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OIG sets secret threshold for fraud investigations

Investigators remain wary of providers who seek to 'game the system' with false claims

Whether your facility gets scooped up in a government fraud probe largely depends on a set of secret minimum thresholds the Office of the Inspector General says a provider must exceed before it will pursue a case against a hospital.

The catch is that OIG won't disclose where those thresholds are set. That's in keeping with OIG's traditional tight-lipped policy and its oft-repeated fear that disclosing investigative parameters will enable providers to game the system. That's a legitimate concern, admits **Ivy Baer**, an attorney for the American Association of Medical Colleges in Washington, DC. But at the same time, it would be "useful information" for providers to have, she adds.

OIG originally made the decision to set a monetary threshold or percentage error rate to determine which providers to go after back in June — around the same time the Department of Justice issued its False Claims Act guidance. **(See "OIG, DOJ back down on use of False Claims Act," *Compliance Hotline*, June 15, 1998, p. 1.)** The threshold decision was part of OIG's own "best practice" guidelines, which responded to criticism by some members of Congress about how national investigations were being handled.

In a briefing paper on OIG/DOJ national investigations, the agency took pains to reassure the hospital industry that only a small percentage of hospitals will be penalized. It also was careful to show that it's complying with its "best practices" pledge, which paralleled DOJ's promise to go

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Senate bills calls for home health fraud task force

If a new Senate bill sponsored by Charles Grassley (R-Iowa) is passed into law, OIG will be ordered to set up a special task force to combat home health fraud.

Bill S.255, titled the Home Health Integrity Preservation Act of 1999, would pursue criminal and civil cases against those "who organize, direct, finance, or are otherwise engaged in fraud in the provision of home health services."

The bill, which is before the Senate Finance Committee, also contains a provision that would

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Medicare audit spotlights medical necessity problems

While documentation problems accounted for almost half of erroneous Medicare claims in 1997, this year the chief culprit was medical necessity, according to a recent OIG audit of Medicare fee-for-service payments.

Unnecessary care accounted for almost 56% of all improper payments, followed by incorrect coding at 18%, documentation at 17%, and non-covered services at 5%. This suggests that providers such as teaching hospitals seem to be getting the message that the Health Care Financing Administration is serious about documentation; improper payments caused by documentation plunged 80% between 1996 and 1998.

But these numbers are misleading, argues **Mary Grealy**, Washington, DC, counsel for the Chicago-based American Hospital Association. Documentation errors in previous audits were inflated because many hospitals did not respond to requests for documentation from their FIs,

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Medicare audit

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which caused their claims to be labeled as erroneous. This time, hospitals cooperated after AHA put out the word, claims Grealy.

OIG is touting the audit, which showed a 50% drop in overpayments since 1996, as evidence that its anti-fraud campaign is succeeding. Yet OIG also found that many of the improper claims were not spotted during the regular claims process.

"The overwhelming majority of these improper payments (90%) were detected through medical reviews coordinated by the Inspector General," notes OIG. "When these claims were submitted for payment to Medicare contractors, they contained no visible errors."

Still, Medicare overpayments in FY 1998 dropped to an error rate of 7.1%, or $12.6 billion of the $176.1 billion Medicare paid that year, according to the OIG audit. That's the lowest level since OIG began comprehensive audits three years ago.

It's a dramatic drop-off compared to the 11% error rate and $20.3 billion in overpayments that OIG calculated in 1997, and the 14% error rate and $23.2 billion estimated for 1996.

But this really reflects better compliance with billing regs and less sloppiness with paperwork, says **Carolyn McElroy**, chief of the Maryland Medicaid Fraud Control Unit. It's not an indication that criminal fraud is on the wane, she says. "There's just as much fraud out there."

Hospitals continue to account for the lion's share of erroneous claims, with 39% of overpayments compared with nearly 26% to physicians and about 13% to home health agencies, according to OIG. Other providers, such as ambulance companies and durable medical equipment suppliers, accounted for the remaining 22%. But these figures don't indicate which types of hospitals, for example, are most prone to committing errors. Nor do they indicate if specific regions or states have more problems than others, notes Grealy.

More importantly, Grealy says these figures don't reflect whether the errors were successfully appealed, or whether providers subsequently offered documentation that justified the claims.

While OIG admits it cannot link the drop to specific causes, U.S. Department of Health and Human Services Inspector General June Gibbs Brown attributes the decline to several factors. Among them are HCFA and OIG fraud initiatives such as more prepayment reviews, attempts by regulators to educate providers on documentation requirements, and last but not least, better compliance by providers with reimbursement rules.

Not everyone is so sure there's been a real change. Grealy says that although compliance programs created by providers may account for the drop, some of the government's apparent success could be merely a statistical artifice. OIG's methodology has been criticized by industry groups that say its survey sample is too small to give meaningful results. The agency's findings were based on medical review of 5,540 claims from 600 beneficiaries nationwide. Auditors found that 915 of those claims violated Medicare regulations.

Despite the praise for HCFA's efforts, OIG warned that future problems could drive the error rate back up. In particular, more than 100 claims processing systems are being renovated to meet the Y2K computer bug. In addition, there has been a record turnover in Medicare contractors, with several either opting out of the program or being accused of sloppy work. ■

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easier on investigations.

But a compliance officer at a Midwestern nonprofit health system isn't buying it. She says that while DOJ and OIG have done preliminary inquiries on lab unbundling in her area, she has not received a demand letter asking for payment. Neither, however, has she been told the investigation has been dropped, says the compliance officer, who asked for anonymity. "We've been waiting in limbo," she complains. "They could at least give us some closure."

Some hospitals under investigation for unbundling lab claims won't be getting closure, either. OIG notes that U.S. Attorneys were investigating hospitals before the new best practice guidelines were devised. The agency is attempting to standardize the language of the compliance provisions in settlement agreements.

Still, some providers are reaping the benefits of OIG's new guidelines. For example, OIG says that creating thresholds for its prospective payment system (PPS) transfer-discharge probe "resulted in a significant narrowing of our investigative focus. We have identified for investigation a small percentage of the 5,487 hospitals that between 1992 and 1997 had been identified as receiving potential overpayments."

The transfer-discharge hunt, which is just getting under way, focuses on hospitals that allegedly billed for patients as discharges even when they were transferred to another hospital. Hospitals that transfer patients get a smaller per diem rate for a patient's stay rather than the full DRG rate. OIG estimates there have been $185 million in potential overpayments between January 1992 and September 1997.

The OIG report, presented at a recent American Hospital Association conference, also presents tantalizing if cryptic hints about where OIG is headed. For example, while the agency is mum on the parameters for its investigation of pneumonia upcoding, it does say that they are based on the rate and volume of various billing codes used by hospitals. "It is significant to note that the establishment of parameters will result in this project focusing on those facilities that appear to have the most widespread coding problems," OIG notes.

Translation: Only those hospitals that are egregious outliers will be chatting with the local U.S. Attorney. However, a hospital that escapes a national investigation won't escape scot-free. OIG still will refer the institution to its local fiscal intermediary for collection of any overpayments. ■

DOJ reigns in use of False Claims Act, study claims

The Justice Department appears to be keeping the promise it made to Congress last year to go easier on massive national investigations of hospitals, according to a new GAO report.

But it's still too early to tell whether DOJ has really softened its national crackdowns cautions **Mary Grealy**, Washington, DC, counsel for the American Hospital Association. The clincher will be if issues such as lab unbundling are not prosecuted as False Claims Act cases, but instead are resolved by fiscal intermediaries (FIs) as routine overpayments.

DOJ's ostensible change of heart came last year after complaints from hospital groups prompted Congress to threaten to restrict the government's ability to wield the False Claims Act. The Justice Department quickly issued new guidelines in June that essentially promised a more cooperative approach to nationwide fraud probes such as the notorious hospital lab unbundling and 72-hour DRG investigations. This meant an end to arbitrary demand letters that say, in effect, pay up or be sued, and consideration of extenuating factors such as whether the fiscal intermediary gave clear guidance.

According to the report, out of 400 lab cases, DOJ terminated 350 without penalizing the provider. Grealy says that shows that the issue was "something that never should have been handled by DOJ. It should have been given to the FIs."

However, a compliance officer at a Southern health system says the FIs were the ones at fault for the lab unbundling fiasco in the first place. "We did not receive any guidance from the FI," says the officer, who asked not to be identified. He also accuses the FIs of stinginess by sending just one copy of its memos to providers. "That's OK for a 25-bed hospital but not for a five-hospital health

system," he adds. "By the time our CEO got it and passed it to the business office, it was six months before I got a Xerox of a Xerox."

The GAO survey of 93 U.S. Attorneys' offices found that "since the guidance was issued, almost seven times as many national initiative matters were closed as were opened." Of 2,101 cases involving national investigations, only about 110, or a slim 5%, were opened since June 3, 1998.

But these figures can be somewhat misleading, says Grealy. Some U.S. Attorneys are more aggressive than others. In Texas, prosecutors have backed off the lab unbundling issue and refunded previously collected penalties, while the investigation appears to be continuing in other states, such as Missouri, according to Grealy. ■

Senate bill

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force home health agencies (HHAs) to offer beneficiaries "a summary of the pertinent findings (including a list of any deficiencies) of the most recent survey of the agency relating to the compliance of such agency." This summary, would, at the discretion of HHS, "also include other information regarding the agency's operations that are of potential interest to beneficiaries, such as the number of patients served by the agency."

"I don't see any benefit to that," replies **Gene Tischer**, executive director of the Associated Home Health Industries of Florida, the state's trade association. "We're going to have to spend a lot of time explaining this to patients. And most of the problems on the surveys are not health- and safety-related, but paperwork deficiencies."

Tischer fears that disclosing survey results will pressure HHAs into seeking error-free surveys. In turn, they will be much more aggressive in appealing unfavorable findings, which will clog the appeals system.

Grassley's bill also would tighten home health regulation in several areas, including new conditions of participation for home health agencies. For example, HHA managing employees would be required to meet minimum education and work experience standards that would be established by HHS. Managing employees also would have to attest that their agencies have sufficient knowledge of reimbursement rules and the penalties for violating them. The bill also specifies several triggers for additional audits of HHAs. These include high rates of utilization, cost per patient, and overpayments and denials relative to the local areas and the rest of the country.

In addition, home health agencies would have to notify their intermediary and state agencies when they entered a joint venture or opened a branch office. New branch offices themselves would be subject to a special survey, while bankruptcy regulations for HHAs would be tightened.

HHS would have a greater regulatory role under Grassley's bill. The department would devise standards governing the screening of home health employees and the filing of HHA cost reports. It would also study ways of strengthening the physician's role in a beneficiary's plan of care, as well as giving patients a greater voice in planning their care. ■

OIG study faults carrier edits for violating HCFA instructions

An OIG audit finds that some carriers are violating HCFA's instructions. Investigators found that at least one carrier overpaid for outpatient psychiatric services, to the tune of an estimated $1 million in 1996. OIG recommends HCFA ensure that carriers fix their edits and, more important, start recovering overpayments from providers.

The study examined 1996 claims in four New England states serviced by Massachusetts Blue Shield to ascertain whether carriers are applying a percentage limitation to those claims. The value of each claim is supposed to be cut by 37.5%, followed by subtracting any outstanding beneficiary deductibles. In turn, that figure is cut by another 20% to determine what Medicare will pay.

However, Massachusetts Blue Shield had simply paid 80% of each claim, OIG found. Auditors then examined claims for January through March 1998 filed with National Heritage, the current New England carrier. Psychiatric providers submitted 4,772 claims that also had been mishandled.

OIG also found that while the New York and Texas carriers had installed edits that correctly subtracted the 37.5%, the Florida carrier had problems that will be disclosed in a later report. ■