Only an ostrich should stick it's head in the sand!

A practical discussion on marrying compliance and revenue cycle with data analytics

About Byron

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Byron is an independent consultant with over 16 years of experience in the healthcare field. He is a recognized expert in many fields including revenue cycle, revenue integrity, healthcare regulatory compliance, chargemaster (CDM) services, coding, billing, and auditing services. Additionally he has been a part of multiple customized data analytic development and implementation teams focused on billing compliance, revenue integrity, clinical documentation improvement (CDI) and ICD-10 impact analysis for integrated healthcare systems, hospitals, physician practices, and other entities on the local, regional and national levels.

About Pam

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Pam is a nationally recognized expert in Health Information Management (HIM) professional with over 30 years of healthcare experience in revenue cycle operations, electronic health record (EHR) applications, reimbursement, coding, billing, compliance, quality control, clinical documentation and coding training. She is also a nationally recognized author.

Pam specializes in the development and implementation of reimbursement related consulting projects; such as Clinical Documentation Improvement, development of accurate coding and billing programs, multifaceted team integration projects, and process improvement strategies for healthcare organizations. Her extensive knowledge of reimbursement, coding and billing guidelines, along with her innovative approach to project management and redesign, encourages organizational acceptance and effective transition plans.

Today's Focus

1. Develop a desire to collaborate with Compliance and other areas of expertise to continually evaluate internal/external threats
2. To increase the participant's desire to proactively self monitor billing/payment data in collaborative process to identify/mitigate risk exposures prior to investigation by an external agency or entity

WHO IS LOOKING?

Comprehensive Error Rate Testing (CERT)

Healthcare Fraud & Prevention Enforcement Action Team (HEAT)

Medicare Fraud Strike Force

Medicare Administrative Contractors (MAC)

Recovery Audit Contractors (RAC)

Medicaid Fraud Control Units

State AG Office

Zone Program Integrity Contractors (ZPIC)

State OIG's

Medicaid Integrity Contractors

CMS

OIG

Just to name a few…

OIG-DHHS

- Office of the Inspector General for the Department of Health and Human Services (OIG-DHHS)

Four offices collaborating to "protect the integrity of DHHS programs, operations, and the health/welfare of the people they serve"	
OCIG: Office of Counsel to the Inspector General	OEI: Office of Evaluations and Inspections
OI: Office of Investigations	OAS: Office of Audit Services

OIG-DHHS' #1 Strategic Goal

- To Fight Fraud, Waste, and Abuse
  - Understanding Fraud, Waste, Abuse
- Key Tool = Data:
  - Consolidated claims databases developed
  - Compare/contrast with other data sets
  - **Think Medicare for our discussion purposes today*

Analytics Supporting Goal #1

- Annual Work Plans
- Investigative trending analysis for any/all potential fraud, waste, and abuse
- Accuracy investigations with provider overlap
- Other customized investigations as reported or identified/determined

Common Analytic Approaches

- Time sequencing:
  - ID billing patterns based on timing/order of events
- Clustering:
  - ID groupings to organize in buckets to investigate anomalies
- Association Rules:
  - ID events, services, conditions that are billed together that don’t make sense

Compliance and Revenue Cycle

<u>Collaboration Reasons:</u>

- Shared time and resources
- Complimentary professional expertise
  - In depth access to industry knowledge, networking, participation with societies, and resources/publications
- Access to information
- Synergized goals and results expectations

837 / 835 Data Sets

- Two (2) data sets (minimum)
  - Billed claims: ANSI ASC 837(x)
  - Paid claims: ANSI ASC 835(x)
  - Others
- HIPPA required electronic standards
- Understand variations between:
  - Providers
  - Insurers

837 / 835 Data Sets

- Data is a starting point, not an end point in most cases
- Data needs to be converted and managed to become useful to the end user

```
GS*HC*850123123*133052123*20130123*125123*358452123*X*005010X223A2~
ST*837*0001*005010X223A2~
BHT*0019*00*482123*12330117*125123*CH~
NM1*41*2*CLAIM.MD*****46*850466123~
PER*IC*EDI SERVICES*TE*5057576123*EM*EDI@CLEAR.HOUSE~
NM1*40*2*CLEARHOUSE*****46*133052123~
HL*1**20*1~
PRV*BI*PXC*123D00000X~
NM1*85*2*YOUR HOSPITAL O*****XX*1116871230~
N3*1475 FM 12345 WEST MAIN STREET~
N4*ORANGE*GA*123389998~
REF*EI*123394123~
HL*2*1*22*0~
SBR*P*18******MA~
NM1*IL*1*PATIENT*NAME*A***MI*123529618A~
N3*2419 FM 123 YOUR STREET~
N4*ORANGE*GA*12351~
DMG*D8*12300919*F~
NM1*PR*2*MEDICARE*****PI*12311~
N3*PO BOX 123156~
N4*PAYER*GA*12306~
CLM*1855*12365.25***13:A:1**A*Y*Y~
LX*1~
SV2*0360*HC:J9355*7110*UN*44**0~
```

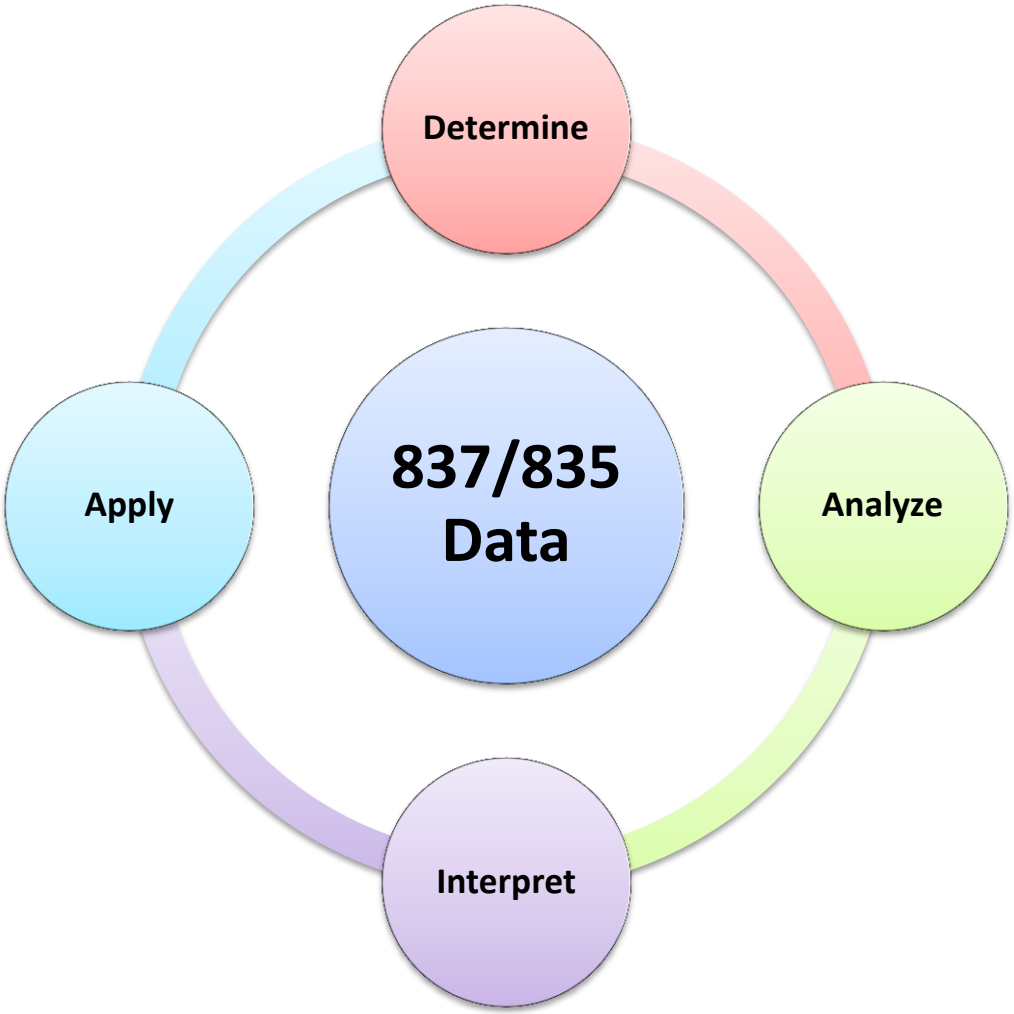
Scrubbed to de-identify; for example use only

837 / 835 Data Sets

Start with the "End" in mind:

- Database structure and maintenance (all data)
- Updating (new)
- Storage/repository (long-term)
- Users
  - Interfacing
  - Reporting
- Build or Buy?

837 / 835 Data Sets



Data Sets: 837 / 835

Other uses:

- Clinical Documentation Improvement (CDI)
- Revenue Integrity
- ICD-10 implementation
- Strategic planning
- Legal defense
- Quality of care

Case Studies

Data in use by the OIG and what it meant to the party under review

Case Study #1

- Issue: Billing entire multiuse vial quantities on individual patients
- *"Medicare Contractors Nationwide Overpaid Millions to Providers for Full Vials of Herceptin"*
  - A-05-13-00024, Nov. 2013
  - Spring 2014 Semi-Annual Report to Congress

Case Study #2

- Issue: Increased billing in targeted procedures lead to audit, investigation, and eventual CIA
- "*Corporate Integrity Agreement [CIA] Between the Office of Inspector General of the Department of Health and Human Services and Saint Joseph Health System, Inc. D/B/A Saint Joseph London*"
  - Spring 2014 Semi-Annual Report to Congress

Case Study #3

- Issue: Targeted Inpatient short stays and claims paid in excess of charges are identified for “judgmental” review
- “*Medicare Compliance Review of University of Washington Medical Center”*
  - A-09-13-02049, June 2014

Recap

- We should Collaborate on expertise, resources, and continually expand your sphere of influence
  - "*Collaborative Organizational Knowledge-Base*" can build a better mousetrap
- With that knowledge we should proactively monitor our billing (837) and payment (835) data internally
  - Utilize claims data for internal analytics
  - Risk Areas (ID, Validate, Investigate)
- Identified risks should direct our corrective actions
  - Resolution monitoring

Thank You!

Questions and Answers?

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