Strategic Interventions: July

The Strategic Interventions newsletter is meant to provide your hospital's financial leaders with practical and effective ideas for improving your finances. They are meant to provide actions to take to improve your hospital's identified long-term financial aims and interests. They may come from industry experts in the form of simple reminders of the "tried and true," new ideas, or shared best practices from other hospitals – and are meant to provide you and your team with check points along the way the "journey to financial improvement." This month, Sandy Sage will share some recommendations for healthcare billing staff and how to meet the expectations set forth by the Office of Inspector General (OIG).

Strategic Interventions: *Is the OIG looking at you?*

Healthcare billing staff work hard to get claims past the edits, transmitted, and cash back to the hospital. They are under constant pressure to move those claims. The weight of a hospital's cash flow is usually squarely on their shoulders. Do you know what your billing staff is doing to get past the billing edits?

The Office of Inspector General (OIG) has identified some areas at high risk for fraud and abuse. Here are some of them related to healthcare billing:

- Billing for items and services that are not documented
- Unbundling services and supplies
- Failure to properly use modifiers
- Billing for discharge in lieu of transfer
- Outpatient services related to inpatient stays
- Knowing misuse of provider ID numbers
- Inadequate resolution of overpayments
- Inappropriate balance billing
- And more…

Let's focus on the first three risk areas.

- **Billing for items and services that are not documented**
- **Unbundling services and supplies**
- **Failure to properly use modifiers**

These three are done every day in hospital business offices across the country. The OIG recommends a strong compliance program and written standards of conduct for billing and coding staff. The OIG are aware of the risks and are watching closely to identify hospitals that are out of compliance.

Here is an example of one claim and one action that violates all three of those risk areas.

A patient is seen for lab testing. The physician order is for a CBC (CPT 85025), a basic metabolic profile

(CPT 80048) and a Calcium, total (CPT 82310). When the claim drops in the billing system with the codes 85025, 80048 and 82310, an edit alerts the biller that there is a conflict with 80048 and 82310. No problem this happens every day, the biller puts a modifier 59 on the CPT code 82310 and the claim flies past the edits and is transmitted to the payer. The claim is paid, and everyone is happy.

Not so fast. CPT code 80048 is a panel of tests and included in that panel is the CPT code 82310. What you have just billed is two calcium tests on the same date of service, but only one was performed. You have just committed fraud by **billing for a service not documented, unbundling a test, and improperly using a modifier.**

And just that easy you could be at risk for an audit and sanctions from the OIG that could lead to fines, other penalties and expulsion from the Medicare and Medicaid program. Adding a modifier 59 to CPT 82310 would not be correct in this case even if the calcium had been repeated. The overuse of this modifier is high on the radar for OIG compliance audits. Yes, it will get the claim past the edits for billing, but in an audit it will be noted that the documentation does not support what was billed. Your billing staff cannot be expected to know or to understand the clinical side of a claim and the codes being added to the account. However, years of manipulating claims has become second nature to billing staff; it is not unusual, but it is fraudulent.

It is important to know if this is happening at your hospital. Please take some time to sit down and watch your billing staff perform their jobs. It is an eye-opening exercise that all CEOs, CFOs, and Business Office Managers should participate in.

Your hospital should have compliance policies in place that indicate that all diagnosis and procedure codes are based on documentation in the record. All claims that are rejected due to diagnosis or procedure codes should be reviewed, by the coding department, prior to any claim manipulation by billing staff. As errors are found, corrections to the revenue cycle can be made to avoid similar errors in the future. Implement and follow compliance safeguards related to the high-risk areas of charging, coding, and documentation.

Billing staff should understand that it is not, and should not be, their responsibility to change, add to, or take from codes that are on the claim. Units should not be changed by billing staff. If errors are triggering edits, your policies and procedures should address this, as well as instruct the billing staff on their standards of conduct and processes to follow on each.

Your hospital employees should be well versed in Medicare Fraud and Abuse definitions and examples, in order to avoid putting them and the hospital at risk. Visit HTHU.net for courses related to fraud and abuse and how to avoid an OIG audit.

https://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

If you have questions or other items related to this article, please contact Sandy Sage at sandy.sage@hometownhealthonline.com. In addition, if you have best practices related to financial improvement and strategies for success, we invite you to share what has worked for your hospital!

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IDPH Iowa Department of Public Health

PURPOSE:
The Rural Hospital Learning Opportunities Program (RHLOP) exists to support Iowa's CAHs in activities that will improve their financial and operational outcomes.

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