2017 2nd Quarter
Volume 11, Issue 2

Compliance Quarterly

From the Compliance Office...

2017 Mandatory Fraud, Waste & Abuse Training

As in past years, our annual mandatory Fraud, Waste & Abuse training will be provided via the *Compliance Quarterly* newsletter. However, this year, rather than waiting until the fourth quarter, it will be done in the third quarter newsletter, which will be the next newsletter.

All UBMD employees - providers and staff - must complete this training, which is a a federal requirement. Additionally, some payors now require practices to either complete the payor's training program, or provide proof or a signed attestation that everyone in the practice has completed equivalent training. It will be up to the practice to attest to this.

Compliance Training Update

New Provider E/M & Documentation Training

This is a one session training class. All are welcome to attend any of the sessions. It's also a good refresher for the not-so-new providers! ***Please contact me if you would like to attend a session so that I can be sure to have enough materials for all attendees.***

Location & Time: 77 Goodell St., Room 208, 11:30-12:30pm

Dates:		
	July 25	October 10 & 24
	August 8 &29	November 14 & 28
	September 12 & 26	December 12

Lunch-n-Learn

Sessions are usually held once a month. Bring your lunch, and join us as we cover a variety of important topics related to coding and compliance! AAPC & AHIMA CEUs are often available for the sessions. All are welcome to attend. ***If you would like to be added to the session contact list, please contact me as noted to the right.***

Location & Time: 77 Goodell St., Room 208, 11:30-12:30

Dates:		
	July 18	October 19
	August 22	November 21
	September 19	December 19

Inside this issue

Training Questions:

If you have questions on any the training, please contact Bev by telephone (888-4702) or e-mail: welshans@buffalo.edu

The Coding Corner

Information for this article was gathered through the AAPC, CMS & DHHS websites.

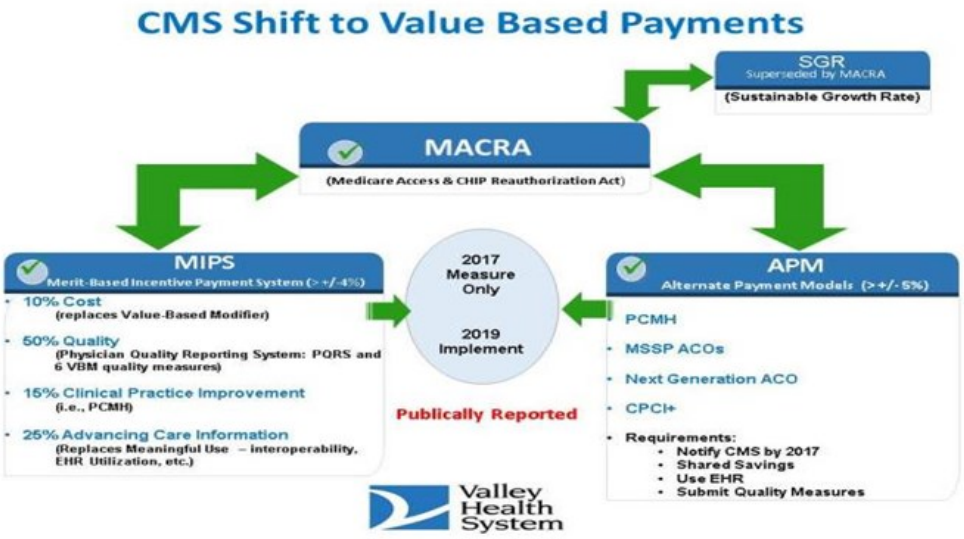
What is MACRA?

By: Beverly Welshans, CHC, CPMC, CPC, CPCI, COC, CCSP
Director of Audit Education

MACRA (Medicare Access and CHIP Reauthorization Act of 2015) has created a new philosophy on which to base all Medicare payment updates. MACRA has the potential to completely transform the structure of healthcare in the United States after repealing the sustainable growth rate (SGR) formula used for physician reimbursement and payment purposes. Beginning in 2019, payment updates will reflect efficacy and proficiency, instead of volume. Various measures of efficiency and quality will assess a provider's performance, and earnings will depend on these metrics.

MACRA provides for two new tracks: the Medicare Incentive Payment System (MIPS) and Alternative Payment Models (APM), in which physicians can earn payment updates; it provides funding to benefactors for technical aid provided to physicians; and it provides capital for research, development, and testing of new APMs. **If you are an eligible clinician, and you did not register in an Advanced or MIPS APM by June 30, 2016, your only option is MIPS.**

The Merit-based Incentive Payment System (MIPS) is a new medical reimbursement framework that consolidates different parts of three existing payment programs that sunset Dec. 31, 2018: Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VBM) and Medicare Electronic Health Record (EHR) Incentive Program. A fourth element, Improvement Activities (IA), has been added to MIPS, which offers providers the flexibility to choose the most relevant and significant activities to demonstrate quality improvement in their practice.



To monitor the performance of the providers, few matrices have been set apart. Instead of quantity being the core of reimbursements, the emphasis will now fall on performance categories: Quality (replaces PQRS and parts of VM), Cost (replaces VM in 2018), Advancing Caring information (replaces EHR meaningful use) and Improvement Activities. Based on your actions in 2017, your payment for Medicare services in 2019 can range from a negative 4% payment reduction to an increased payment adjustment as high as 22%.

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Alternative Payment Models (APMs) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

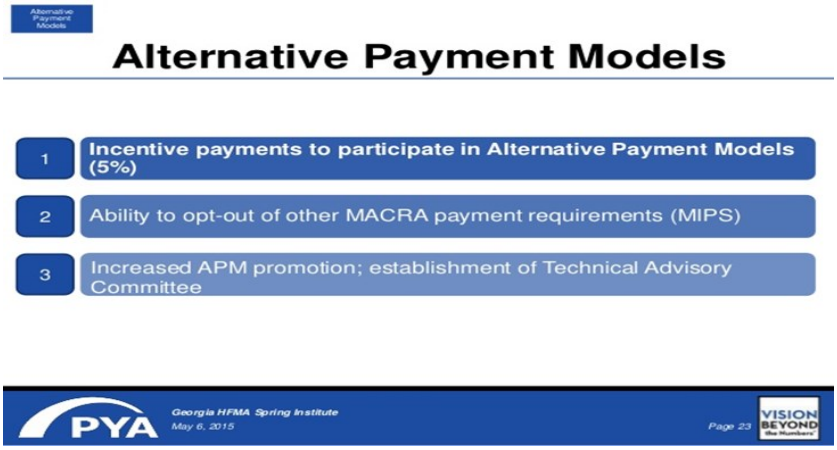
Advanced APMs are a subset of APMs, and let practices earn more for taking on some risk related to their patients' outcomes. You may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM.

In 2017, the following models are Advanced APMs: Comprehensive ESRD Care (CEC) - Two-Sided Risk, Comprehensive Primary Care Plus (CPC+), Next Generation ACO Model, Shared Savings Program - Track 2, Shared Savings Program - Track 3, Oncology Care Model (OCM) - Two-Sided Risk, and Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT).

You can earn a 5% Medicare incentive payment in 2019 for qualified Advanced APM participation during 2017.

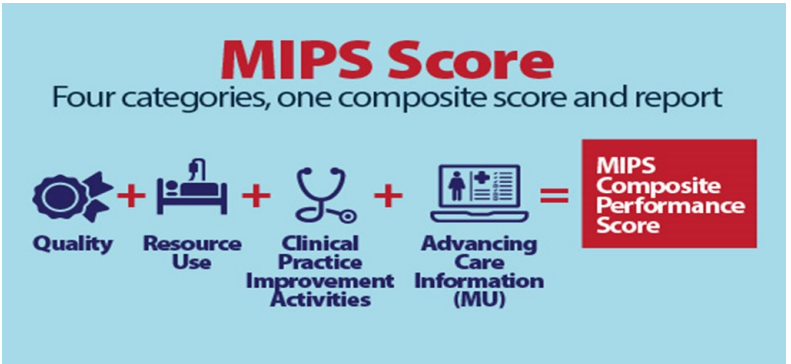
2017 is the first or transitional performance year on which eligible clinicians will report. Performance scores will determine payment adjustments in 2019.

You can choose to start collecting performance data anytime between Jan. 1 and Oct. 2, 2017. The submission deadline is March 31, 2018.



For 2017, physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists are eligible to participate in MIPS if they bill more than $30,000 to Medicare and provide care to more than 100 Medicare patients per year**.** There are a few exemptions from MIPS including; Clinicians who are in their first-year billing Medicare, Clinicians who see 100 or fewer Medicare patients OR bill $30,000 or less in allowable Medicare Part B charges and certain clinicians in Advanced APMs.

There are various reporting methods under MIPS including claims data, through EHR's or qualified registries. ACI performance category factors in meaningful use of a certified EHR for points calculation. A clinician may still be able to participate in MIPS without an EHR, but will not be able to score any points in the ACI category. In that case, the weighting from the ACI category shifts to the Quality category.



Using Spaceflight as a Lesson on Healthcare Compliance

By: Sue Marasi, CHC, CPCA, Compliance Administrator

I recently attended the annual HCCA Compliance Institute, a national compliance conference. Prior to attending, I looked over the various presentations being offered. One of the general session titles piqued my curiosity: "Wonders of Spaceflight and Its Risks: Lessons from the Space Shuttle Program." I wondered what the space shuttle program could possibly have to do with healthcare compliance? This presentation turned out to be one of the most engaging and informative sessions I have ever attended.

The presentation was given by Dr. Garrett Reisman, Director of Space Operations at SpaceX, and formerly a NASA astronaut who flew on two missions, logging over 3 months in space, including over 21 hours of extra-vehicular activity in three spacewalks.

He garnered our full attention with interesting and sometimes humorous stories, accompanied by some truly amazing photos and videos, from his journeys in space. But he switched gears a little when he began to speak of the risks involved in spaceflight: 138 shuttles launched, of which 2 didn't make it back. He explained that on a Logarithmic Scale there is a 1 in 58 change of not coming back in space flight; as he stated, that is the same odds infantrymen who stormed the beaches of Normandy in WWII faced.

Dr. Reisman then soberly went on to talk about the really bad days at NASA, and the great people lost in the Apollo 1, Columbia and Challenger accidents.

"If you properly manage risk with proper safeguards, you can accomplish great things."

We were a captive audience when he tied it all together: What compliance lessons can we learn from the Space Shuttle program? Risk. Risk Management strategies. Learn from our mistakes, and improve.

The Space Shuttle tragedies all had several things in common, having to do with the ways we communicate, the way we judge risk, and schedule pressures, the "normalization of deviance", how we avoid dissent. All of these things can be applied to healthcare compliance.

Dr. Reisman illustrated this with the Columbia accident. He explained that there is foam on the big orange tank, foam that should not be able to come off during launch. On the very first launch, foam did come off. At first NASA made great efforts to do something about the risk, and it was identified as a potentially catastrophic event. However, it proved to be a difficult problem, as they couldn't get the foam to stop coming off. They continued to work on it, and tried to make improvements that really didn't fix the problem. All the while shuttles were being launched and they were getting away with it, successfully. In time, people took the risk and assumed it wasn't as bad as they thought, even considering it to be "within the realm of normal." But the risk never actually went away. As we all know, Columbia was launched, a big piece of foam came off, hit the edge of the wing, made a giant hole, and NASA lost the 7 crew members and the vehicle.

Right after the accident, the program manager stated that it wasn't the foam, that it couldn't be the foam. He had normalized the deviant event, something that is human nature to do. If you get away with something often enough or long enough, people will start treating it as a non-problem. This is a problem we often hear in healthcare compliance: "But we've always done it that way."

The important thing is that we learn from our mistakes. Learn to manage the risks. In doing so, we can find ways to improve on the work we do every day.

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In summary, the lessons learned from the Space Shuttle Program that can be transferred to healthcare compliance go back to the earlier-mentioned commonalities of the Space Shuttle tragedies:

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1. **Free and Open Communication**: It is important to maintain open communication lines between the Compliance Office, the practice personnel, and the governing boards. Open communication, including the use of the Compliance Hotline, helps to mitigate the risk of non-compliance.
2. **Careful/Smarter Decision Making:** As the saying goes, "None of us is as dumb as all of us." Make decisions based on actual data and facts, not group opinions or beliefs.
3. **Keep Schedule Pressure at Healthy Levels:** All projects need pressure from management to control costs and schedules, but if the pressure level gets too high, bad things happen. It pushes people to cut corners, often resulting in non-compliance.
4. **Avoid "Normalization of Deviance":** Just because you've done something incorrectly before without negative consequences, doesn't mean it is not a risk. Think of the "we've always done that" response. In healthcare compliance we often hear this with upcoding and locking computers, or the failure to do so, when walking away from them, and sharing passwords, among other things
5. **Encourage Dissent**: Yes, really. But don't take it too far. People don't like being told they're wrong but healthy dissent will help to identify issues and solutions that will make our organization even more compliant. Management and providers shouldn't squelch what others have to say. This can lead to non-compliance.
6. **Pendulum Swing:** If you are vigilant with compliance one day, then slack the next, it can lead to a permissive culture where non-compliance is tolerated. Always be vigilant in being compliant, and make sure those around you are as well.

General Compliance: Compliance Hotline

By: Sue Marasi, CHC, CPCA, Compliance Administrator

HOTLINE
888-4752

By this time, everyone should be aware of the UBMD Compliance Hotline (click on for link to hotline flier). I'd like to take the opportunity to briefly explain more about why we have a hotline and what it should be used for.

The Office of the Inspector General's guidelines for an effective compliance program include the need for an open line of communication between the Compliance Office and personnel, and the development of a mechanism for reporting possible instances of wrongdoing. As workers in the health care industry, and employees of UBMD, you have an obligation to report actual or potential violations you become aware of to the UBMD Compliance Office or a direct supervisor or manager. Understand that, according to the UBMD Compliance Plan, failure to report misconduct or fraudulent activity may result in disciplinary action .

"It is the responsibility and duty of all UBMD employees to immediately report any known or suspected misconduct, violations of law, or other wrongdoing, either to the UBMD Compliance Office or to a supervisor or manager with the respective Practice Plan." ***~ UBMD Compliance Plan***

The Compliance Hotline offers the opportunity for anyone to make such reports and remain anonymous if so desired. Our hotline is a voicemail box that is monitored during normal business hours. The number calling in cannot be traced by the Compliance staff. If you have a concern, call the hotline, leave a detailed message with relevant information: your department, date & time of incident(s), behavior in question, person in question, and anything else that would help in an investigation. If you wish to give your name and contact information, you may. Because this line is not monitored 24/7, if there is an immediate threat to a person or property, you should contact your supervisor immediately rather than leaving a message.

It is important to note that UBMD Compliance has a strict non-retaliation policy that will be adhered to for those who come forward to report .

A copy of our Hotline flier is being sent with this newsletter. It should be hung where employees can see it, in back office areas, of all practice locations.

"A poor ethical culture breeds ethical breaches. Ethical breaches then often lead to legal violations. Too often accompanying both is finance collapse."

~ Marianne M. Jennings, JD

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FAST FACT

President Trump's proposed budget for FY 2018 increased funding by $70 million to fight healthcare fraud.

By the Numbers: OIG Report - 1st Half of 2017

The HHS OIG recently released its semiannual report on activities for the first half of fiscal year 2017 (10/1/16-3/31/17). If you ever thought compliance education was nothing more than a pesky fly to be swatted to the side, or that the OIG offers nothing more than empty threats, the following numbers should change your mind.

$26 million: Civil Monetary Penalties and assessments imposed on persons who committed false or fraudulent claims.

1,422: Program Exclusions of individuals and entities from Medicare, Medicaid and other federal health care programs.

468: Criminal actions against individuals or entities that engaged in crimes against HHS programs.

461: Civil actions which includes false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters.

Over $2.04 billion: OIG's expected investigative recoveries.

1,504: Sanctions including exclusion of individuals and entities from federal health care programs and the imposition of civil monetary penalties for submitting false and fraudulent claims or for violating the Anti-kickback Statute, Stark Law or EMTALA.

$267 million: Recoveries through investigations by the Health Care Strike Force (investigators and prosecutors that focus on the worst offenders engaged in fraud).

These are all very real numbers that involved or affected very real people and entities just like you and UBMD. The numbers show why healthcare compliance plays an important role in your day-to-day operations.

CONTACT US:

77 Goodell St., Suite 310
Buffalo, NY 14203

Fax: 716.849.5620

Lawrence C. DiGiulio, Esq.
Chief Compliance Officer
716.888.4705
larryd@buffalo.edu

Beverly A. Welshans, CHC, CPMC, CPC, CPCI, COC, CCSP
Director of Audit & Education
716.888.4702
welshans@buffalo.edu

Suzanne M. Marasi, CHC, CPC-A
Compliance Administrator
716.888.4708
smmarasi@buffalo.edu

UBMD COMPLIANCE HOTLINE: 716.888.4752

Report suspect fraud/abuse, potential problems,

or HIPAA concerns.

Ask questions or request guidance | Provide relevant information

Remain anonymous if you wish | Non-retaliation policy will be adhered to

(This is a voice mail box monitored during working hours. If there is an immediate threat to person or property, do not leave a message; contact direct supervisor immediately!)

Note: According to the UBMD Compliance Plan, it is the responsibility & duty of all UBMD employees to immediately report any known or suspected misconduct, violations of law, or other wrongdoing.

Compliance Quarterly Quiz

To submit your quiz answers, please click on the link below:

2017 Second Quarter Quiz

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1. A new Medicare medical reimbursement framework that consolidates different parts of three existing payment programs is:

   A. Physician Quality Reporting System (PQRS)
   B. Value-based Payment Modifier (VBM)
   C. Merit-based Incentive Payment System (MIPS)
   D. Medicare Electronic Health Record (E HR) Incentive Program

2. If you are an eligible clinician, and you did not register in an Advanced or MIPS APM by June 30, 2016, your only option is MIPS.

   A. True
   B. False

3. There are no exceptions from MIPS.

   A. True
   B. False

4. Which of the following is true in regards to reporting wrongdoing and the UBMD Compliance Hotline?

   A. Failure to report misconduct or fraudulent activity may result in disciplinary action.
   B. You may remain anonymous when reporting via the UBMD Compliance Hotline.
   C. A strict non-retaliation policy will be adhered to for those who come forward to report.
   D. All of the above are true.

5. According to the UBMD Compliance Plan, it is the responsibility and duty of all UBMD employees to immediately report any known or suspected misconduct, violations of law or other wrongdoing.

   A. True
   B. False