Bringing it All Together – Compliance and the Revenue Cycle

DHA UBO Support

19 May 2015 (0800-0900 EST)
21 May 2015 (1200-1300 EST)

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This webinar will focus on various compliance requirements from intake/registration to claim adjudication in the MHS Revenue cycle. It will provide attendees with the necessary tools to maximize collection activities while following DoD payer guidelines and operating at optimal compliance levels during each stage of the revenue cycle. A brief historical overview will be provided along with UBO User Guide and Manual References.

- Importance of Third Party Payer (TPP) Revenues & Regulatory Foundations
- Overview of Compliance Program
- Executing Compliance within the MHS Revenue Cycle
- DHA UBO User Guide and DoD Manual Reference
Importance of Third Party Payer (TPP) Revenues & Regulatory Foundations
Importance of Third Party Payer (TPP) Revenues

Money collected from third party payers (TPPs) serves a critical purpose for MTFs:

• All funds collected are retained *by your MTF*
• TPC funds are *in addition to* each MTF’s O&M budget
• Adhering to key federal regulations; UBO policies and procedures and your local MTF guidance will minimize funds that are lost to fraud, waste, and abuse
• Comes down to the basic question:

*Where do you want potential revenues to go?*
Regulatory Foundations

32 CFR §220.2 Statutory obligation of third party payer to pay.

(a) Basic rule. Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer's plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(b) Application of cost shares. If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third party payer is the reasonable charge for the care provided less the appropriate deductible or copayment amount.

(c) Claim from United States exclusive. The only way for a third party payer to satisfy its obligation under 10 U.S.C. 1095 is to pay the facility of the uniformed service or other authorized representative of the United States. Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.
Overview of Compliance Program
A compliance program is comprised of **systematic procedures** instituted by an organization to ensure that the provisions of the regulations imposed by a government agency are *being met*.

The Uniform Business Office (UBO) Compliance Program *demonstrates MTF commitment to honest and responsible conduct*, *decreases the likelihood of unlawful and unethical behavior* at an early stage, and *encourages employees to report potential problems* to allow for appropriate internal inquiry and corrective action.

Each Medical Treatment Facility (MTF) must establish a **UBO Compliance Plan and perform regularly scheduled compliance audits** to provide uniform guidance for UBO billing and accounting activities. These plans outline collection compliance guidance for the Medical Services Account (MSA), Third Party Collection Program (TPCP), and Medical Affirmative Claims (MAC). The **UBO Compliance Plan is a comprehensive strategy**:

- That claims submitted to all payers, including private, government (Medicare and Medicaid), and other Federal agencies and individuals are consistently accurate.
- That accounting of collections is consistently accurate.
- That UBO employees comply with the applicable laws, DoD policies and regulations, and payer requirements relating to its participation in these programs.
Seven Elements of an Effective Compliance Program


- **Element 2. Designation of a Compliance Officer and a Compliance Committee**

- **Element 3. Conducting Effective Training and Education** (Initial and Annual Compliance Training)

- **Element 4. Developing Effective Lines of Communication** (Access to the Compliance Officer, Forms of Reporting Complaints or Questions)

- **Element 5. Enforcing Standards through Well-Publicized Disciplinary Guidelines** (New Employee Policy, Disciplinary Action Policy)

- **Element 6. Auditing and Monitoring** (Post-submission Reviews, UBO Quarterly Compliance Audits, UBO Compliance Plan Effectiveness)

- **Element 7. Responding to Detected Offenses and Developing Corrective Action Initiatives** (Violations)

MTF UBO Staff Responsibilities

- **Employees are expected to follow the standards set forth in this Compliance Plan**, as well as all applicable laws.
- Employees will conduct business and personal activities with the **highest level of integrity**.
- **No employee shall make, file, or use any false, fictitious, or fraudulent statements** or documents in connection with the delivery of, or payment for, health care benefits, items, or services.
- **No employee shall falsify, conceal, or cover up a material fact** in the performance of their duties.
- **Each employee will be responsible for reporting any violations** of this plan to their immediate supervisor or the Compliance Officer, as appropriate.
- **Employees will follow the business rules and procedures** outlined in DoD 6010.15-M., Uniform Business Office Manual, and Service and NCR MD specific guidelines.
- **Employees will possess the necessary skills**, quality assurance processes, systems, and appropriate procedures to ensure that all billing for government and commercial insurance programs are accurate and complete.

**How do I make sure I am following my MTF’s Compliance Plan?**
Executing Compliance within the MHS Revenue Cycle
MHS Revenue Cycle Management (RCM)

Compliance is part of every process within the Revenue Cycle!
Compliance Risk Areas within MHS Revenue Cycle

Known Risk Areas

- HIPAA*, Patient Documentation, DD Form 2659
- Medical Records Accuracy and Documentation
- Up-Coding, Coding Timeframes
- Unbundling, Billing Rates, Duplicate Claims
- Denials, overpayments, underpayments and refunds

Revenue Stream begins with patient seeking care...

We will revisit each of the known risk areas in detail and identify activities to be mindful of along with corresponding UBO Manual and User Guide references.

*Health Insurance Portability and Accountability Act (HIPAA): Federal Law that protects a patient's health information and privacy
DHA UBO User Guide and DoD Manual Reference
UBO Manual (DoD 6010.15-M)

- It prescribes uniform procedures for the management and follow-up of accounts, including recovery, depositing, posting, and reconciliation.
- It also incorporates procedures for third party collection activities, such as identification of beneficiaries who have other health insurance, coordination of benefits, and recovery of claims.


UBO User Guide

- Provides functional guidance on data collection and UBO practices and billing procedures for Military Treatment Facilities (MTFs).
- Living document that is updated by the DHA UBO Program Office in coordination with the Services and NCR MD as necessary.
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| 1  | PATCATs are directly linked to UBO billing and tell what reimbursable rate (if any) is applicable for the healthcare services provided, what billing forms are used, and which cost recovery program is responsible for billing the encounter.                          | • Using Improper Department of Defense (DoD) billing rates  
• Is there an MTF process for on-going education of all intake staff (Admission & Disposition) to ensure correct PATCAT assignment?                                                                                                                  |
| 2  | Upon arrival for care, the patient must present proof of eligibility for care in an MTF.                                                                                                                                                                                                                                           | • Failure to maintain the confidentiality of information/records  
• Is there an MTF process to register patients into CHCS with complete demographic information if needed for billing purposes?  
• Is beneficiary OHI data validated before being input into CHCS?  
• Does someone check the DEERS ineligibility report daily?  
• Does the patient complete a DD form 2569?                                                                                             |
| 3  | The source of OHI information is the DD Form 2569, which is completed by patients during registration. All patients (excluding active duty) are required to complete or update a DD Form 2569 annually or whenever their OHI status changes. |                                                                                                                                                                                                                                              |

Key Risk Areas: Improper Billing Rates, DD Form 2569, HIPAA

For a complete listing of potential risk areas, View Compliance Audit Checklist Template at http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/letters.cfm#Compliance Toolkit
### (4) Clinical Encounter and (5) Medical Records Documentation

#### Risk/Audit Areas of Interest

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<td>4</td>
<td>The clinical encounter may include: collection of patient history, a physical examination, and treatment as needed.</td>
<td>- Does the MTF have procedures to ensure documented pre-certification/pre-authorization actions occur on inpatient admissions, APVs, Ancillary services costing more than $500</td>
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| 5  | Encounters must be documented by the healthcare provider in order to be coded, billed and paid. | - Failure to maintain the confidentiality of information/records  
- Are clear and complete audit trails maintained on all claims forwarded to the appropriate supporting or designated authority? |
| 5  | The provider documents the examination for the clinical encounter, which includes, but is not limited to: detail of patient and family history, extent of physical exam, complexity of medical decision making, nature of patient’s problems, minutes of service, and any counseling. | - Do revenue codes accurately represent documented care?  
- Are billing records maintained separately for each site? |

**Key Risk Areas:** Pre-Certification/Pre-Authorization, Audit Trails, Accurate Coding for Services
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<td>6</td>
<td>Based on the provider's encounter documentation, coding staff assign appropriate diagnosis and procedure codes (ICD, CPT®, and HCPCS codes) to the patient record. Coders must adhere to official MHS coding guidelines</td>
<td><strong>Up-coding:</strong> Using a billing code or DRG code that provides a higher payment rate than the code that accurately reflects the service furnished to the patient. <strong>Unbundling:</strong> When separate billing codes are used for services that have an aggregate code.</td>
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<td>7</td>
<td>MHS systems capture both institutional and professional services and items and pharmaceuticals provided for both inpatient admissions and outpatient visits. MHS billing systems include CHCS (inpatient TPC) and TPOCS (outpatient TPC). For each service or supply documented in the encounter record, MHS billing systems generate a charge using published and effective DHA UBO rates.</td>
<td><strong>Are the current rates packages (e.g., inpatient ASA, outpatient, pharmaceutical)</strong>&lt;br&gt;<strong>Are all current rates tables, mapping tables, code tables etc., loaded in current billing systems/solutions (e.g., ABACUS, CHCS and TPOCS)</strong>&lt;br&gt;See: “File and Table Maintenance” Section of User Guide <a href="#">2014 August UBO User Guide</a> pdf</td>
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### Claims Generation and Submission Risk/Audit Areas of Interest

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| 8  | Billing claims may be generated automatically from CHCS (inpatient and outpatient MSA, inpatient TPC) and TPOCS (outpatient TPC) or manually for submission to the payer in either electronic or paper format. | • Are there billing procedures to prevent duplicate billing?  
• Do you use the most cost-effective billing (e.g., electronic when available)?  
• Are bills completed and sent out (mailed or electronically) on a regular basis?  
• Billing for services without an established DoD billing rate (i.e., pharmaceuticals) |
| 8  | TPC bills third parties using two standard paper claim forms. The UB-04 is for institutional services, and the CMS 1500 for professional services. Claims may also be submitted electronically using the 837 Health Care Claim: Institutional (837I) and the 837 Health Care Claim: Professional (837P) transactions. | • Are inpatient bills generated properly when the patient is transferred to a civilian facility or another MTF?  
• Are APVs billed on three separate claims (Surgeon CMS 1500/837P, Anesthesiologist CMS 1500/837P, and Institutional 99199 UB-04/837I)? |

**Key Risk Areas:** Duplicate Billing, Lack of Bill Rate, APVs, review of MAC claim
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| 8  | If medical care is necessary due to the fault of a third party, a MAC claim can be generated from data in CHCS and TPOCS. | • Does your legal authority overseeing medical care recovery instruct you as to which encounters to generate MAC bills for?  
• Do you use CHCS and TPOCS to generate MAC claims?  
• Do you use MAC rates (i.e., same as DHA UBO inpatient, outpatient and RX, but inpatient and outpatient must be approved by the OMB & published in the federal register prior to use)? |

Key Risk Areas: Duplicate Billing, Lack of Bill Rate, APVs, review of MAC claim
### (9) Payer Follow-Up and (10) Denial Management and Appeals

#### Risk/Audit Areas of Interest

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|    | Once a claim is generated and submitted, the biller reviews the status of the claim and if not paid, follows up with the payer, as necessary.          | • Is follow-up being performed within established timeframes on all claims for which payments are delinquent?  
• Are payments validated for correctness based on patient’s benefits?  
• Inadequate resolution of overpayments                                                                                                                                                                                                                       |
| 10 | For denials management, the biller identifies and resolves denied, rejected, or pending claims with the payer. The biller may request the payer to reconsider denial, rejection, and additional payments. | • Are valid denial and payment write-offs approved by the TPCP/UBO Manager or designated authority and in a timely manner?  
• Are invalid payments/denials referred to the appropriate supporting or designated authority at 180 days or not later than 270 days from date of discharge/outpatient visit?                                                                                                     |

#### Key Risk Areas: Payment Validation, Write-Offs, Payment/Denial Review


1. Bills are generated and sent for patient encounters when other health insurance information exists in CHCS.
2. Collections from insurance providers are adequately followed up.
3. All errors and deficiencies found during audits are corrected.
### Risk/Audit Areas of Interest

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| 11 | Once payment is received, the payment is applied to the patient's account in either CHCS (inpatient and outpatient MSA, inpatient TPC) or TPOCS (outpatient TPC). This step should be performed immediately after payment is received. | - Is the separation of duties (biller, cashier, etc.) adequate to protect cash receipts?  
- How often are unannounced cash counts being conducted?  
- Are all checks/cash received stored in a safe?  
- Are delinquent accounts accurately transferred in a timely manner IAW current debt management policy?  
- Are returned checks for insufficient funds processed correctly?  
- Do account postings equal amounts collected? |
| 12 | Performance measurements help assess progress toward that goal. Each MTF must have tangible, real-time data to measure performance both for internal management purposes and for external measurement in relation to peers, competitors, and the community | - Do audits of MSA occur at least quarterly by a disinterested individual?  
- Are all requisite records maintained to confirm the effectiveness of the MTF’s compliance program and reported to the appropriate authorities and the UBO Manager?  
- Is all billing current, to include a regular and frequent processing of bills to prevent backlogs (e.g., daily or every other day)?  
- Are all deficiencies in the TPCP corrected that were identified during the UBO compliance audit (i.e. items listed and in addition to those on this checklist)? |

**Key Risk Areas:** Separation of Duties, Cash Storage, Audit Trails and Preparation
Questions?

All webinars are available on the DHA UBO Learning Center at: http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/training.cfm#recent
References

1. 10 U.S.C. 1095
2. 10 U.S.C. 1079b
3. 32 C.F.R. Part 220
5. OIG Compliance Guidance for Hospitals, February 1998
6. OIG Supplemental Compliance Program Guidance for Hospitals, January 2005

Compliance Toolkit (Available on UBO Website)

- Anti-Fraud Program at Military Treatment Facilities (MTFs) pdf 58.2 KB
- Compliance Plan Implementation Policy pdf 4954.5 KB
- Code of Conduct doc 26.0 KB
- Certification Memo doc 25.5 KB
- Sample Compliance Committee Charter doc 27.5 KB
- MSA Claim Post-Submission Review Worksheet doc 37.0 KB
- TPCP Claim Post Submission Review Worksheet doc 50.5 KB [updated 08-25-14]
- MAC Claim Post-Submission Review Worksheet doc 37.0 KB
- Compliance Audit Requirements pdf 51.2 KB
- Compliance Audit Checklist Template doc 475.0 KB [updated 08-25-14]
- Annual Review of Compliance Program Effectiveness Checklist doc 151.0 KB
- Model Compliance Document doc 89.0 KB
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• Allergy Testing/Allergen Immunotherapy  
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• Ancillary Services and Hold Periods  
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• FY14 Pharmacy Pricing Rates Update Webinar |
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  – If you receive a passing score of at least 70%, we will e-mail MHS personnel with a .mil email address a Certificate of Approval including an AAPC Index Number

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