Health Care Compliance Adviser: Medicare Outlier Payments for Outpatient Services Also Under Government Scrutiny

Introduction

The current government scrutiny of Medicare inpatient outlier payments has been widely publicized and was the subject last year of a Jones Day Health Care Compliance Adviser. The government has also begun to focus on outlier payments for outpatient hospital services. The HHS Office of Inspector General (“OIG”) included outpatient outlier payments on its 2003 Work Plan. It has also released seven audit reports for outpatient outlier claim reviews conducted at five New England hospitals, one California hospital, and one Illinois hospital. The OIG audits found that systemic hospital billing errors—especially overstating the number of units of drugs dispensed during an outpatient procedure—have caused Medicare to make excessive outpatient outlier payments.

Medicare Outpatient Outlier Payment Methodology

Since August 1, 2000, Medicare has paid hospitals a fixed amount for most outpatient services, based on the ambulatory payment classification (“APC”) group to which the service belongs. In addition, Medicare pays an additional amount for outliers, i.e., for outpatient encounters that are exceptionally costly.
Outpatient outlier payments are calculated based on the costs incurred to provide the services on a given claim. As with the calculation of outlier payments for inpatient services, costs are derived by multiplying the hospital’s charges for the service by the hospital’s relevant cost-to-charge ratio (here, the cost-to-charge ratio for outpatient services). If the hospital’s total costs for the outpatient service exceed a certain threshold (currently, 2.75 times the outpatient payment for the service), an outlier payment is calculated as a percentage of the amount by which the costs exceed the payment (currently, 45%).

Assume the following by way of example:

- Hospital charges for a certain outpatient service: $800
- Hospital cost-to-charge ratio: 0.56
- APC payment: $100
- Threshold: $275 = $100 x 2.75
- Outlier payment: 
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  \left[\frac{\$448 - \$275}{\$448} \right] \times 0.45 = \$77.85
  \]
- Total provider reimbursement: $177.85 = ($100 + $77.85)

Since January 17, 2003, outlier payments have been calculated using the hospital’s outpatient cost-to-charge ratio from its most recent full-year cost reporting period, whether or not settled. Previously, outpatient cost-to-charge ratios were determined based on the hospital’s most recently settled cost report. If the most recently submitted cost report were not settled, CMS applied a “settled-to-submitted” factor to estimate the cost-to-charge ratio for a settled cost report.

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5 This formula is somewhat simplified in that a hospital’s charges for a particular outpatient service are adjusted to costs by applying both an operating and a capital cost-to-charge ratio.
7 See CMS Program Memorandum No. A-00-63 (Sept. 1, 2000).
8 See Eastern Maine Audit at 2–3; Mercy Audit at 2–3; Baystate Audit at 3; MGH Audit at 2–3; Orthopaedic Audit at 3.
9 Eastern Maine Audit at 3.
10 Mercy Audit at 3–4.
11 Baystate Audit at 2.
12 Rhode Island Audit at 3; MGH Audit at 4.
After exposing weaknesses in their billing systems, the OIG recommended that the hospitals (i) improve billing controls; (ii) conduct internal reviews of outpatient outlier claims and resubmit any claims as necessary; and (iii) initiate adjustments with fiscal intermediaries to repay overpayments found by the OIG or identified through the hospitals’ subsequent internal reviews. In addition, the OIG also directed hospitals to perform self audits to determine the full extent of any excessive outlier payments. For example, for one hospital, the OIG found that each of the OPPS claims reviewed was billed incorrectly. Thus, the OIG speculated that there was a risk that payment errors were made for all other claims involving outpatient outlier payments, likely exceeding $1.3 million.

**Risk Areas and Recommendations**

As the OIG audits demonstrate, hospitals may be vulnerable to outpatient outlier overpayments due to billing system errors. These errors could stem from computer changes resulting from OPPS implementation. The OIG acknowledged this possibility in its 2003 Work Plan, where it stated its desire to evaluate “the appropriateness of [outpatient] outlier payments” in light of the fact that “[s]ignificant overpayments can result if providers submit claims with clerical errors that result in overstated charges for services.”

Hospitals should ensure that their billing systems appropriately capture charges for outpatient services, particularly those involving multiple units of a service. The key is for hospitals to ensure that they are billing for the correct number of units of drugs or other supplies or services. Hospitals that consistently err by charging for excessive numbers of units of supplies or services, and thereby receive excessive outpatient outlier payments, risk being accused of a False Claims Act violation. In other contexts, OIG audit reports have inspired hospital employees to bring *qui *t*am* actions under the False Claims Act against their employers based on overpayment scenarios described in the audit reports. Hospitals should thus consider auditing their billing systems to ensure that they are not making the same billing errors as those hospitals audited by the OIG.

Finally, since observation billing errors were identified in two of the OIG audit reports, hospitals should consider reviewing their practices related to coding and billing for observation services.

**Further Information**

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