Guide to Strengthening Your Billing Compliance Approach

BKD
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Health care is no stranger to rapid change. Health care fraud hides in the details—as proof the Office of Inspector General (OIG) is aggressively pursuing fraudulent claims, try to find a week without an OIG settlement headline. These settlements range from $500,000 to $42 million and are significant enough to cause irreparable damage to a system's financials.

Leaders are still in control and understand the OIG is now working to pursue fraud, so we hope leaders will leverage this article and related resource to proactively protect their systems from becoming the next headline.

How is the OIG identifying fraud?

They're using analytics to identify irregular patterns. The increased use of electronic health records (EHR) has made the data available digitally and easy prey to analytics power. The good news is analytics can and should work in your favor—you're capable of leveraging analytics for the same purpose to help stay a step ahead.

What's changed with the OIG work plan?

Prior to June 15, 2017, the OIG was updating the work plan annually; today, it's updating this site monthly. It's assessing U.S. Department of Health & Human Services programs and operations and focusing on the areas deemed as highest risk. If your system is still operating on an annual review, today is the day to match the OIG's efforts and give the work plan attention on a monthly basis.

Who else is ramping up compliance efforts?

We're seeing increased efforts by Medicare Administrative Contractors, Recovery Audit Contractors (RAC) and Zone Program Integrity Contractors—and sometimes there's coordination between these agencies and the OIG. All RACs have websites disclosing the issues they'll be monitoring, so it's important to bookmark their sites and give them regular attention in addition to the monthly OIG update.

This won't be a small feat, so we encourage our clients to take a systemwide team approach with representatives from compliance, finance, health information management (HIM), billing and IT and to tap into department leaders' line of sight when the data creates questions. Initially creating the analytics is part art and part science, but it's a worthwhile investment of time.

Steps to Creating a Strong Billing Compliance Program

Step 1 | Assemble Your Team

Step 2 | Map Your Plan

Step 3 | Identify Your Top 10

Step 4 | Unleash Your Analytics

Step 5 | Build Your Compliance Dashboard

Step 6 | Invest in Targeted Actions

Appendix:

Links to Resources

Step 1 | Assemble Your Team

A strong core team will include professionals from these five groups:

This mix of professionals will have the knowledge base and access to develop the analytics and monitor progress. However, it's advisable to not limit including only the core team. The individuals dealing with billing issues on a daily basis also should be consulted. These key staff often have information that would be important to consider. Because of their familiarity with practitioners and hospital departments, they might see coding or documentation patterns that are worth further investigation.

Examples in Action

When talking to the front-line staff, you discover that for the same procedure, one department may consistently be getting a Health Care Common Procedure Coding System (HCPCS) modifier applied, but in another department it's not being applied.

In addition, the team tracks and monitors additional development requests (ADR) to understand what's being requested and from which types of claims. During this monitoring it's able to identify variations, dig into current claims and correct the issues before they become a full-blown OIG audit.

Step 2 | Map Your Plan

Referencing your internal compliance audit plan and reviewing public data, including the OIG work plan and RAC list of issues, is a good starting point. We strongly recommend listening to staff concerns and tracking ADRs. Front-line staff often can shed invaluable insight on data anomalies.

In addition, here are frequent hospital risk areas to consider:

- **Inpatient short stays**
  Identify the diagnosis-related groups with the most short stays (average lengths of stay less than three days) and their admitting providers.
- **High-cost inpatient claims**
  Focus your attention on payments that exceed $150,000 and most likely include outlier payments too.
- **Intensity-modulated radiation therapy (IMRT) claims**
  While IMRT is not a new focus, it continues to be a hot spot of risk. Leverage data mining to assess your organization's risk level.
- **Outpatient claims with both an evaluation and management (E&M) and surgical code**
  How frequently are your outpatient claims including both an E&M and a surgical code? This can be a strong indicator of coding issues.
- **Medical devices and manufacturer credits**
  This is a two-tailed test. You want to check for frequency of modifier use to report the receipt of a manufacturer's credit—or for the lack of the same modifier.
- **Nonbalanced claims paid and charges billed**
  Payment and charges should balance, so analyze and track any claims paid in excess of charges billed.
- **J-code drugs**
  The OIG has a list of drugs it considers to be high risk for billing errors and many of these are identified in the work plan.
- **Clotting factor**
  Identify and monitor the prevalence of these claims.
- **Emergency department (ED) assigned levels**
  Understand what percent of ED claims are assigned to which level and monitor the trend.

Step 3 | Identify Your Top 10

While 10 is a flexible number, choose a manageable amount so you can effect real change. Pay special attention to claims that are being denied for medical necessity and those with the strongest trend lines.

Use data from your electronic claims and remits. Since this is the same data the payors are mining, you'll be mining from the same source. Consider the complete picture by comparing and analyzing the information.

Decide which source to leverage to access your intended data and consider the ability to query desired data elements from your Physician Fee Schedule system or decision support. Answer the question: "Will I need to extract from the electronic 837/835 files?"

Most likely you can track the service line, department, physician and both primary and secondary diagnoses. We have even seen instances during this phase where the day of the week of an admission contributed to the issues.

While all that information is available at a very detailed level, we advise you start with high-level trends and dig deeper when it becomes necessary. Be realistic—your goal is to find issues and implement improvements.

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Step 4 | Unleash Your Analytics

It's easy to dive in here, but invest your efforts in quality data first. Find the data you want, make sure it's complete and confirm it covers all payors—not just Medicare. It also will be important to design analytics that answer your list of issues and help you create baseline metrics. Like with many projects, it's the front-end prep work that's equally tedious and critical.

Your end goals should be to not only identify trends, but build a process to continually update and track changes. Access your historical data and outline a plan for obtaining updated data, usage permission and a timetable for the update frequency.

Set up the criteria to measure each of your selected focus issues.

1. Identify the first focus issue
2. Determine how you will exclusively mine the claims relevant to this issue from your database of all claims
3. Specify how you will know if you have an issue

This is where the process becomes a bit more of an art than a science. Unfortunately, the OIG doesn't share its formulas for identifying hot spots.

Sourcing Strong Data

If you're a health system, you can look at the issue across hospitals and look for variations and trends, but if you're a single hospital, you're limited to public information or services selling this type of claim information.

Remember, none of this works without the data, so make the investment as needed to enable your organization to monitor performance and track trends.

Step 5 | Build Your Compliance Dashboard

Build out your own billing compliance dashboard. The dashboard's purpose is to help you see change over time—this is among the reasons we advocate for investing time in calculating meaningful baselines. Be prepared to be patient, because as many dashboards as our team has helped build, every dashboard takes a couple of iterations to make the calculations hit the meaningful mark.

There are many software tools available, but you should still be prepared to do the heavy lifting of mapping out your detail calculations. This is the phase where you'll be thankful you have professionals from all five recommended areas. Each background contributes a different frame of reference, helping lead to a sharper, stronger dashboard.

If you have enough data in the beginning you also can establish a target, but don't feel discouraged if it's going to take some time before you're able to define the target goal.

- Build your own compliance dashboard
  - Calculate your baseline
  - Establish your target
  - Track your progress
  - Update with 837/835 data quarterly
- Make it visual
  - There are many available tools for data aggregation and business intelligence
  - Use drill-down methods
    - Share the detail with those who need it
  - Slice and dice
    - By location
    - By provider
- Make it actionable data
  - Establish a plan to refresh the data quarterly

The benefit of a dashboard is you can get a lot of data points on a single page. It's a visual way to help users of the information see the trends.

With many of the new dashboard tools that are available, the detail information resides behind the dashboard and the ability exists to drill down. The most common problem with sharing data is users like to poke holes in the source of the data in an attempt to discount the identified trends. But using this type of process—where claim data is submitted and paid and you have the ability to drill down—can help reduce this behavior.

Step 6 | Invest in Targeted Actions

The overall goal of creating the dashboard is to identify the compliance gap: the difference between your billing compliance and where you want to be.

Now it's time to take action and work through the compliance process.

Define

Define

At this point, you've leveraged your dashboard to identify the issues.

Prevent

Prevent

You want to provide education and communication that will help prevent the trend from continuing. Now would be a good time to review your procedures and make any adjustments.

Detect

Detect

It's important to spend time determining the root cause of the issue. Dig deep into the claims and determine why it's happening. Is it a specific area or department? How is the issue getting applied to the claim? Be sure to check your charge description master and any EHR modules. Once you have a better understanding of how and why the issue is occurring, you will be in a better position to provide additional education, targeting training or even a modification to your procedures.

Respond

Respond

Provide training and retraining to strengthen your team and your compliance program.

Evaluate

Evaluate

Re-evaluate whether you have moved the needle. Has there been a change in the trend line? Are you near your stated target amount?

This framework outlines continual monitoring and improvement.

Links to Resources

- OIG Website & Work Plan
- CMS Nationwide Contractor Map
- RAC Issues List
    - Found on each RAC website
- 835/837 Available Data Elements
    - Electronic Billing & EDI Transactions
    - Medicare Fee-for-Service Companion Guides
- Medically Unlikely Edits