Texas Health System Settles CMP Case for $3.364M Over One Physician’s Billing

A Texas physician practice agreed to pay $3.364 million to settle a civil monetary penalty (CMP) case stemming from one physician’s alleged overbilling.

UMC Physicians in Lubbock, which is a subsidiary of UMC Health System, self-disclosed the errors to the HHS Office of Inspector General. According to the settlement and the OIG website, UMC Physicians “improperly filed claims” with Medicare, Medicaid and other federal health programs for evaluation and management services and Doppler and ultrasound testing services that were upcoded, not provided or not supported by the medical records from January 1, 2011, to September 2, 2015. They were all “purportedly performed” by one physician, who was not identified in the settlement.

This is at least the second time this year there has been a million-dollar-plus CMP settlement over one person’s behavior. Staten Island University Hospital in New York City paid $1.132 million after it discovered that a phlebotomist at a small outpatient lab it owned drew samples from patients allegedly without sufficient documentation (RMC 3/6/17, p. 1). The hospital also self-disclosed the problem to OIG and entered into a CMP settlement.

Houston attorney Adam Robison, who represents UMC Physicians, said in his experience with self-disclosures, “The dollars start adding up when the conduct is over a long period of time even though it may be limited to a single physician or
practitioner.’” It’s also a function of OIG sticking to its guns with the 1.5 multiplier, which was set forth in the Self-Disclosure Protocol (SDP), he says. That means providers who report potential violations and are accepted into the SDP should expect to pay a minimum of one and a half times the amount of the overpayment or other damages to Medicare, Medicaid and other federal health programs, he says.

“Providers probably should be self-disclosing more matters,” Robison says. “It’s unlikely any provider is doing things perfectly. To the extent you have gone for a long period of time without any self-disclosure, it could mean you have a perfectly well-oiled machine or there may be holes in your compliance and auditing program.” At this point in the evolution of compliance and enforcement, Robison believes it’s a part of life for larger providers to file self-disclosures with OIG, CMS or the Department of Justice.

OIG Asks a Lot of Questions

When self-disclosing an overpayment through the SDP, hospitals should do a thorough job with their own audits and investigations, including their sampling and extrapolation, Robison says. “OIG scrutinizes self-disclosures made through the SDP and asks a lot of follow-up questions” about the statistical work plan and methodology, clinical determinations, external reviewers and overpayment calculations. It takes a lot for OIG to get comfortable with overpayment calculations, Robison notes. “OIG is pretty rigid about compliance with the protocol.”

Providers also have to reveal the names of other people and entities involved in the conduct, even though the self-disclosure is all yours. However, the SDP makes clear that the disclosing provider should not use the SDP to disclose conduct of unrelated parties. As a result, “the disclosing party will probably end up paying the whole thing under the theory of joint and several liability as opposed to what the disclosing party perceives to be its responsibility,” Robison says. Suppose a hospital acquires another facility, taking over its Medicare provider number in a change of ownership, and self-reports conduct engaged in by the other facility. “Even though the bad actors may have been the predecessor, you as the successor and self-disclosing provider still have liability and can’t necessarily point the finger at the predecessor,” he says.

UMC Physicians didn’t get a False Claims Act release because the Department of Justice is not a party, which is always the case with CMP settlements, but “there is a reservation of rights to pursue criminal liability,” says former federal prosecutor Robert Trusiak, a principal in Health Care Compliance Support in Buffalo, N.Y. He thinks the physician may be at risk of follow-up criminal action because one of the allegations is non-rendered services, which he says is far worse than upcoding, where reasonable people may disagree, for example, over billing level four vs. level five E/M services. Add to that the fact that Attorney General Jeff Sessions announced that DOJ will continue to enforce the 2015 Yates memo, also known as the Individual Accountability Policy, which says prosecutors will pursue “culpable individuals” in corporate fraud cases (RMC 5/1/17, p. 1), and the CMP settlement “may be a chapter in a story rather than the complete book,” Trusiak says.

Outliers Should Stand Out

Hospitals and physician groups should be focused on outliers in their auditing and monitoring, Robison says. Ideally, they would look at multiple risk areas at the same time (RMC 5/22/17, p. 3). With E/M upcoding, “if you have a physician that is at the right side of a bell curve—maybe 80% or more of the volume is at level four or five, that will jump out, but you also have to look at the volume of patients they are seeing because that gives you a better sense,” says Andrei Costantino, vice president of integrity and compliance at Trinity Health in Livonia, Mich. The combination of a “tremendous amount of patients” billed at a high
level of service should sound some alarm bells, he says. “It’s looking at more than one data point.” At one point, Trinity had a physician who was billing for 25 to 50 E/M visits a day, all at levels four and five. “The guy would have had to work 24 hours a day to do that many visits at that level,” Costantino says.

To benchmark physicians, Trinity compares their billing to other physicians in their specialty, using CMS data and Medical Group Management Association data, says Marion Salwin, director of physician and regulatory compliance. Physicians also are benchmarked against peers in their practice (see box, p. 3).

For example, Trinity uses CPT codes 99211-99215, which are outpatient E/M codes, to determine whether compliance should take a closer look at his or her medical records. “We are identifying if they are an outlier based on CMS bell-shaped curves,” she says.

Salwin has found that, typically, “it’s a one off” when physicians bill at a higher level, rather than their knowingly skirting the rules. “It’s because they don’t understand the documentation requirements associated with the code. It also has to do with the increase in work relative value units used to compensate physicians.” The more that hospitals employ physicians, the more their salaries are tied to work RVUs based on their productivity. Meanwhile, CMS floated the idea in the 2018 proposed Medicare physician fee schedule regulation of changing the Medicare documentation guidelines. Physicians are free to use either the 1995 or 1997 documentation guidelines, both of which are very complicated. “I hope they follow through with it,” she says.

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Looking for Outliers: An Example of Physician Benchmarking

Trinity Health in Livonia, Mich., benchmarks physicians on certain metrics, including evaluation and management services, modifiers and the top procedures (RMC 5/22/17, p. 3). Physicians are compared to their peers in their practice and to Medicare and Medical Group Management Association data for their specialty. For example, one physician, called Dr. ABC in the example below, was benchmarked against his peers for CPT codes 99211 to 99215. Contact Andrei Costantino, vice president of integrity and compliance at Trinity Health, at costanta@trinity-health.org.

<table>
<thead>
<tr>
<th>Code Distribution: Office Visit — Established Patient</th>
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<tr>
<td>Dr. ABC</td>
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<td>99211</td>
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Call Tracey Page at 888.580.8373 x 7936 or Tracey.Page@corporatecompliance.org for rates on bulk subscriptions or site licenses, electronic delivery to multiple readers, and customized feeds of selective news and data...daily, weekly or whenever you need it.
Confusion Over “Home” May Lead to Wrong Admission Source Codes

Hospitals may not be reporting admission source codes accurately, which affects their prevention quality indicators (PQIs) and patient safety indicators (PSIs). In addition to interfering with their ability to get meaningful data on population health and community needs, the wrong admission source codes could have an effect on the integrity of data for reporting to accountable care organizations (ACOs), Hospital Compare and HealthGrades.

PQIs were developed by the Agency for Healthcare Research and Quality (AHRQ). They are a set of measures designed to identify conditions “for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease,” according to AHRQ. CMS also has adapted PQIs for use with ACOs and other value-based payment programs to reduce admissions through high-quality outpatient care.

Hospital registrars usually ask inpatients where they came from (e.g., home, skilled nursing facility, another acute-care hospital) and record their answer in the form of admission source codes, says Leslie Slater, with Deloitte Advisory. Capturing admission source codes is similar to capturing the discharge status. “In a data format, it’s telling the story of where the patient is coming from vs. where the patient is being discharged to,” she says.

One of the AHRQ quality indicator categories are the PSIs, and within that is PSI 03, which is the rate of pressure ulcers. When patients with pressure ulcers are transferred from other hospitals, skilled nursing facilities, intermediate care facilities, or other health care facilities, the admission is excluded from use in the PSI 03 rate calculator, Slater says. If the hospital reports an admission status code indicating the patient came from home rather than from an intermediate care facility, for example, and developed a pressure ulcer, they have inappropriately included the patient in PSI 03, she explains.

It gets tricky, however, because Medicare patients may report they are coming from “home” because in their eyes, the SNF is their home, although that’s incorrect for the purpose of capturing admission status, she says.

Chart Reviews Show Errors

In recent chart reviews, Slater has audited for admission source accuracy. The result: an 8%-12% error rate on average, with the admission source classified as home when patients were actually admitted from a skilled nursing facility or intermediate care facility.

“People aren’t thinking about these admission sources, but admission sources are being used,” she says. For example, PSI 03 is included in PSI 90, which is a composite of patient safety and adverse events. Hospitals’ performance on PSI 90 appears on Hospital Compare and HealthGrades, Slater says. “That composite is shared with the public.” It’s also an important piece of the population-health puzzle “to understand where patients are coming from in order to understand readmission rates, inappropriate admissions or access to community-based clinics.”

Contact Slater at leslater@deloitte.com. Visit http://tinyurl.com/yal37s37.

New Compliance Ideas May Spring from Continuous Quality Improvement

A compliance officer learns that a surgeon isn’t following a new policy requiring surgeons to sign their charts within 24 hours of completing surgery. The surgeon could be written up, or there could be another way to come at the noncompliance that leads to lasting improvement in the quality of documentation.

It requires a closer look at why the surgeon isn’t complying with the new signature policy, said Alan Wilemon, corporate compliance manager at Shriners Hospital for Children in Tampa. The compliance officer could apply a method used for identifying the cause of problems “so you can solve the real problem,” he said. One method is SINC:

◆ System: Maybe the electronic medical records (EMR) system doesn’t prompt surgeons to sign before closing their encounters.

CMS Transmittals Sept. 1 - 7

Live links to the following documents are included on RMC’s subscriber-only webpage at www.hcca-info.org. Please click on “CMS Transmittals.”

Transmittals

Pub. 100-06, Medicare Financial Management Manual

- Revision to Publication 100-06, Chapter 3, Medicare Overpayment Manual, Section 200, Limitation on Recoupment, Trans. 292 (Sept. 1, 2017)

Pub. 100-04, Medicare Claims Processing Manual

- October 2017 Update of the Ambulatory Surgical Center (ASC) Payment System, Trans. 3854 (Sept. 1, 2017)
- Clarification of the Billing of Immunosuppressive Drugs, Trans. 3856 (Sept. 1, 2017)
Ignorance: Maybe the surgeon is unaware which buttons to press when closing charts. The EMR system could be new, and the surgeon wasn’t trained properly.

Negligence: Perhaps the physician refuses to sign, saying “I didn’t go to medical school to sign charts.”

Capacity: “Maybe the doctor has genuine time constraints and isn’t able to get to this,” Wilemon said. What’s the patient volume and is it conceivable it’s interfering with the doctor’s documentation timeliness?

“Start here when trying to identify the problem and you may have success,” Wilemon said Sept. 7 during a webinar sponsored by the Health Care Compliance Association.

Looking more deeply into the reasons for problems is part of continuous quality improvement. “Continuous improvement techniques are not a silver bullet. They will not always make compliance easy,” but the techniques are “helpful tools” and “tested methods to tackle issues when applied appropriately, and we should always look for ways to improve.”

One reason continuous quality improvement resonates in compliance is that it’s not “binary”; you can’t always flip a switch and get back in compliance, Wilemon said. Compliance is largely about satisfying government expectations that may not have a bright line. For example, the HHS Office of Inspector General’s Work Plan uses “subjective terms,” he said, such as reasonable, appropriate, necessary and well-documented. “That’s somewhat in the eye of the beholder,” he noted. Reducing risk, not eliminating it, is also the goal of compliance. Because of the subjectivity, “we must be continuously improving.”

More Strategies to Diagnose Problems

Three major quality improvement methodologies are Lean, Six Sigma and Project Management. Lean, which comes out of industrial manufacturing, focuses on the elimination of waste, Wilemon said. The opposite of waste, which is value, is the key goal of projects. Six Sigma, which often is grouped with Lean, also emphasizes the elimination of waste, but through the removal of variation. The idea is to “remove errors to improve quality,” he said.

Project management is another way to tackle continuous quality improvement. “It’s a method of clearly defined terms, roles and goals used to bring a project to successful completion,” he said. There are five stages: initiation, planning, executing, control and close.

A sponsor, usually a senior executive, “is also incredibly important,” Wilemon said. “This is the power behind your project.” The main reason projects go wrong is a lack of sponsor or a disengaged sponsor.

Sponsors will step in to smooth ruffled feathers or get more resources. It’s also important to meet your deadlines. “Part of being successful is pieces of the project being done on time,” he noted.

The goals of the project should be described up front in a charter and then set out in greater detail in a work plan. Unlike the charter, the work plan will describe the people involved, the organizational structure, goals, resources, deliverables and the reason for the project. He recommends getting input from stakeholders. “There’s nothing worse than launching a project and getting down the road and realizing there was a key stakeholder we didn’t involve and everything we are doing is undermining a critical process that they have and we have been wasteful,” Wilemon said.

As part of quality improvement methodologies, Wilemon described several strategies for identifying and solving compliance problems. One is DMAIC:

- Define: Define the problem
- Measure: Map the existing process
- Analyze: Identify the cause of the problem
- Improve: Implement and confirm the solution
- Control: Maintain the solution

For example, when patients come to a clinic, the registration staff takes their names, verifies the appointment and then asks patients to sit down. “The problem sounds simple: they are not given paperwork,” Wilemon said. But at the root is a failure to train the front desk staff. “It sounds simple, but talking about it can be helpful.”

Another strategy is the problem tree. It gives visual cues to help think through problems, the effects of problems, and their causes and subcauses, he said (see box, p. 6). Suppose patients are not given documentation required by law. As a result, the organization is out of compliance and patients are unaware of key information. Why did this happen? Clinical staff is not presenting the information, and the marketing department is still drafting the document. Why isn’t it completed? Because marketing is not invited to compliance meetings. “That’s what’s really causing the problem here,” Wilemon said. “Marketing is not aware how important the document is and how quickly we need this.”

There’s also the Kaizen action sheet for continuity improvement. It’s a graphic for plotting out problems, goals conditions, plans, follow-up and analysis. “How can we get better and identify wasteful situations?”

Contact Wilemon at awilemon@shrinenet.org.
Using the Problem Tree to Get at the Root of Compliance Problems

The problem tree is a continuous quality improvement tool designed to identify the causes and subcauses of problems and develop more meaningful solutions to them, says Alan Wilemon, corporate compliance manager for Shriners Hospital for Children in Tampa. The Kaizen Action Sheet is a tool for continuity improvement. Contact Wilemon at awilemon@shrinenet.org.

![Problem Tree Diagram]
OIG: Extrapolation Stays in Audit Period
continued from p. 1

resolved their concerns?” Disagreements over errors are “magnified” when overpayments are extrapolated, but they are still disagreements over the substance, not the statistics, he says.

OIG’s “estimated” overpayment amount—its term for extrapolation—is limited to the audit period, and the recovery of the claims must fall within the four-year reopening period allowed by the Social Security Act, Smith says. CMS and its contractors are allowed to re-open claims after determination or redetermination for “good cause” up to four years after they are paid (42 CFR 405.980).

When hospitals receive a “demand letter” for repayment from CMS, usually a month after OIG issues the Medicare compliance review or other audit, “it only demands an estimate for what is within the audit period,” Smith says. The other claims in the reopening period are not extrapolated. “Everything is constrained to the audit period,” he says. In fact, CMS demand letters typically tell hospitals they owe less money than OIG declares in audit reports, Smith says. The reason: by the time CMS sends the letters, some claims have “exited the reopening period and gone outside the range,” he notes.

For example, in a Medicare compliance review of Mount Sinai Hospital in New York City, released in May, OIG said the hospital was overpaid $1.37 million for 12 different types of errors in 2012 and 2013. That amount was extrapolated to a $41.86 million overpayment (RMC 5/8/17, p. 1). The sample for the audit was pulled from an electronic file, and “all estimates only go back to that file,” he says. However, OIG suggested the hospital work with CMS to repay any additional money it might owe for the errors that date back six years, as required by the Medicare 60-day overpayment refund rule. “OIG puts hospitals on notice to look under the 60-day rule, but it’s not part of the demand letter,” Smith says. “There are no dollars associated with it.”

‘Everyone Hates Extrapolation’

In other words, there are three conditions for claims to be covered by CMS’s final demand letter: the claims are overpayments, they are within the four years of the reopening period and they are within OIG’s audit period, he says.

Statistician Bruce Truitt says this is widely misunderstood. Some hospitals seem to think OIG is basing overpayment findings on claims it hasn’t sampled. “But you cannot extrapolate or project to a population you haven’t sampled,” says Truitt, a faculty member of the Medicaid Integrity Institute and Government Audit Training Institute in Washington, D.C. “If I have only sampled 2013 and 2014, the only time periods to which I can statistically extrapolate are 2013 and 2014.”

Everyone hates extrapolation, but it has been upheld by the courts, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. “It’s like taxes,” she says. While Waltz understands the concern that extrapolation would be more fair and square if OIG reviewed a larger sample of claims, “there’s a downside for providers in terms of expense,” Waltz says. “You have to pull additional medical records and it may not be worth it.” She notes there are some statutory limitations on the use of extrapolation by Medicare contractors when calculating overpayments (Chap. 8 of the Program Integrity Manual, Sec. 8.4.1.2). There must be a sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error.

OIG: Methods Are Conservative

Smith says OIG prefers to use large sample sizes. When sample sizes are smaller, OIG’s methods are conservative, and providers benefit from that, he says. “People say OIG should have had a larger sample that is more precise” or they register other complaints that boil down to OIG putting providers at a disadvantage because the sample is not precise, he says. “The instinct of providers is, if we pulled a larger sample, it would have worked out better for them,” Smith says. But that’s not the case, and, in fact, OIG gives providers a break by recovering overpayments at the low end of the scale to account for the inevitable imperfections in sampling and extrapolation, he says.

Hospital complaints about sample size would be “fair” if OIG were extrapolating off the “point estimate,” Smith says. The point estimate is what auditors actually find from the sample, Truitt explains. It’s the average amount of overpayment per sample item multiplied by the number of items in the population. All samples have a margin of error that also must be taken into account. The smaller the sample size, the larger the margin of error, and conversely, as the sample size gets closer to the universe of claims, the margin of error shrinks.

Taking that into account, OIG puts the range of overpayment findings—lower limit and upper limit—into Medicare compliance reviews and then recommends that hospitals repay at the lower limit, Smith says. OIG calculates a 95% lower limit, “and it’s very likely less than the overpayment amount,” he says. In other words, hospitals get a break. For example, $41.86 million was the lower limit in the Mount Sinai Medicare compliance review, and $59.2 million was the upper limit.

Smith says some providers hire statisticians who contend OIG’s methods sometimes are not valid because...
they rely on the central limit theorem. In a nutshell, the central limit theorem says the average value of random samples from even a non-normal population will roughly equal the average value of that population.

“We actually have an estimate approach that doesn’t rely on the central limit theorem,” he says. If OIG did use it, providers would face higher repayments than they do under the methods used by OIG, Smith says. “We try to set it up where we are so conservative. If someone appeals, we know how it will turn out because we accounted for it in our methodology,” he says. “I have never seen an audit overturned fundamentally because of our statistics.”

**Hospitals Are ‘Uneasy’**

Medicare compliance reviews are making hospitals uneasy, Waltz says. “There is some concern about where this is all headed,” she says. Could findings in the audit morph into an investigation? In some cases, OIG auditors are asking to meet with key staff and if there is the possibility of a future investigation, “do you have to worry about having people speak to OIG auditors?” OIG also typically wants a controls analysis to address the reasons for the overpayment, which is tantamount to a corrective action plan. “I have worked with clients who’ve had issues with that,” Waltz says. “It’s kind of grating.”

She also emphasizes that OIG itself technically couldn’t implement recoupment under the 60-day rule to recover an overpayment. It’s a provider’s obligation to report and refund overpayments 60 days after identifying them, not an OIG enforcement tool. The government only plays a role at the intersection of the 60-day rule and the Fraud Enforcement and Recovery Act, which makes it a potential violation of the False Claims Act to knowingly and improperly hold onto an overpayment or when OIG applies a civil monetary penalty for failure to timely refund under the 60-day rule.

Contact Truitt at brucetruitt@gmail.com, Waltz at jwaltz@foley.com and Smith through OIG spokesman Donald White at donald.white@oig.hhs.gov.

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**NEWS BRIEFS**

◆ **Novo Nordisk Inc., a pharmaceutical manufacturer, agreed to pay $58.65 million to settle allegations that it didn’t comply with the Risk Evaluation and Mitigation Strategy (REMS) for its Type II diabetes medication Victoza that was mandated by the FDA, the Department of Justice said Sept. 5.** The resolution includes a $46.5 million payment to resolve False Claims Act violations and disgorgement of $12.15 million in profits for alleged violations of the federal Food, Drug and Cosmetic Act (FDCA). DOJ alleged in a civil complaint that the FDA required a REMS to reduce the possible risk of a rare form of cancer, Medullary Thyroid Carcinoma (MTC), associated with Victoza. Novo Nordisk had to give information to physicians about the drug’s potential risk of MTC. Failure to comply with the REMS means the drug is misbranded under the law, DOJ said. “As alleged in the complaint, some Novo Nordisk sales representatives gave information to physicians that created the false or misleading impression that the Victoza REMS-required message was erroneous, irrelevant, or unimportant,” DOJ stated. “The complaint further alleges that Novo Nordisk failed to comply with the REMS by creating the false or misleading impression about the Victoza REMS-required risk message that violated provisions of the FDCA and led some physicians to be unaware of the potential risks when prescribing Victoza.” The false claims settlement resolves seven whistleblower lawsuits. Visit http://tinyurl.com/y8lpn9k5.

◆ **CMS is vulnerable to legal challenges if it finalizes certain provisions in the proposed 2018 Medicare physician fee schedule regulation that slashed payments to some off-campus provider-based departments (RMc 7/24/17, p. 1), said Washington, D.C., attorney Christopher Kenny, with King & Spalding, during a Sept. 7 webinar sponsored by the law firm.** In July, CMS proposed to cut payments in half to “non-excepted” off-campus provider-based departments. They’re non-excepted because they were established after Nov. 2, 2015, which means they’re no longer permitted to bill the outpatient prospective payment system (OPPS) under Sec. 603 of the Bipartisan Budget Act of 2015, with some exceptions. After the law was enacted, CMS needed a way to pay hospitals for non-excepted services at non-excepted provider-based departments. In the 2017 final rule, CMS announced it would pay 50% of the OPPS amount. Now CMS is proposing to cut that in half, to 25%, an amount based only on outpatient hospital clinic visit HCPCS code (G0463). “It wouldn’t shock me if they back off and wait another year to have a stronger analytic basis,” said Washington, D.C., attorney Christopher Kenny, with King & Spalding at a Sept. 7 webinar. “It is more than imprecise” to cut payments for all outpatient services furnished by hospitals by half “solely on the basis of one particular type of code.” Contact Kenny at ckenny@kslaw.com.