May 13, 2024

NOTICE

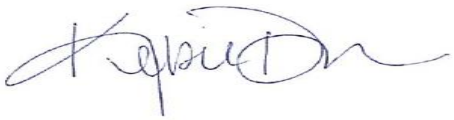
The Board of Directors of the Kaweah Delta Health Care District will meet in an open Audit and Compliance Committee meeting at 2:00PM on Monday, May 20, 2024, in the Kaweah Health Medical Center Executive Office Conference Room, 305 W. Acequia Avenue, Visalia, CA 93291.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Audit and Compliance Committee meeting immediately following the 2:00PM Audit and Compliance Committee meeting on Monday, May 20, 2024, in the Kaweah Health Medical Center Executive Office Conference Room, 305 W. Acequia Avenue, Visalia, CA 93291, pursuant to Government Code Section 54956.8.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
David Francis, Secretary/Treasurer



Kelsie Davis
Board Clerk, Executive Assistant to CEO

DISTRIBUTION:
Governing Board, Legal Counsel, Executive Team, Chief of Staff
http://www.kaweahhealth.org

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
AUDIT AND COMPLIANCE COMMITTEE

Monday, May 20, 2024
400 West Mineral King Avenue
Executive Office Conference Room

ATTENDING: Board Members: Michael Olmos – Committee Chair, Dean Levitan, M.D.; Gary Herbst, Chief Executive Officer; Malinda Tupper, Chief Financial Officer; Rachele Berglund, Legal Counsel; Ben Cripps, Chief Compliance & Risk Officer; Amy Valero, Compliance Manager; and Michelle Adams, Recording

OPEN MEETING – 2:00PM

1. **Call to order** – *Michael Olmos, Committee Chair*

2. **Public / Medical Staff participation –** Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdiction of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

3. **Approval of the Quarterly February Audit & Compliance Committee Open Minutes –** *Michael Olmos, Committee Chair*

4. **Written Reports –** Committee review and discussion of written reports**.**
   4.1 Compliance Program Activity Report – *Amy Valero, Compliance Manager*
   4.2 Audit Executive Summaries – *Amy Valero, Compliance Manager*

5. **Verbal Reports**
   5.1 Compliance Program – Provide an update on the status of Compliance Program activity – *Ben Cripps*

6. **Approval of Closed Meeting Agenda** – Kaweah Health Executive Office Conference Room – immediately following the open meeting

   6.1 **Approval of February Audit & Compliance Committee Closed Minutes** – *Mike Olmos, Committee Chair*
   6.2 **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (11 cases) – *Ben Cripps, Chief Compliance & Risk Officer and Rachele Berglund, Legal Counsel*

6.3 **Conference with Legal Counsel – Quality Assurance** – Pursuant to Health and Safety Code 32155 and 1461, report of first quarter quality assurance – *Ben Cripps, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*

7. **Adjourn Open Meeting** – *Michael Olmos, Committee Chair*

CLOSED MEETING – {Immediately following the 2:00pm Open Meeting}

1. **Call to order** – *Michael Olmos, Committee Chair*

2. **Approval of the Quarterly February Audit & Compliance Committee Closed Minutes** – *Mike Olmos, Committee Chair*

3. **Conference with Legal Counsel – Anticipated Litigation** – Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (11 cases) – *Ben Cripps, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*

4. **Conference with Legal Counsel – Quality Assurance** – Pursuant to Health and Safety Code 32155 and 1461, report of first quarter quality assurance – *Ben Cripps, Chief Compliance and Risk Officer and Rachele Berglund, Legal Counsel*

5. **Adjourn** – *Michael Olmos, Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors committee meeting.

Audit and Compliance Committee - Open
Wednesday, February 14, 2024
Executive Office Conference Room

ATTENDING: Board Members: Mike Olmos (Chair) & Dean Levitan, M.D.; Gary Herbst, Chief Executive Officer; Ben Cripps, Chief Compliance & Risk Officer; Malinda Tupper, Chief Financial Officer; Rachele Berglund, Legal Counsel; Amy Valero, Compliance Manager; Michelle Adams, Executive Assistant

Mike Olmos called to order at 8:00am.

Motion to approve closed agenda: Dr. Dean Levitan made a motion to approve the closed session agenda. Mike Olmos seconded the motion.

Mike Olmos adjourned the Closed Session at 8:01am.

Mike Olmos called the Open Session to order at 8:59am.

Compliance Program Activity Report – Amy Valero provided a high-level overview of the Compliance Program noting:

- Education – New hire orientation is now back to being in person. The Compliance Department is excited to be back in front of the new hires due to a lot of privacy breaches occurring with new hires. The Committee asked that the entire Board of Directors be invited to the new hire orientation.
- Prevention and Detection: CMS Final Rule – The Compliance Department reviews each rule that will take effect on January 1 and sends it out to appropriate leadership. Expectation is that leaders are aware of the rules and respond to any necessary action plan.
- Dialysis Billing Concerns – Workgroups, Root Cause Analysis and Resolutions – The multidisciplinary group has been meeting for several months. The group created two workgroups: (1) planned and unplanned drug changes to get them billed in the system appropriately, and (2) bulk medications.

Audit and Compliance Program Mission and Purpose – Ben Cripps provided a high-level overview of the mission and purpose noting:

- The goal is to make sure there is awareness and what is required of this Committee. There were no substantial changes.
- Internal Audit Director switched roles and the Compliance Office has decided to hold off on recruiting and is absorbing some of the functions within the Compliance Office. The Board needs a venue to receive updates regarding the financial audits and pension audits so the function will stay within the Committee. There is not a requirement Kaweah have an internal auditor, so the Committee may not see a lot of internal audit work outside of the Moss Adams presentations. With limited resources, leadership believes compliance should be the top priority. The expectation is that Kaweah's Chiefs and Directors will enforce adherence to policies and practices. The Moss Adams Financial audit tests internal controls.
- The Committee discussed the difficulty in enforcement due to the organization having 3700 policies. Mr. Herbst explained the expectation is that leaders are the owners of their areas and need to be the experts.

Annual Compliance Plan 2023 and 2024 – Amy Valero provided a high-level overview of the annual compliance plan noting:

- The 2023 workplan is included in the packet for reference of what was completed. One accomplishment was the completion of the program effectiveness tool. The effectiveness tool is a high-level, in-depth analysis of 500 items to determine where there are opportunities. Those opportunities shaped the 2024 workplan. Mr. Cripps explained to the Committee that the Compliance program is required to demonstrate an effective compliance program. Our ability to demonstrate an effective compliance program will ultimately determine whether fines and/or penalties will be avoided. The effectiveness tool was a big effort, but it will also help support and demonstrate that the Compliance Department is continuing to refine our processes, identify opportunities and minimize gaps.
- The Committee discussed whether health information breach violations are subject to progressive discipline. Mr. Cripps explained regulatory infractions that result in a reportable breach led to the employee being terminated and their access to records is terminated indefinitely. Per CDPH, our Compliance Department has implemented a very stringent orientation process that is renewed every year.
- Elements of the workplan will come through the open report as projects.
- Dr. Dean Levitan made a motion to approve the 2024 Annual Compliance Plan. Mike Olmos seconded the motion.

Mike Olmos adjourned the meeting at 9:31am.

Committee minutes were approved for distribution to the Board by the Committee Chair on …

COMPLIANCE PROGRAM ACTIVITY REPORT – Open Meeting
Ben Cripps, Chief Compliance and Risk Officer
February 2024 through April 2024

EDUCATION

Live Presentations

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Management Orientation
- Compliance and Patient Privacy – Tulare Rural Health Clinic
- Compliance and Patient Privacy – Woodlake Rural Health Clinic
- Patient Registration Collaboration Meeting – Patient Access Leaders

Written Communications – Bulletin Board / Area Compliance Experts (ACE) / All Staff

- Physician Gifts / Non-Monetary Compensation Limits 2024
- Email Encryption
- District Facsimile and Email Communication
- Code of Conduct

PREVENTION AND DETECTION

- **California Department of Public Health (CDPH) All Facility Letters (AFL)** – Review and distribute AFLs to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk

- **Medicare and Medi-Cal Monthly Bulletins** – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk

- **Office of Inspector General (OIG) Monthly Audit Plan Updates** – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk

- **California State Senate and Assembly Bill Updates** – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk

- **Patient Privacy Walkthrough** – Monthly observations of privacy practices throughout Kaweah Health; issues identified communicated to area Management for follow-up and education

- **User Access Privacy Audits** – Daily monitoring of user access to identify potential privacy violations

- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of department OIG Exclusion List review and attestations

OVERSIGHT

- **Fair Market Value (FMV) Oversight** – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts

- **Medicare Recovery Audit Contractor (RAC) and Medicare Probe Audit Activity** – Records preparation, tracking, appeal timelines, and reporting

- **Licensing Applications and Medi-Cal/Medicare Facility Enrollment** – Forms preparation and submission of licensing application to the California Department of Public Health (CDPH); ongoing communication and follow-up regarding status of pending applications. Applications currently in process:
    - Hospice Medicare revalidation
    - Sequoia Regional Cancer Center Medical Oncology

- **KD Hub Non–Employee User Access** – Oversight and administration of non-employee user onboarding, privacy education, and user profile tracking; evaluate, document, and respond to requests for additional system access; on-going management of non-employee KD Hub users; the annual renewal process with the new Compliance 360 workflow is currently in process

- **Operational Compliance Committee** – Consultation, oversight, and prevention; Comprised of eight (8) high-risk departments including Patient Accounting, Health Information Management, Revenue Integrity, Case Management, Patient Access and Clinical Documentation Improvement (CDI) Department, Radiology, and Rural Health Clinics. Meetings held bi-monthly to discuss regulations, policies, auditing and monitoring, and educational efforts within the departments.

- **Business Associate Agreements** – Oversight; Review of Business Associate Agreement template to ensure alignment with Federal and California state privacy laws. Template updated and published on the Kaweah Health intranet for ease of access.

- **Compliance Program Effectiveness Tool –** Oversight; A comprehensive Compliance Program Effectiveness Assessment, modeled after the Office of Inspector General's published resource document to evaluate strengths and opportunities of the program. The assessment measured over 500 elements and was used as the basis for the development of many of the Compliance department's annual plan. The following items have been thoughtfully reviewed and developed.

Objective	Task Completed
Compliance Policy Review: Regulatory assessment, effectiveness, and standardization	A review of Compliance policies conducted; updated regulatory language where necessary. Review to occur in alignment with policy expiration
Compliance Program team competency assessment tool	Developed competency tool for Compliance Analysts in alignment with Health Care Compliance Association (HCCA). Desired outcome to identify gaps and develop plan for advancing knowledge and skillsets.

Risk-Based Compliance Education: Further refine compliance education to focus on high-risk topics identified through hotline calls, HR matters, audits, and MAT question analysis. Identify gaps and implement focused education	Assessment of MAT quiz results to identify gap trends. Reviewed logs for Compliance issues, anonymous calls, HR issues. Data to be used to develop Annual Compliance Education hot topics.
Investigation Process: Develop written protocol for investigations to be conducted to ensure consistency and in accordance to policy	Developed written protocol for Compliance and Privacy Investigations in accordance with policy.
New Service line/facility orientation program: Ensure Compliance responsibilities are understood and implemented with new service lines and facilities	Process developed to outline Compliance program responsibilities for new facilities/service lines, including resources available
Policy Communication: Implement communication strategy to notify employees when substantial updates are made to Compliance policies	Communication process developed to notify employees when substantial changes are made to Compliance policies, as they impact the entire organization.

RESEARCH & CONSULTATION

- **Medicare Letters Important Message from Medicare (IMM) & Medicare Outpatient Observation Notice (Moon)** – Research and Consultation; Compliance was consulted to determine if Medicare Letters IMM and Moon notices needed to be initialed by Case Management employees at the time of document delivery. Research was conducted and confirmed that IMM and Moon notices should be dated and signed by employees only if patient or patient's representative refused to sign notice. Regulations do not require employees to sign the notices if successful delivery and signature of notices are captured. Results of research were shared with Case Management leadership.

- **Intensity-Modulated Radiation Therapy (IMRT) Billing Questions** – Consultation and oversight; Compliance was contacted regarding the interpretation of regulatory guidance to allow for the billing of IMRT dose planning with non-IMRT treatments including Stereotactic radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) treatments. Compliance recommended that Legion, our Radiology Billing Consultant, be engaged for review of the matter. Following a review, Legion advised against billing IMRT dose planning in conjunction with the SRS and SBRT treatments. The Radiation Oncology Leadership agreed to follow the recommendation and refrain from billing such services together.

- **AB-1020 HCAI Regulatory Updates** - Research, consultation and oversight; Compliance provided research, consultation and oversight to implement compliance with HCAI's updated requirements of the AB-1020, Health Care Debt and Fair Billing Act, effective January 2024. The Compliance Department worked closely with Patient Accounting and Patient Access leadership to implement policies, processes, and workflows to comply with the new requirements outlined in the bill. The implementation of the updated requirements involved updates to financial assistance policies, signage requirements and discharge notices. The final step for meeting compliance of the updated requirements is the development and issuance of the Discharge Notice, which is expected in June 2024. Additional processes have been put into place to ensure timely notification of such regulatory requirements in the future.

- **Medical Assistants taking Verbal Orders in the RHCs –** Consultation and oversight; Compliance was made aware of a concern regarding the practice of Medical Assistant's (MA's) submitting verbal orders from providers at the Rural Health Clinics (RHC). A review of processes with the RHC leadership team confirmed a misunderstanding that MA's were submitting verbal orders for providers; it was clarified that MA's are receiving verbal instruction from providers to propose orders for provider's to review, sign, and submit. The practice of proposing orders is within the scope for MA's. Education was provided to RHC staff about the appropriate scope and process for submitting proposed orders for provider review.

- **Required Notice to Hospice Patients –** Research and Consultation; Compliance provided guidance to the Hospice leadership team regarding the requirement of required Medical Board of California signage for patient review. Research of Cal. Code Regs. tit. 16 § 1355.4 indicated the option for the sign to be placed in an area visible for patients to see, or for the signage to be provided to the patient in a written notice format. Following a review by Hospice leadership, it was decided that the Medical Board of California Notice will be added to the Admission Packet.

AUDITING AND MONITORING

- **Skilled Nursing Facility (SNF) Probe and Educate -** As part of the effort to lower the SNF improper payment rate, CMS initiated a SNF five (5) Claim Probe & Educate Review program for every Medicare-billing SNF in the country. The Comprehensive Error Rate Testing (CERT) program projected an improper payment rate of 15.1% for SNF services in 2022, up from 7.79% in 2021. SNF service errors were determined to be the top driver of the overall Medicare Fee-for-Service improper payment rate. The goal of the SNF five (5) Claim Probe & Educate program is to assist SNF's in understanding how to bill appropriately under this new payment model and decrease the improper payment rate. On February 14, 2024, Kaweah Health was notified by Noridian (Medicare Claims Administrator) of our probe review consisting of five (5) prepayment SNF claims. Claims were submitted, and Preliminary results from Noridian indicate that all five (5) claims have passed review, however final results are outstanding.

- **Inpatient Rehabilitation Coding Audit** – To meet compliance with the Commission on Accreditation of Rehabilitation Facilities (CARF), Kaweah Health Inpatient Acute Rehabilitation Hospital (Inpatient Rehab)'s accrediting body, an external review of five (5) inpatient rehabilitation records for January 2024 were reviewed. The review's objective was to evaluate the accuracy of Inpatient Rehabilitation Facility Patient Assessment Instrument IRF-PAI criteria, including an assessment of ICD-10-CM diagnoses, etiology assignment, impairment group assignment, and tiered comorbidities. The audit noted a coding accuracy of 100%; the results of the review have been shared with HIM and Rehab Leadership.

- **Inpatient DRG Major Joint or Limb Reattachment and Anterior Posterior Spinal Fusion Procedure Audit –** Through a quarterly review of Medicare Acute Inpatient-specific Diagnosis Related Groups (DRGs) and discharges, it was identified that DRG's 483 (major joint or limb reattachment procedures of upper extremities) and 455 (combined anterior and posterior spinal fusion without Complication or Comorbidity/Major Complication or

Comorbidity (CC/MCCs)) were outliers for high utilization at Kaweah Health when compared to other hospitals in the comparison group. A review of forty-five (45) randomly selected patient accounts was conducted to assess the compliance of the use of DRGs 483 and 455. The results of the review noted an overall DRG accuracy of 91% coding accuracy, in which three (3) out of forty-five (45) accounts were over-coded, and one (1) out of forty-five (45) accounts was under-coded. The net financial error rate totaled 2%. The results were shared with HIM leadership. The affected accounts were corrected and rebilled.

- **Inpatient Rehab Facility (IRF) Audit** – Through an audit risk assessment process, Kaweah Health Inpatient Acute Rehabilitation Hospital (Inpatient Rehab) was determined to be a high-risk department as it has been the subject of recent Recovery Audit Contractor (RAC) and Probe requests; in addition to leadership changes. An internal review of twenty (20) randomly selected Medicare IRF patient accounts for the period of January 1, 2024 – February 29, 2024 were completed to determine the compliance of seven (7) elements of the admission process and medical necessity requirements. The audit noted a 100% compliance rate for six (6) of the seven (7) elements reviewed, and a 95% compliance rate for one (1) missing Plan of Care document, resulting in a 5% net financial error rate. The results were shared with IRF leadership.

- **Kaweah Health Cardiology Center Audit** – Through an audit risk assessment process, Kaweah Health Cardiology Center was determined to be a high-risk department due to multiple claim audit reviews, including a Supplemental Medical Review Contractor (SMRC) for Non-Invasive Cerebrovascular Studies as well as Noridian Targeted Probe and Educate reviews focused on diagnostic procedures. An internal review of thirty (30) randomly selected encounters for the period of January 2023 – June 2023 was conducted to determine the compliance of documentation for diagnostic testing and claim submission for diagnostic services performed at the Kaweah Health Cardiology Center. The review noted a 100% compliance rate for testing documentation and claim submission. The results were shared with Cardiology Center leadership.

- **Patient Status Audit** – Through an audit risk assessment process, patient status was determined to be a high-risk review due to being a closely monitored subject by CMS, in addition to historical compliance issues at Kaweah Health, resulting in a large repayment obligation for failing to comply with patient status requirements. A review of thirty (30) Medicare encounters for the period of April 2023 – November 2023 was completed to determine if claims were submitted in compliance with Medicare billing guidelines for patient status claims reflecting observation, short stay, 2-midnight rule and outpatient surgery. The results noted a 87% billing compliance rate for inaccurate observation hours noted on the claims, however the errors did not impact the amount reimbursed for affected claims. The net financial error rate totaled 0%. The findings of the review have been communicated to the Case Management, Patient Access, and Patient Accounting Departments Patient Access Leadership, and affected claims were corrected and rebilled.

Executive Summary
Kaweah Health Inpatient Rehab Audit Review
Audit Completed: April 2024
Presented to: Audit and Compliance Committee – May 2024

Background

Inpatient Rehabilitation Facilities (IRF) receive a predetermined payment per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries. In accordance with 42 CFR 412.622 (a)(3), in order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be reasonable expectations that the patient meets all of the following requirements at the time of the patient's admission:

1. Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.
2. Generally requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Generally, the intensive rehabilitation therapy program consists of at least three (3) hours of therapy per day, at least five (5) days per week.
3. Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of 42 CFR 412.622
4. Requires supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three (3) days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

Audit

As a part of Kaweah Health's ongoing monitoring of potential risk areas, the Kaweah Health IRF was determined to be a risk area due to Probe audit reviews and RAC requests, as well as an upcoming Choice Demonstration for pre-payment or post-payment claim review for IRF Services expected in Summer 2024. In addition, changes within leadership of the IRF lead to potential risks.

The Compliance Department reviewed a random sample of twenty (20) Medicare IRF patients for the period of January 1, 2024 – February 29, 2024. The Electronic Health Record (.EHR) was reviewed for the following elements:

1. Preadmission Screening provided 48 hours preceding the admission date

2. Documentation that the rehabilitation physician concurred with the admission
3. The Plan of Care was completed within four (4) days of the admission date
4. The Inpatient Rehab Facility Patient Assessment Instrument (IRF-PAI) was completed
5. Interdisciplinary Team Conference Notes were signed by all team members (therapists, CM, MD etc.)
6. Therapy encounters were dated, timed, signed and equaled three (3) hours per day, at least five (5) days per week, or fifteen (15) hours of therapy per seven (7) consecutive days with documented barriers
7. History and Physical completed within 24 hours to support diagnosis and rationale

Findings

Following a review of the sampling population, the Compliance Department noted a 100% compliance rate for six (6) of the seven (7) elements reviewed. The audit noted a 95% compliance rate for one (1) missing Plan of Care document. The audit ultimately resulted in a 5% net financial error rate.

The findings of the review have been communicated to the KH IRF Leadership Team. It was also recommended that it would be advantageous for the documentation within the physician note to state that the physician met face-to-face with the patient to provide greater clarity within the patient note.

Conclusion

The Compliance Department will continue to reassess the risks associated with the review and determine if a reaudit will be required in the future.

Executive Summary
Kaweah Health Cardiology Center Review
Audit Completed: February 2024
Presented to: Audit and Compliance Committee – May 2024

Background

The Centers for Medicare & Medicaid Services (CMS) regulations govern Medicare payments for all Medicare services. Medicare requires that procedures are ordered by physicians, medically necessary, and contain complete documentation to support the claims, including interpretation and result reports for services performed.

Procedures and services provided at Kaweah Health's Cardiology Center have been the subject of multiple claim audit reviews, including a Supplemental Medical Review Contractor (SMRC) for Non-Invasive Cerebrovascular Studies as well as Noridian Targeted Probe and Educate reviews focused on diagnostic procedures. Due to the presence of claim audits and prior compliance concerns, an audit focused on documentation compliance for diagnostic procedures at the Kaweah Health Cardiology Center was conducted.

Audit

The Compliance Department reviewed thirty (30) randomly selected encounters for the period of January 2023 – June 2023. The encounters were selected from procedures performed from a report that contained diagnostic testing in the Cardiology Clinic. The Electronic Health Record (EHR) was used to review and assess the following elements: whether the charge was supported by a physician order, the appropriateness of the billing modifier (as necessary), procedure authorization (if applicable), if the service ordered by the physician match the service billed on the claim, and if Kaweah Health was reimbursed for the charges billed. Additionally, the Local Coverage Determination (LCD) was reviewed to determine if the diagnosis code provided was listed as covered for the procedure performed.

Findings

Following a review of the sampling population, the Compliance Department noted a 100% compliance rate for the population in question based upon the scope of the review. The findings of the review have been communicated to Kaweah Health Cardiology Center and Patient Accounting Leadership.

Conclusion

The Compliance Department will continue to reassess the risk associated with the Cardiology Clinic determine if a reaudit will be required in the future.

Executive Summary
MRA Kaweah Health Inpatient DRG Review
Audit Completed: April 2024
Presented to: Audit and Compliance Committee – May 2024

Background

As a part of Kaweah Health's proactive monitoring activity, a quarterly review of Medicare Inpatient Rehabilitation, Hospice, Mental Health, and Acute Inpatient-specific Diagnosis Related Groups (DRGs) and discharges is conducted, with a focus on accounts that have been identified as usage outliers, and high risk for payment errors. The electronic data report is issued through the Program for Evaluating Payment Patterns Electronic Reports (PEPPER). Through a recent PEPPER review, it was identified that DRG's 483 (major joint or limb reattachment procedures of upper extremities) and 455 (combined anterior and posterior spinal fusion without Complication or Comorbidity/Major Complication or Comorbidity (CC/MCCs)) were outliers for high utilization at Kaweah Health when compared to other hospitals in the comparison group. An audit was conducted to assess the compliance of the use of DRGs 483 and 455.

Audit

MRA (external auditing agency) was engaged to conduct a review of forty-five (45) randomly selected patient accounts with DRGs 455 and 483 from August 2023 through January 2024. MRA assessed the accuracy of the MS-DRG 455 and MS-DRG 483 codes through a documentation review that included query, discharge status, and Present on Admission (POA) opportunities that could impact medical necessity, overall data integrity, and reimbursement accuracy. The results of the review noted an overall DRG accuracy of 91% coding accuracy, in which three (3) out of forty-five (45) accounts were over-coded, and one (1) out of forty-five (45) accounts was under-coded. The net financial error rate totaled 2%.

Findings

The findings of the review have been communicated with the coding leadership team, and education has been provided. Corrections were made to the accounts identified and have been rebilled.

Conclusion

The Compliance Department will continue to reassess the risks associated with DRGs 455 and 483 and determine if a reaudit will be required in the future.

Executive Summary
MRA Kaweah Health Inpatient Rehab
Audit Completed: April 2024
Presented to: Audit and Compliance Committee – May 2024

Background

Kaweah Health's Inpatient Acute Rehabilitation Hospital (Inpatient Rehab) is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). A requirement of CARF accreditation involves a documented review of a sample patient population ensuring compliance with the standards of quality and regulatory requirements for admissions to the Inpatient Rehabilitation Facility (IRF) program. A small sample of Inpatient Rehab patient accounts are audited annually by an external coding agency to ensure the compliance with IRF requirements, coding, and CARF standards.

Audit

MRA (external auditing agency) was engaged to conduct a review of five (5) randomly selected patient accounts for January 2024. MRA assessed the accuracy of the ICD-10 diagnosis, etiology assignment, impairment group assignment, and tiered comorbidities.

The objectives of the review were as follows:

- Ensure the integrity and accuracy of ICD-10-CM diagnosis coding for Inpatient Rehabilitation services
- Validate appropriate usage of the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) to collect patient assessment data
- Validate the existence of specific documentation, assessments, interactions, planning, and signatures
- Identify documentation opportunities that could impact medical necessity, overall data integrity, and reimbursement accuracy

Findings

The results of the review noted 100% coding accuracy and documentation compliance, encompassing all data elements reviewed in totality for the Inpatient Rehab accounts. The findings of the review have been communicated to the Inpatient Rehab Leadership Team.

Conclusion

The Compliance Department will continue audit a small Inpatient Rehab population annually as required by the CARF accreditation.

Executive Summary
Patient Status Billing Review
Audit Completed: March 2024
Presented to: Audit and Compliance Committee – May 2024

Background

Medicare defines observation services as those furnished by a hospital including use of a bed and periodic monitoring by a hospital's nursing or ancillary staff, which are reasonable and necessary to evaluate an outpatient's condition to determine the need for possible inpatient admission. Observation services are covered only when provided by a physician order. Observation stays should not exceed forty-eight (48) hours. In most situations, observation hours exceeding the forty-eight (48) hours should be billed as non-covered unless the medical record supports the rare occurrence of a longer stay.

Observation patients must be regularly assessed to determine if discharge, continued observation care, or admission to inpatient status is the best care plan for the patient's condition. The choice of inpatient admission verses outpatient treatment is a complex patient specific judgment, which can be made only after the physician has considered several medical decision factors.

Medicare allows hospitals to change a patient's status from inpatient to outpatient only if either hospital utilization review or the patient's attending physician determines that, at the time of the admission to the hospital, the patient did not meet the hospital criteria for inpatient admission. Accordingly, condition code 44 is added to the claim to reflect inpatients that have changed to observation status.

Audit

As a part of Kaweah Health's ongoing monitoring of patient status billing, a review consisting of thirty (30) selected Medicare encounters for the period of April 2023 – November 2023 was conducted to determine if accounts met Medicare billing guidelines for patient status. The Electronic Health Record (EHR) and billing claim forms were used to validate billing and patient status.

The Compliance Department identified five (5) encounters in total were billed in error. It was identified that two (2) accounts did not reflect the updated observation admit time from the previous inpatient order, causing additional observation hours. Additionally, two (2) accounts were not reviewed appropriately by Case Management which resulted in a failure to apply code 44 on the claim. Finally, one (1) account reflected the improper admit time, however did have the correct number of IP days reflected on the claim. The net financial impact error rate was 0%, as the errors did not impact the payment of the claims.

Findings

The encounters containing errors were corrected and rebilled. The findings of the review have been communicated to the Case Management, Patient Access, and Patient Accounting Departments Patient Access Leadership, who provided education to the team members responsible for the errors.

Conclusion

The Compliance Department will continue to complete reviews to evaluate compliance with observation status billing guidelines annually.

Agenda item intentionally omitted