UNC HEALTH CARE

Charlotte Regional HCCA Conference

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

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January 17, 2020
Patrick Kennedy, MHA MSL RHIA CHC
Executive System Director Hospital Compliance

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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**

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What type of organization do you represent?
UNC HEALTH CARE
Hospital/Health Care System
Private Physician Practice
Post-Acute/Long Term Care
Third-Party Vendor/Supplier
Government Agency
Other
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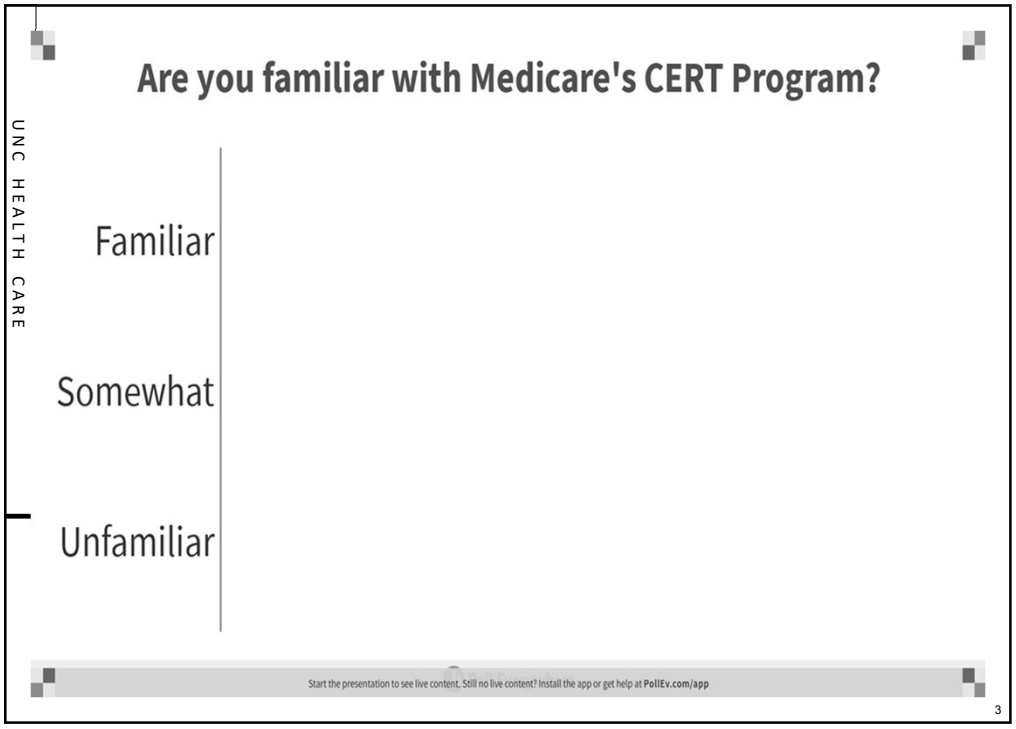
Are you familiar with Medicare's CERT Program?
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Familiar
Somewhat
Unfamiliar
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Overview of Current External Scrutiny: CERT

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Background: Comprehensive Error Rate Testing (CERT)

1996

- 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

1996 – 2002

- 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

2003 – 2012

- 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

2012 – Present

- 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

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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

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

Claim Type	Improper Payment Rate	Improper Payment Amount (2)
Overall FY2019 (July 1, 2017 – June 30, 2018)	**7.25%**	**$28.91 B**
Part A Providers (excluding Hospital Inpatient Prospective Payment System (IPPS))	8.07%	$13.34 B
Part B Providers	8.64%	$8.66 B
Hospital IPPS	3.57%	$4.47 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	30.70%	$2.44 B

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.

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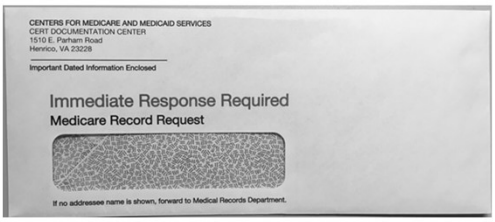
Sample CERT request letter and envelope

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Provider Name
Address 1
Address 2
City ST 00000



Date: 1/1/1900
Reference ID: CID #: 1555555
NPI/Provider #: 0000000000
Phone:
Fax:

Request Type & Purpose: First Letter
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

The Centers for Medicare & Medicaid Services (CMS), through the Comprehensive Error Rate Testing (CERT) program, carries out the task of requesting, receiving, and reviewing medical records.[1] The CERT program reviews selected Medicare A, B and DME claims and produces annual improper payment rates. For more information regarding the CERT program, please visit www.cms.gov/CERT.

Reason for Selection

The CMS' CERT program has randomly selected one or more of your Medicare claims for review.

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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 unchcscar@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.)

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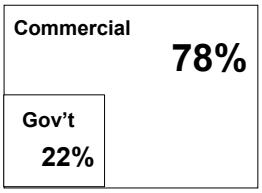
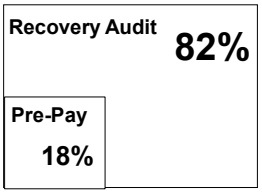
Audit landscape varies by payer type and audit type

Government vs Commercial



Recovery Audits vs Pre-Payment Audits



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

Rationale & Insights

Audit Process Variation:

- Commercial audit process varies from one payer to the next or one auditor to the next.
- Commercial audits have very few limitations on what and how many claims can be audited
- Commercial audits are regulated via payer contracts
- Governmental audits follow regulations and a defined process
- Governmental audits have volume limitations

Audit or Denial Workflow Confusion

- Dollars at Risk/Protected from recoupment versus dollars never received
- Duplicate workflows between audit created in Cobius versus denials posted in Epic
- Confusion regarding what is tracked in the specialized audit software

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Planning, organizing and leading response

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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

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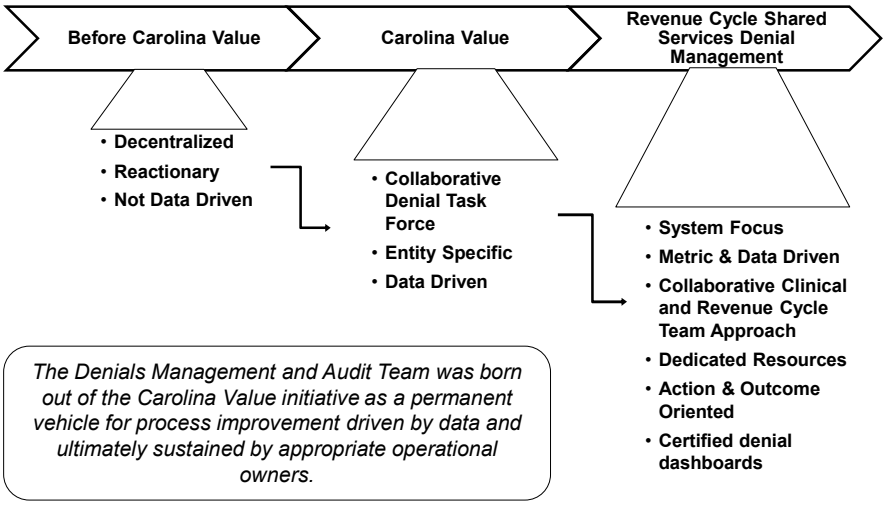
UNC Health Care Denials Management Evolution



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.

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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 64%
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.

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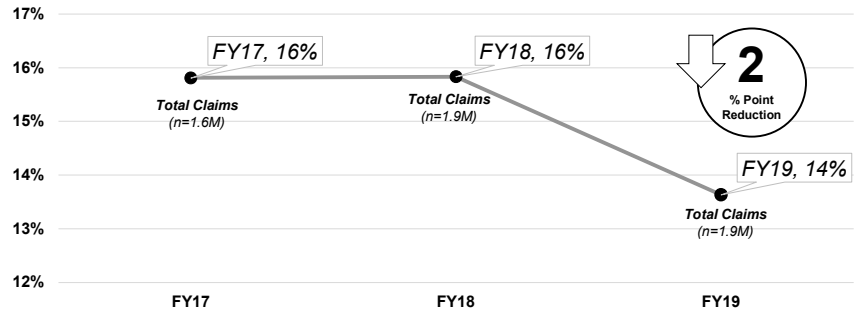
Clinical partnerships working together to drive down hospital billing claims denial rate

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"

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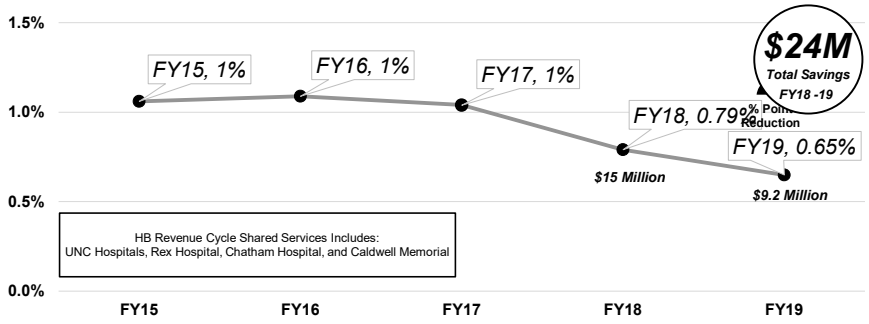
Clinical Partnerships working together to reduce the preventable write-offs (Hospital)

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.

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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

FY19
Q1 & Q2

	Audit Volume				Denials				Financial Impact	
Audit Reason	# Audits	# Open	# Suspended	# Closed	# Denied	# Appealed	# Appeals Won	# Appeals Lost	Dollars at Risk	Dollars Lost
DRG	5	1	0	4	1	1	0	0	$18,535	$0
Lab	1	0	0	1	1	0	0	0	$0	$145
TOTAL	6	1	0	5	2	1	0	0	$18,535	$145

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

FY18

	Audit Volume				Denials				Financial Impact	
Audit Reason	# Audits	# Open	# Suspended	# Closed	# Denied	# Appealed	# Appeals Won	# Appeals Lost	Dollars at Risk	Dollars Lost
DRG	18	4	0	14	6	3	0	0	$25,355	$5,490
Medical Necessity	1	0	0	1	0	0	0	0	$0	$0
TOTAL	19	4	0	15	6	3	0	0	$25,355	$5,490

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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

FY19
Q1 & Q2

	Audit Volume				Denials				Financial Impact	
Audit Reason	# Audits	# Open	# Suspended	# Closed	# Denied	# Appealed	# Appeals Won	# Appeals Lost	Dollars at Risk	Dollars Lost
97140 – Manual Therapy	37	21	0	16	2	0	0	0	$4,883	$0
DRG 291-292-Heart Failure & Shock	15	0	0	15	0	0	0	0	$0	$0
DRG 470-Major Hip And Knee Joint Replacement	14	1	0	13	0	0	0	0	$18,207	$0
HCPCS J1745-Infliximab	17	3	0	14	1	0	0	0	$11,876	$0
HCPCS J2505-Pegfilgrastim	2	2	0	0	0	0	0	0	$5,383	$0
HCPCS J9035-Bevacizumab	1	1	0	0	0	0	0	0	$2,381	$0
HCPCS J9310-Rituximab	7	1	0	6	0	0	0	0	$3,786	$0
TOTAL	**93**	**29**	**0**	**64**	**3**	**0**	**0**	**0**	**$46,516**	**$0**

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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

FY18

	Audit Volume				Denials				Financial Impact	
Audit Reason	# Audits	# Open	# Suspended	# Closed	# Denied	# Appealed	# Appeals Won	# Appeals Lost	Dollars at Risk	Dollars Lost
CMG A0701-A0704	1	0	0	1	1	1	1	0	$0	$0
CMG D0701-D0704	2	0	0	2	2	1	1	0	$0	$43,566
DRG 291-292-Heart Failure & Shock	5	0	0	5	0	0	0	0	$0	$0
DRG 470-Major Hip And Knee Joint Replacement	23	1	0	22	1	1	0	0	$26,296	$0
DRG 885-Psychoses	66	0	0	66	19	11	5	6	$0	$149,035
TOTAL	**97**	**1**	**0**	**96**	**23**	**14**	**7**	**6**	**$26,296**	**$192,602**

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Has your organization received a Targeted Probe & Educate audit in the past 12 months?

Yes

No

Unsure

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What services are being audited, i.e. - therapy, coding, wound. Keep your response to one word.

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Successful collaboration with Revenue Cycle and Operations

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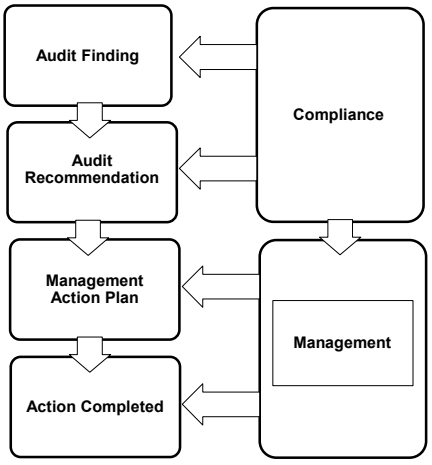
Elements of an Effective Compliance and Ethics Program provide model structure and guidance for UNCHCS

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

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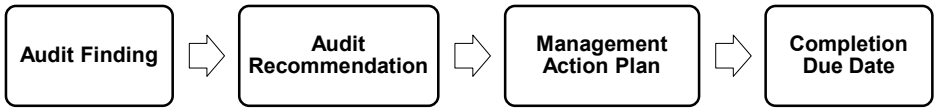
Management is responsible for audit action plans which should be completed by due date

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**



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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

RESEARCH & COLLABORATION

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

RISK ASSESSMENT

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

DYNAMIC PROCESS

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

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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

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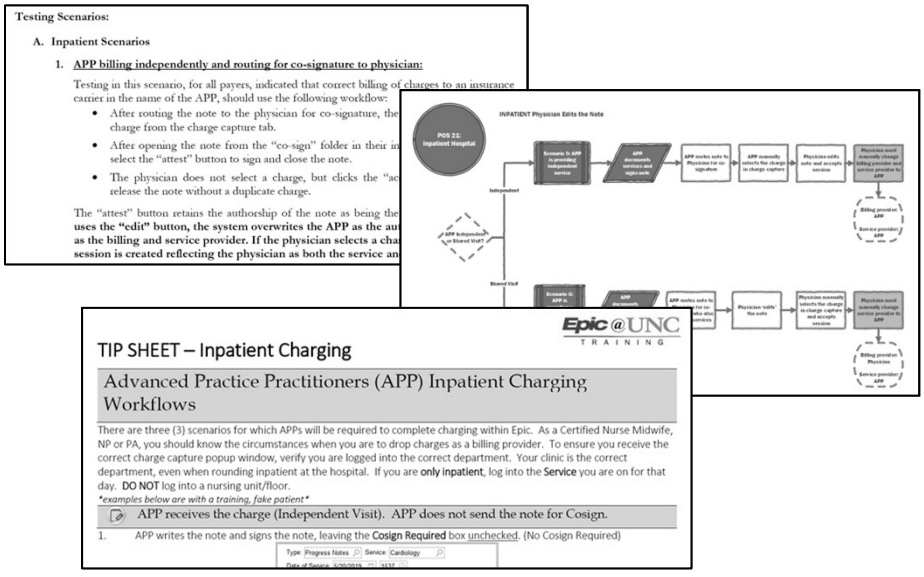
Discovery of risk areas lead to provider education



Testing Scenarios:

A. Inpatient Scenarios

1. APP billing independently and routing for co-signature to physician:

Testing in this scenario, for all payers, indicated that correct billing of charges to an insurance carrier in the name of the APP, should use the following workflow:

- After routing the note to the physician for co-signature, the charge from the charge capture tab.
- After opening the note from the "co-sign" folder in their in select the "attest" button to sign and close the note.
- The physician does not select a charge, but clicks the "ac release the note without a duplicate charge.

The "attest" button retains the authorship of the note as being the **uses the "edit" button, the system overwrites the APP as the au as the billing and service provider. If the physician selects a cha session is created reflecting the physician as both the service an**

INPATIENT Physician Edits the Note

POS 21: Inpatient Hospital

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TIP SHEET – Inpatient Charging

Advanced Practice Practitioners (APP) Inpatient Charging Workflows

There are three (3) scenarios for which APPs will be required to complete charging within Epic. As a Certified Nurse Midwife, NP or PA, you should know the circumstances when you are to drop charges as a billing provider. To ensure you receive the correct charge capture popup window, verify you are logged into the correct department. Your clinic is the correct department, even when rounding inpatient at the hospital. If you are **only inpatient**, log into the **Service** you are on for that day. **DO NOT** log into a nursing unit/floor.

examples below are with a training, fake patient

APP receives the charge (Independent Visit). APP does not send the note for Cosign.

1. APP writes the note and signs the note, leaving the **Cosign Required** box unchecked. (No Cosign Required)

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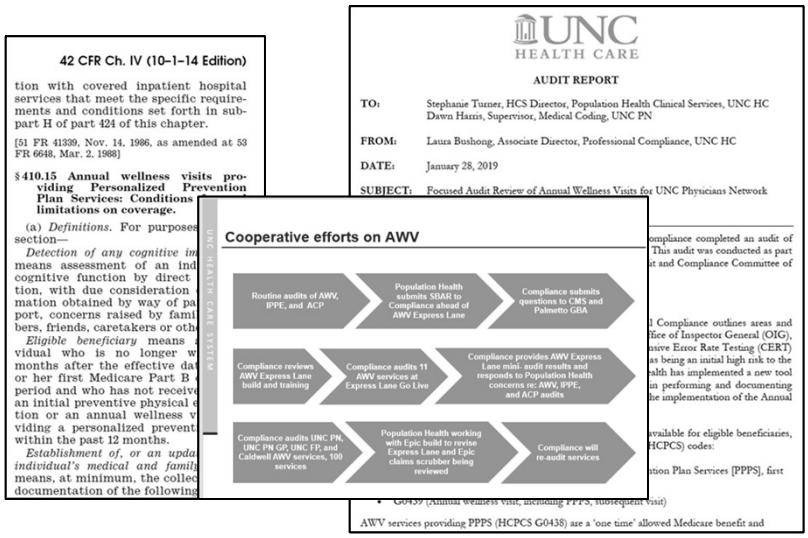
From regulation to audit to collaboration for correction



42 CFR Ch. IV (10–1–14 Edition)

tion with covered inpatient hospital services that meet the specific requirements and conditions set forth in subpart H of part 424 of this chapter.

[51 FR 41339, Nov. 14, 1986, as amended at 53 FR 6648, Mar. 2, 1988]

§ 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions limitations on coverage.

(a) *Definitions.* For purposes section—

Detection of any cognitive im means assessment of an ind cognitive function by direct tion, with due consideration mation obtained by way of pa port, concerns raised by famil bers, friends, caretakers or oth

Eligible beneficiary means vidual who is no longer w months after the effective da or her first Medicare Part B period and who has not receiv an initial preventive physical tion or an annual wellness v viding a personalized prevent within the past 12 months.

Establishment of, or an upda individual's medical and family means, at minimum, the collec documentation of the following

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Cooperative efforts on AWV

Routine audits of AWV, IPPE, and ACP → Population Health submits SBAR to Compliance ahead of AWV Express Lane → Compliance submits questions to CMS and Palmetto GBA

Compliance reviews AWV Express Lane build and training → Compliance audits 11 AWV services at Express Lane Go Live → Compliance provides AWV Express Lane mini- audit results and responds to Population Health concerns re: AWV, IPPE, and ACP audits

Compliance audits UNC PN, UNC PN GP, UNC FP, and Caldwell AWV services, 100 services → Population Health working with Epic build to revise Express Lane and Epic claims scrubber being reviewed → Compliance will re-audit services

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AUDIT REPORT

TO: Stephanie Turner, HCS Director, Population Health Clinical Services, UNC HC
Dawn Harris, Supervisor, Medical Coding, UNC PN

FROM: Laura Bushong, Associate Director, Professional Compliance, UNC HC

DATE: January 28, 2019

SUBJECT: Focused Audit Review of Annual Wellness Visits for UNC Physicians Network

ompliance completed an audit of This audit was conducted as part t and Compliance Committee of

l Compliance outlines areas and ffice of Inspector General (OIG), assive Error Rate Testing (CERT) as being an initial high risk to the alth has implemented a new tool in performing and documenting lle implementation of the Annual

vailable for eligible beneficiaries, HCPCS) codes:

tion Plan Services [PPPS], first

- G0439 (Annual wellness visit, including PPPS, subsequent visit)

AWV services providing PPPS (HCPCS G0438) are a 'one time' allowed Medicare benefit and

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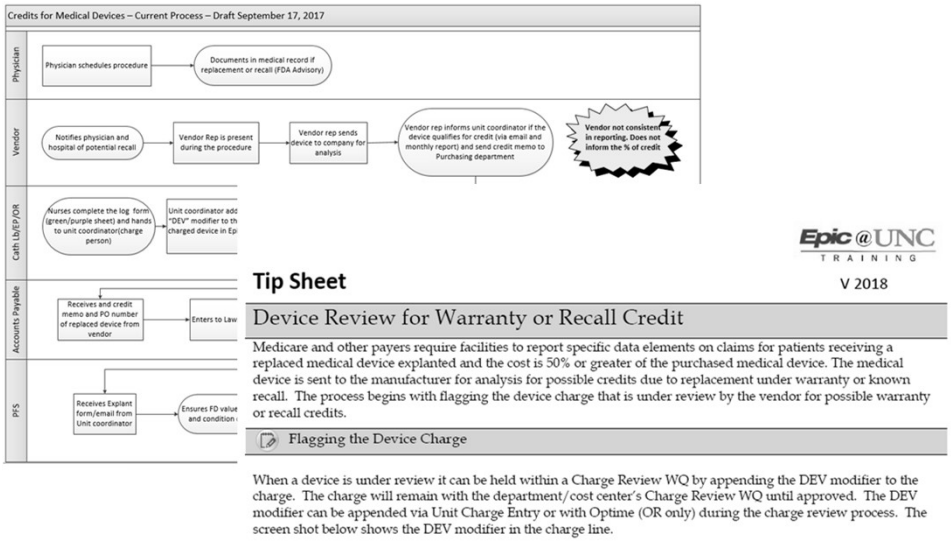
Collaborate with teams to guide and prevent future errors



Credits for Medical Devices – Current Process – Draft September 17, 2017

Physician: Physician schedules procedure → Documents in medical record if replacement or recall (FDA Advisory)

Vendor: Notifies physician and hospital of potential recall → Vendor Rep is present during the procedure → Vendor rep sends device to company for analysis → Vendor rep informs unit coordinator if the device qualifies for credit (via email and monthly report) and send credit memo to Purchasing department → Vendor not consistent in reporting. Does not inform the % of credit

Cath Lb/EP/OR: Nurses complete the log form (green/purple sheet) and hands to unit coordinator(charge person) → Unit coordinator add "DEV" modifier to th charged device in Ep

Accounts Payable: Receives and credit memo and PO number of replaced device from vendor → Enters to Law

PFS: Receives Explant form/email from Unit coordinator → Ensures FD value and condition

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Tip Sheet V 2018

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 explanted and the cost is 50% or greater of the purchased medical device. The medical device is sent to 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 DEV modifier to the charge. The charge will remain with the department/cost center's Charge Review WQ until approved. The DEV modifier can be appended via Unit Charge Entry or with Optime (OR only) during the charge review process. The screen shot below shows the DEV modifier in the charge line.

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Visit the UNC Health Care Compliance Office home page located at unchealthcare.org

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Thank you for your time and attention

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