Office of Inspector General Hospital Compliance Audit

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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

NOTIFCATION 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

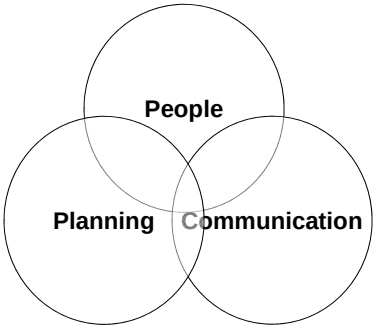
ACA §6402

Reporting and Returning Overpayments

- Within 60 days of "identification" of an overpayment
- New proposed rules

Methods of repayment

STRATEGY



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

STRATEGY

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

RECORD TOOLS

Billing Record	**Medical Record**
OIG Claim #:	OIG Claim #:
MR#:	MR#:
Acct #:	Acct:#
First Name:	First Name:
Last Name:	Last Name:
Admit Date:	Admit Date:
Discharge Date:	Discharge Date:
Service Area:	Service Area:
Total Pages:	Total Pages:

TRACKING TOOLS

Inpatient

Sample ID #	Name	Account #	Admit Date	Discharge Date	DRG Billed	DRG Revised	Discharge Status	Revised Discharge Status	Inter Qual Reference	Severity of Illness Inpatient Criteria Met?	Intensity Of Service Inpatient Criteria Met?	Comments
50	Smith, Jane	9999999	3/5/2010	3/6/2010	378 - GI Hemorrhage w CC	812	01	01	2010 Interqual Level of Care Criteria Gastrointestinal / Biliary / Pancreatic	Met GI Bleeding (page 10), => One: Hct <25% (Hct = 20.3% page 12) / Hb <8.3 (Hb 6.6 page 12)	Met Blood Products (page 15 transfusion record) and Hct <25 (20.3 page 12) / Hb <8.3 (6.6 page 12)	Medical Necessity: GI bleed - patient's Hct-20.3, Hb=6.6 - admitted for 4 units PRBC. **Coding:** Pt admitted with blood in stool. She had acute blood loss anemia requiring packed blood cell transfusion. The focus of the stay was reatment directed at the anemia and not investigation of the source of the bleeding. The anemia (285.1) should be the PDX, resulting in DRG 812 rather than 378. Discharge disposition-p. 50.
51	Doe, John	8888888	1/1/1/2010	1/12/2010	393 - Other digestive system dx w/ MCC	393	06	06	2010 Interqual Level of Care Criteria	Not Met	Not Met	Medical Necessity: 81-y/o female 3 days ago had a G-tube replaced. The patient has had a G-tube for the last 3 or 4 years. Since then, the family has noticed leaking around the G-tube and noticed that it leaks when they flush it, pt. c/o intermittent abdominal pain. G-tube replaced in ER and patient to be discharged from ER - apparently developed a GI bleed after insertion of the G-tube in the ER -admitted for IV fluid hydration, serial HH's, kept NPO, PRIV. VSS, CBC unremarkable, all other labs WNL. 01/11/10 04:29 - ADMIT TO MEDICINE, TEACHING SERVICE. **Coding:** Coded as per Coding Clinic 1st Q 1997, p.11. Discharge disposition as per p.20.

Outpatient

Sample ID #	Name	Account #	DOS	CPT/HCPCPS billed	CPT/HCPCS revised	Original Medicare Payment	Estimated Adjusted Medicare Payment	Comment

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