United Audit Systems Inc.

UASI Analysis of the OIG Work Plan

Inpatient Documentation and Coding Issues

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This white paper presents an analysis of new and ongoing initiatives under the Office of the Inspector General (OIG) Work Plan [1] and Centers for Medicare & Medicaid Services (CMS) approved Recovery Audit Contractor (RAC) reviews [2] as of March 2021. The paper focuses on inpatient initiatives related to HIM coding and documentation requirements and is not intended to review each and every active work plan item. For each relevant inpatient initiative, the paper includes a summary of the OIG and/or RAC compliance concern, the month and year of the initiative and related coding and documentation requirements. More importantly, for each inpatient initiative presented, UASI has included specific suggested compliance activities to assist our clients with their ongoing compliance efforts.

This white paper includes an analysis of the following active inpatient topics:

- Medicare Payments for Inpatient Discharges with COVID-19 (OIG)
- Deep Brain Stimulation for Tremor & Parkinson's Disease (RAC)
- Leadless Pacemaker: Incorrect Coding (RAC)
- Inpatient Hospital MS - DRG Coding Validation (OIG)

Medicare Payments for Inpatient Discharges with COVID-19 (August 2020)

Section 3710 of the Coronavirus Aid, Relief, and Economic Security Act directs the Secretary of Health and Human Services (HHS) to increase the weighting factor that would otherwise apply to the assigned diagnosis-related group (DRG) by 20 percent for an individual who is diagnosed with COVID-19 and discharged during the COVID-19 public health emergency period. The OIG will audit whether payments made by Medicare for COVID-19 inpatient discharges billed by hospitals complied with Federal requirements.

To address potential Medicare program integrity risks, effective with admissions occurring on or after September 1, 2020, claims eligible for the 20 percent increase in the MS-DRG weighting factor were required to have a positive COVID-19 laboratory test documented in the patient's medical record. Positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), consistent with the Center for Disease Control (CDC) guidelines. The test may be performed either during the hospital admission or prior to the hospital admission. For this purpose, a viral test performed within 14 days of the hospital admission, including a test performed by an entity other than the hospital, can be manually entered into the patient's medical record to satisfy this documentation requirement. For example, a copy of a positive COVID-19 test result that was obtained a week before the admission from a local government run testing center can be added to the patient's medical record. In the rare circumstance where a viral test was performed more than 14 days prior to the hospital admission, CMS will consider whether there are complex medical factors in addition to that test result for purposes of this documentation requirement.

The CMS Pricer will continue to apply an adjustment factor to increase the MS-DRG relative weight that would otherwise be applied by 20 percent when determining IPPS operating payments for discharges that report the ICD-10-CM diagnosis code U07.1 (COVID-19). CMS may conduct post payment medical review to confirm the presence of a positive COVID-19 laboratory test and, if no such test is contained in the medical record, the additional payment resulting from the 20 percent increase in the MS-DRG relative weight will be recouped.

A hospital that diagnoses a patient with COVID-19 consistent with the ICD-10-CM Official Coding and Reporting Guidelines but does not have evidence of a positive test result can decline, at the time of claim submission, the

additional payment resulting from the application at the time of claim payment of the 20 percent increase in the MS-DRG relative weight to avoid the repayment. To do so, the hospital will inform its MAC and the MAC will notate the claim with MAC internal claim processing coding for processing. The Pricer software will not apply the 20 percent increase to the claim when that MAC internal claim processing coding is present on a claim with the ICD-10-CM diagnosis code U07.1 (COVID-19). The updated Pricer software package reflecting this change was released in October 2020. Providers were directed to notify their MAC when there is no evidence of a positive laboratory test documented in the patients' medical record by entering a Billing Note NTE02 "No Pos Test" on the electronic claim 837I or a remark "No Pos Test" on a paper claim. [3]

UASI Suggested Compliance Activities

1. Ideally, hospitals should have a concurrent process to ensure documentation includes a positive COVID-19 laboratory test result. If not, identify the risk.
    - Run a report for inpatient discharges on or after September 1, 2020 (for the time frame where no concurrent process was in place) to identify cases with a principal or secondary diagnosis of U07.1 (COVID-19).
2. Conduct an audit of at least 50% of the cases identified to have a 90% confidence level in the audit results.
    - Review laboratory results for a positive lab result.
    - If no positive lab test is found, review the inpatient payment to determine if the 20% adjustment factor was received.
3. Notify the compliance department of the audit results if any payment increases were received without a positive lab test.
4. Develop an action plan that may include one or more of the following:
    - Create or revise facility CDI/coding guidelines to concurrently verify a positive COVID test.
    - Provide physician education on documentation requirements.
    - Establish a timeframe for a follow up audit to assess effectiveness of corrective action(s).

Deep Brain Stimulation 11/3/2020

Medicare will cover different types of unilateral or bilateral Food and Drug Administration (FDA) approved Deep Brain Stimulation (DBS) when medical necessity is met [4]. The types of deep brain stimulation approved for coverage include:

- Thalamic Ventralis Intermedius Nucleus (VIM)
- Subthalamic nucleus (STN)
- Globus pallidus interna (GPi)

According to CMS, for thalamic VIM DBS to be considered reasonable and necessary, patients must meet all of the following criteria:

a. Diagnosis of Essential tremor (ICD-10-CM code G25.0) based on postural or kinetic tremors of hand(s) without other neurologic signs, or a diagnosis of idiopathic Parkinson's disease (PD) (ICD-10-CM code G20) with presence of at least two cardinal Parkinson's features (tremor, rigidity or bradykinesia) which is of a tremor-dominant form.
b. Marked disabling tremor of at least level 3 or 4 on the Fahn-Tolosa-Marin Clinical Tremor Rating Scale (or equivalent scale) in the extremity intended for treatment, causing significant limitation in daily activities despite optimal medical therapy.
c. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

According to CMS, for STN or GPi DBS to be considered reasonable and necessary, patients must meet all of the following criteria:

a. Diagnosis of PD (ICD-10-CM code G20) based on the presence of at least two cardinal PD features (tremor, rigidity or bradykinesia).
b. Advanced idiopathic PD as determined by the use of Hoehn and Yahr stage or Unified Parkinson's Disease Rating Scale (UPDRS) part III motor subscale.
c. L-dopa responsive with clearly defined "on" periods.
d. Persistent disabling Parkinson's symptoms or drug side effects (e.g., dyskinesias, motor fluctuations, or disabling "off" periods) despite optimal medical therapy.
e. Willingness and ability to cooperate during conscious operative procedure, as well as during post-surgical evaluations, adjustments of medications and stimulator settings.

In addition, DBS is not considered reasonable and necessary, and therefore is not covered, for patients with essential tremors or PD who have any of the following:

1. Non-idiopathic PD or "Parkinson's Plus" syndromes.
2. Cognitive impairment, dementia or depression, which would be worsened by or would interfere with the patient's ability to benefit from DBS.
3. Current psychosis, alcohol abuse, or other drug abuse.

The affected ICD-10-PCS codes for DBS are include in the table below.

ICD-10-PCS Code	Description
00H03MZ	Insertion of neurostimulator lead into brain, percutaneous
00H04MZ	Insertion of neurostimulator lead into brain, percutaneous endoscopic
00H60MZ	Insertion of neruostimulator lead into cerebral ventricle, open
00H63MZ	Insertion of neurostimulator lead into cerebral ventricle, percutaneous
00H64MZ	Insertion of neruostimulator lead into cerebral ventricle, percutaneous endoscopic
0H85XZZ	Division of chest skin, external
0JWT3MZ	Revision of stimulator general in trunk, percutaneous
0JWT0MZ	Revision of stimulator general in trunk, open
0JQ60ZZ	Repair of chest subcutaneous tissue & fascia, open
0JQ63ZZ	Repair of chest subcutaneous tissue & fascia, percutaneous

The criteria for coverage are not new, however DBS was added to the RAC required reviews in November 2020. As with any surgery involving medical devices, the cost of providing this surgery is significant. Each DBS surgery can cost between $35,000 and $50,000, and it can increase to as much as $70,000 to $100,000 for bilateral procedures. [5]

UASI Suggested Compliance Activities

1. Identify the risk
    - Run a report for the affected ICD-10-PCS codes listed above to determine frequency of reporting these procedures in claims data
2. Assess the risk
    - Identify the expertise to perform an audit of identified cases. Consider a multi-disciplinary team potentially including ICD-10-PCS coding expertise and clinical expertise.
    - Create a data collection form to capture all of the required criteria for each type of DBS.
    - Conduct a random sample audit of identified DBS cases.

3. Record findings and categorize the risks
    - Identify and tally each error by the missing criteria elements.
4. Develop an action plan that may include one or more of the following:
    - Establish (or refine) a pre-approval process for surgery involving DBS to ensure medical necessity criteria is met prior to the surgery.
    - Develop and disseminate coder education/tip sheets.
    - Provide physician education on documentation requirements.
    - Establish a timeframe for a follow up audit to assess effectiveness of corrective action(s).

Leadless Pacemaker: Incorrect Coding 9/8/2020

Effective January 18, 2017, CMS covers leadless pacemakers when procedures are performed in FDA approved studies. CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA approved label for devices that have either:

- an associated ongoing FDA approved post-approval study; or
- completed an FDA post-approval study.[6]

Leadless or intracardiac pacemakers treat the same conditions as conventional pacemakers, but the components are combined into a single device implanted within a heart chamber. There is no subcutaneous pocket and there is no tunneled lead. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. All components have been miniaturized into a capsule-like device that is introduced into a peripheral vessel, typically the femoral vein, then advanced into the heart chamber and fixed to the chamber wall. Although these devices are commonly referred to as "leadless" pacemakers there is actually a tiny electrode at the end of the battery capsule which delivers the pacing pulse to the heart tissue.

Intra-cardiac pacemakers are currently placed within the right ventricle for single-chamber pacing. Like all pacemakers intracardiac pacemakers must be programmed and then periodically interrogated and reprogrammed.

Correct Coding includes:

1. Arrythmia diagnosis to support medical necessity
2. Secondary diagnosis code Z00.6 (Encounter for examination for normal comparison and control in clinical research program)
3. For discharges on or after 10/1/2016 a new Device value “N Intracardiac Pacemaker” was implemented. The ICD-10-PCS code for insertion of a leadless pacemaker is 02HK3NZ.

UASI Suggested Compliance Activities

1. Identify the risk
    - Run a report for the affected ICD-10-PCS code listed above to determine frequency of reporting in claims data
2. Assess the risk
    - Conduct a random sample audit of identified cases.
    - Confirm the correct ICD-10-PCS code was reported
    - Confirm that the diagnosis code Z00.6 (Encounter for examination for normal comparison and control in clinical research program) was reported.
3. Record findings and categorize the risks
    - Identify and tally each error by the missing criteria elements

4. Develop an action plan that may include one or more of the following:
    - Develop and disseminate coder education/tip sheets.
    - Provide physician education on documentation requirements.
    - Establish a timeframe for a follow up audit to assess effectiveness of corrective action(s).

Inpatient Hospital MS-DRG Coding Validation 2/1/2017

The OIG analyzed paid Medicare Part A claims for inpatient hospital stays from FY 2014 through FY 2019 and identified trends in hospital billing and Medicare payments for stays at the highest MS-DRG severity level. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same. Specifically, nearly a third of these stays lasted a particularly short amount of time and over half of the stays billed at the highest severity level had only one diagnosis qualifying them for payment at that level. Shorter stays are not inherently problematic, but the number of these stays raises questions about the accuracy and appropriateness of the complications billed by the hospital. Although the complications billed suggest sicker beneficiaries, the shorter lengths of stay point to beneficiaries who are less sick. Excluded from this analysis are certain stays that could be expected to be shorter, such as stays during which the beneficiary died. Furthermore, over half of the stays billed at the highest severity level in FY 2019 (54%) reached that level because of just one diagnosis. In total, nearly 2 million stays had just 1 diagnosis (i.e., 1 major complication/comorbidity) that qualified the stay for the highest severity level. The rest of the submitted diagnoses for these stays were considered to be either minor complications or not complications.

As a result of this analysis, the OIG recommended that CMS conduct targeted reviews of MS-DRGs and hospital stays that are vulnerable to up-coding (i.e., those that are billed at the highest severity level) and the hospitals that frequently bill for them. Specifically, CMS should target stays at the highest severity level with certain characteristics, such as those that are particularly short or that have only one major complication. CMS should also focus on MS-DRGs that have a high proportion of stays with these characteristics and on the hospitals that frequently bill them. CMS's RACs currently conduct coding validation reviews that incorporate some of these targeting strategies. However, stays billed at the highest severity level continue to increase. [7]

UASI suggests targeting some of the following MS-DRGs for audit depending on your case mix and volume:

- MS-DRGs 064 – 066 Intracranial Hemorrhage or Cerebral Infarction
- MS-DRGs 193 – 195 Simple Pneumonia and Pleurisy
- MS-DRGs 280 – 282 Acute MI Discharged Alive
- MS-DRGs 291 – 293 Heart Failure and Shock
- MS-DRGs 308 – 310 Cardiac Arrhythmias and Conduction Disorders
- MS-DRGs 377 – 379 Gastrointestinal Hemorrhage
- MS-DRGs 515 – 517 Other Musculoskeletal System & Connective Tissue OR Procedures
- MS-DRGs 637 – 639 Diabetes
- MS-DRGs 689 – 690 Kidney & Urinary Tract Infections
- MS-DRGs 870 – 872 Septicemia or Severe Sepsis
- MS-DRGs 981 – 983 Extensive OR Procedures Unrelated to Principal Diagnosis

UASI Suggested Compliance Activities

1. Select targeted MS-DRGs.
    - Run a report of top 20-25 DRGs and review for any of the above plus any additional MS-DRGs of high volume for your organization.
    - Review the most recent PEPPER reports for MS-DRGs that may be at risk for improper payment.[8]
    - Establish a prioritized list of MS-DRGs for review. If possible, review cases with short lengths of stay and one MCC/CC.
2. Develop an audit plan.
    - Decide if you want to perform audits retrospectively or concurrently.
    - Retrospective audits can be conducted in part or wholly by incorporating selected MS-DRGs into your audit plan. Problem MS-DRGs can then be incorporated into a concurrent review work queue, if warranted.
    - Concurrent coding audits should be limited in scope to address specific areas impacting quality reporting and reimbursement. Timeliness is critical as these accounts are held for additional review prior to releasing the bill. Turnaround time to release cases should be short, 24 to 48 hours, to minimize the impact to DNFB (discharged not final billed) daily/weekly goals.
    - Audits can be conducted either internally or externally. Internal audits should be conducted based on the availability of staff with appropriate technical expertise (in coding and clinical documentation) and proficiency in communicating feedback through written reports and educational sessions.
    - Determine the audit scope, considering opportunities for cross-departmental collaboration to address multiple risk factors. For example, clinical documentation improvement (CDI) staff may collaborate with coding staff to conduct an audit on sepsis DRGs, addressing both coding and clinical documentation compliance perspectives.
3. At a minimum inpatient audits should measure and validate
    - Accurate identification of principal and secondary diagnosis and procedure codes in accordance with official and facility-specific coding guidelines
    - Accurate MS-DRG or APR-DRG assignment
    - Accurate POA indicator assigned for all non-exempt diagnosis codes
    - Accurate Discharge Disposition assignment
4. Develop corrective action plans, including physician and coder education, based on audit findings

End Notes

1. OIG Work Plan: https://oig.hhs.gov/reports-and-publications/workplan/index.asp

2. CMS, Approved RAC Topics, last revised 6/16/2020, accessed on April 10, 2021. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Approved-RAC-Topics

3. Medicare Learning Network. September 11, 2020. "New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHS), and Inpatient Rehabilitation Facilities (IRFs) due to provisions of the Cares Act." MLN Matters number: SE20015 Revised. https://www.cms.gov/files/document/se20015.pdf

4. CMS, Medicare Coverage Database. National Coverage Determination (NCD) for Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (160.24). Publication Number 100-3. Effective date 4/1/2003. https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=279&ncdver=1&bc=AAAAEAAAAAAA&

5. Okun, Michael S., Zeilman, Pamela. (n.d.) "Parkinson's Disease Deep Brain Stimulation: A Practical Guide for Patients and Families." Parkinson's Foundation. https://www.parkinson.org/sites/default/files/attachments/Deep-Brain-Stimulation-Guide-Parkinsons.pdf

6. CMS Manual System. July 29, 2017. Pub 100-03 Medicare National Coverage Determinations: Leadless Pacemakers. Transmittal 201. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R201NCD.pdf

7. U.S. Department of Health and Human Services, Office of Inspector General. February 2021. Data Brief, OEI-02-18-00380. "Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny." https://oig.hhs.gov/oei/reports/OEI-02-18-00380.pdf

8. Program for Evaluating Payment Patterns Electronic Report (PEPPER). Short-Term Acute Care PEPPER User's Guide, Thirty-second Edition, effective with Q4FY20 release. https://pepper.cbrpepper.org/Portals/0/Documents/PEPPER/ST/STPEPPERUsersGuide-Edition32-508.pdf