Insights and actions for successful results

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What Hospitals Need to Know About ZPIC Audits

By Gary Keilty and Kristen McDonald

Although all CMS payment audits should be taken seriously, a ZPIC audit poses the potential threat of a federal fraud investigation.

In recent years, the Centers for Medicare & Medicaid Services (CMS) has increased the number of program contractors that review provider claims and payments (see the sidebar on page 2). The alphabet soup of CMS contractors can be confusing because they all share responsibility for identifying potential overpayments and conducting pre- and post-payment audits.

A recent federal decision further empowers these contractors. They now have the authority to determine payment error rates that, in turn, may justify extrapolation of alleged error rates to the universe of claims beyond the original sample (*Gentiva Healthcare Corp. v. Sebelius*, No. 1:11-cv-00438, D.C.Cir. July 23, 2013).

ZPICs contract with CMS to perform a unique role and responsibility. Although audits by other CMS contractors may result in a provider's obligation to refund previous payments, a ZPIC audit may expose a provider or supplier to potential liability for fraud. Indeed, ZPICs function as the fraud detection arm of the Medicare Administrative Contractors (MACs) and are tasked with identifying instances of potential fraud that may result in large overpayments and/or referral to other government

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agencies, such as the Office of Inspector General (OIG), for further investigation.

A document request by a ZPIC should trigger immediate involvement of a provider's in-house counsel, outside counsel, and compliance department. To understand the unique and serious risks associated with a ZPIC audit, providers should be aware of ZPIC audit triggers and paths, action steps to take in the event of a ZPIC audit, and strategies for challenging ZPIC findings.

ZPIC Audit Triggers and Paths

ZPIC audits are typically not random. Rather, ZPICs conduct inquiries because they have identified a potential fraud concern through various triggers.

Audit triggers. ZPICs often operate somewhat in "the shadows," by using provider payment and utilization data collected by MACs, CMS, and private provider data collection entities to identify possible anomalies, such as high utilization of certain services in relation to local and national patterns, billing trends, and lengths of stay, among others. ZPICs also review referrals of potential fraud from sources like patient complaints (whether made through the OIG's hotline or directly to the ZPIC) and referrals from other CMS program integrity contractors (such as RACs and MACs). In addition, ZPICs often consider general fraud alerts issued by CMS or the OIG as issues ripe for provider data analysis.

Audit paths. ZPICs may initiate pre-payment or post-payment audits with little or no notice to the provider. In both types of audits, the ZPIC reviews a sample of the provider's patient record information. Once initiated, audits usually take the following path:

> Formal request for patient record information
> Interviews with beneficiaries and provider employees
> Review of patient record information and determination of potential overpayments
> Use of statistical sampling to extrapolate the amount of an alleged overpayment based on an error rate within the sampled claims
> Referral of an extrapolated overpayment amount to the provider's MAC for processing of a payment demand letter

A ZPIC may refer its findings to the OIG without the provider's knowledge if the ZPIC's review supports the initial allegation of potential fraud.

Action Steps in the Event of an Audit

Due to the potential serious consequences of a ZPIC inquiry, once providers become aware of a ZPIC inquiry, the following action steps are recommended:

Designate a point person. One person within the organization should be designated to coordinate all responses to the ZPIC's requests. Ideally, this individual should work closely with legal counsel on all actions responsive to the ZPIC's requests. This will help ensure a coordinated collection effort, timely submission, and early involvement of legal counsel. It will also afford the provider the protection of the attorney-client privilege should potential fraud issues be identified.

Conduct an independent data analysis. A prompt, independent data analysis of requested patient record information

A Guide to CMS Payment Review Program Contractors

MACs. Medicare Administrative Contractors (MACs) serve as providers' primary point of contact for enrollment and training on Medicare coverage, billing, and claims processing. They also conduct pre-payment audits.

MICs. Medicaid Integrity Contractors (MICs) contract with CMS to conduct audit-related activities for state Medicaid programs.

RACs. Medicare Recovery Audit Contractors (RACs) are charged with identifying improper Medicare fee-for-service payments—both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect.

ZPICs. Zone Program Integrity Contractors (ZPICs) function as the "fraud detection" arm of the MACs and are tasked with identifying cases of potential fraud that may result in large overpayments and/or referral to other government agencies, such as the OIG, for further investigation.

Robert Fromberg
Editor-in-Chief

Karen Thomas
Senior Editor

Amy D. Larsen
Production

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To submit an article, contact Karen Thomas at kthomas@hfma.org.

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will help determine data/document commonality, time periods, trends, and the type of patient and procedure involved, thereby shedding light on the focus of the ZPIC's review and identifying potential liability. Once again, involvement of counsel is critical to maintain the attorney-client privilege as it relates to the independent data analysis results.

Review the requested patient records. An independent review of the records can help determine a likely error rate, if applicable, and project the potential overpayment amount that may eventually be calculated by the ZPIC.

Ensure availability of information. Collect and provide all available information to support the appropriateness of the requested patient record or claim submitted for payment. Unintentionally omitting certain information in record requests may result in errors that affect extrapolated overpayment amounts or potentially strengthen the allegation of fraud.

Open communication channels with the ZPIC. Proactive outreach to the ZPIC, with involvement of legal counsel, may promote open communication during the investigation and appeal process.

Protect repayments. If applicable, ensure that any repayments, including extrapolated overpayments, related to a particular audited claim and/or patient are protected from additional overpayment requests in the event of a subsequent RAC audit.

Strategies for Challenging ZPIC Findings

Although options are limited once a ZPIC initiates an audit, time frames and attack strategies are key elements to consider when challenging the ZPIC's findings.

Mind the time. Pay close attention to deadlines and time frames. Immediately calculate the deadline to submit an appeal because a missed deadline translates to a lost appeal right. Calendaring a response deadline is particularly important for post-payment reviews because there is a small window of opportunity to stay any recoupment during the first two phases of the appeal process (i.e., 30 days at the redetermination phase and 60 days at the reconsideration phase). Be aware that interest continues to accrue throughout the appeal process, and recoupment cannot be stayed at third and higher levels of appeal.

Pre-payment reviews pose different risks because they can drastically and negatively affect a provider's payment pipeline.

Pre-payment reviews pose different risks because they can drastically and negatively affect a provider's payment pipeline. It is advisable to develop contact persons associated with the contracting agencies to track the status of pending appeals, especially if the contractors have not issued a decision within the regulatory 60-day requirement. Be prepared for a long appeal process for both types of reviews; each level of appeal may take months, if not longer, to conclude.

Consider all angles of attack. When appealing, consider both procedural and substantive attacks. Procedural attacks, for example, may focus on whether the ZPIC provided sufficient information about the grounds for its decision, in compliance with the *Medicare Program Integrity Manual*. Substantive attacks, on the other hand, may focus on challenging extrapolation to a universe of claims beyond the original audited sample, refuting the clinical findings, and/or asserting legal arguments, including those available under the Social Security Act, among others.

From the financial standpoint, focusing on methods to attack an extrapolation may limit the provider's liability to an actual overpayment, which is often a mere fraction of the extrapolated overpayment.

To attack an extrapolation, consider engaging a statistical expert to analyze the definition of the universe, the sample selection method, and the statistical accuracy of the sample, among other evaluations. Also consider whether the statistical expert makes a good witness, because if an appeal reaches the Administrative Law Judge (ALJ) level, ALJs often find credible, personable statisticians to be very useful in analyzing an otherwise complicated issue.

The Importance of Preparation

To mitigate the potential financial and legal consequences of a ZPIC audit, providers should familiarize themselves with ZPIC audit triggers and paths, know the action steps to take in the event of an audit, and be prepared to contest ZPIC findings in a strategic way. As healthcare costs and reimbursement continue to come under scrutiny in the years ahead, ZPIC and other types of payment reviews are likely to increase.

Gary Keilty is managing director, Huron Consulting Group, Washington D.C. (gkeilty@huronconsultinggroup.com).

Kristen McDonald is a healthcare partner, Jones Day, Atlanta (kmcdonald@jonesday.com).

By Dawne Clark and Margaret Dowling

Reconciling Patient Payments Across a Multi-Site Physician Practice

After revamping how it manages patient payments, a multi-site Philadelphia physician practice is now identifying deposit discrepancies within 24 hours.

When an internal audit suggested that better controls were needed for payments collected by physician offices associated with Jefferson University Physicians (JUP), a multi-specialty physician practice consisting of the full-time faculty of the Medical College of Thomas Jefferson University, the physician business services office built an automated process for daily and monthly reconciliation of cash, credit card, and check deposits.

Built at minimal cost, using Microsoft Excel® spreadsheets and standard bank reporting tools, the new process has made daily cash reconciliation part of the physician network's culture, and has virtually eliminated deposit discrepancies across the network of 650 physicians and 61 practices.

Identifying the Issues

When the JUP management team evaluated their organization's deposit procedures, they identified a number of areas for improvement. Cash payments from patients were not clearly identified in the bank deposit process, making it hard to track cash collections by practice location. Reconciliation of bank deposits to a list of patient encounters in the patient accounting system was inconsistent, resulting in deposit discrepancies and a difficult month-end cash reconciliation process. Research for internal audits involved file cabinet searches for paper documents.

With some help from its bank partner, JUP outlined a project that would bring about the needed business process improvements:

- Identify over-the-counter deposits from all sources by JUP practice ID.
- Identify deposits by type (cash, check, or credit card).
- Require daily and monthly reconciliation of over-the-counter deposits by all practices.
- Make the daily reconciliation process easy for practice business office staff.
- Provide a central database of deposit data by practice, for use by the physician business office during month-end reconciliations, for other purposes such as practice collection trending, and for use by the internal audit department when needed.

The first step was to uniquely identify each bank deposit. New deposit tickets were ordered for the physician practices. Each set was encoded with a three-part location identifier containing the division number, the practice location number, and a deposit ticket sequence number. Practices were required to make separate daily bank deposits for cash and checks, allowing cash deposits to be isolated and tracked.

Improving the Credit Card Process

Increased security surrounding patient credit card payments and the timing of credit card deposits makes reconciliation of these transactions difficult. With the bank's help, the physician business office implemented a process to collect patient account numbers at the same time as patient credit cards are processed. Practice registration staff were prompted to enter the patient account number into the credit card terminal when the credit card was swiped. These data then appeared on a report accessible online by the physician business office, facilitating reconciliation to the patient accounting system.

In addition, all credit card terminals at physician offices were mapped to practice location numbers, using a custom table on the bank's platform. Deposits made from credit card terminals appeared on bank statements and the bank's information reporting system with a reference number that began with the practice location number. As part of the credit card system upgrade, terminals were set to settle automatically and transmit a deposit total to the bank after the physician offices had closed, ensuring that deposits would be processed every day, facilitating the end-of-month reconciliation. Previously, physician business office staff had been responsible for manually settling the terminals and initiating the credit card deposit transmission.

Making Daily Cash Reconciliation Easy

As part of the new process, individual practice office managers are required to reconcile the previous day's bank deposits to documentation of payments received for patient encounters on that day (deposit "batch" information). They also reconcile bank deposits to JUP's patient accounting system at month end.

WEB EXTRA

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Two new data fields—Deposit Ticket Cash and Deposit Ticket Check—were added to JUP's patient accounting system to create "cash control totals" and help reconcile patient payments posted to JUP's patient accounting system to daily deposit ticket amounts and to the actual deposit amounts posted to the JUP bank account. Daily reconciliation of deposit and posting activity helps to identify any internal theft issues and deposit discrepancies so they can be researched before month-end.

The new reconciliation process had to be easy, quick, and adaptable to employees with different skill sets. Rather than over-engineering the process, JUP management decided to keep things simple.

The new procedure works as follows: Each day, the practice business office manager logs onto the bank reporting system to access the practice's custom report. The manager matches the deposit totals from the bank report to JUP's patient accounting system "batch" information from the previous day. Deposit discrepancies and deposit corrections (which carry the practice ID from the original deposit ticket and also appear on the practice bank report) must be researched and resolved, preferably on the same business day. Deposit corrections, which typically indicate miscounted cash, an addition error on a deposit ticket, or a missing check, are required to be reported by practice office managers to the physician business office so they can be researched and corrected in the patient record. On most days, the entire process takes less than 15 minutes.

At month end, each practice is responsible for completing a month-end reconciliation comparing all JUP's patient accounting system over-the-counter payments to the month's bank deposits for the practice. Variances are reported to the physician business office using a standard code table.

To maintain controls at the "macro" level, a physician business office staff member downloads practice deposit data for the entire JUP system from the bank, using a spreadsheet template written to automate the reconciliation process. Over-the-counter payment information from JUP's patient accounting system is compared to the bank information, and bank and patient accounting system reports are prepared by the physician business office and distributed to practice office managers.

A "top level" physician business office reconciliation is also performed to monitor the accuracy of the practice level reconciliations. Standard reports used in the reconciliation process include:

- Deposit correction form used to correct deposit or posting errors detected during the reconciliation process
- Monthly deposit correction summary report
- Variance reports produced by a variance database that is used to track and report outstanding issues that are carried from one month to the next

Supporting the System Through Training

To support the transition to the new system, JUP offered classroom and hands-on training at the practices during roll-out. Training included presentations to physicians so they would be aware of the new process and would support their business office managers in making the change. Presentations included a statement of the reasons for making the change, the advantages to the practices, and clarity around expectations. Training on the reconciliation system is now incorporated into the orientation program for new practice business office managers.

Achieving Results

The project has achieved all the results that JUP anticipated, plus a few unexpected benefits:

- Daily reconciliation of physician deposits has become part of the JUP culture.
- Deposit discrepancies are identified within 24 hours of the deposit and are clearly identified by practice.
- Controls for cash deposits have been strengthened: Since the new reconciliation system was implemented, JUP has experienced no incidences of missing cash.
- Deposit discrepancies carried over between accounting periods have virtually been eliminated.
- Month-end reconciliations have been accelerated: Reconciliations are required to be completed within 10 days of report distribution.
- The new reconciliation process has received positive recognition from the JUP internal audit department.

One unexpected result was that credit card receipts increased dramatically during the first year of the project. The increase in collections may be due to the auto-settlement of credit card terminals and the improved reconciliation process, which make accepting credit card payments easier for the physician practice staff.

The project's success is attributed to a combination of simple tools, commitment to the reconciliation process, and training for physician office employees.

Dawne Clark is manager of lockbox, payments, and reconciliation for physician business services, Thomas Jefferson University, Jefferson University Physicians, Philadelphia (dawne.clark@jefferson.edu)

Margaret Dowling is senior vice president, product management, PNC Healthcare, Philadelphia (margaret.dowling@pnc.com)

By Kim Felix

ICD-10 Training for the Rest of Us

Beyond inpatient coders, who else in a hospital or health system needs ICD-10 training? And what type of training does each department need?

Inpatient coders will be a hospital's resident ICD-10 experts so they need the "soup to nuts" training, including anatomy and terminology/physiology, ICD-10 CM, and ICD-10 PCS.

Following are suggestions for ICD-10 training that is suitable for other groups or departments in hospitals and health systems.

Outpatient coders. Ideally, outpatient coders, including those coding for ambulatory surgery, the emergency department, and ancillary departments, would receive the same package of training that inpatient coders do. However, if there is no intention of cross-training or if budget constraints are an issue, focus on anatomy and terminology/physiology and ICD-10 CM training. ICD-10 PCS codes, which are the most difficult part of any ICD-10 training, will not be required on outpatient claims.

Physicians and other documenters. Physicians, physician assistants, wound care nurses, case managers, and others who document in patient records have an impact on code assignment. The sole focus of ICD-10 training for these individuals should be on documentation. Whenever possible, make the training service- or specialty-specific to keep it relevant and reduce training time (and the boredom factor). Don't worry about teaching documenters how to code. Concentrate on improving their documentation skills so coders can assign codes accurately.

Patient access/registration/finance/billing. Although staff in these departments don't assign codes or document in the patient record, they deal with codes on a daily basis. Their training should focus on the impact and code structure of ICD-10. Furthermore, they should have some training on the General Equivalence Mappings (or at least have a copy of the GEMs book), so they can follow a code from ICD-9 to ICD-10 and vice versa to get a sense of how they differ.

Administration. An overview of the implications of ICD-10 will help administrators understand how this new code set will have an impact on their entire facility.

Clinical documentation improvement (CDI) staff. Organizations with very robust CDI programs may want to give CDI staff the same training as inpatient coders, as CDI staff are on the front lines and have become very well-versed in ICD-9 codes. In other CDI departments, the training that physicians and other documenters receive might suffice. CDI staff are the back-up support who will ensure physicians are documenting what they should. They could be game-changers with ICD-10 and may help prevent the onslaught of post-discharge querying that is anticipated with ICD-10 implementation.

Don't worry about teaching documenters how to code. Concentrate on improving their documentation skills so coders can assign codes accurately.

Other departments. Find out what internal/external software systems use ICD-9 codes. GEMs training may be helpful to make them aware of how the code sets differ.

Kim Felix, RHIA, CCS, is director of education, coding division, IOD Incorporated, Philadelphia, and a member of HFMA's Metropolitan Philadelphia Chapter (kim.felix@iodincorporated.com).

By Jennifer Swindle

Coding for Complex Chronic Care Coordination Services

Q. What documentation is required for complex chronic care coordination?

A. New CPT codes 99487-99489 for complex chronic care coordination (CCCC) are not yet separately reimbursable by Medicare; however, some commercial payers do reimburse these codes separately. If all providers capture the codes and track payment, that would help gain recognition and promote broader reimbursement by Medicare and other payers. Codes and their definitions are shown in the exhibit.

Documentation is key to payment. CCCC services by the clinical staff must be captured for the entire month. To justify the minutes reported, all time spent should be captured, including date, minutes spent, what was done, and who provided the service, so that the total time can be accurately reported.

Jennifer Swindle, RHIT, CCS-P, CPC, CPMA, CDIT, is vice president, coding, Salud Healthcare Solutions, LLC, Lafayette, Ind., (jswindle@saludsolutions.us) and a member of HFMA's Indiana Pressler Memorial Chapter.

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Complex Chronic Care Coordination Codes

Code	Definition
99487	First hour of clinical staff time, directed by the physician, with no face-to-face encounter; per calendar month
99488	First hour of clinical staff time, directed by the physician, with one face-to-face encounter; per calendar month
99489	Each additional 30 minutes of clinical staff time, directed by the physician in a calendar month; report in addition to the initial service

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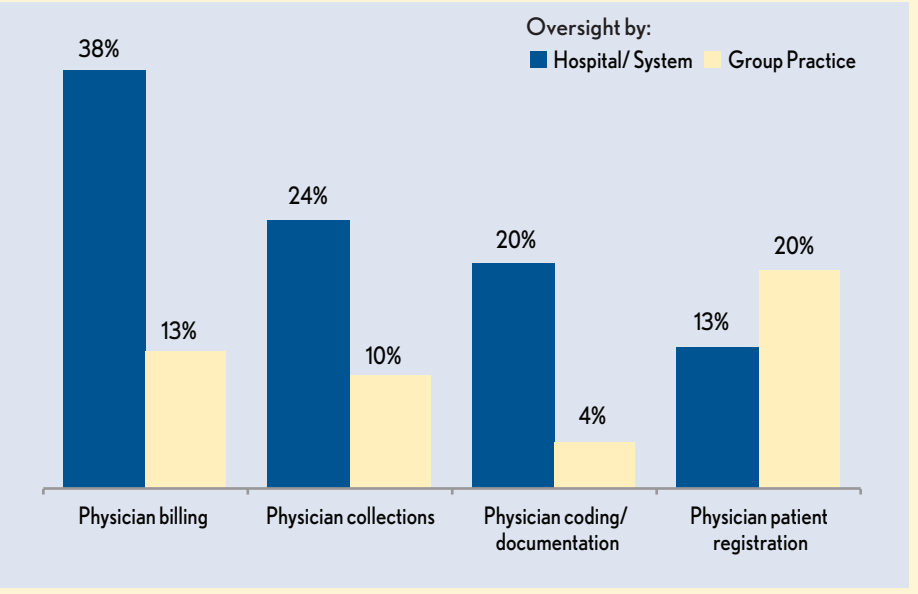
Figures at a Glance

Satisfaction with Physician Revenue Cycle Functions

Hospital and health system CFOs and VPs of finance report a higher level of satisfaction with several physician group processes that report into the hospital, compared with those that report to the physician practice. In an HFMA survey of 139 healthcare finance leaders, 38 percent indicated they were "completely satisfied" with physician billing performance with hospital/system-based oversight, while 13 percent reported the same level of satisfaction with practice-based oversight. Executive satisfaction was also higher for hospital/system-based oversight of physician collections and physician coding and documentation, as shown in the exhibit. However, satisfaction with patient registration in physician offices (which is less likely to report to the hospital/system), was higher for practice oversight.



Source: "Executive Survey on Hospital and Physician Affiliation Strategies, Sponsored by McKesson." HFMA, April 2013.