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OIG Audits Hospitals for New vs. Established Patients, Exposing Flaw in Billing Systems

Out of the blue, the HHS Office of Inspector General is auditing hospital claims for new and established patients, *RMC* has learned. The audits focus on billing by some hospital-based outpatient clinics, which may have overcharged Medicare by treating established patients as if they were new patients. OIG may eventually be staring at a recoupment goldmine because most hospital billing systems can't readily distinguish between new and established patients, experts say.

OIG's Office of Audit Services sent letters to some hospitals in October, asking about a handful of claims for new patient visits that perhaps should have been billed as established patient visits, says Kelly Sauders, a partner with Deloitte & Touche. Medicare pays more for new patients than for established patients treated in hospital-based outpatient clinics and requires hospitals to use different codes to distinguish between the two.

In the letters, OIG instructs hospitals to review their medical records and submit more information about the line items on the claims and their internal controls for billing new versus established patients. For example, OIG's information requests include:

(1) Whether the patient was new or established.

(2) If the patient was new and the hospital believes that information is accurate, OIG wants evidence that the data file record showing the patient's previous visit to the hospital-based clinic is wrong. Reading between the lines, Sauders says that OIG already knows the hospital made a mistake. But it's giving the hospital a chance to justify billing an established patient as a new patient.

(3) If there's an error, the hospital should provide the correct code and explain why the error occurred.

(4) OIG wants a description of written policies and procedures on classifying new versus established patients and internal controls for detecting errors.

OIG is targeting claims submitted in 2010 and 2011 for the three highest evaluation and management (E/M) levels of service for new patients (99203-99205), Sauders says. That makes sense because there's no payment difference for the lower codes, she notes. Only one to four claims per hospital are requested. "They are not doing mass data analysis yet," Sauders says. "They'll wait and see what they get back from the hospitals."

Errors may be pervasive. "This has not been on the radar screen," Sauders says. "These are high volume, low dollar claims, and have not been the focus of hospital compliance efforts for the most part."

CMS's payment differential for new versus established patients dates back to the August 2000 implementation of the outpatient prospective payment system. At that time, patients were considered "established" even if their return visit was 50 years after their initial visit as long as they had a medical record number, Sauders says. However, in the Nov. 18, 2008, OPPS update *(73 Fed. Reg. 68502, 68679)*, CMS changed the requirement. Now patients who visit the hospital outpatient clinic within three years are established patients, and after that they are new, with Medicare paying more for the latter. For example, for 2011, one of the years currently under review by the OIG, there is a payment difference for new versus established clinic patients for the three highest levels (see box below).

And therein lies the compliance rub. With Medicare paying more for new patients, hospitals may be hit for overpayments if they bill an established patient with a new-patient code. Complicating matters, there is a link to the assignment of evaluation and management services under OPPS. Hospital clinics are required to select an E/M level of service that reflects hospital-based resource use according to the system they developed in the absence of national Medicare guidelines, and CMS has explicitly stated that providers should not mimic physician E/M levels. While physicians also are required to distinguish between new and established patients, the definition is different for professional billing, and there may be variance between professional and hospital (technical) E/M levels of service. In practice, however, many hospital-based clinics default to the E/M code selected by the physician for the visit, Sauders says.

Billing Systems Don't ID Established Patients

Another reason hospitals make errors with new versus established visits is their billing systems don't have a way to easily identify established patients. Some

hospitals have coped by billing all patients as established, and eating the difference when they are actually new, Sauders says. A few that have taken the time to understand this issue and whose systems are customizable have built the necessary logic in their billing systems.

"This is a really hard thing for hospitals to keep track of," she says. "It is fixable, but to fix it accurately requires a high level of programming or manual intervention, which is not an attractive option."

Boston attorney Larry Vernaglia, who also represents hospitals that are being audited for new versus established patients, says the audits put many hospitals at risk. "OIG has the ability to cast a wide net with this data mining exercise," says Vernaglia, with Foley & Lardner LLP. "I think this will be broad. It is easy for them to go after it." He says hospitals should evaluate their billing and coding methods to ensure they comply with CMS expectations.

It's possible that OIG stumbled into errors for new-versus-established-patient overpayments during data mining for Medicare compliance reviews, Sauders says. During these comprehensive hospital audits, OIG scours billing for modifier -25, which is used liberally in some outpatient clinics, she says. "This seems to be how they find new areas," Sauders says. Sometimes OIG already has risk areas on its mind when it data mines, and sometimes it appears to trip over them.

This Audit Is an Easy One for OIG

And this audit is a no-brainer for OIG. It's like a RAC automated review, with auditors able to eventually seek recoupment from hospitals without reviewing medical records. "All they have to do is say you were wrong, you owe us this amount of money," Sauders says. That's why she and Vernaglia speculate it could spread to all corners of the country.

To some in the industry, the entire notion of new-versus-established-patient visits makes sense only in the physician office context, where the time needed to care for a new patient truly is different, Vernaglia says. In the hospital context, there is no difference in the level of care or resources delivered for a new patient compared to a patient who may have visited the hospital before, he says. The staff is probably entirely different. "Thus, the CMS framework is built upon a faulty assumption, namely that Medicare should pay less for a visit with a patient who has been to the hospital before," he says. But CMS said in the 2008 rule there are "meaningful and consistent cost differences between visits for new and established patients...."

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