

# NCD-LCD Education: A Proactive Approach to Denials

Greg Harlow, PhD, CHRC

Andrew Conkovich, MBA, CHC

# HHS News Release

- February 11, 2013 - Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius today released a new report showing that **for every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered \$7.90**. This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse (HCFAC) Program.

# Session Goals

- Mindset
- Assist departments in development of educational materials and processes that will reduce denials, enhance and protect revenues
- Assist departments in development of focused educational materials that are clinician friendly, and
- Develop key organizational partnerships.

# Mindset

- Old days
  - Directors/Managers performed patient care
- Regulatory issues have increased to the point this is no longer possible
  - The rules have changed and the roles must continue to adapt to accommodate the rules and protect reimbursement
- If we are to remain competitive Directors and Managers must:
  - Understand the clinical aspects of their area,
  - Understand what must be done to receive payment for services,
  - Establish procedure that integrates best practices in patient care and reimbursement requirements, and
  - Assure their staff follow the rules integrated procedure

# Job Description Line Item Suggestion

- *In collaboration with the Corporate Compliance Officer, maintains a working knowledge of the regulatory issues associated with the functions of the assigned unit(s) or department(s) and promotes adherence to the Corporate Compliance Program and appropriate federal and state guidelines.*

# Proactive Mindset

- Compliance and Operations must both change their mindset
  - We must change
  - We must foster
  - We must reinforce
  - We must educate
  - We must partner and integrate
  - We must hold people accountable
  - We must support each other

# Change and Foster

- Corporate Compliance is a partner not a process owner
- Department directors must
  - Change
    - Embrace the mindset that they must understand reimbursement requirements
  - Foster
    - Develop processes that assure their services fulfill the coverage determination requirements

# Reinforce and Educate

- Reinforce
  - Make this a priority
  - Discuss denials at staff meetings and correlate revenue loss with inability to purchase new equipment, raises, etc.
- Educate associates so they will be successful
  - Staff members want to please you, you must tell them how



# Partner and Integrate

- Partnerships are essential – **health care is a team sport** all the players must be on the same page
  - Revenue Cycle - Finance
  - Admitting
  - Scheduling
  - Case Management
  - Physicians
- Integration
  - Provide the tools needed for success
    - Pre procedure screening
    - Checklists

# Accountability

- Accountability
  - Monitor the expectations
  - We must reinforce the expectations
    - Positive individual reinforcement (warm fuzzes) – **Do not forget the physicians**
    - Positive group reinforcement at staff meetings
  - Consequences for individuals that decide not to be a team member
    - Failure to address non-performers will undermine your high performers moral

# Support

- Support team members
  - **Health care is a team sport** all the players must be on the same page
  - Prosperity is a successful, flourishing, thriving condition – prosperity is not possible if we do not support one another

# Alignment

- Goals must include financial accountability
  - Everyone must care about denials
  - Everyone must care about retrospective payment audits
  - Everyone must care about prepayment audits
  - Everyone must care about implementing processes to address denials and audits
  - Everyone must care about making a plan to assure your staff care as well
- We must educate clinical staff to assure they understand why we must make these changes

# Roles

- Management
  - Create plans, education and hold staff accountable
- Financial
  - Report denials and other financial data to departments
- Admissions, Scheduling
  - Must know the requirements for ABNs, pre-certification, etc.

# Why Change

- Budgets are tightening
  - Providers are only reimbursement a fraction of the billed amount
    - Work with finance to assure each department know what this percentage is for their area
  - Denials
    - Department heads must know what is being denied so they can address the issues in the correct order

# Solution

- Develop a team approach to assure:
  - Clinical staff have a base knowledge of the billing requirements for the services they provide
  - All involved staff have an understanding of the impact denials have on their department and their organization
  - All involved staff have an understanding of the potential regulatory impact of non-compliance
  - Change the mindset to a proactive mindset

# Medicare Cost Containment

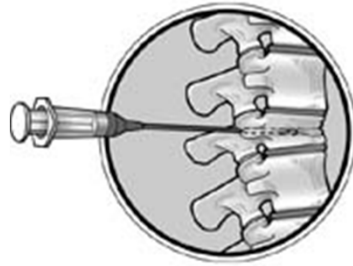
- Growing Gap between spending and revenues
- Gap widens as baby boomers retire
- 15-30% of CMS expenditures are WASTEFUL
- Routine Screening (Risk: Benefit not justified)
  - Colonoscopies PTs > Age 75
  - Cervical Cancer PTs > Age 75
  - Prostate Cancer PTs > Age 75



# Medicare Unnecessary Procedures

- Procedures with no benefit (clinical trial data)
  - Cardiac Stress Tests (without cardiac problems)
  - Chest X-rays before outpatient surgery
  - Sinus CT Scan for sinusitis
  - Blood tests
  - Vertebroplasty/Kyphoplasty

# Vertebroplasty/Kyphoplasty



- Use of bone cement to treat compression fractures of the thoracic or lumbar vertebrae
- Outpatient procedure
- Cost is \$3,000 - \$10,000
- Alternative treatment: analgesics, PT, bracing, and activity limiting rest.

# Vertebroplasty/Kyphoplasty

150,000 procedures in the US in 2009

## **A Randomized Controlled Trial of Vertebroplasty for Osteoporotic Spine Fractures**

N Engl J Med. 2009 August 6; 361(6): 569–579.

### **CONCLUSIONS:**

*Improvements in pain and pain-related disability associated with osteoporotic compression fractures in patients treated with vertebroplasty were similar to the improvements in a control group.*

## **A randomized trial of vertebroplasty for painful osteoporotic vertebral fractures.**

N Engl J Med. 2009 Aug 6;361(6):557-68

### **CONCLUSIONS:**

*We found no beneficial effect of vertebroplasty as compared with a sham procedure...*

# Medicare Coverage of Vertebroplasty

- Noridian Administrative Services (NAS) conducted a literature review and a policy was proposed in 11-MAY-2010.
- NAS received over 100 comments – mostly testimonials – not acceptable for establishing policy.
- Result: restricted coverage with closely specified criteria for CMS reimbursement.

# Noridian: Local Coverage Determination (LCD) for Vertebroplasty, Vertebral Augmentation; Percutaneous (L24383)

Effective 20-JUN-2011

Medical record review has demonstrated widespread, fundamental errors in patient selection, technical performance of procedures, pre and post procedural assessment of patients and the common absence of follow-up of any kind – which initiated our coverage review and resulted in this LCD. Among our clinical concerns are the failure to attempt appropriate conservative management for a reasonable – or any - period of time; failure to inform patients of alternative treatments and potential complications of the injection procedures; treatment of an inappropriate number of levels; treatment during an active infection; treatment in the face of other unaddressed pain generators both spinal and in other body areas; treatment when other procedures are indicated or performed; failure to adequately follow patients for a reasonable period of time; and, a disturbing incidence of complications. These concerns resulted in an extensive literature review, consequent proposal to non-cover any vertebral augmentation procedure and, ultimately, resulted in this policy.

Medical record review has demonstrated widespread, fundamental errors in patient selection, technical performance of procedures, pre and post procedural assessment of patients and the common absence of follow-up of any kind – which initiated our coverage review and resulted in this LCD.

# Noridian: Local Coverage Determination (LCD) for Vertebroplasty, Vertebral Augmentation; Percutaneous (L24383)

Medical record review has demonstrated widespread, fundamental errors in patient selection, technical performance of procedures, pre and post procedural assessment of patients and the common absence of follow-up of any kind – which initiated our coverage review and resulted in this LCD. Among our clinical concerns are the failure to attempt appropriate conservative management for a reasonable – or any - period of time; failure to inform patients of alternative treatments and potential complications of the injection procedures; treatment of an inappropriate number of levels; treatment during an active infection; treatment in the face of other unaddressed pain generators both spinal and in other body areas; treatment when other procedures are indicated or performed; failure to adequately follow patients for a reasonable period of time; and, a disturbing incidence of complications. These concerns resulted in an extensive literature review, consequent proposal to non-cover any vertebral augmentation procedure and, ultimately, resulted in this policy.

Among our clinical concerns are the failure to attempt appropriate conservative management for a reasonable – or any - period of time; failure to inform patients of alternative treatments and potential complications of the injection procedures;

|                        | First Coast | Palmetto<br>(Region IV) | WPS | Trailblazer | Palmetto<br>(Region X) | NHIC | NOVITAS | NGS | CGS | Noridian |
|------------------------|-------------|-------------------------|-----|-------------|------------------------|------|---------|-----|-----|----------|
| Number of Pages in LCD | 6           | 7                       | 9   | 10          | 13                     | 10   | 10      | 13  | 10  | 23       |

**All MACs Cover:**

- Metastatic Disease Vertebra
- Vertebral Collapse/Compression Fracture
- Conservative Medical Management

**Noridian MAC Additional Parameters:**

- Comprehensive Pain Evaluation & Exam
- CT or Fluorographic real-time guidance
- No more than 3 Vertebrae at one time
- Any Other Pain Source Eliminated First

**Some MACs Require:**

- Proof of ADL limitation
- Sufficient Pain Level

- No Treatment in ER or Immediately After Presentation to the ER
- Follow-up arranged for  $\geq 1$  year
- MR must show follow-up at 1W, 1Mo, & 3 Mo.

# NAS Jurisdiction 3 “Service Review”: OP Vertebroplasty/Kyphoplasty

| <b>Probe Audits</b>       | <b>AZ<br/>44 Claims<br/>SEP2011-<br/>JAN2012</b> | <b>MT, ND, SD,<br/>UT, WY<br/>47 Claims<br/>SEP2011-<br/>JAN2013</b> | <b>WA, AK<br/>95 Claims<br/>SEP2011-<br/>SEP2012</b> |
|---------------------------|--|--|--|
| Claims Accepted           | 15   | 6  | 40   |
| Full Denial               | 22   | 38   | 51   |
| Partial Denial            | 7  | 2  | 4  |
| <b>Overall Error Rate</b> | <b>82%</b>                                       | <b>94%</b>   | <b>76%</b>   |



# Noridian: Local Coverage Determination (LCD) for Vertebroplasty, Vertebral Augmentation; Percutaneous (L24383)

## Reasons for Non-coverage:

- ✓ treatment of an inappropriate number of levels;
- ✓ Lack of prior conservative treatment
- ✓ Presentation through the ER
- ✓ treatment during an active infection;
- ✓ treatment in the face of other unaddressed pain generators both spinal and in other body areas;
- ✓ failure to adequately follow patients for a reasonable period of time.

# The Assessed State

- The Noridian Local Coverage Determination (LCD) Guidance for Vertebroplasty is 23 Pages Long.
- A Typical Hospital System includes Many Physicians performing Vertebro/Kyphoplasties.
- How can we assure that we are compliant going forward?

# Actions -Team Effort

- Local Coverage Determination was Reviewed
  - CMOs communicated requirements to physicians
  - “Fast Facts” – Digest Version of LCD/NCD
  - Department management developed a pre-procedure checklist to assure:
    - The required indications were met
    - The required documentation was present, and
    - There were no contraindications

# Checklist for patient eligibility

**PRE-VERTEBROPLASTY PATIENT CHECKLIST PATIENT ELIGIBILITY CHECK LIST FOR CONSULTATION**

ONSET OF NEW BACK PAIN: \_\_\_\_\_ (related predominantly, if not solely related to demonstrated fracture(s) DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_

**ACUTE OR SUBACUTE COMPRESSION FRACTURE DOCUMENTED BY:**

CT Scan AND Nuclear Medicine Bone Scan OR MRI  CORRELATES WITH LEVEL OF PAIN

**ANALGESIC MEDICATIONS:**

NSAIDS: MEDICATION: \_\_\_\_\_

DOSE: \_\_\_\_\_ FREQ: \_\_\_\_\_ LENGTH OF TX: \_\_\_\_\_

**ANTICOAGULATION MEDICATIONS:**

WARFARIN (COUMADIN)  YES LAST DOSE \_\_\_\_\_ (needs to be stopped for 5 days prior to VP)  NO

LOVENOX  YES LAST DOSE \_\_\_\_\_ (needs to be stopped for 5 days prior to VP)  NO

HEPARIN  SQ LAST DOSE \_\_\_\_\_ (needs to be stopped for 8 hours prior to VP)  NO

DRIP LAST DOSE \_\_\_\_\_ (NEEDS TO BE STOPPED 4 HOURS PRIOR TO VP)  NO

Signature RN: \_\_\_\_\_ Date: \_\_\_\_\_

**Forms Review:**

Signature MD: \_\_\_\_\_ Date: \_\_\_\_\_

**Pre procedure:**

Signature MD: \_\_\_\_\_ Date: \_\_\_\_\_

Revised: 1/2012

PATIENT INFORMATION

# NAS Jurisdiction 3 “Service Review”: OP Vertebroplasty/Kyphoplasty

| <b>AZ</b>                 | <b>Probe Audit<br/>44 Claims<br/>SEP2011-JAN2012</b> | <b>Targeted Audit<br/>510 Claims<br/>FEB2012-FEB2013</b> |
|---------------------------|--|--|
| Claims Accepted           | 15   | 359  |
| Full Denial               | 22   | 131  |
| Partial Denial            | 7  | 9  |
| <b>Overall Error Rate</b> | <b>82%</b>   | <b>49%</b>   |

# Proactive Effort to Avoid Denials

- Procedures with no benefit (clinical trial data)
  - Cardiac Defibrillators
    - Monitor heart rhythms and deliver shocks to correct arrhythmias.
  - National Coverage Determination (NCD) for Implantable Automatic Defibrillators (IAD) (20.4)
    - Implementation Date: 27-JAN-2005

# National Coverage Determination (NCD) for Implantable Automatic Defibrillators (IAD) (20.4)

Implementation Date: 27-JAN-2005

- 9 Covered Indications
  - Combinations of VF, VT, LVEF, inherited conditions, prior MI, QRS duration, NYHA Classification
- Non-covered caveats
  - Cardiogenic shock or symptomatic hypotension
  - CABG or PTCA within the last 3 months
  - Acute MI within the last 40 days
  - Any other disease with resultant life expectancy < 1 year
- Established Registry for Patient Data

# ICD Registry Data Mining

JAMA 2011 – Retrospective study of PTs 2006-2009

- 22.5% did not meet the CMS NCD requirements.
- 1227 Hospitals
- 111,707 Patients
  - 25,145 Non-compliant with the NCD
    - 9257 (8.2%) had MI within the 40-day window
    - 814 (0.7%) had CABG within the 3-month window
    - 3022 (2.7%) were NYHA Class IV
    - 15,604 (14.0%) were newly diagnosed HF
    - \$30K/ICD = \$754M



# Implantable Automatic Defibrillators

## Checklist

|  |   |
|--|---|
| <input type="checkbox"/> Primary                                     | ICD Implantation Medical Indications Verification |
| <input type="checkbox"/> Secondary                                   |   |
| <i>All Criteria must be met and documented in the medical record</i> |   |

| SECONDARY PREVENTION Indications   |  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
|--|--|-----------------------------|---|-----------------------------|-----------------------------|--------------------------------------|----------------------------|------------------|----------------------|--|--|
| <input type="checkbox"/>   | Episode of cardiac arrest due to VF; NOT due to transient or reversible cause  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
| <input type="checkbox"/>   | Episode sustained VT; spontaneous or induced by EPS, NOT associated with AMI or due to transient or reversible cause |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
| This patient will be enrolled in the NCDR ICD Registry or is part of an approved clinical trial.   |  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
| Physician Signature: _____ Date: _____ Time _____  |  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
| <p><i>MI Definitions based on ACC 2000:</i><br/> <u>Definition of Acute, evolving or recent MI:</u><br/>                     Typical and gradual fall (Troponin) or more rapid rise and fall (CK-MB) of biochemical markers of myocardial necrosis with at least one of the following:</p> <ol style="list-style-type: none"> <li>1. Ischemic symptoms</li> <li>2. Development of pathological Q waves on ECG</li> <li>3. ECG changes indicative of ischemia</li> <li>4. Coronary Artery intervention</li> </ol> <p><u>Definition of established MI:</u></p> <ol style="list-style-type: none"> <li>1. Development of new pathologic Q waves on serial ECG's. The patient may or may not remember previous symptoms. Biochemical markers of myocardial necrosis may have normalized, depending on the length of time that has passed since the infarct.</li> </ol> |  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |
| <p><i>Abbreviations</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">NICDM Non Ischemic Dilated Cardiomyopathy</td> <td style="width: 33%;">VF Ventricular Fibrillation</td> <td style="width: 33%;">EPS Electrophysiology Study</td> </tr> <tr> <td>IDCM Ischemic Dilated Cardiomyopathy</td> <td>VT Ventricular Tachycardia</td> <td>HF Heart Failure</td> </tr> <tr> <td>EF Ejection Fraction</td> <td></td> <td></td> </tr> </table>  |  |                             | NICDM Non Ischemic Dilated Cardiomyopathy | VF Ventricular Fibrillation | EPS Electrophysiology Study | IDCM Ischemic Dilated Cardiomyopathy | VT Ventricular Tachycardia | HF Heart Failure | EF Ejection Fraction |  |  |
| NICDM Non Ischemic Dilated Cardiomyopathy  | VF Ventricular Fibrillation  | EPS Electrophysiology Study |   |                             |                             |                                      |                            |                  |                      |  |  |
| IDCM Ischemic Dilated Cardiomyopathy   | VT Ventricular Tachycardia   | HF Heart Failure            |   |                             |                             |                                      |                            |                  |                      |  |  |
| EF Ejection Fraction   |  |                             |   |                             |                             |                                      |                            |                  |                      |  |  |

st 3 months

raindicated)

in last 3 mos

ays

han 1 year



Patient Label

# National Coverage Determination (NCD) for Cardiac Pacemakers (20.8)

Implementation Date: 30-APR-2004

- Cardiac pacemakers are covered as prosthetic devices under the Medicare program, subject to the following conditions and limitations. While cardiac pacemakers have been covered under Medicare for many years, there were no specific guidelines for their use other than the general Medicare requirement that covered services be reasonable and necessary for the treatment of the condition. Services rendered for cardiac pacing on or after the effective dates of this instruction are subject to these guidelines, which are based on certain assumptions regarding the clinical goals of cardiac pacing. While some uses of pacemakers are relatively certain or unambiguous, many other uses require considerable expertise and judgment.

# Pacemaker Patient Eligibility Checklist

PPM Implantation Medical Indications Verification

## PPM Implantation Medical Indications Verification

*All Criteria must be met and documented in the medical record*

### Indications for DUAL CHAMBER Pacemaker

- Definitive drop in blood pressure, retrograde conduction or discomfort demonstrated and documented with single chamber (ventricular pacing) pacemaker insertion
- Pacemaker syndrome (atrial ventricular asynchrony) in patients w a pacemaker replacement who have experienced significant symptoms.
- Patients in whom even a relatively small increase in cardiac efficiency will improve quality of life e.g. HF despite adequate other medical measures.
- Patients in whom pacemaker syndrome is anticipated (e.g. young and active people)

### NONCOVERED Dual Chamber Indications

- Ineffective atrial contractions (eg chronic AFib or Aflutter; giant left atrium)
- Frequent or persistent SVT's except where the PPM is specifically for the control of the tachycardia
- Condition in which pacing occurs only intermittently and briefly, that is not associated w reasonable likelihood that pacing needs will become prolonged (e.g. hypersensitive carotid sinus syndrome w syncope due to brady & unresponsive to medical measures)
- Prophylactic PPM use s/p AMI during which there was temp complete and/or Type II block in association w BBB.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

**Abbreviations**  
 PPM Permanent Pacemaker      sx symptoms      w with      wo without  
 Brady Bradycardia              HR Heart Rate

Patient Label

# Going Forward

- RAC prepayment audits
  - FL - 100% Pre-Payment Audits of 15 INPT DRGs:
    - 226 — Cardiac defibrillator implant without (w/o) cardiac catheter with (w/) major complications or comorbidities (MCC)
    - 227 — Cardiac defibrillator implant w/o cardiac catheter w/o MCC
    - 242 — Permanent cardiac pacemaker implant w/MCC
    - 243 — Permanent cardiac pacemaker implant w/CC
    - 244 — Permanent cardiac pacemaker implant w/CC or MCC
    - 245 — Automatic implantable cardiac defibrillator (AICD) generator procedures
    - 247 — Percutaneous cardiovascular procedure w/drug eluting stent w/o MCC
    - 251 — Percutaneous cardiovascular procedure w/o coronary artery stent w/o MCC
    - 253 — Other vascular procedures w/CC
    - 264 — Other circulatory system or procedures
    - 287 — Circulatory disorders except acute myocardial infarction (AMI), w/cardiac catheter w/o MCC
    - 458 — Spinal fusion except cervical w/spinal curve, malign, or 9+ fusions w/o CC
    - 460 — Spinal fusion except cervical w/o MCC
    - 470 — Major joint replacement or reattachment of lower extremity w/o MCC
    - 490 — Back and neck procedures except spinal fusion w/CC/MCC or disc RAC Pre-Payment Audits coming to:
  - RAC Pre-Payment Audits coming to:
    - CA, MI, TX, NY, LA, IL, PA, OH, NC, MO

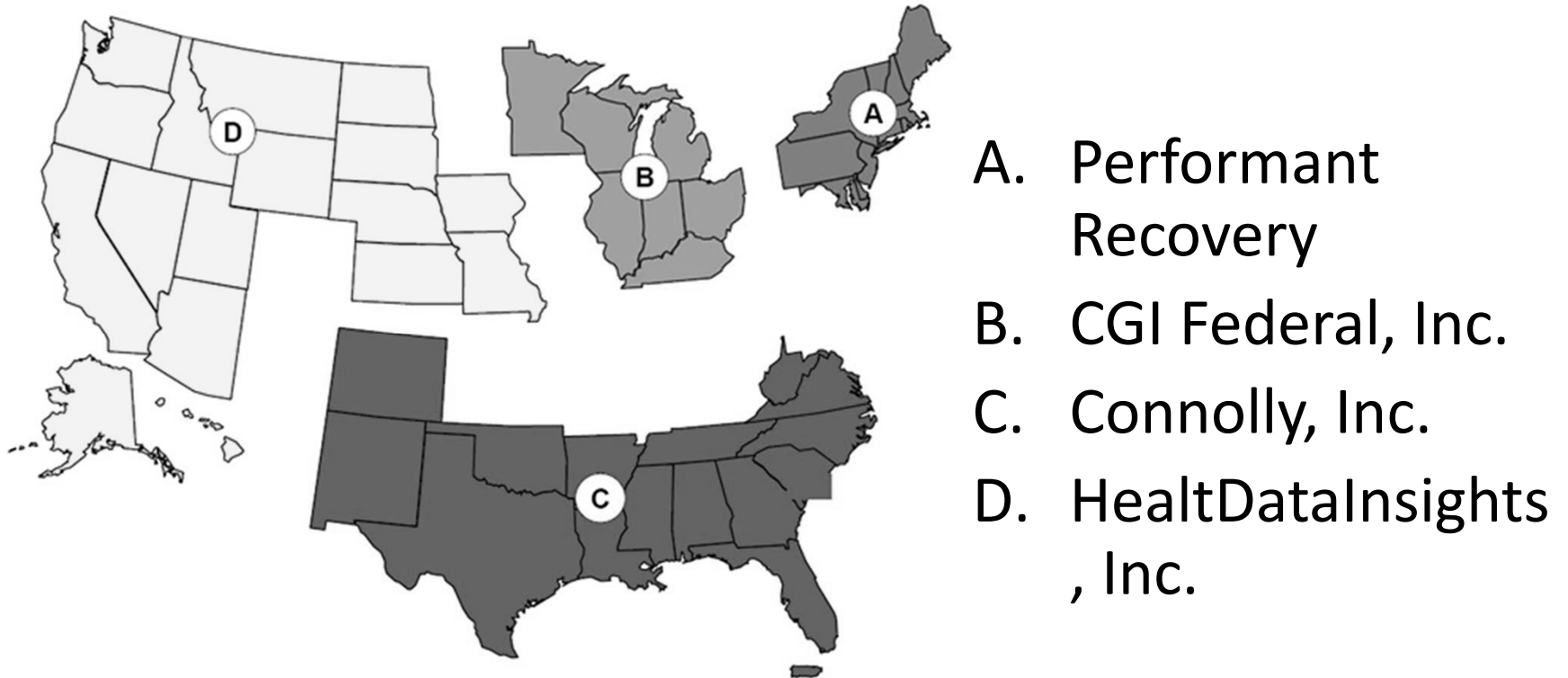
**11 Cardiac**

**4 Orthopedic**

# Proactive Steps to avoid Claim Denials

- NCD/LCD Review should be mandatory
- Use the ABN if you anticipate denial
- Documentation is essential
- In the Absence of an LCD
  - Look at LCDs from other MACs
  - Professional Organizations producing their own Coverage Guidelines based on other LCDs
    - e.g. AAOS submitted Total Joint Arthroplasty to all MAC medical directors and CMS officials

# RAC Surveillance



Source: Centers for Medicare and Medicaid Services

RACs must get prior approval from CMS to conduct audits

# CMS-approved RAC audit issues

|                    | 2009 | 2010 | 2011 | 2012 | 2013 | Total |
|--------------------|------|------|------|------|------|-------|
| Performant         | 10   | 82   | 370  | 116  | 30   | 608   |
| CGI                | 27   | 85   | 68   | 24   | 10   | 214   |
| Connolly           | 123  | 289  | 63   | 116  | 59   | 650   |
| HealthDataInsights | 72   | 41   | 328  | 120  | 2    | 563   |



# RAC Surveillance



- AHA Voluntary Survey
- Recent RAC Trends



- RACUniversity
- BLOG
- Free Webinars



# MAC Draft LCDs

Arizona

| Status Indicators  |                                       |                             | Send Comments to:   |                            |                   |
|--|---------------------------------------|-----------------------------|---|----------------------------|-------------------|
| D = draft under development, not yet released for comment<br>C = draft LCD released for comment<br>E = formal comment period has ended; comments now being considered<br>F = final new/revised LCD has been issued for notice<br>A = active policy: notice period complete and the policy is in effect |                                       |                             | Arizona Part B<br>Attn: Part B Medical Director<br>P.O. Box 6704<br>Fargo ND 58108-6704<br><br>E-mail: <a href="mailto:policyb.drafts@noridian.com">policyb.drafts@noridian.com</a> |                            |                   |
| Draft LCD Title  | Release Date of Draft LCD for Comment | End Date for Comment Period | Current Status  | Date of Release for Notice | Link to Final LCD |
| Application of Bioengineered Skin Substitutes: Ulcers (of the Lower Extremities)   | 04/10/2012                            | 07/16/2012                  | A   | 12/20/12                   | L24273            |
| Chest X Ray  | 08/14/2012                            | 11/12/2012                  | A   | 01/17/2013                 | L32844            |
| Immune Globulin Intravenous (IVig)   | 08/14/2012                            | 11/12/2012                  | A   | 01/17/2013                 | L32846            |
| Laparoscopic Sleeve Gastrectomy  | 08/14/2012                            | 11/12/2012                  | A   | 01/17/2013                 | L32866            |
| MRI and CT Scans of the Head, Brain, and Neck  | 08/14/2012                            | 11/12/2012                  | A   | 01/17/2013                 | L32848            |
| Non-Covered Services   | 04/10/2012                            | 07/16/2012                  | A   | 10/25/2012                 | L24473            |
| Non-Covered Services   | 03/26/2013                            | 07/11/2013                  | C   |                            |                   |
| Paravertebral Facet Joint Nerve Blockade   | 04/10/2012                            | 07/16/2012                  | A   | 10/11/2012                 | L30807            |
| Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)   | 04/10/2012                            | 07/16/2012                  | A   | 10/18/2012                 | L32234            |
| Urinalysis Policy  | 12/04/2012                            | 03/18/2013                  | C   |                            |                   |

# Changing Reimbursement Methodologies

- There is an evolving shift with payers to apply different reimbursement methodologies to incorporate the provider's performance and quality as part of the services rendered.

# Starting the Process

- **OIG Study data**
  - Executive Summary: Skilled Nursing Facilities Often Fail To Meet Care Planning And Discharge Planning Requirements (Oei-02-09-00201 )
  - XXXX Hospital Did Not Comply With Medicare Inpatient Rehabilitation Facility Documentation Requirements; (February 2013; A-01-11-00531)
- **Do you have SNF or an IRF**
  - Review OIG data and assure your units meet the requirements

# Internal Audit Data

- Carefully review audit data
- Assure that your internal audit staff make a list of incidental (out of scope) findings
  - Incidental findings are often a predictor of future issues

# Denials Data

- Partner with finance/revenue cycle to obtain department level denials data
  - Assure affected department leadership is involved in this process
  - Assist the department leadership in drilling down to determine specific reasons for denials
  - Look for trends
    - A particular physician
    - Registration problems
    - Documentation problems

# RAC Data

- Data mine your RAC experience
  - Assist the department leadership in drilling down to determine specific reasons for denials
  - Assure affected department leadership is involved in this process
  - Look for trends
- Review RAC data associated with other providers
  - Develop a list of services you provide that are on the list

# Prioritize the Information

- High Volume
- High Reimbursement
- Assist the department leadership in review of department level processes and education associated with issues
  - Areas that lack formal process and education are high risk
  - Failure to thoroughly document the process will result in multiple processes

# Skill Set Transfer - CAP

- Compliance Officers are skilled in the development and implementation of Corrective Action plans
  - CAP development
  - CAP Implementation
  - Department monitoring and reporting
  - Compliance validation monitoring and reporting
- Must utilize our skill sets to assure management understands and supports our goals



# Summary

- Consider each NCD – LCD a mini project
  - Work with finance to find denials data – drill down on denials to find reason, trends, etc. Compare this data to your policies and education.
- Review processes and compare with NCD-LCD to assure all know what is required
- Develop tools to assist in compliance – describe what tools look like
- Educate staff - use NCD criteria and tools to develop education,
- Role assignment make sure each role knows what is required of them
- Once implemented monitor compliance with program

- Justice Department Recovers Nearly \$5 Billion in False Claims Act Cases in Fiscal Year 2012(12-1439)
- South Carolina Ambulance Company to Pay U.S \$800,000 to Resolve False Claims Allegations(13-232)
- Northern Virginia Therapy Provider to Pay \$700,000 to Resolve False Claims Act Allegations(13-193)
- Florida Physician to Pay \$26.1 Million to Resolve False Claims Allegations(13-183)
- EMH Regional Medical Center and North Ohio Heart Center to Pay U.S. \$4.4 Million to Resolve False Claims Act Allegations(13-023)
- Sanofi US Agrees to Pay \$109 Million to Resolve False Claims Act Allegations of Free Product Kickbacks to Physicians(12-1526)
- Healthpoint Ltd. to Pay up to \$48 Million for False Medicaid and Medicare Claims for Unapproved Prescription Drug(12-1459)

# Questions