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24th Annual Revenue Cycle Conference

Rev Cycling Through Adversity



Revenue cycle compliance Leading practices

Responding to the present and preparing for the future

January 14, 2021

Virtual Webinar

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Compliance Officer

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Agenda



- 1 | Today's business imperative
- 2 | Use cases for data analytics in compliance to help reduce revenue loss and support quality
- 3 | Considerations for path forward

Learning Objectives



After this presentation you should be able to:

- Understand ways to transform your revenue cycle compliance program using data-driven approaches
- Learn leading practices of revenue cycle compliance auditing and monitoring practices
- Leverage learnings from the case studies and tools discussed to tailor an approach that meets your organizations' needs

Today's business imperative

Transforming your compliance program into a proactive, data-driven, and risk-intelligent organization, **requires vision.**













Faced with cost, resource, and regulatory audit pressures, leveraging a risk-based, data-driven approach to compliance risk monitoring can help modernize a program and increase risk intelligence, creating new business insights and demonstrating tangible value.



Department of Justice (DOJ) guidance—data can support effective operations

DATA RESOURCES & ACCESS¹

1. Do compliance and control personnel have sufficient direct or indirect access to relevant sources of data to allow for timely and effective monitoring and/or testing of policies, controls, and transactions?
2. Do impediments exist that limit access to relevant sources of data and, if so, what is the company doing to address the impediments?

DOJ FOCUS AREAS	IMPLICATIONS	EXAMPLE DATA ANALYTICS PRACTICES
 Risk assessment	 Identify, analyze, and address key organizational risks	<ul style="list-style-type: none"> • Connect tools to operational data and information across functions so that controls are tested on an ongoing basis and not just a “point in time” • Build a library of potential risks and lessons learned from prior riskassessment
 Policies and procedures	 Describe ethical norms, address, and aim to reduce risks identified by the company as part of its risk assessment process	<ul style="list-style-type: none"> • Track employees' access to various policies and procedures to help the organization gain a better understanding of what trends exist of policies and procedures that generate the most searches and attention
 Autonomy and resources	 Requisite authority and stature for those charged with a compliance program’s day to-day oversight	<ul style="list-style-type: none"> • Compliance and control personnel need access to relevant sources of data to allow for the timely and effective continuous monitoring and/or testing of policies and controls and transactions
 Incentives and disciplinary measures	 Incentives for compliance and disciplinary action for non-compliance	<ul style="list-style-type: none"> • Ability to monitor and track investigations over a period of time and resulting discipline to assist with consistency across an organization
 Continuous improvement, periodic testing, and review	 An effective compliance program implements controls that will reveal areas of risk for improvement to the program	<ul style="list-style-type: none"> • An organization can focus on using data analytics to support effective operations by adapting its compliance program based upon prior year findings for areas that lack efficiency or are deemed not effective
 Analysis and remediation of underlying misconduct	 Conduct a thoughtful root cause analysis of misconduct and timely and appropriately remediate to address the root causes	<ul style="list-style-type: none"> • An organization can use data analytics to identify prior indications of misconduct and evaluate different trends observed from continuous data monitoring

1. US Department of Justice Criminal Division, Evaluation of Corporate Compliance Programs (Update June 2020) <https://www.justice.gov/criminal-fraud/page/file/937501/download>.

Health Care Fraud and Abuse Control Program (HCFAC) Annual Report – year-over-year trends

FRAUD & ABUSE TRENDS 2018-2019



FY2018 HC FRAUD & ABUSE CONTROL PROGRAM REPORT

- Federal government won or negotiated over **\$2.3 billion** in health care fraud judgments and settlements
- **\$2.3 billion** was returned to the Federal government or paid to private persons
- Of this \$2.3 billion, the Medicare Trust Funds received transfers of **approximately \$1.2 billion during this period, in addition to the \$232 million** in Federal Medicaid money that was similarly transferred separately to the Treasury as a result of these efforts



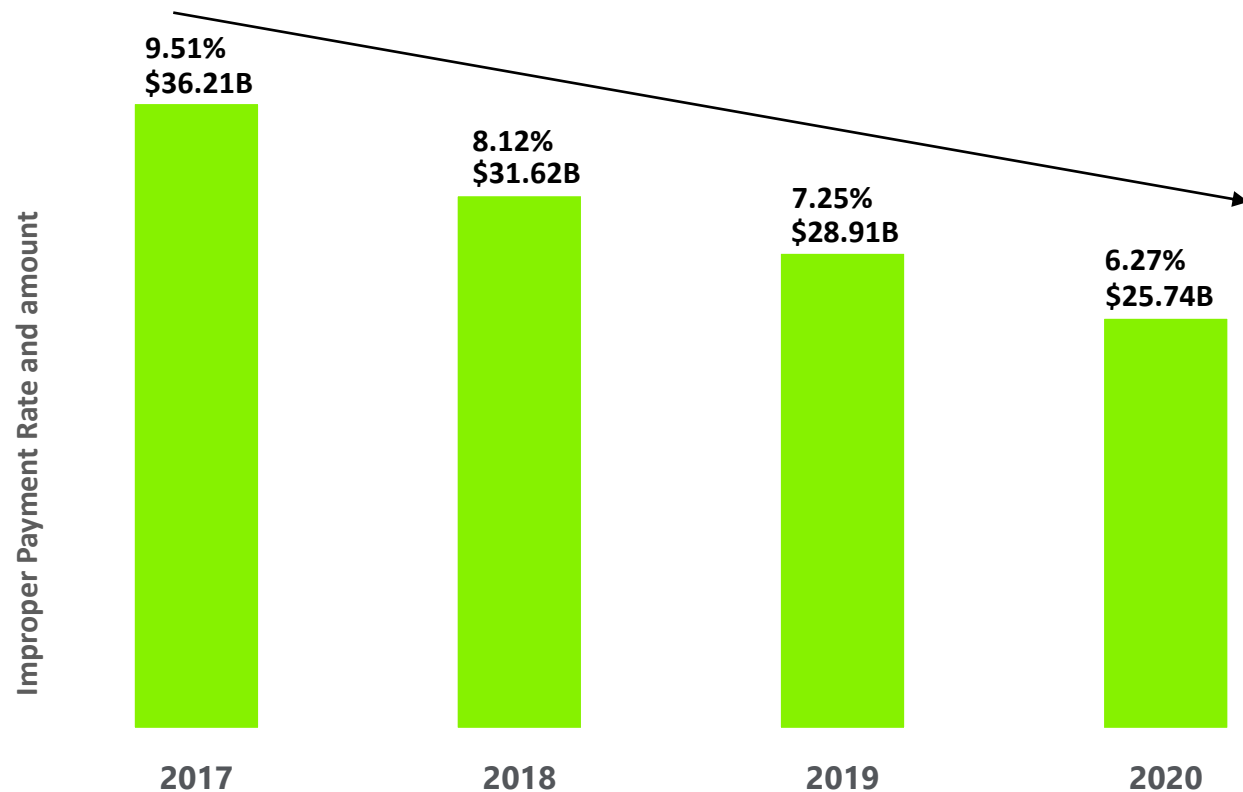
FY2019 HC FRAUD & ABUSE CONTROL PROGRAM REPORT

- Federal government won or negotiated over **\$2.6 billion** in health care fraud judgments and settlements
- **\$3.6 billion** was returned to the Federal government or paid to private persons
- Of this \$3.6 billion, the Medicare Trust Funds received transfers of **approximately \$2.5 billion during this period, in addition to the \$148.6 million** in Federal Medicaid money that was similarly transferred separately to the Treasury due to these efforts

Trends in the Medicare payment error rate

Comprehensive Error Rate Testing (CERT) program is conducted by Centers for Medicare & Medicaid Services (CMS) each year to determine if Medicare Fee-For-Service (FFS) claims were paid properly under Medicare coverage, coding, and payment rules. The tables below highlight national CERT Improper Payment Rate trends for the period 2017-2020.

Each reporting year shows a decrease in Improper Payment Rate



Polling question #1



Does your organization use data analytics to analyze compliance risks and/or assist with monitoring?

A. Yes

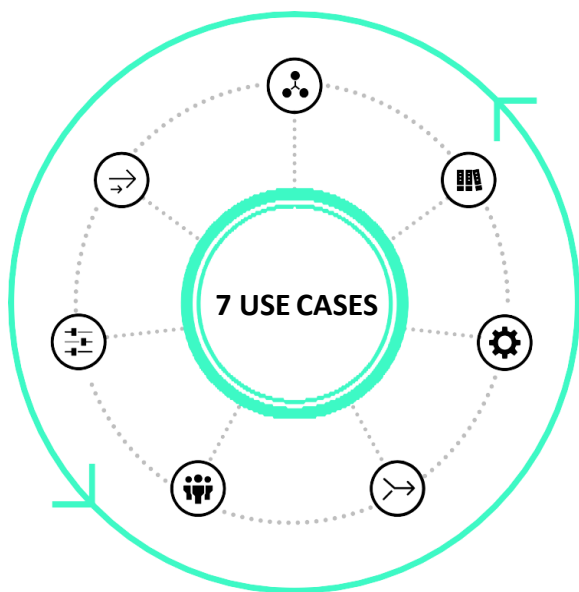
B. No

Use cases for data analytics in compliance to help reduce revenue loss and support quality



Examples of data analytics

Following are examples of using data analysis for strategic actionable goals:



	Professional coding	<ul style="list-style-type: none"> • Benchmarking physician Current Procedural Terminology (CPT) usage for appropriateness, risk-based reviews, and identification of outliers for investigation and resolution • Benchmarking is done using commercially available as well as CMS Provider Utilization & Payment Data Public Use File, and Individual Medicare Administrative Contractor (MAC) reports
	Hospital revenue	<ul style="list-style-type: none"> • Analyzing inpatient and outpatient paid claims data and reviewing medical record documentation to inform impact on payments/accounts, comparison of average length of stay to geometric mean length of stay • Analyzing potential lost revenue through denials and Program for Evaluating Payment Patters Electronic Report (PEPPER) data to identify high dollar, potential high-risk coding, and short-stay claims for further analysis
	Drug unit billing	<ul style="list-style-type: none"> • Analyzing drug units and spending per unit to identify operational improvement and savings opportunities due to a reduction in drug waste and drug spending
	Clinical documentation improvement	<ul style="list-style-type: none"> • Performing clinical documentation and reimbursement analysis for inpatient Medicare, Medicaid, and commercial plans to identify areas of potential revenue, compliance, and quality risk areas and/or opportunities • Medical Provider and Analysis Review (MEDPAR) data and specific Medicaid databases are utilized to perform analysis on claims submitted to governmental payors while Truvan data is utilized for commercial payors
	Quality data	<ul style="list-style-type: none"> • Benchmarking quality data against national averages to identify potential areas for coding and documentation improvement, and focus areas for improvement of quality and safety indicator scores that may be related to provider documentation and code assignments • Hospital Compare, Healthgrades, and Leapfrog are used as sources for benchmark data
	Telehealth reimbursement	<ul style="list-style-type: none"> • Analyzing billed, submitted, and paid claims data for status and/or questionable billing patterns for services
	Payment aberrations	<ul style="list-style-type: none"> • Analyzing payments received from payors, bills submitted to payors, to determine whether appropriate reimbursement is received for services rendered

Examples of internal and external sources of data

All data is not created equal. Using an approach of analyzing and modeling both internally available data and externally sourced data, organizations can be better poised to take data-driven informed decisions.

INTERNAL DATA SOURCES

Revenue, coding, and billing data

*Outpatient and inpatient coding and billing data including codes billed, units, charges etc., can be analyzed to inform both current risk areas and identify future target focus areas
Additionally, internal data can be compared to CMS data to identify trends and run comparative analytics*

Patient accounting and claims data

*Financial data such as patient accounting data, 837 claims data, and 835 remit data can be used to visualize the life cycle of patient financial accounting
Targeted approaches to denials management can help identify and remediate lost revenue opportunities*

Clinical documentation and quality data

*Clinical documentation review and appropriate coding assignment can assist in identifying erroneous down-coding and up-coding to detect both compliance risks and revenue opportunities
Review of internally measured quality metrics and comparison to local/national averages can help in comparing hospital performance and submitting quality data for reimbursement*

EXTERNAL DATA SOURCES

Hospital compare data

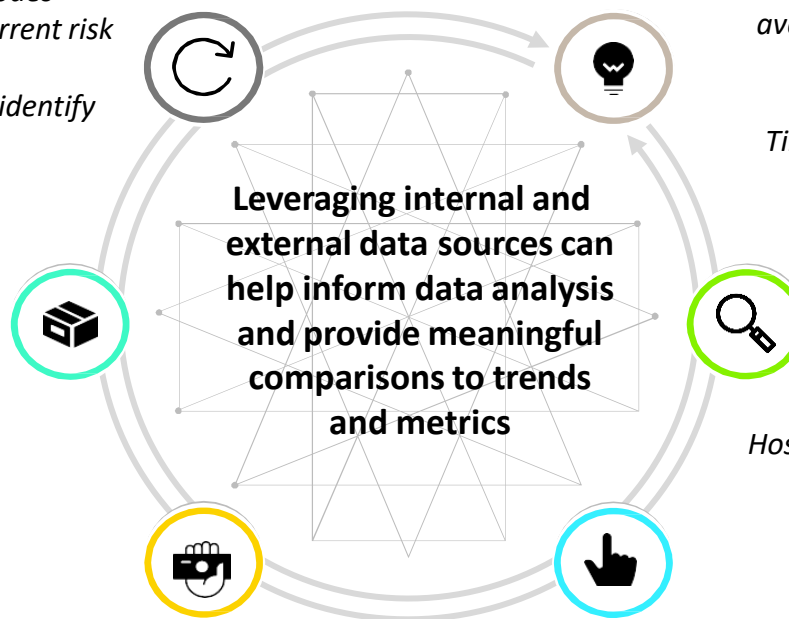
*CMS initiative for hospital performance comparison with state and national averages using a 1-to-5-star rating system, with information on over 4,000 Medicare-certified hospitals
Seven groups of measures including Mortality, Readmissions, Timeliness of care, Effectiveness of care, Safety of care, Patient Experience, and Effectiveness of Medical Imaging*

Healthgrades data

*Public database with information on physicians, hospitals and health care providers using a 1-to-5-star rating system
Hospital data includes three categories of ratings: Clinical quality ratings, Patient experience ratings, and Patient safety ratings*

Leapfrog data

*Public hospital survey which collects safety, quality, and resource use information voluntarily submitted by almost 2,000 hospitals annually
Four categories of survey results include Inpatient care management, Medication safety, Maternity care, and Infections and injuries*



Additional external data sources

Example external data sources that can be leveraged in data analytics processes:

Source	Summary
PERFORMANT CMS REGION 2 and 3 APPROVED AUDIT ISSUES	CMS Region 2 and 3 Recovery Audit program used to identify and correct Medicare improper payments including data from Cotiviti
MEDICARE PART B DRUG SPENDING DASHBOARD	An interactive, web-based tool that presents spending information for Medicare Part B drugs
REPORT ON MEDICARE COMPLIANCE	Weekly newsletter and compliance strategies on Federal regulations, enforcement actions and audits
PROGRAM FOR EVALUATING PAYMENT PATTERNS ELECTRONIC REPORT (PEPPER)	Information, training and support, and resources related to the PEPPER program
National Government Services (NGS)	Information related to NGS, the Medicare contractor for CMS
OFFICE OF INSPECTOR GENERAL (OIG)	Reports and investigations performed by OIG
OIG NEWSROOM	Up-to-date information on new investigations or findings from OIG
TRUVEN Analytics Commercial Data	Compare hospital metrics to commercial data available

Polling question #2



What type of data do you most utilize within your organization?

- A. Internal data sources
- B. External data sources
- C. Both

Professional coding data analysis – Vision

Recognize CPT coding trends per specialty and CPT code to compare to national averages and identify up-coding, down-coding practices. Identify outliers for focused documentation review and follow-up coding and documentation improvement training.

Purpose

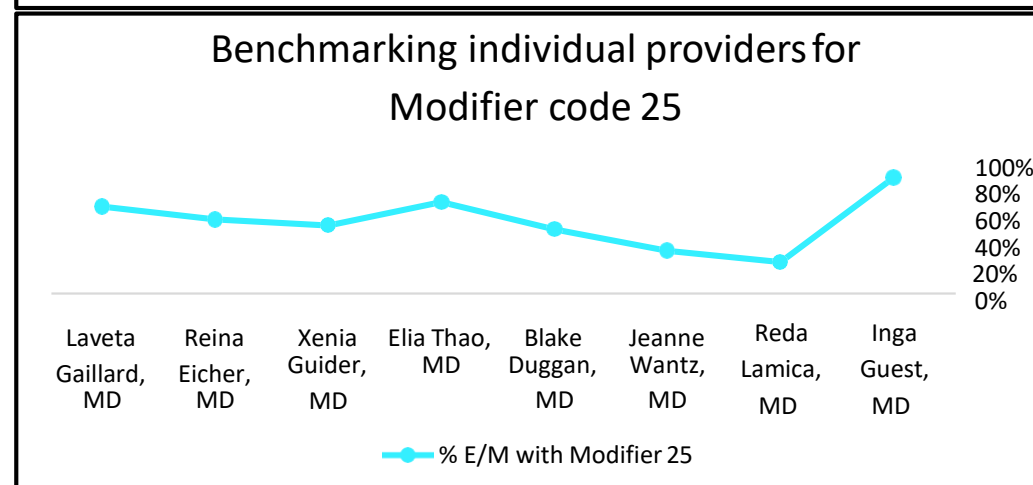
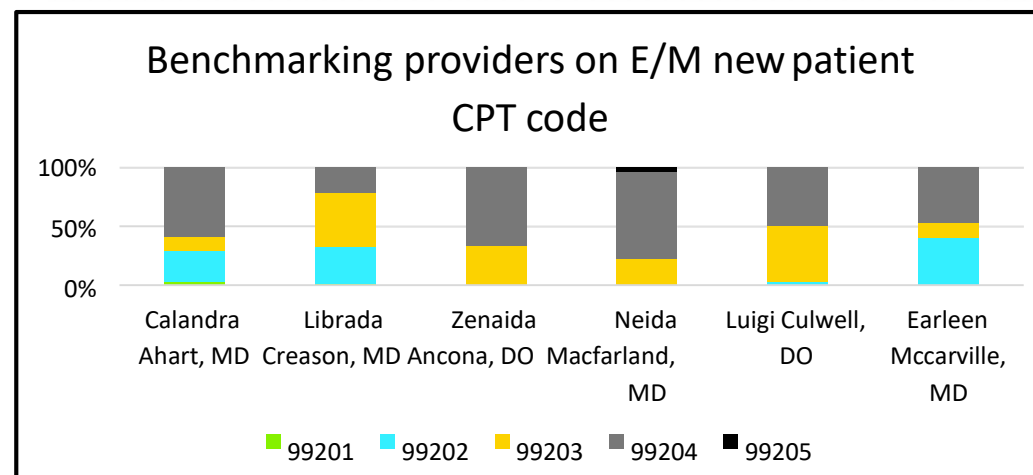
Identify CPT outliers when compared to metrics by CPT, modifier usage, physician

Approach

- **Analysis of internal data:** Data containing CPT usage information per provider based on their specialty will be analyzed to identify internal trends and outliers between providers of similar specialties.
- **Benchmarking of internal statistics to external data:** External data sets such as the CMS Provider Utilization and Payment Data Public Use file and other available individual Medicare Administrative Contractor (MAC) reports are used to compare internal usage statistics to state and national averages and based on specialty to identify if internal trends are in line with the average and identify outlier specialties, physicians, and even specific CPT codes.
- **Identification of target areas for investigation:** Based on internal and external benchmarking, target specialties and CPT codes are identified to review for up-coding or down-coding and to detect root causes of coding errors.
- **Clinical documentation review:** Focused chart review of target CPTs and providers are conducted to determine if clinical documentation can support the code billed.

Examples

Benchmarking E/M code volume and modifier usage by physician



Hospital revenue data analysis – Vision

Create increased coding specificity and accurate reimbursement for services, defend against compliance audits and transition to new health care models, and justify medical necessity, length of stay, and resource consumption.

Purpose

Identify outlier stays, compare to thresholds, by top 10 Diagnosis-Related Groups (DRG), Average Length of Stay (ALOS), and Geometric Mean Length of Stay (GM-LOS)

Approach

- **Analysis of internal claims data to identify key metrics of hospital discharge / claims data:** Such analysis can include but is not limited to:
 - Trend analysis of total volume and payments by payor and month / year
 - Identify top 10 DRG, and Principal Diagnosis Codes (PDX) per payor and analyze the volume of claims and ALOS
 - Compare ALOS per payor, DRG, and selected discharge disposition codes to GM-LOS
 - Analyze volume and usage of new and established E&M codes
 - Analyzing short stays, observations and related condition codes
- **Tailored analytical assessment of inpatient and outpatient medical records:** Comparison of internal coding, billing and claims data to publicly available data can be used to identify specific focus areas for deeper reviews. These reviews are driven by analyzing:
 - PEPPER report
 - Core quality measure data and results from performance in related programs
 - Knowledge of industry risk areas
 - Prior coding and billing audits or investigations

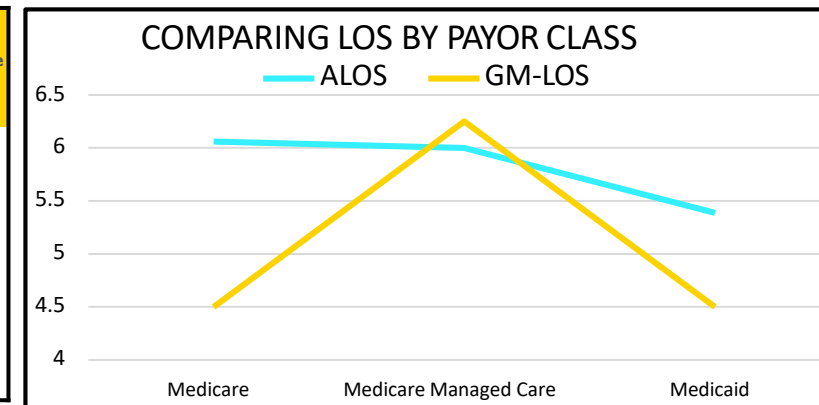
Examples

Trending payments to ALOS and ALOS, GM-LOS by top 10 DRG

Inpatient claims data

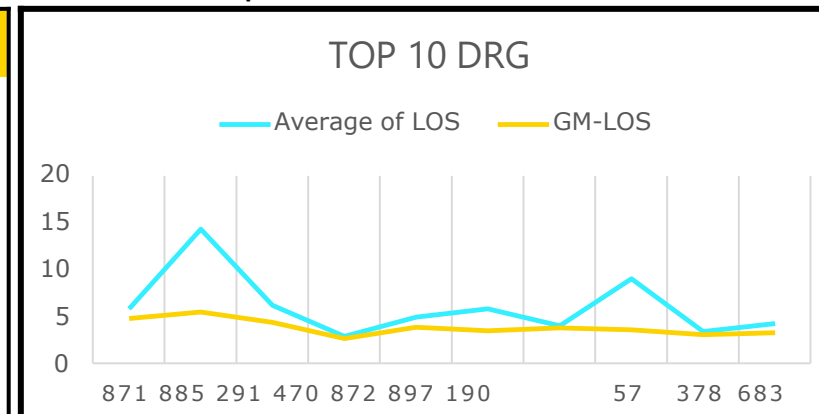
Trend analysis of total volume and payments by payor and calculated ALOS

Primary Payor	Count of Claims	Sum of Payments	Average LOS
Medicare	3975	\$ 80,619,972.92	6.06
Medicare Managed Care	2089	\$ 27,798,081.66	6.00
Medicaid	4201	\$ 38,031,603.45	5.39



Medicare top 10 DRG – Total volume of claims and comparison of ALOS to GM-LOS

DRG	Count of Claims	Average of LOS	GM-LOS
871	412	5.82	4.80
885	289	14.34	5.50
291	158	6.20	4.40
470	139	2.88	2.70
872	133	4.93	3.90
897	111	5.84	3.50
190	92	4.02	3.80
57	81	9.04	3.60
378	74	3.42	3.10
683	71	4.27	3.30



Drug unit billing data analysis – Vision

Improve operational practices such as drug delivery practices by tracking waste and identify opportunities to increase drug spending by benchmarking spending per unit, while reducing expenses related to overspending and waste.

Purpose
Identify drug waste and overspending by drug type, department

Examples
Trend drug spend and waste over time

Approach

- **Internal data files:** Use data analytics to calculate total unit per drug by using billing units per package and number of packages used per dose. This process can become complex without the use of analytics to speed up the calculation of total units. Furthermore, use data analytics to compare billing amounts to the billable units to identify wastage. To identify cases of wastage, the analytical procedures could identify cases where billing amounts exceed billable units.
- **Benchmarking of internal statistics to CMS data:** Medicare Part B drug spending dashboard provides average spending per dosage unit and change in average spending per dosage unit over time. Since the quantity of a drug dosage unit is the same as the quantity of the drug in a HCPCS billing unit comparisons of spending can be performed to analyze wastage and opportunities for operational improvements.

- Using Medicare Part B Spending dashboard may identify:
 - Potential revenue opportunity
 - Potential compliance and quality risks
- Comparing average units used per claim to unit thresholds can highlight drug wastage if unit usage is greater than standard purchasing packages
- Comparing average spending per dosage to internal spending can identify if hospitals are overpaying per dosage
- Therefore, Drug usage may become more efficient saving the hospitals additional expenses to purchase drugs

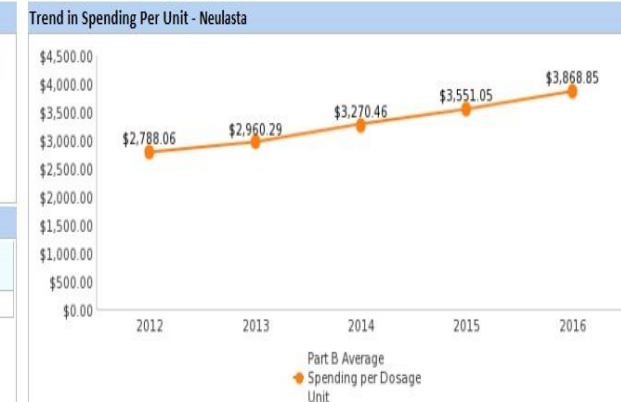
MEDICARE PART B DRUGS

Brand Name	Generic Name	Average Spending per Dosage Unit 2015	Average Spending per Dosage Unit 2016	Change in Average Spending per Dosage Unit (2015-2016)	Annual Growth Rate in Average Spending per Dosage Unit (2012-2016)	Total Spending 2016	Total Beneficiaries 2016	Average Spending per Beneficiary 2016	Average Sales Price (ASP) 2016
Eylea	Aflibercept	\$962.85	\$963.10	0.0%	-0.1%	\$2,208,730,191	210,411	\$10,497	\$980.49
Rituxan	Rituximab	\$724.73	\$765.45	5.6%	5.6%	\$1,665,667,928	69,941	\$23,815	\$780.81
Neulasta	Pegfilgrastim	\$3,551.05	\$3,868.85	8.9%	8.5%	\$1,375,670,105	95,960	\$14,336	\$3,938.12
Remicade	Infliximab	\$75.21	\$80.18	6.6%	6.0%	\$1,338,726,191	58,397	\$22,925	\$81.66
Avastin	Bevacizumab	\$67.50	\$70.04	3.8%	3.5%	\$1,111,678,356	207,422	\$5,360	\$71.58
Prolia*	Denosumab*	\$14.68	\$15.57	6.1%	2.1%	\$1,086,664,413	419,196	\$2,592	\$15.86
Lucentis	Ranibizumab	\$387.25	\$378.23	-2.3%	-1.4%	\$1,044,324,411	106,408	\$9,814	\$384.95
Herceptin	Trastuzumab	\$84.57	\$89.12	5.4%	4.8%	\$703,556,745	20,693	\$34,000	\$90.75
Orencia*	Abatacept*	\$34.36	\$40.80	18.7%	17.2%	\$586,532,893	22,879	\$25,636	\$41.81
Alimta	Pemetrexed Disodium	\$59.95	\$61.19	2.1%	2.6%	\$511,822,425	20,312	\$25,198	\$62.29
Velcade	Bortezomib	\$45.84	\$45.82	-0.0%	1.8%	\$490,438,057	20,668	\$23,729	\$46.68

*Indicates multiple brand and/or generic names for a specific HCPCS code. See "Brand, Generic & Manufacturers" table for additional names.
**Indicates brand/generic names unavailable. Name reflects the HCPCS short description.

Brand, Generic, & Manufacturers - Neulasta		
Brand Name	Generic Name	Manufacturer
Neulasta	Pegfilgrastim	Amgen

Additional Drug Information - Neulasta	
Medicare Billing Code	Drug Description
J2505	Injection, pegfilgrastim, 6 mg



High Risk Diagnosis Related Group (DRG) Testing – Vision

Identify potential medical documentation gaps, avoid repeat audits and payment recoupments, and decrease denials and reduce chances of improper payments, by focusing on CMS' Comprehensive Error Rates (CERT).

Purpose

Identify high risk DRGs and services by DRG, physician, service area

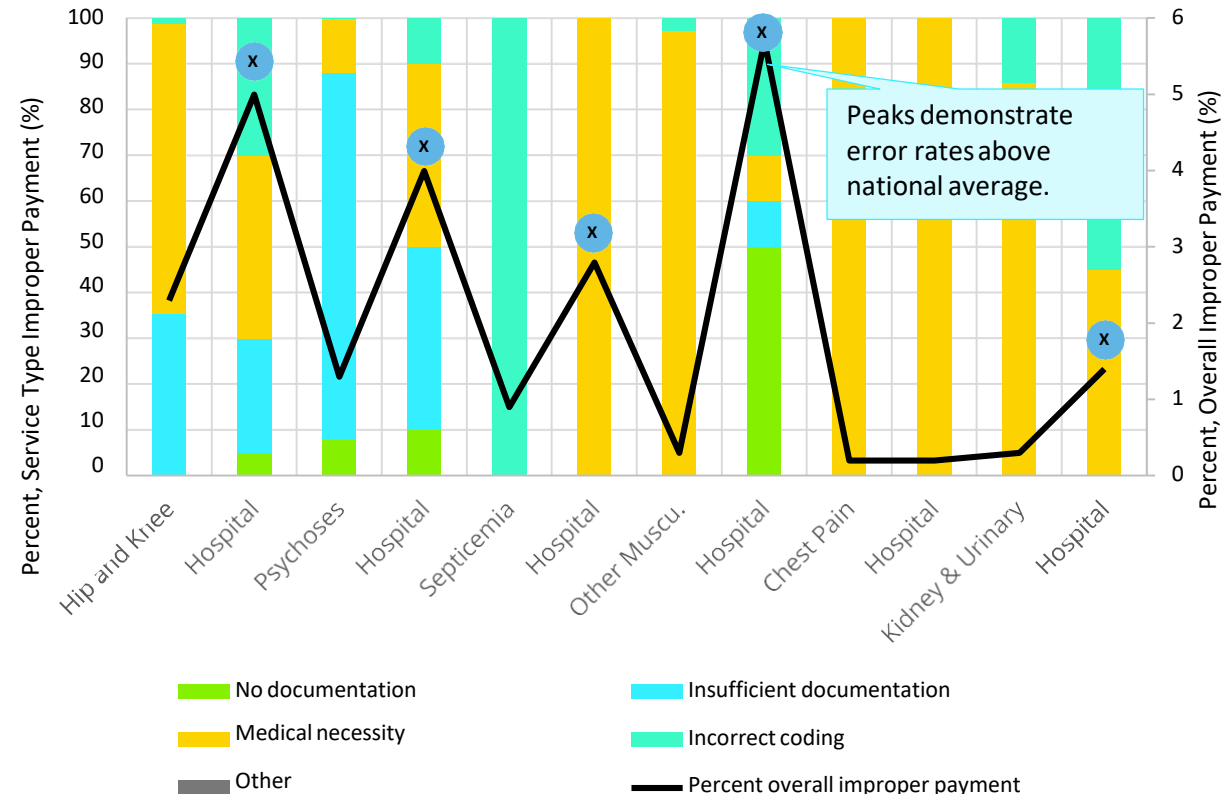
Approach

- **Analysis of claims data against CMS' CERT top twenty service types and related DRG:** An analysis of current claim volume of the top twenty service types and benchmarking against average length of stay and public Medicare data could help identify suspect claims which may be picked up by CMS for audit.
- **Review sample of medical records:** Review sample of medical records to understand if current documentation supports billing for the service could help identify gaps and potential corrective actions to prevent audits and denials in the future.
- **Ongoing monitoring of CERT service focus areas for compliance:** Ongoing monitoring of current CERT service focus areas and potential future CERT focus areas could help confirm that documentation adequately supports billing. Additional information can be added from various sources, such as OIG-focused audits.

Example

Identifying top 20 service types with improper payments, compare to CMS data

COMPARISON OF HOSPITAL ERRORS TO CERT ERRORS BY ROOT CAUSE AND SERVICE TYPE



Telehealth claims data analysis – Vision

Identify and prevent questionable billing patterns, inform compliance controls to mitigate risk, prevent repayments.

Purpose

Identify high risk billing patterns by CPT, modifier usage, Place of Service (POS), physician

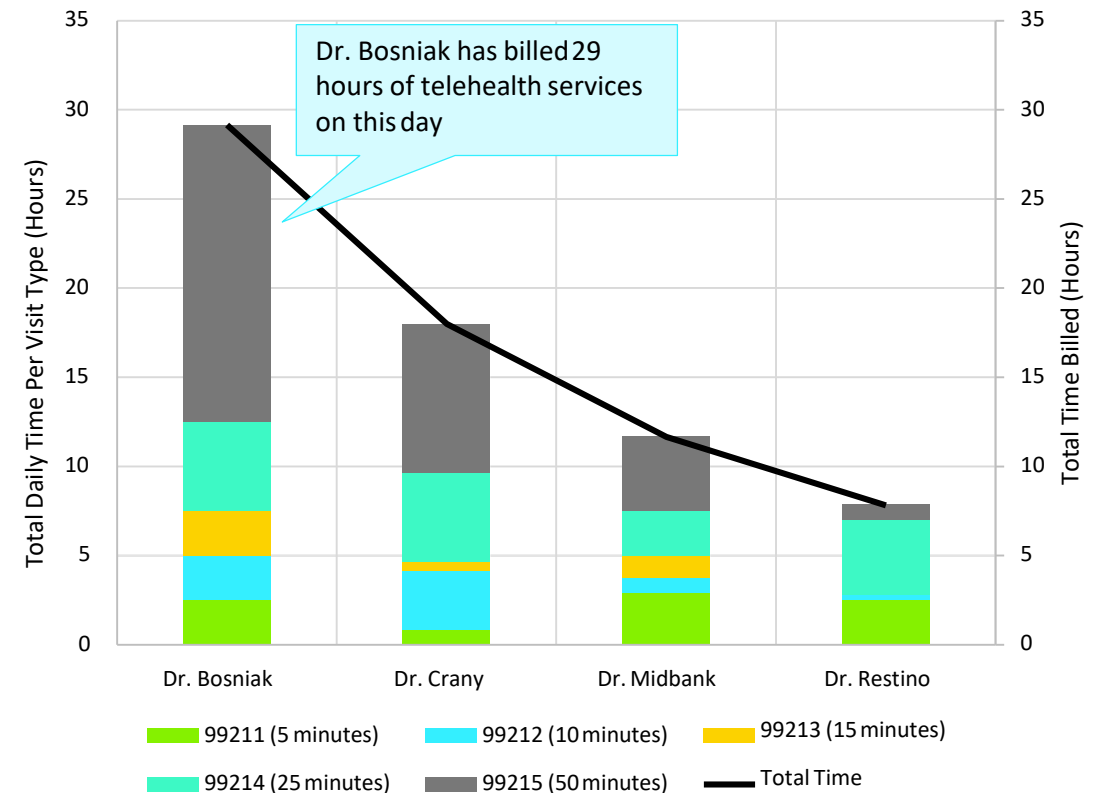
Approach

- **Internal billing data:**
 - Aggregate billing data by CPT and convert to total time per physician. Identify physicians billing more than 24 hours (or threshold identified by compliance). Identify abnormal billing patterns and check for correct application of modifier 95 or Place of Service (POS).
 - Confirm findings through record review to verify services are documented and time spent is documented by start and end times.

Example

Aggregating billing data by service type and comparing to patient schedules, by provider

PROVIDER TELEHEALTH MONITORING



Polling question #3



Are any of the discussed use cases relevant to your organization's current focus areas?

A. Yes

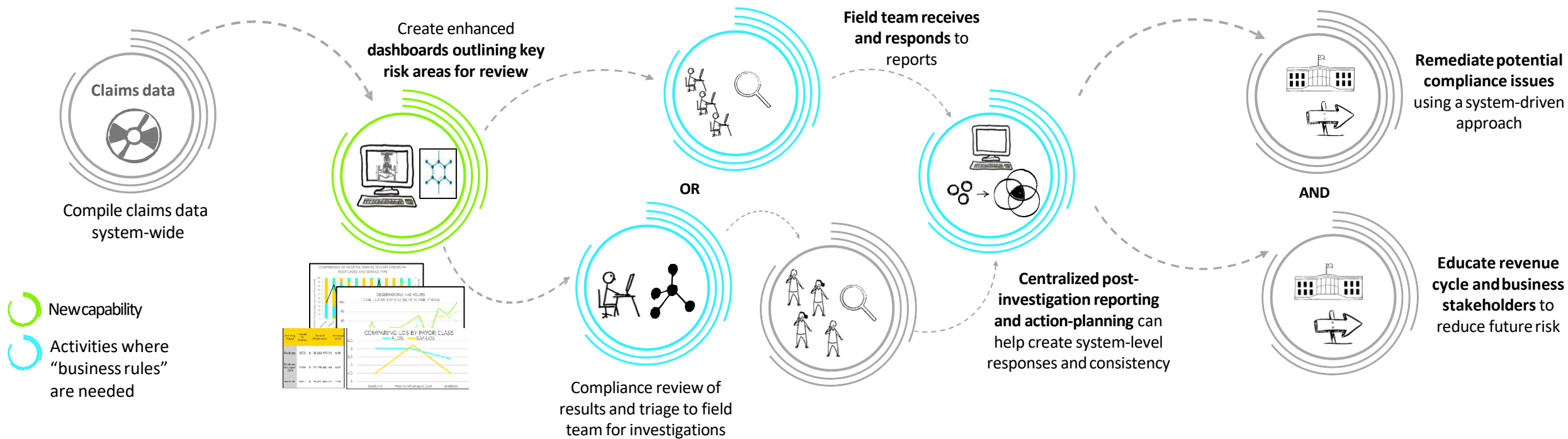
B. No

Considerations for path forward



Compliance data analytics – operating model considerations

The wealth of new data provided by compliance analytics can help to increase oversight of your coding and billing system-wide. Accordingly, it will be important to create an efficient operating model that outlines compliance and business roles, responsibilities, and actions.



Initial risk area questions:

- What initial risk areas do we want to review and monitor?

Organizational questions to answer:

- Will reporting be assessed centrally and then triaged for investigation, or disseminated locally?
- How will consistent post-investigation action-planning be driven by Compliance through the organization?
- What business stakeholders are imperative to these processes?

Polling question #4



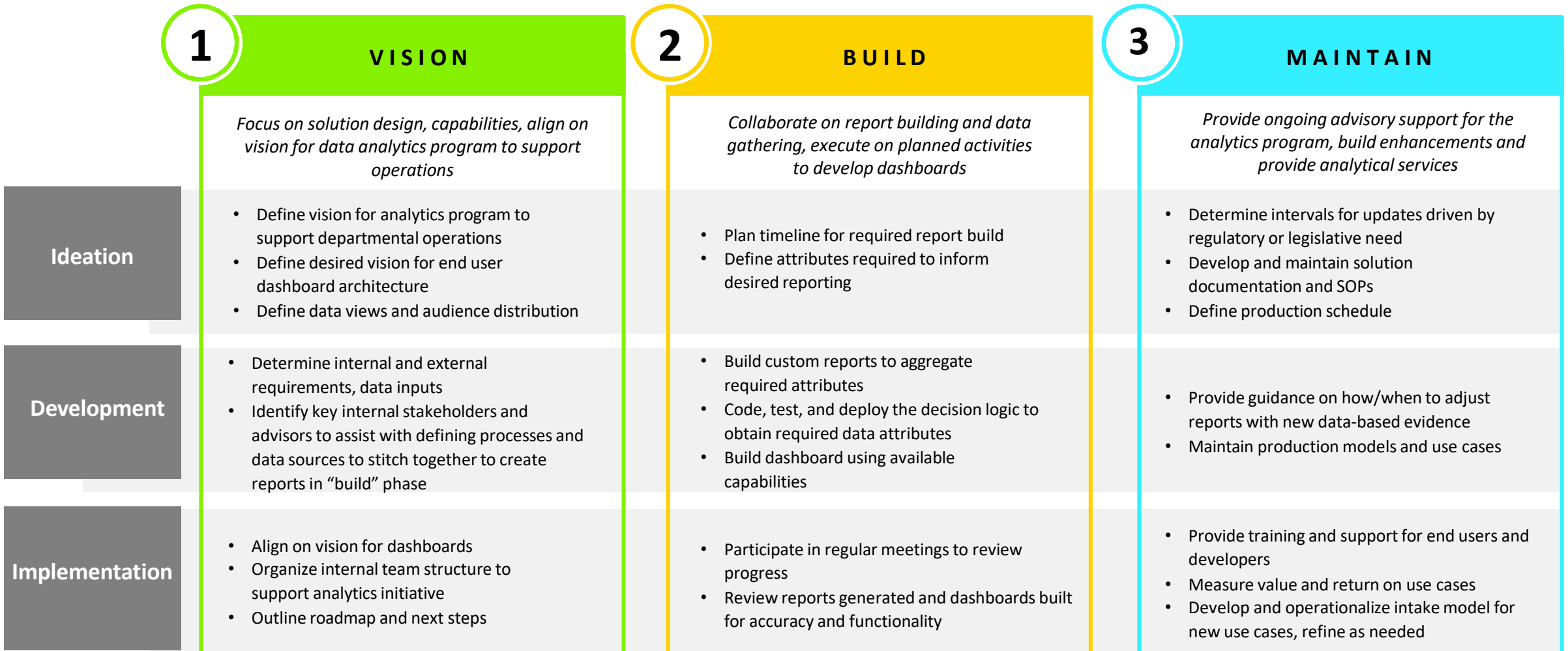
Do you think your organization could benefit from a data-driven approach to support effective operational and compliance practices?

A. Yes

B. No

A path forward

A three-phased approach is recommended to effectively design and implement a robust compliance analytics program.



Speakers



Debbie's Pic
to be added

Debbie Nedder

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Debra Nedder is the Chief Compliance Officer of UMass Memorial Health Care Revenue Cycle. Debbie oversees and aligns the Professional and Hospital Compliance teams, including risk assessment, planning, auditing and monitoring and oversight of external audit and investigations. Debbie is also the Chief Compliance Officer for UMass Memorial Medical Group, where she has developed a leading-edge Compliance Program in collaboration with Medical Group Leadership. She has been with UMass Memorial since 2008. Prior to coming to UMass Memorial she ran her own Compliance and Auditing Consulting business and spent 12 years with the Department of Health and Human Resources' Office of the Inspector General (OIG).



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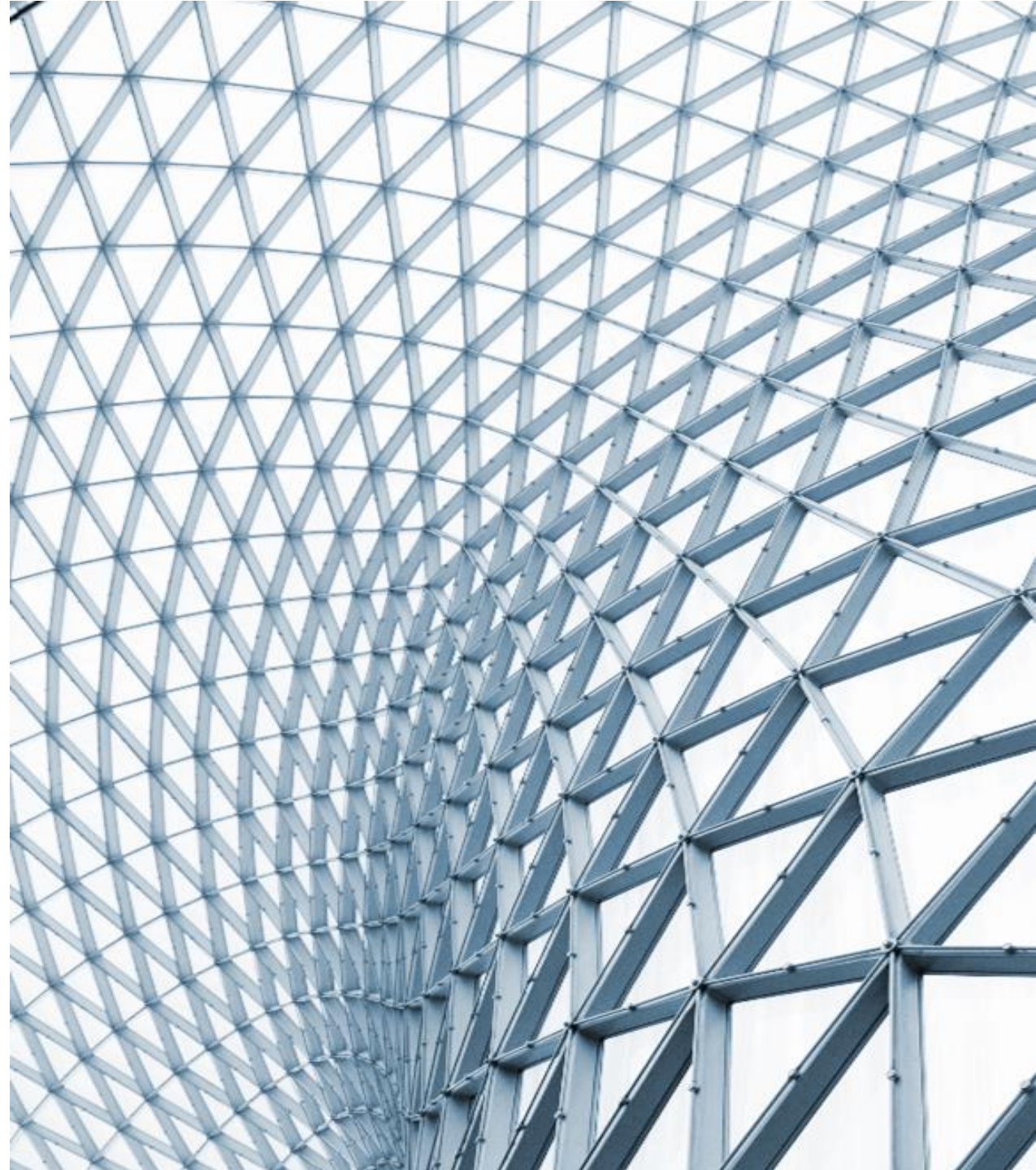
Dhara is a senior manager in the Deloitte Risk & Financial Advisory Practice with nearly 15 years of consulting experience serving health care and life sciences clients. She has experience in managing projects ranging from strategy, operations, regulatory and corporate compliance, risk management, to investigation and litigation support. Dhara has led and participated in several regulatory and compliance projects including but not limited to, compliance readiness and monitoring per Corporate Integrity Agreement (CIA) requirements, government-initiated audits, provider self-disclosures/voluntary refunds, litigation support services, compliance internal audits and investigations, development and implementation of compliance program, compliance monitoring and auditing, compliance training, and corrective action plans.



Thank You!

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Appendix



Short stays data analysis – Vision

Achieve required balance of patient placement and judicious use of condition codes to enhance patient care quality, coding and billing excellence, and improved revenue while protecting from and preparing for regulatory audits and enforcement actions. Create improved and more focused training opportunities for providers and coding staff on process deficiencies identified through data.

Purpose

Identify short stays greater than 48 hrs, by APC and length of stay

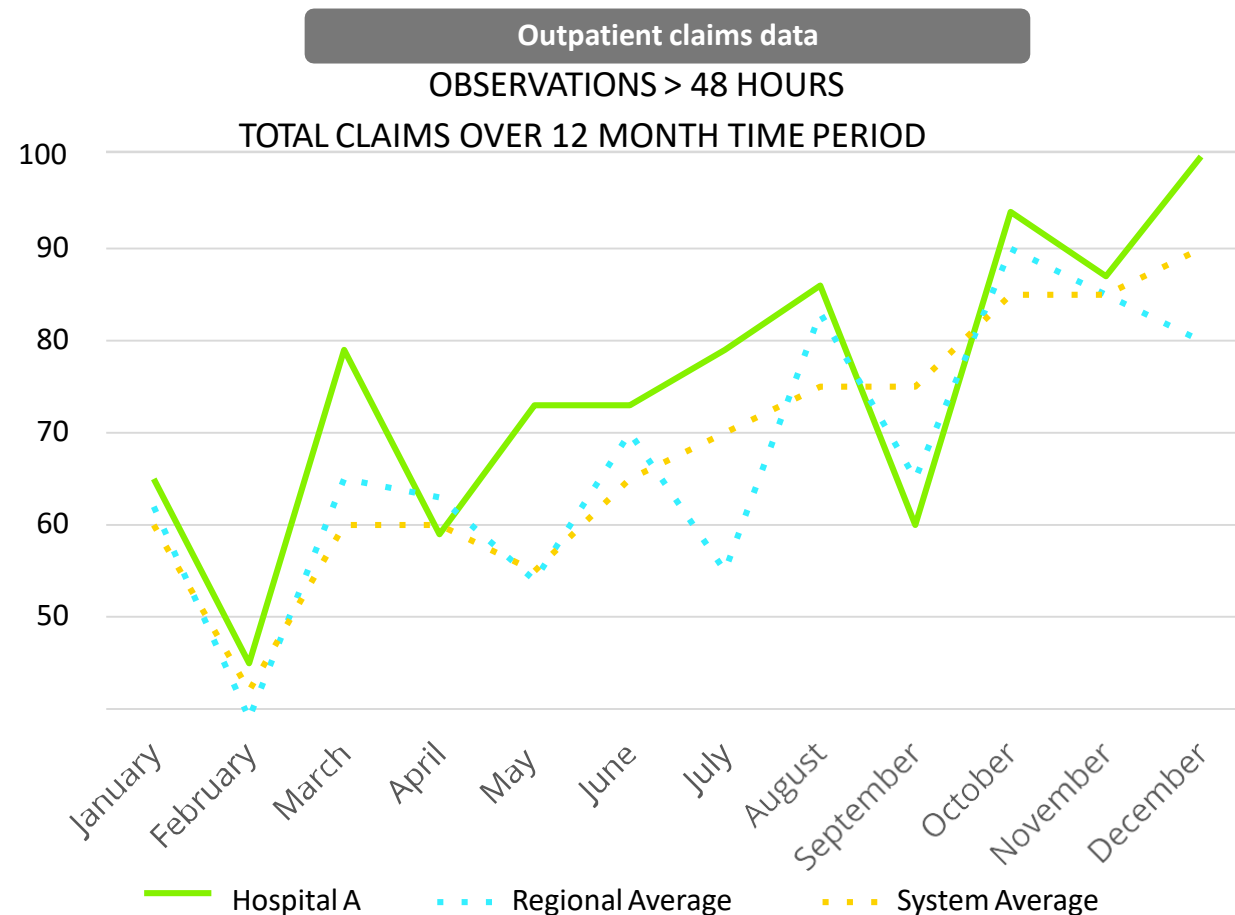
Approach

Hospital claims data analysis: Hospital claims data is analyzed for the following:

- **Condition codes:** A significantly higher usage of condition codes potentially indicates the ineffective patient placement procedures.
- **Short stays for medical and surgical DRGs:** One-day stays for surgeries should be mainly inpatient-only procedures that could explain why they are short stays—CMS only pays for them if the patients are admitted.
- **Observation over 24 hours:** The decision to admit or discharge usually can be made within 24 hours and should rarely take longer than 48 hours. Potential medical necessity issues if observation hours (G0378 units billed) are less than 8 hours. Observation should not last more than 24 hours and never more than 48 hours. It can indicate potential missed opportunity for an inpatient admission.
- **Frequency of one day stays:** Comparison of national capture 40 rates of one day stay with the hospital's rate provides an insight of a possible issue with patient placement. National/state benchmarks are available in PEPPER reports.

Example

Trending volume of observation stays greater than 48 hours



Hierarchical condition category (HCC) data analysis – Vision

Identify the complexity of the patient's health with supporting HCCs to determine fees and cost by predicting future health care needs for patients.

Purpose

Identify the cumulative health risk and care of a patient for future allocation of health care costs

Approach

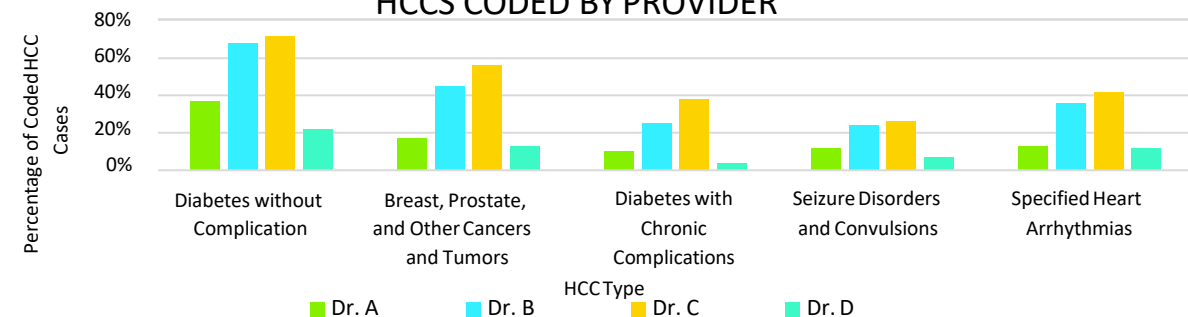
- **Specificity:** It is critical that the provider documents active acute or chronic conditions that are currently relevant to the patient's care. Utilizing the highest and most specific level of coding is also imperative as it drives the determination of the risk score. If documentation does not support the diagnosis or lacks specificity, it can also impact risk score as it does not capture the entirety of the patient's health condition.
- **MEAT:** MEAT is an acronym that can be used to help providers confirm they are being specific and accurate regarding documentation of patients. This requires one of the activities below to confirm the appropriate diagnostic code for HCC calculation.
 - Monitor—signs and symptoms, disease process.
 - Evaluate—test results, meds, patient response to treatment.
 - Assess/Address—ordering tests, patient education, review records, counseling patient and family members.
 - Treat—meds, therapies, procedures, modality.
- **Annual requirement:** Every member requires validation of HCC codes on an annual basis. (January to December).
- **Top 10 common HCCs:** Diabetes without complication; breast, prostate, and other cancers and tumors; diabetes with chronic complications; seizure disorders and convulsions; specified heart arrhythmias; congestive heart failure; other significant endocrine and metabolic disorders; chronic obstructive pulmonary disease; major depressive, bipolar, and paranoid disorders; and morbid obesity.

Examples

Comparison of the effect of identified HCCs and impact on risk score

No HCCs		Some HCCs		All HCCs	
76 yr old Female	0.468	76 yr old Female	0.468	76 yr old Female	0.468
Medicaid eligible	0.177	Medicaid eligible	0.177	Medicaid eligible	0.177
DM not coded		DM with no manifestations	0.118	DM with vascular manifestations	0.368
Vascular Disease not coded		Vascular disease without complication	0.299	Vascular disease with complication	0.41
CHF not coded		CHF missed		CHF	0.368
No interaction		No interaction		+Disease interaction bonus RAF (DM+CHF)	0.182
Patient Total RAF	0.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	\$452	PMPM Payment for Care	\$743	PMPM Payment for Care	\$1,381
Yearly reserve for care	\$5,418	Yearly reserve for care	\$8,921	Yearly reserve for care	\$16,573

HCCS CODED BY PROVIDER



Payment aberrations data analysis – Vision

Identify, aggregate, analyze, and repay, overpayments from governmental payors, while addressing contracting, billing system, charge master, and other operational and system issues to prevent overpayments, audits, and enforcement actions.

Purpose

Identify payments greater than charges by payor class and patient encounter

Approach

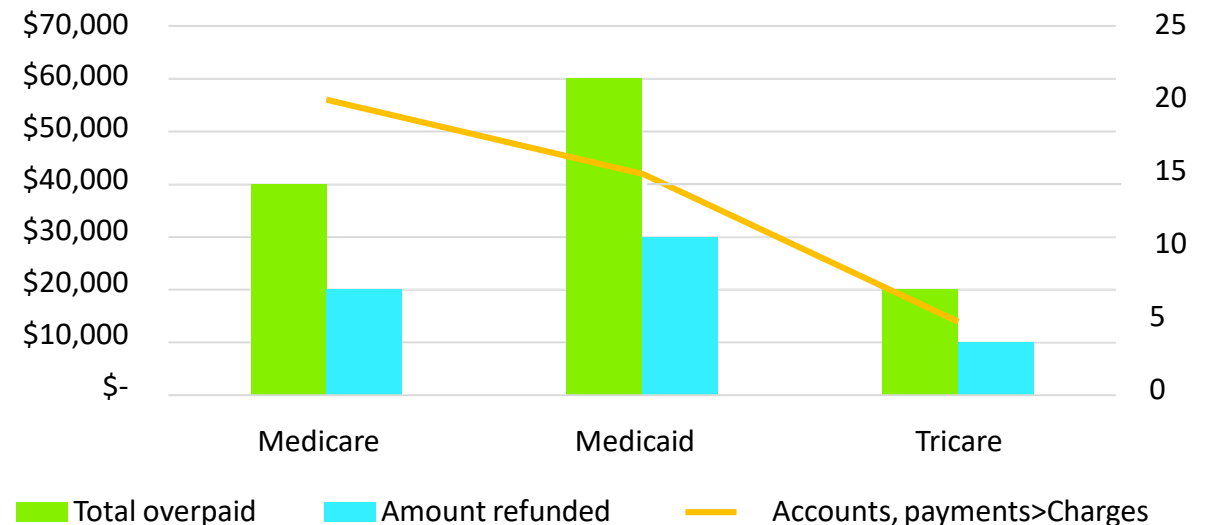
- **Internal data files:** Use data analytics to identify encounters and submitted claims with payments for services rendered greater than charges. Aggregate data to create totals by payor class. Create process to repay identified overpayments in a timely manner. Monitor identified overpayments for timely refund. Investigate root causes that lead to overpayments and update or remediate systems and processes as needed.

Examples

Identify overpayments and refunds for encounters

Payor Class	Count of Encounters, Payments>Charges	Total Overpayments Received	Total Overpayments Refunded
1	1	\$ 50.00	\$50.00
2	5	\$125.34	\$125.34
3	7	\$461.21	\$0.00
4	10	\$741.64	\$250.31
5	12	\$1,726.63	\$521.05

PAYMENTS > CHARGES, BY PAYOR CLASS



Quality data analysis – Vision

Improve quality improvement efforts, public perception, and financial impact when performance related reimbursement.

Purpose

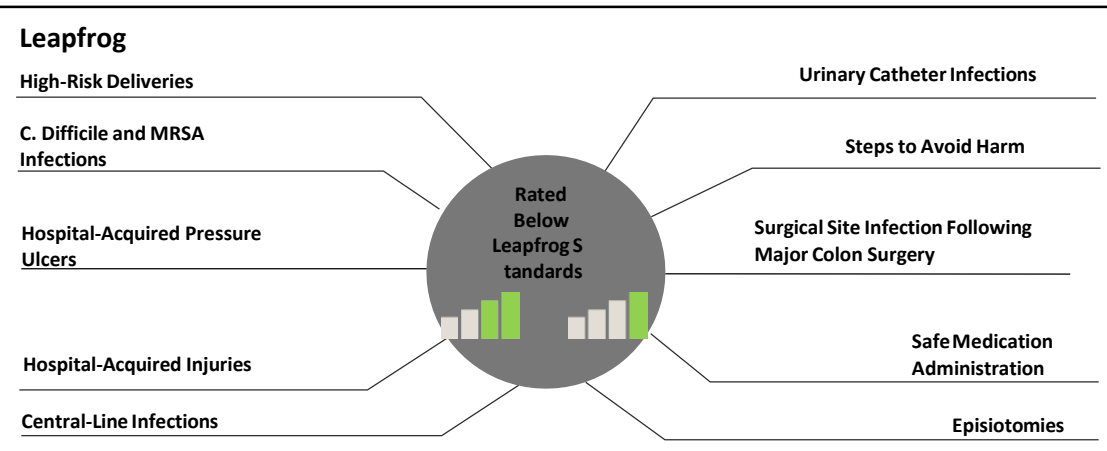
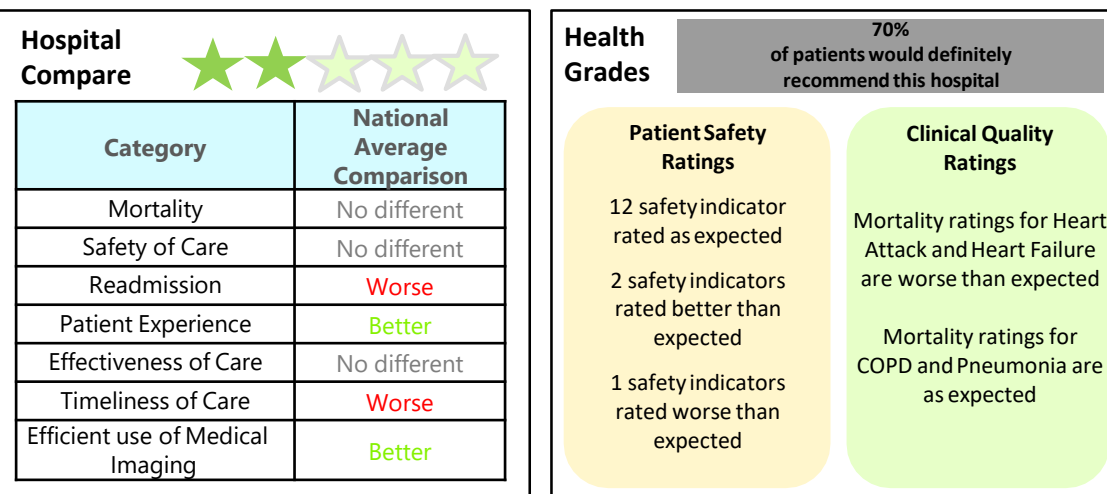
Identify lagging quality indicators by quality measure, service area, physician

Approach

- **CMS Measures Inventory Tool:** Compilation of measures used by CMS in various quality, reporting and payment programs. The Inventory lists each measure by program, reporting measure specifications including, but not limited to, numerator, denominator, exclusion criteria, Meaningful Measures domain, measure type, and National Quality Forum (NQF) endorsement status.
- **Benchmarking of internal statistics to CMS data:** Internal data sets of quality and safety metrics are benchmarked to CMS data (e.g., Provider Utilization and Payment Data Public Use File) to identify target specialties, metrics, providers or clinical operational areas for quality improvement projects and education.
- **Assessment of quality measure reporting process:** An assessment of available policies and procedures, training and education efforts, oversight efforts by company board, analyzing integrity of available data, assessment of IT security measures and confirming the formalized process for tracking and following up on electronic extraction or manual abstraction errors.

Examples

Compare hospital compare, health grades, and leapfrog data to determine quality performance





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