Don’t Let Auditors Cash In At Your Table:
EFFECTIVE AND EFFICIENT BILLING COMPLIANCE PROGRAM STRATEGIES

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Learning Objectives
➢ Provide an introductory overview of the HHS OIG and its mission
➢ Explain through a real time tutorial where and how to utilize the tools on the HHS OIG website
➢ Construct a “toolbox” of information and resources you can take with you to assist with future compliance
What is the HHS OIG?

**Mission:** To protect the integrity of programs and the welfare of the people they serve

1,550+ employees
70+ offices

What does the HHS OIG oversee?

- 100+ HHS programs, including those operated by the Centers for Medicare & Medicaid Services, the Office of the National Coordinator, the National Institute of Health, the Center for Disease Control, and the Food and Drug Administration
- $1 trillion in HHS spending, including grants and contracts

HHS OIG Components

- Audit Services
- Evaluation & Inspections
- Investigations
- Counsel to the IG
HHS OIG Components

Audit Services

Evaluation & Inspections

HHS OIG Components

Audit Services

Evaluation & Inspections

HHS OIG Components

Investigations

Control to the 80
HHS OIG Components

How does the HHS OIG accomplish its mission?

- Prevent/Inform
- Detect
- Enforce

Prevent/Inform

- Reports and recommendations
- Industry guidance
- Integrity agreements
- "Sentinel" and deterrent effect
- External outreach (e.g., congressional testimony and media interviews)
Detect (how we identify work)

- Risk analysis
- Results of audits and evaluations
- Self-disclosure of potential legal violations
- Complaints, referrals, and requests
- Mandated work

Enforce

- Civil monetary penalties
- Federal health care program exclusions
- Recommendations for affirmative litigation and suspension and debarment
- Federal, state, and local partnerships

The OIG Comes Knocking...Now What?

You Should Understand:
- Whether this is an audit or investigation
- What the scope of the audit is
- What the potential exposure is for the findings
- What kind of team you need to assemble
- What the auditors would like you to do
- That if problems are found, the audit could expand to include more records or issues
What can be done to ensure compliance?

- Involvement from the Board of Directors
- Effective communication across the organization
- Continually review procedures and be proactive
- Read the OIG Workplan prior to audit
- Do a risk assessment
- Be organized and proactive
- Be aware of common issues found in audits of your type of organization

Your Toolbox

<table>
<thead>
<tr>
<th>TRAINING</th>
<th>PUBLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Roadmap for New Physicians</td>
<td>Workplan</td>
</tr>
<tr>
<td>Compliance Program Guidance</td>
<td>Top Management Challenges</td>
</tr>
<tr>
<td>Provider Compliance Training</td>
<td>Watch the headlines</td>
</tr>
<tr>
<td>Guidance for Board of Directors</td>
<td></td>
</tr>
<tr>
<td>Self-Disclosure Protocol</td>
<td></td>
</tr>
</tbody>
</table>

A Roadmap for New Physicians
Questions

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OIG Hospital Compliance Reviews

Provider experiences with OIG Hospital Compliance Reviews

- Audit notice and initial request received via telephone call and fax when appropriate
- OIG is typically onsite within 3-5 weeks after the notification
- The initial OIG request typically includes 200 or more records, with larger facilities typically being asked for 300 or more
- OIG team is typically on-site for several weeks, but this can vary
- In some cases, the OIG requires a medical opinion will be sent to their independent medical review contractor or, in some cases, the hospitals' jurisdictional MAC
- In addition to agreeing or disagreeing with the findings, providers are asked to provide brief written “corrective action plans” to the OIG for each area
- OIG uses statistical sampling when the OIG deems it appropriate and necessary to do so. The results of any statistical samples may be extrapolated. The OIG will explain the sampling methodology and the results to the provider. The results will be provided in writing. The OIG may request that the provider conduct a follow-up self-audit of one or more areas using OIG-approved sampling methodology and extrapolation over the designated review period (e.g., exclusion 25% review)
OIG Hospital Compliance Reviews –
Inpatient Risk Areas

- Most hospital stays (0 and 1 day)
- High severity level MS-DRGs
- Same day discharge and readmission
- Transfers to post-acute care providers
- Transfers to inpatient Hospice care
- Manufacturer medical device credits
- Claims paid amount in excess of claims charged amount
- Claims with payments greater than $150,000
- Blood clotting factor drugs
- Hospital-acquired conditions and present on admission reporting
- Outlier payments

OIG Hospital Compliance Reviews –
Outpatient Risk Areas

- Observation outlier payments
- Facility (E&M) coding and "new" vs. "established" patient
- Manufacturer medical device credits
- Services billed with modifier 58
- E&M services billed with surgical services [modifier 25]
- Claims paid amount in excess of claims charged amount
- Outpatient services billed during inpatient stays
- Three-day payment window rule
- Services billed with units greater than one
- Services billed during skilled nursing facility stays
- Outpatient dental services

Other OIG Risk Areas

- Hospital psychiatric facility emergency department adjustments
- Skilled nursing facility payments for ultra high therapy
- Inpatient Rehabilitation facility documentation requirements
- Outpatient brachytherapy reimbursement
- Outpatient claims billed using "Y" codes
- Observation services during outpatient units
- Hemophilia services and epoetin alfa services
- Intensity modulated radiation therapy planning services
- Outpatient claim payments greater than $25,000
- Medical device credits for replaced medical devices
- Medicare payments during 340B payments
- CMS validation of hospital-submitted quality reporting data accuracy
- Skilled nursing facility prospective payment system requirements
- Orthotic braces – reasonableness of Medicare payments compared to amount paid by other payers
- Increased billing for ventilators
- Physicians – referring/ordering Medicare services and supplies
- Anesthesia services – non-covered Services
- Rent & payments for drugs purchased under 340B program
What can you do to prepare?

- Utilize data which exist within the organization to enhance risk assessment processes
- Establish processes to identify, mitigate and track compliance risks
- Educate departments on recent audits, initiatives and settlements with other providers
- Implement and audit policies and procedures for billing compliance with rules and regulations
- Development and implement department-specific compliance plans and self-monitoring based on risks
- Implement self-monitoring tools such as audit programs in selected departments

Arm yourself with Information

- Data-mining
- Benchmarking
- Probe reviews
- Surveys
- Questionnaires

Why data mining? Everyone else is doing it...
Monitoring Internal Data

- Stop focusing on the detail for a little bit to focus on the bigger picture
- Pool data from multiple audit periods
- Look for trends that may not otherwise be apparent
- Put the data into a format that can be understood and digestible to leadership and physicians e.g. dashboard
- Identify data currently being used for other reasons that can be repurposed/mined by compliance/internal audits
- Run editing and denial reports
- PEPPER Reports

Tip: Clearly define goals and stay on track

Data Mining at the “Macro” Level

- Understand existing data sources and pitfalls associated with each source (e.g., late charges, downstream edits).
- Select the source that best meets your objective for the specific initiative underway (e.g., data by revenue and usage cost center vs. final billed data).
- Identify key data elements that will help identify high risk areas and ensure they are included in queries.
- “Clean” the data (e.g., remove duplicates) to facilitate accurate conclusions.
- Although “blind” applications of data mining can work to identify risks, it can also create more questions than answers in the end.
- Consider risk when determining areas of focus (e.g., services for which payment is bundled vs. services with high dollar pass through payments).

Tip: Clearly define goals and stay on track
Data Mining at the “Micro” Level

Data Mining: Other Guiding Principles

Benchmarks
Compliance Program Structure

- Health-system Corporate Compliance Program
- Hospital-based Compliance Program
- Department Specific Compliance Program
  - Self-Monitoring – Reporting
  - Responding to systemic issues

Risk Assessments - Purpose

The objective of a risk assessment is to:

- Assess high risk areas within a selected department
- Provide support to management in mitigating these risk
- Provide assistance in establishing a compliance plan/plan at a corporate and department level

RISK ASSESSMENT

- Perform the risk assessment utilizing department-specific, compliance-risk questions.
- Question Sets are based on documented historical information and present compliance concerns of government enforcement agencies including:
  - The Centers for Medicare and Medicaid Services
  - Office of Inspector General
  - Department of Justice
Sample Tools

- Risk Assessments
- Self-monitoring tools
- Reporting tool
- Questionnaire
Questions

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