Report on
MEDICARE COMPLIANCE

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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

OIG Will Audit DRGs With Mechanical Ventilation; Time Depends on Hours, Not Days

Auditors have been eyeing COVID-19 diagnoses and sequencing, but related MS-DRG risks are now under the microscope, with the HHS Office of Inspector General (OIG) adding inpatient claims with mechanical ventilation to its Work Plan.[1] Maybe that's not a shocker, considering the fact that the use of mechanical ventilation has skyrocketed because of the pandemic, and MS-DRG reimbursement jumps when patients with respiratory diagnoses or sepsis are on ventilators for 96 hours or more, experts say. OIG will review claims to determine whether hospitals billed the higher-paying MS-DRGs for patients who didn't cross the 96-hour threshold, a calculation that may be easier said than done for hospitals.

"COVID has contributed to the uptick in the utilization of vents, especially in the beginning of the pandemic," said Maggie Naawu, a specialist master at Deloitte Advisory. "Since there are different levels of payment for vents based on the duration and whether or not sepsis is a factor, the OIG is probably looking to recoup some money on the accuracy of vent hours coded."

Beneficiaries must be on the vent for 96 hours or more consecutively for MS-DRGs 207 (respiratory system diagnosis with ventilator support 96+ hours) and 870 (septicemia or severe sepsis with mechanical ventilation 96+ hours). If they're ventilated fewer than 96 hours, the DRGs are 208 and 871, which pay considerably less. For example, the MS-DRG for a sepsis patient who is on mechanical ventilation

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Confusion Over IPO List May Cause Noncompliance; Consider A Closer Look at Code Definitions

Hospitals may feel like they've gone to crazy town when they find procedures on the inpatient-only list (IPO) that were dropped years ago, before CMS began the elimination of the IPO list and then changed its mind in the 2022 outpatient prospective payment system regulation finalized Nov. 16.[1] But it isn't the hospitals; the IPO list uses the CPT short descriptors, and it may take extra effort to figure out which procedures are being performed and ensure they get the right code from surgeons, an expert says. A lot rides on this because Medicare only pays for procedures on the IPO list when they're performed on inpatients.

A classic case is total hip arthroplasty (THA). It was moved off the IPO list in 2020, before CMS started phasing out the IPO list, a move it has reversed, according to Ronald Hirsch, M.D., vice president of R1 RCM, who spoke at a Dec. 2 webinar sponsored by RACmonitor.com.[2] If hospitals look only at Addendum E, the IPO list in the OPPS rule, it seems like THA is still there, he said. For the sake of compliance and revenue, hospitals have to do a more comprehensive analysis, looking at Addendum B, the all-surgeries list, and their coding book, to nail down what's truly on the IPO list and what's in the realm of the two-midnight rule, he said. It sounds counterintuitive to say looking at the inpatient-only list isn't adequate, but Hirsch said that's how it's playing out.

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"Look up surgery on Addendum B to make sure [surgeons] gave us the right code," Hirsch said. "You are treading on thin ice if you only look at the IPO list, because the short descriptor is not very descriptive and rarely clearly portrays what surgery is indicated by that HCPCS code. In many instances, such as total hip arthroplasty, there are two codes with the same short descriptor. That cues you to say, 'I better figure out which one my surgeon is doing.'" He points to codes 27130 and 27132, both of which have the short descriptor of THA.

To clarify, THA is off the IPO list, but hip revision is going back on the IPO list Jan. 1, when the OPPS rule takes effect. With a hip revision, the patient has already had hip surgery and the hardware is in their body, but the surgeon will go in to revise or replace it, Hirsch said. "That's different than if the patient had their own bones. It's more complex." But things can easily go awry because the physician may schedule a hip replacement but perform a hip revision. If physicians think the surgery isn't on the IPO list, they may not write an inpatient order, depending on the patient status the surgeon thinks is medically necessary, and then the hospital won't get paid if the physician opts for outpatient. Hirsch noted in the final OPPS rule that at least 1,800 surgeries were performed for free in 2020 in the absence of an inpatient order.

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When it eliminated the phased-out reversal of the IPO list, CMS restored almost all 298 of the mostly musculoskeletal procedures in 2022. Some surgeries stayed off the IPO list, however, and are subject to the two-midnight rule. They include total shoulder and ankle replacements and lumbar spine fusion as well as their corresponding anesthesia codes. To operationalize this, Hirsch said it's critical to know what surgery is planned and make sure you have accurate codes (see box, pages 4-5). If the IPO's end had been realized, all 1,740 procedures on the IPO list would have been gone by 2024.

Conflicting Orders Are a Risk

In other parts of the OPPS regulation touching on the two-midnight rule, CMS reiterated the availability of the case-by-case exception, and Hirsch continues to think it's underused. Because some attending physicians may feel strongly about admitting patients as inpatients without being able to document their expectation of two midnights, CMS in 2016 carved out the case-by-case exception. In the new rule, CMS again said "the 2-Midnight benchmark provides clear guidance on when a hospital inpatient admission is appropriate for Medicare Part A payment, while respecting the role of physician judgment. We stated that the following criteria will be relevant to determining whether an inpatient admission with an expected length of stay of less than 2 midnights is nonetheless appropriate for Medicare Part A payment:

- Complex medical factors such as history and comorbidities;
  - The severity of signs and symptoms;
  - Current medical needs; and
  - The risk of an adverse event."

A word to the wise: don't assume admissions are worth the effort. "Hospitals want to be paid equitably for the care they provide, but sometimes the cost and effort required to get that can exceed the financial return," Hirsch said. When hospital reimbursement doesn't include uncompensated care or graduate medical education, for example, and there's an increased risk of audits because of the one-day stays, the benefits of using the case-by-case exception may exceed the costs, he said.

Hirsch also sounded an alarm about a common physician order snafu. The physician appropriately writes an inpatient admission order in advance of patients having a procedure on the IPO list. When the day of surgery arrives, the physician in the recovery room writes a conflicting order for outpatient, perhaps even with observation because the patient is expected to go home the next day. That sabotages reimbursement because an inpatient order is required for IPO surgeries. When the outpatient order makes its way to the billers, they may bill it as an outpatient surgery "and that

results in zero revenue because" the procedure was on the IPO list, Hirsch said. His advice: Ask the physician to cancel the outpatient order or ignore it. Don't pursue condition code 44.

Contact Hirsch at rhirsch@r1rcm.com. ✧

Endnotes

1. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model, 86 Fed. Reg. 63,458 (November 16, 2021), https://bit.ly/3EgB27v.
2. Ronald Hirsch, "2022 Regulatory Update: Big Changes to IPO List, Ramped-Up Audits and More," Racmonitor.com, December 2, 2021.

Courts Halt CMS Vaccine Rule, But 'It's a Very Fluid Situation'

CMS's Nov. 5 vaccine mandate for Medicare and Medicaid facilities was body-slammed by federal courts the week after Thanksgiving, although its ultimate fate is still an open question.[1] A federal judge in Louisiana on Nov. 30 blocked enforcement of the Omnibus COVID-19 Health Care Staff Vaccination regulation, saying CMS lacks the authority to mandate a vaccination and maybe Congress does as well.[2] A day earlier, a federal judge in Missouri enjoined the vaccine mandate in 10 states[3] and on Dec. 1 rejected CMS's request for a stay in that case.[4]

With the fast-moving developments, it's too early to know how this will land. "It's a very fluid situation," said attorney Jackie Hoffman, with K&L Gates in Dallas, Texas. For the time being, hospitals and other facilities have been transported back to pre-mandate times, she said. They're free to require employees to get vaccinated under their own steam "unless there is something in their state or county that prohibits them from implementing a mandate," Hoffman said.

Meanwhile, it's unclear whether facilities covered by the vaccine mandate will set it far aside because the preliminary injunction will be challenged, said attorney Sandra DiVarco, with McDermott Will & Emery in Chicago. "This is all a bit bonkers," she noted.

CMS's vaccine mandate has two phases: By Dec. 6, providers regulated by the Medicare conditions of participation (CoPs) are required to have a plan for vaccinating staff, providing medical or religious exemptions and accommodations, and tracking and documenting staff vaccinations. Employees and other people (e.g., licensed practitioners, students, trainees, contracted staff and others "who provide care, treatment or other services at the facility") must have the one-dose vaccine or the first shot of the two-dose vaccine by that date or have requested an exemption. Everyone must be fully vaccinated by Jan. 4 unless an exemption has been granted.

The regulation was challenged in separate lawsuits. Ten states—Alaska, Arkansas, Iowa, Kansas, Missouri, Nebraska, New Hampshire, North Dakota, South Dakota and Wyoming—brought a case in the U.S. District Court for the Eastern District of Missouri, which granted a preliminary injunction Nov. 29. On Dec. 1, the court denied CMS's request to stay the injunction while it appeals. Meanwhile, 14 other states—Alabama, Arizona, Georgia, Idaho, Indiana, Louisiana, Mississippi, Montana, Oklahoma, South Carolina, Utah, West Virginia, Kentucky and Ohio—filed their own lawsuit, seeking an injunction against the mandate. On Dec. 30, they got their way when the U.S. District Court for the Western District of Louisiana stayed the vaccine mandate for the whole country (except the 10 states that had already gotten relief).

In granting the preliminary injunction nationally, the U.S. District Court for the Western District of Louisiana found fault with the way the vaccine mandate was rolled out—as an interim final rule without notice and comment rulemaking—and the mandate itself. "There is no question that mandating a vaccine to 10.3 million healthcare workers is something that should be done by Congress, not a government agency. It is not clear that even an Act of Congress mandating a vaccine would be constitutional. Certainly, CMS does not have this authority by a general authorization statue," Judge Terry Doughty wrote.

A CMS spokesperson said CMS is reviewing the court decisions. "While we cannot comment on the litigation, CMS has remained committed to protecting the health and safety of beneficiaries and health care workers. The vaccine requirement for health care workers addresses the risk of unvaccinated health care staff to patient safety and provides stability and uniformity across the nation's health care system. Staff in any health care setting who remain unvaccinated pose both direct and indirect threats to patient safety and population health. That is why it is critical for health care providers to ensure their staff are vaccinated against COVID-19."

'This is Just Such a Glaring Hole'

When the dust settles—and courts have ruled on CMS's appeals to appellate courts, which could include the Supreme Court—"I think portions of the rule will be struck down and the mandate for nursing facilities will continue," said attorney Paula Sanders, with Post & Schell in Harrisburg, Pennsylvania. The mandate would have a better shot at success if CMS had limited it to nursing homes, she said, an opinion based on language in the federal judge's decision in Missouri. The judge stated that "CMS lacks evidence showing that vaccination status has

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Patient Status Tools: Compliance With the Two-Midnight Rule, IPO List

This form helps hospitals elicit information from physicians to ensure surgery is performed in the correct status, said Ronald Hirsch, M.D., vice president of R1 RCM (see story, p. 1).[1] Contact him at rhirsch@r1rcm.com.

You Need to Know What Surgery Is Planned – Words and CPT Code!

Consent to Read: (please spell out complete surgery with no abbreviations, specify left and right)

_____

_____

Diagnosis: _____ ICD-10 Code(s): _____

CPT Code(s) of planned procedure: _____, _____ , _____

Insurance:_____ Pre-Auth Number: _____

Patient Status - Medicare Fee for Service Patient

_____ Day Surgery - plan discharge from recovery room

_____ Outpatient Extended Recovery - plan discharge next day, not high risk

_____ Inpatient Next Day Discharge - high-risk patient or surgery - risk factors must be outlined in documentation

_____ Inpatient - Inpatient Only List Surgery

_____ Inpatient - Expect 2+ Days In-Hospital Recovery

Discharge expected POD #2 or later - factors expected to extend in-hospital recovery must be outlined in documentation. Documentation not needed if LOS is always >2 days.

Patient Status – Other Insurers – Ordered Status Must Match Payer-Approved Status

_____Day Surgery – plan discharge from recovery room

_____Outpatient – Extended Recovery – plan discharge next day

_____Inpatient

Anesthesia guidelines for medical necessity will be followed for all procedures with anesthetic.
Other Pre-admission Orders/Instructions: _____
_____Please initiate pre-procedure orders upon patient arrival.
Other Pre-procedure Orders/Instructions: _____

Physician Signature: _____ Staff Completing Form: _____ Date: _____

Give Your Doctors a Guide

Here's a risk stratification and documentation tool for using the case-by-case exception to the two-midnight rule.

Medicare Total Joint Replacement Example of Wording

- ❒ Admission as an inpatient is reasonable and necessary due to increased risk of surgery due to the factors indicated below or to the need for prolonged in-hospital or skilled post-acute care to improve the patient's functional ability

Surgical Complexity

- ❒ More complex intraoperative surgery anticipated due to _____

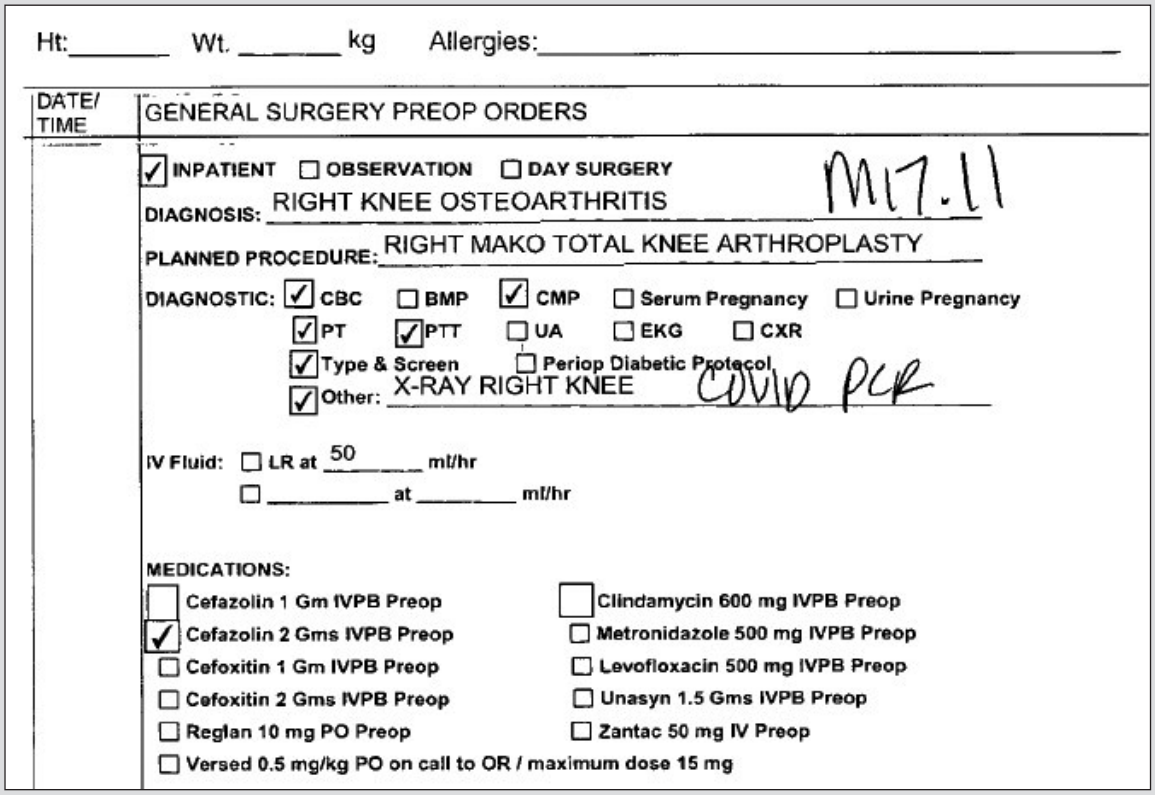
Comorbid Conditions Increasing Perioperative Surgical Risk:

- ❒ Poorly controlled diabetes. HbA1C=_____
- ❒ Hypertension - either poorly controlled or requiring multiple medications for control
- ❒ COPD/Asthma/OSA. Treated with (multi-select):
  - ❒ Home oxygen
  - ❒ Steroid dependent
  - ❒ Regularly scheduled inhalers/nebulizers
  - ❒ CPAP
  - ❒ Other _____
- ❒ Cardiovascular Disease:
  - ❒ CAD
  - ❒ Stroke
  - ❒ Other _____
  - ❒ Anesthesia ASA Score of 3 or higher with factors indicated in anesthesia documentation

    Note: ASA 3 is not automatically inpatient - must be supported with clinical factors documented
- ❒ Anemia Hb<10

Don't Do This!

Hospital scheduling forms should never offer the option of observation preoperatively, as shown below, Hirsch said.



Ht:_____ Wt. _____ kg Allergies:_____

DATE/ TIME | GENERAL SURGERY PREOP ORDERS

☑ INPATIENT ☐ OBSERVATION ☐ DAY SURGERY

DIAGNOSIS: RIGHT KNEE OSTEOARTHRITIS M17.11

PLANNED PROCEDURE: RIGHT MAKO TOTAL KNEE ARTHROPLASTY

DIAGNOSTIC: ☑ CBC ☐ BMP ☑ CMP ☐ Serum Pregnancy ☐ Urine Pregnancy
☑ PT ☑ PTT ☐ UA ☐ EKG ☐ CXR
☑ Type & Screen ☐ Periop Diabetic Protocol
☑ Other: X-RAY RIGHT KNEE COVID PCR

IV Fluid: ☐ LR at 50 ml/hr
☐ _____ at _____ ml/hr

MEDICATIONS:

☐ Cefazolin 1 Gm IVPB Preop	☐ Clindamycin 600 mg IVPB Preop
☑ Cefazolin 2 Gms IVPB Preop	☐ Metronidazole 500 mg IVPB Preop
☐ Cefoxitin 1 Gm IVPB Preop	☐ Levofloxacin 500 mg IVPB Preop
☐ Cefoxitin 2 Gms IVPB Preop	☐ Unasyn 1.5 Gms IVPB Preop
☐ Reglan 10 mg PO Preop	☐ Zantac 50 mg IV Preop

☐ Versed 0.5 mg/kg PO on call to OR / maximum dose 15 mg

Source: https://www.ronaldhirsch.com/total-joint-replacement.html

Endnotes

1. Nina Youngstrom, "Confusion Over IPO List May Cause Noncompliance; Consider A Closer Look at Code Definitions," *Report on Medicare Compliance* 30, no. 43 (December 6, 2021).

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a direct impact on spreading COVID in the mandate's covered healthcare facilities. CMS acknowledges its lack of 'comprehensive data' on this matter but attempts to 'extrapolate' the abundant data that it does have on Long Term Care Facilities ('LTCs'), generally referred to as nursing homes, to the other dozen-plus Medicare and Medicaid facilities covered by the mandate."

Sanders doesn't think it makes sense that CMS is telling nursing homes they must fire employees who don't want to be vaccinated when they can be tested and wear personal protective equipment and visitors must be allowed in without requiring testing or vaccination. "That is just such a glaring hole, you could drive a Mack truck through it," Sanders contended.

Richelle Marting, an attorney in Olathe, Kansas, said nursing homes in her area are at grave risk of losing employees who refuse to comply with CMS's vaccine mandate. "When I read the interim final rule, they cited examples of health care facilities that implemented vaccines successfully and didn't lose staff. It's great for those that can do it, but that is not reality in our area of the country," she noted. "There is such strong opposition to being forced to vaccinate it's putting some health care providers in a dire staffing shortage."

Marting also is worried about nursing homes and other entities between a rock and a hard place when faced with requests for a religious exemption. The Equal Employment Opportunity Commission requires employees to have a sincerely held religious belief to qualify for an exemption, but "employers don't want to be in the business of questioning whether someone's religious beliefs are legitimate," she said. At the same time, facilities are wary of putting their Medicare status in jeopardy if it seems like they're granting too many exemptions. "This is such a heated topic," Marting said. "It's a lose-lose situation for the facilities trying to care for their residents." Meanwhile, hospitals and other facilities aren't allowed to ask state surveyors if they're vaccinated. "The optics of that for the staff are really poor," she said.

The potential loss of employees is larger than the vaccine mandate. Nursing shortages are endemic in health care, and the pandemic has exacerbated this, DiVarco said. "Almost every hospital has so many unfilled positions, and they are concerned even a small amount of forced terminations will impact their ability to staff and risk burnout in the staff they have," DiVarco said. To add insult to injury, some nurses have quit their jobs to sign up as travel nurses for double or triple the pay, only to "travel" to a hospital across town. "Hospitals can't keep up with this financially," she said. "It is kind of a perfect storm with all the different factors." The vaccine mandate is just one of them.

The CMS spokesperson noted that CMS "will continue working with health care providers, clinicians, staff, stakeholders, and others to ensure there are evidence-based policies in place to protect the health and safety of patients and their families. As a part of this emergency regulation, the general public will have 60 days to submit formal comment for consideration. CMS looks forward to continue engaging on opportunities to address COVID-19 and building a resilient health care system together."

Contact DiVarco at sdivarco@mwe.com, Marting at rmarting@richellemarting.com, Hoffman at jackie.hoffman@klgates.com and Sanders at psanders@postschell.com. ✧

Endnotes

1. Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, 86 Fed. Reg. 61,555 (November 5, 2021), https://bit.ly/3mPyG9y.
2. State of Louisiana et al v. Xavier Becerra et al, Case No. 3:21-CV-03970 (W.D. La., November 30, 2021), https://bit.ly/3I9LwrE.
3. State of Missouri et al. v. Joseph R. Biden, Jr. et al., Case No. 4:21-cv-01329-MTS (E.D. Mo., November 29, 2021), https://bit.ly/3ddtrLa.
4. State of Missouri et al. v. Joseph R. Biden, Jr. et al., Case No. 4:21-cv-01329-MTS (E.D. Mo., December 1, 2021), https://bit.ly/3rtxRWm.

Hospital Pays $4.5M to Settle CSA Case; Two Nurses Died From Overdoses

The deaths of two hospital nurses from overdoses of drugs allegedly diverted from the University of Texas Southwestern Medical Center (UTSW) played a part in its $4.5 million settlement for allegedly violating the Controlled Substances Act, the U.S. Attorney's Office for the Northern District of Texas said Nov. 30.[1] This is the second largest settlement in the nation involving drug diversion at a hospital and requires "extensive" corrective action, the U.S. attorney's office said.

Drug diversion is a universal problem, and the opportunities may have multiplied as the COVID-19 pandemic took hold, experts say.[2] For example, to conserve personal protective equipment (PPE), nurses could access automated dispensing cabinets (ADCs) containing narcotics without their fingerprint to avoid taking off their glove. And the stressful work environment and lack of in-person addiction services has made health care workers more vulnerable to drug diversion while attention to the problem has waned.

The alleged diversion at UTSW, however, preceded the pandemic. According to the settlement, which is available on the U.S. attorney's website, the allegations center on UTSW's William P. Clements Jr. University Hospital and Zale Lipshy Pavilion, which are in Dallas.[3]

In a statement of covered conduct included with the settlement, the United States alleges that UTSW's recordkeeping violations included failure to properly document dispensing and wasting of controlled substances and failure to tell the Drug Enforcement Administration (DEA) timely of significant loss or theft of controlled substances. "Theft and diversion occurred at Clements University Hospital and Zale Lipshy Pavilion as a result of UTSW's failure to maintain effective controls and procedures to guard against the theft and diversion of controlled substances," the statement of covered conduct alleged. For example, in December 2016, a UTSW nurse overdosed on diverted drugs and died at the UTSW William P. Clements Jr. Hospital. In April 2018, another UTSW nurse met the same fate. They were found in different Clements bathrooms, the U.S. attorney's office said in a news release.

UTSW Did Compliance Review Beforehand

Another attachment to the settlement that's a memorandum of agreement with the DEA spells out its findings and UTSW's remediation. For example, DEA alleges that diversion investigators in September 2019 identified recordkeeping violations. Among other things, there was a failure to maintain complete and accurate records and readily retrievable records; failure to address an employee's suspected diversion; and failure to maintain effective controls to prevent theft and diversion of controlled substances.

UTSW agreed to a series of compliance reforms. For example, UTSW will hire an external auditor to do unannounced audits of controlled substances dispensed by the Pyxis machines, with an audit emphasis on fentanyl. Deficiencies will be resolved in 30 days and reported to the DEA.

UTSW didn't admit liability in the settlement. In a statement, UTSW said, "As noted in today's settlement agreement with the DOJ/DEA, prior to learning about their investigation, UTSW conducted a comprehensive compliance review of its controlled substances safeguards and procedures and invested significant resources to enhance these processes, including hiring additional staff, acquiring advanced technology and software, and implementing physical security controls like lockboxes and tamper-resistant

IV tubing. In response to, and in collaboration with the DOJ/DEA's investigation, UTSW has continued to strengthen its handling of controlled substances, including the formation of a Controlled Substance Investigation Team and the installation of security cameras to deter diversion of these substances within its facilities."

UTSW added that it's committed to meeting legal and ethical obligations in all its operations. The U.S. attorney noted in its news release that "UTSW cooperated with the DEA's investigation. After the agency launched its probe into the medical center's compliance program in December 2018, UTSW began working with the DEA to address deficiencies and strengthen its controls for handling controlled substances. A number of changes were instituted well before the settlement agreement was signed." ✧

Endnotes

1. Department of Justice, U.S. Attorney's Office for the Northern District of Texas, "UT Southwestern to Pay $4.5 Million to Resolve Alleged Controlled Substance Act Violations That Permitted Drug Diversion by Staff," news release, November 30, 2021, https://bit.ly/3dbtZ4a.
2. Nina Youngstrom, "Drug Diversion Monitoring Took a Hit in Pandemic; Consider High-Level Utilization Reports," *Report on Medicare Compliance* 30, no. 17 (May 3, 2021), https://bit.ly/2ZS7yOq.
3. United States v. University of Texas Southwestern Medical Center, settlement agreement, accessed December 2, 2021, https://bit.ly/3IitRhk.

Federal Register Regulations, Nov. 19-Dec. 2, 2021

Federal Register

Interim final rule with comment period

- Medicare Program; Opioid Treatment Programs: CY 2022 Methadone Payment Exception, 86 Fed. Reg. 66,031 (Nov. 19, 2021)

Final rule

- Medicaid Program; Delay of Effective Date for Provision Relating to Manufacturer Reporting of Multiple Best Prices Connected to a Value Based Purchasing Arrangement; Delay of Inclusion of Territories in Definition of States and United States, 86 Fed. Reg. 64,819 (Nov. 19, 2021)
- Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64,996 (Nov. 19, 2021)

Final rule; correction

- Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program; Correction, 86 Fed. Reg. 67,874 (Nov. 30, 2021)

OIG Will Audit DRGs with Ventilation

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for 96 hours or more may be triple that of a patient on a vent for 95 hours, said Kristen Shattuck, a specialist leader with Deloitte & Touche. "Coders have to make sure they look at those times" and do the math down to the hour or the minute and capture that correctly.

In the new item on the Work Plan, OIG said it will review Medicare payments for MS-DRG assignments that require mechanical ventilation to gauge whether payments were appropriate. "Our review will include claims for beneficiaries who received more than 96 hours of mechanical ventilation," OIG explained. "Previous OIG reviews identified improper payments made because hospitals inappropriately billed for beneficiaries who did not receive at least 96 hours of mechanical ventilation." Its prior audits, including a 2016 report, found significant overpayments, and that was before COVID-19 led to acute respiratory failure in many patients, requiring prolonged mechanical ventilation.[2]

"Realistically, there probably are a lot more [cases] over 96 hours," Shattuck said. "You hear of patients being on vents for a week or two now. It's a longer period of time, and in most cases it's probably OK." But the claims will rise or fall depending on whether the documentation supports the hours the patient was on the vent, and "the coders have to be very diligent in counting the hours and the minutes, not just the days," said Leslie Slater, a specialist leader at Deloitte Advisory. Coders should pay careful attention to guidelines on counting vent hours explained in *Coding Clinic*, the American Hospital Association's quarterly coding newsletter.

Vent Time is Tube In, Tube Out, Weaning Included

Generally, the vent time is tube in, tube out, Shattuck said. When patients arrive at the emergency room already intubated by emergency medical services or at another hospital, the clock starts ticking when they're in the door, she said. Eventually, patients (hopefully) will be weaned off the vent and extubated, which is time included in the count, Shattuck said. However, if they go into respiratory failure again, the episodes of intubation are reported with separate codes and not added together, according to *Coding Clinic* (ICD-9-CM Coding Clinic 1991 Qtr 4, pages 16-21). If hospitals add the hours and exceed 96, they may have a DRG upcoding problem, Shattuck said.

However, if the tube comes out inadvertently and the clinician puts it back in, "you don't have to restart the count," Naawu said. The same goes for taking patients off the vent for a few minutes to evaluate how they're doing, *Coding Clinic* states (ICD-10-CM/PCS Coding Clinic 2014 Qtr 4, page 7).

Although coders probably have a general understanding of the coding rules, there might be a problem if they count the days instead of the hours or don't drill down into the minutes, Naawu said. She reviewed a case where it looked like the patient was on a vent for 96 hours, "but when I looked closely, I realized it was a few minutes less than 96 hours." The problem was locating the documentation of the timing, although that's less of an obstacle with the advent of electronic health records. "You can find it in the respiratory therapist's notes, vent flow sheets and the provider's progress notes," Naawu said.

When patients are on mechanical ventilation only at night, coders should count those hours separately every night and not add them together, Shattuck said.

Also keep in mind that mechanical ventilation provided to patients during surgery is considered integral to the procedure and not separately coded. The only time vent support should be counted for the purposes of a DRG is when it continues for more than two days post-op or if the physician documented an unanticipated extended period of mechanical ventilation.

"If you are a coder, there are lots of considerations to think about as you add up these hours," Slater said. "As this gets more complicated, it increases the compliance risk that they may have assigned the wrong code based on how they calculated the hours." This is not a new problem, Slater said. Even though COVID-19 has intensified it, the solutions are the same: training and due diligence around documentation and coding compliance.

Contact Slater at leslater@deloitte.com, Naawu at mnaawu@deloitte.com and Shattuck at kshattuck@deloitte.com. ✧

Endnotes

1. "Medicare Payments for Inpatient Claims With Mechanical Ventilation," Work Plan, HHS Office of Inspector General, accessed December 2, 2021, https://bit.ly/3pldpEH.
2. HHS Office of Inspector General, "Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation," A-09-14-02041, June 10, 2016, https://bit.ly/3Dg4dGA.

NEWS BRIEFS

◆ **The HHS Office for Civil Rights (OCR) Nov. 30 announced the resolution of five investigations under its HIPAA Right of Access Initiative.**[1] A patient's right to access their records is a cornerstone of the HIPAA privacy rule, which requires covered entities to give patients their records within 30 days, absent an exception. OCR said it entered into settlements with four providers of potential violations of the HIPAA privacy rule and imposed a civil monetary penalty on a fifth:

1. Advanced Spine & Pain Management in Cincinnati and Springboro, Ohio, has agreed to pay $32,150 and "take corrective actions that include two years of monitoring."
2. Dr. Robert Glaser, "a cardiovascular disease and internal medicine doctor in New Hyde Park, NY, did not cooperate with OCR's investigation or respond to OCR's data requests after failing to provide a patient with a copy of their medical record. Dr. Glaser waived his right to a hearing and did not contest the findings of OCR's Notice of Proposed Determination. Accordingly, OCR closed this case by issuing a civil money penalty of $100,000."
3. Denver Retina Center in Colorado will pay $30,000 and take corrective action, including a year of monitoring.
4. Rainrock Treatment Center LLC, dba Monte Nido Rainrock, "a licensed provider of residential eating disorder treatment services in Eugene," Oregon, has paid $160,000 and agreed to take corrective actions, including a year of monitoring.
5. Wake Health Medical Group in Raleigh, North Carolina, will pay $10,000 and implement corrective actions.

◆ **The HHS Office of Inspector General (OIG) has released its *Semiannual Report to Congress*, which covers April 1 to Sept. 30, 2021.**[2] OIG notes, among many other things, that during this period, it released 87 audit reports and 26 evaluation reports. "Our audit work identified $220.82 million in expected recoveries, as well as $934.21 million in questioned costs (costs questioned by OIG because of an alleged violation, costs not supported by adequate documentation, or the expenditure of funds where the intended purpose is unnecessary or unreasonable). Our audit work also identified $318.91 million in potential savings for HHS—funds that could be saved if HHS implemented all of OIG's audit recommendations."

Endnotes

1. U.S. Department of Health & Human Services, "Five enforcement actions hold healthcare providers accountable for HIPAA Right of Access," news release, November 30, 2021, https://bit.ly/3ogxEUx.
2. U.S. Department of Health & Human Services, Office of Inspector General, *Semiannual Report to Congress: April 1, 2021 – September 30, 2021*, accessed December 3, 2021, https://bit.ly/3lh7Qj0.