Office of Inspector General (OIG) Medicare Compliance Reviews

Facilitators

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Agenda

- Engagement Process Tips and Tools
- The OIG Hospital Risk Areas
- Revamping controls

The Engagement Process: Tips

- **Entrance Conference** – Represent!
  - Is this an audit or an investigation?
  - Is the sample selected in a way that is statistically valid or was the sample judgmentally selected?

- **Record Request List** –
  - Does each section represent a sample or an entire population for a period? If a sample, how many more claims might you select?
  - Ask for information necessary to enable you to obtain information efficiently. If you submitted the data to CMS, the OIG should have access to it.
    - Patient account number
    - Medical record number
    - DRG or HCPCS, etc.
The Engagement Process: Tips

- **Assembling the Team:**
  - Finance, Compliance, Coding, Case Management/Physician Advisor, Patient Accounts, Chargemaster, Health Information Management
    - Who will assess the inpatient cases?
    - Who will assess the outpatient cases?
    - Who will obtain claims and remits?
    - Who is going to send information to the OIG?
    - How are spreadsheets going to be completed for submission to the OIG? What level of QC/discussion will occur prior to submission?

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The Engagement Process: Tips

- **Self-Assessment**
  - OIG will ask the entity to review the cases and report
  - OIG will typically describe what they are focusing on and will not have you necessarily verify every line item of claim.
  - Identify claim error with payment impact vs. no payment impact. (i.e., CC or MCC change but no DRG change or CPT change but same APC).
  - Make sure internal assessment methodology is consistent if multiple individuals are involved in evaluating the same types of cases. Document the individuals reviewing each case in case follow up discussions are needed.
  - Be sure to loop in clinicians for clarifications as needed (i.e., mod 25 use) prior to initial response.
  - Review similar cases together (same DRG).
Provider experiences with OIG Hospital Compliance Reviews – Management Tools

<table>
<thead>
<tr>
<th>Sample Number</th>
<th>Admit Day of Week</th>
<th>Claim From Date</th>
<th>Claim Thru Date</th>
<th>Claim Payment Amount</th>
<th>DRG</th>
<th>DRG Description</th>
<th>DRG Reviewed by RAC</th>
<th>RAC Outcome?</th>
<th>IP MD Order (Y N)</th>
<th>Review Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-201</td>
<td>Sat</td>
<td>12/18/10</td>
<td>12/19/10</td>
<td>$6,359.97</td>
<td>069</td>
<td>TRANSIENT ISCHEMIA</td>
<td>Y</td>
<td>2/3 ok</td>
<td>Y</td>
<td>IP</td>
</tr>
<tr>
<td>A-202</td>
<td>Sat</td>
<td>04/23/11</td>
<td>04/24/11</td>
<td>$5,495.90</td>
<td>101</td>
<td>SEIZURES W/O MCC</td>
<td>Y</td>
<td>3/3 ok</td>
<td>Y</td>
<td>IP</td>
</tr>
<tr>
<td>A-203</td>
<td>Sun</td>
<td>10/24/10</td>
<td>10/24/10</td>
<td>$5,114.67</td>
<td>123</td>
<td>NEUROLOGICAL EYE DISORDERS</td>
<td>Y</td>
<td>1/1 ok</td>
<td>Y</td>
<td>IP</td>
</tr>
</tbody>
</table>

The Engagement Process: Tips

- **Submission of Information** –
  - Send electronically, create folders that mirror what is sent and on what date.
  - Label cases, one PDF per patient, naming conventions, MR vs claim info, complete your assessment before sending record.
  - Section titles do not limit assessment focus.
  - Surgical admissions, include prior MD notes. Medical admission, include ED physician notes.
  - Spot check information prior to submission.
  - Hospital comments should support your position for that case and provide enough rationale to help them come to the same conclusion
  - Send in section by section once completed in an effort to manage the back and forth.
The Engagement Process: Tips

- **Rebuttal/Appeal Processes** – OIG & CMS
  - Try to handle related cases at the same time during a rebuttal period with OIG. Ask for regulatory guidance used by OIG as a basis for their determination.
  - Identify other audit outcomes or communications that support your interpretation or coding/admission decisions.
  - Certain types of cases may go to external review.
  - Understand what appeal processes will be available to you through the OIG and CMS and how entity initiated reprocessing of claims will impact your organization’s appeal rights.
    - Identify which claims may be sent to a 3rd party reviewer.

The Engagement Process: Tips

- **Objective Attributes Recap Sheet (OARS)**
  - Do you concur with all, some or none of the findings per section/risk area.
  - Opportunity to explain why errors occurred and what has been done to prevent future errors.
  - Some of OARS information will appear in draft/final report.

- **Exit Conference** – Represent!
  - Administrative finality to review process. Allows access to OIG Audit Team for high-level comments.

- **Draft and Final Reports**
The Engagement Process: Tips

- **Communicating with Sr. Leadership**
  - Communicate regularly the status of the engagement.
  - Identify dollars at risk by review area
    - IP Short stay = delta between IP and OP payment
    - Psych admission source D code = $80 per admission
    - DRG validation, delta between two DRGs that may be very similar.
    - Device Credits = amount of credit received (IP) vs APC reduction % on OP claim.
    - Outpatient E&M with Modifier 25 = refund of E&M payment = $60 - $100 per CPT.

### Provider experiences with OIG Hospital Compliance Reviews - Management Tools

<table>
<thead>
<tr>
<th>Section</th>
<th>Topic</th>
<th># of claims</th>
<th>Medicare Claim Payments</th>
<th>Claims requiring correction</th>
<th>Estimated Over-payment*</th>
<th>Teams looking at this section</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Psych Admissions</td>
<td>82</td>
<td>$975,000</td>
<td>82</td>
<td>$6560</td>
<td>Case Management</td>
<td>OIG would argue that it is &quot;all or nothing&quot; they would not allow us to resubmit the case as OP. Still working through these accounts. 1st batch of claims sent to OIG on 1/25/12.</td>
</tr>
<tr>
<td>F</td>
<td>IP Device Credits</td>
<td>10</td>
<td>$286,000</td>
<td>2</td>
<td>$1,000</td>
<td>Cardiology</td>
<td>Sent file to OIG on 10-17-12. OIG response on 1/9/13. OIG agreed with two cases to be refunded and agreed that the other 8 cases did not require a refund. Two lead credits were not reprocessed.</td>
</tr>
</tbody>
</table>

| Total Medicare payments          | $4,265,334 | 339  | $500,000 |
| Inpatient Medicare payments      | $3,002,934 | 90   | $200,000 |
| Outpatient Medicare payments     | $1,262,400 | 249  | $300,000 |

Total overpayments as % of payments 11.2%
Inpatient overpayments as % of payments 4.6%
Outpatient overpayments as % of payments 25.8%

*Draft as of x/xx/xx – For discussion purposes*
The Engagement Process: Tips

- Communicating with Sr. Leadership (cont’d)
  - Timeline of report and reprocessing of claims.
  - Ask for input on cases that may need to be appealed.
  - Provide updates on corrective actions put in place operationally and from a controls perspective:
    - Education on documentation or coding issues
    - Charge master updates
    - Establishment of routine data monitoring and assessment

OIG Hospital Compliance Review - Risk Areas
OIG Hospital Compliance Reviews – Inpatient Risk Areas

- Short hospital stays (0 and 1 day)
- High-severity level MS-DRGs
- Same day discharge and readmission
- Transfers to post-acute care providers
- Transfers to inpatient hospice care
- Manufacturer medical device credits
- Claims paid amount in excess of claims charged amount
- Claims with payments greater than $150,000
- Blood-clotting factor drugs
- Hospital-acquired conditions and present on admission
- Outlier payments

OIG Hospital Compliance Reviews – Outpatient Risk Areas

- Observation outlier payments
- Facility E&M coding and “new” vs. “established” patient
- 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
- Three-day payment window rule
- Surgeries billed with units greater than one
- Services billed during skilled nursing facility stays
- Outpatient dental services
Other OIG Risk Areas

- Inpatient psychiatric facility interrupted stays
- Inpatient psychiatric facility emergency department adjustments
- Skilled Nursing Facility payments for ultra high therapy
- Inpatient Rehabilitation Facility documentation requirements
- Outpatient brachytherapy reimbursement
- Outpatient claims billed using “J” codes
- Observation services during outpatient visits
- Hemophilia services and septicemia services
- Intensity modulated radiation therapy planning services
- Outpatient claim payments greater than $25,000

OIG Hospital Compliance Reviews – Inpatient Risk Areas – Operational Challenges

- Short stay admissions on weekends with medical DRGs, including transfers for medical and surgical admissions
- Outpatient services rendered while the beneficiary was an inpatient /resident at another facility
- Admission Source Code “D” for psychiatric admissions
  - Operationally a significant challenge if the admission source code from the medical admission is brought over into the psychiatric admission.
OIG Hospital Compliance Reviews – Outpatient Risk Areas – Operational Challenges

• Outpatient dental services
  • Medicare does not have edits in place to reject claims or request medical record documentation prior to payment of claims with dental procedure codes (i.e., D7140 – tooth extraction)
  • Pegaspargase (J9266)
    – Purchased in a single use vial containing 3750 international units
    – Paid by Medicare per vial, patients typically receive less than 1 vial but we can bill for one rounding up.
    – Charging was set up resulted in belief that each vial contained only 750 international units.
    – So, when only 1 unit was supposed to have been billed to Medicare, the number of units submitted was 5 (5 x 750), resulting in an overpayment.

OIG Hospital Compliance Reviews – Outpatient Risk Areas – Operational Challenges

• E&M services billed with surgical services (modifier 25)
  • 38242 – Allogenic lymphocyte infusions - New AMA CPT language in 2013, “these procedures (38240-38243) include physician monitoring of multiple physiologic parameters, physician verification of cell processing, evaluation of the patient before, during and after the HPC/lymphocyte infusion, physician presence during the HPC/lymphocyte infusion with associated direct physician supervision of clinical staff, and management of uncomplicated adverse events (e.g., nausea, urticaria) during the infusion, which is not separately reportable.”

• Joint injections
  • A patient evaluation prior to a decision to administer an injection, if documented well, supports both.
  • An E&M provided during the same session as a planned injection is questionable unless other things are evaluated.
OIG Hospital Compliance Reviews – Outpatient Risks – Controversial Interpretations

• Modifier 59
  • Right heat cardiac catheterization (93451, formerly 93501) and endomyocardial heart biopsy (93505)

• Observation Outlier Payments - start and end time was disputed as well as what documentation in the medical record constitutes a physician order. Carving out time for procedures was also evaluated but had less of an impact on outlier payments compared to start and stop times.

OIG Hospital Compliance Review - Revamping Controls
OIG Hospital Compliance Reviews –
Outpatient Risk Areas – Pre-Billing Controls

• **New Pre-Billing Controls resulting from OIG reviews:**
  - Dental Procedures – Claim hold for all Medicare claims with dental services. Evaluated by for medical necessity prior to billing.
  - Herceptin – claim hold 44, 88 or 132 units and evaluate units.
  - Emend – claim hold to evaluate the appropriateness of billing Medicare Part B vs. Medicare Part D.
  - Pegasparagase – more than 1 unit will be stopped for review.

OIG Hospital Compliance Reviews –
Post-Billing Controls – OP Drug Unit Billing

• Identify the most common dosing guidelines for the particular drugs in question.
• Develop your own weight and height assumptions which will combine with dosing guidelines to provide you with an upper and lower norm/threshold.
  - For drugs billed based on weight, calculated the dosage and number of billable units for patients weighing more than 250 lbs. or less than 100 lbs.
    - 250lb = 113kg (398.08g)
    - 100lb = 45kg (359.23g)
  - For drugs billed based on body surface area, (i.e., square centimeters, calculated the dosage and number of billable units for patients weighing more than 250 lbs. and 6’ 2” or less than 100 lbs and 4’ 11”
    - http://www.halls.md/body-surface-area/bsa.htm
• Convert the dosing upper and lower threshold to Medicare billable units based on your assumptions for each drug
OIG Hospital Compliance Reviews – Post-Billing Controls – OP Drug Unit Billing

- Sample: *Alpha 1–Proteinase Inhibitor (Aralast) (J0256)*
  - Alpha 1–proteinase inhibitor is used to treat alpha 1–antitrypsin deficiency in people who have symptoms of emphysema.
  - The HCPCS code for this drug is J0256 and is described as “Injection, alpha 1–proteinase inhibitor – human, 10 mg
  - Typical dosing instructions per FDA is: 60 mg per kg

- Calculation:
  - For a 250 pound patient, the units needed would be calculated as:
    - 113 kg * 60 mg per kg. = 6780 mg.
    - Billable units then are 6780/10 mg = 678 units (not mg).
  - For a 100 pound patient, the units needed would be calculated as:
    - 45 kg * 60 mg /kg = 2700 mg.
    - 2700 mg. /10 mg = 270 units

- So the range of “normal” billable units for aralast (J0256) would be:
  - < = 680 units or >= 270 units.

OIG Hospital Compliance Reviews – Post-Billing Controls – OP Drug Unit Billing

Drug Unit Billing Example:

- Identified a charge master setup error which was causing the hospital to underreport the number of units being billed while, at another facility, the units exceeded the “normal” range.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Patient Name</th>
<th>Medical Record Number</th>
<th>CPT Code</th>
<th>Units</th>
<th>Charge Covered</th>
<th>Service From Date</th>
<th>Service Through Date</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital B</td>
<td>James, Stephen</td>
<td>654321</td>
<td>J0256</td>
<td>6010</td>
<td>$91,712</td>
<td>06/25/2013</td>
<td>06/25/2013</td>
<td>$1,847</td>
</tr>
<tr>
<td>Hospital B</td>
<td>James, Stephen</td>
<td>654321</td>
<td>J0256</td>
<td>610</td>
<td>$9,368</td>
<td>06/11/2013</td>
<td>06/11/2013</td>
<td>$1,874</td>
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<tr>
<td>Hospital B</td>
<td>James, Stephen</td>
<td>654321</td>
<td>J0256</td>
<td>606</td>
<td>$9,247</td>
<td>04/23/2013</td>
<td>04/23/2013</td>
<td>$1,862</td>
</tr>
<tr>
<td>Hospital B</td>
<td>James, Stephen</td>
<td>654321</td>
<td>J0256</td>
<td>606</td>
<td>$9,247</td>
<td>05/14/2013</td>
<td>05/14/2013</td>
<td>$1,862</td>
</tr>
<tr>
<td>Hospital A</td>
<td>Gillis, Stephen</td>
<td>12345</td>
<td>J0256</td>
<td>001</td>
<td>$10,145</td>
<td>04/12/2013</td>
<td>04/12/2013</td>
<td>$3</td>
</tr>
<tr>
<td>Hospital A</td>
<td>Gillis, Stephen</td>
<td>12345</td>
<td>J0256</td>
<td>001</td>
<td>$10,145</td>
<td>04/26/2013</td>
<td>04/26/2013</td>
<td>$3</td>
</tr>
</tbody>
</table>

- The acceptable range for this drug, based on clinical dosing guidelines, is between 270 and 680 units.
OIG Hospital Compliance Reviews – Post-Billing Controls – OP Drug Unit Billing

• Sample: **Rituximab (J9310)**
  - Rituximab is used to treat a variety of conditions, including Non-Hodgkins lymphoma and rheumatoid arthritis.
  - The HCPCS code for this drug is J9310 injection, rituximab, 100 mg
  - Typical dosing instructions per FDA are: 375 - 500 mg/m² (milligrams per square meter)

• Calculation using a Body Surface Area Calculator:
  - For a 250 pound patient 6’2”, units would be calculated as:
    - The body surface area would be equal to 2.43 m²
    - 2.43 m² * 500 mg = 1215
    - Billable units then are 1215/100 mg= 12 units (not mg).
  - For a 100 pound patient 4’11”, units would be calculated as:
    - The body surface area would be equal to 1.37 m²
    - 1.37 m² * 375 mg = 513.75
    - Billable units then are 513.75/100 mg= 5 units (not mg).

• **The range of “normal” billable units for rituximab (J9310) is:**
  - <= 12 units or => 5 units.

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<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Name of Drug</th>
<th>Upper Threshold</th>
<th>Lower Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0152</td>
<td>Adenosine injection</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>J0256</td>
<td>Alpha 1 proteinase inhibitor</td>
<td>680</td>
<td>250</td>
</tr>
<tr>
<td>J0475</td>
<td>Backslan 10 MG</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>J1459</td>
<td>Privigen 500 mg</td>
<td>226</td>
<td>36</td>
</tr>
<tr>
<td>J1581</td>
<td>Tamoxex-C/Glumetin</td>
<td>226</td>
<td>36</td>
</tr>
<tr>
<td>J1599</td>
<td>Immune globulin, powder</td>
<td>115</td>
<td>12</td>
</tr>
<tr>
<td>J1598</td>
<td>Otagran injection</td>
<td>226</td>
<td>36</td>
</tr>
<tr>
<td>J1745</td>
<td>Infliximab Remicade injection</td>
<td>100</td>
<td>14</td>
</tr>
<tr>
<td>J6035</td>
<td>Neovascumab injection</td>
<td>113</td>
<td>23</td>
</tr>
<tr>
<td>J6041</td>
<td>Fortezimab injection</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>J6043</td>
<td>Calasadase injection</td>
<td>61</td>
<td>54</td>
</tr>
<tr>
<td>J0555</td>
<td>Catumaxim injection</td>
<td>122</td>
<td>35</td>
</tr>
<tr>
<td>J9171</td>
<td>Donastase injection</td>
<td>260</td>
<td>50</td>
</tr>
<tr>
<td>J9217</td>
<td>Cisplatin acetate suspension</td>
<td>Not equal to 1, 3, 4</td>
<td></td>
</tr>
<tr>
<td>J9206</td>
<td>Penetrexed injection (sham)</td>
<td>122</td>
<td>69</td>
</tr>
<tr>
<td>J9310</td>
<td>Rituximab injection</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>J9266</td>
<td>Pegasparase (oncaspar)</td>
<td>Greater than 1</td>
<td></td>
</tr>
<tr>
<td>J9355</td>
<td>Hersonin (Taduzumab)</td>
<td>Equal to 44, 88 or 132</td>
<td></td>
</tr>
</tbody>
</table>

These sample thresholds are for illustrative purposes only. Each organization should develop their own assumptions regarding typical patient height & weight ranges and should confirm typical dosing guidelines used by their own clinicians for their own patients.
OIG Hospital Compliance Reviews –
Post-Billing Controls – Outlier Payments

• Data Monitoring and Assessment Plan:
  – IP and OP populations
  – Created sub-criteria to narrow down the list of cases eligible for
    review (i.e., IP cases with LOS greater than 14 days)
  – Make sure your data is accurate
  – Things to look for:
    • Duplicate charges
    • Charge master set up issues (wrong conversion multipliers)
    • Credits that turn into debits

OIG Hospital Compliance Reviews –
Post-Billing Controls – Payments Greater than Charges

• Payments Greater Than Charges
  – IP and OP
  – Created sub-criteria to narrow down the list of cases eligible for
    review (i.e., payment is 150% of charge, claim payment greater
    than $2,500)
  – Make sure your data is accurate
  – Things to look for:
    • Late charges
    • Charge master set up issues (unit vs. charge)
    • Debits that turn into credits