NAMDRC

WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY, CRITICAL CARE AND SLEEP MEDICINE

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The HHS Office of Inspector General is Auditing Critical Care Services

In 2019, The Office of Inspector General (OIG) of Health and Human Services, will be continuing its efforts to identify errors in provider billing in the Medicare program. The great majority of the OIG's work is focused on Medicare and Medicaid programs with roughly three quarters of its total funding committed to these two programs. This year, critical care services billed to Medicare, American Medical Association Current Procedural Terminology (AMA CPT) codes 99291 and 99292, will be audited by the OIG. While the activities of the OIG seem to be remote from our daily practice there is increasing scrutiny of all we do in the clinical setting. Congress often uses these reports when creating new legislation and they have a significant influence on policies developed by The Centers for Medicare and Medicaid Services (CMS).

Concerned about possible inaccuracies in critical care billing in the mid 1990's, the OIG performed an audit of all claims submitted to Medicare for 99291 and 99292. In the course of that investigation several large practices were targeted and penalized. In response, The American Thoracic Society, The Society for Critical Care Medicine and The American College of Chest Physicians formed an informal group to approach The Centers for Medicare and Medicaid Services to discuss differing interpretations of the AMA CPT definition of the critical care codes. After multiple meetings a mutually agreed upon definition was proposed to the AMA CPT committee and was accepted in 1999. That effort by our societies led to the formation of the current Critical Care Societies Collaborative which now includes the American Association of Critical Care Nurses. The Office of Inspector General published their report on the audit in February 2001. They commented on the provision of critical care services by provider specialties not usually associated with critical care, reimbursements for services included in the critical care service which should not be separately billed, and excessive amounts of services billed. In this final report, the OIG found that few problems existed in those specific areas, however, the report stressed that the OIG had not conducted a medical review to determine the appropriateness or necessity of the critical care services for which Medicare was billed. The current review will determine whether Medicare payments for critical care are appropriate and paid in accordance with Medicare requirements.

*The **WASHINGTON WATCHLINE** is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.*

NAMDRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

INSIDE THIS ISSUE

NAMDRC 42nd Annual Meeting and Educational Conference will be held:
March 14 – 16, 2019
Fairmont Sonoma Mission Inn
Sonoma, CA

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"NAMDRC will directly affect your practice more than any other organization to which you belong."

Previous HHS OIG Activity

Responding to an apparent increase in the use of the higher evaluation and management codes from 2001 to 2010, CMS alerted the Office of Inspector General. The OIG performed an audit of that time period and were able to identify approximately 1,700 physicians who consistently billed higher level E/M codes. Their findings and recommendations were published in a report to Congress in May 2012. Separately, the OIG provided a list of those physicians to the Administrator of the Centers for Medicare and Medicaid Services who then forwarded the list to the Medicare Administrative Contractors and directed the contractors to focus on the top 10 billers in each of their jurisdictions. Those investigations resulted in criminal convictions and penalties, civil settlements, and administrative actions against a number of physicians. This effort was considered a great success as the government recovered more than $7 for every $1 invested in the investigation and litigation.

Since the 2012 report, the OIG has continued to implement sophisticated data analytics and predictive algorithms, using funds included in the Affordable Care Act, to expand investigations into Medicare spending in both Part A and Part B programs. The new technology uses mathematical and statistical algorithms and models to identify suspicious billing behavior. This technology has improved the accuracy of data collection, reduced the cost of audits, and improved the financial return. In addition, the Department of Health and Human Services has engaged private-sector contractor teams to adapt telecommunications and banking industry anti-fraud technology to the unique requirements of characterizing Medicare spending.

The OIG has formed partnerships with private industry to pursue their investigative activities. The current platform incorporates predictive modeling technology from Verizon to scrutinize an individual provider's claims for Medicare services, routing those that raise suspicions to the OIG and others for investigation. In addition to Verizon's technology, Northrop Grumman is providing overall program management and contract oversight for the technology and the National Government Services provides Medicare fee-for-service expertise, development of algorithms for fraud prevention and hosting of information technology and infrastructure. The use of electronic health records (EHR) coupled with electronic billing and electronic prescribing has grown significantly under federal mandates. The transition to increasingly detailed and accurate data collection has been made possible by the electronic medical record program and implementation of ICD-10. Accordingly, evidence collection is moving away from review of paper files to near real time electronic surveillance. The amount of data, collected by the Digital Investigations Branch of OIG's Office of Investigations, has increased ten fold with the implementation of these systems. The OIG has found the new technology to be a powerful tool to establish medical necessity and whether an improper payment was made.

The results of this effort have been impressive and have fueled the interest in more targeted investigations such as the current review of 99291 and 99292 billings. In 2014, OIG audits and investigations resulted in recoveries of $4.9 billion in improperly spent federal health care dollars. In addition, OIG reported estimated savings of more than $15 billion from legislative, regulatory, and administrative actions supported by OIG recommendations. In 2016, the OIG was able to identify 412 individuals involved in fraudulent billing amounting to $1.3 billion in fraudulent payments.

What has Prompted the Current Review?

The Office of Inspector General investigations are usually initiated by financial concerns. In this case there is no evidence that The Medicare Payment Advisory Commission, The Government Accountability Office, or Congress have expressed an interest in possible fraud or excessive billing for critical care services. Nevertheless, the OIG will be spending time and money on this audit with an expectation of a positive return. In 2010 CMS allowed roughly $1,057,186,000 in charges for 99291. There has been a steady, but not necessarily inappropriate, increase in allowable charges since then. In 2017, according to CMS statistics, allowable charges for 99291 were roughly $1,284,937,000, a 22% increase. For comparison, in 2010 the allowable charges for the highest level initial hospital evaluation and management code, 99223, totaled $2,229,051,315 and in 2017 these charges totaled $2,185,001,736 or about a 2% decline. The general wisdom of the investigative agencies is that 10% to 15% of Medicare payments are improper. Based on past experience one would think that the OIG expects to recoup about $100 million in payments on 99291 and 99292 to make this effort worthwhile.

What Will They be Looking For?

Documentation will be key. In previous audits of medical services, the majority of "billing errors" have been related to documentation rather than fraud and abuse. The OIG will be looking for critical care codes submitted for:

- Patients in the ICU who do not meet the definition of critical care or who were critical but have improved.
- Services that did not equal or exceed 30 minutes.
- More than one practitioner billing for critical care during the same time period.
- Patients who are in the post-operative global period and the critical care is related to the surgery.
- Services billed for critical care with an office place of service code but rendered in the hospital.

Simply by virtue of their size and level of activity teaching hospitals will have a high profile in this audit. It will be important to remember that a critical care service can only be billed using the time that the attending physician was actually present for work related to the individual patient's care. The OIG audit will be looking for documentation of the date and exact time spent with the patient on all attending physician notes. If the time and date are not legibly and unequivocally documented, the service may be subject to reduction or denial. The teaching physician's counter signature of the resident's note alone will not be accepted as documentation that the attending was present during the key portion of the service. Also, it is important to remember that time spent teaching may not be counted towards the critical care service time.

Physicians are not necessarily the sole target of this investigation. The OIG has repeatedly expressed concern regarding the performance of the Medicare Administrative Contractors. The OIG has previously identified deficiencies in contractor performance and in CMS's oversight of these contractors. In testimony to Congress, the OIG has stressed that CMS needs to better ensure that Medicare payments are accurate and appropriate and since CMS relies on contractors for most of these crucial functions, ensuring effective contractor performance is a responsibility of CMS.

If your practice runs into problems with this audit, NAMDRC stands ready to assist you.

PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.

NAMDRC Membership Benefits AT *A GLANCE...*

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

https://www.namdrc.org/content/issue-advocacy

One of NAMDRC's primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC's key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

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MEMBERSHIP OPPORTUNITIES WITH NAMDRC

INSTITUTIONAL MEMBERSHIPS

NAMDRC has restructured its membership opportunities to more accurately reflect how physicians practice medicine, acknowledging that genuine "private practice" is nowhere near as prevalent today as it was even five years ago. Physicians are now employees of hospitals and medical systems.

To improve our communication with you and hospital based colleagues, we have revamped our dues structure, with individual/small practice remaining basically the same as it is today. We are renaming our group practice options into two specific categories:

Institutional Membership/Gold for institutions that identify at least seven physicians, but no more than 20 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive two half price registrations for our Annual Conference at the standard member rate.

Institutional Membership/Platinum for institutions that identify at least 21, but no more than 50 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive four half price registrations for our Annual Conference at the standard member rate.

Small Group Practice (1-6 physicians)	$295 for renewal
	$395 for new member (includes one-time $100 initiation fee.)
Gold Institutional Membership (7-20 physicians)	$1750
Platinum Institutional Membership (21 – 50 physicians)	$2500

If you are based at a particular institution, we believe this is an excellent way to bring NAMDRC and its benefits to the attention of many of your colleagues. And the aggregate cost, per membership, drops dramatically under these new membership categories.

RENEW NOW!

JOIN NOW!

Go to www.namdrc.org and join and/or renew your membership online.

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NAMDRC INSTITUTIONAL MEMBERSHIP APPLICATION

Please select the category you are applying for:

☐ Small Group Practice (1-6 physicians)	$295/year for renewal
☐ NEW Small Group Practice (1-6 Physicians) *(includes one-time $100 initiation fee)*	$395 for new member/year
☐ Gold Institutional Membership (7-20 physicians) *Includes two half price registrations for NAMDRC Annual Conference at the standard member rate.*	$1750/year
☐ Platinum Institutional Membership (21-50 physicians) *Includes two half price registrations for NAMDRC* Annual Conference at the standard member rate.	$2500/year

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person:_____

Email address: _____

Address: _____

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City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION *(Make check payable to "NAMDRC")*

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

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Billing Address (If Different From Above) _____

Printed Name_____ Signature _____

Email _____ Phone_____

USE THE ATTACHED MEMBERSHIP FORM TO LIST ALL MEMBERS OF YOUR GROUP

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NAMDRC INSTITUTIONAL MEMBERSHIP FORM

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