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OIG tells HCFA to audit DRGs for upcoding abuse

A new federal study reveals a widespread pattern of abuse for DRGs 14, 79, and 416

A new Office of the Inspector General report chastising the Health Care Financing Administration for its laxity in weeding out hospital upcoding has prompted HCFA to step up its practice of routinely analyzing claims for fraud and looking at specific DRGs. If your facility's claims for these DRGs fall outside certain parameters, expect an HCFA audit. And HCFA won't be the only one looking for patterns; the agency is putting heat on Peer Review Organizations (PROs) to do the same.

The DRGs in question are DRG 79, the infamous pneumonia code that federal investigators are already scrutinizing; DRG 416, a septicemia code; and DRG 14, a code for specific cerebrovascular disorders. A study of billings for those DRGs show upcoding as high as 37%, but virtually no downcoding, according to the OIG. Federal investigators view the disparity as clear evidence that coding is being fudged. OIG is searching for more DRGs that it suspects are being upcoded **(see related story, page 3)**.

And if the government is paying attention to these DRGs, you'd better pay attention to them as well, says **Ron Gaasch**, compliance officer at California-based Community Hospital of the Monterey Peninsula. His audits — monthly for internal checks and quarterly for the external audit — focus on hot buttons such as DRGs named as problems in the press and by OIG. At the least, carefully auditing your DRGs will not only save you legal hassles, but also save you money, notes

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OIG dumps compliance role in laps of DME suppliers

The Office of the Inspector General has released its harshest model plan yet, saddling durable medical equipment suppliers with greatly increased responsibility for ensuring that claims are properly filed.

"This is much more onerous than the guidance they gave to other industries," says **Mark Hobratschk**, assistant government affairs director for the Health Information Distributors Association in Washington, DC. In particular, he points to the OIG's recommendations on cover letters for

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Supreme Court decision unleashes RICO threat

A new Supreme Court decision may open the floodgates for a whole new type of whistleblower lawsuit against health care providers. The court gave the go-ahead to a lawsuit by beneficiaries against Nevada-based Humana Health Insurance alleging that the company engaged in a pattern of racketeering activities.

Now, hospitals and doctors who thought the only law they had to worry about was the False Claims Act (FCA) may be shocked to discover that they too can be hit with the Racketeer-Influenced and Corrupt Organizations Act (RICO), a law originally intended to nail Mafia bosses. Like the False Claims Act, a civil RICO suit allows triple damages. But unlike the FCA, it does not require that the federal government have been defrauded for a suit to be filed, says **Will Kemp**, the Las Vegas attorney representing the beneficiaries. That makes it a useful tool for patients pursuing non-Medicare cases.

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Rico threat

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The case, Humana Inc. vs. Forsyth, involves a suit filed by beneficiaries of Humana Health Insurance of Nevada. The suit accuses the insurer of cutting a special deal with a hospital owned by its parent company, the Humana corporation. The insurer was supposed to pay 80% of patients' bills, while the patients picked up the remaining 20%. But Humana Insurance got a discount from the hospital, and allegedly failed to pass that discount on to beneficiaries.

A federal district court had dismissed the case, agreeing with Humana's argument that the company did not do anything prohibited by Nevada insurance law. Humana cited the federal McCarran-Ferguson Act, which bars federal law from interfering with state regulation of insurance.

But the Supreme Court backed a federal appeals court decision that the case could go forward. The high court concluded that applying RICO in this case would not circumvent Nevada insurance laws. Nevada already allows state agencies and private citizens to sue insurers and recover damages that exceed the triple damages allowed under RICO, the justices noted. "When federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application," the court unanimously concluded.

In a statement, Humana said it was disappointed with the Supreme Court's decision. But it also noted that the court did not rule whether the company had done anything wrong.

The company maintains that it just followed industry practices. "Throughout the health insurance industry, it was not uncommon for patients to pay as coinsurance a percentage of the gross hospital bill rather than a percentage of the discounted charges negotiated between the hospitals and health plans," the company says. "In fact, this is the manner in which the federal government settles the claims of providers and beneficiaries who participate in the Medicare program."

While the False Claims Act is likely to remain the law of choice for prosecutors and whistleblowers, the Supreme Court decision will make it easier to file a RICO suit against providers, particularly if private health insurance is involved, argues Kemp. ■

Quorum split off from Columbia whistle-blower lawsuit

Hospital chain Quorum says it and the government will ask a Tampa judge to split Quorum off from a whistle-blower suit that names both Quorum and Columbia/HCA. The action comes as a Department of Justice suit claims that cost reports filed by Quorum hospitals defrauded Medicare by at least $50 million.

Quorum wants to distance itself from Columbia. "We believe that this means we won't be impacted by what's happening to the other defendant," says Quorum spokeswoman **Shea Davis**. "They have larger issues. It's a criminal case."

Columbia appears to be the main target of a qui tam suit filed by a former Columbia reimbursement manager who alleges that Columbia manipulated its cost reports to have Medicare pay for the costs of acquiring home health agencies.

Davis denies her company did anything wrong and says it has not made any changes to its cost-reporting system as a result of the case.

One source familiar with the Columbia probe says splitting the case into two could be a prelude to a settlement. However, Davis says no settlement negotiations are currently under way. ■

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DRG upcoding

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Gaasch. Audits that reveal downcoding enable hospitals to get money they're entitled to.

In this case, the potentially troublesome DRG trio was cited in a OIG memorandum to HCFA that raises a disturbing question: How can HCFA come down on hospitals for upcoding if it doesn't even bother to check its own data to identify problem coding?

OIG singles out HCFA's neglect of its Clinical Data Abstraction Centers (CDACs), which are two specialized contractors who validate DRGs by examining an annual sample of 20,000 Medicare claims. The CDACs submit a monthly report to HCFA's Office of Clinical Standards and Quality. "However, we found that HCFA performs no routine, ongoing analysis of CDAC data," says the OIG memo. Nor has HCFA given any instructions to Peer Review Organizations on using CDAC data for DRG oversight.

Perhaps more important, HCFA doesn't take advantage of a wealth of "clinical, demographic, and administrative data that form the underlying basis of the over 10 million DRG-based claims each year," according to the memo. (HCFA can peruse data on diagnoses, cost reports, admissions, and discharges.) HCFA hasn't asked PROs to do so, either, even though they get complete inpatient billing data from HCFA. "In fact, HCFA staff told us that the PROs were instructed not to do 'coding projects' within their current contract," says OIG. About the only time that PROs analyze DRG data is when they're called for by an OIG investigation.

The consequences are severe, as OIG pointed out in a report last year on commercial software used to detect upcoding. While some hospitals had rates of upcoding that were more or less equal to their downcoding rates, others upcoded twice as many claims than were downcoded. In one sample, some hospitals had an 11% upcoding rate and a 5.1% downcoding rate, vs. 5.2% and 3.9% for others. Those disparities "suggest intentional abuse of the DRG system by some providers," OIG says. Even if a hospital isn't upcoding, having DRG outliers means you can expect scrutiny and a demand for documentation to justify the anomalies.

As usual, HCFA says it agrees with OIG's recommendation that it routinely monitor hospital billing and clinical data for upcoding. Some of the proposed remedies HCFA is working on include requiring PROs to detect payment errors, hiring a contractor to perform statistical analysis, and creating a pilot program in which a fiscal intermediary will use data from PROs and CDACs to identify problems and refer them to law enforcement.

That will be a departure for PROs that are more familiar with medical review than fraud-fighting, says **Andrea Goldstein**, vice-president for utilization review at IPRO, the New York PRO. While PROs are supposed to report suspected fraud to regulators, Goldstein says PROs would prefer a more cooperative "quality improvement" approach, in which the reviewers would discuss coding problems with hospitals.

In the meantime, Gaasch recommends hospitals keep a close eye on their DRGs. For example, you can audit a few physicians on a rotating basis. ■

OIG identifies 46 hospitals for DRG 475 upcoding

As part of its crackdown on upcoding, OIG has started identifying hospitals that it believes are upcoding to DRG 475, which encompasses respiratory diseases for patients who need continuous mechanical ventilation.

The good news is that only a small percentage of hospitals — 46 institutions out of 3,714 — in OIG's sample appear to be upcoding. The hospitals were not identified. The bad news is that because DRG 475 is one of the pricier diagnostic groups, the federal fraud hounds are likely to pay special attention to it. An earlier OIG analysis found that upcoding lower DRGs to DRG 475 cost Medicare about $10,000 per case. All 46 hospitals have been referred to the agency's Office of Investigations.

The study looked at claims from between 1993 and 1996. At the institutions in the sample, DRG 475 discharges made up more than 1.5% of all discharges, and the proportion of DRG 475 discharges to total discharges blossomed by more than 100% between 1993 and 1996. ➨

The 46 hospitals flagged for having abnormal billing patterns had DRG 475 rates that soared 160% over three years, compared to a national average of 23%. The proportion of total discharges bloomed 159%, or 2.12% of total discharges, compared to a national increase of 16% or .85% of all discharges. That should give you a good clue as to the baseline numbers OIG and carriers will be using in their audits.

OIG estimates that these problem hospitals were overpaid as much as $11.5 million in 1996, or 31% of their total DRG 475 reimbursement. An earlier HCFA study estimated that upcoding accounted for 7% of all DRG 475 claims, for overpayments of $67 million.

OIG admits it can't say for certain that upcoding occurred in each case. "We recognize that only record reviews by trained professionals will establish if incorrect coding has occurred at the 46 hospitals identified," it concedes in the conclusion of the report. As in previous reports, OIG recommends that HCFA routinely analyze hospital billing data for upcoding. ■

DME suppliers

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Certificates of Medical Necessity (CMNs). The OIG plan warns that while cover letters should not include diagnostic information, they should address HCFA or DMERC policies, changes in patient regimen, and descriptions of the items provided. Hobratschk says that this contradicts earlier HCFA guidance that a cover letter just needs to confirm a verbal conversation with a doctor. It also preempts a HCFA guidance on cover letters that should be coming out soon.

The OIG plan, which is open for public comment until March 1, contains a long list of do's and don'ts that should be specifically addressed in the compliance plan that every DME firm would be wise to have. Many of the don'ts focus on the ways that some suppliers have boosted their reimbursement, or at least skirted the law to help physicians with their paperwork. OIG says:

- Don't sign the Certificate of Medical Necessity for the treating physician.
- Don't urge doctors to order more equipment than is necessary.
- Don't deliver anything that requires preauthorization without first getting a CMN and physician order.
- Don't submit a claim until the CMN is completed by the physician.
- Do keep the original CMNs in your files.
- Do complete sections A and C of the CMN before sending it to the physician.

OIG also lists a slew of risk areas that DME suppliers better address. If they don't, federal investigators will take the position that the model plan gives suppliers ample warning of what auditors will be looking for. The risk areas include the following: ordering unnecessary equipment; upcoding claims for more expensive items; billing for new equipment even though old items were supplied; billing for rental equipment that's no longer medically necessary; refusing to file a claim on behalf of a beneficiary; providing excessive amounts of supplies; and completing portions of the CMN that should be filled out by the physician.

In line with a special fraud alert that warned doctors against dishonest DME suppliers, the OIG plan admonishes suppliers not to violate the anti-kickback statute by paying physicians to sign CMNs, bribing referral sources such as hospitals, or paying patients for ordering services. Many cases against suppliers "have involved the DMEPOS supplier giving the beneficiary free gifts such as angora underwear, microwaves and air conditioners in return for providing and billing for unnecessary items," OIG notes.

As with the model plan for billing companies, OIG expects DME companies to educate doctors on complying with regulations and paperwork. Echoing complaints from the billing industry, Hobratschk says that will put suppliers in an awkward position in which lecturing to doctors could mean losing their clientele.

In other respects, the DME plan resembles earlier OIG model plans for other health care industries. For example, suppliers should have a compliance officer, even if it just an existing employee who wears an extra hat. For the vital question of when a supplier has to report a violation to the government, OIG says the time limit is 60 days after the company first discovers credible evidence of a problem. ■