COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 28, Number 6. February 18, 2019
OIG Audit: Community Hospital Was Overpaid $22M; Lawyer: Feels 'More Like Enforcement'

By Nina Youngstrom

In an audit finding that gives the False Claims Act a run for the money, the HHS Office of Inspector General said that Community Hospital in Munster, Indiana, should repay Medicare $22 million based on an overpayment of $1,266,758. OIG also suggested Community Hospital "exercise reasonable diligence to identify and return any additional similar overpayments" outside the two-year audit period to comply with the Medicare 60-day refund rule.

Community Hospital billed for medically unnecessary inpatient rehabilitation facility (IRF) stays and MS-DRGs based on incorrect diagnosis codes, according to the Feb. 13 Medicare compliance review, a comprehensive audit of multiple risk areas. In response, the hospital vehemently disagreed with almost all the findings and will appeal them, calling the use of extrapolation "inappropriate" and the overpayment amount "grossly excessive."

There's a dynamic here that raises red flags for hospitals and other organizations. While the numbers rival a false claim settlement, OIG audits don't play out in the same way as an investigation. "The bigger issue is, using this audit in combination with the overpayment rule to recoup past overpayments is a powerful weapon that's different from the False Claims Act process, yet the numbers are kind of staggering," says attorney Sara Kay Wheeler, with King & Spalding in Atlanta, Georgia. There's usually more back and forth on facts and context in an investigation, which often starts with a subpoena, she says. As audit losses mount, hospitals may want to change the context of the audits because of the risk. "Interact as early as possible" with OIG, producing additional documentation to support your claims and possibly inviting auditors onsite, Wheeler says. "You are in a different posture when you're fighting Medicare compliance reviews. If you get stuck with final findings, it gets harder."

For the audit, OIG selected a stratified random sample of 170 Medicare claims submitted by Community Hospital in 2015 and 2016, with payments totaling $2,824,623. An independent medical review contractor reviewed 120 of them to evaluate whether the claims met medical necessity and coding requirements. There were errors on 86 claims, OIG said. "On the basis of our sample results, we estimated that the Hospital received overpayments of at least $22,051,602 for the audit period."

The majority of the errors were for inpatient rehabilitation, which has exacting coverage requirements. OIG said Community Hospital received $1,126,690 in net overpayments because patients didn't meet Medicare criteria for the expensive, higher acute rehabilitation level of care. OIG also contends that incorrect diagnosis codes were used to assign DRGs, which accounted for net overpayments of $140,068.

Community Wants Do-Over With MD Reviewer

Community Hospital has big problems with the results of the Medicare compliance review, according to a letter from CEO Luis Molina to OIG. For one thing, Community disputes OIG's conclusions about the IRF claims and hired an independent medical expert, Dr. Karl Sandin, to review the records. "Dr. Sandin concluded that 51 of the patients definitely met Medicare coverage requirements, and the admitting physician could reasonably have determined that the other 12 met Medicare requirements." The letter asserts that OIG relied on the *Medicare*

Benefit Policy Manual (MBPM), which is non-binding guidance. "The MBPM was not issued using notice and comment rulemaking as required under the Medicare statute and the Administrative Procedure Act ('APA'). Federal courts and the Attorney General have both concluded that guidance does not have the force of law. OIG therefore erred when denying IRF claims that allegedly did not meet standards in the MBPM that are not also clearly stated in regulations," the letter contends, referring in part to the 2018 Brand memo issued by then-Associate Attorney General Rachel Brand.

The memo says that for affirmative civil enforcement cases, "the Department may not use its enforcement authority to effectively convert agency guidance into binding rules…the Department should not treat a party's noncompliance with an agency guidance document as presumptively or conclusively establishing that the party violated the applicable statute or regulation" ("Brand Memo May Affect Self-Disclosures; Lawyer: Providers Have 'Contract' Obligations," *RMC* 27, No. 11).

Historically, however, while OIG and contractor audits have been viewed as administrative oversight with potentially significant financial and other ramifications, they may not have been viewed as enforcement actions, Wheeler says. OIG audits are not enforcement actions. "But when findings add up to $22 million, it feels a lot more like enforcement than administrative review. Facts will be critical," she says.

Community Hospital also contends that OIG disregarded its written responses to the draft audit, which included a report from the hospital's independent medical expert "refuting OIG's claim determinations." Instead, OIG scheduled an exit conference and "informed Community that it would not discuss any specific findings during the exit conference." Community would like OIG to redo the IRF review with a physician reviewer, Molina wrote. "OIG's reviewer demonstrates a lack of understanding of rehabilitation medicine and improperly denied 63 claims." They were subject to its three-tiered comprehensive preadmission screening process, and the hospital stands by them.

On the DRG coding errors, the hospital agreed with 20 of them and has already repaid Medicare. It will appeal three others.

As for extrapolation, the CEO contended it's premature. "For each claim that is ultimately determined to be proper following appeal, the extrapolated amount will decrease proportionally," he wrote. Also, medical necessity determinations are individual; they "cannot be replaced by an examination of a sample that is then projected to the whole," Molina said. He cited two court cases to support this assertion. Because the hospital doesn't think it made IRF mistakes, "Community does not agree that it has any duty to investigate further under the 60-day rule."

OIG responded to the hospital's criticism about extrapolation. "We note that the use of statistical sampling to determine overpayment amounts in Medicare is well established and has repeatedly been upheld on administrative appeal within the Department and in Federal courts…our use of sampling and extrapolation was based upon a statistically valid methodology."

Molina also said the hospital "cannot understand why the OIG subjected it to this audit. In fact, Community has already been subjected to audits of this time period, with largely favorable results." But Wheeler says that won't fly in rebuttals. "It's not the case it's unfair to be audited by OIG," she says. "The conditions of participation say specifically that you agree to be audited."

Consider Finding a 'Go-To Statistician'

Audit findings with large dollar amounts are the reason why hospitals need protocols on risk assessment and internal investigations. "Your audit committee, lawyers and compliance officers need to understand this case

with precision," Wheeler says. Is the physician order missing? Is it a DRG validation or clinical validation? Is the auditor finding weaknesses in documentation? Was there a transition to a new regulation during the audit period?

With this insight, hospitals can take certain steps to minimize the possibility of incorrect audit findings, and they should be assertive when they think OIG is wrong or overlooking important information. For example, "OIG doesn't necessarily ask for every category of information you think is relevant," Wheeler says.

In one audit, a program safeguard contractor didn't receive critical information housed in case management software that was not part of the medical record proper. Without case management notes in the software, the outcome of the audit was affected.

Hospitals have to consider pushing back because there's so much money at stake, extrapolation is almost the norm, and appeals to administrative law judges can take four years or longer, Wheeler says. "The audit capability of the OIG is fierce," she says. "Trying to find a go-to statistician you work through regularly is becoming a must for major and even mid-level systems."

Contact Wheeler at skwheeler@kslaw.com. View the report at https://go.usa.gov/xEQyT. ✧