ELICO® healthcare services

Healthcare Audit

WHITE PAPER

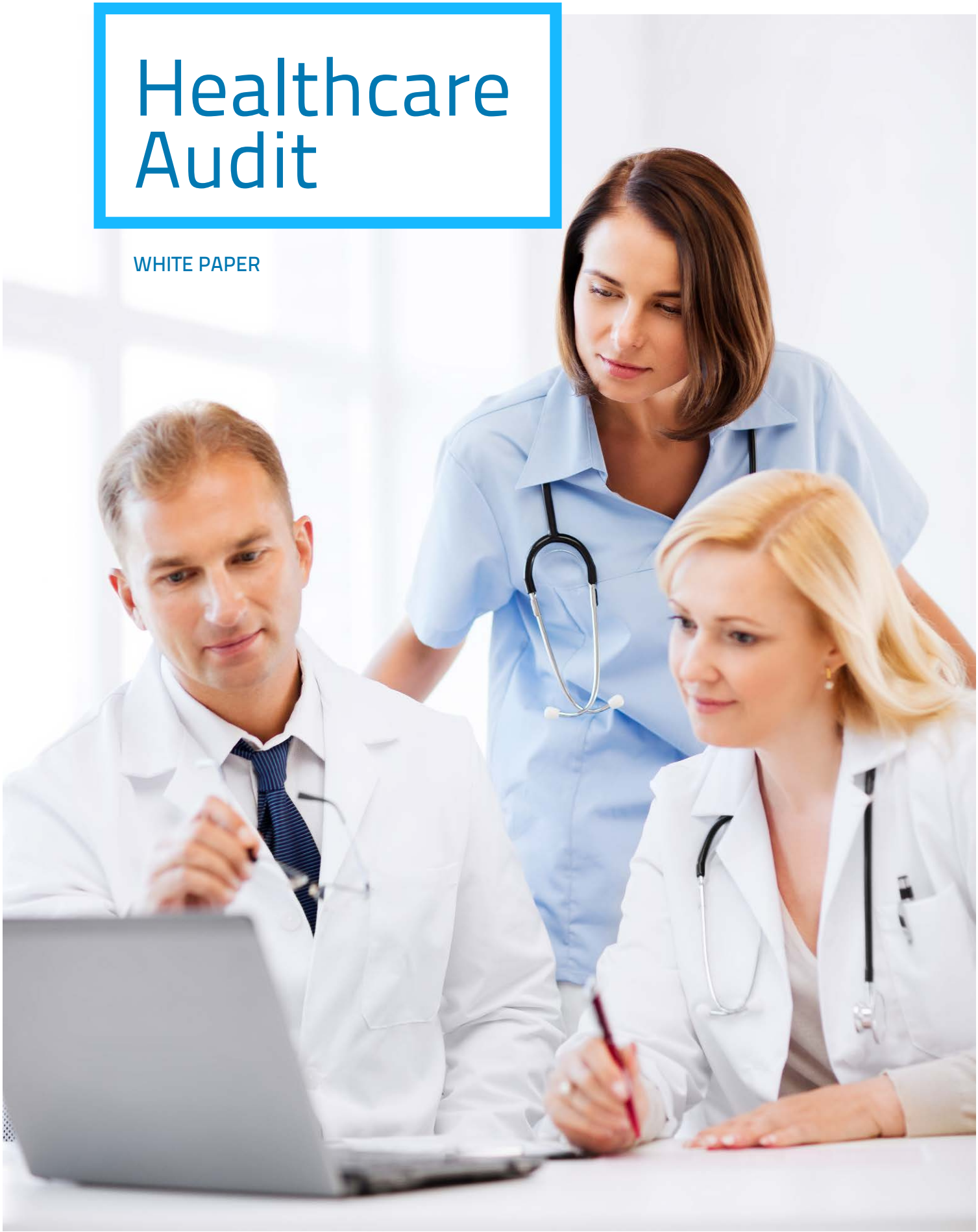


Table of Contents

Scope of Audit

The Audit provides an objective evaluation of the existing risk and control systems and framework within an organization. Audits ensure monitoring functions are working as intended and identify where management monitoring and/or additional Board oversight may be required. Audit helps management (and the compliance function) develop actions to enhance controls, reduce risk to the organization, and promote more effective and efficient use of resources.

Keeping pace with changing compliance demands:

Auditors are striving to keep pace with a steady procession of HIPAA, OIG and new PPACA-related compliance demands.

Understanding and addressing Revenue loss risks:

Audit functions have always helped their organizations fortify revenue risk management programs by ensuring these capabilities sufficiently address longstanding risks (e.g., fraud) and newer risks (e.g., cloud computing and social media applications, Breach of Information, provider and payer liability).

Improving effectiveness, efficiency, and quality:

In response to the growing reliance on data in the healthcare industry, auditors are increasing their use of data analysis tools and incorporating more automation into their activities. Audit functions are beginning to bolster their quality assurance and improvement programs.

Audit program analyzes processes, controls, and policies of selected covered entities pursuant to the audit mandate. The entire audit protocol is organized around modules, representing separate elements of privacy, security, and breach notification. The combination of these multiple requirements may vary based on the type of covered entity selected for review.

Covered Entities:

Everyone at a covered entity that could be involved in an audit should take time to learn and understand what's required of their organization. Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the Rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. A Covered Entity is one of the following:

Health Care Provider:

Doctors.
Clinics.
Psychologists.
Dentists.
Chiropractors.
Nursing Homes.
Pharmacies.

Health Plan

Healthcare Payers.
HMOs.
Company health plans.
Government programs that pay for health care, such as Medicare, Medicaid, and the military and veterans health care programs.

Health Care Clearinghouse:

This includes. Entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa. Entities selected for an audit were informed by OCR of their selection and asked to provide documentation of their privacy and security compliance efforts.

Audit Protocol Coverage:

The audit protocol covers Privacy Rule requirements for

a. Notice of privacy practices for PHI.
b. Rights to request privacy protection for PHI.
c. Access of individuals to PHI.
d. Administrative requirements.
e. Uses and disclosures of PHI.
f. Amendment of PHI.
g. Accounting of disclosures.

The protocol covers Security Rule requirements for administrative, physical, and technical safeguards.

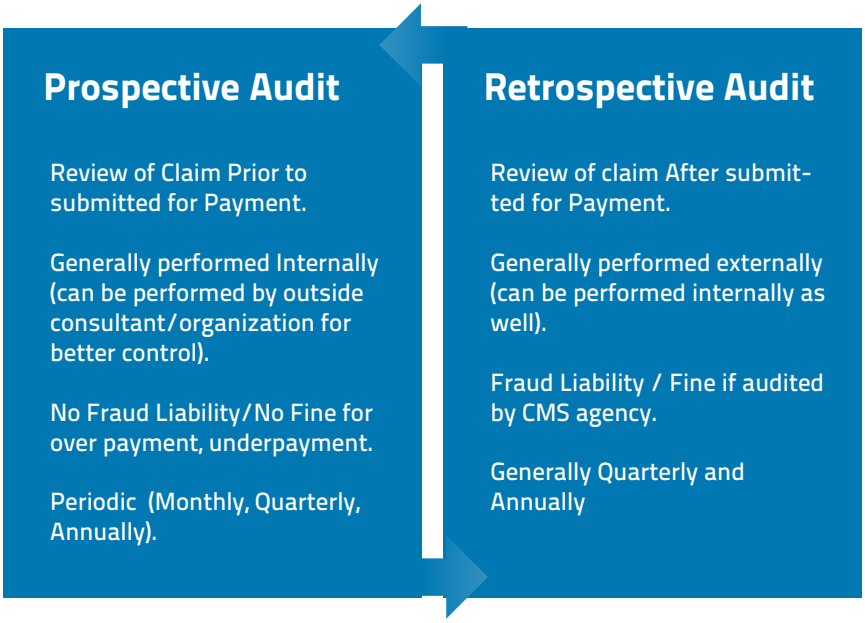
The protocol covers requirements for the Breach Notification Rule.

Type of Organization Audits for Payment

Audit methods may be similar to those of research e.g. prospective or retrospective, which required well designed studies.

Prospective Audit:

Prospective audits are done before the claim is submitted to the payer. The auditor reviews the record, selects the correct CPT®, ICD-9 codes and modifiers, and determines if the claim meets other government regulations. The practice then submits the claim with codes selected by the auditor. There is no claim to correct, because the claim isn't submitted until after the medical record is reviewed. That is one of the main advantages to prospective audits.



The disadvantage is that the practice has to hold the claim until after the audit is done. If a co-pay or coinsurance amount was collected, the practice must have a system in place to post that payment, before the charge is posted. The charges aren't submitted, and if the audit is large, that delays payment to the practice. The audit needs to be scheduled carefully with the auditor, and the notes submitted to the auditor according to a schedule.

Because prospective audits do not require any claim re-submission, some practices do not use an attorney when doing prospective audits. But, keep in mind that any audits done without attorney-client privilege can be obtained by CMS.

Retrospective Audit:

Retrospective audits are audits performed in a physician practice after the claims are submitted to the payer. There are some advantages to this. The practice or auditor can select from a large sample of claims submitted, and use a random number technique to select the claims. This typically results in a large variety of codes selected to audit. The

claims have been submitted, so the group doesn't need to hold the claims and delay payment. This type of audit is typically less time sensitive (because claims aren't held) and can be scheduled more easily.

The auditor reviews the medical record and assigns CPT® and ICD-9 codes and modifiers and reviews that the claim is submitted according to coding rules and government regulations. If the audited code differs from the code submitted and that result in the group collecting additional funds, the group must correct and re-submit the claim, refunding the money to the government payer.

Some groups elect to do these audits through their attorney, giving the work product attorney-client privilege.

Different Vertical of Audit

HIPAA Audit:

HIPAA and the HITECH Act mandate security audits for performance and privacy in medical practices. The goals of these audits are to examine mechanisms for compliance with HIPAA, identify best practices, pinpoint where the risks and vulnerabilities are and encourage a renewed resolve to pay attention to compliance activities.

Compliance Audit:

A compliance audit is a comprehensive review of an organization's adherence to regulatory guidelines. Independent accounting, security or IT consultants evaluate the strength and thoroughness of compliance preparations. Auditors review security polices, user access controls and risk management procedures over the course of a compliance audit. Compliance auditors will generally ask CIOs, CTOs and IT administrators a series of pointed questions over the course of an audit. These may include what users were added and when, who has left the company, whether user IDs were revoked and which IT administrators have access to critical systems. IT administrators prepare for compliance audits using event log managers and robust change management software to allow tracking and documentation authentication and controls in IT systems. The growing category of GRC (governance, risk management and compliance) software enables CIOs to quickly show auditors (and CEOs) that the organization is in compliance and will not be not subject to costly fines or sanctions.

Technical Audit:

The most successful technical audit reports leave no doubt about their purpose. They

clearly present the conclusions of an audit plan chartered to identify deficiencies in a company's process or operation. Because deficiencies drive up costs and delay production, companies waste no time conducting audits that spot these shortcomings in manufacturing products or providing services. Typically, the findings of audit reports become plans for future action, such as adding steps to a process that improve an operation's safety or efficiency.

MR Review:

Simple Solutions offers quality medical record review that ensures medico-legal case review companies easy access to patient case information. SIMPLE SOLUTIONS is a reputable provider of a range of medical process outsourcing solutions such as medical record review, medical chart review, medical chart organization, medical chart conversions, and medical chart indexing. Our review solutions are of great benefit to medical record management companies, legal support companies and insurance firms, since all critical information located in medical records are effectively summarized for easy perusal. We assist in summarizing Medical/Legal document organization by deciphering and summarizing their client's medical records. We specialize in Workers' Compensation Discovery and offer record retrieval for attorneys on both the applicants' and defendants' side, primarily relating to the medical treatment and condition of the applicant. We process the scanned records that are in Adobe's PDF format, run it through an OCR process, and page number the file. This is where the medical abstracting and summarization is performed.

Audit in News

For the last few years, the U.S. Department of Health and Human Services (DHHS) has been persistent in their application of the Recovery Audit Program which is designed to detect and collect any Medicare or Medicaid overpayments made on claims for health care services. As a result, more and more healthcare providers are facing increased scrutiny and investigation into their billing practices. The Recovery Audit Program originally began on a trial basis between 2005 and 2008 which resulted in the recovery of over $900 million in overpayments returned to the Medicare Trust Fund, according to the CMS. The initial audits also found $38 million in underpayments, which were returned to heath care providers. As a result Congress created the permanent Recovery Audit Program to be enforced in all fifty states by 2010. Since then, the CMS has contracted with contractors to investigate and monitor improper billing and payments and potential acts of fraud. Third-party contractors conduct these comparative billing audits on healthcare providers across all specialties and practices, from hospitals to private home care providers. These audits have the potential to open up a healthcare agency or facility to exposures involving many types of violations which can result in fees, settlements and other financial losses.

Payment System

Fee-for-Service:

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

Inpatient Prospective Payment System:

Medicare pays for inpatient services under its Inpatient Prospective Payment System (IPPS). This system is called prospective because rather than paying for each service based on what the hospital charges, the rate has been set in advance. The IPPS uses diagnosis-related groups (DRGs) to classify patients into similar treatment and length-of-hospital-stay units and sets prices for each classification group. A hospital's geographical location and labor and supply costs also affect the DRG pay rate it negotiates with CMS. Hospitals receive the predetermined DRG amount regardless of the actual cost of care, although adjustments may be made in some cases. This system uses a complex set of formulas to determine reimbursement. The formulas take into account a variety of factors, including not just the treatment and services provided to the patient but also the wages paid in the hospitals' geographic areas, whether they are teaching hospitals and whether they provide a higher than average amount of Medicare services. Based on these factors, reimbursement rates are customized for individual hospitals. One component of the formula is the diagnosis-related group (DRG). Services provided to each patient are categorized, based on the patient's diagnosis and treatment, into a DRG. There are currently about 579 DRGs. Another of the factors included in the reimbursement formula is the wage index. The wage index adjusts Medicare reimbursement to account for geographic differences in wages paid to healthcare workers.

Outpatient Prospective Payment System:

The Medicare Outpatient Prospective Payment System (OPPS) is used to pay hospitals for services to Medicare patients that are provided on an outpatient basis. These services include most Medicare Part B services. Mirroring the DRGs for the IPPS, the OPPS is based on a prospective payment system that uses a pricing unit called the ambulatory payment classification (APC). APCs, which have predetermined payment amounts, are assigned for each outpatient procedure, service, or item. The total payment the hospital receives for the visit is computed as the sum of the individual APC payments for each service. All services paid under the OPPS are classified into groups called ambulatory payment classi-

fications (APC), of which there are about 862. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. The wage index also adjusts payments received by hospitals under the OPPS.

Capitation Model:

There are basically two kinds of capitation models: 'Global Capitation" and 'Partial" or 'Blended Capitation". Each can be applied in various scenarios. Under global capitation, whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis. Generally, providers sign a single contract with a health plan to cover the care of groups of members, and then must determine a method of dividing up the capitated check among the provider group. Under a partial or blended capitation model, a single payment is made for a defined set of services, while other services involved in a patient's care are paid for on a fee-for-service basis. Under each model of capitation, risk adjustment is essential to adequately compensate providers for the risk they take-on. Payments are differentiated based on the characteristics of the enrolees in each provider patient group. Common risk adjustment factors include age, sex, health status, and prior health care utilization, as well as socio-demographic factors such as residence, income, etc.

Global Capitation:

A global capitation model is applicable in a health maintenance organization (HMO) structure. The HMO is paid a specified amount per patient to deliver services over a set period of time. Usually the payment is determined on a per member/per month (PMPM) basis. The rates are generally calculated form projections of the services and costs of the provider's patient population, based on historic costs. The payments vary to reflect the total number of patient for a provider and the demographic and acuity factors of the patient population. In some cases, co-payments may also be collected from embers for certain services. Under global capitation all care is covered under the fee including primary care, hospitalizations, specialist care and ancillary services.

Partial or Blended Capitation:

Under partial or blended capitation models, only certain types or categories of services are paid on a capitated basis. Typical scenarios under which partial capitation applies include primary care capitation where a capitation amount is paid to primary care practices for primary care services and in some cases, ancillary services provided under the direction of the primary care practice. Alternatively, specialists may be paid on a capitated basis for services they provide while the primary care services are paid fee-for-service. Other 'carve-out" capitation arrangements may involve paying for certain care such as mental health on a capitation basis. This differs from episode-based payment in that all

the services included to care for a patient by the mental health provider are covered. Partial capitation models are also being considered under accountable care organizations (ACOs) whereby the ACO would be at financial risk for some but not all of the items and services it provides

Fee schedule

A fee schedule is a list of the plan's maximum payment amounts for specific services or supplies. Preferred providers have agreed to accept these fees as payment in full for services to enrollees.

Medicare physician fee schedule:

The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

Relative Value Units and Medicare Reimbursement Calculation:

Relative value units (RVUs) – RVUs capture the three following components of patient care.

Physician work RVU:

Physician work RVU is the relative level of time, skill, training and intensity to provide a given service. Each CPT code is targeted for review at least every five years to determine the work RVU for a particular service and consider if it remains the same as the value previously set. Code values can increase or decrease if the components of service have changed during the preceding years. A code with a higher RVU work takes more time, more intensity or some combination of these two. Some radiation oncology codes, such as treatment codes, have no associated physician work.

Practice Expense RVU:

The practice expense RVU is made up of six different cost centers, including non-physician salaries, lease and rent, consulting and professional services, etc. Interestingly, because this is a true resource-based model, it also uses the same time metrics that are used to assign work RVUs, with the addition of assigned expenses. The work RVU accounts for, on average, 44 percent of the total RVU value.

Malpractice RVUs:

Malpractice insurance identifies the relative risk or professional liability associated with the service represented in numeric scale. These are generally the smallest component of the RVU values. RUC and CMS rules suggest that these expenses are to be reviewed and updated on a bi-annual basis, but in practice, that has frequently not occurred.

Geographic Practice Cost Index (GPCI):

Geographic Practice Cost Index is used along with Relative Value Units by Medicare to determine allowable payment amounts for medical procedures. There are multiple GPCIs: physician work, practice expense and malpractice. GPCIs are reviewed every three years.

Conversion Factor (CF):

The conversion factor converts the relative value unit's into an actual dollar amount. The dollar multiplier (CF) is updated on an annual basis according to a formula specified by statute. (OR) National multiplier that converts the geographically adjusted relative value units into Medicare fee schedule dollar amounts that applies to all services paid under the Medicare physician fee schedule.

Facility/Non Facility:

This designation identifies where services are provided. The Facility pricing amount generally covers services to inpatients or in a hospital outpatient clinic setting, but can include other settings. Off-site hospital-owned sites are also considered as 'facilities" in the context of payment. Non Facility services are generally provided In a freestanding physician's office, but can include other freestanding settings.

2009: Non-Facility Pricing Amount:
[(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor

Facility Pricing Amount:
[(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor

OPPS Non-Facility Payment Amount:
[(Work RVU * Work GPCI) + (OPPS Non-Facility PE RVU * PE GPCI) + (OPPS MP RVU * MP GPCI)] * Conversion Factor

OPPS Facility Payment Amount: [(Work RVU * Work GPCI) + (OPPS Facility PE RVU * PE GPCI) + (OPPS MP RVU * MP GPCI)] * Conversion Factor
Or
2015: Non-Facility Pricing Amount: [(Work RVU * Work GPCI) +(Fully Implemented Non-Facility PE RVU * PE GPCI) +(MP RVU * MP GPCI)] * Conversion Factor (CF)

Medicare Part B:

Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. It also covers certain drugs furnished by suppliers. The Centers for Medicare and Medicaid Services (CMS) uses a separate methodology to reimburse for Part B drugs. The methodology used is known as the average sales price (ASP) and it was established in the Medicare Modernization Act (MMA). Medicare pays for most Part B–covered drugs based on the average sales price plus 6 percent (ASP + 6 percent).

DRG:

A Diagnosis-Related Group (DRG) is a statistical system of classifying any inpatient stay into groups for the purposes of payment. The DRG classification system divides possible diagnoses into more than 20 major body systems and subdivides them into almost 500 groups for the purpose of Medicare reimbursement. Factors used to determine the DRG payment amount include the diagnosis involved as well as the hospital resources necessary to treat the condition. Also used by a few states for all payers and by many private health plans (usually non-HMO) for contracting purpose. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient. There are several different DRG systems that have been developed in the US. They include:

a. Medicare DRG (CMS-DRG & MS-DRG)
b. Refined DRGs (R-DRG)
c. All Patient DRGs (AP-DRG)
d. Severity DRGs (S-DRG)
e. All Patient, Severity-Adjusted DRGs (APS-DRG)
f. All Patient Refined DRGs (APR-DRG)
g. International-Refined DRGs (IR-DRG)

Ambulatory surgery center:

ASC is a distinct entity that operates exclusively for the purpose of furnishing surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission. ASC operated by a hospital is not the same as a provider-based outpatient surgery department of a hospital. Medicare makes a single payment to ASCs for covered surgical procedures, including ASC facility services furnished in connection with the covered Procedure. Examples of covered ASC facility services paid through the payment for covered surgical procedures include:

- Nursing services, services furnished by technical personnel, and other related services.
- Patient use of ASC facilities.
- Drugs and biologicals for which separate payment is not made under the OPPS, surgical dressings, supplies, splints, casts, appliances, and equipment.

- Administrative, recordkeeping, and housekeeping items and services.
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies.
- Materials for anesthesia.
- Intraocular lenses.
- Implantable devices, with the exception of those devices with pass-through status under the OPPS; Radiology services for which payment is packaged under the OPPS.

Covered ancillary services include:

- Drugs and biologicals separately paid under the OPPS.
- Radiology services separately paid under the OPPS.
- Brachytherapy sources.
- Implantable devices with OPPS pass-through status.
- Corneal tissue acquisition.

Workers compensation:

Workers' compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence. (OR) Workers' Compensation is a century old 'no-fault" social insurance system in which employers receive protection from civil liability and in exchange they provide indemnity (cash) benefits and medical care for employees who lose time from work as a result of a work related injury, accident, or exposure. Workers' Compensation is a social insurance program that provides:

- Medical care.
- Cash benefits.
- Rehabilitation services.

Workers' Compensation Benefits:

- Unlimited medical care.
- Disability-income benefits.
- Death benefits.
- Rehabilitation services.

Auto insurance:

It is a contract between you and the insurance company. You agree to pay the premium and the insurance company agrees to pay your losses as defined in your policy. Auto insurance provides property, liability and medical coverage: Property coverage pays for damage to or theft of your car.

Organization Capabilities

Elico offers reliability and consistent quality through its ISO 9001:2000 certified and HIPAA compliant processes. We have developed an excellent Quality framework, certified for meeting the requirements of ISO 9001 & ISMS Policy to ensure business continuity by assuring confidentially, integrity, and availability of information and complying to legal, regulatory requirements and contractual obligations through active participation of all stakeholders and continually improving the security management system by effective incident management. We process over one million claims per year, offering our clients savings of up to 30%. Our clients profit from our high degree of accuracy, Turn Around times and reduced denials of over 85%. Net collection rates have gone up significantly by over 95%. Despite the breadth of capabilities health care organizations need to build, the hospital and care system executives who responded to the survey were largely confident in their senior management team. In fact, nearly 70 percent expressed confidence that their current senior management team has the experience and skill sets to help the organization achieve its strategic priorities.

Routines and standard operating procedures.
Outstanding customer services.
Excellent product development capabilities.
Innovativeness or products and services.
Ability to hire, motivate, and retain human capital.

Current Client Deliverables and Workforce

SPECIALITY	NUMBER OF FTE (including backup)
ED	250
EMS (Ambulance Coding)	150
Surgery (Multi-specialty)	150
Physician (office practice, group Practice)	100
IP -Facility based	30
IP -DRG based	30
Radiology (Including IVR)	45
Anesthesia	45
Healthcare Audit	40
Total	**800**

ORGANIZATION CHART