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Pam Joslin, MM, CMC, CMIS, CMOM, CMCA-E/M, CEMA

On the topic:

Top 10 Compliance Concerns for Medical Practices
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Top 10 Compliance Concerns for Medical Practices

Brought to you by
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Overview

- Healthcare reform
- Patient experience as a priority
- Active shooter and gun violence
- Opioid crisis management
- Social factors that affect our patients
- Responding to natural disasters
- Data breaches
- Social Media
- OIG Workplan
- Coding and Documentation Accuracy
Healthcare Reform

• The debate over U.S. health care reform and the future of the Affordable Care Act dominated headlines in 2017.

• The individual mandate under the 2010 Affordable Care Act will end next year.

• The mandate requires Americans to buy their own health insurance or face a penalty if they are not already covered by their employer or by a government program such as Medicaid or Medicare.

• The new tax law eliminates the penalty beginning in 2019.
• Some 8.8 million Americans signed up for 2018 coverage via the federal health insurance exchanges created by the ACA, despite a shortened registration window.

• According to Wharton health care management professor, Mark Pauly, those who signed up for coverage for this year may well be the “core portion of the population that finds getting their health insurance through the exchanges a good deal because the great bulk of them get subsidies”.

• Understanding Health Care Reform and employers’ responsibilities under it presents perhaps the single biggest challenge to employers in the HR compliance area.

• The escalating cost of employer-supplied health insurance is the other critical challenge facing employers in the employee benefits administration area.

• Organizations realize that these costs can actually prevent their company from achieving its business goals. The larger the company, the more likely they are to have a plan/strategy in place to control these costs. What they are doing also varies by size.
Confidence in Understanding Employer Responsibilities As Required by ACA

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<td>Small (1-49 EEs)</td>
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<td>70%</td>
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<td>Midsized (50-999 EEs)</td>
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<td>Large (1,000+ EEs)</td>
<td>41%</td>
<td>52%</td>
<td>7%</td>
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Analysis of Company’s Potential Exposure to Penalties

**Estimate how many EEs would qualify as 'full-time' under the Shared Responsibility provisions**
- Small (1-49 EEs): 50%
- Midsized (50-999 EEs): 67%
- Large (1,000+ EEs): 67%

**Determine whether you have at least one current health plan that has a 60% actuarial value, meaning that the plan is expected to pay, on average, at least 60% of the expected cost of covered benefits**
- Small (1-49 EEs): 44%
- Midsized (50-999 EEs): 56%
- Large (1,000+ EEs): 56%

**Estimate how many EEs have W-2 earnings that fall between 133% and 400% of the Federal Poverty Level**
- Small (1-49 EEs): 41%
- Midsized (50-999 EEs): 51%
- Large (1,000+ EEs): 51%

**Estimate the # of EEs for whom current health coverage may be deemed 'unaffordable' under these regulations (i.e., single premium exceeds 9.5% of their W-2 earnings with your company/organization)**
- Small (1-49 EEs): 32%
- Midsized (50-999 EEs): 53%
- Large (1,000+ EEs): 53%

**Estimate the potential penalty amount that your company/organization might have to pay under these regulations**
- Small (1-49 EEs): 27%
- Midsized (50-999 EEs): 47%
- Large (1,000+ EEs): 47%

* May be eligible for an Exchange subsidy
PATIENT EXPERIENCE AS A PRIORITY
Patient Experience as a Priority

Almost 50% of healthcare executives indicate that improving the patient experience will be top priority in 2018 and for the foreseeable future. In order to remain competitive in a particular market, healthcare organizations are looking for initiatives to engage the patient and provide a positive experience with the implementation of technologies, social media and personal all to not only impact the bottom line, but what the patient experiences.

Developing a value-based organizational culture that has patient experience at its core is the full commitment of the organization's executive leadership and board.

Before patient expectations can be influenced, the organization must clearly and concisely:

• communicate to internal and stakeholder the role that value plays in the organization
• define the specific roles that all employees, physicians, and administration play creating this “culture of patient experience.”

Why is This So Important?

• Delivering on promises creates expectations
  – Expectations are viewed by the customer as a promise
• Failing to deliver on promises is not an option in a competitive, consumer-driven healthcare system where information on quality healthcare is expected.
• Patients are expecting the organization to deliver on its promises and are watching.
• Second and third impressions are just as important as first impressions.
  – Unhappy and frustrated patients express themselves online with negative reviews.
  – Delivering, or failing to deliver, on promises directly impacts the organization's competitive position.
• A 2012 HealthLeaders Media survey asked hospital executives about priorities for improving patient experience.

The top recommendations included:

– interactive bedside computers
– quiet time to ensure rest, new facilities, private rooms and food on demand.

In contrast, the results of CMS satisfaction scores, which have been published online since 2008, indicate that patients desire:

– cleaner rooms
– happy people
– greater respect
– improved communication and attentiveness to their needs and concerns.

When executives running large healthcare organizations fail to design their patient experience strategies around needs identified by their patients, value suffers.

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• A 2015 American Society for Quality survey found that 83% of patients desired improved communications between patients and caregivers as a priority for improved patient experience.

• Leadership that prioritizes a patient-centered philosophy among staff also ranked high at 81% while 71% of respondents said organizations should view improvement in quality of patient experience and service delivery as being of equal priority to financial and clinical performance measures.

• These results demonstrate that patients have a strong desire for their healthcare services be delivered with empathy, compassion and other emotional connection that recognizes the personal nature of the service.

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Healthcare Workers are at Increased Risk for Workplace Violence

- OSHA reports indicate, from 2002 to 2013, incidents of serious workplace violence (those requiring days off for the injured worker to recuperate) were 4 times more common in healthcare than in private industry on average.

- In 2013, the healthcare and social assistance sector had 7.8 cases of serious workplace violence per 10,000 full-time employees.

- Other large sectors such as construction, manufacturing, and retail all had fewer than 2 cases per 10,000 full-time employees.
Patients are the largest source of violence in healthcare settings, but they are not the only source.

- In 2013, 80% of serious violent incidents reported in healthcare settings were caused by interactions with patients
- Other incidents were caused by visitors, coworkers, or other people
Prevalence of Violence Among Healthcare Occupations

• **21%** of registered nurses and nursing students reported being physically assaulted—and **over 50%** verbally abused—in a 12-month period (2014 American Nurses Association’s Health Risk Appraisal survey of 3,765 registered nurses and nursing students).

• **12%** of emergency department nurses experienced physical violence—and **59%** experienced verbal abuse—during a seven-day period (2009–2011 Emergency Nurses Association survey of 7,169 nurses).

• **13%** of employees in Veterans Health Administration hospitals reported being assaulted in a year (2002 survey of 72,349 workers at 142 facilities).
Early Warning Signs

• Early warning signs of workplace violence:
  – Intimidation and bullying of others in the workplace. Discourteous, disrespectful and uncooperative behavior toward customers, co-workers or supervisors
  – Other warning signs include personal life stressors, including financial, marital and family issues. All can contribute to a person’s loss of control.

• Level-two warning signs involve escalation. That’s where a person starts arguing with co-workers and supervisors and refuses to comply with the organization’s policies and procedures.

• Further escalation includes displays of extreme rage, loss of control and bringing or threatening to bring weapons to the workplace.

• All of these actions are emergencies and serious signs of possible trouble to come.

Plan of Action

• Importance of “foreseeability”. The days of saying active shooter incidents are not foreseeable are long gone.

• Employers must have policies in place to prevent, anticipate and protect employees against workplace violence (i.e., active shooter, other violent behavior).

• The response plan has to be practical, public and practiced.
Active Shooter and Gun Violence
Life-Saving Tips

• 37% of active shooter incidents happen in less than 5 minutes and about half the time the shooter commits suicide.

• The most common locations for active shooter incidents include businesses and schools, and almost half the time the shooting is over by the time police arrive.

• Tips if you encounter an active shooter:
  – Your life is your responsibility.
  – It is not the best option to hunker down and wait for the police.
  – Know your exits and consider alternative exits.
  – How you react is going to influence your chances of survival.
  – Keep your hands empty at all times; you don’t want police to mistake you for the shooter.
  – If you are able to make it outside, move in the direction of law enforcement.
  – If you can’t get out; hide.
  – Don’t scream, don’t yell and don’t be distracting.

Available Resources

• The U.S. Department of Homeland Security has an active shooter preparedness portal on its website that offers tips, webinars and workshops on planning for active shooters in the workplace.

• The FBI offers “Run, Hide, Fight: Surviving an Active Shooter Event, an online video that depicts an active shooting situation in the workplace played by actors. The video instructs you to shut off your cellphone, turn off the lights, lock your door and put a file cabinet up against the door to protect yourself from the shooter if you are unable to exit your workplace.

• “Active Shooter: What’s the Plan of Action for Your Workplace?” is sponsored by the ABA Center for Professional Development, Commission on Disability Rights, Committee on Disaster Response and Preparedness, Division for Public Services, Standing Committee on Gun Violence, Law Practice Division, Section of Administrative Law and Regulatory Practice, Solo, Small Firm and General Practice Division and Tort Trial and Insurance Practice Section.

Source: https://www.dhs.gov/active-shooter-preparedness
OPIOID CRISIS MANAGEMENT

Opioid Crisis Management

THE OPIOID EPIDEMIC BY THE NUMBERS

IN 2016...

116 People died every day from opioid-related drug overdoses

11.5 m People missed prescription opioids

42,249 People died from overdosing on opioids

2.1 million People lost or had an opioid use disorder

948,000 People could be saved

170,000 People initiated for the first time

2.1 million People misused prescription opioids for the first time

17,087 Deaths attributed to overdosing on commonly prescribed opioids

19,413 Deaths attributed to overdosing on heroin

15,469 Deaths attributed to overdosing on heroin

504 billion $ Economic cost

Background on Opioid Crisis

• In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to opioid pain relievers and healthcare providers began to prescribe them at greater rates.

• Increased prescription of opioid medications led to widespread misuse of both prescription and non-prescription opioids before it became clear that these medications could indeed be highly addictive.

• Opioid overdoses accounted for more than 42,000 deaths in 2016, more than any previous year on record. An estimated 40% of opioid overdose deaths involved a prescription opioid.

• In 2017 HHS declared a public health emergency and announced a strategy to combat the opioid crisis.

• Devastating consequences of the opioid epidemic include increases in opioid misuse and related overdoses, as well as the rising incidence of newborns experiencing withdrawal syndrome due to opioid use and misuse during pregnancy.
Social Factors that Affect our Patients

• Social factors are things that affect lifestyle, such as religion, family or wealth.

• Examples of social determinants of health:
  – Economic stability
  – Neighborhood and physical environment
  – Education
  – Food
  – Community and social context
  – Health care system

States Integrating Social Determinants into Medicaid Managed Care Contracts - Examples

- **Arizona** requires coordination of community resources like housing and utility assistance under its managed long-term services and supports (MLTSS) contract. The state provides state-only funding in conjunction with its managed behavioral health contract to provide housing assistance. The state also encourages health plans to coordinate with the Veterans’ Administration and other programs to meet members’ social support needs.

- The **District of Columbia** encourages MCOs to refer beneficiaries with three or more chronic conditions to the “My Health GPS” Health Home program for care coordination and case management services, including a biopsychosocial needs assessment and referral to community and social support services.

- **Louisiana** requires its plans to screen for problem gaming and tobacco use and requires referrals to Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and the Louisiana Permanent Supportive Housing program when appropriate.

- **Nebraska** requires MCOs to have staff trained on social determinants of health and be familiar with community resources; plans are also required to have policies to address members with multiple biopsychosocial needs.
<table>
<thead>
<tr>
<th>Ongoing Trends</th>
<th>What to Watch</th>
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<tr>
<td>Eligibility</td>
<td>State waivers to impose premiums and restrict eligibility (including work requirements)</td>
</tr>
<tr>
<td>ACA Medicaid expansion</td>
<td>MCO contracts focused on social determinants and value-based payment</td>
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<tr>
<td>Initiatives to connect justice-involved individuals to coverage</td>
<td>Focus on housing and direct care workforce shortages</td>
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<tr>
<td>Managed Care</td>
<td>MCO carve-ins of complex populations and behavioral health services</td>
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<tr>
<td>Long-Term Care</td>
<td>Expansion of community-based care</td>
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<tr>
<td>Provider Rates and Taxes</td>
<td>More provider rate increases than restrictions</td>
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<tr>
<td>Benefits, Pharmacy, and Opioid Strategies</td>
<td>Benefit expansions for mental health and substance use</td>
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<td>Growing adoption of CDC prescribing guidelines for opioids</td>
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**RESPONDING TO NATURAL DISASTERS**
Responding to Nature Disasters

- During a natural disaster, health systems face closure, chaotic revenue cycle operations, destroyed or damaged physical assets and displaced workforces and patients.

- Pharmaceutical supply chains can be disrupted by offline manufacturing operations, leading to product shortages, labor shortages and lab testing issues.

- Health systems and pharmaceutical companies with strategies in place can increase the pace of recovery and avoid making decisions that could do harm in the long term.
Examples:

- The CHRISTUS Health Southwest Louisiana system was able to avoid significant disruption because it had moved back-office functions out of state.

- After Hurricane Sandy caused a drop in patient volume, NYU Langone Medical Center underwent a credit review. Thanks to planning, the system was able to quickly resume services, and its credit rating was maintained.

Mitigate legal and reputational damage by planning for clear lines of communication and alternative care standards in the event of a disaster.

- Facilities that do suffer damage must handle patient concerns about practice viability and continuity of care.

- After Hurricane Katrina, over 200 lawsuits were filed against providers alleging liability for patients' deaths and suffering.
Possible Strategies

- Put measures in place to protect physical facilities and keep care going:
  - Generators and other critical systems in underground concrete location or back-up system in another location not as vulnerable.
  - Virtual back-up to traditional services
  - Evaluate insurance policies
    - Coverage
    - Period of indemnity, limitations and deductible to meet the consequences of a major event
Data Breaches

• Healthcare continued to be a lucrative target for hackers in 2017 with weaponized ransomware, misconfigured cloud storage buckets and phishing emails dominating the year.

• In 2018, these threats will continue and cybercriminals will likely get more creative despite better awareness among healthcare organizations at the executive level for the funding needed to protect themselves.

• This collection highlights some of the biggest breaches across the industry – and points to some mistakes to avoid in the future.

Top Headlines for Data Breaches in 2018

Hackers expose data of 30,000 Florida Medicaid patients

Data of 43,000 patients breached after theft of unencrypted laptop
NEWS

OCR investigating Banner Health for breach of 3.7 million records
by Jessica Davis | March 21, 2018

Ransomware breaches data of 85,000 patients
by Jessica Davis | April 26, 2018

UnityPoint Health System hit with cyberattack affecting 16,000 patients

California medical device manufacturer reports breach of 30,000 consumers

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Top Headlines for Data Breaches in 2018

DoD IG finds massive security flaws in Army, Navy EHR
by Jessica Davis | May 08, 2018

NEWS

205,000 patient records exposed on misconfigured FTP server
by Jessica Davis | May 18, 2018

SOCIAL MEDIA
Social Media

• Social media is used by 74% of Internet users and 80% of people using social media actually use it to research doctors, hospitals, and medical news and information.

• Social Media can be an extremely powerful tool for communicating general healthcare information to the public, creating professional connections, and sharing experiences.


If healthcare employees were better educated on potentially hazardous mistakes while using social media and medical blogs, HIPAA violations could be avoided.

• Understand what is considered a HIPAA violation on social networks.

Examples of Social Media HIPAA

- Common examples of social media HIPAA violations include:
  - Posting gossip about a patient to unauthorized individuals, even if the name is not disclosed.
  - Sharing of photographs, or any form of PHI without written consent from a patient.
  - A mistaken belief that posts are private or have been deleted when they are still visible to the public.
  - Sharing of seemingly innocent comments or pictures, such as a workplace lunch which happens to have visible patient files underneath.


DON’T: Post anything you wouldn’t say in an elevator or coffee shop.

- If there is any doubt at all about a certain post, picture or comment then check with your compliance officer before publishing.

• **DO:** **Thoroughly train employees** on your organization’s HIPAA Privacy and HIPAA Security policies and procedures at the time of hire (and at least annually thereafter). Your organization’s social media policy should be integrated into these policies and procedures.

• One of the best ways to avoid legal pitfalls with social media HIPAA violations is to have a clear, widely distributed company policy on the use of social networking sites during working and non-working hours.

• Consider extending your existing polices on HIPAA compliance relating to social media networks.

The Office of Inspector General's (OIG) work planning process is dynamic and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available.

Previously, OIG updated its public-facing Work Plan to reflect those adjustments once or twice each year.

In order to enhance transparency around OIG’s continuous work planning efforts, since June 15, 2017, the OIG has updated its Work Plan website monthly.
How They Plan Their Work

• The OIG assesses risk in HHS programs and operations to identify those areas most in need of attention and sets priorities for the sequence and proportion of resources to be allocated.

• Audits and evaluations may be cancelled based on OIG staff availability, changes in the environment, legislation that substantially affects the issue, or similar recent studies that provided definitive results.

• Reports are cancelled only after senior staff have reviewed and approved the cancellation.

• In evaluating potential projects to undertake, they consider a number of factors, including:
  – mandatory requirements for OIG reviews, as set forth in laws, regulations, or other directives
  – requests made or concerns raised by Congress, HHS management, or the Office of Management and Budget
  – top management and performance challenges facing HHS
  – work performed by other oversight organizations (i.e., GAO)
  – management's actions to implement OIG recommendations from previous reviews
  – potential for positive impact

• In addition to working on projects that often result in audits, reviews, and reports, OIG's work portfolio includes a number of legal and investigative activities.
Coding and Documentation Accuracy

- CMS implemented the Comprehensive Error Rate Testing (CERT) Program to measure improper payments in the Medicare FFS Program.

- Under the CERT Program, a random sample of all Medicare FFS claims are reviewed to determine if they were paid properly under Medicare coverage, coding, and billing rules.

- It is designed to help providers understand how to provide accurate and supportive medical record documentation.
Once the CERT Program identifies a claim as part of the sample, it requests via a faxed or mailed letter the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim.

If there is no response to the request for medical records, the CERT may also make a telephone call to solicit the documentation.

Once the documentation is received, it is then examined by medical review professionals to see if the claim was paid or denied appropriately.

The CERT Program is managed by two contractors:

1. CERT Statistical Contractor (CERT SC)
   - determines how claims will be sampled and calculates the improper payment

2. CERT Review Contractor (CERT RC)
   - requests medical records from providers and suppliers who billed Medicare
   - the selected claims and associated medical records are reviewed for compliance with Medicare coverage, coding, and billing rules

**Remember:** Providers should submit adequate documentation to ensure that claims are supported as billed.
Third-Party Additional Documentation Requests

• Upon request for a review, it is the billing provider’s responsibility to obtain supporting documentation as needed from a referring physician’s office (i.e., physician order, notes to support medical necessity) or from an inpatient facility (i.e., progress note).

• The Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.3, “Third-Party Additional Documentation Request” states: The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, Recovery Auditor and ZPIC.

Insufficient Documentation Errors

• Reviewers determine that claims have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed (that is, the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, or were medically necessary).

• Reviewers also place claims into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.
• Insufficient documentation errors identified by the CERT RC may include:
  – Incomplete progress notes (for example, unsigned, undated, insufficient detail)
  – Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures)
  – No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services to be provided).

***Office Visits Established, Hospital Initial, and Hospital Subsequent were identified as the top three CERT errors in E/M service categories.

***High errors consisted of insufficient documentation, no documentation, and incorrect coding of E/M services to support medical necessity and accurate billing.

Tools, Tips and Techniques

• Decision to cultivate a “Compliance Culture”
• Identify risk areas in your individual organization
• Develop a Compliance Plan
• Train employees on cultural compliance norms and get “buy in”
• Monitor and make necessary changes on a regular basis
Questions?

• Thank you for your attendance!

• If you have any questions, please contact: pjoslin@pmimd.com

Resources

• [http://www.healthcarefinancenews.com/blog/culture-patient-experience](http://www.healthcarefinancenews.com/blog/culture-patient-experience)