# 2003 *Red Book* Reveals Cost-saving Recommendations



*by Sue Prophet-Bowman, RHIA, CCS*

Although the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has already saved tax payers more than $12 million this year, it offers still more cost-saving recommendations for the Centers for Medicare & Medicaid Services (CMS) in its annual *Red Book* that have not been fully implemented. These recommendations may require one of three types of actions: legislative, regulatory, or procedural. Many of these recommendations are based on findings from reviews and investigations. Below, we'll look at some of the significant recommendations from the 2003 *Red Book*.

## Old, New Recommendations

Each recommendation is designated as either "new" or "previous." New recommendations are those that have been made since the previous edition of the *Red Book*. Previous recommendations are those that have been published in at least one past edition of the *Red Book*, but the action expected of CMS has not been substantially completed. The current status of each recommendation is updated each year.

- Establish more consistent outpatient surgery rates that reflect only necessary costs (new)

*OIG Recommendation*: CMS should seek authority to set rates that are consistent for both hospital outpatient departments (OPDs) and ambulatory surgical centers (ASCs) and remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures.

*CMS Action*: CMS agreed to consider seeking authority to set consistent rates and issued a notice of proposed rulemaking that would remove certain procedure codes from the ASC list of covered procedures.

- Recover overpayments and prevent inappropriate Medicare Part B payments for nail debridement and related services (new)

*OIG Recommendation*: CMS should require Medicare carriers to recoup the overpayments for nail debridement identified by the OIG in its review and to scrutinize payments for nail debridement services through medical reviews. It should also require podiatrists to adequately document the medical necessity of all nail debridement services and require CMS regional offices and carriers to educate podiatrists on Medicare payment policies for nail debridement claims.

*CMS Action*: CMS plans to continue to maximize the effectiveness of its medical review strategy, collect the overpayments identified by the OIG review, and educate podiatrists about Medicare policy for paying nail debridement claims.

- More closely monitor same-day hospital readmissions (previous)

*OIG Recommendation*: CMS should work with the OIG in reviewing hospital readmissions to identify overpayments, monitor the quality of hospital care, profile aberrant hospital providers, and ensure that corrective action plans are instituted and appropriate referrals are made to the OIG. CMS should also reinstate hospital readmission reviews by quality improvement organizations.

*CMS Action*: CMS agreed to work with the OIG to better monitor quality of care and overpayment issues associated with hospital readmissions. At CMS' request, the OIG provided CMS with further analysis of the patterns of readmissions.

- More closely monitor one-day inpatient hospital stays (previous)

*OIG Recommendation*: CMS should expand its initiative to conduct one-day inpatient hospital stay reviews on a nationwide basis.

*CMS Action*: CMS agreed to instruct the quality improvement organizations to include these stays in their analysis.

- Expand the diagnosis-related group (DRG) payment window (previous)

*OIG Recommendation*: CMS should propose legislation to expand the DRG payment window to at least seven days immediately before the day of admission.

*CMS Action*: CMS did not concur and has not pursued a legislative proposal.

- Preclude payment for mutually exclusive procedure codes for hospital outpatient services (previous)

*OIG Recommendation*: CMS should instruct fiscal intermediaries to implement edits to preclude payment for Medicare Part B mutually exclusive procedure codes and notify hospitals that Medicare Part B will no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

*CMS Action*: The edits for hospital outpatient services were implemented as a component of the correct coding initiative edits when the outpatient prospective payment system was implemented. CMS agreed to instruct fiscal intermediaries to implement edits addressing mutually exclusive procedure codes and to notify hospitals that Medicare Part B would no longer pay for mutually exclusive procedure codes related to radiology and pathology/laboratory services.

- Require physician examination before ordering home health services (previous)

*OIG Recommendation*: Medicare regulations should be revised to require that physicians examine patients before ordering home health services.

*CMS Action*: Although the Balanced Budget Act of 1997 included provisions to restructure home health benefits, CMS still needs to revise regulations to require that physicians examine Medicare patients before ordering home health services. CMS indicated that it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. CMS also provided additional payments for physician care plan oversight and education for physicians and beneficiaries.

- Ensure appropriateness of Medicare payments for mental health services (previous)

*OIG Recommendation*: CMS should ensure that mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services.

*CMS Action*: CMS agreed with the recommendations and has initiated some efforts, particularly with regard to community mental health centers.

- Conduct medical reviews of Part B therapy services (previous)

*OIG Recommendation*: CMS should instruct fiscal intermediaries to conduct focused medical reviews of therapy payments and encourage them to educate providers about documentation requirements. CMS should also consider options when developing a new reimbursement system for Part B therapy, such as a system based on an episode of therapy and prior authorization for therapy that exceeds a separate monetary cap for each type of therapy.

*CMS Action*: CMS instructed its contractors to concentrate their efforts on random reviews of all claims and planned to use the results of those reviews to focus additional efforts. The Balanced Budget Refinement Act of 1999 required the secretary of HHS to conduct focused medical reviews of therapy services during 2000 and 2001. A contract was awarded for the Therapy Review Program, which was a study of the use of therapy services. A significant number of focused medical reviews of therapy claims in skilled nursing facilities and other settings have been and will continue to be performed.

- Stop inappropriate payments for chiropractic maintenance treatments (previous)

*OIG Recommendation*: CMS should develop system edits to detect and prevent unauthorized payments for chiropractic maintenance treatments. Examples include requiring chiropractic physicians to use modifiers to distinguish the categories of

spinal joint problems and requiring all Medicare contractors to implement system utilization frequency edits to identify beneficiaries receiving consecutive months of minimal therapy.

*CMS Action*: CMS plans to require all contractors to establish utilization frequency edits and chiropractic physicians to use modifiers to distinguish the categories of spinal joint problems.

## Compliance Pays Off

It is very important to stay abreast of current government enforcement activities in order to ensure that your corporate compliance program is responsive to the latest trends and risks. Review of the OIG *Red Book* each year provides insight into areas of potential increased scrutiny by CMS, Medicare contractors, and quality improvement organizations, or possible regulatory or policy changes affecting federal healthcare programs.

## OIG Announces 2003 Fraud Enforcement, Cost-saving Accomplishments

According to the OIG's Semi-Annual Report to Congress, it saved US taxpayers more than $12 billion for the first half of fiscal year 2003 (October 2002 through March 2003). These savings consist of $11.6 billion in implemented recommendations and other actions to put funds to better use, $174 million in audit disallowances, $40 million in additional recoveries, and more than $187 million in investigative receivables.

For this reporting period, exclusions of 1,241 individuals and entities for fraud and abuse, 320 convictions of individuals or entities, and 106 civil actions were reported. During the first half of fiscal year 2003, the OIG accepted 15 and issued eight advisory opinions. To date, the OIG has received 174 submissions under the Provider Self-disclosure Protocol. Self-disclosure cases have resulted in 40 recoveries and 22 settlements, collectively totaling more than $60 million.

## Fiscal Year 2002 Medicare Error Rate

For the seventh and final year, the OIG reported the extent of Medicare fee-for-service payments that did not comply with Medicare laws and regulations. Based on a statistical sample, the OIG estimated that improper Medicare payments made during fiscal year 2002 totaled $13.3 billion, or about 6.3 percent of the processed fee-for-service payments. This figure is significantly less than the $23.3 billion first estimated for fiscal year 1996. The 6.3 percent estimated error rate is the same as the previous year's rate, which was the lowest to date, and less than half the 13.8 percent reported for fiscal year 1996.

Beginning in fiscal year 2003, CMS will develop a national error rate through the Comprehensive Error Rate Testing and Hospital Payment Monitoring Programs. CMS initiated these programs in response to the OIG's recommendation that CMS develop its own error rate process.

## PPS-exempt Inpatient Services

The OIG found that routine statistical analysis and medical reviews of prospective payment system (PPS)-exempt inpatient services for medical necessity and reasonableness were not being conducted. In the OIG audit report "Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," $800 million of improper payments were attributed to issues of medical necessity in PPS-exempt facilities. After the release of the OIG report, CMS notified fiscal intermediaries that they may include PPS-exempt hospitals in their reviews. However, no additional funding was provided for this expansion of review responsibility.

The OIG is concerned that the amount of oversight that will occur remains unclear, given the lack of dedicated funding and an explicit level of effort or performance goal. It recommended that CMS ensure oversight of PPS-exempt hospital services.

## Payment Disparity between OPDs, ASCs

The OIG assessed the effect of payment variation between ASCs and OPDs on the Medicare program. This variation results in Medicare paying an estimated $1.1 billion more in payments. In most cases (66 percent), OPD rates for the same service are higher than ASC rates.

Also, failing to remove certain procedure codes from the ASC list of covered procedures results in an estimated $8 to $14 million in additional program payments. The OIG recommended that rates between settings be more uniform and that procedure codes should be removed from the list of ASC-covered procedures using established criteria.

## Criminal, Civil Enforcement Activities

During the reporting time period, the OIG collected more than $1.4 million in civil monetary penalties and assessments. More than $156.7 million was recouped through False Claims Act civil settlements related to the Medicare and Medicaid programs. This included cases of upcoding, falsification of cost reports, anti-kickback violations, improper claims submission related to lack of documentation to support reported services, and claims submitted for services that were not provided or were medically unnecessary.

In one case cited in the OIG report, a healthcare provider was required to pay civil monetary penalties and enter into a corporate integrity agreement as a result of upcoding by a billing agency. Other examples of specific case citations include:

- Failure of employed physicians to appropriately document their presence during the provision of professional services by residents and interns
- Submission of claims for professional evaluation and management services whereby the physician did not provide the length of examination or degree of medical decision making required for reimbursement under the reported code
- Submission of claims by a pathology laboratory for second opinion consultations and reports that were not performed, and for tests that were not medically necessary
- Submission of claims for psychological services that contained a higher code than was necessary or included services that could not be substantiated
- Submission of claims for procedures that were not performed

## Reference

OIG. “Semi-Annual Report to the Congress, October 2002 through March 2003.” Available at http://oig.hhs.gov/ publications/docs/semiannual/2003/03SpringSemi.pdf.

## Reference

The OIG 2003 *Red Book* is available at http://oig.hhs.gov/ publications/docs/redbook/ 2003RedBook.pdf.

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