Medicare Compliance Reviews:
Introduction
First Medicare Compliance Review report: March 2, 2011 – South Shore Hospital, MA
- First official mention: 2012 OIG Work Plan

Medicare Inpatient and Outpatient Payments to Acute Care Hospitals (New) - "We will review Medicare payments to hospitals to determine compliance with selected billing requirements. We will use the results of these reviews to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations, and inspections have identified areas that are at risk for noncompliance with Medicare billing requirements. Based on computer matching and data mining techniques, we will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same data analysis techniques, we will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. We will then review the hospitals’ policies and procedures to compare the compliance practices of these two groups of hospitals. We will also survey or interview hospital leadership and compliance officers to provide contextual information related to hospitals’ compliance programs."
Medicare Compliance Reviews: Introduction

Stated Purpose of Medicare Compliance Reviews:

“Our objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.”

Facility Selection

“Based on computer matching and data mining techniques, we will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same data analysis techniques, we will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky.”

- PEPPER rankings
- Results of prior OIG audits

Evolution of the Audits

Began as educational, not punitive:

Auditors don’t pick every claim for a particular service within a two-year window of time, he said. Rather, the goal is to pick a few and use them to instruct the hospital on best practices and prevent any future problems. “If it’s short stays, we’re not picking 100 short stays, we’re picking a handful and working with them on that,” Ritchie said. “While it does require some time, we do think there is a benefit to the provider as well as the federal healthcare programs.”

Modern Healthcare, “Audits said to put hospitals on track,” October 22, 2012 (quoting Brian Ritchie, Asst. IG for Audit Services, OIG-HHS)
What is a Medicare Compliance Review?

- The Office of Inspector General (OIG) performs independent reviews of Department of Health and Human Services (HHS) programs pursuant to the Inspector General Act of 1978 which authorized the OIG to have access to all records and other materials which relate to programs and operations to which the Inspector General has responsibility.
- A Medicare Compliance Review is an audit that is based on data mining of inpatient and outpatient claims from the National Claims History Database for 25 risk areas.

Investigation Process and UPMC’s Response

- UPMC Presbyterian Shadyside, which is part of the UPMC health system, is a 1,532-bed acute care hospital located at two campuses, UPMC Presbyterian and UPMC Shadyside, in Pittsburgh, Pennsylvania. Medicare paid UPMC Presbyterian Shadyside approximately $1.05 billion for 62,755 inpatient and 398,989 outpatient claims for services provided to beneficiaries during CYs 2008 through 2011.
- In June 2012, the UPMC Presbyterian Shadyside Compliance Officer and UPMC Corporate Compliance Officer received a letter announcing that the hospital was a target of an audit by the Office of the Inspector General for calendar years 2008 – 2011.
- UPMC sent the final response to the OIG in August 2013.
- The OIG audit covered $3,702,396 in Medicare payments consisting of 156 inpatient and 83 outpatient claims.

Investigation Process and UPMC’s Response

- The OIG auditors contacted us to set up an entrance meeting to discuss the audit process with both Compliance Officers.
- The OIG provided a list of claims and the documentation they wanted to support each type of claim. The entrance meeting was conducted by phone and UPMC agreed to do a self audit of all the claims and report the results with supporting evidence back to the OIG.
- A team consisting of members from Corporate Compliance, Supply Chain Management, Corporate Care Management and the Revenue Cycle reviewed all of the claims and collected the information requested.
- Spreadsheets of the results were completed for each area of review. Packets were compiled and cross referenced to the spreadsheet for each claim.
Investigation Process and UPMC’s Response

The areas for review included:

A. Inpatient Short Stays – 60 Claims
B. Inpatient Claims with High Severity Level DRG – 38 Claims
C. Inpatient and Outpatient Manufacturer Credits for Replace Medical Devices – 90 Claims
D. Outpatient Use of Modifier 59 – 24 Claims
E. Outpatient Claims for Dental Services – 10 Claims
F. Outpatient Billing for Lupron Injections – 1 Claim
G. Outpatient Claims Billed During and Inpatient Stay – 24 Claims

The most difficult area to collect all the information requested was manufacturer credits.

Investigation Process and UPMC’s Response

• OIG reviewed our findings and the support provided for each area. Any area in which they disagreed with our conclusion was discussed. We came to a consensus with the OIG on all cases except one.
• Errors were identified in 66 of the 156 inpatient claims audited and 47 of the 83 outpatient claims.
• For each area in which an error was identified, the OIG submitted an “Internal Controls Questionnaire” for completion.
  – Condition
  – Criteria
  – Key Controls in Place
  – Cause of Incorrect Billing
  – Corrective Action Plan
  – Internal Audit and Compliance Activity

Investigation Process and UPMC’s Response

• Internal Control Questionnaire Completion
  – Controls over accurate billing needed to be identified.
  – The cause of the error needed to be determined.
  – Action Plan to prevent the error had to be created and implemented.
  – Our goal was to use technology to identify and correct the errors as much as possible.
• Medical Device Credits is a complicated issue.
• Devices are replaced in many areas of our hospitals.
• Common medical devices implanted include pacemakers, cardioverter defibrillators, and their associated leads so we started with the Electrophysiology Department to create a process.
• We had two types of credits to address- recalls and warranties.

UPMC’s Response for Medical Device Credits

Issues that needed to be addressed:
1. How to identify the devices being replaced that were under warranty or recalled?
2. How to make sure these devices were returned to the manufacturer for credit?
3. How to get credit for recalled devices that could not be removed without injury such as leads?
4. How to communicate to coding so that the proper modifiers and value codes were appended to the claim?
5. How to identify the dollar amount of the credit that needed to be on the bill and communicate this to billing?

SOLUTION: ALL EXPLANTED DEVICES ARE LOGGED IN A SHARED DATABASE AND RETURNED TO THE MANUFACTURER FOR POTENTIAL CREDIT.
UPMC's Response for Medical Device Credits

How to get credit for recalled devices that could not be removed without injury such as leads?

- UPMC Sourcing worked with the device vendors to identify what was needed to support credits for failed leads and other such devices that could not be fully removed from the patient.

UPMC's Response for Medical Device Credits

How to identify the dollar amount of the credit that needed to be on the bill and communicate this to billing?

How to communicate the credit so that the proper modifiers and value codes were appended to the claim?

- Tracking CDMs were created in each area and attached to all replaced device cases. This allows the cases to be tracked by billing and reconciled to the shared database.
- Sourcing enters the type of credit (warranty or recall), the percentage of the credit, and the dollars received into the shared database.
- Billing utilizes the tracking CDM to monitor pending credits and adds the dollars, modifiers and value codes based on what sourcing enters.

Database Input Screen
OIG Rationale – From Gloria Jarmon (Deputy IG for Audit Services)

“As we did more hospital compliance audits, we began the use of statistical sampling to draw conclusions about a larger portion of the hospital’s claims.”

“Determining the overpayment through sampling and extrapolation, rather than reviewing each claim, is both economical and in the interest of the provider and the Government. OIG uses a conservative method under which overpayment estimates will almost always be lower than the estimates that would result from reviewing every claim.”

January 15, 2015 letter responding to AHA challenge to OIG’s continued performance of Medicare Compliance Reviews

OIG Rationale – Quote from Jared Smith, OIG statistician:

When asked why many recent OIG audits had used statistical sampling:

“Statistical sampling gives OIG the ability to cover thousands or even millions of claims in a fair and objective fashion.”

When asked when the OIG uses statistical sampling:

“In general, we consider using sampling whenever it’s not possible to review every claim.”

January 12, 2015 interview of OIG statistician Jared Smith by OIG senior auditor Lisa Wombles, as posted to OIG website

STH would like to comment on the application of the “statistical” vs. “judgmental” sampling methodology that was utilized for this audit. In reviewing the Medicare Compliance Reviews audit reports the OIG has issued in the past two years, all of them were based on a “judgmental” sampling methodology. In some cases, it was noted that some hospitals had no extrapolation even though their overpayment audit results appeared to exceed those of STH. STH respectfully questions the rationale for selecting a hospital for the “statistical” vs. “judgmental” sampling methodology, particularly so far in to this present hospital compliance audit initiative.

May 26, 2013 – OIG released copy of 1st report to include extrapolation – Saint Thomas Hospital in Tennessee
Cost to the Organization

- Much higher overpayment findings
- More complex analysis/review of OIG report
- Engagement of statistician to assist
- More likely to appeal rather than agree to report findings – cost, delay, resources, attorney’s fees

Approach to Argue/Appeal Use of Extrapolation

- Attack the use of extrapolation in absence of finding of sustained or high error rate
- Attack the use of extrapolation without final overpayment amounts (Part B offsets) (use actual, net overpayments, not gross)
- Attack any duplication (if any claims in sampling frame are reviewed by RAC)
- Attack use of extrapolation in medical necessity cases – reference success rate on appeal
- Attack sample selection
- Engage a statistician to assist in reviewing and challenging extrapolation methodology and results
- Look for errors in assumptions by auditors
- Work with your CMS Action Official and MAC contact to challenge OIG audit and use of extrapolation
- Exercise all appeal rights – most likely to be successful at level 3 (ALJ)
Medicare Compliance Reviews: Extrapolation
The Good, The Bad, and The Ugly

Appeal Process
- Same as for other appeals – once you get demand letter from the MAC
- But → All appealed under single appeal number even if several types of issues (DRG, medical necessity, discharge disposition, medical device plus extrapolation in some but not all areas)
  - Request for redetermination
  - Request for reconsideration
  - Appeal to ALJ
  - Medicare Appeals Council
  - Court

Medicare Compliance Reviews: Extrapolation
The Good, The Bad, and The Ugly

Appeals
- Appeals of OIG audits area a relatively new thing – historically, most providers agreed with OIG findings by the time the final report was issued and paid the overpayment
- Extrapolation = game changer
- Query whether OIG auditors/OIG medical review contractor will testify at ALJ level
- Stay tuned – may take a while given moratorium on assigning new appeals to ALJs and delay in deciding cases

Questions?

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