



Penn Medicine

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# Hot Topics in Billing Compliance

*HCCA Delaware Valley*

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- Home Care & Hospice Services
  - PENN Care at Home / PENN Home Infusion Therapy
  - Wissahickon Hospice



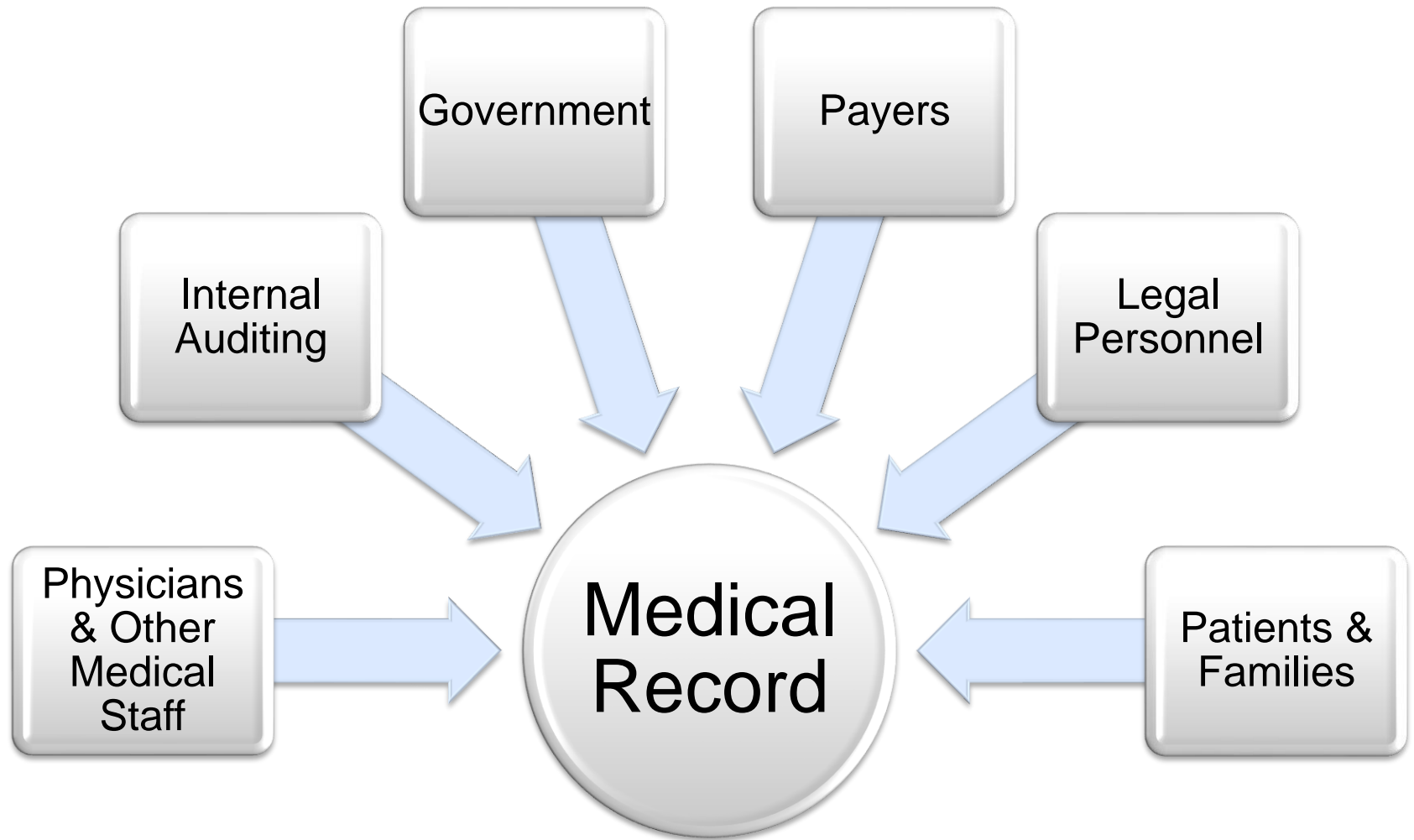


## Learning Objectives



- CMS Targeted Probe & Educate Audits
- Evaluation & Management Services
- Patient Driven Groups Model (PDGM)
- Clinical Decision Support for Radiology Order Entry
- Opioid Crisis

# Who can access the Medical Record?



Who	What
RACs	Recovery Audit Contractors
MACs	Medicare Administrative Contractors
PSCs	Program Safeguard Contractors
ZPICs	Zone Program Integrity Contractors
CERT	Comprehensive Error Rate Testing
MIP	Medicaid Integrity Plan
MIG	CMS Medicaid Integrity Group
MICs	Medicaid Integrity Contractors
MIGs	Medicaid Inspector Generals
PERM	Payment Error Rate Measurement
OIG	Office of Inspector General
DOJ	Department of Justice
FBI	Federal Bureau of Investigation

## Federal Scrutiny of Health Care Continues

- Justice Department Recovers Over **\$2.88B** From False Claims Act Cases in FY 2018
  - ***\$2.5B involved the health care*** industry, including drug companies, hospitals, pharmacies, laboratories, and physicians
  - 9th consecutive year recoveries exceeded \$2B; \$1.9B attributable to Qui Tam
- Amerisource Bergin Corp paid \$625M to Settle False Claims Act Allegations
- Health Management Associates (HMA) paid \$216M for billing Medicare patients as inpatient that should have been observation or outpatient services



## Federal Scrutiny (continued)

- Purdue Pharma (maker of OxyContin) reaches \$270M settlement with the State of Oklahoma over the company's role in the opioid addiction epidemic
- United Therapeutics paid \$210M for using a foundation as an illegal conduit to pay copay obligations
- Office of Inspector General (OIG) Extrapolated Audit Findings:
  - University of Wisconsin Hospitals & Clinics: \$2.4M
  - Memorial University Medical Center: \$1.4M
  - Carolinas Medical Center: \$1.7M





## The ABCs of TPEs

- **A**nticipate
- **B**e cautious
- **C**oordinate

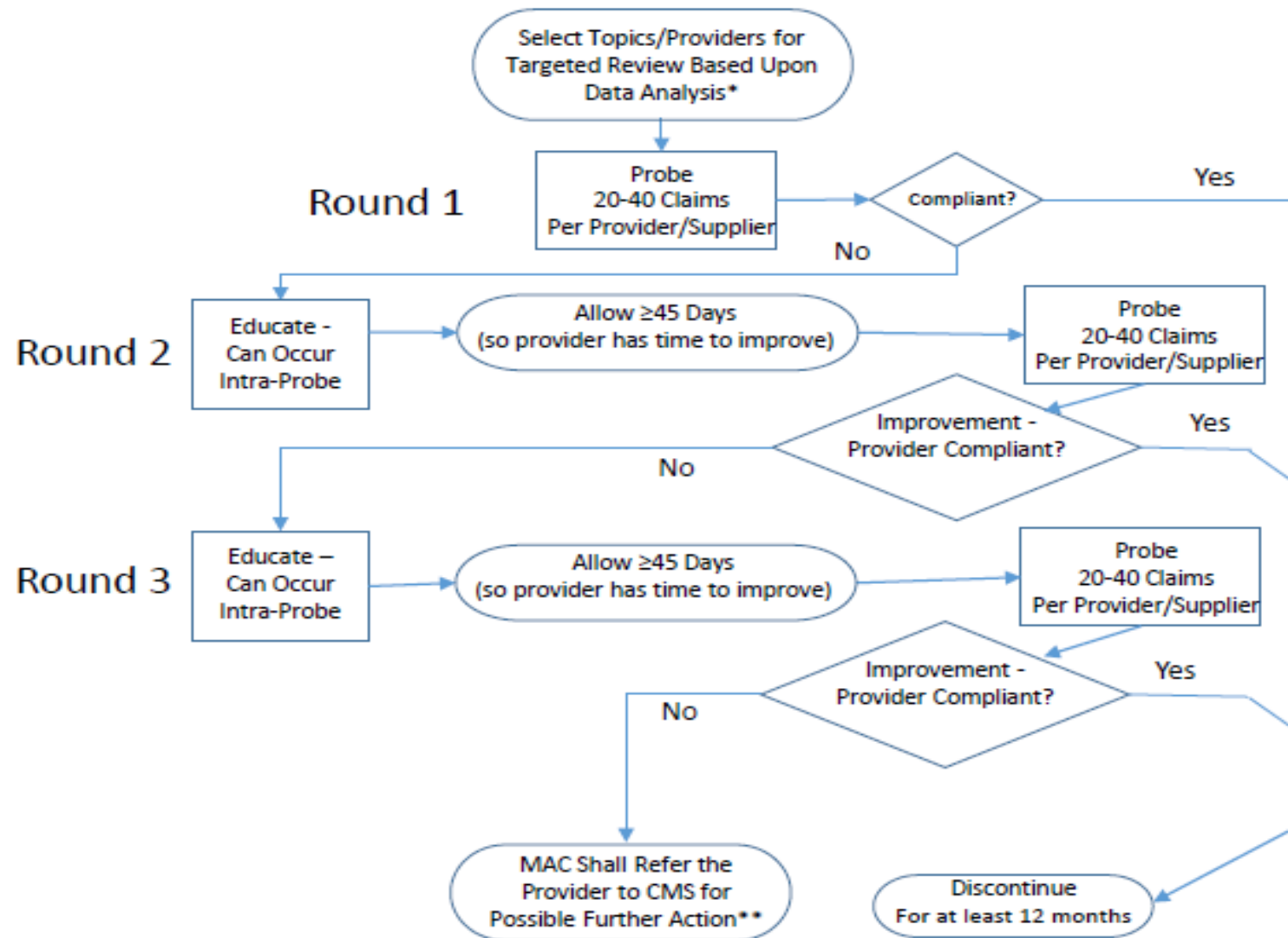


## Targeted Probe and Educate

- New audit process includes 3 rounds of a prepayment probe review with education
- If there are continued high denials after the first 3 rounds, provider will be referred to CMS
- CMS will determine additional action, which may include:
  - Extrapolation
  - Referral to the Zone Program Integrity Contractor (ZPIC)
  - Referral to the Unified Program Integrity Contractor (UPIC)
  - Referral to the Recovery Auditor (RA)



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\*Data Analysis definition per [PUB 100-08.52.2](#)

\*\*Further Action May Include Extrapolation, Referral To ZPIC/UPIC, etc.



## TPE Current Areas of Review: Part A

- 90999 – End Stage Renal Disease (ESRD)
- E41 & E43 Severe Malnutrition
- DRG Validation
- Inpatient Rehab Facility (IRF) based on billing of CMG X20XXX (Traumatic Brain Injury)
- Skilled Nursing Facility (SNF)
- 3 Day Qualifying Hospital Stay
- Cardiovascular Nuclear Medicine
- Inpatient Psychiatric Facility

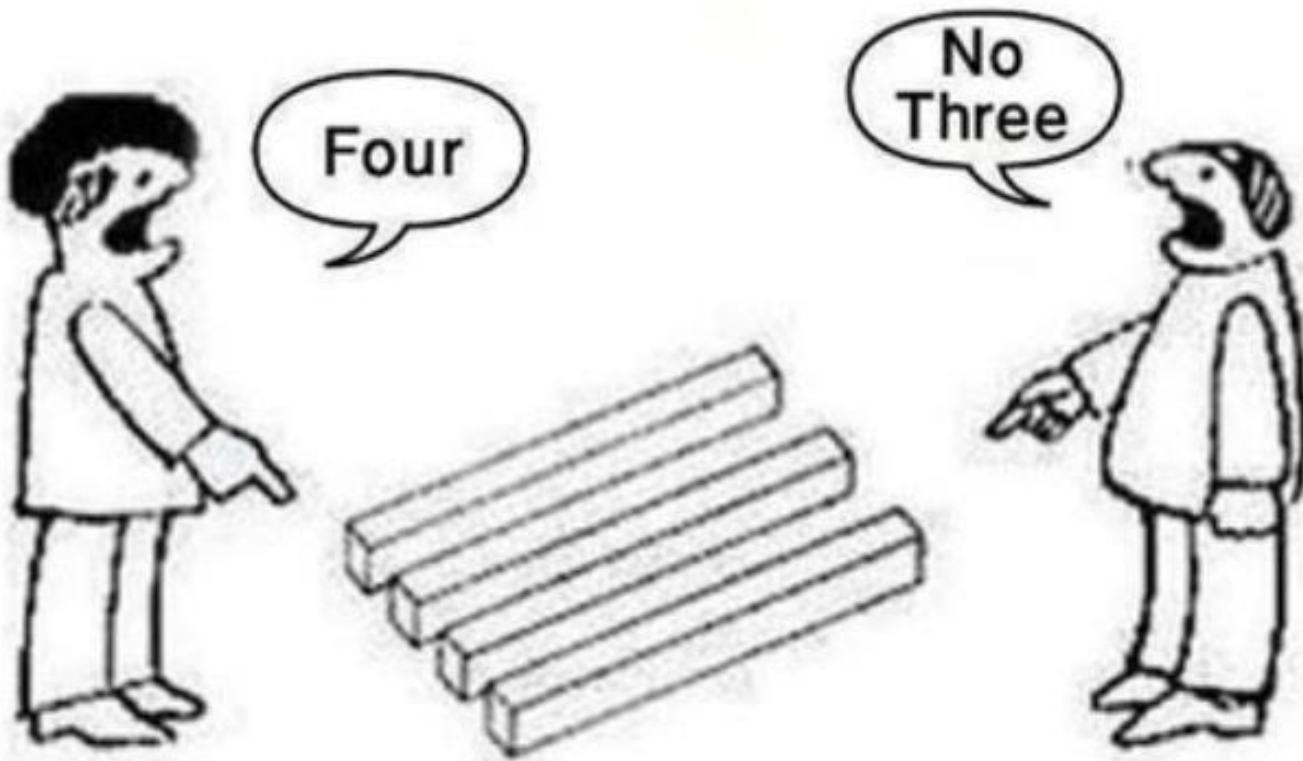


## TPE Current Areas of Review: Part B

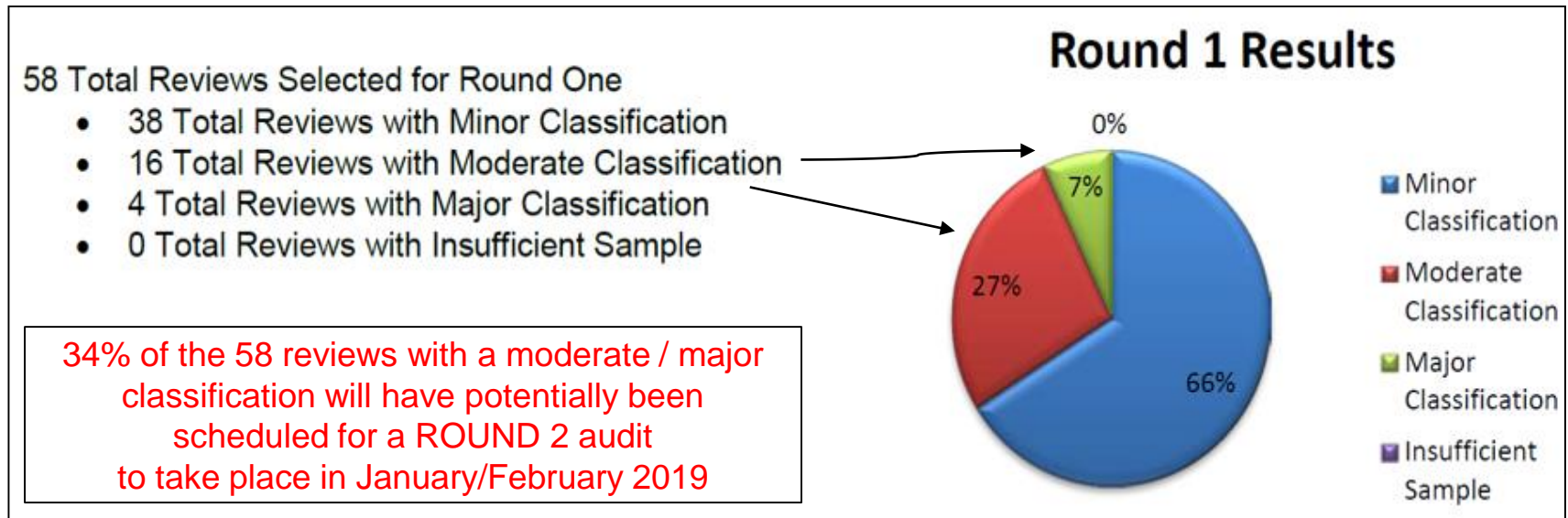
- Psychotherapy (90832 - 90840)
- E/M 99232 and 99233 (Inpatient Hospital)
- Physician Home Health (H/H) Certification and Recertification G0179 -G0180; Physician Care Plan Oversight G0181-G0182
- E/M 99211-99215 (Established Patient)
- Chronic Care and Transitional Care Management
- E/M 99281-99285 (Emergency Medicine)



## Perception



# Jurisdiction L: New Patient [99201-99205]

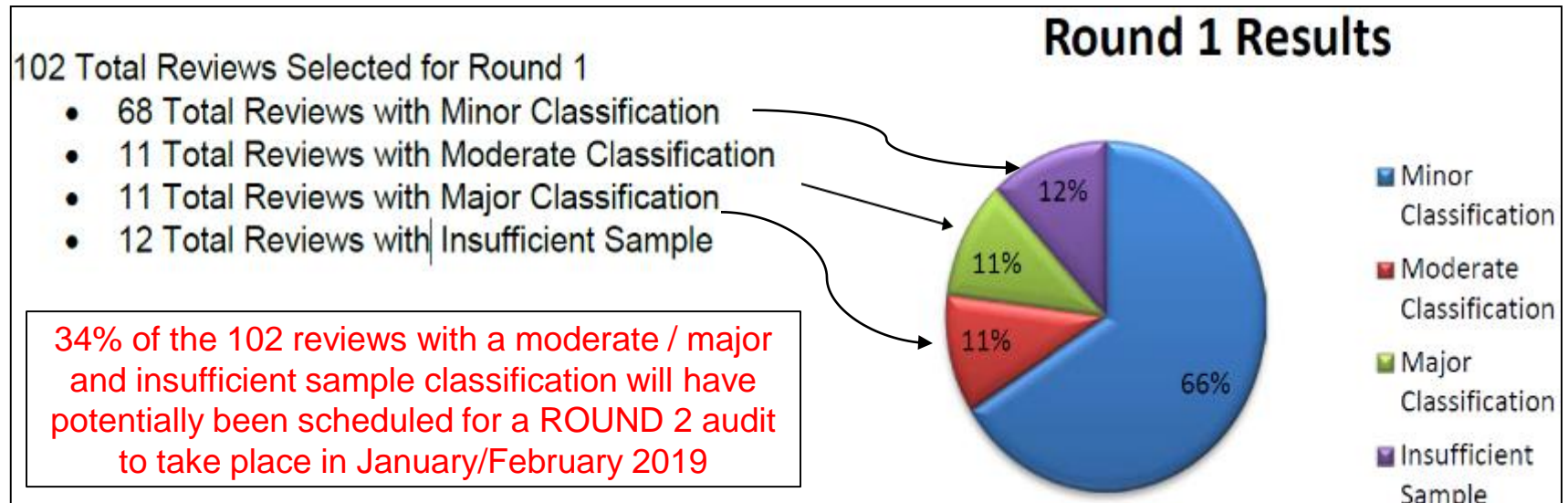


**The most common reasons for denial or partial denials are the following:**

1. Level of Care / Incorrect Coding
2. Insufficient documentation:
  - Incorrect rendering provider
  - Incorrect Date of Service
  - Untimely/no response to Additional Documentation Requests (ADRs)
3. Billing Errors – billed in error to Medicare



# Jurisdiction L: Established Patient [99211-99215]



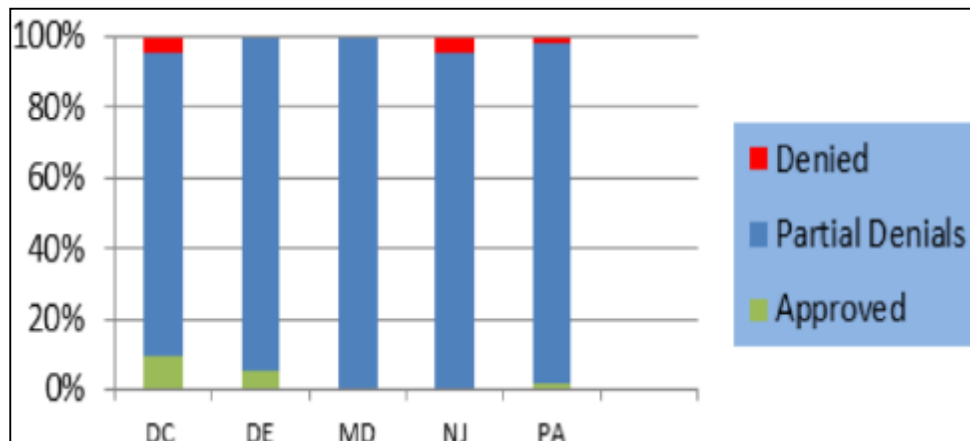
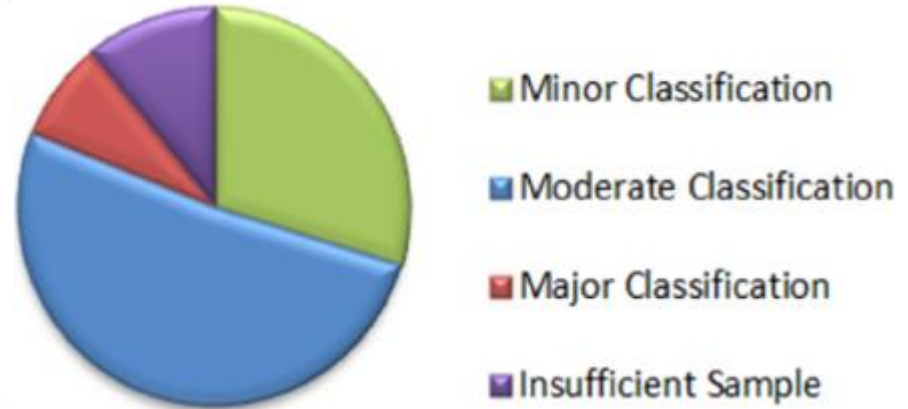
**The most common reasons for denial or partial denials are the following:**

1. Level of Care / Incorrect Coding
2. Insufficient documentation:
  - Incident to Requirements not Met
  - Untimely/no response to Additional Documentation Requests (ADRs)

# Jurisdiction L: Severe Malnutrition

Severe Malnutrition TPE Round One are as follows:

- 37 probes completed
- 11 probes closed with a minor error classification
- 19 probes closed with a moderate error classification
- 3 probes closed with a major error classification
- 4 probes closed with an insufficient sample size



Most common reason for partial denials was based on **insufficient documentation** to support the billing of diagnosis code E43 Severe Protein Calorie Malnutrition

## Common Characteristics - Malnutrition

- Cases reflect patients admitted with preexisting nutritional concerns & compromise related to chronic diseases
  - Metastatic cancer, interstitial lung disease, dementia, cardiac, pulmonary & renal compromise
- Conditions noted H & P and/or initial progress note
  - Documentation terms: failure to thrive, weight loss, body mass index, nutritionally at risk have been denoted



## Common Characteristics (continued)

- Nutritional compromise complicated by acute illness including intubation and inability to maintain adequate oral intake
- Patients assessed by primary team physicians
  - Clinical documentation includes severe protein calorie malnutrition
- Orders placed for follow-up labs, enteric supplements, total enteral nutrition, and continued assessment by Clinical Nutrition support to address the nutritional deficiency

# Malnutrition Diagnosis

	Moderate Malnutrition (E44.0)	Severe Malnutrition (E43)
Phenotype - requires presence of 1		
<i>All phenotypes and Etiologies below are applicable to patients at any level of BMI</i>		
Unintentional Weight Loss (%)	1-2% over 1 week 5% over 1 month 5-10% over 6 months 10-20% in > 6 months	>2% over 1 week > 5% over 1 month >10% over 6 months >20% in > 6 months
Loss of Muscle Mass <sup>a</sup>	Mild-moderate	Severe
BMI (kg/m <sup>2</sup> ) <sup>b</sup>	BMI <20 BMI <22 if >70 years old	BMI <18.5 BMI <20 if >70 years old
Etiology- requires presence of 1		
Reduced food intake or Malabsorption or GI symptoms <sup>c</sup>	Less than 50% of Energy Requirements/usual intake for >1 week or any reduction for >2 weeks or any chronic GI condition impacting food intake or absorption	
Inflammation <sup>d</sup>	Acute or chronic disease or injury. Elevated C-reactive protein or low albumin, pre albumin are supportive measures of inflammation	

Soeters PB et al. Advances in understanding and assessing malnutrition. Curr Opin Clin Nutr Metab Care 12:487-494, 2009

Jensen GL et al. Malnutrition syndromes: a conundrum vs. continuum. JPEN 33: 710-716, 2009

White J et al. Consensus Statement: Academy of Nutrition and Dietetics and ASPEN: Characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). JPEN 36 : 275-283, 2012

Jensen GL et al. GLIM criteria for the diagnosis of malnutrition: a consensus report from the global clinical nutrition community. JPEN 43: 32-40, 2019

# TPE Risk: Home Health Care and Hospice

- Potential Risk Areas - Pennsylvania
  - Hospice:
    - HCPCS codes Q5003 (Hospice care provided in LTAC or non-skilled nursing facility) and Q5004 (Hospice care provided in SNF), for any non-oncologic diagnosis code and a length of stay greater than 180 days
    - Revenue code 0656 greater than or equal to 7 days
  - Home Health Care:
    - Eligibility and Medical Necessity (Errors identified in HH Probe Round 2)
    - Diagnosis of Hypertension and a length of stay greater than 120 days
- New Jersey
  - Home Health Care LUOA Avoidance (5-7 visits)





## Practical Considerations & Key Decision Points (ABC's)

- Anticipate
  - Question is *not will* your organization receive audit notice *but when*
  - Plan for identifying and tracking medical record requests (ADRs)
  - Timely submission of documentation
  - Communication plan to all stakeholders pre and post audit





## Practical Considerations & Key Decision Points (ABC's)

- **Be cautious**
  - Specific data requested beyond progress notes such as labs, consults, etc.
  - ADRs could arrive at different locations such as lock box
  - Lack of timely submission will result in full denial
  - Review charts for completeness



## Practical Considerations & Key Decision Points (ABC's)

- **Coordinate**
  - Involved parties aware of the audit program and urgency to prioritize
  - Education session; potential to defend institutional position
  - Filing appeals timely and quickly

# Evaluation and Management

## *'Reducing the Burden'*



- 2019 OPPS MPFS Final Rule, released November 1, 2018
- Three payment buckets for Evaluation and Management codes
- Implementation Date: January 1<sup>st</sup>, 2021
- **Providers may choose the way they want to document**
  - Traditional: 1995 or 1997 guidelines
  - New Standards include: Medical Decision Making or by Time
- **Primary Care and Specialty add-on codes = \$13.00**
  - Placeholder codes are: GPC1X [Primary], and GCG0X [Specialty]
- **Extended Service Time for E&M and Psychotherapy services, 30 minutes**
  - e.g. weighted average of code range 99212-99214 is 19 minutes, which means GPRO1 can be reported if an additional 15 minutes is reached. Total time 34 minutes.

# Evaluation and Management: CY2021

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	\$76	\$130	\$143	\$197 (at 38 minutes)	\$210	
	Level 3	\$110					
	Level 4	\$167					
	Level 5	\$211	\$211				\$344 (at 90 minutes)
Established Patient	Level 2	\$45	\$90	\$103	\$157 (at 34 minutes)	\$170	
	Level 3	\$74					
	Level 4	\$109					
	Level 5	\$148	\$148				\$281 (at 70 minutes)



## Practical Considerations – Billing Compliance Programs

- Implications to audit work plan
  - Risk/benefits - same reimbursement for levels 2 through 4
  - Risk associated with level 5 services
  - Documenting time (especially for billing extended services)
- Documenting medical decision making and vs time



## Practical Considerations – Billing Compliance Programs

- Dual documentation requirements
  - Non-Medicare payors following traditional coding guidelines
- Clinical shortcomings
  - Communicating pertinent clinical facts to other care givers
  - Unintended consequences & Medical/legal considerations



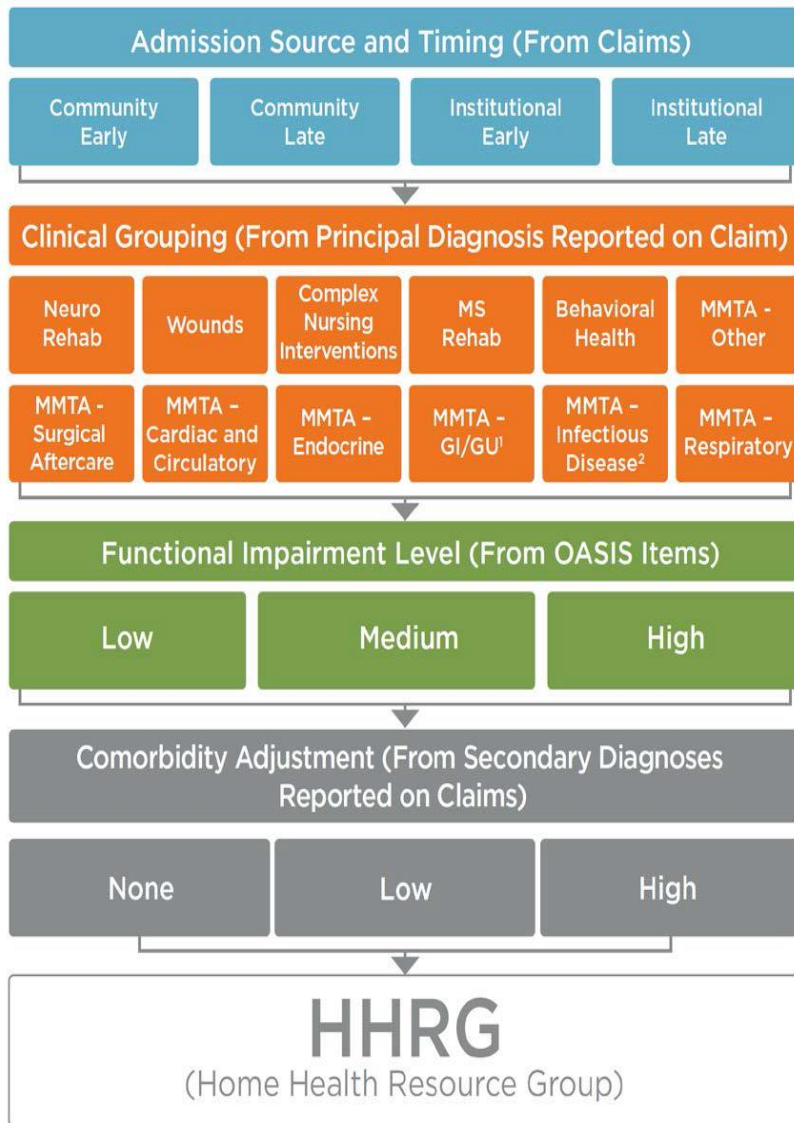
## Patient Driven Groupings Model (PDGM)

- Major paradigm shift in home health care reimbursement effective January 1, 2020
- Reducing the episode from 60 to 30 days
- Currently, home health is paid based on 1 of 153 Home Health Resource Groups (HHRGs)
  - Changing to **432** possible case mix adjustments





- 5 main case-mix variables
  - Admission Source
  - Timing
  - Clinical Grouping
  - Functional Impairment Level
  - Comorbidity Adjustment
- 432 possible case-mix adjusted payment groups



## Other Implications Attributable to PDGM

- Referral source
  - Either “community” or “institutional” (inpatient acute or post-acute within 14 days (SNF, IRF, LTAC or inpatient psychiatric)
  - Lower base rates for community
- Low Utilization Payment Adjustment (LUPA) defined today as 4 visits or less resulting in a per diem payment
  - Change to 2 to 5 visits within 30 days depending upon the grouping



- Institutional:
  - Acute (inpatient acute care hospitals), or;
  - Post-acute (skilled nursing facility, inpatient rehabilitation facility, long term care hospital, or inpatient psychiatric facility) care in the 14 days prior to the HH admission
- Community: No acute or post-acute care in the 14 days prior to the HH admission
- 30-day periods with an institutional admission
  - Higher resource use than periods with a community admission source



## Practical Considerations – Billing Compliance Programs

- Education program for home health care providers and referral sources
- Implications to audit work plan
  - Increased role of clinical documentation impacting clinical grouping, functional impairment and comorbidity adjustment
  - LUPA avoidance

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## Protecting Access to Medicare Act (PAMA):

- CMS alternative to preauthorization
- Effective 01/01/20 (penalties begin 01/01/21)
- Impacted area: Advanced diagnostic imaging services provided in outpatient & emergency department (Part B FFS)
  - Computed Tomography (CT)
  - Positron Emission Tomography (PET)
  - Nuclear Medicine
  - Magnetic Resonance Imaging (MRI)



## PAMA Key Definitions

- Clinical Decision Support Mechanism (CDSM)
  - Interactive electronic tool
  - Electronic portals through which appropriate use criteria (AUC) is accessed
- Appropriate Use Criteria (AUC)
  - Criteria developed by professional medical specialty societies
  - Make patient-appropriate treatment decision for the specific clinical condition



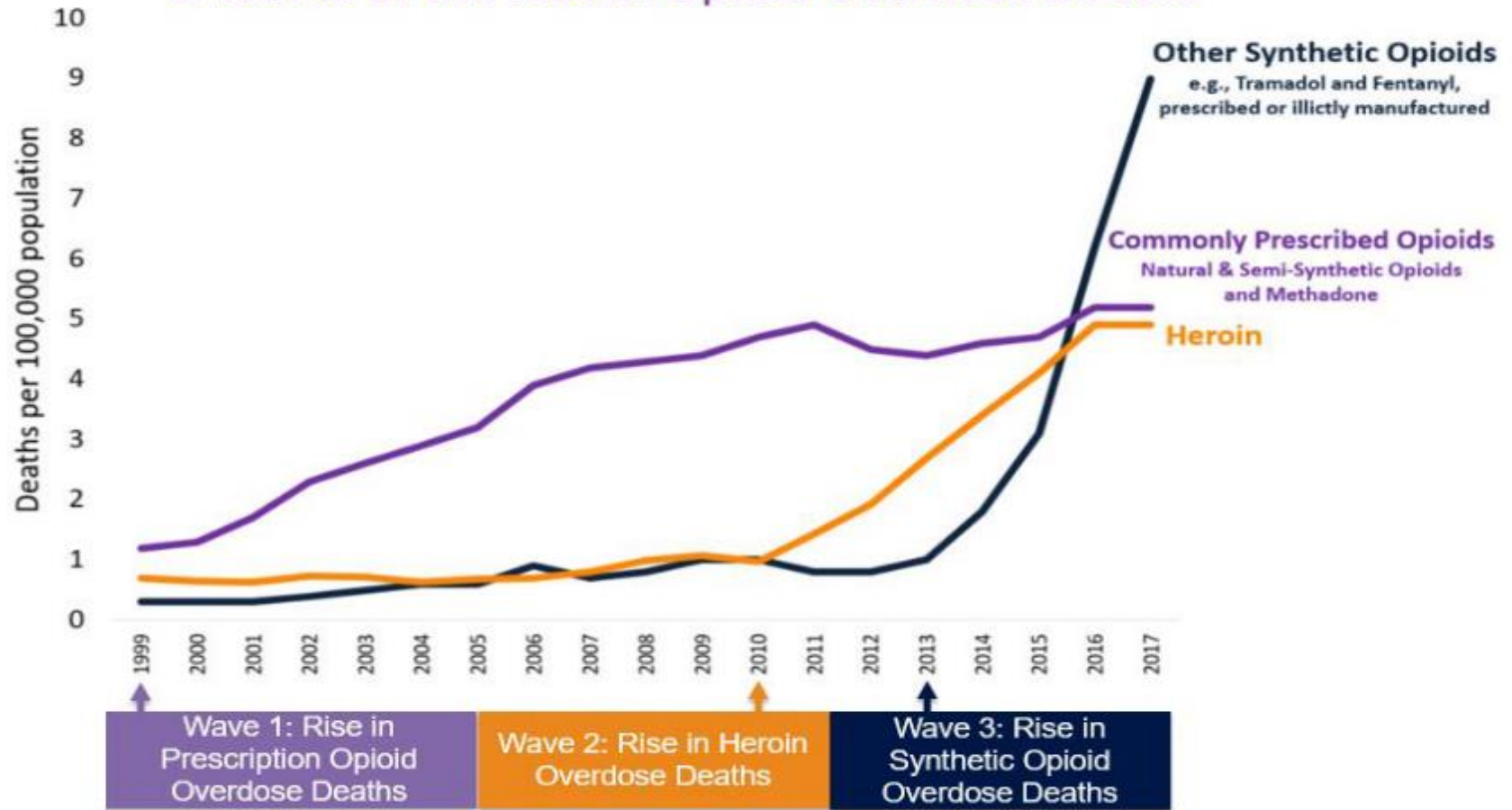
## PAMA (continued)

- Providers must consult a Clinical Decision Support Mechanism (CDSM) when ordering studies
- Ordering Providers must provide information to the Radiology facility to be provided on their Medicare claims
- Identified Ordering Provider “outliers” will be subject to prior authorization requirements





## 3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.



## Controlled Substance Act

- Hospital Obligations
  - Complete & accurate inventories and records
  - Security controls and operating procedures in place to guard against theft & diversion
  - System to identify suspicious orders



## DOJ Settlements

- University of Michigan Health System agrees to pay \$4.3M
  - Largest DOJ settlement with a hospital for drug diversion allegations
  - Cited for system wide violations
- Effingham Health System agrees to pay \$4.1M
  - Could not account for oxycodone tablets believed to have been diverted



## Purdue Pharma & Oklahoma reach settlement in landmark opioid lawsuit

- Maker of OxyContin agreeing to a \$270 million out-of-court settlement
- First major test of who will pay for more than two decades of death and addiction
- \$102.5M addiction treatment & research at Oklahoma State University
- \$20M treatment drugs
- \$60M litigation costs



## Opioid Crisis – Institutional Responsibility

- Diversion detection/prevention system
- Controlled access
- Accurate recordkeeping
- Training & communication
- Uniform prescribing and treatment process



- Establish an operational and communication plan for addressing Targeted Probe & Educate Audits from preparation through appeals
- Monitor for updates regarding revised payment methodology for outpatient E&M services
  - **Do not** make changes until final rule released next year
  - Consider unintended consequences for include non-Medicare and medical/legal considerations



- Prepare for the major change in home health care associated with Patient Driven Groupings Model (PDGM)
  - Staff training
  - Prepare proforma to understand implications to net patient revenue
- Prepare for the adoption of Clinical Decision Support Mechanism (CDSM)
  - Provider training
  - Institutional state of readiness



- Critical importance of the medical record
  - Documentation is key to all areas of healthcare supporting medically necessary services from establishing medical necessity to defending paid charges in audits







1. Did you hear about the guy whose whole left side was cut off? He's all right now
2. There was a sign on the lawn at a drug rehab center that said 'Keep off the Grass'
3. He was wheeled into the operating room, and then had a change of heart
4. The patient has no history of suicides
5. Patient has two teenage children, but no other abnormalities



6. Discharge status: alive but without permission
7. Rectal exam revealed a normal size thyroid
8. He had a left-toe amputation one month ago.  
He also had a left-knee amputation last year
9. The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days



## Medical Humor

10. Therapy dogs are now required to write progress notes

