OIG Medicare Compliance Audits: Tactical Tips for Surviving One…from the Battlefield

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Top Ten Billing Compliance Rules

1. Just because it has a rule doesn’t mean it’s covered
2. Just because it’s covered doesn’t mean you can bill for it
3. Just because you can bill for it, doesn’t mean you should get paid for it
4. Just because you’ve been paid for it, doesn’t mean you can keep the money
5. Just because you’ve been paid once doesn’t mean you’ll be paid again
6. Just because you got paid in one state for it, doesn’t mean you’ll get paid in another state
7. You will never know all the rules
8. Now knowing all the rules can land you in jail
9. There’s always some schmuck who doesn’t get the message
10. There’s always some other schmuck who gets the message, but ignores it. (Have fun in jail. Hope you look good in stripes).
OIG Medicare Hospital Audits: How Did We Get Here?

It was in the cards…or at least, in the Plan:

OIG Work Plan, FY 2012

Medicare Inpatient and Outpatient Payments to Acute Care Hospitals (New)

“We will review Medicare payments to hospitals to determine compliance with selected billing requirements. We will use the results of these reviews to recommend recovery of overpayments….. Based on computer matching and data mining techniques, we will select hospitals for focused reviews of claims that may be at risk for overpayments…..”
What Are They Looking At?
The List Grows & Grows

Identified “Risk Areas” – Inpatient

- Manufacturer medical device credits
- Claims paid amount in excess of claims charged amount
- Claims with payments greater than $150,000
- Blood-clotting factor drugs
- Short hospital stays
- Same day discharge and readmission
- Transfers to post-acute care providers
- Transfers to inpatient hospice care
- Hospital–acquired conditions and present on admission reporting
- Outlier payments
What Are They Looking At? The List Grows & Grows (Cont’d)

Identified “Risk Areas” – Outpatient

- Manufacturer Medical device credits
- Services billed with Modifier-59
- E&M services billed with Surgical Services (Modifier -25)
- Claims paid amount in excess of claims charged amount
- Outpatient services billed during inpatient stays
- 72- Hour Rule
- Surgeries billed with units greater than one
- Services bill during skilled nursing facility stays
- Outpatient dental services
What Are They Looking At?
The List Grows & Grows (Cont’d)

Other “Risk-Areas” identified in the OIG Work Plan and Current Audit Experiences

- Inpatient Psychiatric Facility Interrupted Stays
- Inpatient Psychiatric Facility Emergency Department Adjustments
- Inpatient High Severity Level DRGs
- Major Complication and Co-morbidities
- Outpatient Brachytherapy Reimbursement
- Outpatient Claims Billed Using “J” Codes
- Observation Services During Outpatient Visits
- Hemophilia Services & Septicemia Services
- Intensity Modulated Radiation Therapy Planning Services
- Claim Payments Greater than $25,000
## Other Massachusetts Acute Medical Center’s Experience

<table>
<thead>
<tr>
<th>Outpatient Issues</th>
<th>Inpatient Issues</th>
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<tr>
<td>OP during IP stay</td>
<td>Short stays</td>
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<td>Pay greater than charges</td>
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<td>Dental services</td>
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<td>Two procedures</td>
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<td>Device credits</td>
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<td>Observation claims</td>
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- Device credits
- Observation claims
OIG Medicare Compliance Audit: The Process

- OIG has begun using data analysis to identify highly vulnerable claims for providers nationwide.
- They judgmentally select claims and conduct hospital site visits to perform a review of billing and medical record documentation.
- This was an internal controls audit: OIG requires the hospital to evaluate and disclose its analysis of the claims to them as it reviews the claims.
- The BWH was chosen for this audit because it was an distinct outlier for replacing ICDs (Cardiovascular Defibrillators) on an inpatient (vs. outpatient basis).
The BWH Experience

- BWH was notified in late June 2011 that we had been chosen for one of these new hospital compliance audits.
- Given an initial request of 200 inpatient and 100 outpatient judgmentally selected claims. Request later expanded to an additional 59 inpatient claims.
- Three (3) auditors were on site from August 2 through mid-September – during such time active “negotiation” on each claim determination/finding until agreement/consent is reached.
The BWH Experience (Cont’d)

- OIG leaves and begins work on formulating the Internal Control Questionnaires (ICQs – see Handout #1) on each of the reviewed “areas” that the hospital will be asked to complete
- Hospital submits ICQs and OIG uses responses to complete draft report
- Hospital receives draft report and submits back a formal response
- The final audit report was issued on March 16th, 2012 (see OIG website for detailed report)
The Direction These Audits Can Go

During the audit, OIG can choose to:

- Expand the review to look at issues identified through the record reviews that were not anticipated.
- Expand the case sample to look at more claims in similar areas (they have access to all your claims data while they are onsite).
- Extrapolate to a larger universe of claims (examples include Fletcher Allen, BMC).
- Make a referral for Civil or Criminal Investigation.
It’s About Managing Information

As soon as OIG arrived, BWH did the following:

- Appointed 2-3 “faces” that would control communication and information exchange
- Created a SWAT team that included Compliance, Care Coordination, Patient Accounts, Revenue Operations, Medical Records, and Coding that met DAILY at the end of the day (via conf call)
- Developed a Shared File Area (SFA) that had folders for each risk area – Only 3 people had direct access to SFA - VERSION CONTROL IS CRUCIAL!!!
- Issued weekly summary e-mails to Executive Leaders including COO, CFO, CEO and VPs that communicated how audit was going and potential risks/losses (constantly in flux) – There should be no surprises
Section 1 – Issue A – Inpatient Short Stays
Condition: For XXX of the XXX sampled claims, the Hospital incorrectly billed Medicare Part A for beneficiary stays that should have been billed as outpatient or outpatient with observation services or did not obtain a credit for a replaced medical device that was available under the terms of the manufacturer’s warranty.

Section 2 – Key Controls
Please describe your key internal controls during the period of our review for determining whether the patient should be admitted as an inpatient or should remain as an outpatient/outpatient-observation.

Section 3 – Cause of Incorrect Billing
Please describe the reason(s) why your key controls did not prevent the types of errors listed in Section 1 from occurring.

Section 4 – Tentative Corrective Action Plan
Please describe any tentative corrective action measures you will be taking to address the control deficiencies listed in Section 3.
Orders are specific as to level of care (e.g. “admit” or “place in observation”)

Physicians are actively engaged in determining the level of care, issuing orders and documenting in the medical record.

Documentation of physician intent/thought processes at the time of admission is critical

Case managers review Medicare admissions for appropriateness (concurrent review)

There is an operating utilization review committee (URC) to override an inpatient admission ordered by a physician and with overall responsibility for the Hospital’s utilization of inpatient services.
Findings from medical record review of short stays:

- There is no order or clear intent for inpatient admission. “Admit to CARD” does not imply level of services but rather a place.

- The intensity of services provided was not consistent with Inpatient level of care.

- There is no order for Inpatient admission as such. The documentation does not imply or infer Inpatient status was ordered or required. The order to “admit to EP-PAS” is not defined as to what it means.
OIG Review of Physician Documentation

- Medicare definitions for “inpatient” and “observation” are unclear.

- For both observation and admission you must show the thinking of the clinician as to why the patient's status and anticipated course requires observation care (outpatient) or admission (inpatient) and should include:
  - anticipated time course
  - trajectory
  - intensity of care
  - comorbidities
Medicare: Inpatient or Outpatient?

- “An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

- Generally, a patient is considered an inpatient if formally admitted as inpatient ….”
  - Source: Medicare Benefit Policy Manual 100-2
  - Chapter 1: Inpatient Hospital Services, 10

- “A hospital outpatient is a person who has not been admitted by the hospital…and receives services…”
  - Source: Medicare Benefit Policy Manual 100-2
  - Chapter 6: Hospital Services Covered, 20.2
Utilization Review Efforts are Critical

- Care Coordinators must apply admission criteria to Medicare patients placed in a hospital bed and document this review in an auditable format (entry points such as the Emergency Department are critical).
- All cases that do not pass criteria are referred to a Physician Advisor designated by the UR Committee.
- The Physician Advisor reviews cases, speaks with admitting physician, renders final decision or seeks additional UR Committee input.
- UR Committee undertakes periodic assessment to determine if the UR Plan is effective.
Ongoing Challenges with Levels of Care Determinations

- Medicare’s billing rules requiring physicians to determine and document the level of care for patients in the medical record are somewhat inconsistent with a clinical model of providing the utmost care to all patients in our beds regardless of insurance.

- Medicare’s rules on what constitutes an appropriate admission vs. observation vs. outpatient care only are not clear.

- Documenting more specifically the reasons for our care plans – while critical to Medicare -- is an added burden on our physicians.

- Level of care changes significantly impact revenue.

- Copays may be greater for observation care than an inpatient deductible and we are required by Medicare regulations to inform patients of their status and financial obligations at the time of presentation.
Other Audit Areas: Replacement Devices

- While OIG focused solely on Cardiovascular devices, it has advised they will review Orthopedic devices too.

- Scalability of operational processes created around cardiovascular devices to other types of devices:
  - Manual, labor-intensive process to reconcile invoices to purchase orders to credit memos to credit letters
  - Lack of a central system/database to flow information between the key Departments and staff managing this process (Clinical Department, Materials Management, Accounts Payable, Finance, Patient Accounts)
Common Implanted Medical Devices

- Pacemakers

- Cardioverter Defibrillators –
  - Pulse Generator Lead(s)
    - Battery lifetime varies
  - Leads

- Neurostimulators

- Note: CMS Provides a List of Devices Subject to these Rules in Annual OPPS Regulations
Device Warranties – Does Your Organization Readily Know What They Are?

- 1 Year
- Lifetime?
- To Purchaser?
- To Patient?
- For Which Device?
CMS/Medicare Billing Requirements for Devices = Complicated!!

- Modifier Code FB: Full Credit
  - Append to HCPCs Procedure Code

- Modifier Code FC: Credit of 50% or more
  - Append to HCPCs Procedure Code

Must also add a Condition Code
- 49: For Malfunctioning Device
- 50: For Device Subject to Recall
  - For example, Fidelis Lead Recall

Extensive Operational Procedure Required
See Handout #2
CMS Requirements

- Hospital Inpatient Claims – DRG Coding
  - Discharge on or after October 1, 2008
  - Transmittal 1509 (May 16, 2008)

- Outpatient Claims – APC Coding
  - Services on or after January 1, 2007
  - Transmittal 1383 (November 23, 2007)
Lessons Learned About Modifier 59

- OIG wants to see clear documentation of different session or site/organ system, and/or separate incision/excision, and/or separate lesion
- Sometimes the 59 gets attached to the E/M erroneously
- There can be confusion or inconsistency amongst Coders
- Obvious areas to look at: debridement, GYN procedures
Other Lessons Learned

- FISS Edits don’t always work the way you think they do (Example: Outpatient during inpatient stay)
- Some things are very difficult to monitor – such as claims paid greater than charges
  - Getting a snapshot out of your system to determine this may be very challenging
Post Apocalypse Audit – Now the Hard Work Begins

- Determine stakeholders immediately and engage them early and often – you can’t get this done without them
- Develop Communication Plan immediately
- Convert your corrective action items into a project plan to start tracking - **Tracking is key!!** (see Handout #3)
- Beware of battle fatigue – this stuff takes a long time to fix and people get burned out
Questions?