2003 OIG Work Plan Highlights Aberrant Coding Patterns: Plan Puts New Spin on 2002 Work Plans, Introduces New Projects

by Sue Prophet-Bowman, RHIA, CCS

This article includes highlights of the OIG's 2003 Work Plan. The plan can be found in its entirety on the OIG Web site at http://oig.hhs.gov/ publications/workplan.html.

Many of the projects described in the 2003 Work Plan of the Office of Inspector General (OIG) of the Department of Health and Human Services may look familiar, as they have appeared in previous work plans. But compliance professionals should take note: some of the projects carried over from 2002 contain new twists.

There are some new projects, too. New in the 2003 work plan is the provision of the date the OIG expects to issue a report on the results of each project. An interesting trend is an increasing focus on identification of "aberrant coding patterns." It is in providers' best interests to ensure they compare their code distributions with those of their peers to identify any aberrations and explore reasons for these variances. The OIG is closely monitoring data patterns, so providers need to identify any aberrations and either resolve inappropriate coding practices that led to these aberrations or be able to explain why the differences exist.

This article does not address all the projects outlined in the 2003 work plan. Review the plan in its entirety to identify any additional projects that may be of significance to your organization.

A New Twist on 2002 Projects

Update on DRG Coding

2002: This project was titled "Payments to Acute Care Prospective Payment System Hospitals."

2003: The project essentially remains the same, but it is now titled "Update on Diagnosis-related Group Coding." The OIG will examine DRGs that have a history of aberrant coding to determine whether some acute hospitals exhibit aberrant coding patterns. They will determine coding payment error rates and incorporate the results of a recent review by quality improvement organizations.

Procedure Coding of Outpatient and Physician Services

2002: The OIG indicated that it planned to review the procedure coding of outpatient services billed by a hospital and a physician for the same service.

2003: Ambulatory service centers have been added to the review. The OIG will review the procedure coding of outpatient services billed by both a physician and a hospital/ambulatory service center for the same service.

Coding of Evaluation and Management Services

2002: The OIG planned to determine whether physicians correctly coded E/M services in physician offices and effectively used documentation guidelines.

2003: The OIG will still examine whether physicians accurately coded E/M services. However, the 2003 review will also involve an assessment of the adequacy of controls to identify physicians with aberrant coding patterns, specifically coding

disproportionately high volumes of high-level E/M codes that result in greater Medicare reimbursement. Note the shift from proper application of documentation guidelines to identification of aberrant coding patterns.

Coding of Physician Evaluation of Dialysis

2002: The OIG planned to determine whether Medicare payments for inpatient dialysis services met the billing requirements of Medicare Part B. The Medicare Carrier Manual requires that the physician be physically present with the patient at some time during the dialysis and that the medical records document this in order for the physician to be paid on the basis of dialysis procedure codes.

2003: The description of the project has been modified to state that the OIG will review claims for physician evaluation during dialysis to determine the extent of any improper Medicare reimbursement due to upcoding. The OIG will assess the ability of controls to identify providers who bill for the higher-paying codes significantly more often than their peers. Procedures requiring multiple evaluations are reimbursed at a higher rate than those requiring a single evaluation. The emphasis has shifted from physician presence to upcoding issues related to the number of physician evaluations required during a dialysis procedure.

Expansion of DRG Payment Window

2002: The description of the project simply stated that the OIG would determine the extent of preadmission services rendered outside the current 72-hour DRG payment window and the amount of savings that can be achieved by expanding the payment window. No particular time frame for consideration of expansion of the window was given.

2003: The 2003 work plan specifically states that the OIG will determine whether it would be reasonable and appropriate to treat as inpatient services all admission-related services rendered up to 14 days before a hospital admission. The 2003 review will focus on those DRGs that contribute to the highest percentage of Medicare payments outside the three-day window.

Consecutive Inpatient Stays

2002: The OIG planned to examine the extent to which Medicare beneficiaries receive acute and postacute care through sequential stays in different providers. As part of its review, it planned to assess the Centers for Medicare & Medicaid Services' (CMS) instructions for identifying and evaluating consecutive beneficiary stays, including those in skilled nursing facilities, long-term care hospitals, and prospective payment system-exempt units.

2003: The OIG still plans to examine the extent to which Medicare beneficiaries received acute and postacute care through sequential stays at different providers. However, the 2003 work plan specifically indicates that it will analyze claims to identify questionable patterns of inpatient and long-term care. No claims review was mentioned in the 2002 work plan.

Consolidated Billing Requirements

2002: The OIG planned to monitor CMS' efforts to determine the extent of overpayments during calendar year 2000 for certain Part B services subject to the consolidated billing provisions of the prospective payment system for skilled nursing facilities.

2003: The description of the project has been modified to indicate that the OIG will determine whether controls are in place to preclude duplicate billing under the skilled nursing facility prospective payment system. Prior OIG work identified millions of dollars in potentially improper payments associated with outpatient hospital, ambulance, laboratory, radiology, and durable medical equipment services during calendar year 1999. The 2003 review will identify any additional potentially improper payments for such services during calendar years 1999 and 2000.

Work Plan Changes for 2003

Prospective Payment System for Inpatient Rehabilitation Facilities

The OIG will monitor implementation of the new prospective payment system for inpatient rehabilitation facilities. It will conduct surveys and pilot audits at fiscal intermediaries, providers, and other participants to identify potential vulnerabilities. They will also review controls and payments under the new system to test any vulnerability, assess their impact, and consider solutions to the problems.

Nursing Home Reporting of Minimum Data Set

The OIG will assess nursing home compliance with Minimum Data Set (MDS) reporting requirements. Although the MDS partially determines payment for Part A stays, Medicare Conditions of Participation require that the MDS be reported on all residents for quality oversight purposes. This study will focus on nursing home MDS reporting for residents who are not in a Part A covered stay. The OIG will review data submissions and nursing home records to assess the accuracy and timeliness of reporting.

Resource Utilization Group Assignments: Follow Up

The OIG will examine changes in the proportion of Medicare beneficiaries assigned to each resource utilization group in light of recent legislative changes to the prospective payment system for skilled nursing facilities. They will examine the trends in the proportion of Medicare beneficiaries categorized in each group as well as any changes in these trends since the recent legislative changes to the payment rate.

Medicare Payments in Outpatient Settings

The OIG will determine the extent to which payments for the same procedure codes vary between hospital outpatient departments and ambulatory surgical centers and assess the effect of this variance on the Medicare program.

Improper Medicare Fee-for-Service Payments

The OIG will determine whether fiscal year 2002 Medicare fee-for-service benefit payments were made in accordance with Medicare laws and regulations and are medically necessary, accurately coded, and sufficiently documented. The determination will be made from a review of claims and patient medical records, with the assistance of medical staff. The OIG will use statistical sampling techniques to project results nationwide and to compute a national error rate.

Analysis of Medicare Errors

The OIG will review Medicare fee-for-service claims that were found to be in error and determine how future inappropriate payments can be avoided. CMS is employing contractors under the Medicare Integrity Program to review claims for medical necessity and proper payment. The OIG will determine whether the resulting database accurately reflects the results of the claims reviews and ascertain the status of efforts to use the database to prevent future errors.

Coding of Medicare Physician Services

The OIG will test whether carriers are appropriately applying edits required by Medicare's National Correct Coding Initiative. It will determine whether physicians were improperly paid for claims that should have been rejected based on the coding initiative.

Billing for Chiropractic Care

The OIG will determine the appropriateness of Medicare billings for chiropractic services. Currently, the only Medicare-reimbursable chiropractic treatment is manual manipulation of the spine to correct a subluxation. Medicare does not cover chiropractic maintenance treatments. In 1996, 759,400 Medicare beneficiaries received almost 2.9 million probable chiropractic maintenance treatments costing Medicare $68 million. The OIG will update the estimate of such treatments inappropriately billed to Medicare.

Nail Debridement Services

This OIG study will determine the underlying reasons why Medicare carriers made inappropriate payments for nail debridement services. This study will also assess the adequacy of CMS policy on these services and carriers' consistency in applying the policy. Nail debridement services were also the subject of an OIG inspection report (see "OIG Cites Nail Debridement as High-risk Compliance Area," below).

OIG cites nail debridement as high-risk compliance area

The OIG's June 2002 inspection report "Medicare Payments for Nail Debridement Services," summarized the results of an OIG review of the appropriateness of Medicare payments for nail debridement services performed in calendar year 2000. The OIG contracted with a podiatrist to review medical records for 110 randomly sampled nail debridement claims.

This review, which focused on evaluation of medical necessity, determined that Medicare inappropriately paid $51.2 million for nail debridement services in calendar year 2000. In about one in every four of the nail debridement claims reviewed, the medical justification for nail debridement was not documented in the patients' medical records. Of the inappropriately paid claims, 17.3 percent did not contain sufficient documentation to demonstrate that the services were necessary.

For example, a clinical description of the medical condition or a diagnosis of mycosis may have been lacking from the medical record documentation. In 2.7 percent of the inappropriately paid claims, there was no indication in the medical records that nail debridement services were provided on the date claimed. In another 2.7 percent of the claims, no medical records were supplied to the OIG to support the claims for reimbursement.

Medicare covers nail debridement when at least one of the following conditions exists:

- systemic condition involving neurological or vascular diseases
- clinical evidence of mycosis of the toenail, marked limitation of ambulation, and pain in an ambulatory patient (nail debridement may also be covered by Medicare for a secondary infection resulting from one or more mycotic toenails in an ambulatory individual)
- clinical evidence of pain or a secondary infection resulting from one or more mycotic toenails in a non-ambulatory individual

The OIG recommended that CMS require:

- Medicare carriers to closely scrutinize payment for nail debridement services through medical reviews. Carriers should require podiatrists to adequately document the medical need for all nail debridement services
- CMS regional offices and carriers to educate podiatrists on Medicare policy for payment of nail debridement services
- CMS carriers to collect the overpayments identified by the OIG during this review

For more information, go to http://oig.hhs.gov/oei/reports/oei-04-99-00460.pdf.

Medicaid Outpatient Hospital Payments

The OIG will identify any Medicaid expenditures for outpatient hospital services that were either unnecessary or unsupported. They will examine the extent of any inappropriate Medicaid payments and the potential impact on federal Medicaid outlays.

Medicaid DRG Payment Window

This OIG review will determine whether prospective payment system hospitals submitted Medicaid claims for inpatient stay-related laboratory and other services within three days of hospital admission and the potential cost savings that would result from state prohibition of this practice. Separate reimbursement for outpatient diagnostic services provided within three days of hospital admission is disallowed under the Medicare prospective payment system and similar cost savings may be able to be achieved if it was also disallowed under Medicaid prospective payment systems.

Coding of Medicaid Physician Services

The OIG will analyze physician claims to determine whether Medicaid can potentially save money by using the Medicare National Correct Coding Initiative edits to detect and correct improper coding.

Putting the Plan into Practice

As part of their effective compliance programs, organizations should review the annual work plan, identify those target areas that are relevant to their business operations, prioritize them, and update their compliance programs to reflect activities that address pertinent risk areas under OIG focus.

A proactive process for detecting and resolving problems internally and preventing them from recurring reduces the provider's risk of being targeted for an OIG investigation. And even if the provider does become a target of an investigation, evidence of proactive efforts to detect and resolve problems demonstrates the provider's commitment to compliance to the government and serves as a mitigating factor in determining any criminal, civil, or administrative penalties.

Sue Prophet-Bowman *(sue.prophet@ahima.org) is AHIMA's director of coding policy and compliance.*

Article citation:
Prophet-Bowman, Sue. "2003 OIG Work Plan Highlights Aberrant Coding Patterns: Plan Puts New Spin on 2002 Work Plans, Introduces New Projects." *Journal of AHIMA* 74, no.1 (2003): 76-79.
