OPTUM™

Special Investigations Unit (SIU)

Coding and Auditing of Behavioral Health Services

Agenda

- **Overview of changes ahead for Optum and Program Integrity**
  - Introduction of new Executive Lead
  - Why we are in place
  - What we do
  - Distinctions between SIU; Practice Management; Peer to Peer
- **Differences in:**
  - Flagging
  - Prospective
  - Retrospective
- **Focus on Billing / Coding Guidelines**
- **Algorithms and current trends seen within Behavioral Health**
- **Algorithms in place today**
- **Where to go for up-to-date information**
- **Questions**

Introduction

"Physicians are doing their best to provide high-quality patient care in a fragmented health system . . . Health & Human Service should target areas where fraud truly occurs to be most effective instead of adding onerous burdens on physicians. The administration should establish clearly defined goals for fraud efforts to appropriately target scarce resources and better measure success. Increasing resources for outreach and education to the medical community on anti-fraud initiatives, including a clear set of mechanisms on how to report fraud, should also be a high priority." - AMA President Ardis Dee Hoven, MD

- Optum believes that providers are an integral part of our program integrity work.
- Protecting clients, providers and stakeholders through the prevention, early detection, investigation and ultimate resolution of Fraud, Waste and Abuse (FWA) issues is a fundamental component of quality care and sound clinical practice.
- We are pleased to work in consultation with providers to find solutions that address fraud without adding unnecessary burdens to the physicians' office that take time away from critical patient care

Introduction, cont'd.

- **Difficult and necessary program.** We are all charged with ensuring the most appropriate care for those we serve with the precious/sparse resources at our disposal.

- **Federal law** requires the establishment of "Special Investigations Units" or their equivalents and the "Effective System for Routine Monitoring, Auditing and Identification of . . . Risks" and to "carry out **appropriate corrective action**." *CMS requirement.*

- "Appropriate corrective action" is on a continuum commensurate with the continuum of questionable activity – simple mistakes &need for **education** to fraudulent activity & **referra**l to law enforcement. And there is an ever-present requirement of **corrective action** and **recoupment** of precious dollars –- it is critical that dollars not appropriately directed get recovered while education and other appropriate action is under way. Different funding agencies have different standards. 6 month look back versus five years

- Between these polar extremes is an array of activity, practice and process that can be improved and educated on in the ever-changing word of health care

- ***How we do it is key.*** Strike a balance between the rare but real truly fraudulent practice and the vast majority of other cases that fall on the continuum of clinical care, in a highly complex environment that is constantly changing and hopefully improving. The fundamental focus – always – is the patient/consumer. We must be vigilant and work to improve any practice that impedes care - either in our practice (aggressive, unfriendly or unduly burdensome) or a provider's clinical practice (quality improvement and/or education).

Introduction, cont'd.

- **Important to note:** Optum does not determine "fraud" - only law enforcement does. Through process and technology, we focus on improving practice (ours and yours) across the array of activity defined as fraud, waste and abuse that we are all charged with monitoring. Our approach is fact-based only. We try to prevent and educate where possible and investigate and refer when such education has little to no impact over time.
- We are pleased to work in consultation with providers to find solutions that address fraud without adding unnecessary burdens to the physicians' office that take time away from critical patient care.
- To that end you will be seeing some significant changes over the coming months:

  - A name change that will more closely reflect the larger focus on improving practice through education
  - More educational and training opportunities
  - A renewed focus on customer care in our letters, outreach, phone calls and audits
  - Active consultations with providers and their associations
  - A commitment to reducing burdensome activities to the extent possible.
  - A new lead:

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Our Commitment

A balanced approach, along with open and clear communication with the provider community, helps to ensure maximum recoveries without harming vital provider relationships.

- **To that end, Optum is committed to**:
  - A comprehensive view of how the Program Integrity unit interacts with our network;
  - Building and sustaining trust in provider communities regarding FWA initiatives and activities;
  - More transparency into our activities;
  - Ensuring reliability and timeliness in our practice and methodology;
  - Improving overall education and awareness for both Optum and the Network; and
  - Soliciting critical feedback in developing long-term strategies for battling FWA from the network and your associations.

What is Fraud, Waste and Abuse (FWA)?

- U.S. health care spending growth decelerated in 2012, increasing 3.9%. Total health expenditures reached $2.79 trillion*, which translates to $8,915 per person or 17.2% of the nation's GDP.

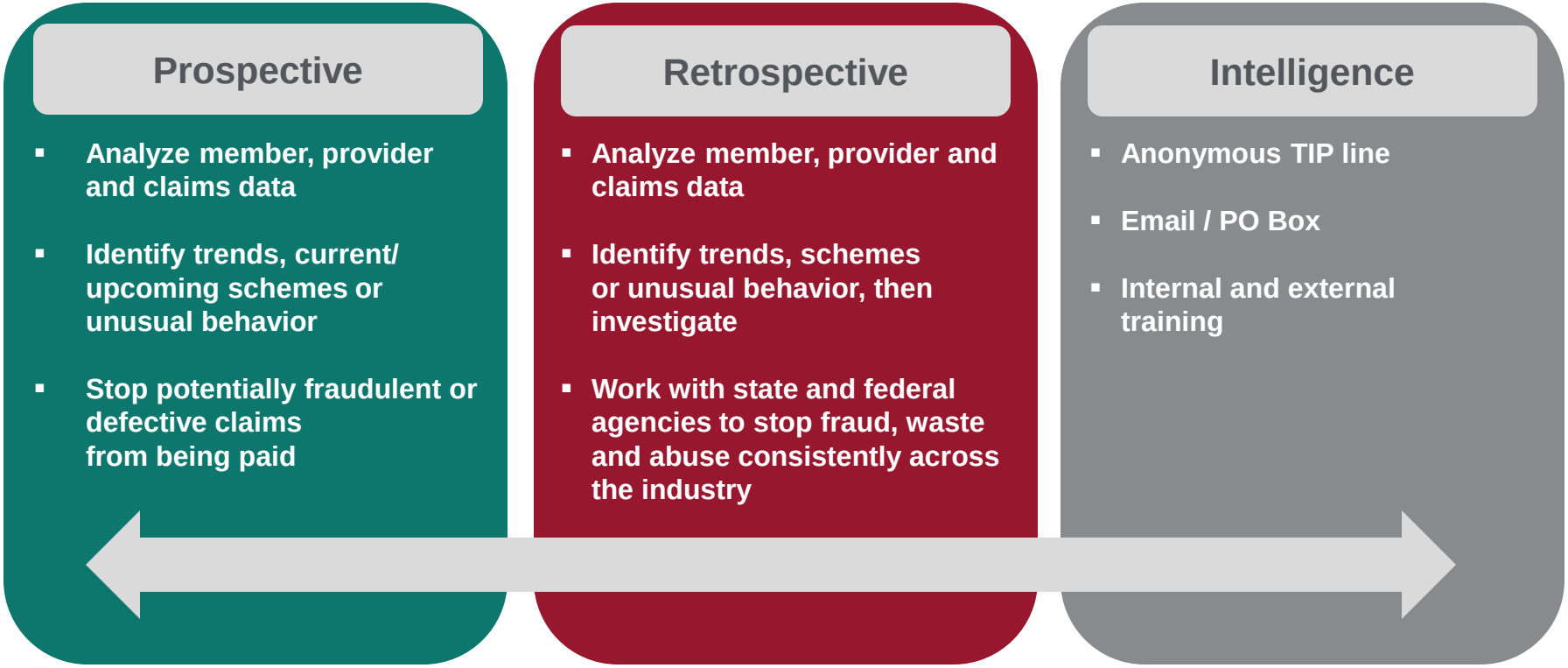
- Conservatively it is estimated that 3% to 10% of all health care dollars are spent on Fraud, Waste or Abuse annually according to the National Health Care Anti-Fraud Association (NHCAA). Which correlates to between 70B and 250B annually.

* NHE cited by https://cms.gov/NationalHealthExpendData/downloads/tables.pdf

Optum's SIU Department

•A dedicated group responsible for working with providers to prevent, detect, investigate and ultimate resolve potential issues.

•Skilled and trained investigators, clinicians, data analysts and medical coding personnel.
•The department consists of three main investigative pathways:



Those accountable

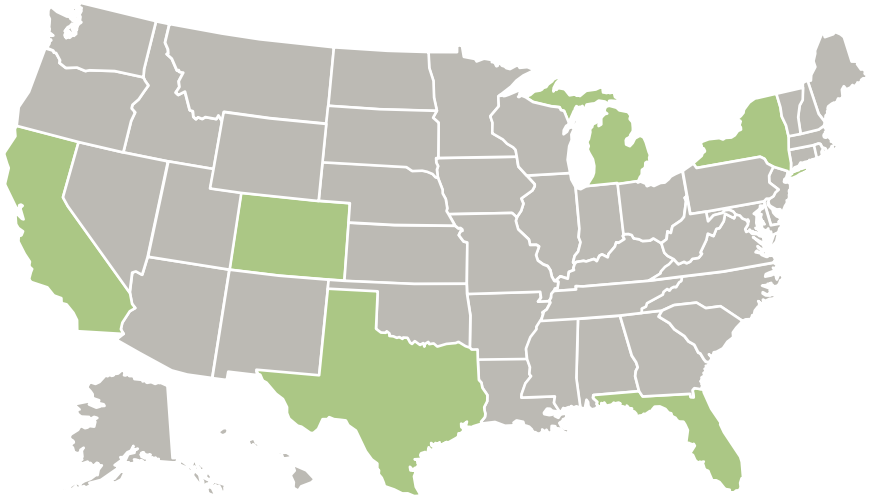
- All of us:

- Members
- Family members of consumers
- Providers
- Independent physician associations
- Billing companies
- Pharmaceutical companies
- Sales agents
- Health plans

"Fraud is committed by health care providers, owners of medical facilities and laboratories, suppliers of medical equipment, organized crime groups, corporations, and even sometimes by the beneficiaries themselves."

Federal Bureau of Investigation (FBI)

Where is FWA Generally Most Prevalent?



Source: http://www.fbi.gov/news/stories/2010/june/health-care-fraud/health-care-trends

Delivering the Message; Fostering a Partnership

- **Sustain** and continuously build industry leading teams and systems
- Sustain trust and **relationships** with provider communities
- Continuously **adapt** to emerging trends and schemes
- Monitor and **improve** FWA program and processes

*Our **providers** must be included as an **integral part of our program**, any barrier in communication must be removed, any perception about intent or methodology will be answered and strategizing both short and long term will result in reducing unnecessary costs that burden our fragile healthcare delivery system.*

*Over the coming months we will be working with you, your respective associations to develop a new view toward **collaboration** and **partnership**.*

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The FWA Detection Process

Coding and Auditing of Behavioral Health Services

Behavioral Health: Fraud, Waste & Abuse Program

Claim Editing	• Publishing claim reimbursement policies that will give clear guidance on industry or internal standard rules that may impact claims payment. Target for completion Q3'14
Flagging	• Monitor activity flagged for compliance • This may include, but not limited to sanctioned, excluded and/or otherwise potentially suspicious individuals
Prospective Investigations	• Identifies potential outlier claims – those aberrant in relation to norms • Review claim after processing and prior to payment • Transition from 'Pay and Chase' methodology per Federal guidance
Retrospective Investigations	• Complete due diligence and data analysis • Audit and record review • Provider education followed by potential overpayment and/or settlement

Prospective Detection Flow

Retrospective Investigative Program Workflow

This is an example of a retrospective plan, items within the plan may vary depending on need.

Focus on Billing / Coding Guidelines

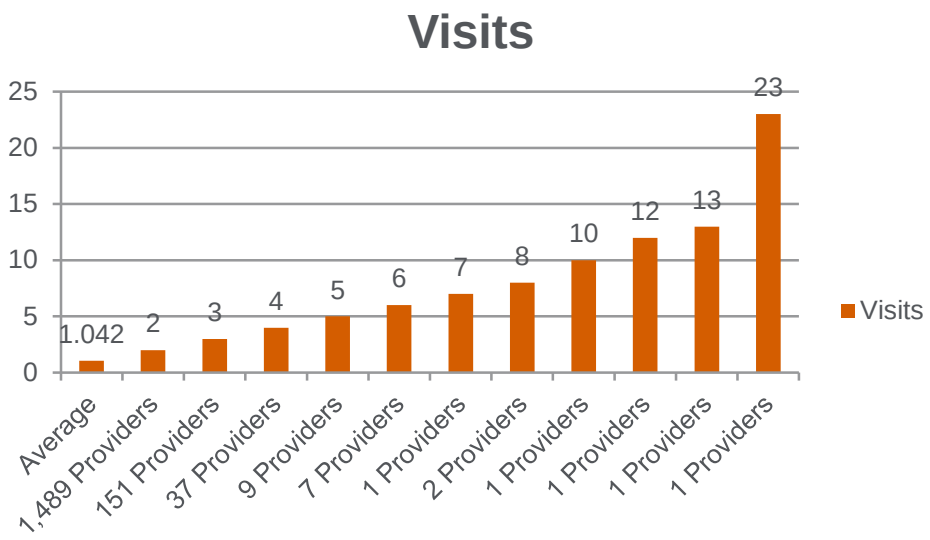
- Audit tools are created using industry and internal guidelines.
- Resources for Evaluation and Management Audit tools:
  - American Medical Association (AMA) Current Procedural Terminology (CPT) for guidelines, definitions and requirements. Updated annually.
  - Centers for Medicare & Medicaid Services (CMS) 1995/1997 Documentation Guidelines.
  - Optum Network Manual & Treatment Record Requirements

  - Evaluation and Management Resources
    - E/M Service Guide
    - CMS 1995 Documentation Guidelines
    - CMS 1997 Documentation Guidelines
    - CMS FAQs on Documentation Guidelines
    - APA 2013 CPT Code Changes
    - APA E/M Documentation Template
    - APA E/M Services Guide: Coding by Key Components
    - APA E/M Webinar Presentations

Algorithms in place today

Diagnostic Evaluations (90791/90792)

- Definitions:
  - 90791: Psychiatric diagnostic evaluation
  - 90792: Psychiatric diagnostic evaluation with medical services
- Rule:
  - Typically we wouldn't expect to see more than 2 of these services within a given treatment episode.
  - A treatment episode is defined as 120 days between any service with a provider and member. We will be soliciting feedback on the length of the treatment period
  - If we receive a 3rd diagnostic evaluation within a treatment episode we will request medical records to verify the service documented. If the service is for anything other than the service billed the claim would be denied as not supported by the documentation. Rebilling of the appropriate code is necessary in order to receive reimbursement for the claim.



Algorithms in place today – Continued

National Correct Coding Initiative (NCCI) Edit

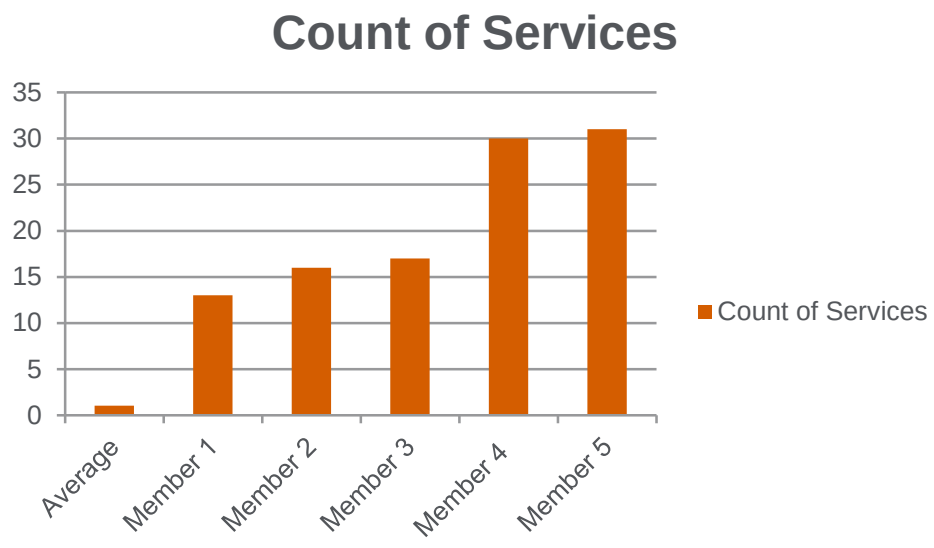
- NCCI edits are services that Centers for Medicare and Medicaid Services (CMS) has determined should not be billed together on the same day by the same practitioner. In NCCI edits there is a payable code (Column 1 of the table below) and a non-payable code (Column 2) in each code pair. If an NCCI modifier is allowed for the code pair (see Modifier Indicator), both codes will pay if an NCCI modifier is used with either code.
- In the even that a non-payable code was submitted and paid prior to the payable code being submitted for payment the payable code will be paid, resulting in both codes being paid. In this case, Optum will manually recoup the non-payable service from the provider.
- For additional information regarding the NCCI edits, please visit the CMS website at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
- To better understand NCCI edits, please visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf
- Sample of the NCCI edit code pairs released by CMS January 1, 2014:

Column 1	Column 2	Modifier 0=not allowed 1=allowed 9=not applicable
90832	90791	0
90832	90792	0
90832	90839	0
90832	90840	0

Algorithms in place today – Continued

Outliers

- This rule identifies claims that are viewed as an outlier by looking at a variety of different factors (member, provider, length of care, frequency of services, etc).
  - When claims are identified as a potential outlier they are pended and medical records are requested.
  - Once the medical records are received an administrative review is completed to validate the services documented.
- Outlier Example 1:
  - Average New Patient codes for member/provider combination is 1.04 visits within a year
  - 69 Providers saw a member more than twice, but below are 5 examples of extreme usage.



Algorithms in place today – Continued

- Outlier Example 2:
  - Average visits per member per year = 8.59
  - 71 members had over 300 visits

Member	Claim Counts	Member Avg
1	380	8.58884
2	380	8.58884
3	380	8.58884
4	380	8.58884
5	380	8.58884
6	380	8.58884
7	380	8.58884
8	380	8.58884
9	379	8.58884
10	379	8.58884
11	378	8.58884
12	377	8.58884
13	377	8.58884
14	377	8.58884
15	377	8.58884
16	376	8.58884
17	375	8.58884
18	375	8.58884
19	375	8.58884
20	375	8.58884

Evaluation and Management with Psychotherapy

APA Coding Summary Guide

Optum EM and Psychotherapy

In consultation with the APA, Optum is developing a provider alert for E/M Codes with Psychotherapy. Below is a little information that will be published soon regarding the documentation requirements of these services:

- Patients with psychiatric diagnoses may receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician (or other qualified health care professional). To report both E/M and psychotherapy, the two services must be **significant and separately identifiable** (within the same progress note is acceptable).
- Time parameters should be documented to denote the approximate time developed to the psychotherapy service. These services are reported by using both the appropriate E/M code and add-on codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838).
- When psychotherapy is provided in conjunction with an E/M service, the standalone psychotherapy codes (90832, 90834, 90837) should *not* be used. See the CPT code book for descriptions and additional information.

ONE EXAMPLE - New Patient
OF AN E/M PLUS PSYCHOTHERAPY PROGRESS NOTE

Patient Identifier

Date

Diagnosis

E/M:

History

[Include required number of elements based on E/M level billed]

Examination

[Include required number of bullets based on E/M level billed]

Medical Decision Making

[Include required documentation based on E/M level billed]

Psychotherapy:

Time spent on psychotherapy services only_____

[Include description of type and content of psychotherapy provided]

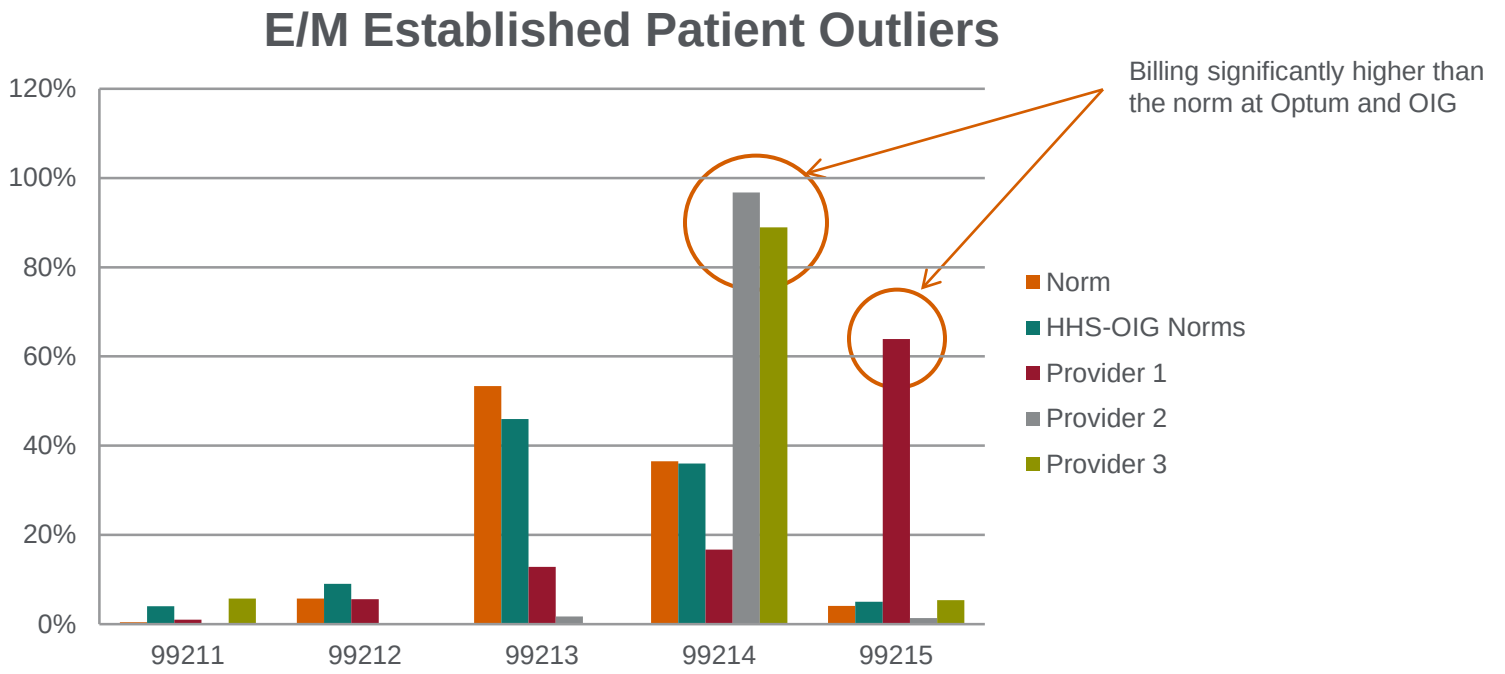
List additional attendees, if any:

Legible Signature of Practitioner, Degree , Licensure

Historical Algorithms – No longer active

99214/99215

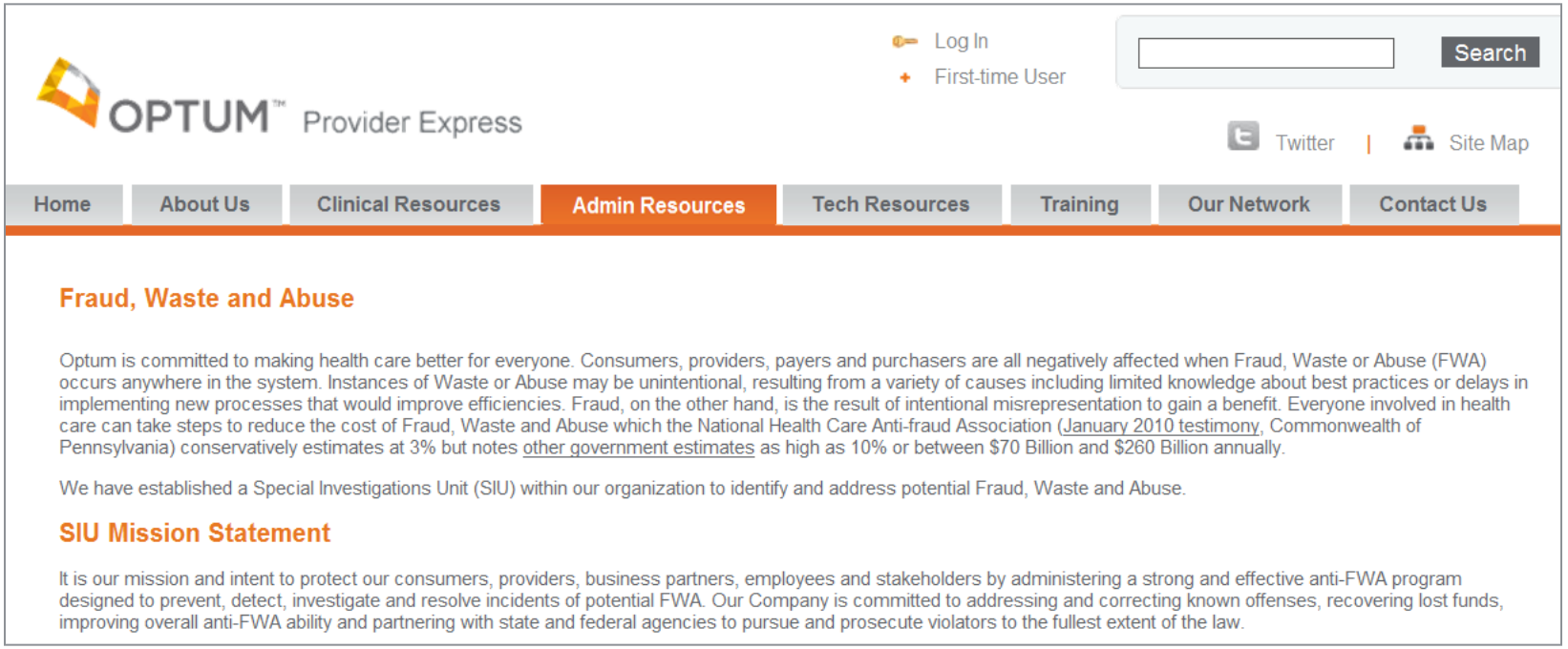
- Some of you may have experienced activity from our department around 99214/99215 codes. After the Evaluation and Management (E/M) code roll-out in January 2013, Optum was seeing higher than usual activity around 99215 and 99214s. Upon review of requested clinical records, however, it was apparent that approximately 80% or more records did not meet documentation standards. Clearly, more education on these codes were needed.
- Due to this, Optum decided to turn off the edit in July 2013 and educate the provider community with a Provider Alert that better explained the documentation requirements for E/M Services.



HHS-OIG Norms: https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf

Where to go for up-to-date information

- Provider Express: Fraud, Waste and Abuse Page
- **Contact us:**
  - Telephone: 877-972-8844
    E-Mail: ohbs.siu.tips@optum.com
    Mail: P.O. Box 30535, Salt Lake City, UT 84130-0535
    Fax: 248-733-6379
    General inquiries (communications to SIU other than TIPs: ohbs.siu.communications@optum.com



Questions?