ADVANCED DISCUSSION GROUP—EPIC

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Agenda

- Overview of the User Group, Survey Results, Webinars and Conference educational offerings

- Today’s Topics
  - Data Governance and Reporting (Mark)
  - AHIMA Risk Areas (Catherine)
  - Charge Router/Charging Controls (Jill)
  - Interfaces (Mark)
  - Audit Cycles/Facility Audits (Catherine)
  - Examples of 6 month post go-live audits (David)

- Summary
Overview

- User Group Activities
- Webinar schedule
- Conference education
- Survey Results
User Group Activities

- Epic survey to AHIA members
- Planning 4 webinars in 2013
  - May 23—Complete; 87 attendees
  - July 26—Security and Access
  - Sept—Meaningful Use
  - Nov—Segregation of Duties
- Advanced Discussion Group at Annual Conference
Survey Results—71 Responses

- Security and Access: 73.2% (webinar)
- Meaningful Use: 73.2% (webinar)
- Cycle Audits: 73.2%
- Examples of 6 mo. post go-live audits: 59.2%
- Charge Router/Charging Controls: 56.3%
- Interfaces: 56.3%
- AHIMA Risk Areas: 53.5%
- Data Governance and Management (Clarity/Cache): 52.1%
How long has your organization used EPIC?

- Implemented in the past 1 – 5 years: 47.4%
- Just Implementing now: 34.6%
- Implemented over 5 years ago: 17.9%
Which EPIC systems or applications does your organization use?

- EpicCare Ambulatory EMR
- Cadence (Enterprise Scheduling)
- MyChart for Patients (Web-based Communication with Patients)
- Willow (Pharmacy)
- ADT/Prelude Registration (Enterprise Admission/Registration)
- EpicCare Inpatient Clinical Documentation
- EpicCare Inpatient Physician Order Entry
- ASAP (Emergency Department)
- Op Time (Operating Room)
- Radiant (Radiology)
- HIM Chart Tracking, Release of Information & Deficiency Tracking
- Resolute Hospital Billing
- Resolute Professional Fee Billing
- Stork (L&D)
- Beacon (Oncology)
- EpicCare Link (Web-based Communication with External Providers)
- Anesthesia Cardiant (Cardiology)
- Welcome (Patient Self-Service Kiosk)
- Haiku (Hand Held Mobile Device Dictation)
- Canto (iPad Dictation)
- Beacon (Lab)
- Kaleidoscope Ophthalmology
- EpicCare Home Health
- Tapestry (Managed Care)
- Other (please specify)

CUPID; Care Everywhere; Reporting Tools, incl RW and Clarity; ePrescribing interface; Incoming lab results interface; vaccinations registry interface; outgoing surveillance interface; HIM ROI

- EpicCare Hospice
- Rover (Mobile Functionality for Medications)
What are topics of interest to you?

- Security and Access
- Cycle Audits (Order – Documentation – Charge Capture – Coding – Billing) – Ambulatory; Ancillary Services; Specialty Services
- Meaningful Use
- Examples of 6-Months Post Go-Live Audits by Application Rolled Out
- EHR – HIM Aspects – AHIMA Risk Areas
- Charge Router/Charging Controls
- Interfaces
- Data Governance and Management (Clarity/Cache)
- Optimizing Workqueues
- Clinical Research Billing Medication
- Management - MAR
- Break the Glass Back End PFS
- Pre-implementation Audits
- Build Decisions
- Project Governance
- Conversion Home
- Health/Skilled Nursing/Hospice
- Other (please specify):
  - Disaster recovery solution
  - Federal / State regulations that apply to document retention surrounding design, development, implementation, maintenance, upgrading, testing, etc. of an EHR. (Non-ePHI and non-MU documentation which have their own set of regulations)
  - SOD’s for access
  - Charge Master, Contract Management
  - Cash Drawer Utilization and Reconciliation Controls
  - Research charges, charge edits, Research charges, charge/patient reconciliation, and Research Charges
  - Segregation of Duties
  - How to make use of Clarity and Workbench to identify accounts or transactions for audit - continuous audit. Segregation of Duties

- Benefit Engine
- DAP
Have you performed any audits of EPIC applications? (Select all that apply)
Planned audits?

Planned Audits

- Charges/Revenue
- Security/Access
- Unsure/trying to determine
- Meaningful Use
- Implementation/Post Implementation
- Break the Glass/Physician notes/Make me the Author
- Cash/Collections
- Interfaces
What ways would you like to receive info regarding auditing Epic applications?

- Webinar/Go-to Meeting: 90.0%
- New Perspective “how to” articles: 80.0%
- Newsletter: 70.0%
- E-learning: 60.0%
- Regional Seminar: 50.0%
- AHIA Annual Conference Track or Unique Sessions throughout various tracks: 40.0%
- User Roundtable: 30.0%
- AHIA Annual Conference Pre-conference Seminar: 20.0%
What tools would you like to have access to (i.e. through AHIA Audit Library) to support how you approach auditing Epic?

- Audit Programs
- Top Risks/Risk Assessments
- System Documentation/Workflows/Charts
- Internal Control Questionnaires
- Data Analytic Ideas/ACL Test Scripts
- Lessons Learned/Issues Identified from Audits
- Epic Reports Auditors Should Access
- Security Issues
- Information Exchange/Discussion Thread (not ListServe)
Data Governance and Reporting
Data Governance and Reporting

Background

- Who owns Data and how is/should reporting of Data Controlled?
  - IT Function versus Operations
    - How much access is afforded:
      - Operations Personnel, Internal Audit, Corporate Compliance, etc.?
  - Lack of Epic “support” for data governance and knowledge outside of IT professionals?
    - Lack of audit specific courses
    - Lack of support for auditor “Epic Certification”
  - Without this non-IT validation how might quality and other reporting be impacted?
Data Governance and Reporting Examples

- Governance / Reporting Examples
  - Traditional / Ideal:
    - IT provides infrastructure, programming, data management and system implementation services.
    - Operations owns the data and uses both IT and in-house personnel to access source data for validation & reporting.
    - Internal Audit has open read access.
  - Epic Environment: Truly Non-Traditional?
    - IT provides infrastructure, programming, data management and system implementation services.
    - IT appears to own the data and the reporting of it.
    - IT has open read access.
Best Practice here is likely found in frameworks like COCO, ISO, etc.

- IT is a service provider who maintains the tools to generate, manage and report data.
- IT then owning and actually reporting the data would not seem ideal, if for not other reason than application of the duty segregation control principal.
Data Governance and Reporting
Lessons Learned

- Working in this new environment is difficult at best:
  - Data mining and analytics may be impossible.
  - Application control focus has been an easier path into Epic data for us so far, albeit through screen shot validations in many cases for source validation.
  - Operations personnel are eager to learn Epic but often frustrated if we don’t know more than they do.
  - The situation gets more difficult and more complex as more and more Epic modules are implemented.
  - Even with EMR and Rev Cycle implemented, we have not yet been able to gain a full data set from registration to discharge.
Data Governance and Reporting

Q&A

- What data governance successes do you have to share?
- What data governance challenges are you willing to share?
- What data reporting success do you have to share?
- What data reporting challenges are you willing to share?
AHIMA Risk Areas
Noridian Administrative Services, LLC

Documentation to support services rendered needs to be patient specific and date of service specific. These auto-populated paragraphs provide useful information such as the etiology, standards of practice, and general goals of a particular diagnosis. However, they are generalizations and do not support medically necessary information that correlates to the management of the particular patient. Part B MR is seeing the same auto-populated paragraphs in the HPIs of different patients. Credit cannot be granted for information that is not patient specific and date of service specific. (italics mine—CW)

Source:
Background: AHIMA Risk Areas

- “For example, electronic health records (EHR) may not only facilitate more accurate billing and increased quality of care, but also fraudulent billing. *The very aspects of EHRs that make a physician’s job easier—cut-and-paste features and templates—can also be used to fabricate information that results in improper payments and leaves inaccurate, and therefore potentially dangerous, information in the patient record.* And because the evidence of such improper behavior may be in entirely electronic form, law enforcement will have to develop new investigation techniques to supplement the traditional methods used to examine the authenticity and accuracy of paper records. “

Examples: AHIMA Areas of Risk

- Authorship Integrity Risk
- Auditing Integrity Risk
- Documentation Integrity Risk
- Patient Identification and Demographic Data Risks

Guidelines for EHR Documentation to Prevent Fraud

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp
Examples: AHIMA Risk Areas

Authorship

- Residency program audits: Students, residents, faculty documentation
- Note editing (physician note “edited” by nurse or resident)

- Authentication requirements

Auditing

- Audit trails in Epic: how many to turn on???
  - Consider impact on system efficiency
  - What are you going to use?
Examples: AHIMA Risk Areas

Documentation integrity

- Auto inserted data from smart phrases/text
- Copy/paste; copy forward; cut and paste
- Template
  - All could result in documentation that is not relevant to the patient on that specific visit

Patient Identification and Demographic data

- Automated registration data
- Community provider access to EHR
Examples: Copy and Paste Risks

- Nurse was updating her resume (using Word) and copied a portion of her resume into a patient chart.
- ED nurse had two records open. She copied part of Patient A's record into Patient B's record—drug use and bi-polar diagnoses showed on Patient B's medical record and billing information.

Need Error Correction Policy from the start: reporting, roles (HIM, IS, other), customer service.
Examples: Copy and Paste Risks

- A note was copied "in total" to include the PREVIOUS performing provider's name.
- NO original documentation by the 'today' provider; just an electronic signature with 'today's date and time'.
- Reviewed 10 visits over a year period for a provider....every exam finding was the same despite current complaints to the contrary. Found to be copying and pasting exam......forgot to 'edit' for today's findings.

AHIMA article: [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp)
Examples: AHIMA Risk Areas

Clinical Data (shared)

Demographic Data (shared)

Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data
Service Area X Financial Data

Financial Data is segregated by tax ID or billing entity
Examples: AHIMA Risk Areas

- Structured data (fields/canned text) versus Free text
- “My” 99214/standard template
- Lack of continuous monitoring and feedback to providers (who owns this?)
Best Practices

- Policies—Error Correction, Cut and Paste, Documentation
- Physician Handbook
- Required education and competencies for clinical users
- On-going auditing (documentation and coding; template use; history carry-forwards) with feedback to providers
- Medical Staff approval on selected policies
Auditing Suggestions

- Audit for compliance with policies
- Include documentation review in coding audits
  - Cut and Paste
  - Unique patient visits
- Use Plagiarism software

Plagiarism software download: http://plagiarism.phys.virginia.edu/
AHIMA article: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok3_005520.hcsp
How are you managing these risks in your organization?
Charge Router/Charging Controls
Revenue Cycle Phase II

Phase II: Services, documentation, coding and charge capture.

Revenue Cycle
Revenue Cycle Phase II

Background:

- Phase II — Focus on high revenue-producing ancillary departments:
  - Operating Room, Cardiology (Invasive/Noninvasive), Radiology, Lab, Pharmacy, Respiratory, GI/Endoscopy, Emergency Department

- Work Performed:
  - Interviews with department leadership
  - Process flows within each clinical area
  - Review of relevant policies and procedures
  - Detailed testing
  - Data analytic using ACL data mining tool
  - Findings and Recommendations
  - Interview/Consult:
    - Mercy Revenue Management Team
    - Charge Description Master (CDM) Team
    - Mercy Compliance Department
    - Central Coding Management
Revenue Cycle Phase II

- Use of Data Analytics:
  - Operating Room – presence of pre-op charge/OR level, anesthesia time, recovery time

<table>
<thead>
<tr>
<th>Location</th>
<th>Missing Pre Op</th>
<th>Missing Anesthesia Time</th>
<th>Missing Recovery Time</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases</td>
<td>% of Total</td>
<td>Gross Charges</td>
<td># Cases</td>
</tr>
<tr>
<td>FACILITY A</td>
<td>6</td>
<td>0.1%</td>
<td>$4,000</td>
<td>82</td>
</tr>
<tr>
<td>FACILITY B</td>
<td>0</td>
<td>0.0%</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>FACILITY C</td>
<td>10</td>
<td>0.2%</td>
<td>$6,670</td>
<td>35</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16</td>
<td>0.1%</td>
<td>$10,670</td>
<td>129</td>
</tr>
</tbody>
</table>

- Opportunities to improve charge capture
- Define start and stop times
- Enhance reconciliation
### Revenue Cycle Phase II

#### Use of Data Analytics:

- **GI/Endoscopy** – presence of pre-op, Anesthesia time, sedation drug, recovery time

<table>
<thead>
<tr>
<th>Location</th>
<th>Missing Pre Op</th>
<th>Missing Anesthesia Time</th>
<th>Missing Sedation Drug</th>
<th>Missing Recovery</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Exceptions</td>
<td>% of Total</td>
<td>Gross Charges</td>
<td># Exceptions</td>
<td>% of Total</td>
</tr>
<tr>
<td>FACILITY A</td>
<td>12</td>
<td>0.2%</td>
<td>$ 5,200</td>
<td>46</td>
<td>0.8%</td>
</tr>
<tr>
<td>FACILITY B</td>
<td>63</td>
<td>15.4%</td>
<td>$ 27,279</td>
<td>9</td>
<td>2.2%</td>
</tr>
<tr>
<td>FACILITY C</td>
<td>175</td>
<td>5.0%</td>
<td>$ 75,775</td>
<td>79</td>
<td>2.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>250</td>
<td>2.5%</td>
<td>$108,254</td>
<td>134</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

- Opportunities to improve charge capture
- Enhance pharmacy charging
- Define start and stop times
Revenue Cycle Phase II

- Use of Data Analytics:
  - Radiology – procedures with or without contrast for contrast media charge

<table>
<thead>
<tr>
<th>Location</th>
<th>Missing Contrast Charge</th>
<th>Radiology Procedures with Contrast</th>
<th>% of Missing Contrast Charges</th>
<th>Gross Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACILITY A</td>
<td>24</td>
<td>12,685</td>
<td>0.19%</td>
<td>$ 10,800.00</td>
</tr>
<tr>
<td>FACILITY B</td>
<td>103</td>
<td>5,807</td>
<td>1.77%</td>
<td>$ 46,350.00</td>
</tr>
<tr>
<td>FACILITY C</td>
<td>8</td>
<td>2,477</td>
<td>0.32%</td>
<td>$ 3,600.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>135</td>
<td>20,969</td>
<td>0.64%</td>
<td>$ 60,750.00</td>
</tr>
</tbody>
</table>

- Enhance process for capturing charge for contrast media
## Revenue Cycle Phase II

### Use of Data Analytics:
- Emergency Department – presence of, or duplication of, facility fee

<table>
<thead>
<tr>
<th>Location</th>
<th>Total ED Encounters</th>
<th>Missing Facility Fee</th>
<th>Missing Facility Fee as a % of Total ED Encounters</th>
<th>Duplicate Facility Fees</th>
<th>Duplicate Facility Fees as a % of Total ED Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACILITY A</td>
<td>19,739</td>
<td>9</td>
<td>0.05%</td>
<td>21</td>
<td>0.11%</td>
</tr>
<tr>
<td>FACILITY B</td>
<td>8,540</td>
<td>890</td>
<td>10.42%</td>
<td>463</td>
<td>5.42%</td>
</tr>
<tr>
<td>FACILITY C</td>
<td>23,466</td>
<td>13</td>
<td>0.06%</td>
<td>4</td>
<td>0.02%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>51,745</td>
<td>912</td>
<td>1.76%</td>
<td>488</td>
<td>0.94%</td>
</tr>
</tbody>
</table>

- Opportunities to improve charge capture
- Enhance process to eliminate duplicates
- Similar analytic for professional fees and supplies
Revenue Cycle Phase II

- **Best Practices:**
  - Areas with charge auditors embedded in the process have better results
  - Departments with fully integrated Epic functionality benefit from system controls
  - Ability to analyze professional and technical charges across Epic modules

- **Lessons Learned:**
  - Revenue Reconciliation
    - Current process is manual and time consuming and is not comprehensive
    - Automation through data analytic is more efficient and accurate
  - Specificity to each area will eliminate false exception hits
  - Comparison across facilities will expose charge process inconsistencies
Charge Router/Charging Controls

- How are you addressing revenue risks?
Interfaces
Interfaces - Background

- Interface Challenges are common in most healthcare environments:
  - Traditional Best of Breed Approach
  - Automated and Manual Interface Situations
  - HL7 Interface Standard
  - Data Integrity
  - Testing Issues
  - Error Identification and Follow-up
What is the status of your Epic environment?

- All Epic
- Revenue Cycle Only
- EMR
- Physician Offices
- Bolt-ons
Interfaces – Best Practices

☐ Is there an Epic best practice scenario against which to compare your organization?

❖ It may be too early to know

❖ Not a lot of Epic information sharing yet, at least in the audit profession

❖ Cedars-Sinai Resources and Outcomes Measurement Function – Focused Data Quality Function – Possible Best Practice for post-Epic implementation data and interface error identification and remediation
Testing, revalidation and a routine error correction process can be very helpful:

- Dedicated Data Validation Function
- Cross-Functional Participation
- Regular Follow-up
- Prioritization
- Feedback to Epic?
What interface issues have you addressed?
Audit Cycles/Facility Audits
Audit Cycles/Facility Audits

- Risk Assessment
  - What are the high risk areas?
    - Revenue
    - Volume
    - Complexity of transactions (e.g., Lab panels)
    - Complexity of regulations (e.g., Pharmacy quantity billing)
    - # of handoffs (e.g., Nursing acuity => room charges)
    - Current audit activity by payers
    - What’s in the news/settlements
    - Cycle coverage
Audit Cycles/Facility Audits

- **Process components**
  - Physician orders, documentation, charging, coding, billing

- **Applicable Standards**
  - Joint Commission
  - National Patient Safety Goals
  - Policies
MHS Cycles

- Wanted a three year cycle; have a 4+ year cycle
- Other
  - Sedation
  - Observation
  - Acuity
  - OB ED
  - Research
  - And more....

<table>
<thead>
<tr>
<th>Facility Services within the 4 year rotation cycle</th>
<th>Orders, Documentation, Billing, Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORs</td>
<td>Level Charges, supplies, implants/devices</td>
</tr>
<tr>
<td>ED</td>
<td>Level Charges, supplies, drugs</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Billing units, admin fees, 340B, LCD/NCD issues</td>
</tr>
<tr>
<td>CT/MRI/PET/Nuc</td>
<td>Contrast</td>
</tr>
<tr>
<td>Rad Onc</td>
<td>panels, bundling</td>
</tr>
<tr>
<td>Lab</td>
<td></td>
</tr>
<tr>
<td>RT</td>
<td></td>
</tr>
<tr>
<td>AIS</td>
<td>drug billing, admin fees</td>
</tr>
<tr>
<td>Oncology</td>
<td>drug billing, admin fees, LCD/NCD issues</td>
</tr>
<tr>
<td>Echo</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>Trauma designation</td>
</tr>
<tr>
<td>GI</td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td></td>
</tr>
<tr>
<td>Rehab Services</td>
<td>PT/OT/Speech</td>
</tr>
<tr>
<td>Inpt Services</td>
<td>Acuity charges, supplies, nursing procedures</td>
</tr>
<tr>
<td>Imaging--General</td>
<td>Contrast</td>
</tr>
<tr>
<td>Consultant Services</td>
<td>CCIA does not have specific expertise in these services</td>
</tr>
<tr>
<td>Cath Lab/IR</td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>IP Rehab</td>
<td></td>
</tr>
</tbody>
</table>
Exam

p

le #1

51

Audit

Step:

Chart and Claim Analysis

Audit Name:

Observation Services

Purpose:

Ensure billing compliance for Observation Services

Sources:

Epic

Preparer:

Staff A

Reviewer:

Reviewer B and C

Date:

11-Jun

Note:

Fieldwork comments made by the auditor are available on a request-basis

Legend:

Y - Compliant

N - Noncompliant

N-C: Noncompliant - Corrected

N/A - No data available to test.

<table>
<thead>
<tr>
<th>Patient</th>
<th>MRN</th>
<th>Account</th>
<th>Location / Unit</th>
<th>DOS range</th>
<th>Final Patient Class (Observation, Inpatient, IP to Obs, Obs to IP)</th>
<th>Consent form signed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2746387</td>
<td>10603578</td>
<td>GS A WEST CARDIAC UNIT</td>
<td>3/11/11-3/13/11</td>
<td>IP</td>
<td>Y</td>
</tr>
</tbody>
</table>
## Example #1

<table>
<thead>
<tr>
<th>CHART DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Order</strong></td>
</tr>
<tr>
<td>CMS BM CH15, 290.1</td>
</tr>
<tr>
<td>Original Physician Order (Includes date, time, and service requested)</td>
</tr>
<tr>
<td>Revised (by CM) Physician Order Details (Date, time, and service requested)</td>
</tr>
<tr>
<td>Signed physician Order for final status determination (IP / Observation prior to discharge?)</td>
</tr>
<tr>
<td>Beginning Observation Time (physician order)</td>
</tr>
<tr>
<td>Evidence of UM Review?</td>
</tr>
<tr>
<td>Recommended Patient Status per UM?</td>
</tr>
<tr>
<td>Evidence of EHR Review (if applicable)?</td>
</tr>
<tr>
<td>Recommended Patient Status per EHR?</td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td>Y</td>
</tr>
</tbody>
</table>
### Example #1

| Were Services Performed that are Covered under Part B Insurance? | Total time Part B service was performed? | Ending Observation Time (Last patient care service rendered) | Total Observation Time per chart documentation (Beginning : Ending : Part B Services) | Patient Class Appropriate? | Type of Bill Appropriate? | Observation HCPCS (G3078) Appropriate? | Revenue Code Appropriate for Observation? | Attending phys ID Appropriate? | Code 44 claim appropriate (Inpatient to Outpatient - Medicare)? | Code 44 education given to patient (per MHS Code 44 Policy)? | Other phys ID |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Y | 7 | 1241 | 33 | Y | Y | Y | Y | Y | Y | Y | Y |
| N/A | N/A | 1644 | 18 | Y | Y | Y | Y | N/A | N/A | N/A | Y |
## Example #1

<table>
<thead>
<tr>
<th>Number of Observation Hours Billed</th>
<th>Number of hours for Chart Documentation</th>
<th>Billed Hours Equal Chart Supported Hours?</th>
</tr>
</thead>
<tbody>
<tr>
<td>43</td>
<td>33</td>
<td>N</td>
</tr>
<tr>
<td>18</td>
<td>18</td>
<td>Y</td>
</tr>
</tbody>
</table>
Chart and Claim Review
OB Hospitalist Program: Facility E/M Services

To determine compliance to CMS requirements and EMTALA requirements.
N/A

MultiCare Connect

Auditors A and B
Reviewers C and D
10/1/2012
Inpatient
Issues were identified.

<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>PATIENT IDENTIFICATION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>MEDICAL RECORD NUMBER</strong></td>
</tr>
<tr>
<td></td>
<td>NPSG 01.01.01:</td>
</tr>
<tr>
<td>1</td>
<td>2987777</td>
</tr>
<tr>
<td>2</td>
<td>52791</td>
</tr>
<tr>
<td>3</td>
<td>164652</td>
</tr>
</tbody>
</table>

Tickmark Legend

√ Testwork performed without exception.
X Testwork performed with exception. Services provided, with order, but not coded or billed.
X1 Testwork performed with exception. Services provided, billed and coded but no order.
X2 Testwork performed with exception. Facility Evaluation and Management (E/M) under billed or over billed.
X3 Testwork performed with exception. Ob ED not a distinct service.
X4 Testwork performed with exception. 2 Ob ED visits in same calendar day.
NA Attribute is not applicable to the sample item.
# Example #2

<table>
<thead>
<tr>
<th>QUALITY ASSURANCE</th>
<th>CONSENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders</td>
<td>CMS Requirements, JC Requirements, and CoP; MHS Policy</td>
</tr>
<tr>
<td>Chief Compliant documented by physician or non-physician practitioner (NPP)</td>
<td>CMS Requirements, JC Requirements, and CoP</td>
</tr>
<tr>
<td>Medical Screening Exam</td>
<td>EMTALA, GS Policy &quot;Pregnant Patient, Imminent Delivery&quot;</td>
</tr>
<tr>
<td>AMA - Signed AMA form by Patient</td>
<td>EMTALA</td>
</tr>
<tr>
<td>Supporting Documentation for Services (Nurses’ Notes)</td>
<td>Procedures Performed &amp; Documented</td>
</tr>
<tr>
<td>Physician Supervision Present</td>
<td>Consent for Treatment/Financial Agreement Signed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>X 1</td>
<td>√</td>
<td>√</td>
<td>X 3</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
<td>√</td>
<td>X 3</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
<td>√</td>
<td>X 3</td>
</tr>
</tbody>
</table>
## Example #2

### BILLING/CODING/MODIFIERS - ASSOCIATED WITH THE OB ED FACILITY E/M LEVEL OF SERVICE

<table>
<thead>
<tr>
<th>Claim information available for review</th>
<th>Claim dates - match MR</th>
<th>Revenue code reported on Claim</th>
<th>Facility ED E/M Code/Procedure Code</th>
<th>Procedures Performed</th>
<th>HCPCS/CPT4 Appropriate</th>
<th>Modifier appropriate</th>
<th>Services Billed and Submitted</th>
<th>Principal diagnosis - appropriate</th>
<th>ICD 9 Codes (Not including Principal Diagnosis)</th>
<th>Attending phys ID appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Requirements</td>
<td>Identify procedures performed from documentation. Did we bill for all procedures?</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
<td>CMS Claim Requirements</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
<td>√</td>
<td>X3</td>
<td>√1</td>
<td>X1</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>N/A</td>
<td>√</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
<td>√</td>
<td>X3</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>N/A</td>
<td>√</td>
</tr>
<tr>
<td>√</td>
<td>√</td>
<td>√</td>
<td>X3</td>
<td>X</td>
<td>X</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

Note: The table highlights the CMS Claim Requirements with specific codes (X3, X1, and X) indicating the status of each requirement.
Cycle Audits/Facility Audits

- What audits are you doing?
- What can you share about your processes?
Examples of 6 month post go-live audits
Examples of 6 month post go-live audits

- **Security**
  - Make sure Epic personnel are restricted out of Chronicles within some reasonable post go-live timeframe
  - Check the number and nature of staff with this highest level of access
  - How robust is your IS Change Management Process?
  - Changes to your Master files should all be well documented and tested prior to moving into production
Examples of 6 month post go-live audits

- **Work Queues**
- Run Data on all work queues

- **Month** | **Charges** | **Payments** | **Adjustments** | **To Bad Debt** | **A/R Change**
--- | --- | --- | --- | --- | ---
Dec 12 | 352,995,988 | -110,900,476 | -231,438,801 | -11,491,678 | -834,967
Jan 13 | 401,525,218 | -111,009,833 | -228,570,958 | -9,681,954 | 52,262,473
Feb 13 | 362,519,766 | -104,894,503 | -245,179,536 | -10,115,864 | 2,329,863
Mar 13 | 391,861,426 | -117,325,575 | -259,957,523 | -8,726,359 | 5,851,968
Apr 13 | 382,445,431 | -109,290,101 | -253,892,195 | -7,762,792 | 11,500,343
May 13 | 404,110,980 | -122,765,406 | -273,680,790 | -11,394,735 | -3,729,952
Jun 13 | 289,837,460 | -78,959,626 | -206,785,985 | -6,598,541 | -10,908,545

- Look for Anomalies
Examples of 6 month post go-live audits

**Work Queues**

<table>
<thead>
<tr>
<th>Top 10 Inpatient DNBs/Stop Bills</th>
<th>Error ID</th>
<th>Owning Area</th>
<th>Count</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SB Resp Charges To Be Reviewed</td>
<td>1018</td>
<td>CLIN FIN</td>
<td>34</td>
<td>2,790,216</td>
</tr>
<tr>
<td>2. DNB HIM CODING STATUS NOT COMP</td>
<td>4146501</td>
<td>HIM</td>
<td>42</td>
<td>2,744,357</td>
</tr>
<tr>
<td>3. DNB HIM PRIMARY DX CHECK</td>
<td>4140005</td>
<td>HIM</td>
<td>41</td>
<td>2,723,963</td>
</tr>
<tr>
<td>4. DNB HIM DRG CHECK</td>
<td>4142002</td>
<td>HIM</td>
<td>41</td>
<td>2,723,963</td>
</tr>
<tr>
<td>5. SB Late Charges</td>
<td>11</td>
<td>BILLING</td>
<td>40</td>
<td>2,131,904</td>
</tr>
<tr>
<td>6. SB Rehab IP Hipps Review</td>
<td>1027</td>
<td>REHAB</td>
<td>25</td>
<td>1,266,041</td>
</tr>
<tr>
<td>7. DNB COD DRG CHECK</td>
<td>4142001</td>
<td>HOSP CODING</td>
<td>14</td>
<td>993,416</td>
</tr>
<tr>
<td>8. SB MEDASSETS EXCEPTION</td>
<td>1023</td>
<td>CHARGE CAPTU</td>
<td>14</td>
<td>982,823</td>
</tr>
<tr>
<td>9. DNB COD PRIMARY DX CHECK</td>
<td>4140004</td>
<td>HOSP CODING</td>
<td>13</td>
<td>971,919</td>
</tr>
<tr>
<td>10. DNB COD CODING STATUS NOT COMP</td>
<td>4146502</td>
<td>HOSP CODING</td>
<td>13</td>
<td>971,919</td>
</tr>
</tbody>
</table>
Examples of 6 month post go-live audits

- **Work Queues**

- **Denials Trending Summary as of:** 6/30/13

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Amount</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-23-PAYMENT ADJUSTED BECAUSE</td>
<td>9,308,677</td>
<td>1459</td>
</tr>
<tr>
<td>16-CLAIM/SERVICE LACKS INFO</td>
<td>2,167,803</td>
<td>451</td>
</tr>
<tr>
<td>18-18-DUPLICATE CLAIM/SERVICE.</td>
<td>1,785,572</td>
<td>203</td>
</tr>
<tr>
<td>96-96-NON-COVERED CHARGE(S).</td>
<td>1,138,071</td>
<td>393</td>
</tr>
<tr>
<td>15-15-PAYMENT ADJUSTED BECAUSE</td>
<td>743,995</td>
<td>50</td>
</tr>
<tr>
<td>A1-A1-CLAIM DENIED CHARGES.</td>
<td>561,222</td>
<td>128</td>
</tr>
<tr>
<td>97-97-PAYMENT IS INCLUDED IN T</td>
<td>439,025</td>
<td>5</td>
</tr>
<tr>
<td>22-22-PAYMENT ADJUSTED BECAUSE</td>
<td>309,472</td>
<td>97</td>
</tr>
<tr>
<td>29-29-THE TIME LIMIT FOR FILING</td>
<td>281,615</td>
<td>28</td>
</tr>
</tbody>
</table>
Examples of 6 month post go-live audits

- **Interfaces**
  - Identify non-Epic systems that require interface into Epic
  - Obtain data output from these systems
  - Ensure Epic is receiving all data from these systems
  - For Ex., If Lab system says they are interfacing 1,500 accounts and $2,500,000 over to Epic, are all of these coming in to Epic?
  - How does IS manage the nightly interface process?
Examples of 6 month post go-live audits

- **Outbound Data Sets**
  - Contracted Physicians should be getting ADT info to do their own billing
  - Check to make sure they are getting minimum necessary info, but also ALL the patients they have seen
  - If there are gaps in the data pull, you could end up owing your group $$ that they didn’t bill for due to the incomplete interface!
Examples of 6 month post go-live audits

- **Statistics**
  - Test the accuracy of your post go-live statistics
  - Are admissions and discharges counted correctly?
  - Are you pulling from all the right sources? For example, OpTime accumulates admissions. You need to add these to the ADT admits for a total.
  - How are Observation patient conversions to/from IP status handled?
  - When you pull admit data based on UB or 837 claim files, you may miss Self Pay accts which don’t get UB’s but get statements
Summary

- Epic has many modules, features and functionality
- Auditors need to know how to use Epic fully
  - Many roles
  - Many views
  - Audit trails
- Learn from each other
- Have fun with it (that which doesn’t kill you, makes you stronger)!
Summary

- Epic has many modules, features and functionality
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Save the Date
September 21-24, 2014
33rd Annual Conference
Austin, Texas