OIG Focus on Hospital DRG Outlier Payments

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The FY 2003 Work Plan for the Office of Inspector General of the Department of Health and Human Services ("OIG") includes a review of Medicare inpatient claims for cost outliers. The workplan focus on this issue complements recent media attention to reports of outlier payment variation among hospital systems.

Outlier payments compensate hospitals paid on a fixed amount per Medicare "diagnosis related group" discharge with extra dollars for patient stays that substantially exceed the typical requirements for patient stays in the same DRG category. The OIG indicates that it will be examining whether these payments "were appropriate" and whether there are adequate controls over them. While the issue of the formulaic accuracy of outlier payments is fairly straightforward, it is unclear whether the focus on "adequacy of controls" is intended to address the fiscal intermediary ("FI")/Centers for Medicare and Medicaid Services ("CMS") level or the provider level. Therefore, it is difficult to know the precise scope of the investigation.

Providers can get some insight as to the scope of this investigation from several audit reports regarding outliers that the OIG has issued during the past two years. By and large, overpayments attributable to outliers involve general compliance issues that we have seen in other contexts. These include clerical errors on claims, lack of proper documentation, and claims submitted for services that were not ordered by a physician.

However, with respect to the more technical aspects of outlier payments, one audit report asserts that a hospital was overpaid substantially because its FI improperly calculated the hospital's FY 1999 inpatient operating "cost to charge" ratio. The error reputedly caused the hospital's outlier payments to increase from less than $1 million in FY 1998 to $4.3 million in FY 1999. In recommendations made in this report, the OIG stated that the hospital should "strengthen its controls to prevent future outlier overpayments." The OIG also recommended that the FI "perform a comparative analysis" of provider payments from the current year to prior years so that they can identify any overpayments.

Several fiscal intermediaries have apparently recently asked CMS whether they should seek recoveries for overpayments made on outlier claims because they incorrectly determined the hospitals' cost to charge ratios. It is our understanding that CMS is currently considering its options. CMS may not be elect to actively revisit old cost to charge ratio claims because (1) there may be FI errors that resulted in underpayments to hospitals and (2) in many other PPS areas CMS has long held the view that hospitals have very limited opportunities to request modifications of FI determinations made for the purpose of establishing PPS payment rates and that once those opportunities pass, the determinations are final and not subject to review.

Hospital providers may want to consider reviewing their outlier claims, and outliers claims submission process, to assure that they are complying with Medicare requirements. In addition to the issues mentioned above, hospitals ought to assure that all of the services included in the claim were medically necessary and otherwise covered by Medicare. With the increased attention being given by the OIG to outliers, qui tam attorneys may also be exploring litigation opportunities.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.