

MEDICARE COMPLIANCE

Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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OIG Hits Hospital for \$3.7 Million After Extrapolating Errors for Short Stays

University of Miami Hospital was hit with the largest overpayment in the history of Medicare compliance reviews — \$3.7 million. The HHS Office of Inspector General arrived at that figure partly by extrapolating errors for short inpatient stays, which took experts by surprise because medical necessity is still somewhat of a moving target. This is only the third time that OIG used statistical sampling and extrapolation to broaden its overpayment horizons in Medicare compliance reviews, but there is probably more to come.

“This seems to be the wave of the future,” says one former government lawyer, who prefers not to be identified. “We are up into major bucks. They are changing the stakes.”

In Medicare compliance reviews, OIG audits multiple risk areas at a hospital and evaluates its internal controls. What’s intriguing about the Oct. 8 Medicare compliance review at University of Miami Hospital is that OIG scrutinized six risk areas and found errors in all of them, but only extrapolated the short stays to a larger universe of claims.

Meanwhile, one statistician thinks OIG made a mistake in its extrapolation calculation, a sign that hospitals generally may have grounds to challenge OIG’s methodology. “The point estimate for the short-stay stratum, the only stratum for which extrapolation can be performed, is about \$200,000 too high,” says Harold Haller, Ph.D., director of the Case Western Reserve University Statistical Consulting Center in Cleveland and a consultant to HHS administrative law judges.

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Two-Midnight Stays May Be Audited Due to The Separation of Part A and Part B Claims

There may be a crimp in CMS’s plans to steer clear of audits of inpatient stays that last two midnights.

Claims for inpatient stays that cross the two-midnight threshold will still be pulled for review when patients spend the first night in observation or the emergency room because, on the surface, they resemble one-day stays, experts say. Without delving into the medical records, auditors won’t be able to distinguish between dubious one-day stays and medically necessary two-midnight stays where only the second midnight was pursuant to an inpatient order.

CMS has said the clock starts ticking on the two midnights when patients begin receiving care regardless of the setting (*RMC 9/30/13, p. 1*), but that may not do hospitals much good audit-wise, depending on how audits play out.

“The question is, when the auditors dig into the medical record and find that the patient did cross the two midnights, will they close the file? Or, having gone this far, will they continue with the audit to see if the medical record was documented correctly and the order and certification requirements are met? My guess is the latter,” says

Washington, D.C., attorney Don Romano, former director of the CMS Division of Technical Payment Policy. "It will all depend on what instructions CMS gives the auditors."

That's one of the lingering concerns with the two-midnight rule, which is a controversial part of the 2014 inpatient prospective payment system regulation that took effect Oct. 1. CMS generally will assume inpatient admissions that cross two midnights are medically necessary unless they are delayed on purpose, and auditors will turn their attention to shorter stays except for procedures on the inpatient-only list (*RMC 8/12/13, p. 1*). However, CMS delayed until Jan. 1 recovery audit contractor (RAC) reviews and most Medicare administrative contractor (MAC) reviews of inpatient admissions with dates of service from Oct. 1 to Dec. 31, 2013, although MACs will audit 10-25 short stays per hospital over the next three months to get a feel for compliance with life under the two-midnight rule (*RMC 9/30/13, p. 1*). Meanwhile, hospitals are adapting to new physician certification requirements that are part and parcel of the two-midnight rule (*RMC 9/2/13, p. 1, 9/16/13, p. 1*).

Jessica Gustafson, an attorney with The Health Law Partners in Southfield, Mich., says the segregation of Part

A and B claim data is the reason there will be audits of two-midnight stays. "There is nothing hospitals can do at this point to avoid claims being targeted for medical review by RACs and MACs after Jan. 1. These are exactly the claims that will be audited," says Gustafson, who spoke at a Sept. 26 webinar sponsored by Atlantic Information Services. "The hope and expectation is that CMS in reviewing those cases will apply the two-midnight benchmark in good faith." Auditors use MedPARS data that do not include Part B observation and emergency room services in the dates of Part A stays, says Romano, who is with Foley & Lardner. "If RACs go over a lot of cases where there are not two midnights on the surface, then a lot of those stays will end up getting denied," he says. Obviously, this dilemma doesn't exist for inpatient stays where the admission order kicked off an inpatient stay of two or more midnights.

Two-Midnight Rule Is a Yardstick for Docs

The two-midnight rule is a yardstick for physicians making clinical decisions, and as long as they document their expectations that the medically necessary inpatient stay will be two midnights, hospitals should avoid denials even if patients recover faster and are discharged sooner, Gustafson says. In the IPPS rule, CMS introduced two medical review policies related to the two-midnight rule: a two-midnight "presumption" and a two-midnight "benchmark." The presumption refers to CMS telling auditors to steer clear of cases where a hospitalization crosses two midnights after an inpatient order is written (for the purposes of determining whether an inpatient admission is medically necessary), as long as hospitals aren't playing games and the services provided are medically necessary.

However, the two-midnight benchmark may be applied to those cases where the entirety of a hospital stay crosses two midnights, but the time spent in the hospital after the inpatient order doesn't cross two midnights, Gustafson says. If the entire stay crosses two midnights, hospitals shouldn't face denials for medically unnecessary admissions. For example, if patients receive observation services across one midnight and the physician feels the patient requires hospital care for at least one more midnight, the physician may properly order inpatient admission, she says. "When the claim is pulled for medical review — which is likely since in the Medicare system, the inpatient time will appear to have crossed only one midnight — CMS auditors may apply the two-midnight benchmark and not deny the claim, since the entirety of the hospital stay crossed two midnights," Gustafson says.

While inpatient stays clearly begin when the admission order is written, it's a little fuzzy when hospitals can start counting outpatient hours for purposes of crossing

Report on Medicare Compliance (ISSN: 1094-3307) is published 45 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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two midnights. Is it when physicians put their hands on the patient in an emergency room? Or when the nurse does? “Some consultants say it needs to be a doctor, but I’m not sure I agree,” Gustafson says. “But sitting in a waiting room won’t count.” This should be fleshed out in forthcoming CMS subregulatory guidance.

In terms of other aspects of the two-midnight rule, hospitals should expect reviews of admissions for MS-DRG coding, for the medical necessity of services and “for evidence of systemic gaming” to push patients across two midnights, Gustafson says. Documentation will be your saving grace, especially in the history and physical and the progress notes. “Often we see thorough H&Ps and not a lot more from the physician except maybe one to two sentences throughout,” she says. “It will be more important for doctors to document the continued medical necessity of hospital care, especially with the close-call cases” that Medicare auditors focus on (e.g., chest pain, transient ischemic attacks).

ALJs also will look for physician documentation of the expectation of a two-midnight stay and an explanation for it, says Abby Pendleton, a lawyer with The Health Law Partners, who also spoke at the AIS webinar. “You have to train doctors to write like this. It may fall on deaf ears, but with the review activity and the False Claims Act, you have to document for the regulatory environment,” she says.

Contact Romano at dromano@foley.com, Gustafson at jgustafson@thehelp.com and Pendleton at apendleton@thehelp.com. ♦

FDA Rule May Improve Reporting of Medicare Credits for Devices

Hospitals may soon stop wringing their hands over compliance with Medicare rules for reporting medical-device credits. An FDA regulation should make it easier for hospitals to identify manufacturer credits for replaced devices so they can be passed on to Medicare, experts say.

On Sept. 24, the FDA finalized a rule that requires most medical devices to have a “unique device identifier” (UDI). Congress and the FDA probably didn’t have Medicare credit-reporting problems in mind when they devised the UDIs, but alleviating them is a nice side effect, says Kelly Sauders, a partner with Deloitte & Touche.

“Devices will become completely trackable from the manufacturer to the seller to the buyer to the patient,” notes Janelle Wissler, a specialist manager at Deloitte & Touche. “There is no reason not to track every credit back to specific accounts, and then auditing this will be easier.” UDIs also will make a massive amount of apples-to-apples data available to accountable care organizations (ACOs), enabling them to compare the cost and quality of medical devices, she says.

Device-credit reporting is a seemingly intractable compliance problem and a popular item in HHS Office of Inspector General audits (see story, p. 1). Hospitals are required to pass on manufacturer credits for devices under warranty when the devices are replaced because they malfunctioned or interacted poorly with the patient’s

Addendum to Physician Certification for Two-Midnight Rule

To help surgeons and other physicians think through the two-midnight rule for inpatient admission, WellSpan Health in York, Pa., has added this language to its physician certification. WellSpan also has revised its physician certification in response to ongoing CMS statements about the two-midnight rule, which was set forth in the 2014 inpatient prospective payment system regulation (*RMC 9/30/13, p. 1, 9/23/13, p. 1, 9/16/13, p. 1*). “We have a soft alert at the initiation of hospital care that prompts the [certification] form,” says Ann Kunkel, director of case management at WellSpan. “Then we have a hard stop at the discharge order that will not let them write a discharge order unless we have a compliant certification signed by an attending physician” — for themselves, as well as co-signing for physician assistants, nurse practitioners and residents. “Our forms are signed electronically so we believe we need to add a statement about that on the form,” she notes. Kunkel says compliance is going “pretty smoothly,” and the addition will help with provider education. Contact Kunkel at akunkel@wellspan.org.

When completing the inpatient certification, the surgeon/provider should consider the following to determine a reasonable expectation of crossing two midnights:

- In general, do I reasonably expect (80% of the time), when this procedure is performed/condition is treated, for my Medicare population that the patient’s recovery will cross two midnights?
 - If Yes, please make inpatient and document on the certification form.
 - If No, consider the next question:
- Are there particular concerns, co-morbidities, risks that make me believe this patient will require a longer recovery crossing two midnights?
 - If Yes, please make inpatient and document rationale on the certification form.
 - If No, then the procedure/condition should be an outpatient procedure with extended recovery or observation services.
- The exception to this guidance are the inpatient-only procedures, which are required to be inpatient by Medicare.

body. When it receives credit information, Medicare reduces payments for inpatient and outpatient procedures to replace or fix the faltering devices, such as pacemakers and defibrillators. But giving Medicare credit where credit is due is harder than it sounds (*RMC 7/25/11, p. 1*). It requires hospitals to coordinate different departments, from materials management, which receives manufacturer credits, to patient accounting, which bills Medicare for procedures to replace devices. Then there are Medicare rules on modifiers. When replacement devices are inserted during outpatient procedures, CMS requires hospitals to report the amount of the credit by appending modifiers to their claims. The FB modifier means the hospital received a full refund or credit for the replacement device from the manufacturer, while the FC modifier indicates the hospital received a credit of 50% or more for the replacement device. Apparently compliance in this area is not an easy task for hospitals, because the HHS Office of Inspector General keeps hitting them for overpayments for device credits.

But the UDI may change the compliance picture. Most devices have identifiers on them now, but there is no consistent format. "This requires a specific format that everyone must [use]," Wissler says.

The UDI was designed to improve patient safety through better adverse event reporting. The FDA says it will be able to identify device problems faster and zero in on product recalls. UDIs are numeric or alphanumeric codes with two parts:

- (1) A device identifier that identifies the labeler and the version or model of the device, and
- (2) A production identifier, which gives certain information about the device, such as lot/batch number, serial number, expiration date, and manufacture date.

All UDIs must be entered into the Global Unique Device Identification Database, which is under development by the FDA. The UDI was created by Sec. 226 of the FDA Amendments Act of 2007 and Sec. 614 of the FDA Safety and Innovation Act of 2012.

UDI compliance deadlines are staggered and understanding the specifics can be complicated. For example, by Sept. 24, 2014, "the labels and packages of class III

medical devices and devices licensed under the Public Health Service Act (PHS Act) must bear a UDI," FDA says. One year later, implantable, life-sustaining devices must bear a UDI on their labels and packages.

UDIs should make it easier for hospitals to connect the dots in their own systems when it comes to device credits, Wissler says. But it won't happen by waving a wand — not a magic one anyway. Hospitals will have to scan the UDI for each medical device into their electronic medical records so it can be searched and retrieved as needed. "The data point should be available throughout the revenue cycle, from the point of order to implant to accounts payable to billing," Wissler says. "These data will then tie to any manufacturer rebates or credits and allow patient account billing adjustments to seamlessly occur." Wissler says software may not exist yet to accomplish this chain of events, but it wouldn't be hard to develop. When ICD-10-PCD takes effect, the UDI also could link to coding tables for implantable devices, she says.

OIG also will benefit from UDIs because they can more easily identify when hospitals received credits they should pass on to Medicare, Sauders says. Under the prudent-buyer standard, hospitals are held liable not just for the credits they actually receive from the manufacturer but for the credits they should have gotten their hands on. "This will allow [OIG] to do a much better tracking on the device credit side," she says.

UDIs are a big deal generally because medical devices — and the procedures to implant, explant and replace them — cost a lot of money and put patients at risk of harm. "As we move into ACOs, UDIs will help them be more efficient in their ordering and tracking of quality," Wissler says. ACOs can run reports showing how many of ABC devices implanted three years ago have required replacement compared to a competitor's device, for example.

Contact Sauders at ksauders@deloitte.com and Wissler at jwissler@deloitte.com. Read about UDIs at <http://tinyurl.com/6tj8lro>. ✦

Miami Hospital Is Nailed by OIG

continued from p. 1

According to the Medicare compliance review of 560-bed University of Miami Hospital, OIG's universe was 2,194 Medicare claims with potential billing errors. From there, auditors selected a stratified random sample of 200 inpatient claims with dates of service from April 1, 2009, to Dec. 31, 2010, worth a total of \$2,905,695.

Six inpatient risk areas were chosen. Of the 200 inpatient claims, OIG contends it found 68 errors. The breakdown of the errors and the overpayments aren't a perfect match for the chart in the Medicare compliance review

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(see box, below), which OIG attributes to the different way it categorizes the errors. Here are the findings:

- ◆ **Short stays:** For 56 of the 200 inpatient claims reviewed, the hospital incorrectly billed Medicare Part A for inpatient admissions that should have been billed as outpatient services or outpatient with observation. OIG says the overpayment is \$447,982, but the chart lists it as \$325,060, and notes that some claims may be rebilled under Part B.
- ◆ **Incorrectly billed high-severity level MS-DRGs:** For five of the 200 claims, the hospital got the codes wrong. The overpayment was \$17,475, although the chart reports the overpayment as \$2,252.
- ◆ **Separate inpatient stays:** For three of the 200 claims, the hospital billed Medicare separately for patients who were discharged or transferred and then readmitted on the same day for related symptoms or evaluation and management of related conditions. That was inappropriate, OIG said, and caused an overpayment of \$33,645.
- ◆ **Incorrect discharge status:** For three of the 200 claims, the hospital incorrectly billed patient transfers as discharges. Medicare requires hospitals to charge per diems when patients are discharged and then admitted to another hospital unless it's unrelated to the discharge. The overpayment was \$16,407.
- ◆ **Medicare device credits:** Out of 200 claims reviewed, the hospital failed to get a manufacturer credit for one

replaced device even though it was available under the warranty. Its resulting overpayment was \$8,500.

- ◆ **Claims paid in excess of discharges:** In a confusing move, OIG provided almost no details on this risk area, which appears only in the chart. The hospital purportedly was overpaid \$138,145 for this risk area.

After the Medicare compliance review, OIG concluded that University of Miami Hospital overcharged Medicare \$524,009. Based on that number, OIG recommended the hospital return \$3,717,557 to Medicare in estimated overpayments, which is the lower limit of an extrapolated amount.

A big chunk of the overpayment is the extrapolation from the short stays. "The reason they extrapolated on the short stays is the Willie Sutton law: that's where the money is," says Boston attorney Larry Vernaglia, who is with Foley & Lardner. Extrapolation of error rates should make providers nervous because the potential for large overpayment returns is much greater, Vernaglia says. "When they pull from a random sample, providers should start sweating. That means they are looking for an extrapolation," he says. "If it's a random sample, you should probably hire a statistician to evaluate the methodology they are using."

Haller says there's no mystery as to why OIG extrapolated only for one "stratum" — the short stay risk area. Consistent with the Medicare Program Integrity Manual's section on the use of statistical sampling for

Medicare Compliance Review: OIG Extrapolates for Larger Overpayment

University of Miami Hospital was asked to return \$3.7 million in its Medicare compliance review after OIG identified \$524,009 in overpayments. Here is a

breakdown of the actual overpayments identified, before any extrapolation. View the report at <http://go.usa.gov/DFhh>.

Results of Review by Risk Area				
Risk Area	Selected Claims	Value of Selected Claims	Claims With Overpayments	Value of Overpayments
Inpatient				
Claims for Short Stays	74	\$549,048	48	\$325,060
Claims Paid in Excess of Charges	27	357,325	12	138,145
Claims With Same-Day Discharges and Readmissions	10	98,424	3	33,645
Transfers	3	29,826	3	16,407
Manufacturer Credits for Replaced Medical Devices	13	907,734	1	8,500
Claims With High-Severity Level DRG Codes	73	963,338	1	2,252
Inpatient Totals	200	\$2,905,695	68	\$524,009

Notice: The table above illustrates the results of our review by risk area. In it, we have organized inpatient claims by the risk areas we reviewed. However, we have organized this report's findings by the types of billing errors we found at University of Miami Hospital. Because we have organized the information differently, the information in the individual risk areas in this table does not match precisely with this report's findings.

SOURCE: OIG

overpayment estimation (Chapter 8), OIG drew samples from two risk areas: short stays and high-severity level DRG codes, he says. But there was only one error in the 73 claims audited for high-severity level DRG codes, which was stratum two. "They have admitted this error rate is so low that it isn't even worth the trouble to extrapolate," Haller says. The rest of the risk areas were subject to a "census" audit, which means every single claim in the sample was audited. "You can't extrapolate a census," Haller says. But, he notes, "there is nothing wrong with extrapolating based on stratum number one alone," he says, referring to the short stays. "The extrapolations should consist of finding a point estimate for stratum one and subtracting from that the 1.645 times the standard error of the estimate to compute the lower 90 percent confidence interval."

In any audit, Haller says hospitals should challenge the findings if they think auditors have not obtained random samples or have cherry-picked samples. "Sufficient documentation must be retained so that the frame and sample can be recreated or regenerated if the sampling methodology is questioned," he says.

Haller also is troubled by a possible error on OIG's part. The Medicare compliance review states that the point estimate is \$4,462,013, an amount that inflates the lower limit of the extrapolated overpayment by \$200,000. "\$200,000 is not close to me," he says.

Extrapolating Short Stays 'Doesn't Make Sense'

Extrapolation of short stays doesn't make sense because they are unique, says Ernie de los Santos, founder of the Appeal Academy. "Documentation is difficult for each patient," he says. "I don't think a certified statistician would have much difficulty attacking the extrapolation on the basis of that type of claim. There is the assumption that data have some homogeneity, and the trouble with short stays is they are not very similar." And he is skeptical that OIG found no underpayments in any of the University of Miami Hospital risk areas.

Statistical sampling is nothing new to Medicare auditors. "Federal courts have consistently upheld HHS's use of statistical sampling for determining overpayments," says John Bartell, a former manager for National Government Services, a Medicare administrative contractor. But there are still avenues for challenging statistical sampling and extrapolation, he says. For example, was the sample size adequate? Was proper randomization used? Was the sample truly representative of the services provided?

Meanwhile, extrapolation may get more popular as the government looks at maximizing its resources amid funding cuts, says Bartell, a partner with Wipfli, a CPA and consulting firm in Milwaukee.

In University of Miami Hospital's response to OIG, Chief Financial Officer Darryl Caulton emphasized its commitment to accurate billing, described the improvements it had made in coding and case management and said it would return the overpayments to Medicare "taking into consideration that the total amount refunded may vary based upon factors raised in this response."

Hospital Says Stays Were Necessary

Despite the findings of OIG's independent medical reviewer, the hospital believes the five short stays were medically necessary. But if it can't prevail on this, the hospital wants the option to rebill Part B for some services, which OIG acknowledged was possible. Until this is resolved, OIG shouldn't use the full short stay amounts as a basis for extrapolation, the CFO said.

Generally, the hospital "disagrees with the decision to extrapolate the results from the audit sample." Caulton noted how rare extrapolation is in Medicare compliance reviews. "There is no reasoned basis for treating [University of Miami Hospital] differently," he wrote. "The lack of clarity regarding the standards for short stays and the controversy over rebilling also argue strongly against extrapolation."

OIG has extrapolated overpayments only in the Medicare compliance reviews of Saint Thomas Hospital in Nashville (*RMC 6/3/13, p. 1*) and Fletcher Allen Health Care in Burlington, Vt. (*RMC 6/4/12, p. 8*).

Meanwhile, the hospital has taken a number of steps to reduce medically unnecessary admissions, the letter states. For example, "all Medicare accounts with LOS three days or less are placed on an automatic bill hold and are not released for billing until reviewed for appropriateness by case management."

In terms of DRG coding errors, the hospital has hired four clinical documentation improvement specialists and educated coders on physician queries. In the area of medical-device credits, it has drafted a new policy for relevant clinical service lines and adopted an auditing plan.

Contact Haller at halhaller@aol.com, Vernaglia at lvernaglia@foley.com, de los Santos at erniedls@appealacademy.com and Bartell at jbartell@wipfli.com. View the Medicare compliance review at <http://go.usa.gov/DFhh>. ✧

With the government shutdown, there are no CMS transmittals and regulations to list this week.

NEWS BRIEFS**◆ HHS released a contingency plan explaining how the government shutdown affects its workforce and activities, including those of CMS.**

In the short term, Medicare, for the most part, will not be disrupted. Additionally, other non-discretionary activities, including the Health Care Fraud and Abuse Control program, Center for Medicare & Medicaid Innovation, and Pre-existing Condition Insurance Plan, would continue. However, CMS will not be able to continue discretionary funding for health care fraud and abuse strike force teams, so they must stop work until appropriations are allocated. In addition, fewer recertification and initial surveys for Medicare and Medicaid providers can be completed, putting beneficiaries at risk of quality of care deficiencies. CMS will continue many ACA activities, including coordination between Medicaid and the marketplace, as well as insurance rate reviews, and assessment of a portion of insurance premiums that are used on medical services. States will have funding for Medicaid on Oct. 1, due to the advanced appropriation enacted in the FY 2013 appropriations legislation, as well as for the Children's Health Insurance Program (CHIP). Visit <http://tinyurl.com/kkhw5o2>.

◆ The University of Wisconsin Hospital in Madison and its 117 clinics overbilled Medicare for \$316,172, according to a Medicare compliance review posted by the HHS Office of Inspector General on Oct. 10.

OIG reviewed 186 claims from a three-year period (2008–2010) — 85 inpatient and 101 outpatient — and found that 87 of the claims had errors. On the inpatient side, incorrect admission of patients who should have been treated as outpatients led to \$140,471 of the \$179,056 in overpayments. The hospital also reported the incorrect source-of-admission code on 22 claims. In all instances, the source-of-admission code for beneficiaries admitted to its psychiatric unit upon discharge from its acute care section was incorrect. While the overpayment was minimal (\$1,965), the high percentage of claims with this error (43%) indicates a vulnerability. Incorrect discharge status, unreported manufacturer device credits, inclusion of charges for services or medications in cost outlier computations, and an incorrect procedure code accounted for the rest of the inpatient errors. On the outpatient side, five of the 48 claims with errors (\$53,406 of the \$137,116 net overpayment) were attributable to incorrect reporting of manufacturer credits for replaced devices. The incor-

rect assignment of one HCPCS code on 13 claims accounted for \$40,855 of the overpayment. Ten of the claims had the incorrect code for Lupron injections and five claims were incorrectly billed with modifiers -59, -50, and -73. Eight claims overstated the hours of observation because they counted time prior to the order for observation care and/or included observation time for services that were part of another Part B service. In its comments, the hospital disagreed with the OIG finding on 10 of the inpatient/outpatient claims and submitted a claim-by-claim examination to OIG. OIG had an independent consultant review the claims and, in the end, did not change its finding. The hospital also corrected the claims for incorrect reporting of the replaced medical device, assigning modifier "FC" on advice of its Medicare contractor. OIG, however, still maintained that the correct modifier was "FB," because the hospital received either a full credit for the replaced device or the credit covered the full cost of the replacement device, not a partial credit, which modifier "FC" represents. Visit <http://go.usa.gov/DMFk>.

◆ Concerns about the growth in Medicare spending for polysomnography services and a \$15 million False Claims Act settlement in January prompted OIG to conduct a study of these services, and its findings should prompt providers to review the Medicare rules and their billing practices.

Polysomnography is a type of sleep study used to diagnose medical conditions like sleep apnea and evaluate the effectiveness of positive airway pressure devices used to treat sleep apnea, for which Medicare spending increased 39% between 2005 and 2011. OIG's objective was to identify payments for polysomnography claims that did not meet Medicare requirements and to identify providers with patterns of questionable billing. OIG constructed a data set based on the first 11 months of 2011, which comprised 626,212 claims for which Medicare paid \$470 million. Of the sample, Medicare paid providers \$16.8 million for polysomnography claims that did not meet one or more of the Medicare requirements. Incorrect diagnosis codes submitted by hospital outpatient departments accounted for the majority of the errors; same-day duplicate claims or claims with an invalid NPI accounted for the rest. Thirty-five percent of the providers represented in the sample submitted at least one claim that did not meet one or more of the requirements. Of the 6,339 providers of

NEWS BRIEFS (continued)

polysomnography services in the data set, OIG identified 180 with questionable billing practices. Most providers with patterns of questionable billing had an unusually high percentage of same-day duplicate claims, submission of claims for beneficiaries with claims for the same services submitted by other providers in 2011, what appeared to be the unbundling of split-night services (unbundling almost doubles the payment amount), and claims for beneficiaries with no evidence of a visit with the ordering provider in the preceding year, which is required to determine whether polysomnography services are warranted. While CMS does have medically unlikely edits for polysomnography, which should catch claims for same-day services, OIG still recommended that CMS implement more claims processing edits and improve existing ones. To address incorrect diagnosis codes, CMS could work with Medicare administrative contractors on edits to check the diagnosis code on the claims. CMS should review its MUEs to determine why they are not preventing payment on same-day service claims. Finally, CMS could establish edits to validate the presence of the national provider identification number. As expected, OIG also recommended that CMS recover the overpayments identified in the study. OIG recommended strengthening the algorithms in its Fraud Prevention

System and investigating providers identified in the study. CMS concurred with all the recommendations. Visit <http://tinyurl.com/kw7j8nb>.

◆ **The city of El Paso, Texas, has agreed to pay \$1.162 million for billing an incorrect level of ambulance service, OIG announced on Sept. 27.**

The city self-disclosed the alleged conduct to OIG, and then entered a civil monetary penalty settlement agreement. OIG alleged that El Paso submitted claims to Medicare for emergency advanced life support ambulance transportation services when the medically reasonable and necessary level of services was the lower cost emergency basic life support ambulance transportation services. Visit http://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp.

◆ **Reliance Medical Systems of Utah has sued the HHS OIG in the U.S. District Court for Central California over its special fraud alert on physician-owned distributorships.**

The alert, issued in March, labels as “inherently suspect” PODs that sell implantable medical devices to hospitals for use by the physician-owners (*RMC 4/8/13, p. 3*). This position, Reliance maintains, is wrong and inconsistent with the law and legal precedent. Among its requests, it asks the court to declare the alert “invalid, incorrect and/or inaccurate.”

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