangements May Result in Significant Liability
- June 22, 2016 OIG Alert – Improper Arrangements and Conduct Involving HHAs and Physicians
- The strict liability nature of the Stark Law makes review of employment agreements and employed practices important.
- A violation of the Stark Law can lead to nonpayment of claims, civil monetary penalties, program exclusions and may create liability under the FCA.
- Hospitals need to document that physicians are furnishing “bona fide” services

Provider Based Department

Provider Based Department Billing Risks:

- Comparison of Provider-Based and Freestanding Clinics' payments added to OIG work plan on June 2019
- Billing with the correct Modifiers "PN" and "PO" for off-campus provider based departments (PBD)
- Billing with the correct place of service on the 1500 claim form
- Validating that excepted off-campus provider based departments meet the requirements
- Validating that on campus provider based departments also meet the PBD requirements

Non-Physician Providers (NPP)

Non-Physician Provider Coding and Compliance Risks:

- Billing unsupported ‘incident to’ services
- Billing under the incorrect provider
- Documentation not supporting active involvement of the supervising physician
- The billing physician not present in the office suite during the patient’s visit
- Billing ‘incident to’ services for new patients
- Billing ‘incident to’ when a new treatment plan is developed by the NPP

Evaluation & Management (E/M) Services

E/M Coding and Compliance Risks:

- Over-Coding can be a compliance risk for the organization
- Under-Coding can be a compliance risk as well as a financial risk to the organization
- Critical Care Services – Most highly reimbursed E/M code billed by physicians
- Not knowing your organization’s provider’s Bell Curve distribution
- Not adhering to scribe documentation requirements
- Incorrectly billing Split/Shared Services

Modifier Utilization

Modifier Coding and Compliance Risks:

- Modifiers 24, 25 (XE, XS, XP, XU) & 59
- Inaccurate application of the above modifiers can be a risk to the organization
- Modifiers applied by staff that is not knowledgeable in their utilization (i.e. billing staff vs. coding staff)
- “Hard Coding” of Modifiers into the CDM instead of requiring of review of documentation to be certain that the application of the modifier is appropriate.
- Inaccurate application can result in payments for a separate service that is not separately billable or a service that is included in another comprehensive service.

Copy & Paste/Cloning

Copy & Paste/Cloning Coding and Compliance Risks:

- With the utilization of Electronic Health Records (EHR), the ease for providers to copy/paste patient notes provides for a unique coding compliance risk.
- The note may not accurately reflect the patient's current condition if the record isn't updated appropriately.
- Documentation may not be considered for utilization for determination of the E/M level Cloning documentation from one patient to another is strictly prohibited

OIG Focus Areas

Short Term Acute Hospital

Hospital Inpatient

OIG Work Plan – Hospital Inpatient

“On the Radar” – 2019 OIG Work Plan

- Post-Acute Transfer Policy – Home Health Services
- Inpatient Hospital Billing

Post-Acute Transfer Policy

Transfers to Home Health Care

- Post- Acute Transfer Policy Summary
- MS-DRG’s impacted
- Patients discharged to Home Health Services but coded as discharged to home
- Patient Discharge Status Code 06 (Home Health Service Organization)
- Applies to Home Health Services that occur within 3 days of discharge
- Condition Code 43 – If more than 3 days
- Exception: Not related to the hospital care

Complexities of Discharge Status Assignment

- Assignment of Discharge Status
  - Determination
  - Documentation
  - Population on claim with understanding of Exceptions
- Verification of Discharge Status
  - Prior to claim submission
  - After discharge follow-up
  - Application of CC 43

Inpatient Hospital Billing

Over/Up Coding to Increase Payment

- Announced December 2018
- “Identified problems with upcoding in hospital billing”
- Rises in Case Mix
- Assignment of CC’s and MCC’s
- MS-DRG risk areas previously targeted by the OIG
- Reporting of single MCC’s and CC’s that impact MS-DRG

Reducing Risk of OIG Focused Audit - Inpatient

- Analysis of factors impacting change
  - Case Mix Index (CMI)
  - Inpatient Volume
  - Payment

- Assess Risk
  - Ongoing internal coding audits
  - External coding audits
  - MAC review activity
  - PEPPER “outlier” areas

Hospital Outpatient

OIG Work Plan – Hospital Outpatient

“On the Radar” – 2019 OIG Work Plan

- Podiatry and Ancillary Services
- Billing for Replaced Medical Devices
- Cardiac & Pulmonary Rehab
- End-Stage Renal Disease (ESRD) Dialysis Services

Podiatry and Ancillary Services

Medical Necessity of Services

- Podiatry related covered and non-covered services
- 2018 podiatry-related CPT HCPCS code updates
- Monitoring of claim denials for podiatry related services
- Use of modifier -25 on same day as a procedure

Replacement Devices

Outlier Payments With a Reported Medical Device Credit

- Focuses on overstated charges on OP claims with both an outlier payment and a reported medical device credit.
- FD value code
- Full VS partial credits
- Inclusion of reduction in cost of device
- Outpatient areas most impacted

OP Cardiac and Pulmonary Rehab Services

Medical Necessity of Services

- Medical necessity requirements - NCD
- Documentation requirements
- Required regimen to include exercises, assessments and individualized treatment plan
- Frequency limits
- Place of service requirements

ESRD Dialysis Services

Payments for ESRD Services

- Documentation to support medical necessity
- Physician order by treating physician
- Medicare consolidated billing requirement
- Guidelines from Medicare Claims Processing Manual and the Medicare Benefit Policy Manual
- Compliant billing of professional services

Reducing Risk of OIG Focused Audit - Outpatient

- Prospective
  - Medical Necessity Screening tools to include NCD applications
  - Controls to prevent provision of services without a physician order
  - Area specific policies and procedures
  - Ongoing training of clinic, charge entry and coding staff

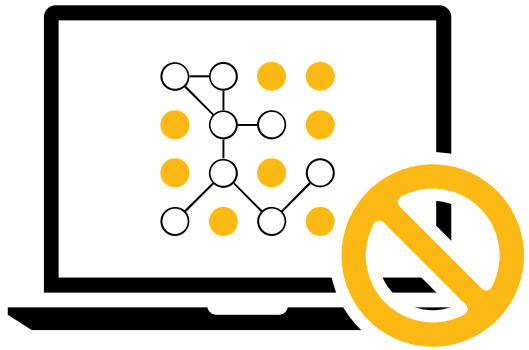
- Retrospective
  - Ongoing internal audits
  - Billing frequency edits for ESRD and Cardiac and Pulmonary rehab services
  - Analysis of denied services

Data Analytics – How your Organization looks from the Outside

Data Analytics – The Government Continues to Improve

The combination of data analytics and the Yates Memo is reaping rewards.

- Data analytics is identifying potential individual wrongdoing
- The Yates Memo provides the incentive to hold individuals accountable
- Result – increase in prosecutions and settlements with smaller entities/individuals
- Additional Result – increase in excluded providers



Data Analytics – The Government Continues to Improve

The Fraud Prevention System

"Since June 2011, CMS uses the Fraud Prevention System (FPS) on all Medicare fee-for-service claims on a streaming, national basis. Similar to the fraud detection technology used by credit card companies, FPS applies predictive analytics to claims before making payments in order to identify aberrant and suspicious billing patterns. CMS uses leads generated by FPS to trigger actions that can be implemented swiftly."

"Since 2011 the FPS identified savings (certified by HHS OIG) associated with these prevention and detection actions were $820 million... This resulted in more than a 10-to-1 return on investment for the first three years of implementation."

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-26.html

Data Analytics – The Government Continues to Improve

Healthcare Fraud Prevention Partnership

"The HFPP's purpose is to improve the detection and prevention of healthcare fraud by:

- Exchanging data and information between the public and private sectors.
- Leveraging various analytic tools against data sets provided by HFPP partners.
- Providing a forum for public and private leaders and subject matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud."

https://hfpp.cms.gov/about/index.html

Data Analytics – The Government Continues to Improve

Medicare Provider Utilization and Payment Data

“The Physician and Other Supplier Public Use File (Physician and Other Supplier PUF) provides information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals. The Physician and Other Supplier PUF contains information on utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service. This PUF is based on information from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program. The data in the Physician and Other Supplier PUF covers calendar years 2012 through 2014 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.”

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html

Open Payments / Sunshine Act

“Open Payments is a federal program, required by the Affordable Care Act, that collects information about the payments drug and device companies make to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. It also includes ownership interests that physicians or their immediate family members have in these companies.”

https://www.cms.gov/OpenPayments/

Data Analytics – The Government Continues to Improve

Integrated Data Repository

"The Integrated Data Repository (IDR) is a high-volume data warehouse integrating Parts A, B, C, D, and DME claims, beneficiary and provider data sources, along with ancillary data such as contract information, risk scores, and many others. Access to this robust integrated data supports much needed analytics across CMS."

https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html

Medicare Program Integrity Manual Chapter 2 – Data Analysis

"This chapter specifies resources and procedures to the MACs, ZPICs, Recovery Auditors, and the [Supplemental Medical Review Contractor] SMRC. The contractors shall use these instructions to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively use analytical methodologies to evaluate potential errors…"

Data Analytics – The Government Continues to Improve

Department of Justice Health Care Fraud (HCF) Unit Creates Data Analytics Team – 2017

"As part of the HCF Unit's efforts to lead and coordinate a national approach to combating health care fraud, in 2017 the HCF Unit created and launched the Data Analytics Team. This team allows the HCF Unit to better assist prosecutors in effectively and efficiently identifying and prosecuting individuals and entities, and to learn about emerging health care fraud trends in the field. The Data Analytics Team also offers and provides U.S. Attorney's Offices with customized HCF data analytics training and ongoing case-specific investigation and prosecution assistance. The Data Analytics Team will continue to strengthen the HCF Unit's partnerships with U.S. Attorney's Offices across the country in combating health care fraud."

https://www.justice.gov/criminal-fraud/file/1026996/download

How Does Your Entity Look from the Outside?

Consider the following questions:

- What are your entity's most utilized codes?
- Who are your entity's highest paid providers?
- Who utilizes the highest and lowest E&M codes?
- Who is responsible for denials?
- Are you and your entity performing claims reviews?
- Is your entity being reimbursed for non-medically necessary services?
- Are you trending findings?
- Is your entity refunding money?
- Has your entity's compliance program been assessed?
- Who receives reimbursement from potential referral sources?
- Which physicians are receiving the most $ from industry?
- Does your entity do business with PODs?
- How does your entity assess FMV when acquiring physicians?
- Does your entity have a documented, strategic, compliant approach to physician compensation and acquisitions?
- Have you compared physician contract amounts to accounts payable?

Data Analytics – Next Steps

Throughout this presentation the picture at the right has been utilized to Indicate when data analytics can be utilized by your organization to Identify risks:

- **Physician Arrangements** – To identify your highest reimbursed providers.
- **Provider Based Departments** – To determine the accuracy of modifiers for off-campus departments and place of service on physician claims.
- **NPPs** –To analyze 'incident to' services billed for new patients and for physicians who are out of town/office.
- **E/M coding** –To analyze ~~your~~ physician~~'s~~ bell curves and to compare other providers of the same specialty. Run analytics to see if your provider's critical care services are being billed more frequently than peers.
- **Modifiers** – To Review your provider's utilization of modifier 25, 59 and 24.

Knowing your data as the government does will help your organization mitigate risk.

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Thank you

Delena Howard, CCS, CCS-P, CPC, COC
Senior Manager
+1 314 802 2008
Delena.Howard@crowehrc.com

Jill Sell-Kruse, RHIA, CCS
Manager
+1 314 802 2859
Jill.Sell-Kruse@crowehrc.com