



**Advancing Healthcare
Crowe Healthcare Summit 2017**

Compliance Programs, Data Analytics, and Risk-Based Coding Analysis

Smart decisions. Lasting value.™

Data Analytics and Compliance Program Effectiveness

Program Overview:

A discussion regarding compliance program effectiveness, government data analytics programs, and how to improve compliance program effectiveness through data analytics.

Upon completion of this session, participants will:

- Distinguish compliance program strengths and opportunities for improvement
- Learn about the federal government's data analytic capabilities
- Consider utilizing data analytics to improve compliance program effectiveness

Data Analytics and Compliance Program Effectiveness

What Should a Compliance Program
Look Like?

Three Lines of Defense

“The Third Line”

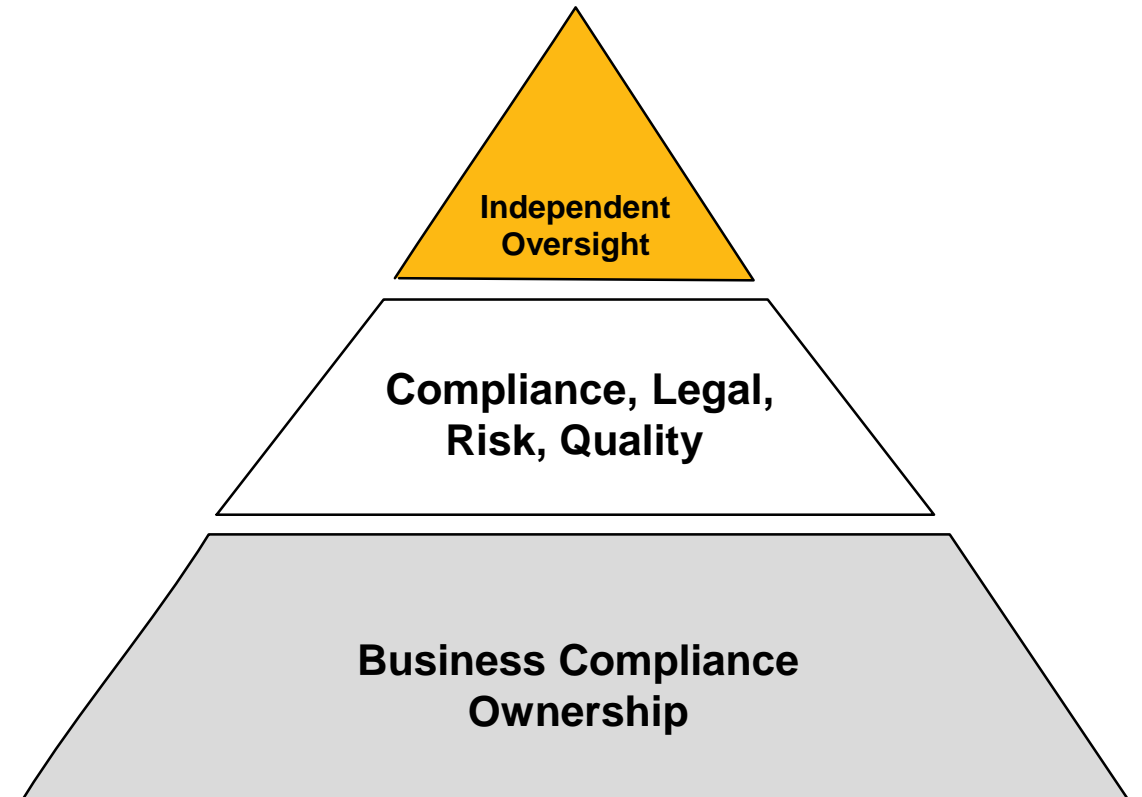
Internal Audit and possibly Compliance will provide independent oversight and auditing.

“The Second Line”

Compliance will provide compliance management, facilitation, framework and policies.

“The First Line”

Management is accountable for identification of risks, internal controls, compliance activities and monitoring in order to be compliant with laws and regulations.



What is an Effective Compliance Program?

Effective compliance programs should mitigate/eliminate regulatory/criminal risks, **foster a culture of integrity** and provide organizations with the ability to defend against allegations of fraud or abuse.

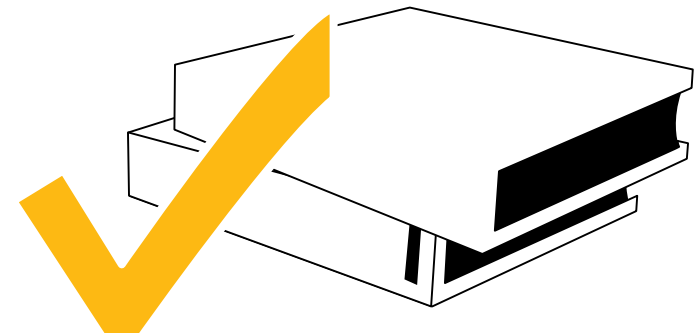
Incorporated into the OIG's various Compliance Program Guidance Documents and promulgated in the Federal Sentencing Guidelines; the Seven Elements represent the basic tenets of an effective compliance program.

1. Oversight:

- Compliance Office & Committee
- Oversight-boards

2. Written Standards:

- Code of Conduct
- Policies & Procedures
- Event/Function specific guidance documents



What is an Effective Compliance Program?

3. Training:

- Adequate training on company specific compliance policies and expectations
- Should include all relevant employees and 3rd party agents working on behalf of the organization

4. Communication:

- Anonymous Compliance Hotline
- Access to supervisors and compliance personnel
- Positive compliance tone from leadership

5. Risk Based Auditing & Monitoring:


- Risk Assessment
- Internal and 3rd party auditors
- Business-based monitoring

6. Disciplinary Guidelines and Enforcement of Company Standards:

- Clear, specific and transparent disciplinary policies
- Consistency with consequences
- Intentional/material vs. negligent violations

7. Responding to Detected Problems & Corrective Action

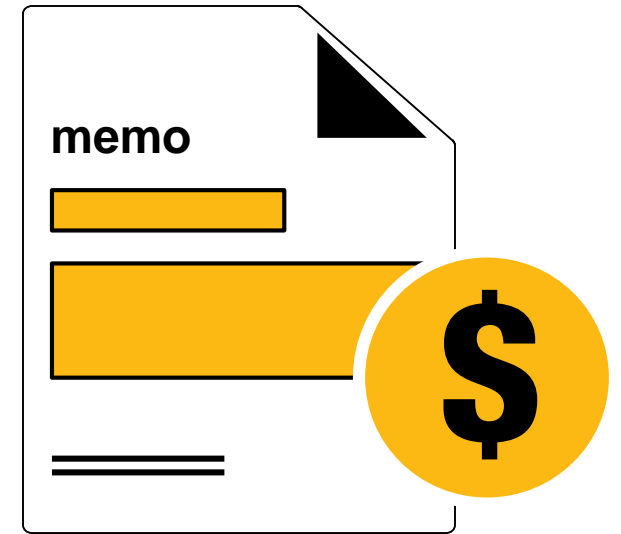
- Investigations process
- Identification of Root Cause
- Development and corrective action/mitigation plan



The Yates Memo, Forrest Park and July 13, 2017 Fraud Takedown

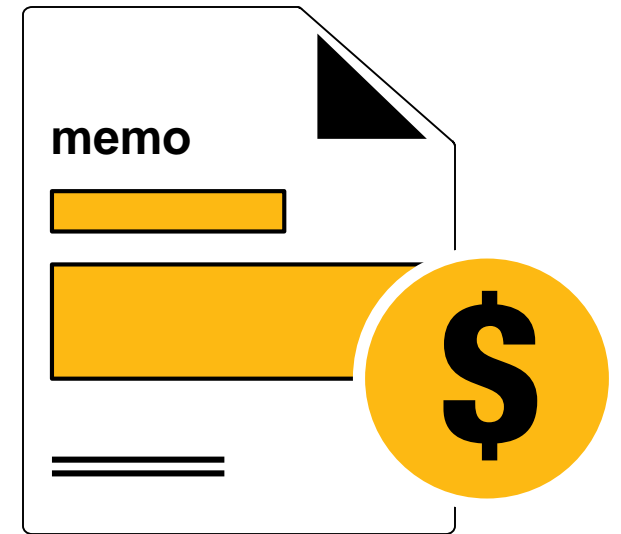
The Yates Memo and Fiduciary Responsibility

1. In order to qualify for any cooperation credit, corporations must provide to the Department all relevant facts relating to the individuals responsible for the misconduct.
2. Criminal and civil corporate investigations should focus on individuals from the inception of the investigation.
3. Criminal and civil attorneys handling corporate investigations should be in routine communication with one another.



The Yates Memo and Fiduciary Responsibility

4. Absent extraordinary circumstances or approved departmental policy, the Department will not release culpable individuals from civil or criminal liability when resolving a matter with a corporation.
5. Department attorneys should not resolve matters with a corporation without a clear plan to resolve related individual cases, and should memorialize any declinations as to individuals in such cases.
6. Civil attorneys should consistently focus on individuals as well as the company and evaluate whether to bring suit against an individual based on considerations beyond that individual's ability to pay.



The Yates Memo and July 13 Fraud Takedown

Forest Park Medical Center – Dallas – December 1, 2016

Christmas comes early – Uncle Sam indicts 21 individuals for massive conspiracy to pay and receive kickbacks and bribes totaling more than \$40 million for patient referrals. Unique use of the Travel Act and Health Care Fraud Statute.

July 13, 2017 National Health Care Fraud Takedown

The largest ever health care fraud enforcement action by the Medicare Fraud Strike Force, involving 412 charged defendants across 41 federal districts, including 115 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$1.3 billion in false billings.



The Impact of Enforcement Activities on Ancillary Entities and Physician Practices

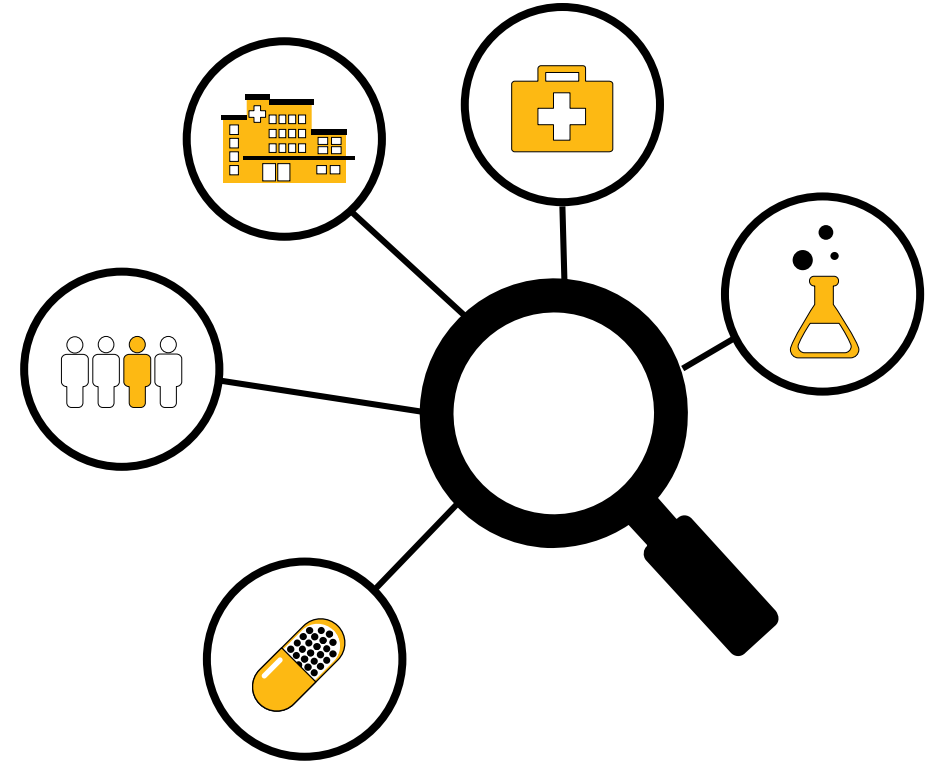
Enforcement Activity

The following entities are being scrutinized:

- Labs/Toxicology Labs
- Specialty Pharmacies
- Workers Comp/DOL
- Pain Management

Beware:

- Alleged Federal Carve Outs
- Uneducated sales reps willing to push the envelope for huge commissions
- Physicians' relationships with questionable entities
- Guilt by association





Data Analytics: The Playing Field Has Changed

Data Analytics

Interviewed Current and Past Government Enforcement Individuals:

- Data analytics has changed the way they do their jobs
- Increased productivity
- Improved morale
- Increased collaboration
- Improved ability to find fraud, waste and abuse
- Combined with the Yates Memo – very powerful



New Investigative and Enforcement Strategies

“Twin-Pillar” Approach

- Fraud Prevention System (“FPS”)
 - Utilizes three data analytic strategies:
 1. Anomaly detection models
 2. Predictive models
 3. Social network analysis
- Automated provider screening program
 - Identifies ineligible providers or suppliers before they are enrolled or revalidated by using enhanced screening procedures



The Fraud Prevention System

“Since June 2011, CMS uses the Fraud Prevention System (FPS) on all Medicare fee-for-service claims on a streaming, national basis. Similar to the fraud detection technology used by credit card companies, FPS applies predictive analytics to claims before making payments in order to identify aberrant and suspicious billing patterns. CMS uses leads generated by FPS to trigger actions that can be implemented swiftly.”

“Since 2011 the FPS identified savings (certified by HHS OIG) associated with these prevention and detection actions were \$820 million... This resulted in more than a 10-to-1 return on investment for the first three years of implementation...”

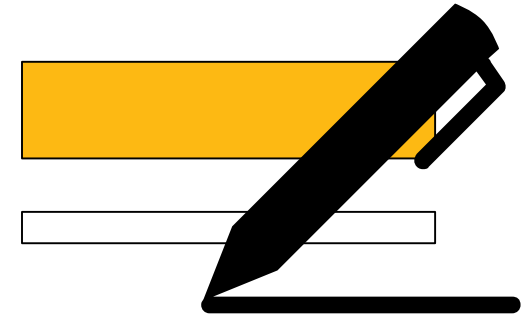
<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-26.html>

Healthcare Fraud Prevention Partnership

“The HFPP’s purpose is to improve the detection and prevention of healthcare fraud by:

- Exchanging data and information between the public and private sectors.
- Leveraging various analytic tools against data sets provided by HFPP partners.
- Providing a forum for public and private leaders and subject matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud.”

Source: <https://hfpp.cms.gov/about/index.html>



Medicare Provider Utilization and Payment Data

“The Physician and Other Supplier Public Use File (Physician and Other Supplier PUF) provides information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals. The Physician and Other Supplier PUF contains information on utilization, payment (allowed amount and Medicare payment), and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and place of service. This PUF is based on information from CMS administrative claims data for Medicare beneficiaries enrolled in the fee-for-service program. The data in the Physician and Other Supplier PUF covers calendar years 2012 through 2014 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.”

Source: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html>

Integrated Data Repository

“The Integrated Data Repository (IDR) is a high-volume data warehouse integrating Parts A, B, C, D, and DME claims, beneficiary and provider data sources, along with ancillary data such as contract information, risk scores, and many others. Access to this robust integrated data supports much needed analytics across CMS.”

Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/index.html>

Medicare Program Integrity Manual, Chapter 2 – Data Analysis

“This chapter specifies resources and procedures to the MACs, ZPICs, Recovery Auditors, and the [Supplemental Medical Review Contractor] SMRC. The contractors shall use these instructions to identify and verify potential errors to produce the greatest protection to the Medicare program. Contractors should objectively use analytical methodologies to evaluate potential errors...”

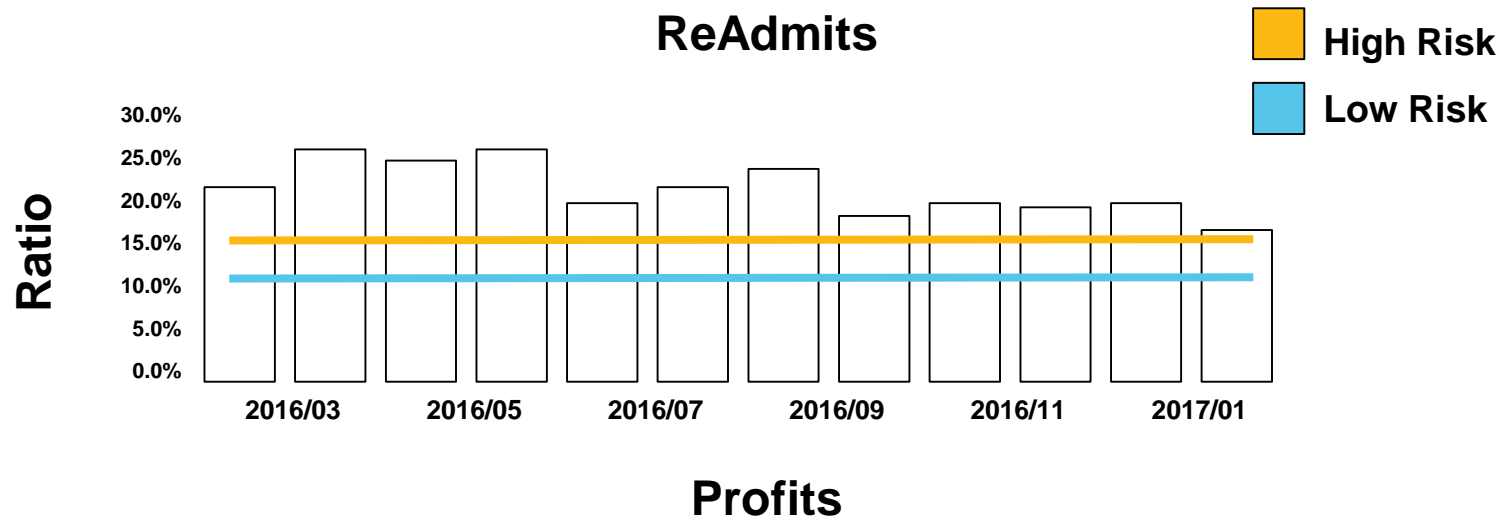


Sample Provider Data Analysis

Sample Provider Data Analysis

30-day Readmissions to Same Hospital - Medicare Claims Only

Patients discharged home and readmitted within 30 days may indicate a potential premature discharge or incomplete care. Readmissions have been associated with billing errors, premature discharge, incomplete care and inappropriate readmission. Readmissions are at risk for improper payment.

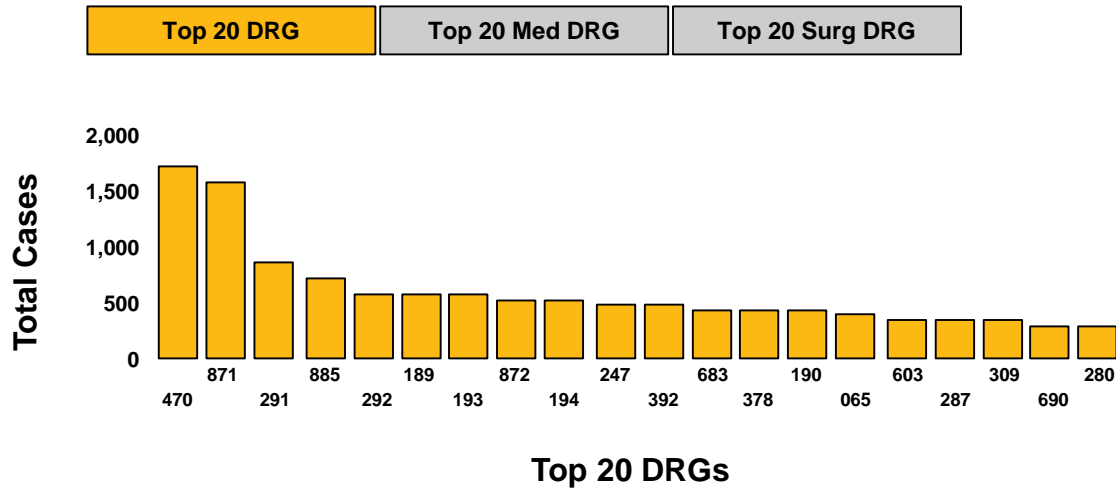


Source: CHAN's Proactive Detection Tool

Sample Provider Data Analysis

Top 20 DRG Analysis – System Total

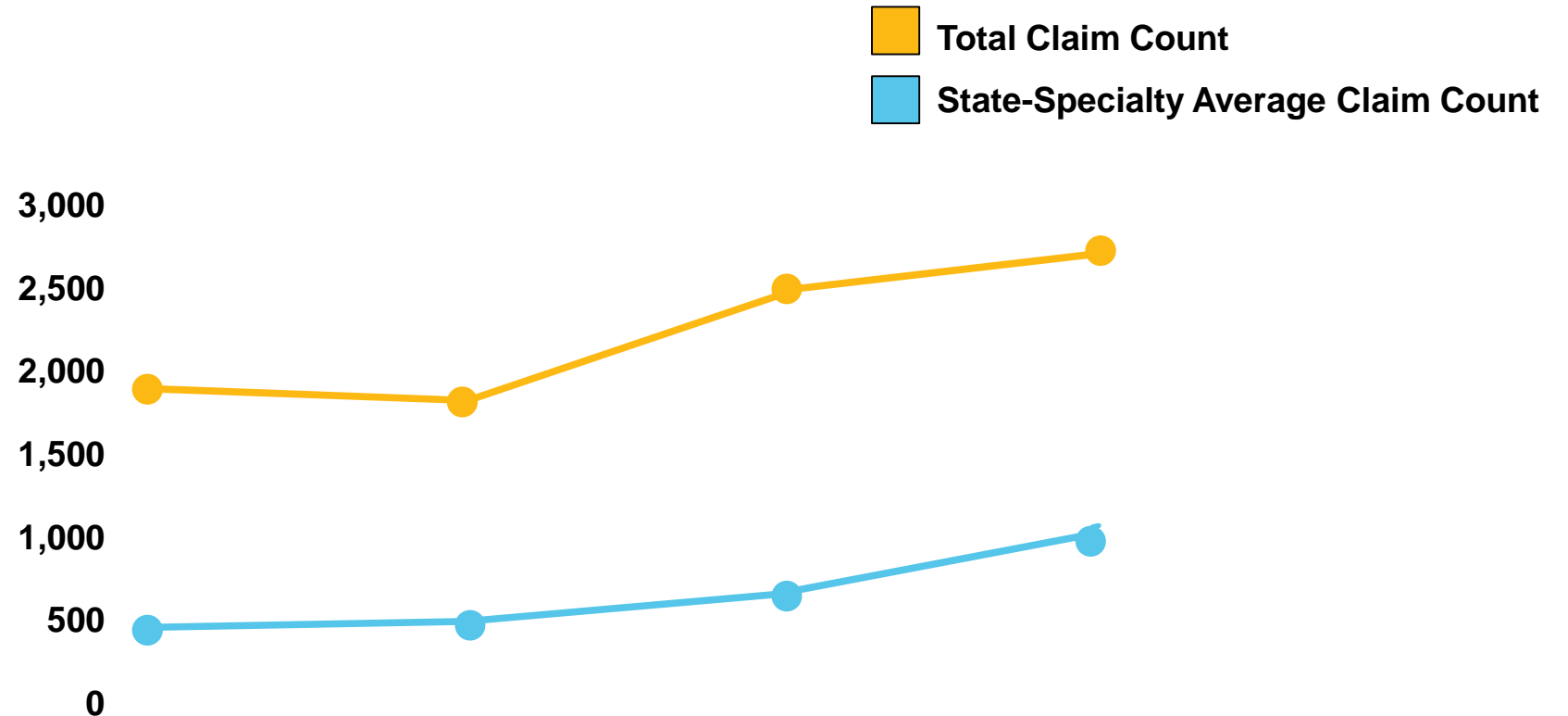
Period: 2016/02, 2016/03, 2016/04, 2016/05, 2016/06, 2016/07, 2016/08, 2016/09, 2016/10, 2016/11, 2016/12, 2017/01



DRG	DRG TITLE	CHASE COUNT	% OF TOTAL CASES
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1,775	5.64%
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1,598	5.08%
291	HEART FAILURE & SHOCK W MCC	923	2.93%
885	PSYCHOSES	723	2.30%
292	HEART FAILURE & SHOCK W CC	583	1.85%
189	PULMONARY EDEMA & RESPIRATORY FAILURE	554	1.76%
193	SIMPLE PHENUMONIA & PLEURISY W MCC	553	1.76%
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	542	1.72%
194	SIMPLE PNEUMONIA & PLEURISY W CC	493	1.57%
247	PERC CARDIVOSAC PROC W DRUG-ELUTING STENT W/O MCC	476	1.51%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	474	1.51%
683	RENAL FAILURE W CC	450	1.43%
378	G.I. HEMORRHAGE W CC	442	1.40%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	431	1.37%
065	INTRACRANIAL HEMORRHAGE OR CEREBRA INFACION W CC OR TPA IN 24 HRS	406	1.29%
603	CELLULITIS W/O MCC	381	1.21%

Sample Provider Data Analysis

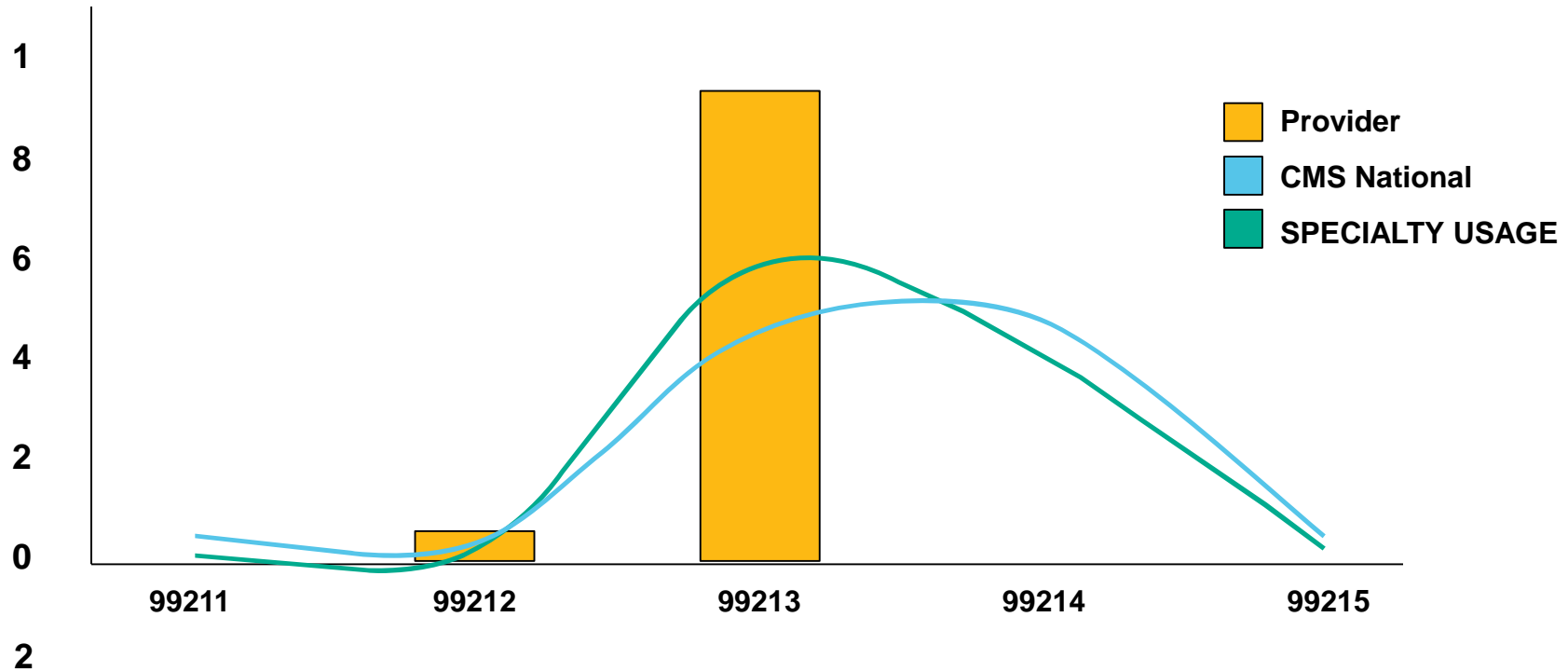
Prescription Counts by Year



Source: <http://www.doctors.healthgrove.com>

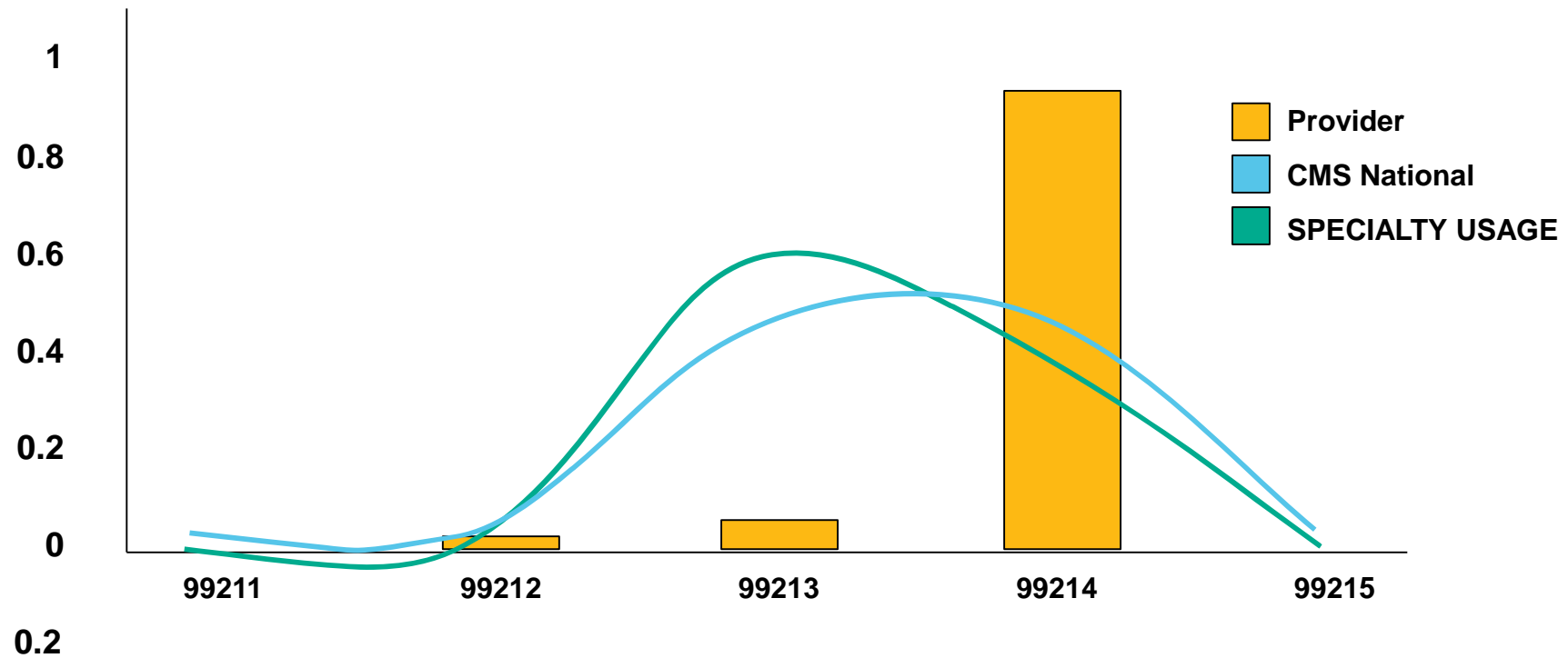
Sample Provider Data Analysis

E/M Bell Curve



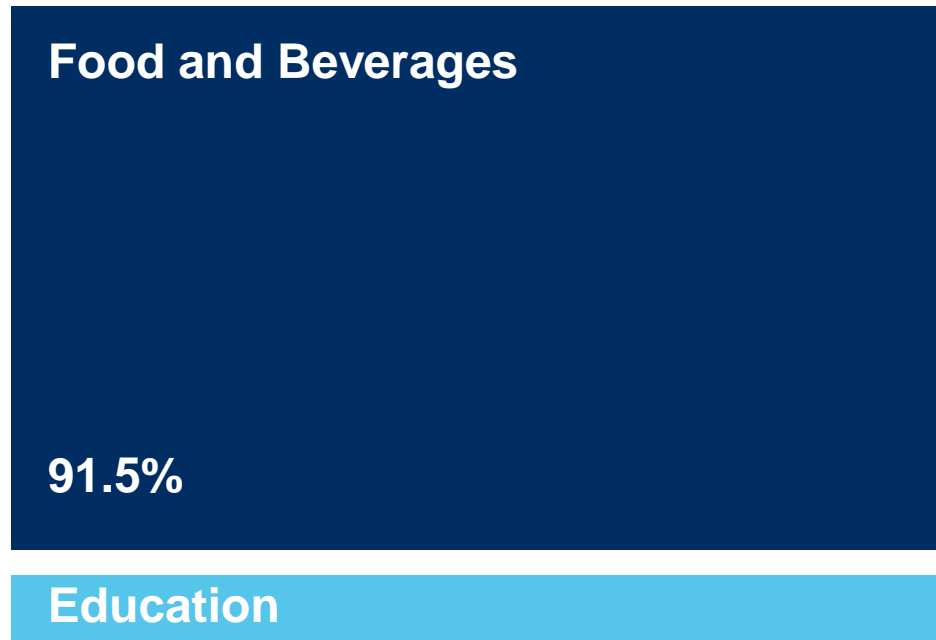
Sample Provider Data Analysis

E/M Bell Curve Discussion

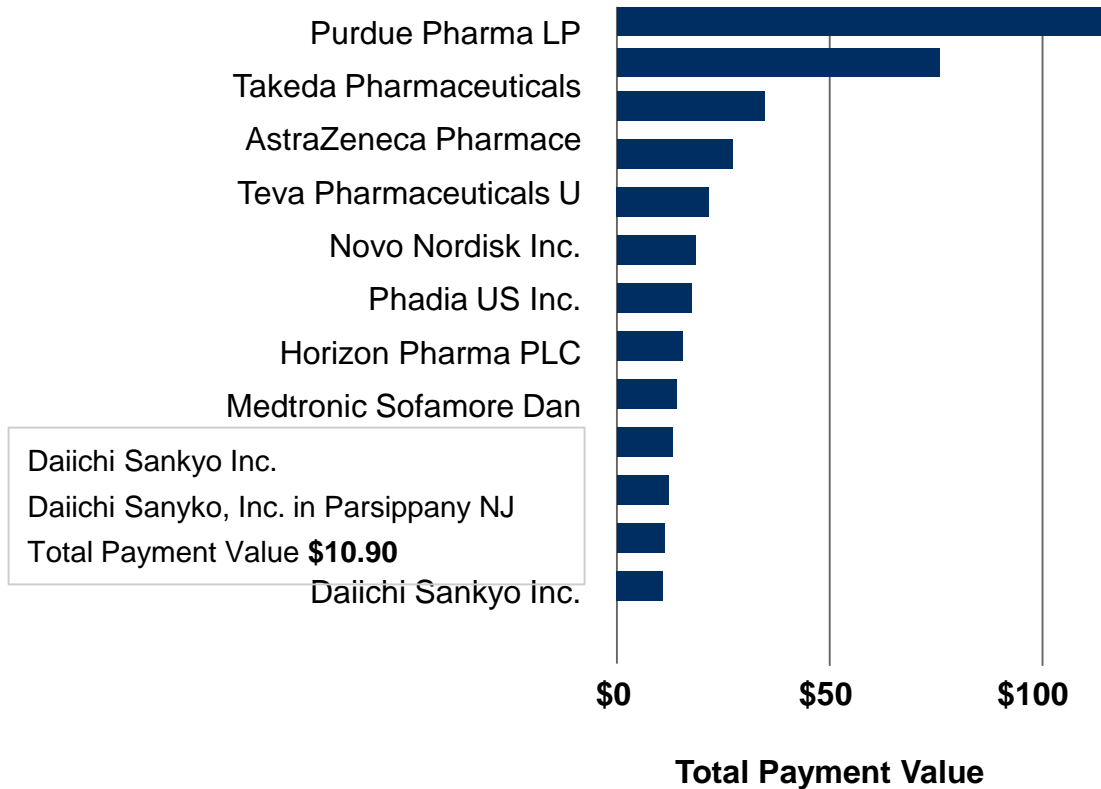


Sample Provider Data Analysis

Reasons for Payment



Companies Making Payment



Source: <http://www.doctors.healthgrove.com>

Sample Data Analytics from Law Enforcement Report

Table 1. Overall Provider Summary

Category	Value
Provider Name	X
Provider NPI	5555555555
Number of Patients	429
Number of Claims	2064
Billed Amount	\$2,148,577
Allowed Amount	\$2,034,499
Paid Amount	\$1,630,365
Billed Services	20794
Allowed Services	20063
Denied Services	731

Sample Data Analytics from Law Enforcement Report


Table 2. Provider Tax ID Summary

Provider Tax ID	Provider Address	First DOS	Last DOS	Nbr Pts	Nbr Claims	Billed Amt	Allowed Amt	Paid Amt	Billed Srvcs	Allowed Srvcs	Denied Srvcs
55555555		06/08/2009	07/30/2009	429	2064	\$2,148,577	\$2,034,499	\$1,630,365	20794	20063	731

Sample Data Analytics from Law Enforcement Report

Table 6. HCPC Summary by Allowed Amount (Top 10)

Proc	Desc	Nbr Pts	Nbr Claims	Billed Amt	Allowed Amt	Paid Amt	Billed Srvcs	Allowed Srvcs	Denied Srvcs
91120	RECTAL SENSATION, TONE, AND COMPLIANCE TEST (IE, RESPONSE TO GRADED BALLOON DISTENTION)	348	1628	\$936,411	\$909,279	\$727,423	2623	2547	76
51784	ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, OTHER THAN NEEDLE, ANY TECHNIQUE	348	1630	\$516,337	\$490,830	\$392,664	2621	2492	129
95010	PERCUTANEOUS TESTS (SCRATCH, PUNCTURE, PRICK) SEQUENTIAL AND INCREMENTAL, WITH DRUGS, BIOLOGICALS OR VENOMS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT BY A PHYSICIAN, SPECIFY NUMBER OF TESTS	399	399	\$195,591	\$193,611	\$154,889	11854	11734	120
93306	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY	402	402	\$120,600	\$107,484	\$85,988	402	398	4
99205	OFFICE OUTPT NEW 60 MIN	425	425	\$85,000	\$76,441	\$61,040	425	421	4
93924	N-INVAS PHYSIOLOGIC STD LXTR ART COMPL BI	296	296	\$64,824	\$60,225	\$48,180	296	275	21
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY	284	284	\$52,540	\$51,985	\$41,588	284	281	3
76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	311	311	\$41,985	\$41,580	\$33,264	311	308	3
93882	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR LIMITED STUDY	258	258	\$41,280	\$39,680	\$31,744	258	248	10
94620	PULMONARY STRESS TESTING; SIMPLE (EG, 6-MINUTE WALK TEST, PROLONGED EXERCISE TEST FOR BRONCHOSPASM WITH PRE- AND POST-SPIROMETRY AND OXIMETRY)	400	400	\$18,000	\$17,820	\$14,256	400	396	4



How does your organization
look from the outside?

How Does Your Organization Look from the Outside?

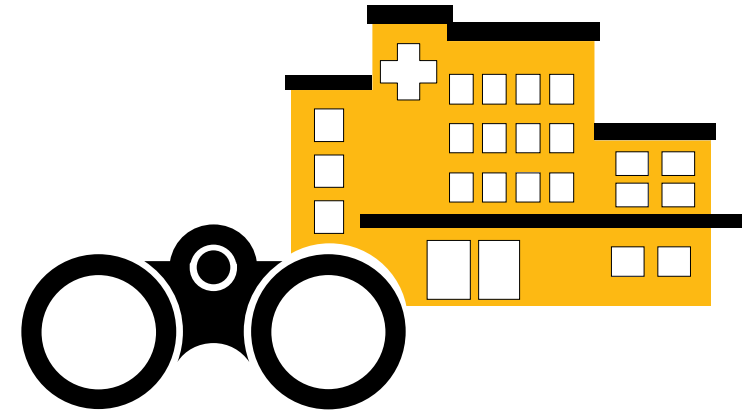
Consider the following:

- What are your most utilized codes?
- Who are your highest paid providers?
- Who utilizes the highest and lowest E&M codes?
- Who is responsible for denials?
- Are you performing claims reviews?
- Are you being reimbursed for non-medically necessary services?
- Are you trending findings? Are you refunding money?
- Who receives reimbursement from potential referral sources?
- Which physicians are receiving the most \$ from industry?
- Do you do business with PODs?
- Do you assess FMV when acquiring physicians?
- Do you have a documented, strategic, compliant approach to physician compensation and acquisitions?
- Have you compared physician contract amounts to accounts payable?

How Does Your Organization Look from the Outside?

Ultimately...

- Do you know what your organization's compliance risk profile looks like?
- Do employees know their compliance responsibilities?
- Are they held accountable for them regardless of title?
- Are your compliance efforts satisfactory?
 - Could you attest that they are?
 - Could your board?
 - Could your executive leadership team?
 - Could operational management?
- Has the compliance program ever been assessed?



Thank you

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