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Today's Discussion

- Compliance Program Effectiveness
- Impactful Data: Driving Your Risk Assessment and Auditing & Monitoring
- Case Studies: Using Data Analytics to Identify Risks
- Recent OIG Settlements: Would Your Auditing & Monitoring Program Identify This Issue?
- Questions & Discussion

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2

Compliance Program Effectiveness

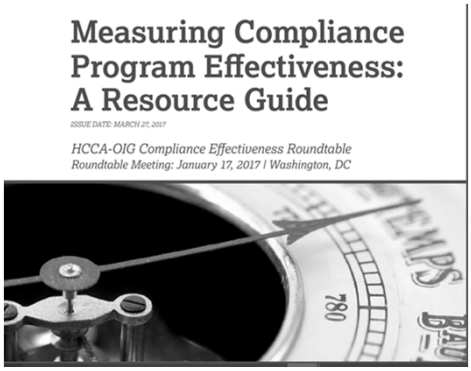
Industry Standards: Auditing & Monitoring Guidance Documents

OIG Model Compliance Guidance – Physicians & Small Group Practices

- Published - September 2000
- Outlined the "7 Elements" including guidance for Auditing & Monitoring
- Recommended "benchmarking" as a way reducing / eliminating risks

Measuring Effectiveness

- Auditing and monitoring should be based on risk assessment
- Frequency and scope of risk assessments should be appropriate for practice/group/provider types
- Risk assessments help to **zero in** on compliance risks



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https://oig.hhs.gov/compliance/101/files/HCCA-OIG-Resource-Guide.pdf

3

Compliance Program Effectiveness

Auditing & Monitoring Plan Development

Risk Assessment Best Practices

- ✓ Perform / update annually
- ✓ **Customize** to your practice/group/ specialties/providers
  - By specialty(ies) / provider type(s)
  - Include full scope of services / procedures
- ✓ Incorporate **known industry and organizational risk areas**
  - OIG Work Plan
  - RAC or other identified payer audit risk issue(s)
  - Coverage guidelines
  - Hotline or other department feedback (e.g. Revenue Cycle)

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4

Compliance Program Effectiveness

Auditing & Monitoring Plan Development

Risk Assessment Best Practices (cont.)

- ✓ Include **analysis of claims / billing data**
  - Code outlier based
  - High risk modifier usage (e.g. -59 and -25)
- ✓ Include testing of system functionality and business process
  - ✓ Charge capture interfaces with other clinical systems (e.g. MUSE – Cardiology)
  - ✓ Automatic charge capture or modifier assignment (default coding)
  - ✓ Use of Copy/Paste functionality
- ✓ **Prioritize** based on potential risk and compliance resources

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5

Compliance Program Effectiveness

Auditing & Monitoring Plan Development

Potentially Less Effective Approaches

- Reactive (focus only on known risk areas)
- 10 Encounters / year / provider
- Random / non-targeted sampling
- No data analysis
- Includes limited code sets / provider types:
  - E/M services only
  - High level E/M services only (e.g. 99204 – 99205 and 99214 – 99215)
  - Physicians only (excludes APPs, other billing providers)

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6

Compliance Program Effectiveness

Risk Assessment: Constructing a Playbook

Know the Risk Areas for Your Provider Types / Specialties

- Applicable NCD / LCD guidelines
- Payor coverage guidelines
- OIG work plan / settlements
- Claim denials
- RAC audit issues
- High-risk modifier combinations (e.g., 25, 59)
- System(s) functionality and tools
  - Computer-assisted coding (CAC) systems
  - CDM default code sets
- Copy/Paste functionality and Policies & Procedures

7

Compliance Program Effectiveness

Developing a Customized Audit Plan

Example – Audit Plan Components		
Risk Area	**Objective(s)**	**Process**
Physician Orders	To ensure proper orders are documented by the treating physician per published LCDs.	• Verify treating provider order exists
JW Modifier	To ensure proper documentation exists for single use vial drug usage and wastage	• Verify single dose vial usage and wastage amounts are documented • Verify billed units for single dose vial usage and wastage correspond to documentation • Verify JW modifier used appropriately
Supervision Requirements	To ensure supervision requirements were met per CMS guidelines for services performed • General • Personal • Direct • Incident to • Split / Shared • Teaching Physician	• Verify documentation reflects supervising physician's presence for the key components of the service rendered or • Verify billing physician was immediately available in the office suite (e.g., review of clinic schedules)

8

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Paid Claims Data	
Data Source	**Field Detail Needed**
Billed Charge / Paid Claim Data	Most recent 6-12 months to include: • Billing Provider • Rendering Provider (if available) • CPT • Modifier(s) • Units • ICD code(s) • Payer • Payment detail • Date of service • Place of service
Claim Denials	Most recent 6-12 months to include: • Denial reason code - Filter to those related to coding / charge capture / medical necessity • $$ value • Count /Volume
Pre-bill claim edit work queues	• Rejection type • Volumes
Explanation of Benefits / Remittance Advice (sampled claims)	• Reconciliation to billed charges • Denial / Rejection reason codes • Trend identification

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9

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Paid Claims Data – Example of Benefits / Remittance Advice

PERF PROV	SERV DATE	POS	NOS	PROC MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
[redacted]										
[redacted]	053116 053116 REM: N111	11	0 SUB NOS: 1	17311	-1471.00	0.00	0.00	0.00	CO-97 -1471.00	0.00
[redacted]	053116 053116	11	1	17311	-1471.00	-646.75	0.00	-129.35	CO-45 -824.25 CO-253 -10.35	-507.05
[redacted]	053116 053116	11	1	13121 XS 51 SUB PROC: 13121	-935.00	-209.00	0.00	-41.80	CO-45 -517.00 CO-253 -3.34 CO-59 -209.00	-163.86
[redacted]	053116 053116 REM: M80	11	0 SUB NOS: 1	13122	-289.00	0.00	0.00	0.00	CO-B15 -289.00	0.00
[redacted]	053116 053116	11	1	17000 51 SUB PROC: 17000	-166.00	-32.66	0.00	-6.53	CO-45 -100.68 CO-253 -0.52 CO-59 -32.66	-25.61
[redacted]	053116 053116	11	1	17003	-16.00	-5.49	0.00	-1.10	CO-45 -10.51 CO-253 -0.09	-4.30
PT RESP: 0.00				CLAIM TOTALS:	-4348.00	-893.90	0.00	-178.78	-3468.40	-700.82
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00			NET:	-700.82
[redacted]										
[redacted]	053116 053116	11	1	17311 76 SUB PROC: 17311	1471.00	646.75	0.00	129.35	CO-45 824.25 CO-253 10.35	507.05
[redacted]	053116 053116	11	1	17311 51 SUB PROC: 17311	1471.00	323.38	0.00	64.68	CO-45 824.25 CO-253 5.17 CO-59 323.37	253.53
[redacted]	053116 053116	11	1	13121 XS 51 SUB PROC: 13121	935.00	209.00	0.00	41.80	CO-45 517.00 CO-253 3.34 CO-59 209.00	163.86
[redacted]	053116 053116	11	1	13122 XS SUB PROC: 13122	289.00	130.35	0.00	26.07	CO-45 158.65 CO-253 2.09	102.19
[redacted]	053116 053116	11	1	17000 51 SUB PROC: 17000	166.00	32.66	0.00	6.53	CO-45 100.68 CO-253 0.52 CO-59 32.66	25.61
[redacted]	053116 053116	11	1	17003	16.00	5.49	0.00	1.10	CO-45 10.51 CO-253 0.09	4.30
PT RESP: 269.53				CLAIM TOTALS:	4348.00	1347.63	0.00	269.53	3021.93	1056.54
ADJ TO TOTALS	PREV PAID: 0.00			INTEREST: 0.00		LATE FILING CHARGE: 0.00			NET:	1056.54

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10

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Paid Claims Data – Example Denials Analysis

Specialty / Department	# of Denials	Charge Amounts
Anesthesiology	**442**	**$12,884,318**
CO - INVALID CPT CODE/DIAGNOSIS/MODIFIER	411	$12,823,318
CO - MISSING/INVALID	26	$41,577
CO - MODIFIER	5	$19,423
Behavioral Health	**243**	**$139,991**
CO - INVALID CPT CODE/DIAGNOSIS/MODIFIER	230	$137,032
CO - MISSING/INVALID	11	$2,561
CO – MODIFIER	2	$398
Cardiology	**776**	**$1,606,180**
CO - INVALID CPT CODE/DIAGNOSIS/MODIFIER	642	$1,258,796
CO - MISSING/INVALID	128	$332,451
CO – MODIFIER	6	$14,933
Dermatology	**154**	**$108,458**
CO - INVALID CPT CODE/DIAGNOSIS/MODIFIER	130	$84,185
CO - MISSING/INVALID	23	$22,165
CO – MODIFIER	1	$2,108
Emergency	**311**	**$1,434,734**
CO - INVALID CPT CODE/DIAGNOSIS/MODIFIER	287	$1,408,903
CO - MISSING/INVALID	17	$2,222
CO - MODIFIER	7	$23,609

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11

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Supplemental Data	
Data Source	**Purpose**
Appointment Schedules	• Verify supervision and physical presence requirements are met
Provider enrollment	• Determine specialty designation • Validate provider type (PA, NP, LCSW, etc.)

Coding / Billing Guidelines by Specialty	• Utilize applicable industry guidance
	  • CMS / NCCI
	  • CPT® / HCPCS
	  • ICD-10-CM

CMS / Medicare NCDs / LCDs	• Identify applicable coverage guidelines for procedures performed by specialty providers • Determine what documentation guidelines will be used when completing audit

Medical Record Documentation	• Ensure encounter specific documentation exists to support billed services
	  • Orders, results
	  • H&Ps, Progress Notes / Office Visit Notes, Discharge Summaries
	  • Procedure Notes / Operative Reports
	  • Treatment Logs, Care Plans

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12

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Supplemental Data – Example NCD / LCD
National Government Services – Psychiatry and Psychology Services (L33632)
Coverage Criteria. The services must meet the following criteria: Individualized Treatment Plan. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.) *Reasonable Expectation of Improvement.* Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 70.1). *It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met* (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 70.1). *Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected* (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 70.1). When stability can be maintained without further treatment or with less intensive treatment, the psychological services are no longer medically necessary. *Frequency and Duration of Services.* There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage may be continued (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 70.1). When a patient reaches a point in his/her treatment where further improvement does not appear to be indicated and there is no reasonable expectation of improvement, the outpatient psychiatric services are no longer considered reasonable or medically necessary.

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13

Impactful Data: Driving Your Auditing & Monitoring

Data to Incorporate in Your Audit Plan

Industry Data	
Data Source	
CMS – Utilization Benchmarking Data	Centers for Medicare & Medicaid Services (CMS) Medicare Provider Utilization and Payment Data: Physician and Other Supplier https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html
CMS – MAC Audit Results / Audit Data	Example: National Government Services (NGS) New York State E/M Pre-payment Medical Review Audit Results

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14

Impactful Data: Driving Your Auditing & Monitoring

Data Analytics for Identification of Outliers / Potential Risk Areas

Methodologies:

- Benchmarking
  - E/M
  - Procedures – Top 20
  - Services outside expected scope for provider / specialty
- Data Normalization ("Bell Curve")
- Trend Identification
  - Code Utilization Patterns / Variances
  - Omissions
  - Potential Unbundling / Inappropriate Modifier Usage

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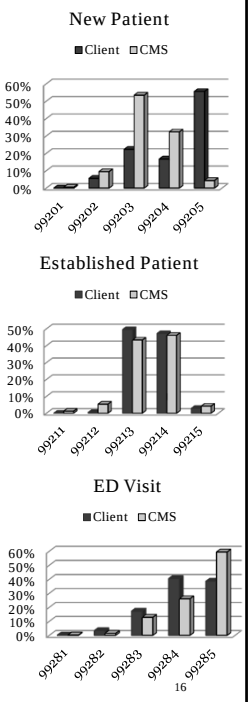
15

Impactful Data: Driving Your Auditing & Monitoring

Benchmarking: E/M Example

Evaluation & Management	CPT	CPT Description	CPT Count	%	CMS CPT Count	CMS %
New Patient	99201	New Patient, Office or other outpatient visit		0%	2,069	1%
	99202	New Patient, Office or other outpatient visit	1	6%	34,859	9%
	99203	New Patient, Office or other outpatient visit	4	22%	197,141	53%
	99204	New Patient, Office or other outpatient visit	3	17%	119,184	32%
	99205	New Patient, Office or other outpatient visit	10	56%	16,019	4%
		Grand Total	**18**	**100%**	**369,272**	**100%**
Established Patient	99211	Established Patient, Office or other outpatient visit		0%	16,957	1%
	99212	Established Patient, Office or other outpatient visit	1	0%	77,022	5%
	99213	Established Patient, Office or other outpatient visit	104	50%	625,921	43%
	99214	Established Patient, Office or other outpatient visit	99	47%	666,508	46%
	99215	Established Patient, Office or other outpatient visit	6	3%	59,766	4%
		Grand Total	**210**	**100%**	**1,446,174**	**100%**
ED Visit	99281	Emergency Department Visit	3	0%	35,654	0%
	99282	Emergency Department Visit	84	3%	227,577	1%
	99283	Emergency Department Visit	423	17%	2,094,385	13%
	99284	Emergency Department Visit	991	41%	4,258,494	26%
	99285	Emergency Department Visit	942	39%	9,680,517	59%
		Grand Total	**2,443**	**100%**	**16,296,627**	**100%**



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16

Impactful Data: Driving Your Auditing & Monitoring

Benchmarking: Procedure – Top 20 Example

Procedure	Description	2017 Practice Data: Medicare Claim Lines	2017 Practice Data: % of Medicare Claim Lines	2016 CMS National Benchmark: % of Medicare Claim Lines	Difference from National Benchmark: % of Medicare Claim Lines
43239	**Biopsy of the esophagus, stomach, and/or upper small bowel using an endoscope**	1,741	38%	30%	**8%**
45380	Biopsy of large bowel using an endoscope	714	16%	21%	-6%
43249	Balloon dilation of esophagus using an endoscope	166	4%	2%	1%
45385	Removal of polyps or growths of large bowel using an endoscope	312	7%	18%	-11%
43248	**Insertion of guide wire with dilation of esophagus using an endoscope**	296	7%	2%	**4%**
45378	Diagnostic examination of large bowel using an endoscope	452	10%	8%	2%
43235	Diagnostic examination of esophagus, stomach, and/or upper small bowel using an endoscope	213	5%	7%	-3%
43255	Control of bleeding of esophagus, stomach, and/or upper small bowel using an endoscope	61	1%	1%	0%
45388	Destruction of large bowel growths using an endoscope	12	0%	1%	0%
43264	Removal of stone from bile or pancreatic duct using an endoscope	84	2%	1%	1%
91110	Imaging of digestive tract done from the inside of the digestive tract	141	3%	1%	2%
45331	Biopsy of large bowel using an endoscope	77	2%	1%	1%
45381	Injections of large bowel using an endoscope	37	1%	2%	-1%
43242	Ultrasound guided needle aspiration or biopsy of esophagus, stomach, and/or upper small bowel using an endoscope	59	1%	1%	1%
43262	Incision of pancreatic outlet muscle using an endoscope	41	1%	1%	0%
43274	Placement of stent pancreatic or bile duct using an endoscope	32	1%	1%	0%
46221	Removal of hemorrhoid by rubber banding	49	1%	1%	0%
43259	Ultrasound examination of esophagus, stomach and/or upper small bowel using an endoscope	48	1%	1%	0%
Total		**4,535**	**100%**	**100%**	**0%**

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17

Impactful Data: Driving Your Auditing & Monitoring

Benchmarking: Outside Expected Scope Example

DOS	Provider	Procedure Code	Modifier
1/12/2017	Ob/Gyn	59510	AT
2/21/2017	Ob/Gyn	59514	AT
3/21/2017	Ob/Gyn	99223	25 GC
7/5/2017	Ob/Gyn	59400	AT
11/17/2017	Ob/Gyn	59400	AT
11/24/2017	Ob/Gyn	99232	25 GC
12/30/2017	Ob/Gyn	59400	

Modifiers

AT: Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942 – chiropractic manipulative treatments)

GC: This service has been performed in part by a resident under the direction of a teaching physician

25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

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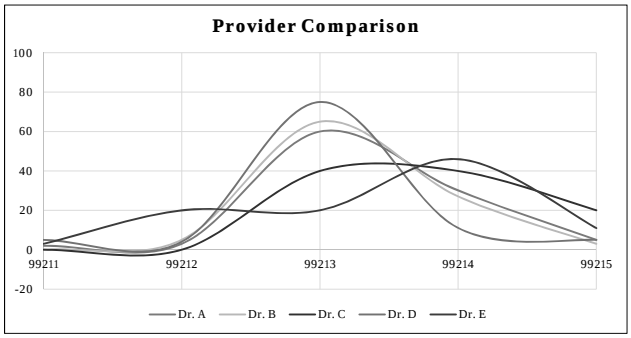
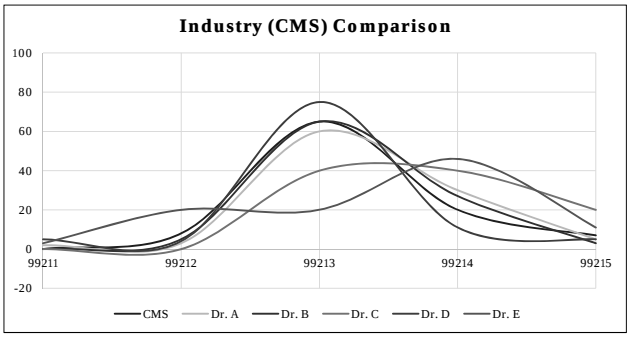
18

Impactful Data: Driving Your Auditing & Monitoring

Data Normalization ("Bell Curve")





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19

Impactful Data: Driving Your Auditing & Monitoring

Trend Identification: Code Utilization Patterns / Variance

DOS	Provider	Procedure Code	Modifier
01/26/2016	Pathologist	88305	26 TC
02/03/2016	Pathologist	88305	26 TC
02/16/2016	Pathologist	88305	26 TC
02/17/2016	Pathologist	88305	26 TC
03/03/2016	Pathologist	88305	26 TC
03/03/2016	Pathologist	88312	26 TC
04/21/2016	Pathologist	88305	26 TC

88305: Level IV – Surgical pathology, gross and microscopic examination
88312: Special stain including interpretation and report; Group I for microorganisms

Modifiers
26: Professional Component
TC: Technical Component

DOS	Provider	Service Location	ICD-10-CM	HCC
2016-01-27	Internist	Office	G83.30	104
2016-01-27	Internist	Office	F12.20	55
2016-05-04	Internist	Office	G40.909	79
2016-05-04	Internist	Office	F22	58
2016-11-17	Internist	Office	F22	58
2016-12-03	Internist	Office	I63.9	100
2016-12-22	Internist	Office	E11.51	18
2016-12-22	Internist	Office	E11.51	108

I63.9: Cerebral infarction, unspecified (Stroke NOS)

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20

Impactful Data: Driving Your Auditing & Monitoring

Trend Identification: Omissions

DOS	Provider	Service Location	ICD-10-CM	HCC
2016-02-18	Internist	Office	N18.6	136
2016-02-18	Internist	Office	I50.22	85
2016-02-18	Internist	Office	Z99.2	134
2016-04-11	Internist	Office	Z99.2	134
2016-05-23	Internist	Office	F10.21	55
2016-05-23	Internist	Office	T82.7XXA	176
2016-08-02	Internist	Office	F32.1	58
2016-09-01	Internist	Office	T82.29XA	134
2016-09-01	Internist	Office	T82.898A	176
2016-09-30	Internist	Office	F32.1	58
2016-09-30	Internist	Office	T82.898A	176
2016-12-08	Internist	Office	F32.1	58

Z99.2: Dependence on renal dialysis

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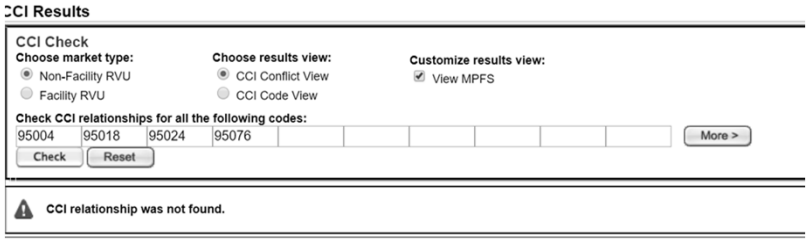
21

Impactful Data: Driving Your Auditing & Monitoring

Trend Identification: Potential Unbundling / Inappropriate Modifier Usage

Allergy Testing				
Service Date	**CPT Code**	**Modifier**	**Units**	**Procedure Description**
3/16/2018	95004	59	6	Percutaneous tests (scratch, puncture, prick)
3/16/2018	95018		8	Allergy Testing with drugs or biologicals, any combination of percutaneous and intracutaneous, sequential and incremental
3/16/2018	95024	59	5	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests
3/16/2018	95076	59	1	Ingestion challenge test ; initial 120 minutes of testing (sequential and incremental ingestion of test items, e.g., food, drug or other substance)



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22

Case Studies: Using Data to Uncover Issues

Benchmarking

		2017 Practice Data		2015 CMS National Benchmark	Difference from National Benchmark
Procedure	Description	Medicare Claim Lines	% of Medicare Claim Lines	% of Medicare Claim Lines	% of Medicare Claim Lines
88185	Flow cytometry technique for DNA or cell analysis, technical component, each additional marker	27,548	55%	3%	52%
99233	Subsequent hospital inpatient care, typically 35 minutes per day	13,070	6%	7%	-2%
78816	Nuclear medicine study with CT imaging whole body	10,368	4%	0%	4%
96372	Injection beneath the skin or into muscle for therapy, diagnosis, or prevention	20,794	9%	14%	-5%
96413	Infusion of chemotherapy into a vein up to 1 hour	6,894	3%	14%	-11%
96365	Infusion into a vein for therapy, prevention, or diagnosis up to 1 hour	5,810	3%	6%	-3%
88184	Flow cytometry technique for DNA or cell analysis	4,724	2%	0%	2%
96367	Infusion into a vein for therapy prevention or diagnosis additional sequential infusion up to 1 hour	9,499	4%	16%	-12%
96361	Hydration infusion into a vein	11,084	5%	5%	0%
96375	Injection of different drug or substance into a vein for therapy, diagnosis, or prevention	6,410	3%	13%	-11%

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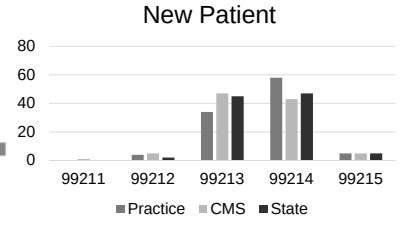
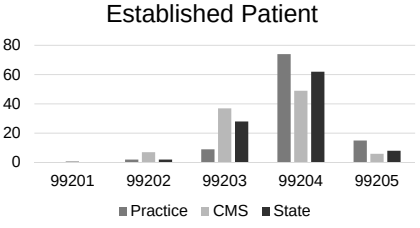
23

Case Studies: Using Data to Uncover Issues

Data Normalization

					2016 CMS State Benchmark	2016 CMS National Benchmark	Difference from State Benchmark	Difference from National Benchmark
CPT	Description		Medicare Claim Lines	% of Medicare Claim Lines				
99201	New patient office or other outpatient visit	Typically 10 minutes	1	0%	0%	1%	0%	0%
99202		Typically 20 minutes	17	2%	2%	7%	0%	-6%
99203		Typically 30 minutes	85	9%	28%	37%	-19%	-28%
99204		Typically 45 minutes	707	74%	62%	49%	12%	26%
99205		Typically 60 minutes	139	15%	8%	6%	7%	8%
99211	Established patient office or other outpatient visit	Typically 5 minutes	2	0%	0%	1%	0%	0%
99212		Typically 10 minutes	98	4%	2%	5%	2%	-1%
99213		Typically 15 minutes	922	34%	45%	47%	-12%	-14%
99214		Typically 25 minutes	1,593	58%	47%	43%	10%	15%
99215		Typically 40 minutes	136	5%	5%	5%	0%	0%





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24

Case Studies: Using Data to Uncover Issues

Trend Identification

Dermatology Services				
Service Date	**CPT Code**	**Modifier**	**Units**	**Procedure Description**
5/17/2018	99214	25	1	E/M – Est Pt – Level 4
5/17/2018	11301	XS	1	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm
5/17/2018	11301	76	1	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm

Modifier	Description
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure

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25

Recent OIG Settlements: Would Your Auditing & Monitoring Program Identify This Issue?

Physician Supervision

04/28/2017 Voluntary Disclosure	Repayment: $14,638
Allergy Provider: Immunotherapy injections provided without the requisite physician supervision	
Your Auditing / Monitoring Approach:	

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26

Recent OIG Settlements: Would Your Auditing & Monitoring Program Identify This Issue?

Up Coding

07/27/2017 Voluntary Disclosure	Repayment: $3,364,000
Physician group improperly filed claims for: • Upcoded E/M services • Upcoded Doppler & Ultrasound testing services	
Your Auditing / Monitoring Approach:	

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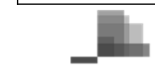
27

Recent OIG Settlements: Would Your Auditing & Monitoring Program Identify This Issue?

Physical Therapy

06/23/2017 Voluntary Disclosure	Repayment: $368,741
Physical therapy group filed claims for: • Billing for direct one-on-one (individual) therapy when the PT was treating more than one patient at the same time (group) • Re-evaluations when the provider was only re-certifying an existing plan of care	
Your Auditing / Monitoring Approach:	



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28

Questions / Discussion

29

Thank you