MA OIG Coding Audits

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SPEAKERS

Janessa Nelson, Wendy Rubas, Intro Music

I **Intro Music** 00:03
Welcome to Working Smarter, concise compliance conversations featuring Wendy Rubis. Sponsored by VillageMD, primary care physicians practice medicine, the way you always wanted. Data, resources, and clinical decision support to care for your patients inside and outside the exam room.

W **Wendy Rubas** 00:24
Hi, welcome to Working Smarter. I'm Wendy Rubis, General Counsel of VillageMD. I'm here today with Janessa Nelson. Janessa, How are you?

J **Janessa Nelson** 00:32
Hi, good. Thanks for having me back.

W **Wendy Rubas** 00:34
And today, we're, we're we have a new episode of the scoop. We'd like to call it the scoop. Whenever we're talking about enforcement, we've got some enforcement to share today.

J Janessa Nelson 00:44

Yeah, you know, we've been seen some activity recently, Wendy. It paused a lot in 2020. Do you know the reason why?

W Wendy Rubas 00:54

Well, there's a couple of things that are really interesting going on right now. And the first thing is that during COVID, enforcement really was on a reprieve. And in part that was because courts were really not in session as much. And there was many delays in cases, for obvious reasons. And also, just because of the healthcare crisis, all audit activity really ceased during COVID. And so we had a long period of quiet really, in enforcement. What I've noticed in the last, I really feel like it's been 30 to 60 days, it's it feels like a change is, is it's kind of like we're back. And so we're seeing a lot more activity. At the same time, of course, we have a new administration, cabinet members have now been appointed. And they're starting to put out their priorities, and we're seeing activity there as well. And so those two factors are coming together. And that's really why we're back with the scoop at this time.

J Janessa Nelson 01:55

Yeah, so maybe we should level set and give some background to our listeners, you know, there's there's a lot of different federal agencies that are involved in these enforcement cases. So can we talk about how they're different how they work together, and what we typically see, related to this.

W Wendy Rubas 02:11

It does get confusing. And so we sort of call it the enforcement sandwich. Because there's a number of different avenues that these cases can emerge. So the first is the Department of Health and Human Services Office of Inspector General. And they do a number of different audits and reports. Many times if they do an audit, they can find an overpayment, and then they refer that to CMS. So that does become an actual overpayment. But that part is enforced by CMS. One thing that's very controversial we'll talk about later, as many times you see extrapolation in those cases. Another totally different world of enforcement is from the DOJ. And that's really the obviously the judicial branch. So these are court cases, often these emerge from a whistleblower, although, as we heard from Linda was insky, in our recent podcasts that is starting to change. But those go through a court process, we know that that can include criminal charges and personal charges, which isn't really the case with the OIG. In addition, CMS has a number of

different audit programs that reach out to physicians. Here at village, we do a monthly compliance newsletter. And we were just kind of going through recently the different kinds, but the main thing to know is they can come from contractors, or different types of payment reviews, more and more of this is getting sophisticated and based on data, which is actually a good thing and a lot of ways because you get feedback a lot more real time. And then lastly, of course, in Medicare Advantage, payers are required to do their own procedures, as they sort of step into the shoes and administer Medicare dollars. And so many times they'll do audits as well. So there are a number of pathways where these kinds of matters and particular Medicare Advantage matters can originate.

J Janessa Nelson 04:07

Got it. That was a helpful explanation. Maybe we should talk a little bit about what we're seeing from the DOJ. We had a great podcast with Linda Wawzenski who shed some light on that but maybe our if someone didn't listen to that episode, what are the highlights?

W Wendy Rubas 04:23

Well, every year the DOJ puts out a report. It's kind of like a corporate responsibility report in a way. It's kind of like a year and review. Here's what we did this year. So we do have the report from 2020. We know that 2.2 billion was recovered from fraud and false claims and 83% of that is from health care. That number is slightly down likely due to the pandemic. Interestingly, we have numbers of cases and we've got a chart if you're watching along and you can see that the number of whistleblower cases was up significantly, which is interesting because whistleblowers We're sort of in the news during the year. And we had, you know, a lot of mixed messages coming from the federal government on whistleblowers. But anyway, we had 13 a week on false and fraud and false claims, which is just astounding. But in addition to that we heard from Linda was in scan, we can see in the data as well. DOJ is initiating many of their own cases, more than ever, for you many years. If you're looking at this chart, you can see for many years, years, yeah, it really this almost enforced itself, and very little effort was made to go out and initiate cases, well, that's changing now. And the DOJ told us on our podcast, and they've said in other forums, publicly, agents have their own set of data. And they can find their own patterns and bring their own cases directly out of those data packets. And so that's just a bit a major change. We know that they're the tactics and methods that they're using, includes special enforcement units. And, and we're seeing, and they're telling us that they've got those for COVID-19. Also elder abuse. And of course, there's a lot of activity going on around opioid abuse. But they also have this this rapid response teams, which mobilized quickly on a special project, and we're seeing a lot of that in telemedicine, lots of telemedicine, enforcement and abuse for obvious reasons. But a new thing that we've

seen in the last year or two is cases on electronic health records, where some of the major big brand names have had penalties. So we'd like to hear from our listeners, if you want more detail about those electronic health records cases, you know, send us a note or give us a message on LinkedIn. And let us know if you'd like to hear about those cases. Janessa, what's the email?

J Janessa Nelson 06:46

They can email sharon@villagemd.com. So Wendy, you know, we've done a previous podcast on the MA enforcement where we talked about three cases, I believe two are still ongoing. I just think that we should just remind listeners that are watching these, right.

W Wendy Rubas 07:02

So the DOJ, as we said, that's a that's a judicial enforcement, we've got a couple cases to watch here, they were brought in 2020, they're still pending, we're in there's a lot of procedural things going on motion, practice, your venue, jurisdiction, etc. So not a lot development there. The main thing to take away from these cases is that if you're doing audits, natural language processing or other automated audits, you have to be careful that your protocols that you're using are making adjustments for what you find up and down. It's not just an effort to, you know, paste on codes. And when you find things that you know, are wrong, you have to fix them. And most of these cases, as I said, come from whistleblowers. And so you know, we always talk about listening to your people if they have concerns. One thing to note is we've also got on here, there's a medical group that had a case, that's a little bit unusual, we usually see these cases, going directly to payers, but basically what they're telling us is, if a medical group, you know, has practices that they know are wrong, and they're, they're, you know, basically juicing their codes, the DOJ will join a case or go after a medical group directly. So that's kind of been a question for some time. And that's, that's been made clear from this beaver Medical Group case.

J Janessa Nelson 08:21

Great. So we talked about the DOJ, let's talk about what we're seeing from OIG because they recently released their enforcement priorities in April. So when do you what were we expecting these or is there anything on here that we didn't expect?

W Wendy Rubas 08:36

Yeah, this is really interesting. We just got these in April, we have a new, obviously,

Secretary of the Department of Health and Human Services. First time in history, I think he's not a physician. And he's he's actually a litigator, and he's got a record of very aggressive enforcement. So it's going to be interesting to watch. When I look at these priorities, there's a lot on here we were expecting to see COVID. Enforcement telehealth I mentioned already. We know there's tons and tons of activity around opioid and substance abuse, fraud, and also Medicare Advantage enforcement, which really isn't a surprise, this was on the OIG work plan. We've been hearing for some time that this was really going to start to ramp up just because so many more patients and there's so much more activity moving to Medicare Advantage. What is surprising about this plan, there are some things in here that are new or a little bit unexpected. Patient Safety in nursing homes is a priority, which I think we could surmise maybe comes from what happened with COVID. Advancing health equities is on here. And really, I can't think of a time in my career where I've seen that as a priority. I interpret this to mean, they're going to be looking at Medicare and Medicaid programs to make sure that they're equitable, not so much app providers. modernizing compliance guidance, which is welcome. And I would tell the OIG if you're listening, my name is Wendy Rubis, I would be more than happy to give, participate in the modernizing compliance guidance looks like they're going to be looking for guidance from industry. So I'm raising my hand. But also cybersecurity is on here, which is a little new, we know that we have always had cyber security rules. But the idea that the OIG, is going to be targeting people who aren't prepared as new. And the inflammation blocking really surprised me. That's a new rule. We've got a podcast on it. I didn't expect to see that as an enforcement priority during this year, so that's but that's really an overview of where the OIG is going,

J Janessa Nelson 10:39

OIG has announced that they're going to be releasing the results of several different audits throughout this year, when he is at seven and nine. Is that what we've heard?

W Wendy Rubas 10:49

We're expecting to see seven to nine. Yeah, they've released four so far. And I think we're going to talk about three of them today that are kind of useful in terms of, you know, what we're looking at on these is, is what can we learn and enhance our own program to make sure that we're staying on top of where enforcement is, and so that's really why we like to look at these.

J Janessa Nelson 11:12

Right, so let's start with the in chronological order. The first one that we got in February, I believe that this is with Blue Cross Blue Shield of Michigan, is that correct?

W Wendy Rubas 11:20

Yes. So this was an audit in February. This was the first one they published. This was an audit of high risk codes.

J Janessa Nelson 11:27

But Wendy, what does that mean? They only looked at specific codes, or they looked at, they only looked at specific charts. Can you, can you clarify?

W Wendy Rubas 11:35

That's a good question. They described a process that they went through in order to determine high risk codes. By the way, these high risk codes are not a surprise, we've already known that these are considered by high risk, I mean high error, these are likely to be an error, or they're subject to misunderstanding or even abuse. Okay, so they but they did have a process that they used to determine that. And then what they did is they determined a statistically valid sample of just these codes. So they didn't pull all charts, they only looked at charts with these codes. Got it, I think that's helpful for everybody to know. And we're gonna put them in two buckets. Okay. There's a couple of codes, types of codes that really are the reason they're high error is because they describe an acute condition, you'd be unlikely to have that condition unless you're in the hospital. Okay, that's acute stroke and acute heart attack. And so the era that they're defining is, and this is interesting to kind of think about what they're doing is they're saying, you have this code, but that beneficiary was not in the hospital, there was no corresponding hospital claim. And so as a result, we assume it's an error. Okay, that's the acute conditions bucket. Then we have this other bucket, which is really, we we have this code, but there's no evidence that they were treated for this. And so basically, these are this is my words, not the OIG. But, but basically, the condition is coded as too severe, or there's no evidence of the condition. And that is an embolism of vascular claudication. And major depressive disorder.

J Janessa Nelson 13:12

A lot of that comes around them not being prescribed medication, it looked like so they were looking at the medication list and saying, well, you're not actually treating via

medicine for this coondition

W Wendy Rubas 13:23

So one interesting thing is if you know, we can say is on the major depressive disorder as an example. Not only does it say it wasn't ordered, but it says that the medication wasn't dispensed, which, of course, many times physicians don't actually know that, whether that was dispensed. I don't know how a plan would say, well, a physician and a face to face visit diagnosis, but they didn't get a medication. So that's a little bit surprising to see that but but this is basically under a category of diagnose but not treated. So they think that these are overstated conditions. So what you see here is 100, the sample size was 248.

J Janessa Nelson 14:04

There were 188 errors, which is a 75% error rate, by the way, that's really high.

W Wendy Rubas 14:10

Yeah, that's really high. The OIG recommended repayment of that money, they also recommended that that this particular party, go back and identify other high risk diagnosis that were in this report that will for other periods. So this was an audit period for, you know, a defined year. They suggested you now need to now that you know you have this problem, you need to go to other periods and do that as well. And then finally, improve your compliance program. And so in this case, the party being audited did not actually dispute the finding.

J Janessa Nelson 14:51

So Wendy, how do you get from 188 errors to $14.5 million?

W Wendy Rubas 14:57

Great question. And the answer is the sad, sorry, math of extrapolation. And so what that means is an error rate is determined. And then it's applied to an entire body of claims over a period of time. So they don't review each and every one. But they apply an error rate across a body of claims. And so this is very high on the pain scale. Because it raises the stakes exponentially. It means that if you disagree on two or three or four out of 200, it has an exponential change. It's very controversial. We could do a whole separate conversation about it.

J Janessa Nelson 15:37

Let's look at the next one that we saw that came in during April of this year, I think it was with Humana. So what did we see here?

W Wendy Rubas 15:46

Okay, totally different audit methodology here, you see a sample size that's much bigger, this 1525. And the reason it had to be bigger to be valid is because they're not just looking at those high error codes, they're looking across all codes, you see a much lower error rate 13% error, we would normally have an error tolerance in a case like this anywhere to up to probably 5%. We can talk a little bit more about that later. But but here that was 13%. We've got a visual for you can kind of see like, you might look at this and go okay. Not bad. But but with extrapolation. And again, extrapolation not just across a subset of claims across all claims that took them quickly up to 197 million. So a huge, a lot of huge amount that they were demanded.

J Janessa Nelson 16:42

Yeah, and I think that we have a breakdown of those errors. So the largest bucket it look like we're 166 didn't have records that supported the code. So you know, either they didn't have a treatment plan, or, you know, the the medical record wasn't robust enough to support that code. And that, that is, that's a huge amount, actually. And then 18, we saw 18, were actually overcoated. They, you know, when they did their audit, they, after looking at the record, they evaluated that they there should have been a lower code. And then 79 had other problems, like it wasn't signed, they can find the record, which is always a bad day. And then interestingly enough, they actually identified the two were undercoated, which I think means it was probably a pretty good audit. Most of the time, when you do an audit, you're expecting to get both over codes and also under codes. But I mean, obviously, we want the under coded to be a little bit more than a little sliver, right?

W Wendy Rubas 17:46

So in this case, obviously, there's this huge overpayment. The OIG also recommended that that this particular payer, enhance its procedures to detect compliance, they did not make that other recommendation, they did not say, now you need to go into other periods, just for whatever reason, I don't know why, but, but they did say you have to enhance your compliance program. In this case, the payer vehemently disputed the findings. And there is some controversy about what they, you know, they made, they made some claims that probably do have some veracity. We're gonna see controversy about some of the way

that the extrapolation was done, you always have controversy about that, we're gonna see some back and forth about when coders disagree, and this is the kind of thing that just makes providers crazy, is that when you're talking about high stakes like this on an extrapolation, and you have claims where two different coders did not agree, it's very, very challenging to extrapolate in that case. And so we're gonna see that get debated that was an issue in the past with the OIG audit as well. And then there's just some other, you know, just procedural claims that they made. So this is hotly disputed and controversial. This isn't over, in my view.

J Janessa Nelson 19:10

Yeah, I think we're, we're probably still gonna see a large fight into on this specific audit. So the last audit that we're going to talk about came in May of 2021, with Anthem. And I believe that this is very similar to what we saw from the February BlueCross, BlueShield. audit.

W Wendy Rubas 19:28

Yes, very interesting. Same thing, high risk codes. And, and in this case, the OIG made a statement at the beginning of their summary. And they said, most of the sample had errors. Now, it's a little it's slightly lower than the other one. It was a 60% error rate. I think, that error rate, though, it's not a good area, but what was the other 175 85%? Yeah. And you can see here, if you're watching along, we have a graph. This was this came right out of their report. similar kinds of cases where we have the bucket for acute, and then the bucket for not supported by the treatment plan. In this case, the OIG recommended the same as they did in the original one we talked about where they directed the payer to go back and look at other periods. And they also, you know, said you need to improve your compliance program, the oddity the payer here, did dispute these findings, and objected to in particular, the idea that they have to go into these other periods and refund and they objected to the idea that they need to improve their compliance program, among other things.

J Janessa Nelson 20:43

Yeah. So So when did let's summarize you know, what, what did we learn from these three audits that have been released so far? What should providers know? How should they proceed moving forward?

W Wendy Rubas 20:57

Well, one of the things that is a takeaway, we like to say it's a good time to be a VillageMD. And, and then, and this applies here, because at VillageMD, we have you know, and we are in have at the core of our mission, our providers. And really, these, these codes are used for reimbursement. But they're at their core, they're clinical in nature. And so they really need to come from a provider from a physician or provider, as part of their face to face visit, and they they're diagnostic. And so the bottom line to all of this is, if if the diagnosis is correct, and accurately describes the patient's condition, for the most part, it's going to be okay. If If a physician diagnosis a patient with one of these conditions, they're likely going to be recommending or trying to recommend treatment because these only become HCC codes, because they're likely to be serious and cause, you know, expense. And so. But the core of the compliance here is clinical, really, the other takeaways aren't new. But they're worth repeating that all providers, payers, whoever is involved in the chain of this really needs to just make sure they have procedures for audit accuracy, it's recommended that you do audits for these high error codes. And there's different ways to do them. Some of them are easier than others. But going forward, they're going to be expected, they're letting us know that they're expecting us to detect if there's misunderstandings about these codes. Many times it might be somebody wrote acute stroke, and they meant to write history of stroke, or you know, could be a keying error. And so they're just expecting us to find those. And then the last thing, of course, is, it's always good to have an open dialogue with or so that people feel like they can report problems and ask questions. That's a big part of our culture here at VillageMD. That's always an important part of compliance with any kind of billing, but especially in this controversial area.

J Janessa Nelson 23:03

Great, I think that those are important lessons for everyone to take away. And we'll just keep watching these, you know, there's a lot more that's going to unfold throughout 2021.

W Wendy Rubas 23:13

So So Janessa, we have some enhancements to the podcast, why don't you tell our listeners about those?

J Janessa Nelson 23:20

Right, yeah. So you know, we've had some feedback, and we're listening to you and to any of our listeners. So we have made all of our podcasts moving forward, we'll have closed

captioning on them to allow for, you know, whatever different listening or watching types that you are. And then we also will will have a transcript available on our website, which is vmdworking smarter.com, so you can always access our transcript on our website. And then we're also you know, going to make sure that we're publishing our key takeaway. So if you're interested in bringing something with you, or it's a helpful guide, as you're watching or listening, feel free to download that as well. And then obviously, we think that this is great, and we hope that all of you enjoy listening. And so we encourage you to like subscribe, and also we would love a comment on whatever channel or whatever way that you watch or listen to this podcast.

W Wendy Rubas 24:23

Janessa, Thank you so much for joining me today. And like you said, we'll be back with more information as this develops.

I Intro Music 24:30

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