Office of Inspector General
Hospital Compliance Audit

HCCA Desert Southwest Regional Annual Conference

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Marc Tatarian, MBA, RN, CHC
Regional Compliance Officer, Sutter Health

DISCLAIMER

- The opinions expressed are those of the presenter and are not intended to be statements or reflections of the opinion or position of Sutter Health
- This presentation is general in scope, seeks to provide relevant background and hopes to assist in the identification of pertinent issues and concerns. The information is not intended to be, nor should it be construed or relied upon, as legal advice
- The presenter did not receive compensation from any vendor or consulting firm referenced during the presentation
OBJECTIVES

- Understand the background and scope of an HHS OIG Hospital Compliance Audit
- Outline the key elements of the audit process
- Provide strategies and tools to manage the audit

BACKGROUND

Paradigm Shift

Testimony by Daniel Levinson, HHS, Inspector General:

"Over the past 3 years, for every $1 spent on the HCFAC Program, the Government has returned an average of $7.20. From 1997 to 2011, HCFAC activities have returned more than $20.6 billion to the Medicare Trust Funds."

HCFAC: Health Care Fraud and Abuse Control
Source: The United States Senate Committee on Finance – "Anatomy of a Fraud Bust: From Investigation to Conviction" (April 24, 2012)
BACKGROUND

“OIG is using information technologies and analytics, including data mining, trend evaluation, and modeling, to better identify fraud vulnerabilities and target our oversight efforts. OIG is leveraging an analytical foundation that provides an enterprise view of questionable activities, suspected fraud trends, and prevention opportunities. When united with the expertise of our agents, auditors, and program evaluators, OIG brings a formidable combination of cutting edge techniques and traditional investigative skills to the fight against fraud, waste, and abuse.”

Source: “OIG Chief Counsel Lewis Morris Testifies on the Role of New Technology in Fighting Health Care Fraud” (July 12, 2011)

BACKGROUND

Prior Audits / Overpayments

- South Shore Hospital, Weymouth, MA: $341,033
- UC San Francisco Medical Center: $784,277
- Springhill Medical Center, Mobile, AL: $34,454
- Brigham & Women's Medical Center, Boston, MA: $1,518,895
- Georgetown University Hospital, Washington, DC: $659,371
- Intermountain Medical Center, Murray, UT: $198,141
  2011 = 8;  2012 YTD = 29

Source: Office of Inspector General, Reports & Publications, Oig.hhs.gov.
BACKGROUND

- Evolutionary vs. Revolutionary
- Data mining – Medicare Common Working file
- Typical look back period
- High Risk Coding and Billing areas – 16 → 25

BACKGROUND – High Risk Areas

**Inpatient**
- Inpatient short stays
- Inpatient one-day stays
- Inpatient same-day discharges and readmissions
- Inpatient claims with payments greater than $150,000
- Inpatient claims for blood clotting factor drugs
- Inpatient hospital-acquired conditions and present on admission indicator reporting
- Inpatient claims paid in excess of charges
- Inpatient claims involving manufacturer credits for replacement of medical devices
- Payments for Kyphoplasty procedures
- Post-acute transfers to SNF/HHA/Another Acute Care/Non-Acute Inpatient
- Inpatient claims billed with high severity level DRG codes
- Inpatient psychiatric facility emergency department adjustments
- Inpatient psychiatric facility interrupted stays

**Outpatient**
- Outpatient claims billed with modifier -59
- Outpatient claims billed during an inpatient stay
- Outpatient claims for evaluation and management services billed with other services
- Outpatient surgeries with greater than one unit
- Outpatient claims paid in excess of charges
- Outpatient manufacturer credits for replacement of medical devices
- Payments for drug injections (doxorubicin and Lupron)
- Payments for Intensity Modulated Radiation Therapy
- Outpatient claims paid in excess of $25,000
- Outpatient claims billed during diagnosis-related group payment windows
- Outpatient services billed during skilled nursing facility stays
- Outpatient claims billed on the date of an inpatient admission
SCOPE

- Notification Letter / Claims data (samples)
- Internal Controls Questionnaire
- Entrance conference
- The Audit
- Error Summary reports
- Exit conference
- Final report

NOTIFICATION LETTER

- Addressee
- Provider number specific
- Claim years under review
- Authority to review / HIPAA disclosure
- HHS/OIG Delivery Server
- “Examples” of audit areas
- Required supporting documentation
INTERNAL CONTROLS QUESTIONNAIRE

- Focus on process and structure
- Billing Process
  - "Describe the billing process, internal controls, and quality controls for inpatient claims."
- General Controls
  - Roles and responsibilities of those involved in claims billing processing
  - Case management and utilization review processes.
  - Use of outside consultants for claims processing
  - Current or previous audits by hospital or external agencies.

INTERNAL CONTROLS QUESTIONNAIRE

- Specific Controls
  - Description of key internal control and common edits for identified risk areas employed during period of review
- Purpose
  - "To get an understanding of the overall billing process within your organization."
ENTRANCE CONFERENCE

- Purpose:
  - Objectives of review
  - Audit methodology
  - Q & A

- Methodology:
  - Judgmental sample (no extrapolation of finding)
  - May review additional claims
  - Schedule walkthroughs of various aspect of billing process

THE AUDIT

- Parallel Review:
  - Review of claim to determine:
    - Medical Necessity
    - DRG / CPT / UOS
    - Discharge Disposition
    - Device Credits
    - Etc.

- Meet and Confer:
  - Review claim by claim
  - May require explanation…
  - Agreement / Disagreement / Pending
ERROR SUMMARY REPORTS

Error Type:

Applicable Medicare Criteria:

Samples in Error:

Please describe why these errors occurred:

Please describe the hospital's corrective action plan:

EXIT CONFERENCE

- Review Results:
  - Background and Objective
  - Scope & Methodology
  - Preliminary Results
  - General Cause of Errors
  - Reporting
  - Q & A
FINAL REPORT

- Initial draft report – 20 business days to review and comment
- Final report consists of:
  - Executive Summary
  - Error Details
  - Hospital Response Letter
- Publically available on OIG web site
  
(REports and Publications → Office of Audit Services → Centers for Medicare and Medicaid Services (CMS))

REPAYMENT

ACA §6402
Reporting and Returning Overpayments
- Within 60 days of “identification” of an overpayment
- New proposed rules
Methods of repayment
STRATEGY

- People –
  - Leadership Team
  - Operational Team
  - Consider:
    - Legal Counsel
    - CEO/CAO/CFO
    - Coding
    - HIM
    - Business Office
    - Case Management
    - Compliance SME
STRATEGY

- Planning – Pre-audit
  - Audit location / Building access
  - IT needs
  - Medical records
  - Liaisons to OIG
  - Consultants
  - Clinical resources
  - Meeting dates
  - Record Review
  - Tracking

- Communication
  - ACP
  - Etiquette
  - Contact list
  - Frequency
  - OIG Team Lead(s)
  - Consultants
  - Documentation
  - OIG Delivery Server
### RECORD TOOLS

**Billing Record**
- OIG Claim #: [Blank]
- MR#: [Blank]
- Acct #: [Blank]
- First Name: [Blank]
- Last Name: [Blank]
- Admit Date: [Blank]
- Discharge Date: [Blank]
- Service Area: [Blank]
- Total Pages: [Blank]

**Medical Record**
- OIG Claim #: [Blank]
- MR#: [Blank]
- Acct #: [Blank]
- First Name: [Blank]
- Last Name: [Blank]
- Admit Date: [Blank]
- Discharge Date: [Blank]
- Service Area: [Blank]
- Total Pages: [Blank]

### TRACKING TOOLS

#### Inpatient

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Account #</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Service Area</th>
<th>Total Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>John Smith</td>
<td>123456</td>
<td>01/01/2020</td>
<td>01/02/2020</td>
<td>[Blank]</td>
<td>[Blank]</td>
</tr>
</tbody>
</table>

#### Outpatient

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Account #</th>
<th>DOS</th>
<th>OPM/PCS Initial</th>
<th>OPM/PCS Revis</th>
<th>Original Medicare Payment</th>
<th>Estimated Adjusted Medicare Payment</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Jane Doe</td>
<td>123456</td>
<td>01/01/2020</td>
<td>[Blank]</td>
<td>[Blank]</td>
<td>[Blank]</td>
<td>[Blank]</td>
<td>[Blank]</td>
</tr>
</tbody>
</table>
TOOLS

Considerations:
- Assess “high risk areas” for inclusion on annual workplan
- Robust Coding Education:
  - Validating physician admission order status
  - Validating discharge/transfer status
  - Reviewing chapter specific coding guidelines
- Coding quality audits
- Pre-bill audits of one-day stays
- Medical Necessity reviews early in admission process and use of physician advisor/utilization review
- Standard work process for device credits

CONTACT INFORMATION

Marc Tatarian, MBA, RN, CHC
tatarim@sutterhealth.org
(415) 600-7022