WELCOME

Summit 101

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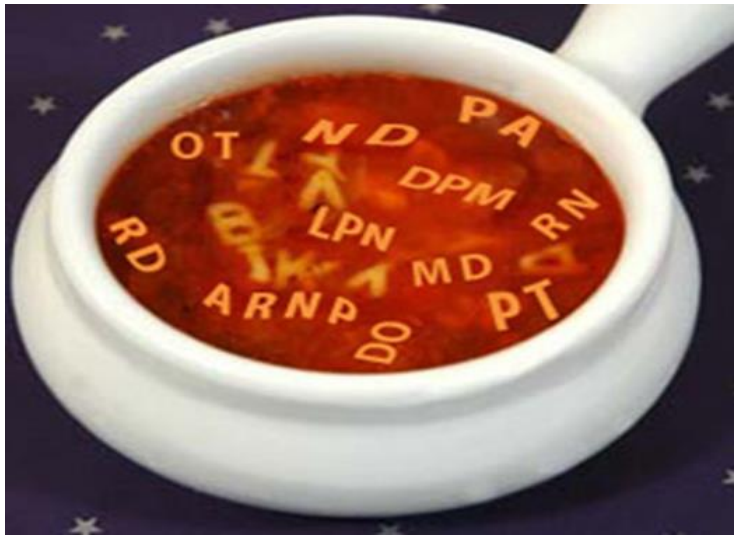
Goal

- To have fun
- Informal – all questions welcomed
- Use the white boards
- Nuts & Bolts
- Leave with a basic understanding of where we are headed the next 3 days



ABC's of Healthcare

Cathie Biga, CEO,
Cardiovascular Management of Illinois
Team of experts:
Charles Brown MD, Richard Kovacs MD, Linda Gates-Striby,

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Goal

- Acronyms make up the language of our industry… and that is confusing!
- Develop a better understanding of their definitions and what they mean for your practice, CV SL, or academic center

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The "Triple Aim"

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on **3 areas**

- **Incentives**
- **Care Delivery**
- **Information Sharing**

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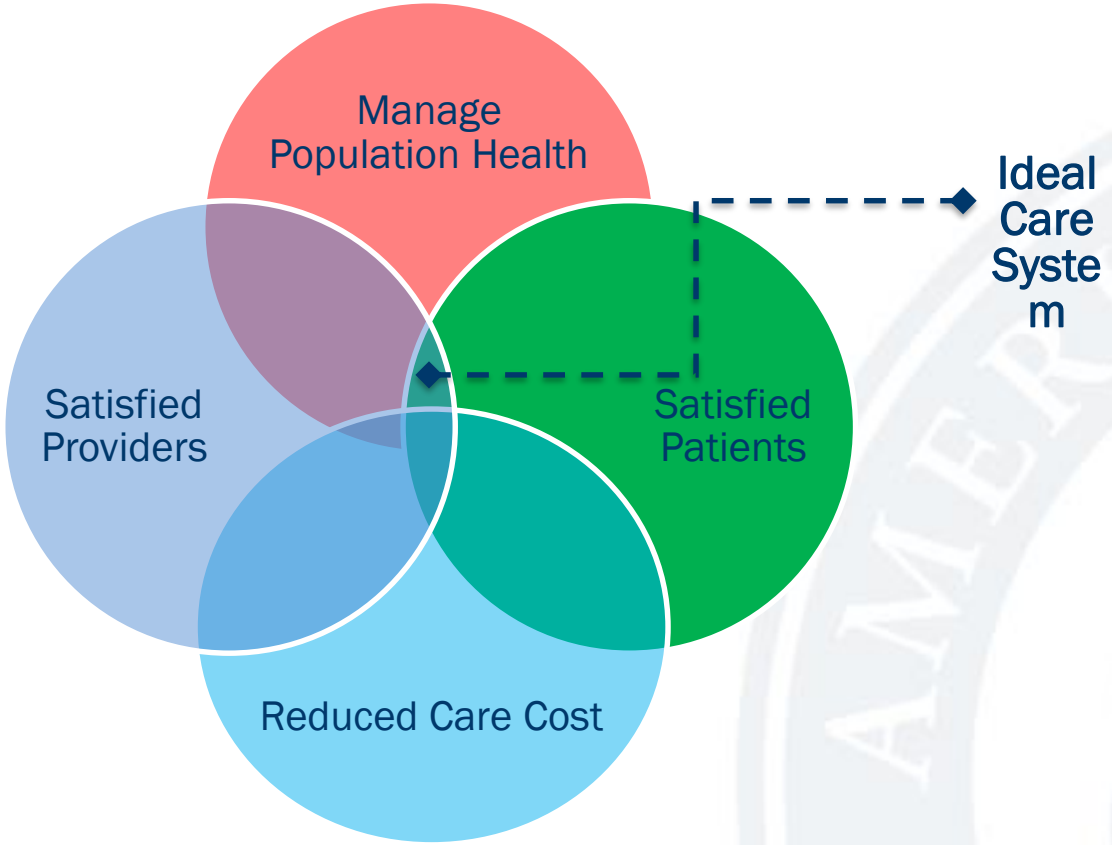
Quadruple Aim



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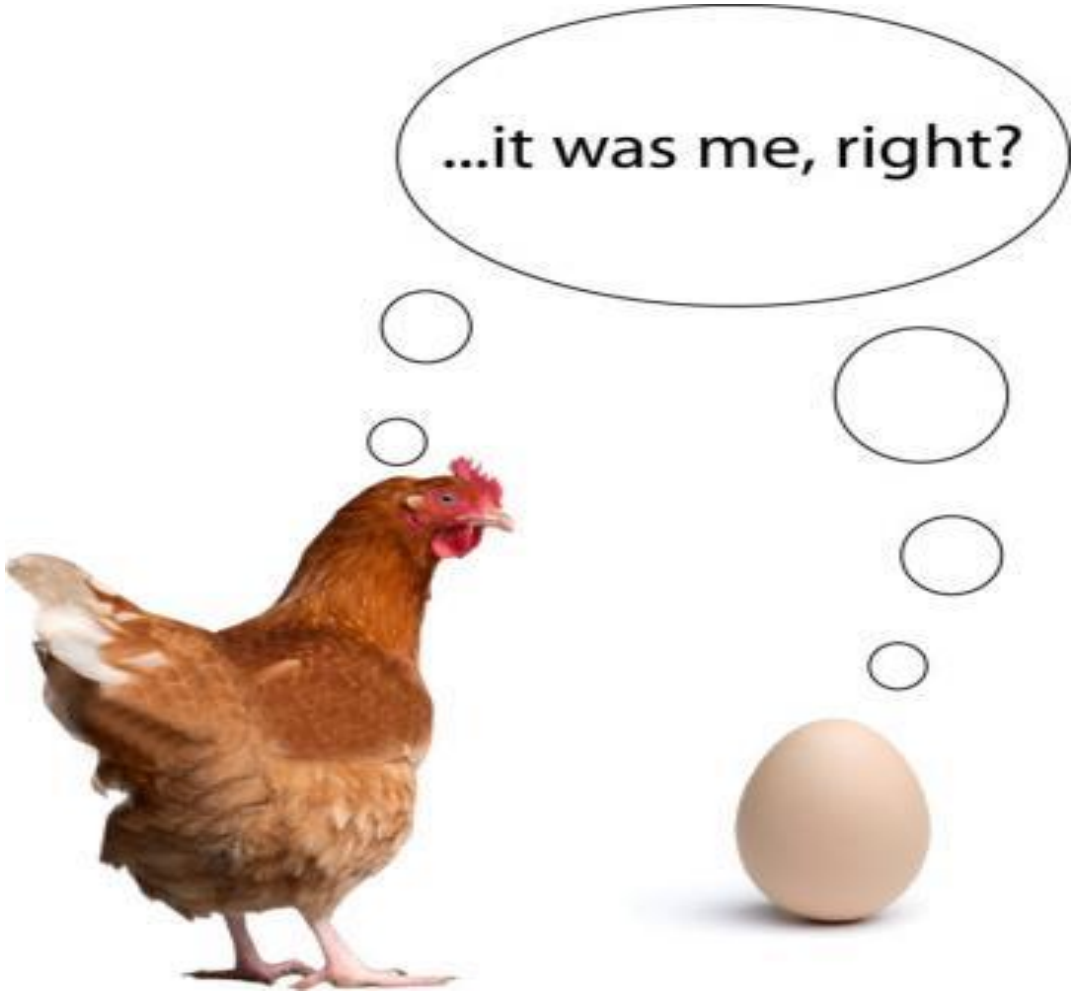
Payment Reform: What Came First?



- It all started with ACA – Affordable Care Act
- Maybe it all started with SGR: Sustainable Growth Rate!

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Payment Reform Elements

ACA – Affordable Care Act

APM's: Alternative Payment Models

ACO's: Accountable Care Organizations such as Pioneer and Medicare Shared Savings (MSSP)

CMMI: Centers for Medicare and Medicaid Innovation with programs such as BPCI: Bundled Payments for Care Improvement, SmartCare……

SGR: Sustainable Growth Rate

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Language Of Payment

- RVU: Relative Value Unit
  - Includes GPCI (where you live), med mal, practice expense, etc.
    - GPCI: Geographic Practice Cost Index
    - Work RVU (GPCI) + Practice Expense RVU (GPCI) + Malpractice RVU (GPCI) = Total RVU
    - Total RVU * Conversion Factor = Medicare Fee
- Fee schedules
  - PFS: Physician Fee Schedule
    - Billed with CPT codes & ICD-10 –
  - OPPS or HOPPS: Outpatient Prospective Payment System
    - Billed with APC: Ambulatory Payment Codes
    - Currently being bundled into “families”
  - IPPS: Inpatient Prospective Payment System
    - Billed with DRG’s
    - MCC’s

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In English what does that mean

$$\{ (\text{RVU work} \times \text{GPCI work}) + (\text{RVU practice expense} \times \text{GPCI pe}) + (\text{RVU malpractice} \times \text{GPC MP}) \}$$

X

Conversion Factor

=

$224.09

$$(1.50 \times 1.009) + (4.37 \times 1.053) + (.07 \times 1.565)$$

X

$35.9996

=

$224.09 for 5.94 RVU

ECHO PAYMENT

Language Of Payment Reform

- APM: Alternative payment model
  - ACO: accountable care organizations (470)
    - MSSP: Medicare Shares Savings Plans (4 models)
      - Track 1+
    - Pioneer: currently 9 left
    - Next Generation ACO – 21 in 13 states
  - BPCI: Bundled Payment for Care Improvement
    - 4 models
    - 337 using 1254 episodes (3 yr. model) done 9/30/18
  - BPCI –A: Newest kid on the block
  - Several models: Maryland, ESRD, CPC
  - CMS mandated bundles aka EPM

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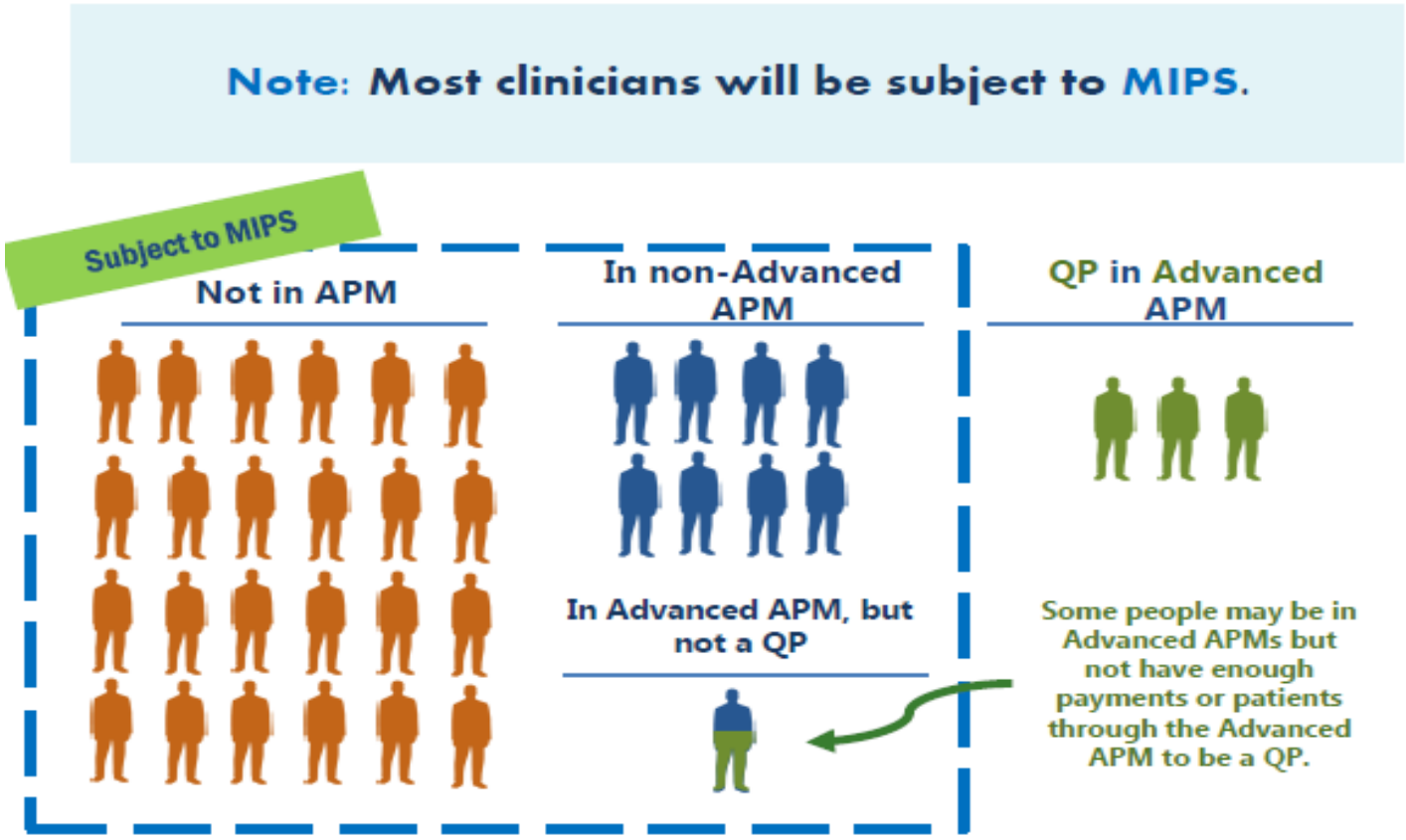
The language of APM

- Qualifying APM
- Qualifying provider in a qualifying APM
- MIPS and APM provider

Qualifying ACO *AND* Qualifying Provider



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Language of Physician Quality

PQRS: Physician Quality Reporting System

QCDR: Qualified Clinical Data Registry

EP: Eligible Provider

GPRO: Group Practice Reporting Option

MU: Meaningful Use

VM: Value modifier

QRUR: Quality & Resource Utilization Report

S-QRUR: Supplemental QRUR

QPP: new Name for MACRA : Quality Payment Program

MIPS: Merit-based Incentive Payment System

FTR: Field Tested Reports – new s-QRUR – used in MIPS

MACRA Shift To QPP

- QPP: Quality Payment Programs
  - MIPS: Merit/Quality
    - ACI: Advancing Care Information
    - CPIA/IA: Clinical improvement activities
- CR and ICR incentive payment: cardiac (intensive) rehab

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Newest kids on the block

- QP's: qualifying APM's participants
  - Best of the best ☺
  - Not subject to MIPS + 5% lump sum
- PQP's: partially qualifying providers
- PROM: Patient Reported Outcomes
  - Watch this one
- PRC: Patient relationship codes
- CQS: Composite quality score – used to set Bundle pricing
- LAN: Health Care Payment Learning and Action
- PFPM: Physician-Focused Payment Model
- AUC Mandate: Appropriate Use – Law in 2014……delayed until 2020

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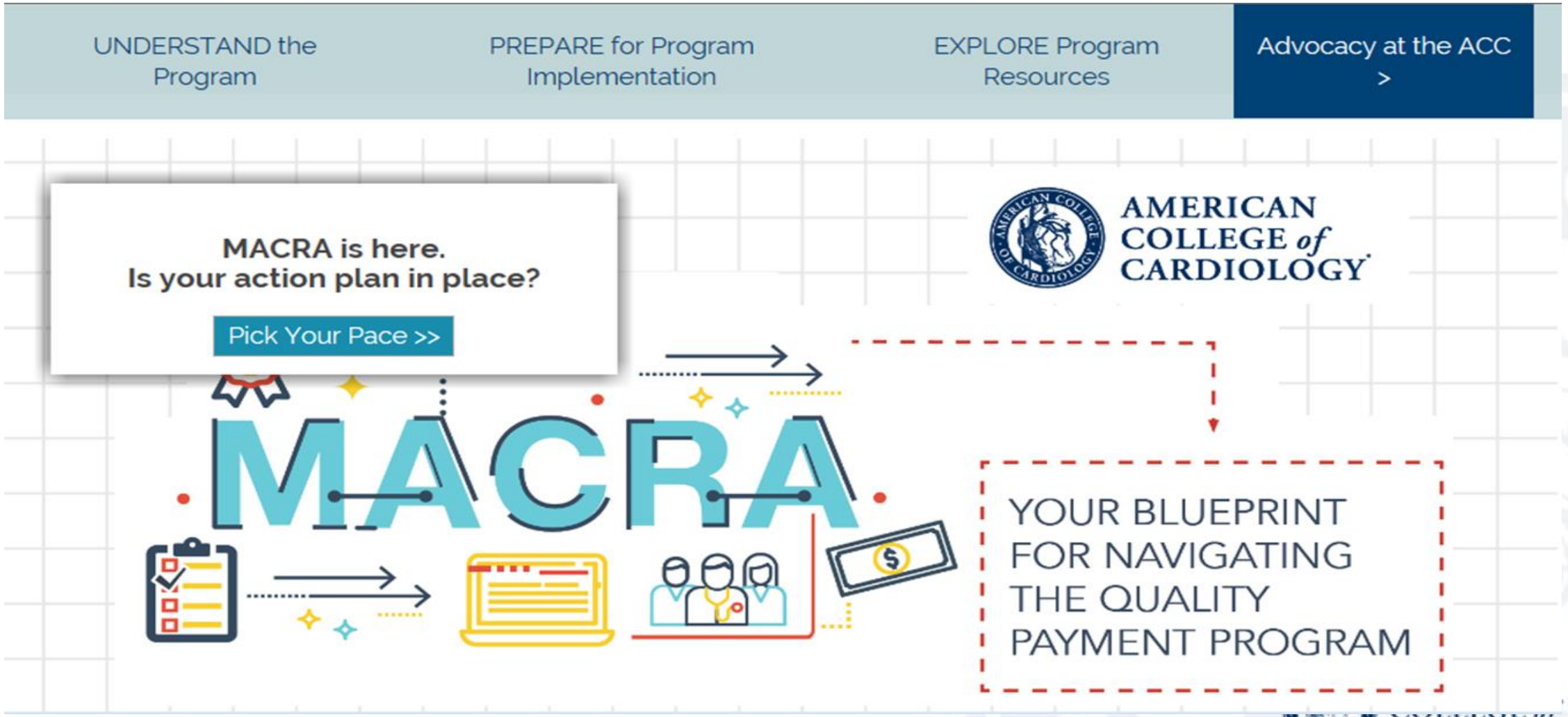
ACC MACRA HUB



Breathe In, Breathe Out, Move On

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Hospital Quality

QIO: Quality Improvement Organizations

HAC: Hospital Acquired Conditions

RRP: Readmission Reduction Program

MU: Meaningful Use

IQR: Inpatient Quality Report

HVBP: Hospital Value Based Purchasing

Excess Day Report: EDR

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This and That…….

- CMI: Case Mix Index
- CCs: Complication and Comorbidities
- FFS: Fee for Service
- V2V or FFV: Volume to Value; Fee for Value
- MSPB: Medicare Spend per Beneficiary

Medical Necessity

ABN – Advance Beneficiary Notice of Non-coverage

AUC – Appropriate Use Criteria

LCD – Local Coverage Determination

NCD – National Coverage Determination

TWO-MIDNIGHT RULE

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Billing and Compliance

APP – Advance Practice Provider

CCM – Chronic Care Management

TCM – Transitional Care Management

CDI – Clinical Documentation Improvement

RAC – Recovery Audit Contractor

ZPIC – Zone Program Integrity Contractor

ICD-10 – International Classification of Diseases

MLN – Medicare Learning Network

PECOS: Provider Enrollment, Chain, & Ownership

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Finance and Revenue

RAF: Risk Adjustment Factor

HCC: Hierarchical Condition Coding

ICD 10: Codes used for diagnosis

CPT: codes used to bill and activity

wRVU: factor assigned to each CPT code - professional

RVU: factor assigned to each code - pro + tech

APC: codes used to bill outpt activities

Incident 2: Office based billing for APP's and others

Shared Service: Hospital based shared billing

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Need A Break?

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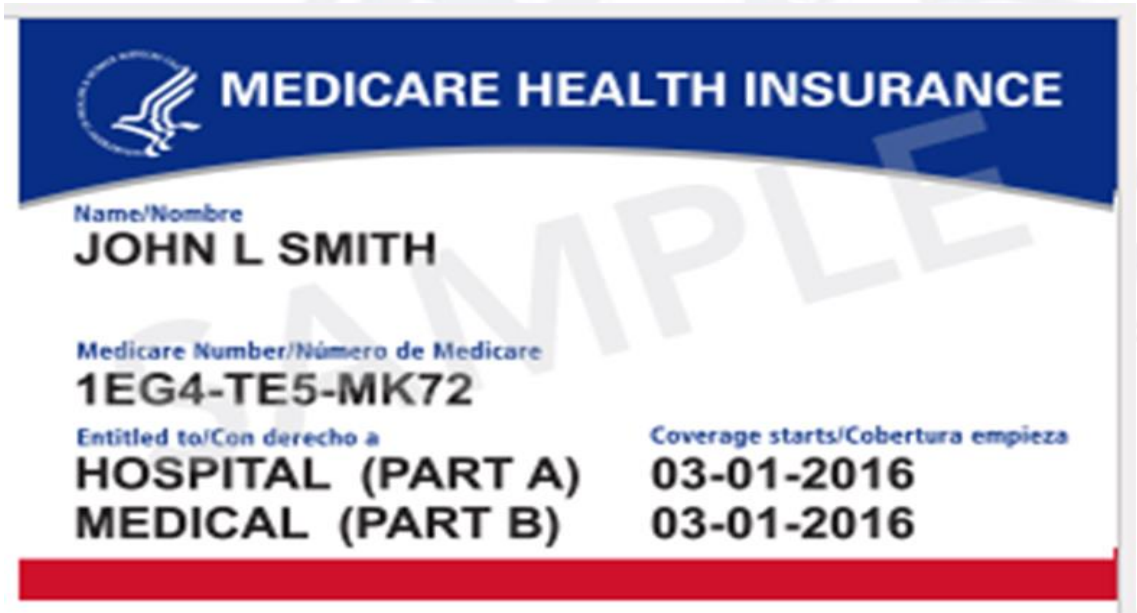
This and That

- New ICD NCD
  - Shared Decision Making
  - ICD registry
- Proposed MRI NCD
  - MAY be able to do MRI's on pts with devices

New Medicare Cards In 2018

- New cards will consist of eleven characters, a combination of numbers and uppercase letters.
- It is a randomly generated number, no connection to any other personal identifying information. This new number will replace the Social Security-based number currently used on all Medicare cards, and it's designed to protect the personal information of Medicare beneficiaries.
- CMS plans to begin mailing the newly designed Medicare cards in April 2018, and we'll replace all cards by April 2019

- In September CMS released a sample of the newly designed card
- CMS is hosting web sessions with info




ZDOGGMD

Precon Part 2-
RAF-HCC-Pt Relationship Codes

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Diagnosis Coding: Sharpening Our Focus

- Clinicians have focused patient care CQI for years… but what are we doing about CQI of diagnosis coding?
- Coding specificity, accuracy, and compliance NOW is having an increasing impact on Medicare reimbursement in the years to come.
- Coders and Clinicians need to understand and work together to sharpen the focus on coding in our “new world” of value.

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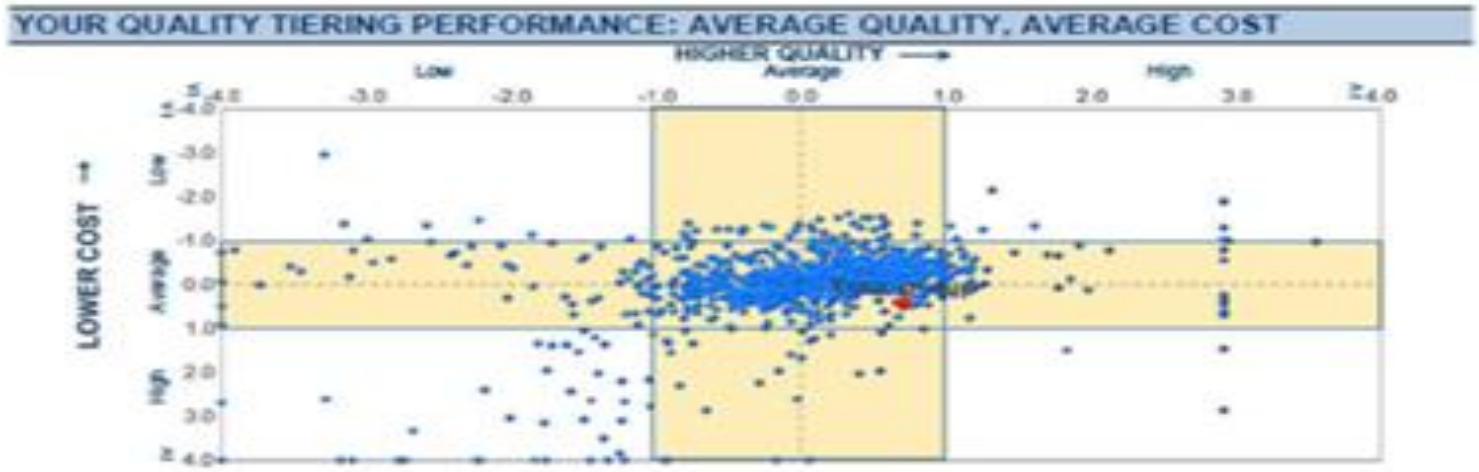
HCC Impact on Sample Contracts

National Quality Benchmarks

MSSP ACO Benchmark

Anthem MA
(PMPM and Savings)

Preventive Health				
Measure Number	Measure Name	Mean Performance Rate (SSP ACOs)	30th Percentile Benchmark	90th Percentile Benchmark
ACO-14	Preventive Care and Screening: Influenza Immunization	62.03%	30.00%	90.00%
ACO-15	Pneumonia Vaccination Status for Older Adults	63.73%	30.00%	90.00%



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RAF - Risk Adjustment Factor
What Do We Mean By RAF?

- Used to access the clinical complexity of a patient and predict the burden of illness for individuals and populations
- Acts as a multiplier when calculating CMS payments in a year
- Factors into bidding and payment of MA plans
- Focuses on identification, management, and treatment of chronic conditions

Additional Resources

- Provides a payer with additional resources to manage the health of a riskier population

Better Analytics

- More accurate coding leads to improved practice modeling and stratification of a population

Encourages **Regular** Management

- Encourages regular outreach to patients who aren't coming to the practice but may need follow-up

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HCC – Hierarchical Condition Category 101

The Least You Need To Know

Model Is Here To Stay In One Form Or Another

- The HCC model has been the basis for reimbursement to MAO plans since 2004.
- Due to it's proven success in predicting resource use it is now being used to determine much more and by more payors.

Goes To A Blank Slate Every Calendar Year

- The CMS model is accumulative – a patient can have more than one HCC category assigned to them. Some categories override others and there is a hierarchy of categories.
- **The HCC must be captured using claims data every 12 months.**

Subject To Data Validation Sampling

- The HCC must be documented and supported in the medical record and this can be subject to a "data validation" review
- The plan must submit the "one best medical record" that supports the patient's HCC scoring if identified for validation.

The HCC & RAF Connection 79 to 3,000

- Patients with multiple HCCs in a single category will be scored at the highest level
- *Additional risk is scored when certain conditions coexist
- When multiple conditions are present in the same patient a higher score will be used . i.e. CHF & COPD or CHF and CRF

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Documentation & Coding = RAF/HCC Score

All Conditions Documented & Coded Appropriately		Chronic Conditions Not Documented & Non-specific		Chronic Conditions Not Documented or Coded	
76 year old female	0.437	76 year old female	0.437	76 year old female	0.437
Medicaid female Aged	0.151	Medicaid female Aged	0.151	Medicaid female Aged	0.151
Demographic RAF Total	0.588	Demographic RAF Total	0.588	Demographic RAF Total	0.588
Diabetes w/ chronic manifestation (HCC 18)	0.368	Diabetes documented as uncomplicated (HCC 19)	0.118	Diabetes not documented but clinically supported	X
CHF (HCC 85)	0.368	CHF not documented but clinically supported	X	CHF not documented but clinically supported	X
Disease Interaction (DM + CHF)	0.182	No Disease Interaction	X	No Disease Interaction	X
Total Risk Score	1.506	Total Risk Score	0.706	Total Risk Score	0.588
Total Risk Score Value	$13,554	Total Risk Score Value	$6,354	Total Risk Score Value	$5,292

Capturing Comorbidities Is Essential

- In our Fee-for-Service model we have gotten used to making sure a diagnosis justifies medical necessity for the CPT codes on a claim.
- Many practices stop short of documenting and capturing comorbidities that show complicated medical decision making, treatment plans, and more accurately reflect the condition of the patient.
- In contrast – the majority of practices indicate that their physicians do a good job of documenting these comorbidities in the note.
- The change may not be one of documentation, but more of a coding change that is needed.

Practices who want to more accurately reflect patient acuity need to do a good job of coding comorbidities

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Documentation & Coding Guidelines

Per ICD-10 Official Guidelines for coding and reporting *"Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."*

Access all conditions that coexist that day are treated, managed, & affect patient care

Consider, document and report the disease as accurately as possible – use specificity codes

Ensure you are addressing and reporting/coding these conditions at least once per calendar year

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“Don’t Miss” Chronic Conditions

- DM & complications
- CHF
- COPD
- A Fib
- Morbid Obesity
- HTN & complications (HTN alone does not have a RAF score)
- Major Depression
- PVD
- Malnutrition

Use ICD-10 Appropriately I.E. as specific as possible

Provider’s role is to accurately capture the conditions that are treated, managed, or impact care

Coded conditions must be documented – i.e. “MEAT” – manage, evaluate, assessment, treatment plan

Accurate coding and documentation is critical to risk scoring and our future

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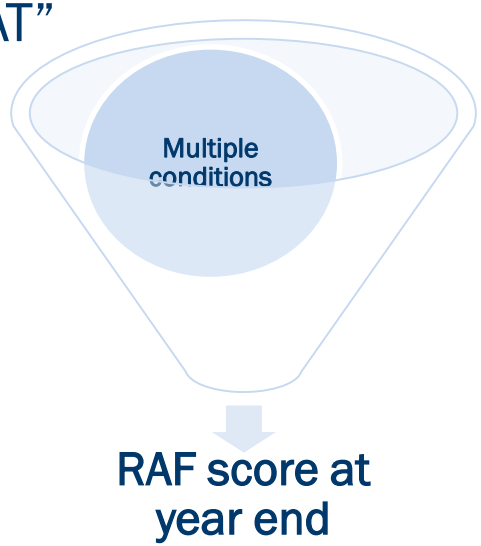
“MEAT” The Condition(s)

- Conditions billed
- Subject to random sampling to review documentation
- Documentation contains “MEAT”



Monitor
- Signs, symptoms, disease progression, disease regression

Evaluate
- Test results, medication effectiveness, results to treatment

Assess Address
- Ordering tests, discussion, review of records

Treat
- Medication, therapy, other modalities

Example: CHF symptoms well controlled with Lasix and ACE continue current doses

What Does And Does Not Risk Adjust

Does

- CKD stage IV & V
- Morbid Severe Obesity
- Angina, Unstable Angina
- Complete AV Block
- ASCVD with intermittent claudication

Does Not

- CKD Stage I, II, and III
- Obesity Unspecified
- Chest Pain
- AV Block 1st or 2nd degree
- ASCVD unspecified

Seeing a pattern?

Don’t code to a greater degree than you document!

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Patient Relationship Codes Voluntary Reporting in 2018

How Does This "Fit" into MACRA?	How Would We Report These Codes?	How Will CMS Use This Info and How Can It Impact Me?
Section 1848(r)(4) of MACRA requires that claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2018, include codes for the following: ***care episode groups** ***patient condition groups** ***patient relationship categories**	➢ Your relationship to the patient will be categorized and reported through claims beginning in January 2018 using Level II HCPCS Modifiers. ➢ The relationship codes are reported along with procedures to applicable episodes ➢ Reporting is voluntary for 2018 to provide us with an opportunity to learn how to do this correctly	• CMS plans to use these codes to attribute patients and episodes (in whole or in part) to one or more physicians/clinicians. • This information will allow CMS a systematic means of distinguishing the patient-clinician relationship to look at plurality of care, whether items/services are delivered as acute or non-acute, and to pin-point resource use (cost) during a care episode or for a patient condition

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Patient Relationship Codes

No	HCPCS Modifier	Patient Relationship Categories	
1X	X1	Continuous broad services	Clinicians who provide the principal care for a patient, where there is no planned endpoint of the relationship. Care in this category is comprehensive, dealing with the entire scope of patient problems, either directly or in a care coordination role.
2X	X2	Continuous focused services	Specialist whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.
3X	X3	Episodic/broad services	Clinicians that have broad responsibility for the comprehensive needs of the patients, but only during a defined period and circumstance, such as a hospitalization.
4X	X4	Episodic focused services	Specialist focused on particular types of time-limited treatment. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.
5X	X5	Only as ordered by another clinician	Clinician who furnishes care to the patient only as ordered by another clinician. This relationship may not be adequately captured by the alternative categories suggested above and may need to be a separate option for clinicians who are only providing care ordered by other clinicians.

All These Quality Metrics Take Longer!

- I can only see so many patients in my clinic each day – and I am under pressure to increase my wrvu/production
- I am so tired of "clicking" on my computer
- We have had to or need to hire more people to meet all these quality goals
- *What if you are already doing things you aren't being paid for, but if you tweak them a bit you could be billing them?*

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ACP – Advanced Care Planning

Advance care planning involves multiple steps designed to help individuals :

- a) learn about the health care options that are available for end-of-life care
- b) determine which types of care best fit their personal wishes
- c) share their wishes with family, friends, and their physicians.

- May be billed with an E/M on same date (pt copay will apply, attach 25 modifier)
- May be billed during service period of TCM, CCM, and within global surgical periods.
- May ***NOT*** be billed on same day as critical care, neonatal critical care or pediatric critical care

- Time based Code – Time must be met and documented

- Must be billed by physicians or NPP.
  - Incident to rules apply – requires direct supervision
  - "…accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services…"
- May be billed by any specialty in any place of service.
- Time you spend treating a condition does not count in the ACP Time

Remember this Friday when we talk about BPCI-A

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ACP: Time Based Service

- **99497** – *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other healthcare professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.*
- **99498** - *each additional 30 minutes (List separately in addition to code for primary procedure)*
- Medicare's FAQ #1 addresses the time requirement and references CPT guidance
- CMS has chosen to follow the CPT time guidelines for ACP, so 16 minutes is also the minimum time for Medicare billing.
- By CPT guidelines, a unit of time is attained when the mid-point is passed, which means that code 99497 can be reported only if the face-to-face service lasts at least 16 minutes.
- If the minimum time requirement is not met, CMS states in its FAQ document that the provider may consider billing a different evaluation and management code, assuming that the requirements for that code are met.

  The CPT manual states that "no active management of the problem(s) is undertaken during the time period reported." In other words, time spent managing the patient's medical problems cannot be counted as ACP time
- AS WITH ALL TIME BASED CODES – TIME MUST BE DOCUMENTED

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official Information Health Care Professionals Can Trust

Open a Text-Only Version

Advance Care Planning

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Table 3. Hyperlink Table, at the end of the document, provides the complete URL for each hyperlink.

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for **voluntary** Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS).

ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it. This publication includes:

- Information on how to code ACP services
- Provider and beneficiary eligibility information
- How to bill ACP services
- An example of ACP in practice
- Resources

Resource	Website
"Advance Care Planning: An Introduction for Public Health and Aging Services Professionals" (free course offering continuing education credit)	CDC.gov/Aging/AdvanceCarePlanning/Care-Planning-Course.htm

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Prolonged Service w/o Direct Patient Contact

- Effective 1/1/17
- 99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

  ** 99358- actually billed for the first 30 to 74 minutes
- 99359 each additional 30 minutes(List separately in addition to code for prolonged service)
- Prolonged service less than 30 minutes not separately reported
- ***This service can be reported for a different date than the primary service***
- Cannot be reported during same service period as Chronic Care Management or Transitional Care Management Services

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Prolonged service w/o face to face

Prolonged Service Office Codes for services W/O Direct Contact CPT Description
99358 Prolonged evaluation and management service before and/or after direct patient care, first hour
99359 Prolonged evaluation and management service, each additional 30 minutes (List separately in addition to code for prolonged service)

Total Duration of services	Codes
< 30 minutes separately	Not Reported
30-74 minutes	99358
75-104 minutes	99358,99359
105-134 minutes	99358,99359 X 2 Or more for each additional 30

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Who Can Provide Non-Face to Face?

Physicians or NPPs may furnish the following non-face-to-face services:

- Obtain and review discharge information (for example, discharge summary or continuity of care documents)
- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver
- Establish or re-establish referrals and arrange for needed community resources
- Assist in scheduling required follow-up with community providers and services

Licensed clinical staff under your direction may provide the following services, subject to the supervision, State law, and other rules discussed above:

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment regimen adherence and medication management
- Identify available community and health resources
- Assist the beneficiary and/or family in accessing needed care and services

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TCM – Transitional Care Management

- The requirements are intended to assist the patient with their transition back into their community post qualifying hospital discharges
- The provider accepts care of the patient post D/C and ensures care without a gap – they accept the responsibility for the patient's follow-up care
- Eligible patients are those who need this additional assistance and they have "medical and/or psychosocial problems that require moderate or high complexity medical decision making".
- The 30 day TCM period begins the day the patient is discharged from an inpt setting and continues for the next 29 days.

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TCM - What Are The CPT Codes?

- **99495** Transitional Care Management Services with the following required elements:

++ Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.

++ Medical decision making of at least moderate complexity during the service period.

++ Face-to-face visit, within 14 calendar days of discharge.

- **99496** Transitional Care Management Services with the following required elements:

++ Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.

++ Medical decision making of high complexity during the service period.

++ Face-to-face visit, within 7 calendar days of discharge.

How Do We "Bill" For TCM

- Just as with the service itself, there are requirements to billing for the service as well.
- Most importantly – The date of the required face to face service is the date of service to be reported on the TCM claim. You no longer need to hold the claim for 30 days – but you can not submit the code in advance of the face to face service being rendered.
  - Implementation Hint – have the provider select the TCM code on the day of the face to face visit versus the E/M code.
  - You will need a process to confirm the 2 day contact was documented.

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TCM - Reimbursement

- TCM services have a facility and non-facility reimbursement amount.
- The TCM code is not separately billable by RHC areas
- As a reminder – this INCLUDES the required face to face E/M
  - Other and add'l visits in the 30 day period ARE billable when necessary

- The "#" represents the non-facility rate

NOTE	PROCEDURE	MOD	PAR AMOUNT
	99495		156.30
#	99495		107.10
	99496		221.15
#	99496		155.12

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TCM – Additional Resources

- The MLN article and FAQ documents are very helpful

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But Wait…. There's More

- Maybe one of the best pieces about the TCM service besides the many benefits to the patient is that it very nicely converts to the CCM service – and even more patient benefits

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What is CCM?

- Comprehensive Care Management
  - Electronic, person-centered care plan tracking all health issues, periodically reviewed and updated
  - Ensure receipt of preventive services
  - Medication management and reconciliation
  - Transitional care management – facilitate and coordinate referrals and follow-up after ER or facility discharge
  - Coordinate with home- and community-based clinical service providers
- Timely sharing of health information within and outside the billing practice
  - Certified electronic health record (EHR)- structured recording of a limited data set
- Continuity of Care with Designated Care Team Member
- Enhanced Communication (e.g., secure patient email)
- 24/7 Access to Address Urgent Needs
- Advance Beneficiary Consent
- For complex CCM, moderately or highly complex medical decision-making by the billing practitioner

CCM: What Are The Codes

CCM	
CPT 99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month	
Complex CCM	
CPT 99487	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
CPT 99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

New In 2017 – Initiating Visit

- **G0506** - Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services billed separately from monthly care management services
- **This is a code providers are eligible to bill to account for the additional work that they may personally do.**
- CMS states "Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506"

Chronic & Complex Chronic Care Management

Common To Both

- Many of the guidelines are common to both categories of codes . Common elements include:
  - Pt at home, domiciliary, rest home or assisted living
  - Care management services available 24/7
  - 2 or more chronic conditions – place pt at significant risk of death, acute exacerbation/decomp or functional decline
  - A comprehensive care plan established, implemented, revised or monitored

Complex only – 60 minutes

- In order to qualify for complex, one or more of the following must apply:
  - Requires Moderate or High complexity MDM (defers to E/M definitions)
  - Need for coordination of a number of specialties or services
  - Inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the tx plan w/o substantial assistance from a caregiver
  - Psych and or other co-morbidities (i.e. dementia, COPD, DM) that complicate their care and/or
  - Social support requirements or difficulty with access to care

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CCM Coding Summary - Beginning January 1, 2017

BILLING CODE	PAYMENT (PFS NON-FACILITY)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
Non-Complex CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised or monitored	Ongoing oversight, direction and management
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction and management + Medical decision-making of moderate-high complexity
CCM Initiating Visit (AWV, IPPE, TCM or Other Face-to-Face E/M)	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Wait… We Aren't Finished Yet

- What if you could be reimbursed by almost every payor for the time you spend telling your patients to stop using tobacco products?
- What if you could be paid for then telling them they should also consider getting a LDCT scan?

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Smoking and Tobacco Use Cessation

- Limited to face-to-face services (also telehealth)
- This a distinct from an E/M service and may be reported separately – the 25 modifier would be attached to the E/M to signify a significant and separate service.
- These are time based services and time spent must be documented

99406 – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 – intensive, greater than 10 minutes

Tobacco Cessation Services

Who Is Covered ?

Outpatient and hospitalized Medicare beneficiaries for whom all of the following are true:

Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease	Competent and alert at the time of counseling	Counseling furnished by a qualified physician or other Medicare-recognized practitioner

Wait For It….

- What If I told you that while you have that smoker in the room
- You have already reminded them they need to quit
- You suggested a LDCT due to their smoking history
- You can also be reimbursed for that!

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Criteria for Coverage of LDCT Lung Cancer Screening Counseling Visit & CT

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

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G0296 Counseling and Shared Decision-Making

- Part B deductible and co-ins waived
- Covered 1 x a year (at least 11 months must have passed in between)
- ICD 10 code Z87.891 Personal history of nicotine dependence is the **ONLY Covered Code**

- Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section1861(aa)(5) of the Act)

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Written Orders For Subsequent Annual LDCT Screens

- Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:
- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The National Provider Identifier (NPI) of the ordering practitioner.

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OK – Now I am Out Of Time

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CVSL

- What is it?
- What services does it cover?
- How is it governed?
- What is a clinical co-management agreement?
  - Do I have to be employed to have a CCM?

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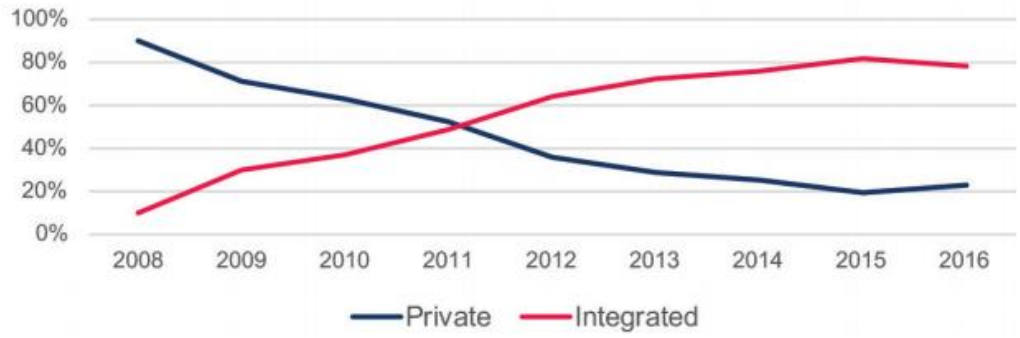
Trend Towards Integration: A Deeper Dive

The shift toward integration is particularly complex and requires cardiovascular practices to be adept at responding to market trends.

Private vs Integrated Ownership

- About 80% of CV practices are integrated as of 2016.
- The market in the last decade has dramatically shifted from private ownership to integration. Only recently has the ratio of private versus integrated practices stabilized.
- While the overall trend is clear, the shift is complex practice by practice. A recent review revealed that many hospitals increased, decreased, or even vacillated between models.

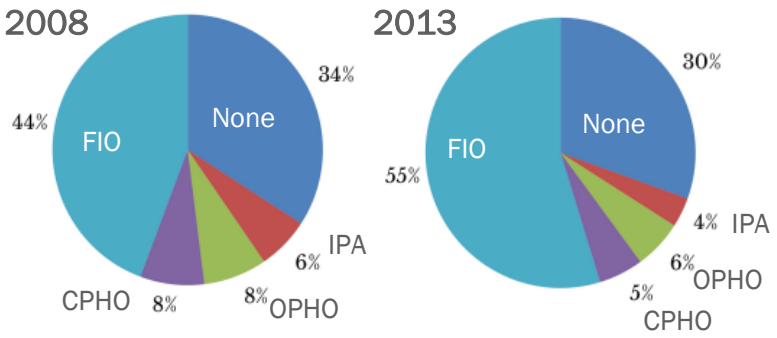
Private vs Integrated Ownership Ratio, CV, 2008-2016[1]



Level of Integration

- In an American Hospital Association (AHA) survey, most hospitals were either fully integrated or not integrated at all.
- There was an increase in the number of fully integrated hospitals and a decrease in the number of hospitals with no integration.
- About 15% of hospitals utilized intermediate forms of integration, such as Independent Practice Associations (IPAs) or Physician Hospital Organizations (PHOs).

Number Of Hospitals by Level of Integration, 2008-2013[2]



None: No Integration; **IPA:** Independent Practice Association; **OPHO:** Open physician-hospital organization; **CPHO:** Closed physician-hospital organization; **FIO:** Fully integrated organizations

[1]*Copyright MedAxiom. Cardiovascular Provider Compensation & Production Survey, MedAxiom, 2017.* [2]*The Integration and De-integration of Physicians and Hospitals Over Time, Rice University Center for Health and Biosciences, 2017.*

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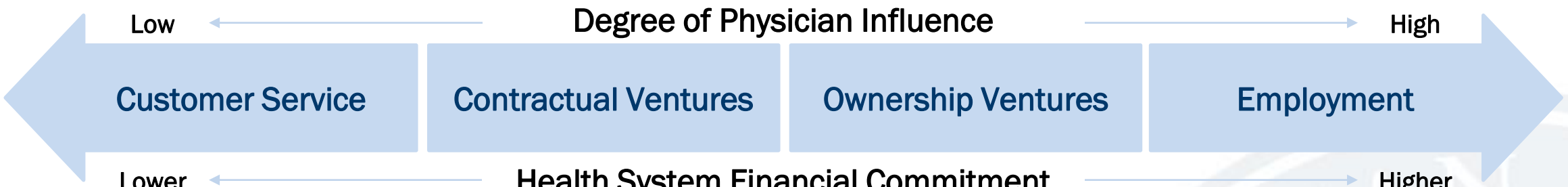
The Integration Continuum



	Customer Service	Contractual Ventures	Ownership Ventures	Employment
Description	Physician-hospital alignment though EMR technology	Developing a contract with physician/groups to purchase services or provide services	Risk and benefit sharing between a health system and physician(s)/groups to form and operate as a common enterprise	Hospital/health system employs physician
Examples	• Equipping community physicians with hospital's EMR system	• Professional Services Agreement (PSA) • Physician-Hospital Organization (PHO) • Co-management Agreement • Management Services Organization (MSO) • Clinical Integration Program	• Joint ownership between hospital/health system and physicians typically for ambulatory surgery centers, imaging facilities, etc.	• Direct employment by hospital • Practice acquisition

Adapted from A Guide to Physician Integration Models for Sustainable Success, Signature Leadership Series, Kaufman, Hall and Associates Inc., Health Research & Educational Trust, 2012.

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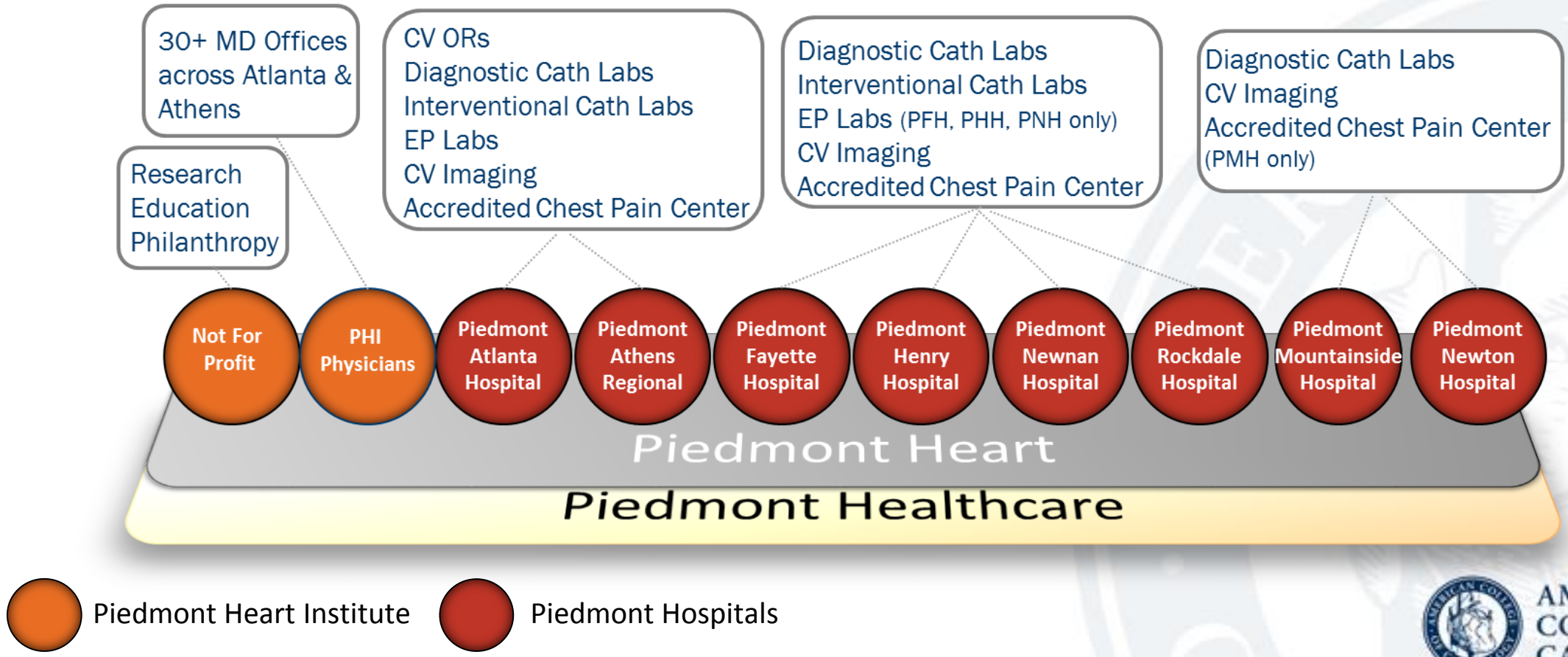
CCM Agreements

- Scope
- Governance
- Financial
  - At risk/quality/operational efficiencies
  - Leadership/admin/directorships

Case Study: Piedmont Heart Institute (PHI)

PHI was founded 2007 by blending 3 cardiology practices into one Institute. PHI has spent 10 years building a strong foundation to embrace the changing landscape of healthcare.



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Case Study: Piedmont Heart Institute (PHI)

The CV Service Line is comprised of the Piedmont Heart Institute and the CV services at all 8 Piedmont Hospitals.

Piedmont Heart Institute

PHI is the **Cost Center:**
- Operates at a **loss**
- Functions as the system's **investment** in CV

The investment includes:
- Over 95 MDs and 142 APPs in 30 offices
- Practice employees, operations, and professional fees
- Research and education, including the employees and investments needed for these programs

+

Piedmont Hospitals

Piedmont Hospitals are the **Profit Center:**
- Generates **Revenue**

The hospitals encompass:
- CV services at 8 hospitals, including staff, equipment and supplies, and technical revenue

=

Contribution Margin for CV to the hospitals and to the system

System-Wide CV Service Line

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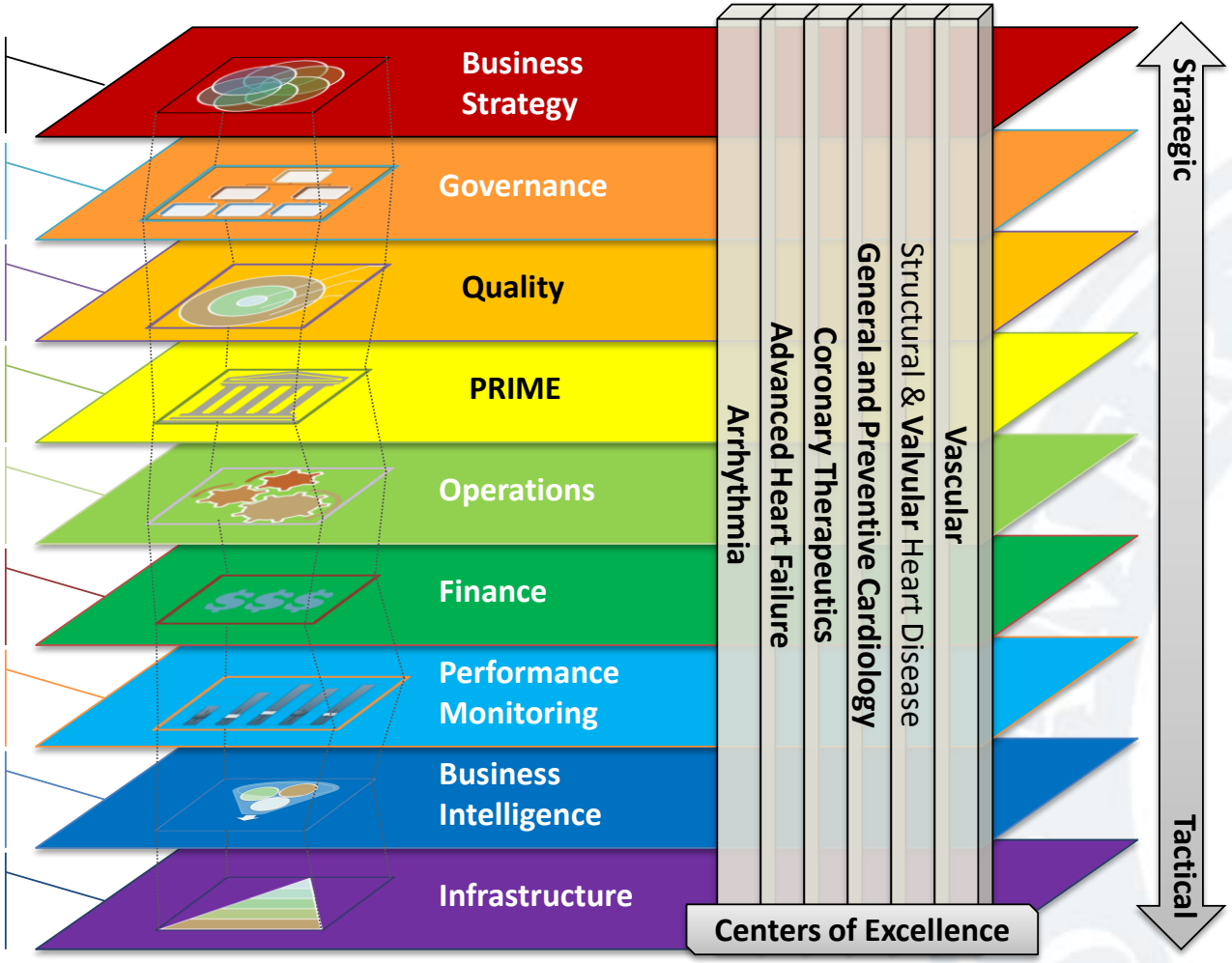
Case Study: Piedmont Heart Institute

PHI physicians and administrators work together from the strategic to the tactical.



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Case Study: Piedmont Heart Institute

Where has alignment gotten us?

Infrastructure

- Dyad Leadership – Physician and Administrator
- Organized in patient-centric COEs providing a comprehensive continuum of care
- CVSL integration across the PHC system
- Quality program
- CIT expansion

Brand and Reputation

- Cutting-edge programmatic growth: STEMI programs at PFH, PHH, EMC; CTO program (world's busiest); TAVR program
- Marcus Grant for Marcus Valve Center
- Lead enrollers in Research: (EXCEL, SYMPLICITY)

Value

- More than doubled the Cardiovascular contribution margin to the health system since 2008
- Reducing clinical variation through the Pathway Development team

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Break Time ….. Please!

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Primer on QPP

- More alphabet soup
- Timeline
- Resources

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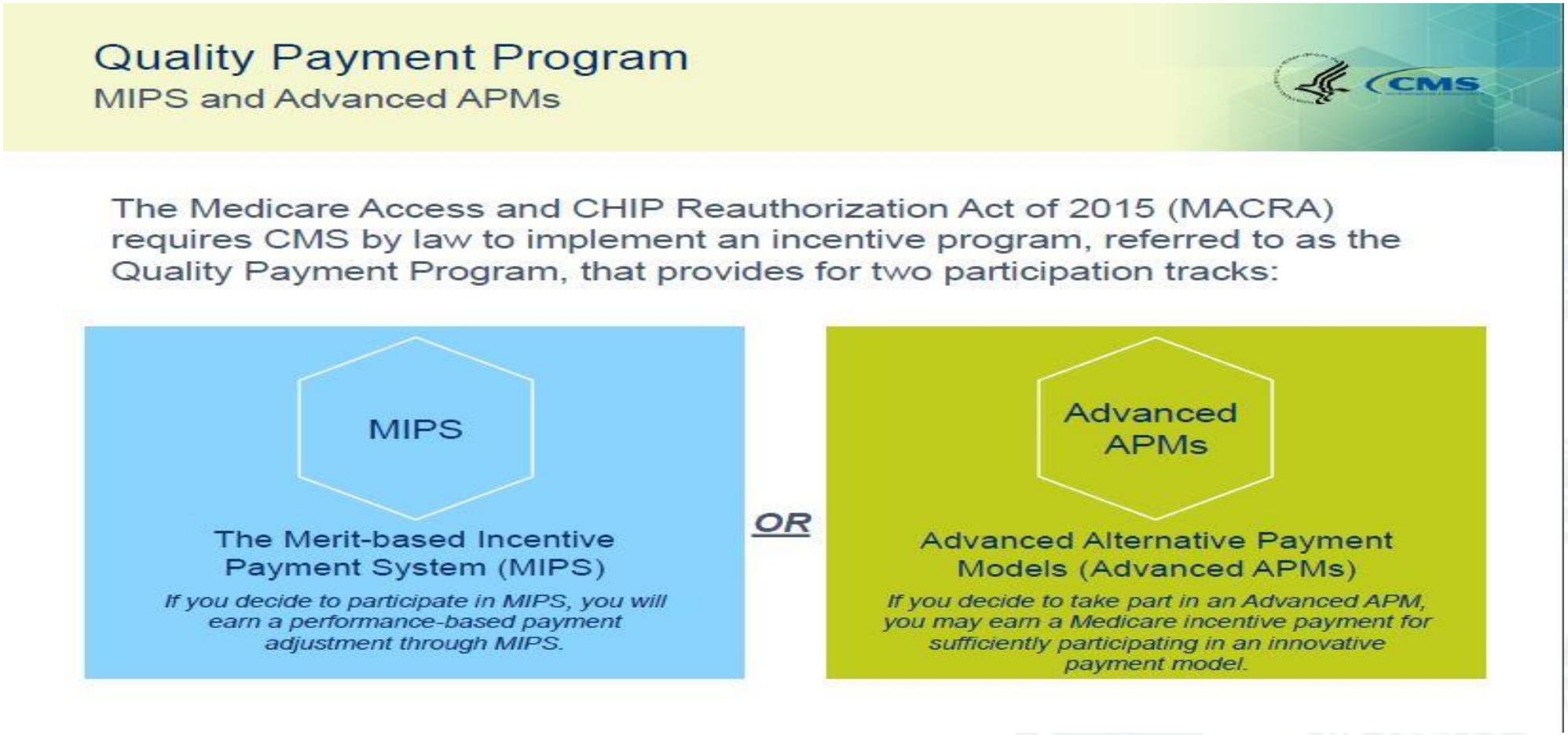
Basics of QPP



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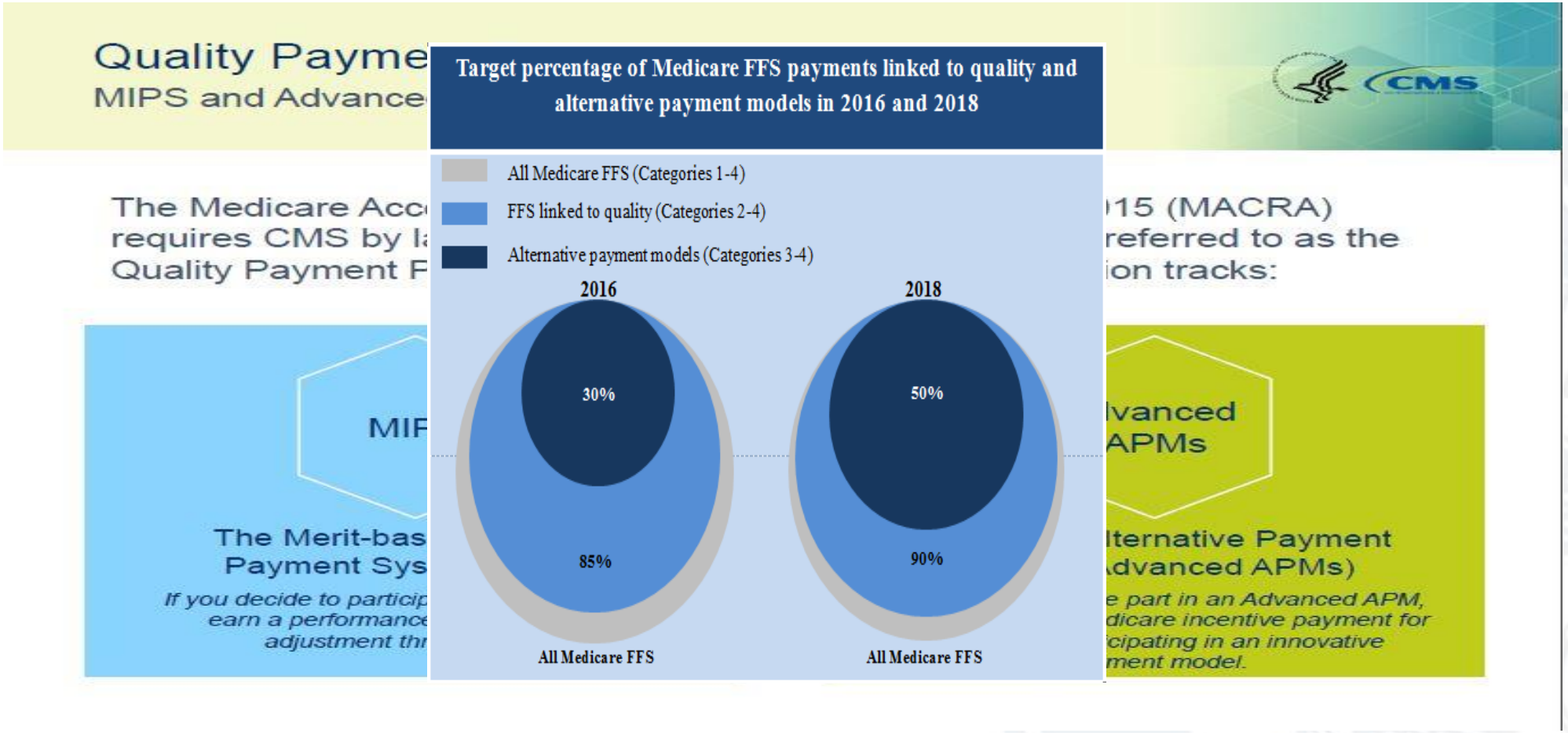
Basics of QPP



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Merit-based Incentive Payment System (MIPS)

Quick Overview

Combined legacy programs into a single, improved program.

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Basics of QPP

Participation Status

Included in MIPS

RICHARD JOSEPH KOVACS **must submit data to MIPS** by March 2018. This clinician will need to report as an individual or with a group.

What Can I Do Now? >

Clinician Details

RICHARD JOSEPH KOVACS, MD

1447215777

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Basics of QPP

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What has ACC done on your behalf?

- MACRA hub on acc.org
- Health Affairs Committee
- Partners in Quality
- Alternative Payment Models
- Qualified Clinical Data Registries

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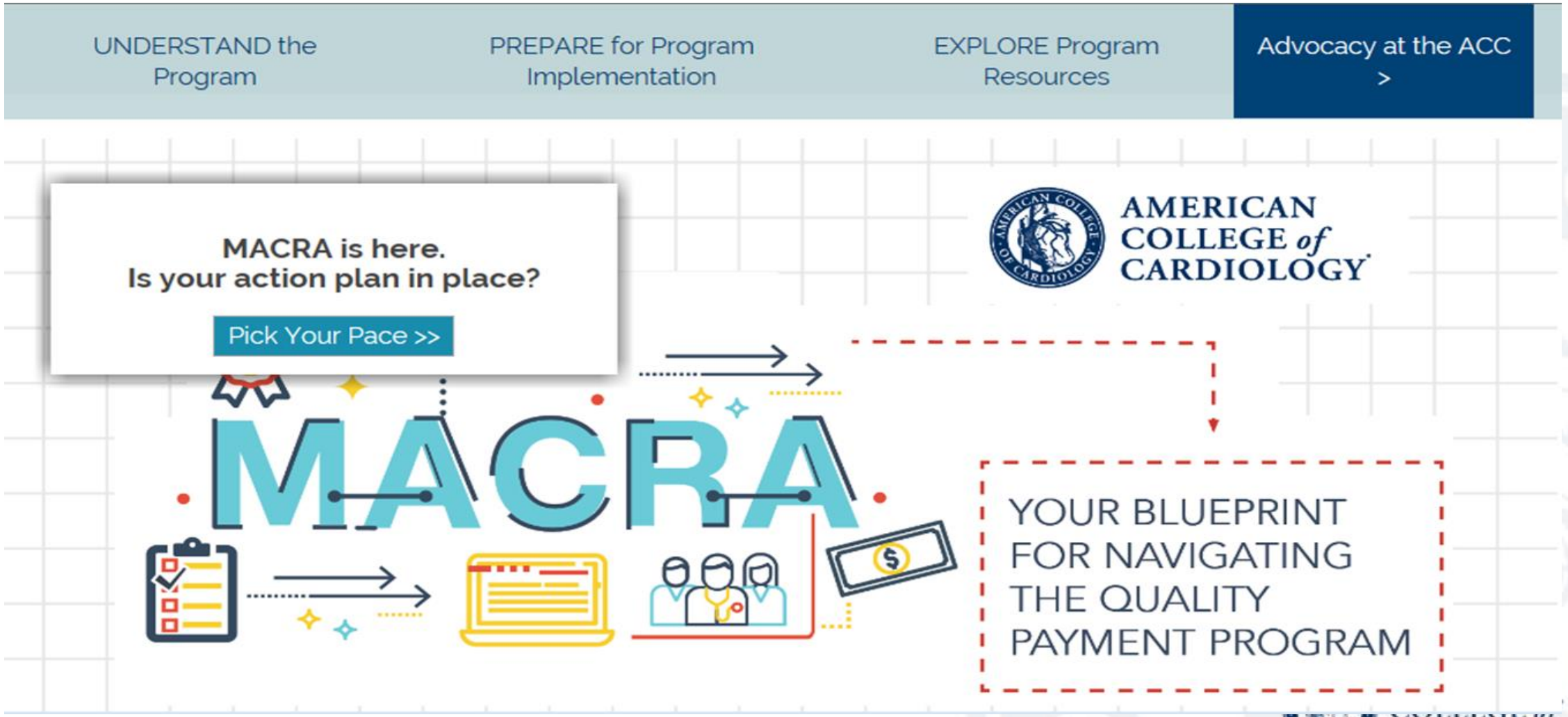
ACC MACRA HUB



In Case You Are Wondering….

This is NOT the correct response

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Episodes of care - historical

- 1990's Bundled payments CABG
  - Successful in reducing cost, improved quality, and provided services more efficiently
- ACE project: tested bundled payments in early 2000's
  - Cardiac and ortho
  - Ortho widely successful
  - Medicare savings while maintaining quality
- BPCI: CMMI project
- LAN – proposed but not implemented to date
- Ortho Mandated bundle – pulled back a bit

Where are we: 2/22/18

- Mandated CMS bundles:
  - 8/16/17:
    - Scaled back for ortho
    - Cardiac was cancelled
  - 1/9/18 – are they back ??
- Alex Azar, Health and Human Services nominee, advocated for **mandatory pilot programs** as part of efforts to **transition physicians and hospitals to value-based care models**
  - **Statement as part of confirmation hearings**
  - Last week it seemed clear that Voluntary Bundles would be the way to go, however……

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What constitutes an episode

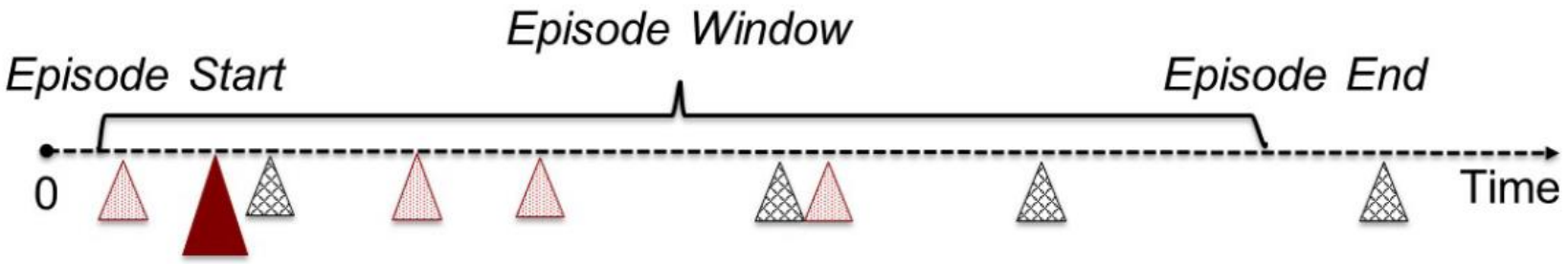
- Billing claim indicates the presence of one of the episodes or procedures
- Clinically relevant services are then “allocated” to one or more episodes
  - Tx, care for s/s, complications, tests, post-acute
- Part D is normally not included
- Episode groupers are becoming more and more relevant
  - Part of ACA

Basic episode

Trigger Event (Step 1)

Clinically Relevant Service Grouped to Episode (Step 2)

Service Not Grouped to Episode



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Voluntary Bundle aka BPCI-A

- 1/9/18 – The release of BPCI –Advanced
  - BPCI: Bundled Payments for Care Improvement
  - Original BPCI:
    - 1,600 current participants in the 4 models of BPCI
    - Retrospective bundled payment model: actual expenditures reconciled against a target price – semi-annual measurement

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BPCI - A

- Completely voluntary
- Will qualify as an Advanced APM (if thresholds met)
  - financial risk, CEHRT, quality
- 32 Episodes released – 29 inpt. and 3 outpt.
- Inpatient Cardiac episodes:
  - Acute myocardial infarction - CHF
  - Cardiac arrhythmia - CABG
  - Cardiac defibrillator - Pacemaker
  - Cardiac valve - PCI
- Outpatient: PCI and cardiac defibrillator

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Comp

- When you have seen one comp model – you have seen one

Monday ….back at the office

Overview

- Keep the new Value agenda in mind
- Compensation plan is not a distribution plan
- There are no guarantees
- The plan has to have relevance & facilitate goal alignment
- It must migrate to a common platform
- Set a “take home” amount that is sustainable
  - Provide physicians with stability

Critical Elements

- Identify key call elements
  - EP call
  - Interventional
  - Call in when not on call
- Value it
- Define call wind-down
- Define retirement path
- Define disability

Physician comp and value

- Is it really ever going to happen? Or has it happened?
  - Comp aligned with strategy
- Alignment of new market realities
  - Quality
  - Outcome
  - Patient experience
- Failure to align will increase the risk of penalties for overutilization
- How much should be at risk??

What is Changing

- Will be paid and graded on:
  - Coordinated Care / Preventative Care
  - Efficiency
  - Outcomes
  - Quality metrics
  - Patient Engagement
- Payment will be achieved thru:
  - Episodes of care
  - APM's

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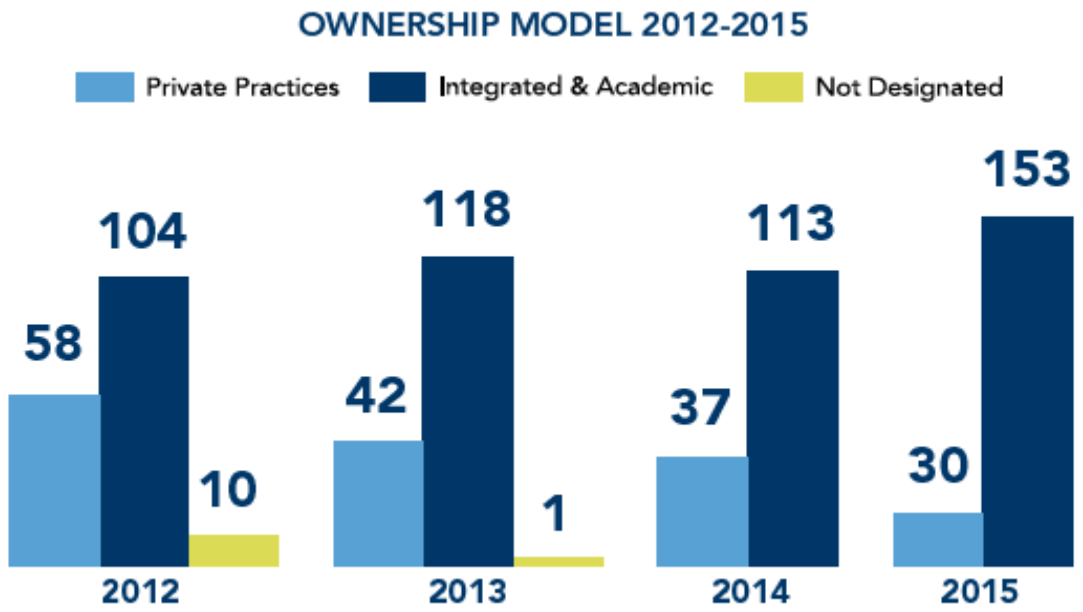
What stays the Same (sort of)

- Volume still matters:
  - From providing a Lot services to patients
  - To providing services to a Lot of patients
  - The more patients you do/can service the more attractive you will be to insurers, employers, etc.
  - Larger Patient Panel = dilution of risk
    - Utilization analyzed via patient panel
  - Scale matters to insurers
    - Single point of contact & coordination of care

Ownership Trends



Medaxiom 2016

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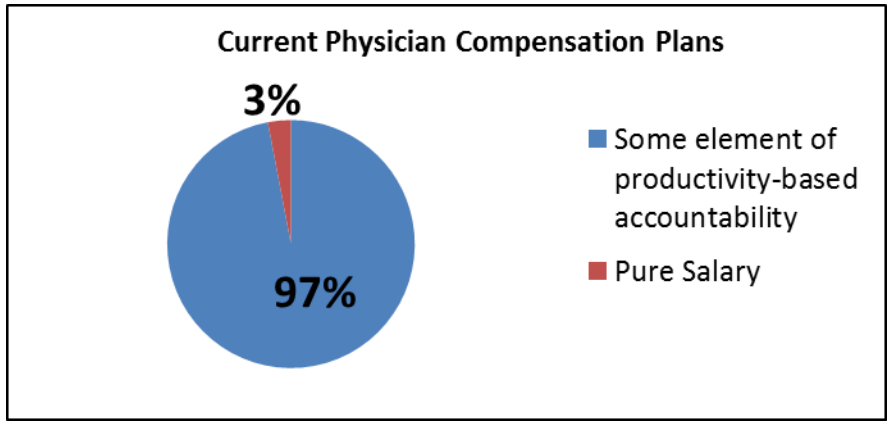
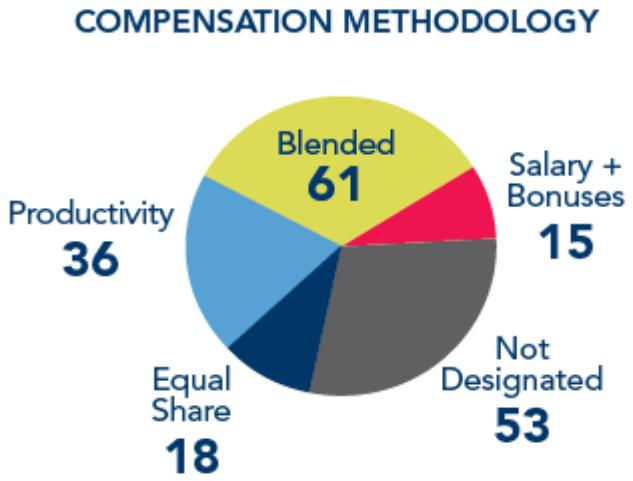
Has the pendulum swung?



Source: Strategy-Aligned Physician Compensation Plans, Health Care Advisory Board, 2009).

Medaxiom 2016



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Harvard Business Review:

- Michael Porter and Tom Lee:
  - “The transition will be neither linear nor swift, and we are entering a prolonged period during which providers will work under multiple payment models with varying exposure to risk.”[3]

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Components of Value-Based Compensation

Base Compensation
+
Call
+
Production Value Compensation
+
Group Performance Based At-Risk Compensation
=
Physician Total Compensation

Aligned Incentives Reward Results

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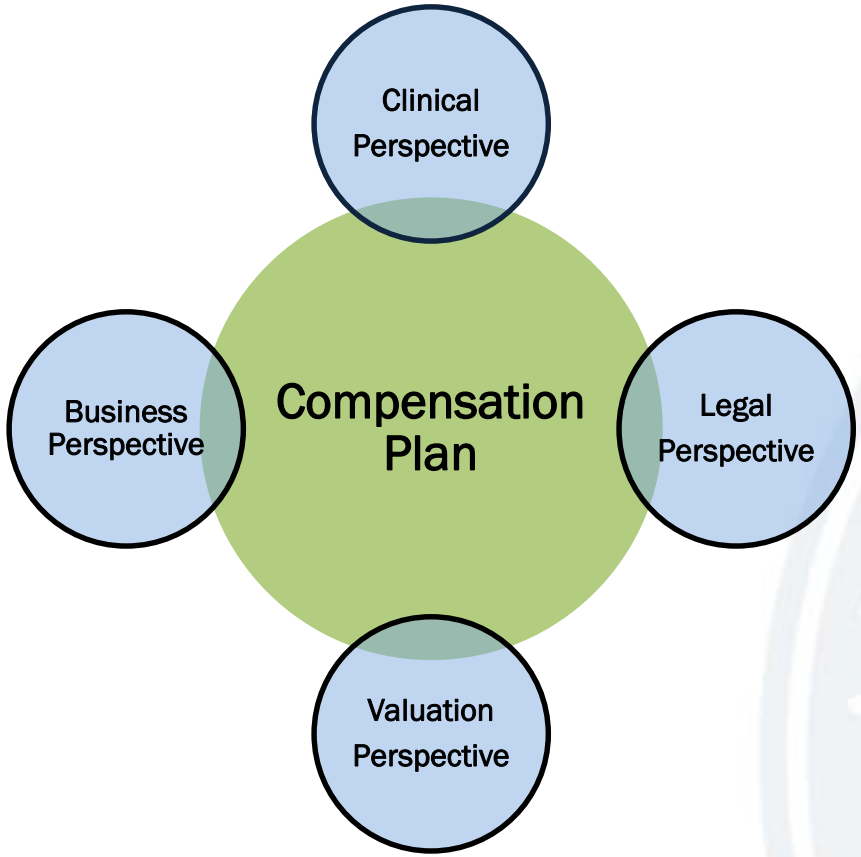
Designing a Comp Plan



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What is important……

Hierarchy of Outcomes Measures that Matter to Patients[6]

Tier	Description	Outcome Measurement Examples (based on a procedure like hip replacement)
Tier 1	Health Status Achieved or Retained (survival, degree of health or recovery)	Mortality Rate Functional level achieved Ability to return to work
Tier 2	Process of Recovery (time to recovery, disutility of care or treatment process)	Time to return to work Occurrence of deep vein thrombosis Occurrence of myocardial infarction
Tier 3	Sustainability of Health (recurrences, long term consequences)	Maintained functional level Presence of regional pain syndrome Susceptibility to infection

Guiding Principles

- The compensation plan must have ***relevance*** in the currently emerging Value Based Economy payment model
- The compensation plan must ***facilitate goal alignment*** of the physicians with each other, as well as the physicians with the health system
- The compensation plan will ultimately ***incentivize physician performance required to execute the cardiovascular service line strategic plan***
- The compensation plan will, to the extent possible given the current transformational nature of the healthcare industry, provide ***physician's economic stability***

Are You Ready……

- Last but not least…….

COMPLIANCE

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Sample Comparative Report – Testing

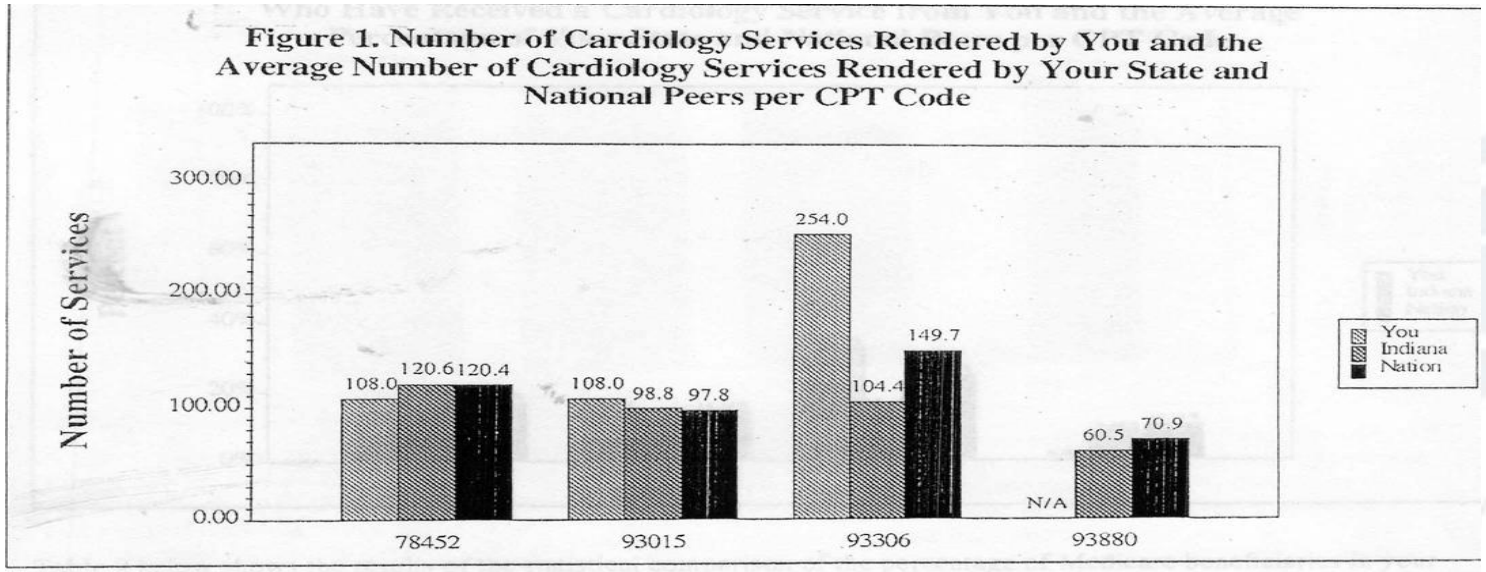

Table 1 below shows the results of the statistical comparison of the number of cardiology services rendered by you to the average number of cardiology services rendered by your state and national peers per CPT code. A statistical test was used to determine if there was a significant difference between the number of cardiology services rendered by you and the average of your state and the nation.

Table 1. Statistical Comparison of the Number of Cardiology Services Rendered by You to the Average Number of Cardiology Services Rendered by Your State and National Peers per CPT Code

	You	Indiana			Nation		
CPT Code	Number	Number	Difference	Significance*	Number	Difference	Significance*
78452	108.0	120.6	-12.6	within the norm	120.4	-12.4	lower
93015	108.0	98.8	9.2	within the norm	97.8	10.2	higher
93306	254.0	104.4	149.6	higher	149.7	104.3	higher
93880	N/A	60.5	N/A	N/A	70.9	N/A	N/A

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Top Billing Errors: It's Not Just E/M

E/M Coding

- Comprehensive ROS – 10 systems
- PFSH – Missing a family or social Hx
- Detailed exam on level 3 hospital F/U
- Consultation codes still accepted by most commercial payors

Intervention

- Understand AMI code
- Make distinction between CTO and 100% occlusion
- Use the bypass code if you go through a graft to a native artery
- Use two primary procedure codes for two different arteries

Electrophysiology

- LA catheter is billable with SVT ablation
- Understand use of the secondary arrhythmia codes in ablations
- Watch for errors with ambulatory monitoring, 24 hr, 72 hr, 7 day, MCOT

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CERT – Comprehensive Error Rate Testing (Goal: Estimate accuracy of payments)

- The CERT Documentation contractor requests medical records from the provider or supplier that submitted the claim (several follow-up requests may be made by letter/fax/phone depending on the response or nonresponse)
- Additional documentation requests are also made to the referring provider who ordered the item or service

If no documentation is received within 75 days of the initial request, the claim is classified as a “no documentation” claim and counted as an error

- CERT Reports and Supplementary Appendices https://www.cms.gov/Research-Statistics-Data-andSystems/Monitoring-
- Provider Website
- https://www.certprovider.com/
- Payment Accuracy Website https://paymentaccuracy.gov/

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TPE – Targeted Probe and Educate Audits

- The TPE review process includes three rounds of a prepayment probe review with education. You may be released from further review after any round if your documentation shows the required improvement. If there are continued high denials after three rounds, WPS GHA will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

- This letter serves as notice that you have been selected for a TPE claim review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason of Review

Your facility was selected for review based on . .

A prepayment review has been initiated to probe a sample of 20-40 claims billed with the following code(s):

- CPT 99221-99223 – Initial Hospital Visit Evaluation and Management Service

Additional Documentation Requests

- Please do not send any documentation at this time. The claims processing system will notify you of the Additional Documentation Request (ADR) for each claim selected for review. The ADR will include a list of suggested documentation needed to support the service on review. Please ensure the process for routing ADRs to the person(s) responsible for submission is timely and effective. Inform your staff responsible for receiving the ADR letters and submitting the required documentation of this review.

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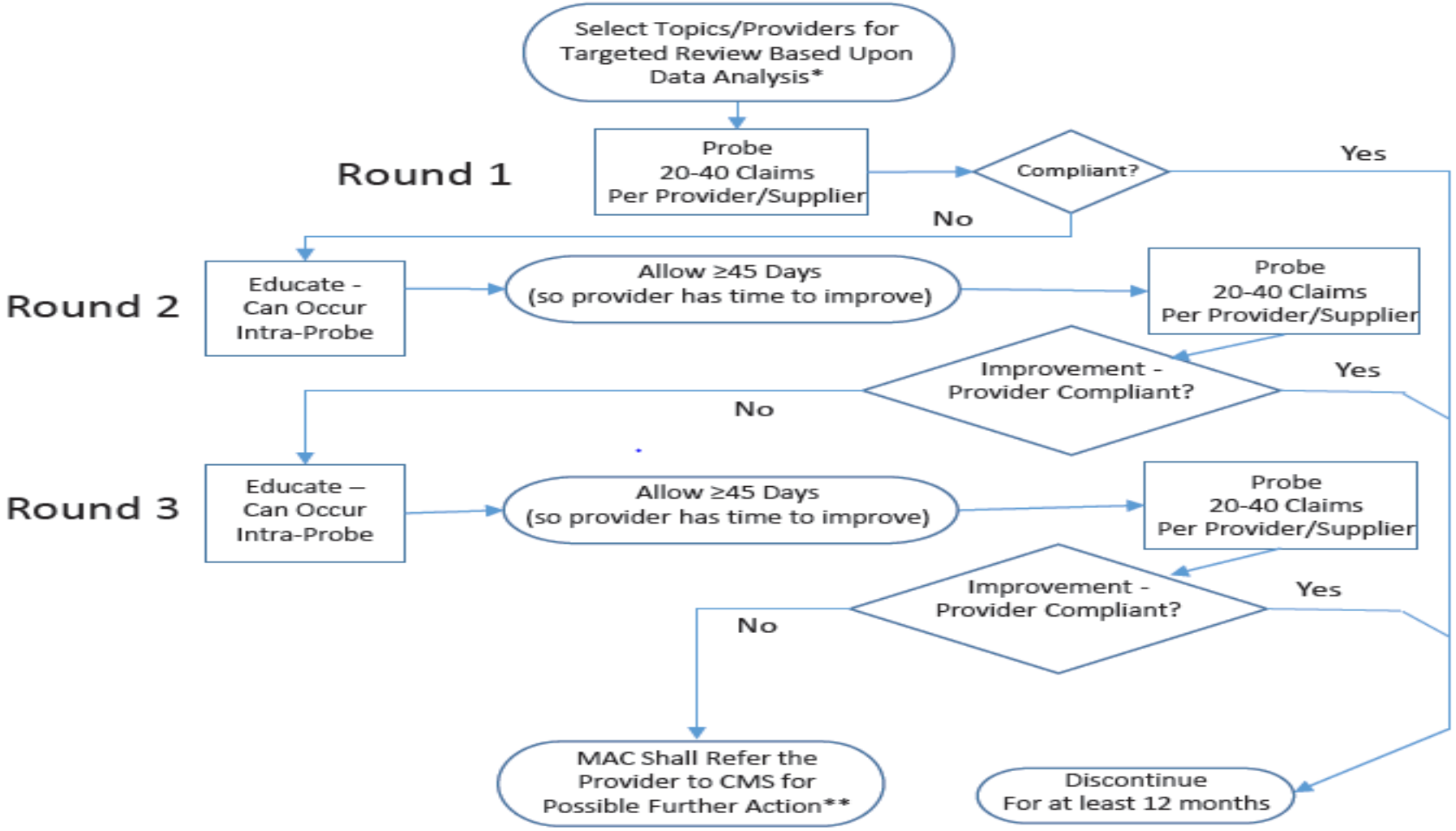
Targeted Probe & Educate Audits



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CBR – Comparative Billing Report

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

What is a CBR?

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

Why did I get a CBR?

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.

What should I do with this CBR?

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

Do I need to reply to explain my utilization?

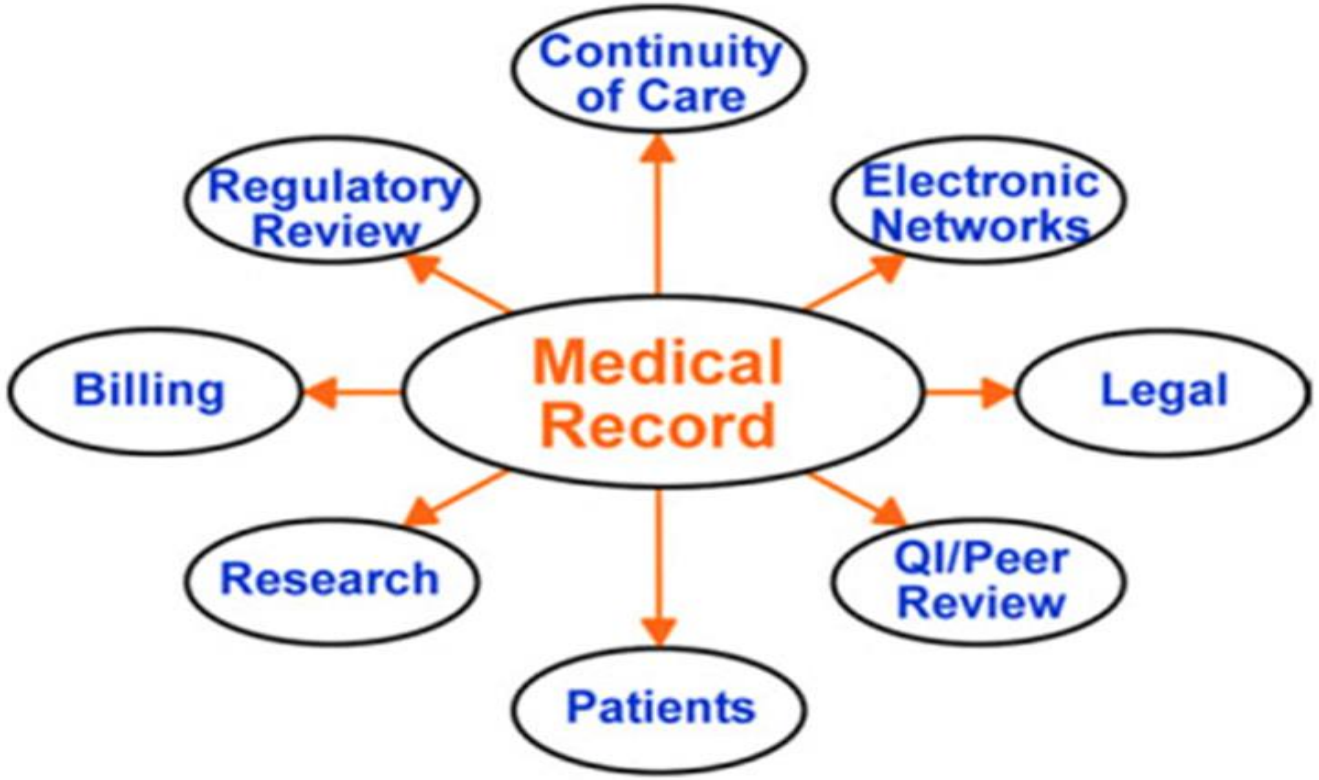
- No reply is necessary, as this report is for educational purposes.

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Excuse me Provider, but your data doesn't look correct to us.

Documentation In The Medical Record

Care Team Communication!



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Top Cardiology E/M Errors - From This Auditor's Perspective

1) Less than 10 systems in a ROS when a comprehensive history is required
2) Missing a family or social history when a comprehensive history is required
3) Billing at a high level of medical decision making when the code is better as a moderate
4) Not having the required exam elements on a hospital level 3 follow-up visit
5) Problems with "incident to" (office setting) documentation
6) Problems with "split/shared" visit documentation in the hospital setting
7) Visit does not clearly identify a "significant and separate" condition on the day of a procedure or within a global period
8) Not clearly documenting the consultation request when the consult code is billed (valid for most Commercial Payors)
9) Conflicting information in the HPI versus the ROS with electronic medical records
10) Not clearly documenting the patient's "new pt" status

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Cloning – Copy/ Paste Inaccurate Info?

- Maintain the integrity of your patient encounter – be sure to update for accuracy on each patient encounter
- Per the Centers for Medicare & Medicaid Services (CMS), “Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries”

Per the OIG:

- Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient’s medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims.
- Overdocumentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider, may be inaccurate. Such features can produce information suggesting the practitioner preformed more comprehensive services than were actually rendered

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MAC – Medicare Administrative Contractors

- 23 MAC Contractors versus 51 in 2011
- 15 Part A/Part B vs 25 Part A (FI's) and 18 Part B (carriers) – Working now to reduce to 10 MACs
- 4 data centers vs 16 data centers
- **It was no accident that the HIPPA transactions codes and NPI numbers were put in place first**

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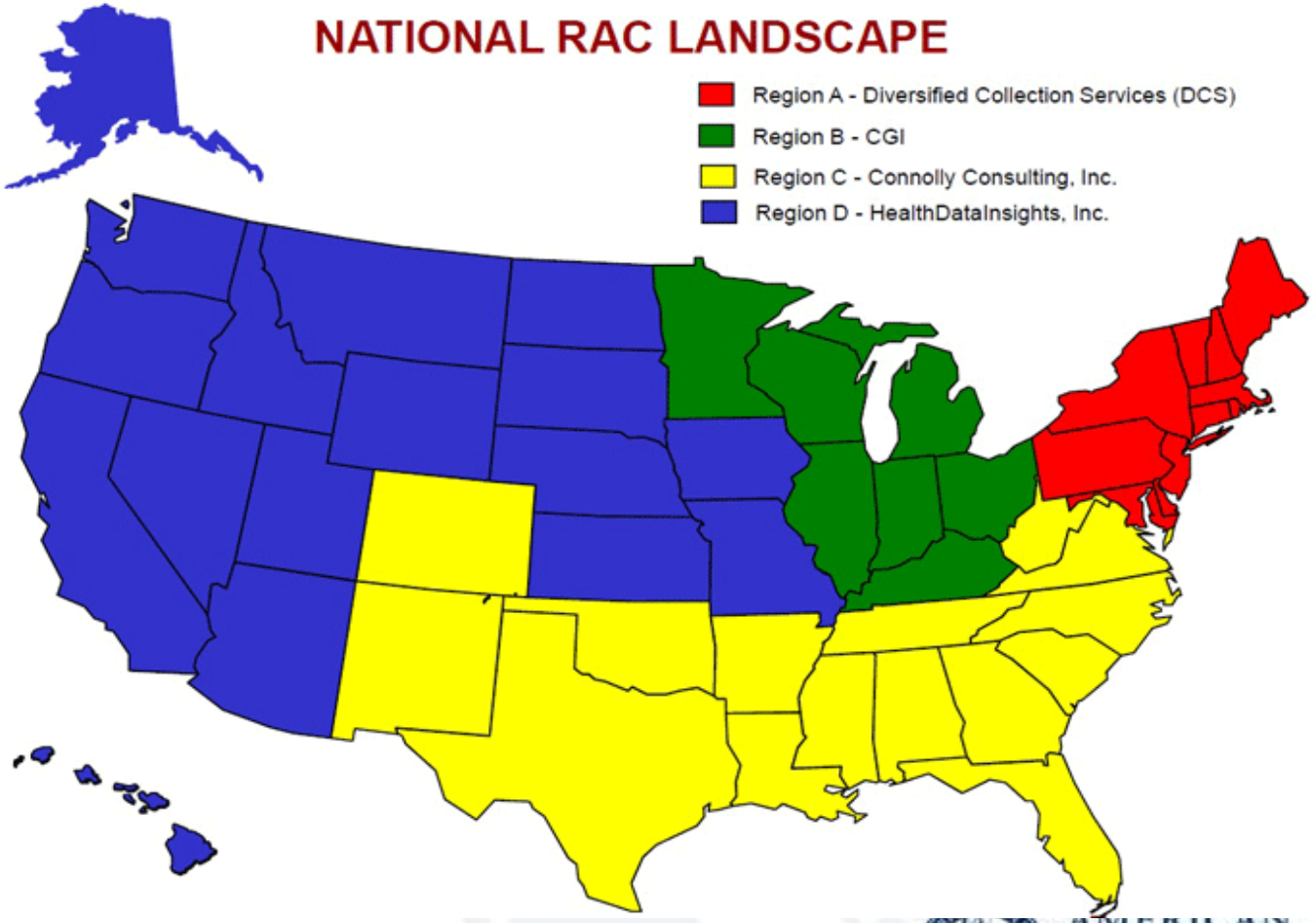
Recovery Audit Contractors (RAC)

- Created by Congress to help the CMS identify and correct improper payments made by Medicare and Medicaid.
- Initial demonstration (2005 – 2008) and was a huge success.
- RAC program became permanent as a result and is now active in all 50 states



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Who Are The RACs?

- Four private companies: CGI Federal, Connolly, HealthData Insights, Performant Recovery
- Paid on contingency basis
- New modifications to reduce provider burden, create more oversight and transparency
  - Limits on additional documentation requests (ADRs)
  - Delay auditor contingency fees until 2nd level of appeal is exhausted
  - Restrict review timeframes

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RAC Reviews

- Use OIG and GAO reports to help identify vulnerable areas
- Use claims data and "proprietary techniques"
- Required to "post" CMS approved list of projects/focus (You can review focus areas on their web sites)
- Must follow guidelines established by local MAC and or CMS Nat'l when available
- Free to apply their own criteria if other guidelines are not available

2 Primary Types Of Review

- 1) **"Automated review"** – involves data analysis and does not require a medical record review – will just send a refund request for what appears to be a clear error on the claim
- 2) **"Complex review"** – requires medical record review and common focus is medical necessity

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Bigger Budgets – We Have A Winner Here!

- FY 2015 – Congress more than doubled HCFA Fraud & Abuse efforts budget to $672 million
- With the $8.10 return on every $1 spent – they anticipate generating more than $54 billion
- OIG Civil penalties - $2 million in 2011
  - $14.4 million in 2014 – OIG initiated
  - Plus $23 million in self disclosures
- Whistle blower suits:
  - 30 in 1987
  - 300-400 a year 2000 to 2009
  - Over 700 a year in the last two years

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STOP Medicare Fraud

U.S. Department of Health & Human Services and U.S. Department of Justice

Where can you go for more information?

Stopmedicare/fraud.gov

- **About the Senior Medicare Patrol**
- The Senior Medicare Patrol (SMP) is a group of highly trained volunteers who teach others about health care fraud.
- Protect our citizens' health
- Protect their health benefits
- Strengthen Medicare and Medicaid

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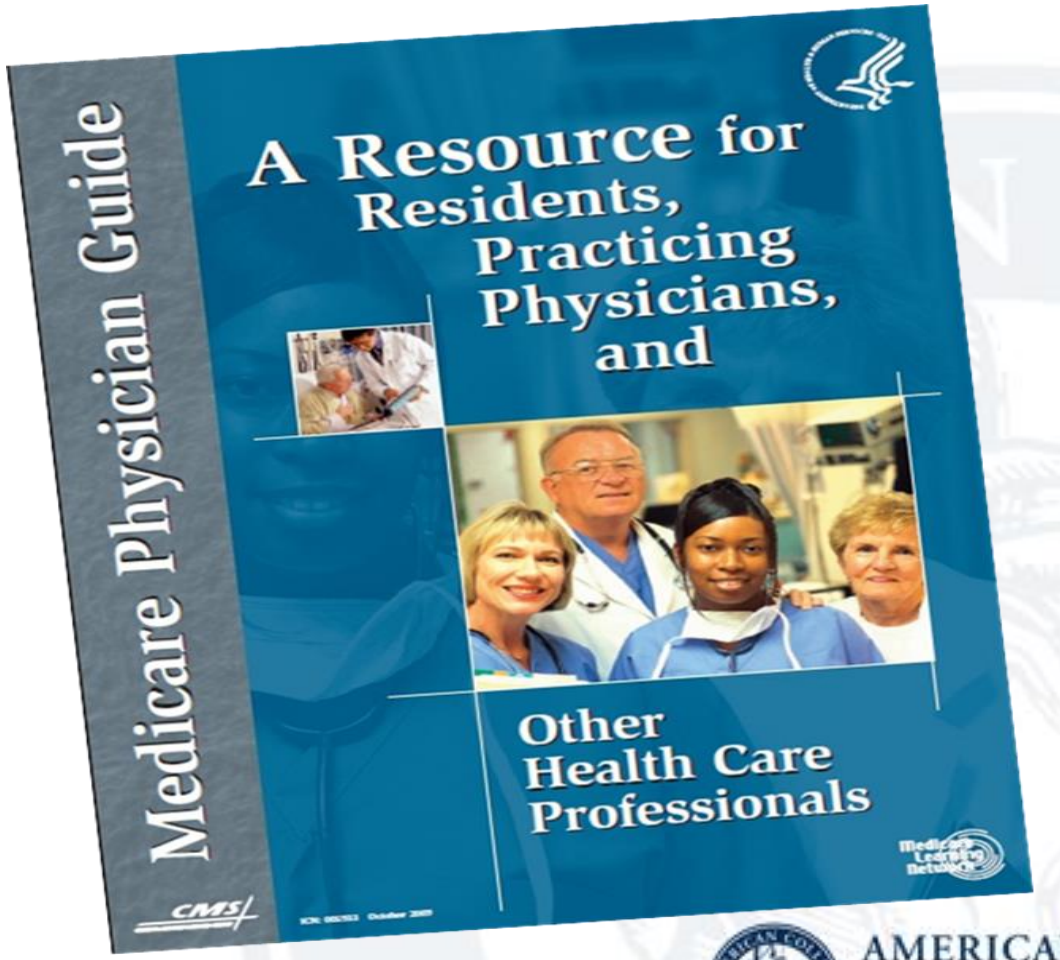
CMS Educational Info For Providers

- There are lots of resources available to you

- Especially if you need some late night reading



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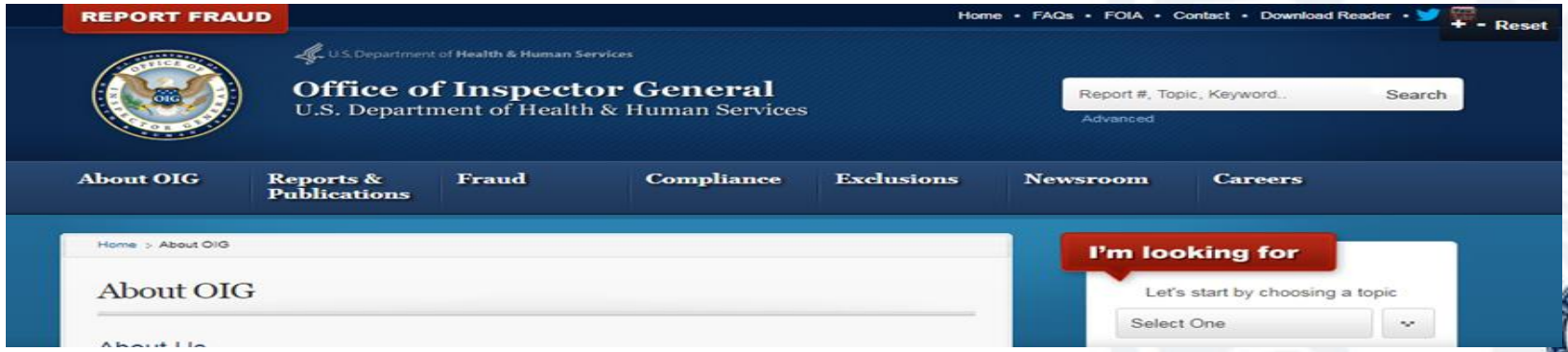
Where Eagles Fly…OIG.hhs.gov

What We Do

- We carry out our mission using a multidisciplinary, collaborative approach, with each of our six components playing a vital role.
- A nationwide network of audits, investigations, and evaluations results in timely information as well as cost-saving or policy recommendations for decision-makers and the public. That network also assists in the development of cases for criminal, civil and administrative enforcement.
- OIG develops and distributes resources to assist the health care industry in its efforts to comply with the Nation's fraud and abuse laws and to educate the public about fraudulent schemes so they can protect themselves and report suspicious activities



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OIG.hhs.gov/compliance

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OIG Training

- Provider Compliance Training
- Compliance training widget Below are links to free training for health care providers, compliance professionals, and attorneys. OIG's Provider Compliance Training was an outreach initiative developed as part of HHS's and the U.S. Department of Justice's Health Care Fraud Prevention and Enforcement Action Team.
- Videos and Audio Podcasts
- Webcast
- Presentation Materials

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Pharmacy and Device Company Relationships & "Sunshine Act" To "Open Payments"

- Interactions with industry are under an increased focus
- Bottom line – we can not accept a "service of value" or something that would be considered a "normal business expense" from someone we are in a potential referring relationship with
- There is national momentum behind public reporting of all financial "gifts" on a per provider basis - "Sunshine Act".

2 reports

- 1) Payments and transfers
- 2) Ownership and investment interests - Initial public data release was in 2014

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Go to : CMS.GOV/open payment

Search yourself

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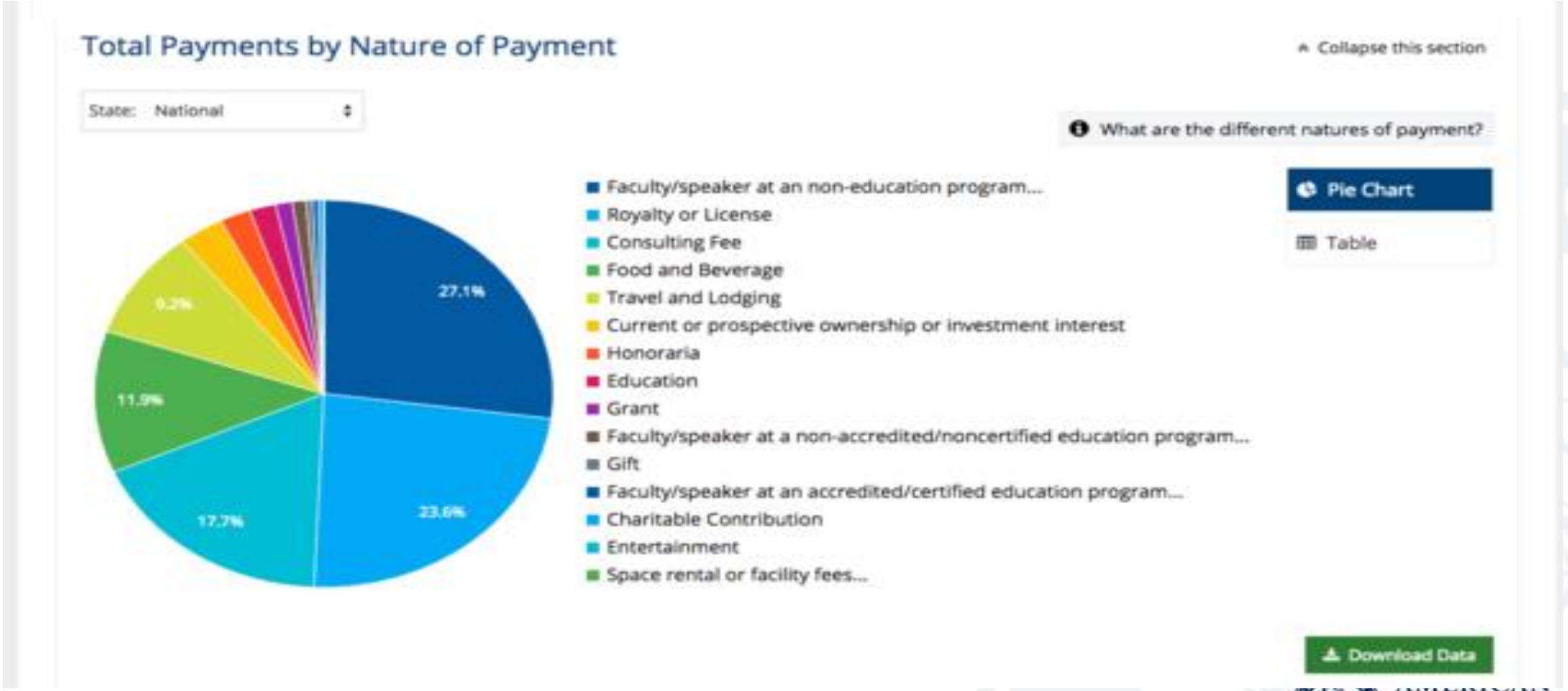
Nature of Payments



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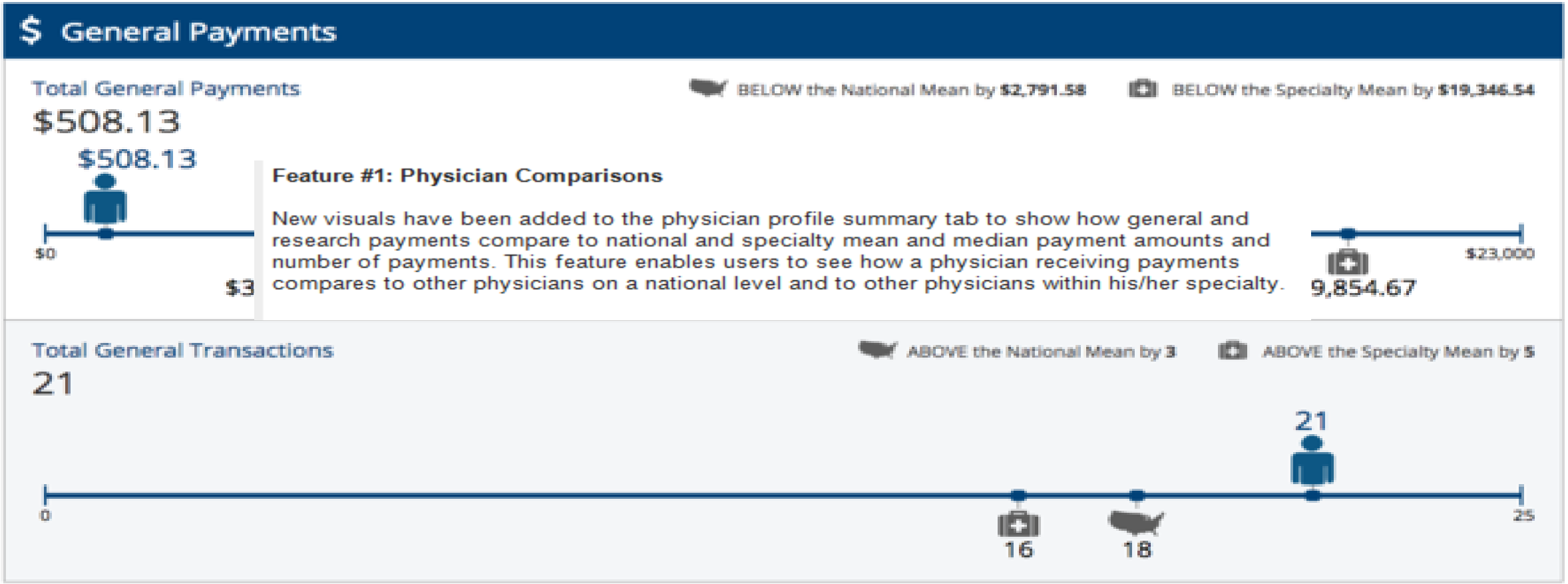
Provider Comparisons



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CMS Data Release

We Aren't Finished Yet….

CMS Comments

- An April 2015 CMS blog from Johnathan Blum:

  "harnessing the power of data"
  - This represents the first of it's kind so far as publically available physician coding and payment data
  - Go to www.cms.gov – Medicare Provider Utilization & payment data
  - Excel files by provider last name
  - FAQ – questions the physician's privacy – "Public interest outweighs the privacy interests"
  - 10 page report with detail on data and sources

Then There Are The Attorneys

- Within hours they were "on it" (Reuters April 2014)
- "A small fraternity of lawyers who specialize in representing whistle blowers in healthcare fraud cases began to mobilize."
- The database link was sent to the entire 400-lawyer group under the heading "Have Fun!"
- One is quoted as commenting he used to have to rely on his client's personal knowledge and subpoena governmental agencies for supporting documentation – Now I have the data at my fingertips

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Compliance In Action

- What would your internal reviews, corrective actions, education logs, audit results etc. show?
- Do you have the documentation necessary to show you have an active and effective compliance program?
- A compliance program isn't something that should just sit in a binder on a shelf
- Have you performed a risk assessment and developed a plan to review high risk areas?
- Are you promoting a culture of compliance?
- Would discussion on compliance concerns be evident in your Board minutes?

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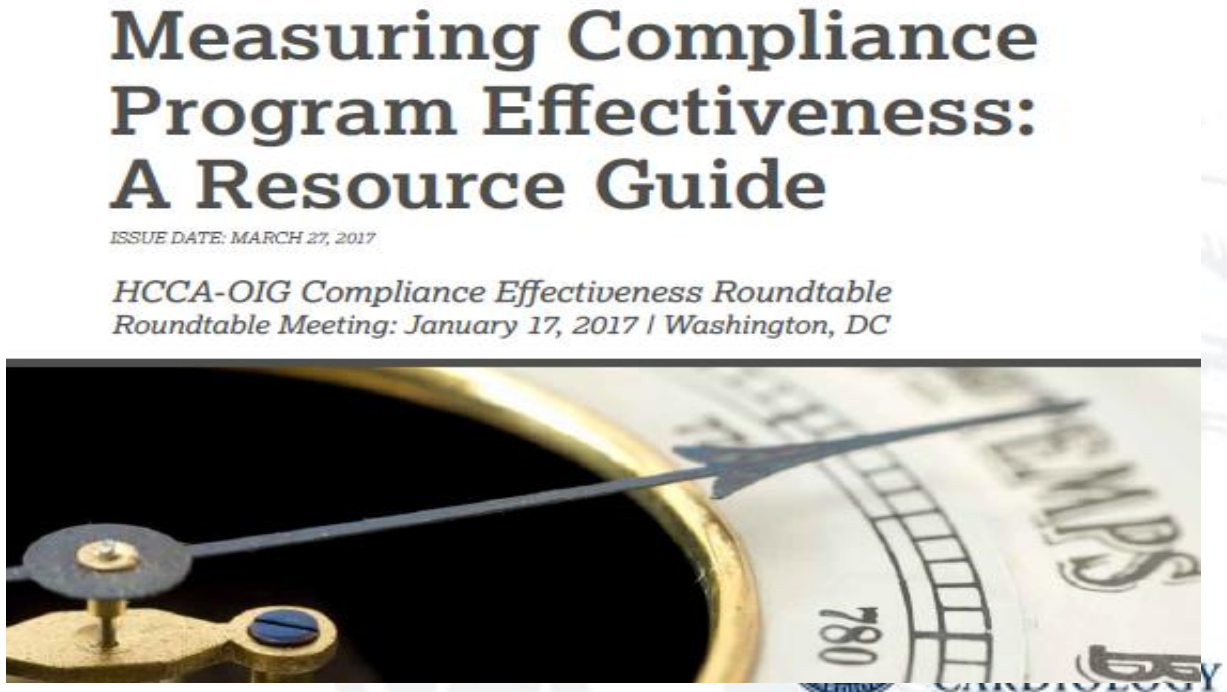
HCCA-OIG Effectiveness Guidance

1. *Analysis and Remediation of Underlying Misconduct*
2. *Senior and Middle Management*
3. *Autonomy and Resources*
4. *Policies and Procedures*
5. *Risk Assessment*
6. *Training and Communications*
7. *Confidential Reporting and Investigation*
8. *Incentives and Disciplinary Measures*
9. *Continuous Improvement, Periodic Testing and Review*
10. *Third-Party Management*
11. *Mergers and Acquisitions*

Released Early in 2017 – This is the first of it's kind guidance on assessing the effectiveness of compliance programs



Medical Directors – OIG Special Fraud Alert – June 9, 2015

- Focuses on compensation arrangements with medical directors
- Have you reviewed and documented:
  - How they are chosen?
  - How the compensation is determined?
  - Are you tracking duties and performance?
- Administrative approval for all arrangements
  - Fair market value
  - Appropriate business justification
  - Meets all legal requirements
  - Does it need to be updated?
  - Keep detailed duty tracking records
  - Stay on top of all space, & equipment leases

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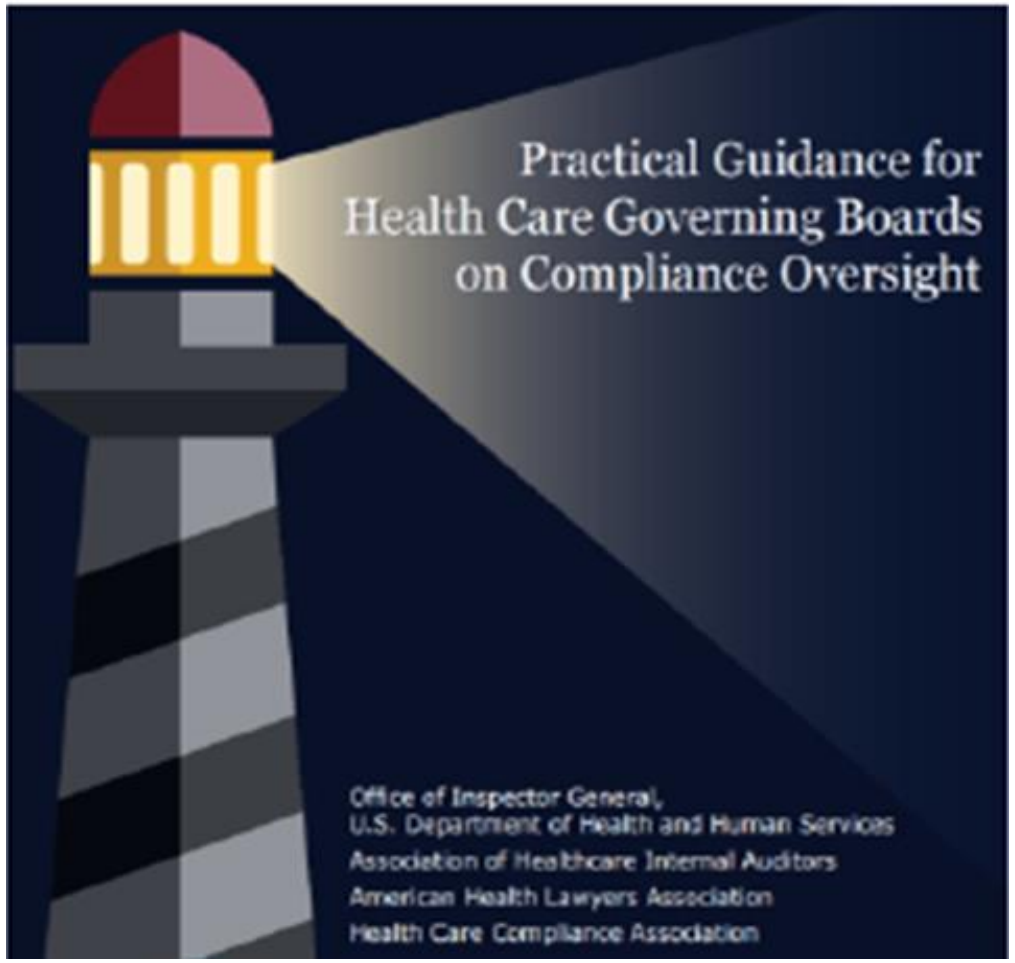
OIG Guidance For Boards



- Document the board's compliance oversight responsibilities
  - Includes the board asking the right questions
- Document education/discussion of high risk areas
- Document open communication and assessment of compliance program

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Time for the main show

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