October 2022

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OIG Audits - What to Know

October 2022

agshealth

Leigh Poland RHIA, CCS

AGS Health, VP of Coding Services

Coding Education

- Leigh has over 25 years of coding experience and has worked extensively in the coding and education realm over the last 20 years. Her true passion is coding education and making sure coders are equipped to do their job accurately and with excellence.
- She was the Corporate Auditor/RAC Coordinator for a major healthcare provider and had the opportunity to work closely with HIM directors, supervisors, and coders across the United States. She managed the following in her role as corporate auditor: coding education, auditing support, interim coding management, and HIM system implementation. She also served as the RAC Coordinator at the corporate level during this time.
- Leigh has also worked as coder, coding supervisor, and director of HIM in a 250-bed acute care facility. She has experience in an acute care setting, post-acute care, behavioral health and a physician-owned ambulatory surgery center.
- Academically, Leigh has graduated from Louisiana Tech University with a Bachelor's of Science
- Leigh is also certified in RHIA, CCS and is an AHIMA approved ICD-10-CM/PCS Trainer

Leigh has had the opportunity to present at the AHIMA National Convention, ACDIS Convention, and AAPC Convention on multiple occasions. She has spoken at multiple state AHIMA Conventions including TXHIMA, PHIMA, ILHIMA, LHIMA, WHIMA. She has been a guest speaker on AHIMA webinars, written articles for the AHIMA Journal & has published articles in the AHIMA CodeWrite publication. Leigh has traveled the US and Internationally providing coding education.

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In Brief

At the Completion of this educational activity, the learner will be able to:

- Understand what the OIG is and how it relates to healthcare
- Review OIG MS-DRG focus areas:
  - Transfer MS-DRG’s
  - High-Risk MS-DRG’s
- Identify High-Risk Modifier Issues
- Discuss the OIG focus on malnutrition documentation
- Provide best practices for preventing an OIG audit investigation

OIG Work Plan

OIG Background

Office of Inspector General Mission

- Established in 1976
- OIG states that it is
  - An independent and objective organization that fights fraud, waste and abuse and promotes efficiency, economy, and effectiveness in Department of Health & Human Services (HHS) programs and operations
  - An oversight agency to promote excellence, integrity, and accountability
- Conducts nation-wide audits, investigations and inspections
- Oversees $1.3 trillion in HHS spending
- Requires $419 million to oversee HHS programs

OIG At-A-Glance

Data Analysis and Risk assessments of emerging issues to identify suspected fraud, waste, and abuse and deploy OIG oversight and enforcement resources

At-a-Glance FY 2021 Highlights

Statistic	FY 2022 *(10/01/2021 – 03/31/2022)*
Audit Reports Issued	47
Evaluations Issued	14
Expected Audit Recoveries	$1.14 billion
Questioned Costs	$1.6 billion
Potential Savings	$162.1 million
New Audit and Evaluation Recommendations	130
Recommendations Implemented by HHS OpDivs	265
Expected Investigate Recoveries	$1.44 billion
Criminal Actions	320
Civil Actions	320
Exclusions	1,043

Investigations can result in criminal convictions, civil penalties, civil settlements and administrative sanctions against those who commit fraud

Key focus areas,

Medicare and Medicaid Program Integrity

https://oig.hhs.gov/reports-and-publications/archives/semiannual/2022/2022-spring-sar.pdf

OIG Work Plan

- **OIG has simplified viewing their work plan**
- **All items for review are found on an active work plan web page**
- **Updated monthly to identify and respond to emergent issues**
- **Continuous review is now necessary to remain current on OIG work plan focus areas**

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp*

OIG Risk Areas

MS-DRG Review

Transfer MS-DRG and High Severity Level MS-DRG

Modifiers

High Risk Modifier Review

Documentation

Clinical Criteria for Severe Malnutrition

Best Practices

Tips for Success

MS-DRG Review-Transfer

“Medicare improperly paid

acute-care hospitals

$54.4 million for 18,647 claims

subject to the transfer policy

- The Post-Acute Care Transfer (PACT) policy was originally enacted in 1998 to prevent CMS from “paying twice” for a patient’s care. In these cases, CMS was paying the hospital the full DRG rate, regardless of the patient’s length of stay (LOS), and also paying the post-acute provider their full case rate
- CMS concluded that, for these cases, the acute hospital should receive a per diem payment instead of the full DRG rate to account for the short stay

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp*

MS-DRG Review-Transfer (Cont)

Active OIG Work plan Item as of March 2020

When a patient is transferred to a post acute provider and the actual length of stay is more than one day less than the geometric mean length of stay and the discharge is reimbursed under one of the current 280 MS-DRGs, the hospital will receive a reduced payment, generally on a per diem basis

The DRG is one of the 280 “Transfer DRGs”

The length of stay (LOS) is less than the geometric mean length of stay (GMLOS) for that DRG, and

The patient was discharged to a qualifying post-acute facility, namely a home health agency or skilled nursing facility

When these criteria are met, CMS automatically applies a **per-diem payment** to the claim to account for the short stay

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp*

Applicable Transfer MS-DRG Discharge Status Codes

1. A hospital or distinct part hospital unit excluded from IPPS:
    - Inpatient rehabilitation facilities and units (Patient Discharge Status Code 62 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 90)
    - Long-term care hospitals (Patient Status Code 63 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 91)
    - Psychiatric hospitals and units (Patient Discharge Status Code 65 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 93)
    - Cancer hospitals (Patient Discharge Status Code 05 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 85)
    - Children's hospitals (Patient Discharge Status Code 05 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 85)
2. A skilled nursing facility (Patient Discharge Status Code 03 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 83) or
3. Hospice care at home (Patient Status Code 50) or Hospice Medical Facility (Certified) Providing Hospice Level of Care (Patient Status Code 51)
4. Home under a written plan of care for the provision of home health (HH) services from a HH agency and those services occur within 3 days after the date of discharge (Patient Discharge Status Code 06 or Planned Acute Care Hospital Inpatient Readmission Patient Status Code 86)

Does the Discharge Status Impact “Other” MS-DRG’s?

- Currently, cases are classified into Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment under the IPPS based on the following information reported by the hospital: the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay.
- MS-DRGs, classification is also based on the:
  - Age
  - Sex
  - Discharge status of the patient

For example:

- MS-DRG 280-282, Acute Myocardial Infarction, Discharged Alive
- MS-DRG 789, Neonates, Died or Transferred to Another Acute Care Facility

Avoid Unnecessary Adjustments to Claims

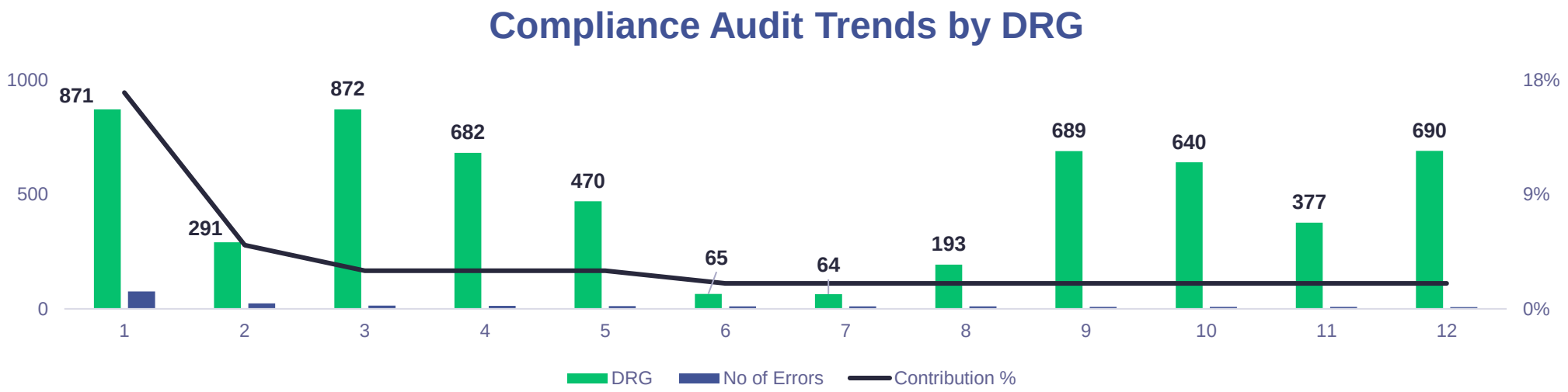
Plans can change after the patient is discharged resulting in the patient going to a different location than what was expected or documented in the medical record. For example, a patient can refuse care; family can decide they want the patient to go somewhere else.

Facilities are encouraged to follow-up with the patient after discharge and prior to submitting the claim to Medicare to ensure the patient went to the planned facility that was recorded in the medical record. Best practice is to follow-up with the patient within 30 days of the patient's discharge. Will need a strong relationship between financial services, case management, & home health and SNF agencies.

This will prevent incorrect billing of the Discharge Status Code and avoid unnecessary adjustments to claims when the incorrect code is used

Sample Discharge Status Audit Trends

- Total of 278 Post Acute transfer DRGs were coded for March and April 2021
- 134 DRGs have been identified with errors on discharge disposition of which 45% of errors were identified in 12 DRGs listed below
- DRG 871 was identified as a top error contributor (17%) on discharge disposition codes
- 21% of errors were identified in discharge disposition code 01 (home) which should actually be coded as discharge disposition code 06 (home health).



MS-DRG Review-High Level Severity MS-DRG

Active OIG Work Plan Item as of December 2018

Inpatient High Severity Level DRG codes

Up-coding

- PEPPER Reports
- Procedure/Diagnosis Codes Not Supported

Outlier Overpayments Not Supported in the Medical Record

Incorrectly Billed as an Inpatient

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000332.asp*

Hospital Claims at Risk for Incorrect Billing

St. Joseph Hospital Health Center OIG Report:

Hospital Claims at Risk for Incorrect Billing Previous OIG audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, as well as other areas we identified for this provider, 3 we focused our audit on the following:

- Inpatient hospital-acquired conditions and present on admission indicators (adverse events),
- Inpatient claims billed with DRG codes that have high Comprehensive Error Rate Testing (CERT) error rates, 4
- Inpatient high-severity level DRG codes,
- Inpatient mechanical ventilation,
- Inpatient claims paid in excess of charges,
- Inpatient same day discharge and readmit,
- Inpatient claims paid in excess of $150,000,
- Inpatient DRG 003 (hospital-specific outlier code),
- Inpatient DRG 219 (hospital-specific outlier code), and
- Inpatient DRG 470 (hospital-specific outlier code)

- **REF:** December 2021 Medicare Hospital Provider Compliance Audit: St. Joseph's Hospital Health Center
    - https://oig.hhs.gov/oas/reports/region2/22001004.pdf

What OIG Recommended:

Refund to the Medicare contractor $389,000 in estimated overpayments for the audit period for the claims that it incorrectly billed that are within the 4-year claim reopening period;

Based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and

Strengthen controls to ensure full compliance with Medicare requirements.

Hospital Claims at Risk for Incorrect Billing

Sunrise Hospital & Medical Center OIG Report:

- Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:
- Inpatient rehabilitation facility claims
- Inpatient claims billed with DRG codes that have high Comprehensive Error Rate Testing (CERT) error rates,
- Inpatient high-severity level DRG codes,
- Inpatient mechanical ventilation,
- Inpatient claims paid in excess of $25,000, and
- Inpatient same day discharge and readmit,

- **REF:** March 2021 Medicare Hospital Provider Compliance Audit: Sunrise Hospital & Medical Center
  - https://oig.hhs.gov/oas/reports/region4/41908075.pdf

Based on these findings, the OIG recommends that Sunrise Hospital & Medical Center:

- **Refund to the Medicare contractor $23,606,895 in net estimated overpayments for the audit period**
- Identify, report, and return any additional overpayments in accordance with the 60-day rule
- Strengthen controls to ensure proper coding and billing for certain rehabilitative services

Hospital Claims at Risk for Incorrect Billing

Jewish Hospital OIG Report:

Previous Office of Inspector General (OIG) audits at other hospitals identified types of claims at risk for noncompliance. Out of the areas identified as being at risk, we focused our audit on the following:

- Inpatient rehabilitation facility claims,
- Inpatient claims billed with DRG codes that have high Comprehensive Error Rate Testing (CERT) error rates
- Inpatient high-severity level DRG codes,
- Inpatient mechanical ventilation,
- Inpatient same day discharge and readmit,
- Inpatient claims paid in excess of charges,
- Inpatient claims paid in excess of $25,000

- **REF:** August 2021 Medicare Hospital Provider Compliance Audit: Jewish Hospital
  - https://oig.hhs.gov/oas/reports/region4/41908077.pdf

The OIG recommends Jewish Hospital refund the $13.5 million in estimated overpayments; exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule; and strengthen controls to ensure compliance with Medicare requirements

Medicare Payments for Inpatient Claims with Mechanical Ventilation

OIG Work Plan Active Item:

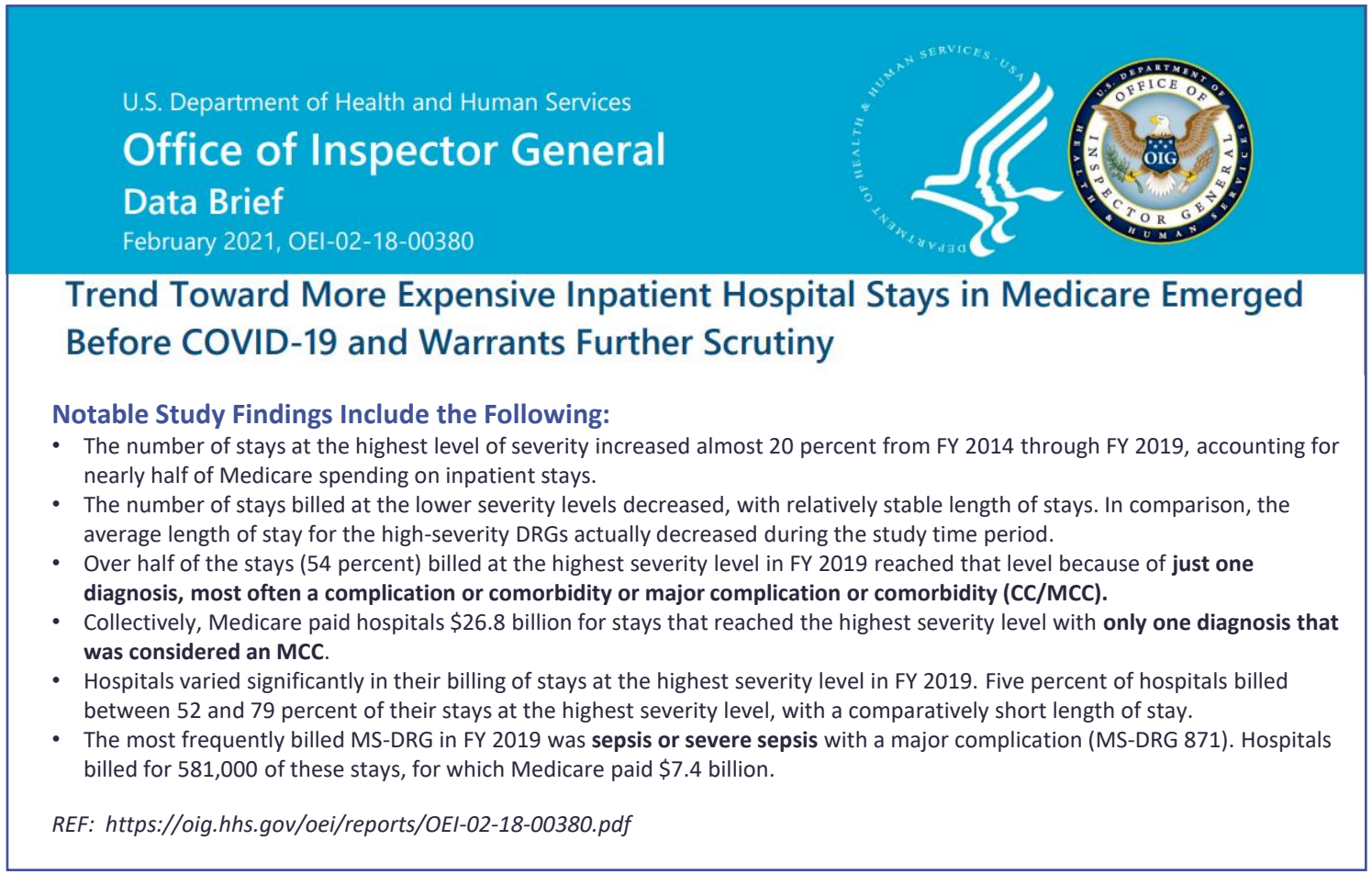
- We will review Medicare payments for inpatient hospital claims with certain Medicare Severity Diagnosis Related Group (MS-DRG) assignments that require mechanical ventilation to determine whether hospitals' DRG assignments and resultant Medicare payments were appropriate.
- Mechanical ventilation is the use of a ventilator to take over active breathing for a patient. For certain MS-DRGs to qualify for Medicare coverage, a beneficiary must have received more than 96 hours of mechanical ventilation. Our review will include claims for beneficiaries who received more than 96 hours of mechanical ventilation.
- Previous OIG reviews identified improper payments made because hospitals inappropriately billed for beneficiaries **who did not receive at least 96 hours of mechanical ventilation.**

- **REF:** https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000629.asp
- **REF: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17017.pdf**

"Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation," the OIG states that hospitals often use incorrect procedure codes when billing for mechanical ventilation.

- In their study of mechanical ventilation billings, the OIG looked at the relation between Medicare Severity - Diagnosis Related Groups (MS-DRGs) billed to the procedures coded for those DRGs. Specifically, the OIG looked at the MS-DRG 207 (Respiratory system diagnosis [with] ventilator support 96+ hours) and MS-DRG 870 (Septicemia or severe sepsis [with mechanical ventilation] 96+ hours).
- The OIG focused on claims where the estimated potential mechanical ventilation procedure length was 4 days or less, based on the date the hospital reported on the claim that mechanical ventilation started. Some hospitals billed MS-DRGs that indicated a stay where they provided 96 or more consecutive hours of mechanical ventilation to the patient, while the estimated potential mechanical ventilation procedure length indicated 4 days or less.
- Such claims represent overpayments

Trend Toward More Expensive Inpatient Hospital Stays in Medicare



U.S. Department of Health and Human Services

Office of Inspector General

Data Brief

February 2021, OEI-02-18-00380

Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

Notable Study Findings Include the Following:

- The number of stays at the highest level of severity increased almost 20 percent from FY 2014 through FY 2019, accounting for nearly half of Medicare spending on inpatient stays.
- The number of stays billed at the lower severity levels decreased, with relatively stable length of stays. In comparison, the average length of stay for the high-severity DRGs actually decreased during the study time period.
- Over half of the stays (54 percent) billed at the highest severity level in FY 2019 reached that level because of **just one diagnosis, most often a complication or comorbidity or major complication or comorbidity (CC/MCC).**
- Collectively, Medicare paid hospitals $26.8 billion for stays that reached the highest severity level with **only one diagnosis that was considered an MCC**.
- Hospitals varied significantly in their billing of stays at the highest severity level in FY 2019. Five percent of hospitals billed between 52 and 79 percent of their stays at the highest severity level, with a comparatively short length of stay.
- The most frequently billed MS-DRG in FY 2019 was **sepsis or severe sepsis** with a major complication (MS-DRG 871). Hospitals billed for 581,000 of these stays, for which Medicare paid $7.4 billion.

REF: https://oig.hhs.gov/oei/reports/OEI-02-18-00380.pdf

This study looked specifically at Medicare Part A claims for payments made from FY 2014 through FY 2019, checking for noteworthy trends in coding and billing over time that warrant further investigation.

RESPIRATORY COMPLICATIONS

Respiratory Complications Financial Impact

COVID		
Complication- Acute Respiratory Distress (R06.03-Non CC/MCC)	**Complication- Chronic Respiratory Failure (J96.10-CC)**	**Complication-Acute Respiratory Failure (J96.00-MCC)**
MS-DRG 179: Respiratory Infections & Inflammations without CC/MCC	**MS-DRG 178: Respiratory Infections & Inflammations with CC**	**MS-DRG 177: Respiratory Infections & Inflammations with MCC**
Relative Weight: 0.8727	**Relative Weight: 1.2078**	**Relative Weight: 1.8491**
National Average Reimbursement: $5,271.70	**National Average Reimbursement: $7,295.93**	**National Average Reimbursement: $11,169.82**

Difference in Reimbursement: $2,024.23 to $5,898.12

Acute Respiratory Failure due to COVID-19

Respiratory failure is a serious condition that develops when the lungs can't get enough oxygen into the blood. Buildup of carbon dioxide can also damage the tissues and organs and further impair oxygenation of blood and, as a result, slow oxygen delivery to the tissues.

Acute Respiratory Failure

- Unspecified respiratory Failure - **J96.90**
- Acute Respiratory Failure- J96.00 - **J96.02**
- Acute on Chronic Respiratory Failure - **J96.20 - J96.22**
- Chronic Respiratory Failure - **J96.10 - J96.12**

EXCLUDES 1

acute respiratory distress syndrome (J80)
cardiorespiratory failure (R09.2)
newborn respiratory distress syndrome (P22.0)
postprocedural respiratory failure (J95.82-)
respiratory arrest (R09.2)
respiratory arrest of newborn (P28.81)
respiratory failure of newborn (P28.5)

Adult respiratory failure CANNOT be coded with ARDS due to Excludes 1 Note

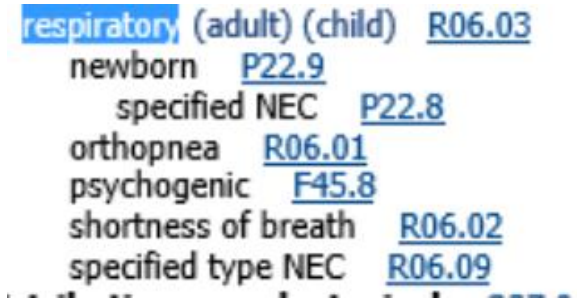
Acute Respiratory Failure and Acute Respiratory Distress Syndrome are both MCC Conditions Chronic Respiratory Failure is a CC condition

Coding Reference: FY 2022 ICD-10-CM Coding Conventions & FY 2022 ICD-10-CM Coding Index

Acute Respiratory Distress Syndrome due to COVID-19

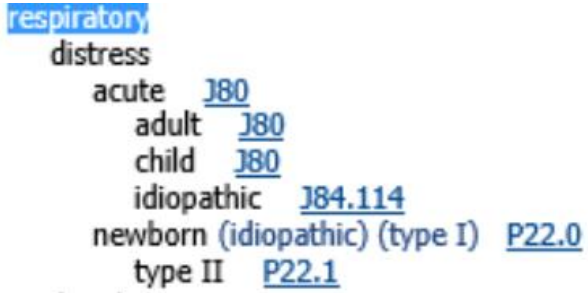
ARDS is a rapidly progressive disorder that has symptoms of dyspnea, tachypnea, and hypoxemia. Fluid builds up in the alveoli and lowers the amount of oxygen that is circulated through the bloodstream. Low levels of oxygen in the blood threatens organ function.

Acute Respiratory Distress



Respiratory distress refers to difficulty breathing that may be due to conditions such as asthma, aspiration, trauma, heart disease, pneumonia, etc. Respiratory distress is not associated with a respiratory system inability to supply adequate oxygen and/or eliminate carbon dioxide to maintain metabolism

Acute Respiratory Distress Syndrome



Acute Respiratory Distress Syndrome is MCC Conditions

Acute Respiratory Distress is not a CC or MCC

Respiratory Complications Financial Impact

PDX- Viral Sepsis (A41.89)		
COVID (U07.1-MCC)		
Complication- Acute Respiratory Failure (J96.00-MCC)		
Complication- Acute Respiratory Failure (J96.00-MCC)	Complication- Acute Respiratory Failure (J96.00-MCC)	Complication- Acute Respiratory Failure (J96.00-MCC)
Procedure- Ventilation Less than 24 Hours (5A1935Z)	Procedure- Ventilation 24-96 Hours (5A1945Z)	Procedure-Ventilation greater than 96 hours (5A1955Z)
MS-DRG 871: Septicemia or Severe Sepsis without MV > 96 Hours with MCC	MS-DRG 871: Septicemia or Severe Sepsis without MV > 96 Hours with MCC	MS-DRG 870: Septicemia or Severe Sepsis with MV > 96 Hours
Relative Weight: 1.8722	Relative Weight: 1.8722	Relative Weight: 6.4390
National Average Reimbursement: $11,309.36	National Average Reimbursement: $11,309.36	National Average Reimbursement: $38,895.94
Difference in Reimbursement: $27,586.58		

Respiratory Complications Financial Impact

COVID		
Complication- Acute Respiratory Failure (J96.00-MCC)		
Procedure- Ventilation Less than 24 Hours (5A1935Z)	**Procedure- Ventilation 24-96 Hours (5A1945Z)**	**Procedure-Ventilation greater than 96 hours (5A1955Z)**
MS-DRG 208: Respiratory System Diagnosis with Ventilator Support <= 96 Hours	**MS-DRG 208: Respiratory System Diagnosis with Ventilator Support <= 96 Hours**	**MS-DRG 207: Respiratory System Diagnosis with Ventilator Support > 96 Hours**
Relative Weight: 2.5448	**Relative Weight: 2.5448**	**Relative Weight: 5.7361**
National Average Reimbursement: $15,372.32	**National Average Reimbursement: $15,372.32**	**National Average Reimbursement: $34,649.94**
Difference in Reimbursement: $19,277.62		

Mechanical Ventilation Operative Note

Ventilator Flow Sheet- Start Time 02/26 @23:15

Ventilator Flow Sheet

Today's Date: 2/26/20		Initial Set Up Date: 2/26/20	
ETT Size: 8.5	Secured @ Lip: 23 T	Date Trached:	
IBW: 77.6	6mL 460	7mL	8mL 620

Time	Mode	Set Vt	RR set/total	Insp P	Delta P
2315	VC SIMV	620	17/17	—	14

Ventilator Flow Sheet

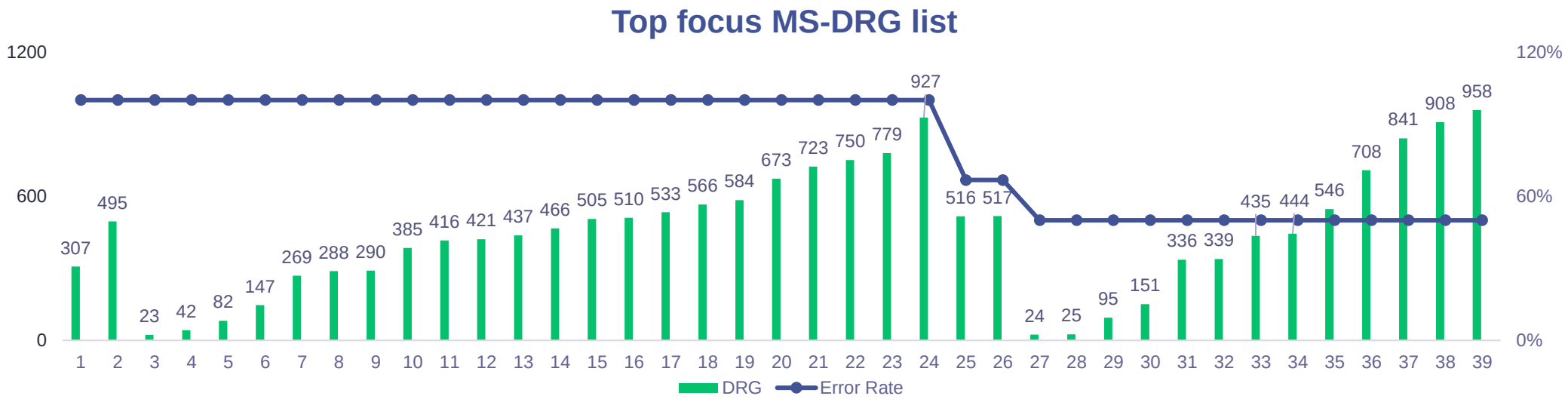
Today's Date: 3·02·2020		Initial Set Up Date: 2·26·2020	
ETT Size: 8.5	Secured @ Lip: 25 T	Date Trached:	
IBW: 77.6	6mL 460	7mL	8mL 620

Time	Mode	Set Vt	RR set/total	Comments	Initial
0435	PSV	—	/	Peep to 5 per weaning	[illegible]
0526	PSV	—	–/27	BS SxN clear, small amt FiO2 [illegible]	[illegible]
0730	PSV CPAP	—	/29	Changes per Dr. Krell. B.S. Clear.	[illegible]
0810			/	Extubated to NC 4lpm 93/79	[illegible]

Do you Have a Focus MS-DRG Audit Plan? - High Severity

Our focus DRGs are identified using the below criteria

- Client recommended focus DRGs
- DRGs with high error contribution in client audits and low volume
- High Charge Claims
- Review Denial Feedback- Documentation



OIG Risk Areas

MS-DRG Review

Transfer MS-DRG and High Severity Level MS-DRG

Modifiers

High Risk Modifiers

Documentation

Clinical Criteria for Severe Malnutrition

Best Practices

Tips for Success

Modifiers

Modifier -25

THE UNITED STATES DEPARTMENT of JUSTICE

Premier Medical Associates Agree To Pay $750,000 To Resolve Claims Of False Billing

Tampa, FL – United States Attorney Maria Chapa Lopez announces today that Premier Medical Associates (PMA), a medical practice located in The Villages, Florida, has agreed to pay $750,000 to resolve allegations that it violated the False Claims Act. As part of the settlement, the United States contends that it has certain civil claims against PMA related to PMA's billing of federal healthcare programs for services that were not medically necessary and reasonable.

Specifically, the government alleges that PMA knowingly billed for higher and more expensive levels of medical services than were actually performed and also billed for certain claims using "modifier 25," indicating that a separate evaluation and management service was performed, even when there was no such separate service.

"This settlement reflects our continuing efforts to protect patients and taxpayers by ensuring that the care provided to beneficiaries of government-funded healthcare programs is dictated by patient needs, not a provider's financial gain," said U.S. Attorney Chapa Lopez. "We will continue to hold health care providers accountable when they misrepresent the services billed to our federal healthcare programs and their patients."

https://www.justice.gov/usao-mdfl/pr/premier-medical-associates-agree-pay-750000-resolve-claims-false-billing

Modifier -25

Allegations of:

- Adding E/M with modifier -25 to scheduled diagnostic services (e.g., INR, blood tests)
- Adding procedures (e.g., X-ray, echo) to scheduled E/M when procedures weren’t performed
- Whistleblowers were billing specialists employed by the practice

Modifier -25

THE UNITED STATES DEPARTMENT of JUSTICE

Leading Oncology Practice To Pay $4.1 Million To Settle False Claims Act Investigation

FOR IMMEDIATE RELEASE

Georgia Cancer Specialists Overbilled Medicare for Evaluation and Management Services

ATLANTA, GA - The United States Attorney's Office for the Northern District of Georgia announced today that it has reached a settlement with Georgia Cancer Specialists I, PC, which agreed to pay $4.1 million to settle claims that it violated the False Claims Act by billing Medicare for evaluation and management services that were not permitted by Medicare rules. Georgia Cancer Specialists is one of the largest private oncology practices in the country with 27 offices located throughout the Atlanta metro area.

Sally Quillian Yates, United States Attorney for the Northern District of Georgia, said, "Health care providers should be on notice that if they inflate their billings, we will aggressively seek to recover not only the overcharges, but also significant penalties under the False Claims Act."

Ricky Maxwell, Acting Special Agent in Charge, FBI Atlanta Field Office, stated: "The FBI continues to do its part in ensuring that federal funds appropriated to Medicare are spent appropriately and today's

https://www.justice.gov/archive/usao/gan/press/2012/09-19-12b.html

Modifier -25

Key Findings:

- Agreed to pay 4.1 million to settle allegations
- Practice allegedly billed E/M service on the same day as a related procedure when it was not justified.
- “Because of widespread abuse of the use of modifier-25, the U.S. DHHS, OIG has targeted the use of modifier -25 in its yearly work plans.”

Modifier -25

THE UNITED STATES DEPARTMENT of JUSTICE

Skyline Urology to Pay $1.85 Million to Settle False Claims Act Allegations of Medicare Overbilling

Skyline Urology has agreed to pay the United States $1.85 million to resolve allegations that it violated the False Claims Act by submitting improper claims to the Medicare program for evaluation and management services, the Department of Justice announced today.

"Physicians and practice groups are expected to bill Medicare properly for the services they provide," said Assistant Attorney General Jody Hunt of the Department of Justice's Civil Division. "This settlement sends a clear message that the Department of Justice will hold healthcare providers accountable if they knowingly overbill federal healthcare programs."

Between Jan. 1, 2013, and Dec. 31, 2016, Skyline Urology allegedly submitted false claims to the Medicare program for evaluation and management (E&M) services that were not allowable under Medicare. Medicare generally prohibits healthcare providers from separately billing for E&M services provided on the same day as another medical procedure, unless the E&M services are significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the medical procedure. If an E&M service satisfies these criteria, the provider can use a billing code known as "Modifier 25" to bill for the significant and separately identifiable E&M services. In this case, the government alleged that Skyline Urology used Modifier 25 to improperly unbundle routine E&M services that were not separately billable from other procedures performed on the same day, and, as a result, improperly claimed compensation from Medicare for certain urological services.

https://www.justice.gov/opa/pr/skyline-urology-pay-185-million-settle-false-claims-act-allegations-medicare-overbilling

Modifier -25

Key Findings:

- Relator alleged modifier -25 error rate overall for the practice to be 58% and 100% for some doctors.
- 3-yr Corporate Integrity Agreement (CIA) requires IRO Reviews
- “This settlement is an example of how whistleblowers and government can work together to recoup and deter overbilling practices.” U.S. Attorney Robert K. Hur

Modifier -25

THE UNITED STATES DEPARTMENT of JUSTICE

FOR IMMEDIATE RELEASE

Friday, August 27, 2021

Hospital to Pay More Than $3 Million to Settle Whistleblower Suit

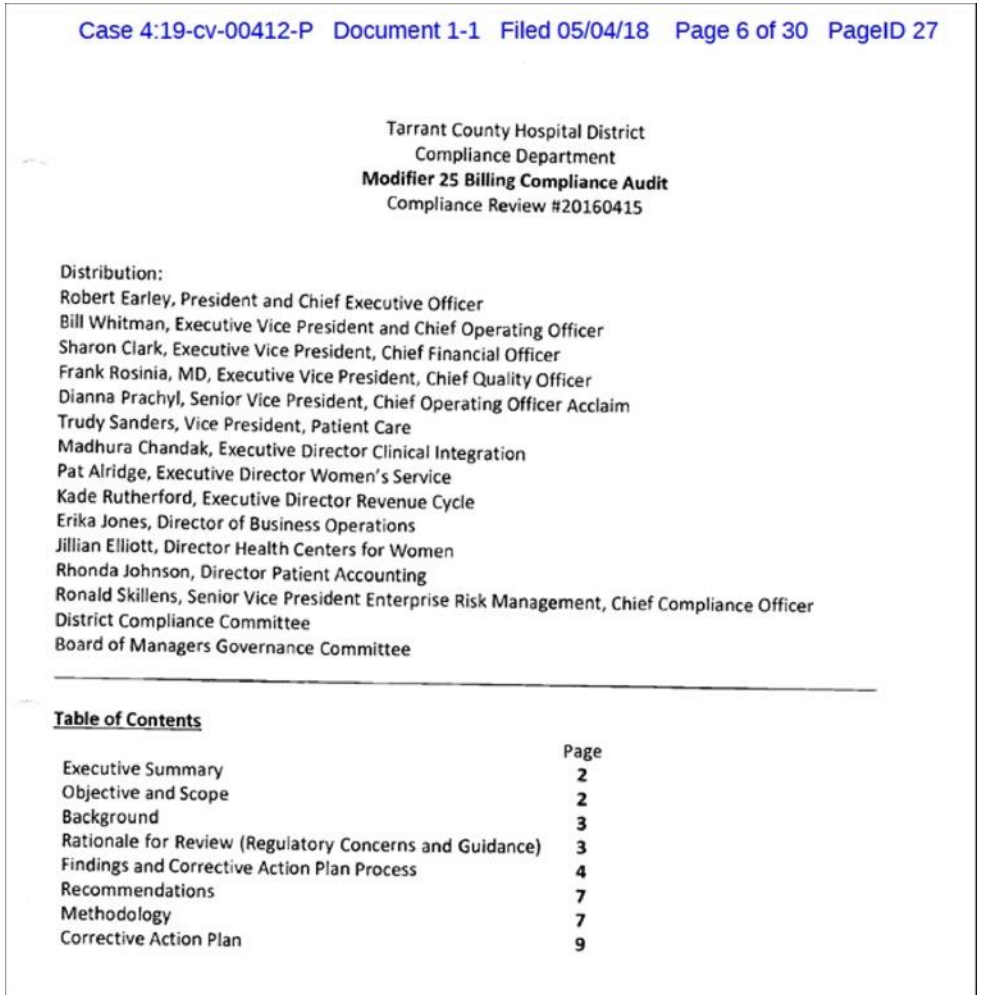
Tarrant County's John Peter Smith Hospital (JPS) has agreed to pay more than $3.3 million to settle allegations that it violated the False Claims Act by upcoding certain claims submitted to federal healthcare programs, Acting U.S. Attorney Prerak Shah announced today.

The settlement resolves a whistleblower suit filed in 2018 by JPS's former Director of Compliance Erma Lee, whose complaint asserted that the hospital improperly appended billing modifiers -25, -59, and -XU to hundreds of claims in order to obtain payments to which it was not entitled.

https://www.justice.gov/usao-ndtx/pr/hospital-pay-more-3-million-settle-whistleblower-suit

Modifier -25

Court records included 12-page internal audit report performed through the compliance department



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Tarrant County Hospital District
Compliance Department
Modifier 25 Billing Compliance Audit
Compliance Review #20160415

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Ronald Skillens, Senior Vice President Enterprise Risk Management, Chief Compliance Officer
District Compliance Committee
Board of Managers Governance Committee

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Modifier -25

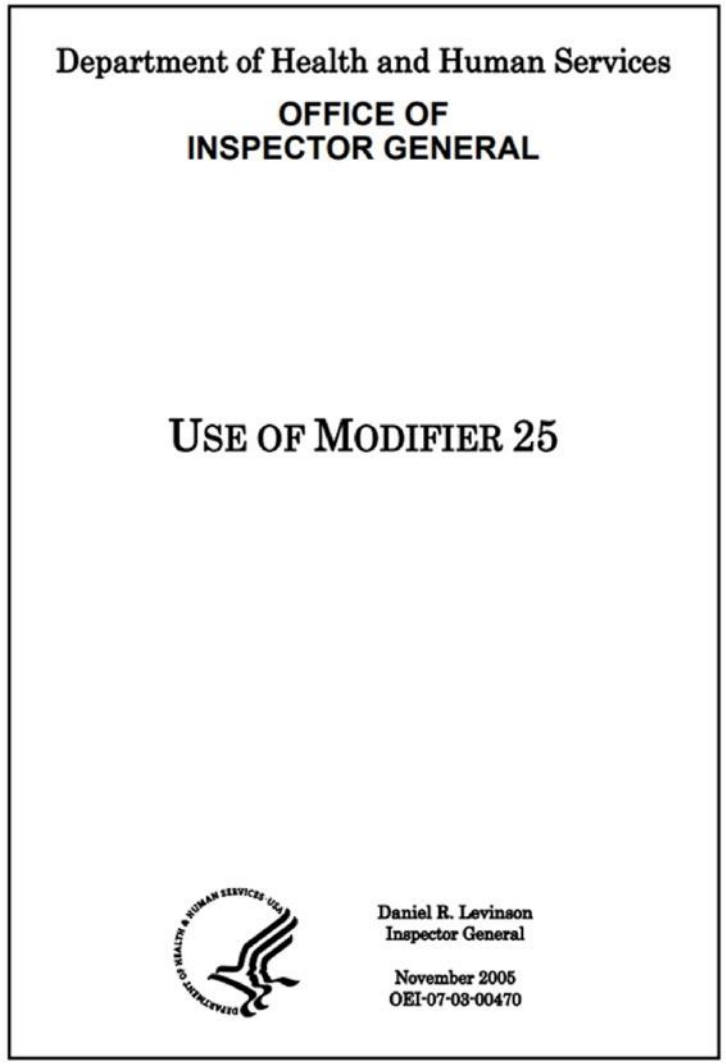
"Another example of upcoding related to E&M codes is misuse of Modifier 25. Modifier 25 allows additional payment for a separate E&M service rendered on the same day as a procedure.

Upcoding occurs if a provider uses Modifier 25 to claim payment for an E&M service when the patient care rendered was not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure."

Modifier -25

For one calendar year:

- OIG identified 35% of claims using modifier -25 did not meet payment requirements • $538 million in improper payments
- OIG recommended CMS reinforce the requirements that E/M services billed using modifier 25 be “significant, separately identifiable” and “above and beyond the usual preoperative and postoperative care associated with the procedure.”


Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

USE OF MODIFIER 25

Daniel R. Levinson
Inspector General

November 2005
OEI-07-03-00470

https://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf

Modifier -25

- Payment for procedures includes necessary pre- and postoperative Services
- In general, E/M on same day as a procedure is included in the procedure and not separately reportable/ reimbursable (including decision to perform a minor procedure)
- About 56% of dermatologists' claims with an E/M service also included minor surgical procedures (such as lesion removals, destructions, and biopsies) on the same day
- *“This may indicate abuse…”*
- Expect report to be issued in 2022

Modifier -59 and -XU

Modifier -59 and -XU

THE UNITED STATES DEPARTMENT of JUSTICE

Coordinated Health and CEO Pay $12.5 Million to Resolve False Claims Act Liability for Fraudulent Billing

PHILADELPHIA, PA – United States Attorney William M. McSwain announced today that Coordinated Health Holding Company, LLC ("Coordinated Health") and its founder, principal owner, and Chief Executive Officer, Emil DiIorio, M.D., agreed to settle allegations under the False Claims Act that they submitted false claims to Medicare and other federal health care programs for orthopedic surgeries. Coordinated Health agreed to pay $11.25 million and DiIorio agreed personally to pay $1.25 million, for total settlement of $12.5 million. Coordinated Health has also entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services that will require regular monitoring of its billing practices for five years.

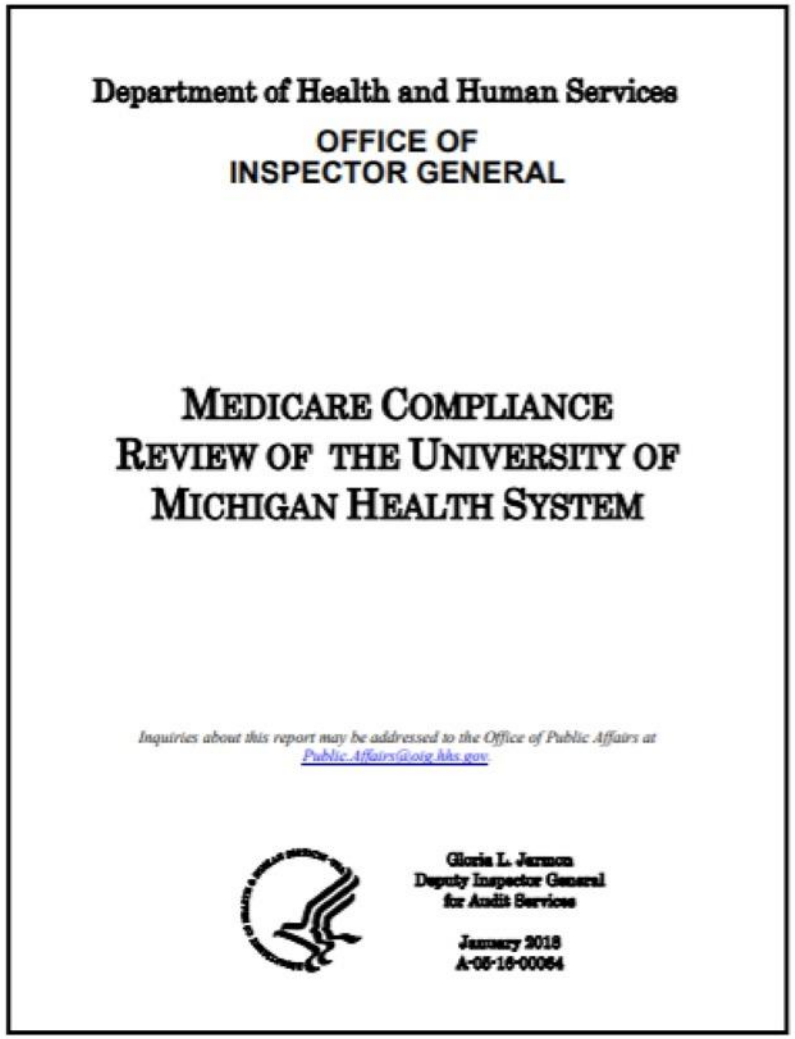
https://www.justice.gov/usao-edpa/pr/coordinated-health-and-ceo-pay-125-million-resolve-false-claims-act-liability

Modifier -59 and -XU

- Executives were directly informed at least twice that Coordinated Health improperly unbundled many orthopedic surgeries by misusing Modifier 59.
- The 2013 consultant specifically advised Coordinated Health to self-report and repay Medicare and other federal payers
- The consultant also provided on-site training on the proper use of Modifier 59 to Coordinated Health coders in November 2013.

Modifier -59 and -XU

"For 6 of the 30 sampled claims, the Hospital billed Medicare using incorrect HCPCS codes appended with modifier -59. The amounts the codes represented were already included in the payments for other services billed on the same claim, or the claim did not require modifier -59."



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE COMPLIANCE
REVIEW OF THE UNIVERSITY OF
MICHIGAN HEALTH SYSTEM

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

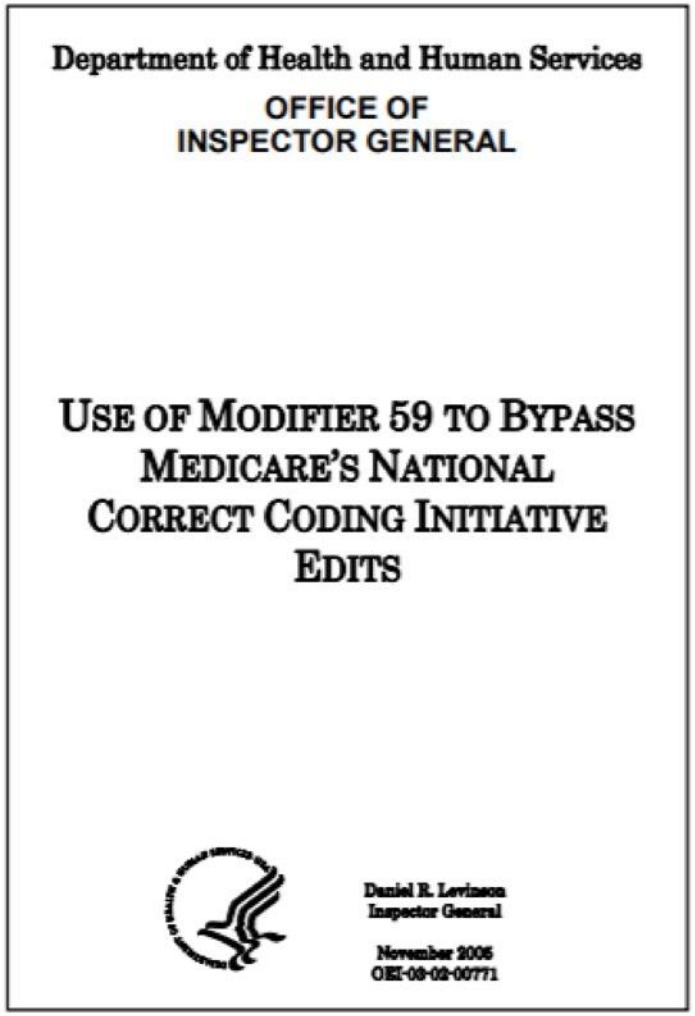
Gloria L. Jarmon
Deputy Inspector General
for Audit Services

January 2018
A-05-16-00064

https://oig.hhs.gov/oas/reports/region5/51600064.pdf

Modifier -59 and -XU

Forty percent of code pairs billed with **modifier 59** in did not meet program requirements, resulting in **$59 million** in improper payments.


Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

USE OF MODIFIER 59 TO BYPASS MEDICARE'S NATIONAL CORRECT CODING INITIATIVE EDITS

Daniel R. Levinson
Inspector General

November 2005
OEI-03-02-00771

https://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf

OIG Risk Areas

MS-DRG Review

Transfer MS-DRG and High Severity Level MS-DRG

Injections

Facet Joint; Stelara; and Eylea/Lucentis

Documentation

Clinical Criteria for Severe Malnutrition

Best Practices

Tips for Success

Documentation – Severe Malnutrition

Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims

The essence of this case is that they reviewed a random sample of 200 out of 224,175 claims from fiscal years 2016 and 2017 in which E41, Nutritional marasmus, or E43, Unspecified severe protein-calorie malnutrition, were the sole major complication or comorbidity (MCC). They determined that 27 out of the 200 claims (13.5 percent) were correctly billed. For 164 claims (82 percent), they believed that malnutrition was either not a legitimate diagnosis or was not of the severity asserted. The amount of estimated overpayments was $914,128. When they extrapolated the overpayments over the entire cohort, they arrived at $1.024 billion at risk.

Coding Reference: *https://oig.hhs.gov/oas/reports/region3/31700010.asp and https://acdis.org/articles/news-oig-says-hospitals-overbilled-medicare-1-billion-severe-malnutrition*

Documentation – Severe Malnutrition

Active OIG Work Plan Item as of October 2015

Completed Status

- **Hospitals Billing for Severe Malnutrition on Medicare Claims**
- Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher Diagnosis Related Group
- This review will assess the accuracy of Medicare payments for the treatment of severe malnutrition
- We will determine whether providers are complying with Medicare billing requirements when assigning diagnosis codes for the treatment of severe types of malnutrition on inpatient hospital claims

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000258.asp*

Documentation – Severe Malnutrition

Active OIG Work Plan Item as of November 2021

Active Status

- **Hospitals Billing for Severe Malnutrition on Medicaid Claims**
- Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher Diagnosis Related Group
- This review will assess the accuracy of Medicare payments for the treatment of severe malnutrition
- We will determine whether providers are complying with Medicare billing requirements when assigning diagnosis codes for the treatment of severe types of malnutrition on inpatient hospital claims

Coding Reference: *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000258.asp*

Documentation – Severe Malnutrition

- Have a system-wide plan
  - **University of Wisconsin** - 88 of 100 claims, the billing errors resulted in net overpayments of $562,361. For these claims, the hospital-provided medical record documentation did not contain evidence that the malnutrition was severe or that it had an effect on the treatment or the length of the hospital stay. On the basis of our sample results, we estimated that the Hospital received overpayments of at least $2,412,137 from 2014 through 2016
  - **Vidant** - Vidant Medical Center incorrectly billed inpatient claims with severe malnutrition, resulting in overpayments of approximately $1.4 million over 2.5 years
- Verify Code Assignment
- Clinical Validation is Key

Malnutrition Criteria

Two factors in the table below must be present for a malnutrition diagnosis.

	Acute Illness or Injury		Chronic Illness		Social or Environmental Factor	
	Moderate Protein Calorie Malnutrition	Severe Protein Calorie Malnutrition	Moderate Protein Calorie Malnutrition	Severe Protein Calorie Malnutrition	Moderate Protein Calorie Malnutrition	Severe Protein Calorie Malnutrition
Energy Intake	<75% of EEE >7 days	≤50 % of EEE >5 days	<75% of EEE ≥1 month	< 75% of EEE ≥1 month	<75% of EEE ≥3 months	≤50% of EEE ≥1 month
Weight Loss	**1-2%** 1 week **5%** 1 months **7.5%** 3 months	**> 2%** 1 week **> 5%** 1 months **> 7.5%** 3 months	**5%** 1 month **7.5%** 3 months **10%** 6 months **20%** 1 year	**> 5%** 1 month **> 7.5%** 3 months **> 10%** 6 months **> 20%** 1 year	**> 5%** 1 month **> 7.5%** 3 months **> 10%** 6 months **> 20%** 1 year	**> 5%** 1 month **> 7.5%** 3 months **> 10%** 6 months **> 20%** 1 year
Body Fat Loss	Mild	Moderate	Mild	Severe	Mild	Severe
Muscle Mass Wasting	Mild	Moderate	Mild	Severe	Mild	Severe
Fluid (Edema)	Mild	Moderate to Severe	Mild	Moderate to Severe	Mild	Moderate to Severe
HandGrip Strength	N/A	Measurably Reduced	N/A	Measurably Reduced	N/A	Measurably Reduced

EEE: Estimated energy expenditure N/A: Not applicable
Reference: Academy of Nutrition and Dietetics & American Society of Parenteral and Enteral Nutrition Clinical Characteristics of Malnutrition 2011.

Physician Query- Malnutrition Clinical Indicators

The clinical indicators include:

- Loss of muscle mass or subcutaneous fat or visible wasting away of muscle/tissue
- Cachexia
- Documentation of Infectious/Inflammatory disease reducing dietary intake/absorption: _____
- Diminished functional status as measured by hand grip strength
- Deficiency with any of the following: iron, vitamins, minerals, zinc, iodine
- Insufficient energy intake
- Edema/fluid retention
- Documented Weight Loss/Loss of Appetite
- Dietary Consult
- Inability to consume adequate caloric intake
- Physician/Dietician/Nursing BMI Documentation:_____
- Other Clinical Indicator:_____*(Requires two of the above clinical indicators to be present in order to add an "other clinical indicator")*

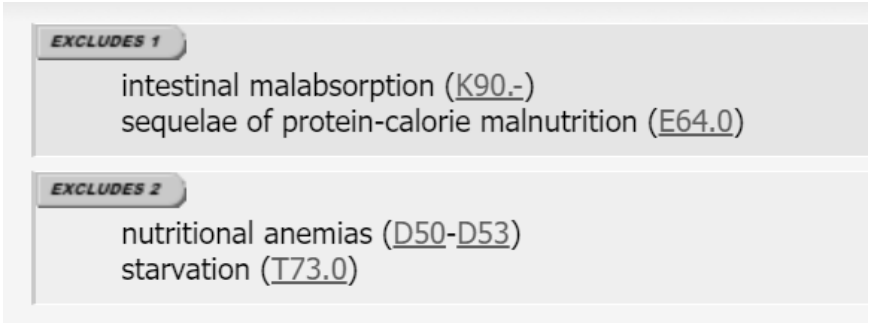
IS A PHYSICIAN QUERY REQUIRED?

Malnutrition

Malnutrition

- Unspecified malnutrition- **E46**
- Moderate protein-calorie Malnutrition – **E44.0**
- Mild protein-calorie malnutrition – **E44.1**
- Unspecified severe protein-calorie malnutrition – **E43**

Unspecified severe protein-calorie malnutrition is a MCC Condition.
Mild, moderate, and unspecified malnutrition are CC conditions



Coding Reference: FY 2022 ICD-10-CM Coding Conventions & FY 2022 ICD-10-CM Coding Index

Malnutrition Complications Financial Impact

COVID		
Complication- Unspecified Malnutrition (E46-CC)	**Complication- Moderate Malnutrition (E44.0-CC)**	**Complication- Severe Malnutrition (E43-MCC)**
MS-DRG 179: Respiratory Infections & Inflammations without CC/MCC	**MS-DRG 178: Respiratory Infections & Inflammations with CC**	**MS-DRG 177: Respiratory Infections & Inflammations with MCC**
Relative Weight: 1.2078	**Relative Weight: 1.2078**	**Relative Weight: 1.8491**
National Average Reimbursement: $7,295.93	**National Average Reimbursement: $7,295.93**	**National Average Reimbursement: $11,169.82**

Difference in Reimbursement: $3873.89

OIG Risk Areas

MS-DRG Review

Transfer MS-DRG and High Severity Level MS-DRG

Injections

Facet Joint; Stelara; and Eylea/Lucentis

Documentation

Clinical Criteria for Severe Malnutrition

Best Practices

Tips for Success

Best Practices

Keep on top of Medicare Rules and Updates

Identify Important Areas of Focus

Periodic Auditing is Essential

Provide Sessions Focused On Retraining

Notify Clinical Staff of any Serious Documentation Trends

Coding Reference: *https://oig.hhs.gov/oas/reports/region3/31700005.asp*

Coding Reference
Appendix

References

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Questions?


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