OIG Report Updates

Aug 15 2018

Posted By: Stacy C. Gerber Ward

Practice Area: Health Law & Healthcare Billing and Collection & Regulatory Compliance and Fraud and Abuse

OIG Report: Outpatient Physical Therapy Services

Outpatient physical therapy has been under considerable scrutiny by Medicare for many years. Demonstrating its continued focus on therapy services, the Office of the Inspector General for the Department of Health and Human Services (OIG) released a report of an audit which found that 61% of sampled Medicare claims between July and December 2013 did not comply with rules requiring that services be medically reasonable and necessary, be submitted with proper coding, or submitted with sufficient documentation.[1] Providers of outpatient physical therapy services should closely review the report and consider using its metrics for reviewing services billed to federal health care programs.

Medicare Part B covers outpatient physical therapy services. In order to qualify for Medicare Part B coverage, outpatient physical therapy services must be medically reasonable and necessary; provided in accordance with a plan of care established by a physician or qualified physical therapist and periodically reviewed by a physician; and the need for such services must be certified by a physician.[2] To be deemed reasonable and necessary, physical therapy services must meet each of the following conditions:

- The services provide specific and effective treatment for the patient's condition under accepted standards of medical practice,
- The services are of such a level of complexity and sophistication or the condition of the patient is such that the services required can be safely and effectively performed only by a therapist, or under the supervision of a therapist,
- It is expected that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state, and
- The amount, frequency, and duration of the services must be reasonable under the acceptable standards of practice.[3]

In addition, Medicare coding requirements for timed procedures include reporting units in 15-minute intervals based on the number of times the procedure is performed.[4] For untimed procedures, one unit of service is appropriately reported by a provider regardless of the number of minutes spent providing the service.[5] Providers also must use certain functional reporting codes (G Codes) and severity modifiers that provide information about the beneficiary's functional status.[6] Finally, Medicare requires that outpatient physical therapy services be provided in accordance with a written care of plan established before treatment begins[7]; therapists are required to recertify the plan of care when a significant modification is needed or at least every 90 days[8]; and therapists must create a treatment plan for each service that includes the type, amount, frequency and duration of the physical therapy services; indicate a diagnosis; and state the anticipated goals.[9]

In its recent audit, the OIG reviewed 300 claims and found that 61% of the claims reviewed did not meet all requirements. Specifically, the OIG found:

- 91 claims where the medical record did not support the medical necessity of the services.
- 89 claims where the amount, frequency, and duration of the services were not reasonable and consistent with the standards of practice.
- 30 claims where there was no evidence that the services provided would have been effective.
- 28 claims that did not require the skills of a therapist.
- 86 claims where the number of timed units claims did not match the number of units documented in the treatment notes.
- 78 claims that were missing required functional reporting information.
- 59 claims were incorrectly coded.
- 112 claims for services that were not provided in accordance with one or more Medicare documentation requirements.

Based on the sample reviewed, the OIG estimated that Medicare overpaid therapists $367 million. As a result, the OIG recommended that the Medicare contractors notify providers that were found to be noncompliant in this study of possible overpayments. In response to this report, providers of outpatient physical therapy services should review their policies and procedures to ensure compliance with Medicare's requirements for outpatient physical therapy providers. Providers should also keep in mind that, under the 60 day rule, upon receiving credible information of a potential overpayment, providers must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayment within 60 days of identifying the overpayment.

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[1] Department of Health and Human Services, Office of Inspector General, "Many Medicare Claims for Outpatient Physical Therapy Services Did not Comply with Medicare Requirements," A-05-14-00041 (March 2018).

[2] 42 U.S.C. §§ 1862(a)(1)(A), 1861(p), and 1835(a)(2)(C) and 42 C.F.R. §§ 4110.60 and 410.61.

[3] Medicare Benefit Policy Manual, Chapter 15, § 220.2.B. (Rev. 63).

[4] Medicare Benefit Policy Manual, Chapter 15, § 220.3A.

[5] Medicare Claims Processing Manual, Chapter 5, § 20.2.

[6] Medicare Benefit Policy Manual, Chapter 15, § 220.4 (effective 1/1/13).

[7] 42 C.F.R. § 410.60.

[8] 42 CFR § 424.24(c)(4) and Medicare Benefit Policy Manual, Chapter 15, § 220.1.3C.

[9] Medicare Benefit Policy Manual, Chapter 15, § 220.3E.

OIG Report: Cardiac Device Credits

The Office of Inspector General for the Department of Health and Human Services (OIG) recently issued a report that identified significant overpayments related to cardiac device warranty credits. Cardiac devices generally have lifetime warranties which provide hospitals with a full or partial credit for the cost of the failed or recalled device or with a replacement device at no cost. When a hospital receives one of these credits, federal rules typically require a reduction in any in-patient or out-patient payment by Medicare. An OIG report released earlier this year[1] reviewed 296 hospital claims involving warranty credits for cardiac devices and none of the claims were properly adjusted to reflect those credits, resulting in a $4.4 million overpayment to the subject hospitals. Hospitals that perform cardiac procedures should consider incorporating this OIG report into their compliance risk assessment process.

Medicare regulations require reductions in inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS) payments for the replacement of an implanted device if: (1) the device is replaced without cost, (2) the provider receives full credit for the device cost, or (3) the provider receives a credit equal to 50 percent or more of the device cost.[2] In order to correctly bill for a cardiac device for which the hospital received a payment or replacement under a warranty, hospitals must code their Medicare claims with a combination of condition code 49 (product replacement within product lifecycle), or 50 (replacement for a known recall of a product) along with value code FD (a credit of 50% or greater was received from the manufacturer for a replacement medical device) to communicate the amount of the credit or cost reduction.[3]

When the OIG reviewed the qualifying claims in its audit covering the years 2008-2013, it found that none of the hospitals complied with Medicare reporting requirements. In all 296 claims, which included inpatient and outpatient procedures, hospitals that received reportable manufacturer credits did not report the condition codes, value code, or modifiers that would reduce the payment as required. CMS is unable to detect when a procedure was the result of a device recall unless condition code 49 or 50 are used. These codes are only required when an FD value code is present on the claim, but because hospitals often failed to report the FD value code, the codes were not used. Because of these errors, Medicare paid hospitals $7.7 million for claims involving cardiac device warranty claims when the hospitals should have received $4.4 million.

As a result, OIG recommended that: (1) Medicare contractors notify the hospitals whose claims were evaluated in their review so that the hospitals can conduct their own review and determine if they were overpaid for the procedures, and (2) educate providers about the use of the FD code and condition codes.

Providers who perform procedures involving cardiac devices should consider incorporating this report in their risk assessment process and review their policies or practices to determine if, when they receive a credit of over 50% or a replacement at no cost for any recalled cardiac devices, they properly report the condition and value codes. Providers should also keep in mind that, under the 60 day overpayment rule, upon receiving credible information of a potential overpayment, providers must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayment within 60 days of identifying the overpayment.

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[1] Department of Health and Human Services, Office of the Inspector General "Hospitals Did not Comply with Medicare Requirements for Reporting Certain Cardiac Device Credits," A-05-16-0059 (March 2018)

[2] 42 CFR §§ 412.89 and 418.45.

[3] CMS Medicare Claims Processing Manual, Pub. No. 100-04.

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