

MEDICARE COMPLIANCE

OIG Extrapolation in Medicare Compliance Review Triples Hospital's Overpayment

Medicare compliance reviews have turned a corner, with the HHS Office of Inspector General (OIG) using extrapolation for the first time to capture more of the money the hospital presumably owes Medicare. One auditor says this is par for the course in program-integrity audits, but there are different stakes with Medicare compliance reviews, attorneys contend, because hospitals have no direct line to appeal the results and, more specifically, challenge statistical sampling methods.

In the new Medicare compliance review, released May 24, OIG audited a stratified random sample of 250 claims submitted by Saint Thomas Hospital in Nashville. There were errors in 44 of them, causing an overpayment of \$293,359 that was extrapolated to \$1.092 million. OIG explained that its use of statistical sampling and extrapolation is a refinement of the audit methodology it is using as its hospital review initiative matures.

"It is a huge deal. Extrapolation is very punitive when the OIG truly did not find fraud, abuse or intentional waste," says Christine Hogan-Newgren, chief compliance officer and chief audit executive at University of Colorado Health, which went through a Medicare compliance review last year (*RMC* 6/25/12, p. 1). "When you combine this with all of the other government recovery programs that are in operation, this is even more than punitive."

Extrapolation Yields Big Bucks

In the Medicare compliance review of 541-bed Saint Thomas, OIG said the hospital was paid about \$261 million for 26,855 inpatient and 71,176 outpatient claims for services provided to Medicare beneficiaries in 2009 and 2010. Of those claims, OIG narrowed down the potential audit population to 3,297 claims that were potentially at risk of billing errors. From there, auditors focused on 195 inpatient and 55 outpatient claims.

Usually, Medicare compliance reviews involve judgmental sampling instead of random sampling, which means OIG typically uses computer matching and data mining to pick claims for review and bases its overpayment findings on the actual claims audited. This time

around, OIG extrapolated the overpayment findings for four of the six risk areas audited at Saint Thomas.

Here's a breakdown of the findings, based on appendix B and C, which OIG said reflect a confidence rating of 90% (the lowest extrapolated overpayment):

Inpatient Claims

◆ **Short stays:** Of 50 claims audited, OIG says the hospital billed Medicare Part A for nine inpatient stays that should have been billed as outpatient or outpatient with observation services. The actual overpayment was \$56,050, which extrapolated to a \$325,141 overpayment.

◆ **Inpatient claims paid in excess of charges:** Of 40 claims audited, OIG found 12 overpayments worth \$86,240 and extrapolated it to \$358,353.

◆ **Claims billed with high-severity-level DRG codes:** There were errors on four of the 50 claims audited. For example, Medicare was billed for an MS-DRG based on a principal diagnosis code associated with a myocardial infarction when documentation showed the principal diagnosis code should have been supraventricular tachycardia. The overpayment amount was \$14,945, and for this risk area, OIG did no extrapolation.

◆ **Same-day discharges and readmissions:** Hospitals are supposed to combine claims when patients are discharged or transferred out and then readmitted for related symptoms or evaluation and management services related to the earlier stay. One of four claims audited was incorrect. The resulting overpayment was \$3,624 and OIG extrapolated it to \$34,518.

◆ **Manufacturer credits for replaced medical devices:** Hospitals are required to pass on credits to Medicare if the manufacturer replaces an implanted device for free or gives the hospital a credit worth 50% or more. The hospital failed to adjust Medicare claims for manufacturer credits for 14 of 51 claims audited, including a \$3,600 credit for a pacemaker that was covered by the manufacturer's warranty. OIG contends the hospital

was overpaid \$109,181, an amount it extrapolated to \$1.031 million.

Outpatient Claims

◆ *Claims with payments greater than \$25,000:* OIG audited 30 claims and found one error with an overpayment of \$565, and did no extrapolation.

◆ *Manufacturer credits for replaced medical devices:* When hospitals replace devices during outpatient procedures and receive manufacturer credits, they must pass the credits on to Medicare using either the FB modifier (full credit) or FC modifier (half credit). OIG says the hospital dropped the ball on three claims. The overpayment was \$22,754, which OIG extrapolated to \$359,764.

OIG urged the hospital to refund the overpayments to Medicare.

It was inevitable for OIG to adopt statistical sampling and extrapolation in its Medicare compliance reviews, because that's the path that many, if not most, health care compliance audits have taken, says Bruce Truitt, an instructor in government auditing, fraud and statistical sampling for the Government Audit Training Institute in Washington, D.C. "Random sampling has a long, long history in CMS procedure, administrative hearings and case law," he says. "Pretty much everyone out there doing program-integrity reviews does some sort of random sampling — RACs, ZPICs, MICs and state entities. Institutional and other providers should assume it will be in play and find out for sure."

But CMS contractors and OIG auditors play in slightly different ballparks, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "It is a surprise OIG will be trying to use extrapolation in 'routine' audits," she says. "It blurs the role of OIG and the role of CMS and its contractors in terms of determining overpayments." Waltz says extrapolation belongs in the CMS arena because providers have clearly defined appeal rights to address overpayment determinations, including the designs of statistical strata. "It all goes back to due process. Congress created parameters for Medicare contractors on extrapolation and OIG can just go around them." According to statute, Medicare contractors may extrapolate in their quest to quantify overpayments only where there is a "sustained or high level of payment error" or "documented educational intervention has failed to correct the payment error" (*RMC 1/21/13, p. 1*). But the statute is applicable only to contractors, not to OIG.

The Stakes Are Now Higher

"This is upping the ante," says Heidi Sorensen, former chief of the OIG Administrative and Civil Recoveries Branch. "If there is going to be extrapolation based on

audit results, that is a much more significant issue for hospitals."

Perhaps the most critical issue is the lack of clarity around appeal rights with OIG audits, Waltz says. But OIG spokesman Donald White says "the standard appeals process applies to Medicare compliance reviews" — redetermination, rehearing, administrative law judge, Medicare Appeals Council and federal court. However, Waltz says, hospitals can't fight an OIG overpayment until there is a claims determination and demand for payment, which has to come from a Medicare contractor. And as far as she knows, there are no directions in Medicare manuals or elsewhere on how Medicare contractors implement OIG Medicare compliance review findings. That leaves it to hospitals to refund the money voluntarily, even if they don't agree, Waltz says. "An OIG [repayment] recommendation is more than just an invitation to a party," she says.

Sorensen is also worried about the way OIG went about the Saint Thomas audit, which she calls more of a hybrid — a judgmental sample of risk areas mixed with a random sample within each risk area. "I have concerns about the fairness of the methodology." There may be too many "decision points along the way" to ensure the fairness of the audit, says Sorensen, who is with Foley & Lardner.

Truitt agrees that auditors can't extrapolate from judgmental samples. But he says statistical sampling "is just good auditing. Once they have identified areas that appear to be at high probability of errors, they take a judgment sample to see if their hypothesis is accurate and move on from there."

Hospitals should consider hiring a statistician if they are facing a Medicare compliance review, experts say. And "they need to take the entrance conference very seriously," Waltz says. "It should be more than a meet and greet. You should really grill the auditors on their expectations and audit methodology."

Meanwhile, Medicare compliance reviews may expand beyond hospitals, Sorensen says. "I think OIG really likes this project because it allows them to look at a lot of issues" simultaneously, she says. "Given what they perceive as their success, it could spread to other types of providers," such as skilled nursing facilities.

In response to the Medicare compliance review, Saint Thomas Corporate Responsibility Officer Cynthia Figaro wrote in a letter to OIG that the hospital is committed to compliance and quality of care and will pay back most of the money. But it disputes some of the findings, saying 11 admissions were medically necessary. The hospital plans to appeal these cases and, if necessary, use the new CMS Part A/B rebilling policy.

She also expressed concern about OIG's use of extrapolation. Other hospitals with worse findings in Medicare compliance reviews did not suffer the same fate. Medical necessity decisions should not be extrapolated, especially in light of how often claims denials based on setting are overturned, Figaro said.

Saint Thomas didn't even know about OIG's plans to extrapolate until the audit was approaching its final stage, Figaro said. But OIG tells a different story, asserting that the hospital was informed at the June 26, 2012, entrance conference of its plan to use statistical sampling

techniques to pick claims to review and project audit findings across the population.

Figaro described improvements in internal controls at Saint Thomas. For example, in the area of medical device credits, the hospital revised its policy and procedure, assigned an employee to the issue, is working with vendors to get credit reports and will audit through the compliance department.

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