Another Piece of the Puzzle — The OIG Initiates a New Hospital Audit Program to Focus on Hospital "Risk Areas"

by Joanne B. Erde

An Overview of What the OIG is Looking For and What Hospitals Need to Do Going Forward

The Office of Inspector General (OIG) has initiated a new audit initiative to determine whether Medicare is making erroneous payments to hospitals in a number of specifically identified areas. This new OIG initiative is expansive in its scope. Not only is it reviewing the inpatient and outpatient claims that were paid, but it is also engaging in a detailed review of the hospital systems that produced the claims.

Based upon prior audits and investigations, the OIG has identified certain areas for which it believes hospitals are at risk for not complying with Medicare billing requirements and, as a result, have been paid erroneously. To remedy this, the OIG has begun a new type of audit to determine whether hospitals are being paid improperly in these risk areas. The OIG is focusing on Medicare payments made from 2008 through 2010, for both inpatient and outpatient services, in the identified risk areas.

These audits are unique in a number of ways. First, they require the target hospitals to conduct a significant self-audit prior to the OIG beginning its audit. Second, the audits are not limited to claims review; they include a review of the hospitals' internal controls applicable to the areas under audit. Lastly, they require the hospitals to establish new systems to prevent the erroneous payments going forward.

To date, it appears that only a few hospitals in a small number of key states have been chosen for these audits. But, regardless of the small number of these audits to date, hospitals should take note due to the identified risk areas and the emphasis on internal controls. Even if the OIG does not target your hospital, the recovery audit contractors (RACs) are watching. Many of these risk areas are straightforward and made for RAC audits or other increased enforcement efforts.

The "Risk Areas" — What Is The OIG Looking For?

Through computer matching, data mining, and analysis techniques, the OIG has identified a number of types of payments that it believes are at high risk of being billed and paid inconsistently with Medicare rules and regulations. They refer to these areas of high risk of incorrect billing as "risk areas." The risk areas that they have identified will not surprise any hospital that has been subjected to a RAC audit. In many ways these risk areas are low-hanging fruit — areas that hospitals should be billing correctly, but may not be. The OIG's list of risk areas includes both inpatient and outpatient payments. The list that the OIG has identified to date includes the following:

Inpatient

- One-Day Stays
- Two-Day Stays
- Same-Day Discharge and Readmission
- Transfers to Home Health Agencies (HHAs) for Post-Acute Care
- Medical Device Credits
- Claims Paid Amount in Excess of Claim Charged Amount
- Claims With Payments Greater Than $150,000
- Blood Clotting Factor Drugs — Hemophilia Claims

Outpatient

- Medical Device Credits
- Services Billed With Modifier - 59
- E & M Services Billed with Surgical Services
- Claims Paid Amount in Excess of Claim Charged Amount
- 72-Hour Rule
- Surgeries Billed with Units Greater than One
- Services Billed During Skilled Nursing Facility (SNF) Stays

Each audit does not include every area listed above. Instead, prior to initiating the audit, the OIG determines which risk areas it believes apply to the particular hospital being audited. It then provides the hospital with a sample of claims for each risk area that the OIG wants to review at that hospital. Significantly absent from this list of risk areas is any review of the medical necessity of any services for which payment has been made. It is also important to note that the samples pulled by the OIG are judgmental samples; ones from which there will be no extrapolation.

The Audit Process

Self-Audit

The audit process begins with a self-audit. The OIG provides the targeted hospital with a self-audit workbook that includes a sample of claims that have been paid by Medicare in some of the risk areas set forth above. The workbook contains three sections, which are referred to as tabs. The first tab contains the sample of inpatient claims that the OIG expects the target hospital to review. The second tab contains the OIG sample of outpatient claims, and the third tab describes the areas of vulnerabilities that the OIG has found in prior audits.

The first and second tabs are also subdivided by the specific risk area for which the OIG is auditing the target hospital. If, for example, the OIG has determined that the target hospital may have been paid erroneously for one-day stays, same-day discharges and readmissions, and blood clotting factor drugs, there will be a sample of claims that were paid by Medicare in each risk area. The hospital must review all of the claims in the workbook to determine whether the hospital did, in fact, bill the claims correctly.

There are blank columns in the workbook for the hospital to set out its self-audit findings and to either explain why the billing was correct or why it was not. The instructions provide that, if during the self-audit, the hospital identifies errors in its original coding of the claims, the hospital can recode the claim and the OIG will give the hospital credit for any errors that it identifies prior to the OIG's completion of its audit fieldwork. Early on, the OIG explains that as part of this review, it will be looking for admit orders, discharge status codes, sequencing and selection of codes based on medical record detail, as well as any other factors that would impact the Medicare payment. And, as the audit progresses, these are the items for which they are looking.

The OIG provides the hospital with approximately two weeks to complete the self-audit but also advises that if the hospital cannot complete the audit within the allotted time, it is to submit the partially completed workbook to the OIG within that timeframe. Although the OIG advises that the audit does not have to be complete prior to the entrance conference, our experience is that it creates a better working environment with the OIG if the workbook is completed prior to the entrance conference.

OIG Entrance Conference

The completion date of the self-audit is timed to precede the scheduled entrance conference. The entrance conference is intended to give the OIG auditors an opportunity to introduce themselves to the hospital staff and explain the scope of the review, the audit process that the OIG will follow, and the anticipated milestone dates. The OIG also wants to meet the key individuals at the hospital with whom they will be working. Although this is somewhat standard in any type of audit/investigation, during the entrance conference, the OIG team also schedules meetings with the hospital's coders, claims processing staff, and accounting staff. The OIG's purpose in scheduling these interviews with the coders is to (i) gain an understanding of the coding process and the software used by the coders, and (ii) identify any quality control processes that are in place. Similarly, the purpose in interviewing the claims processing/accounting staff is to gain an understanding of (i) the software programs used by the hospital that go into making the medical record and, eventually, the claims, and (ii) how the information is processed. The OIG actually requested flow charts to further explain these processes and demonstrations of the software.

Review of Hospital Internal Controls

As part of the entrance conference, the OIG requires each hospital to make presentations regarding the internal controls that it maintains to assure that it is billing correctly. The OIG specifically asked for audited financial statements, including any management letter comments associated with them. The OIG is specifically looking to see if any of the areas of deficiencies identified in the comment letters relate to its identified risk areas and whether the hospital responded appropriately to these management letter comments. The OIG also asked for documentation to allow the agency to have a complete understanding of the hospital's software systems and the hospital manual procedures used to create medical records, including pharmacy, labs, and physician orders. Finally, the OIG also asked for documentation and presentations that would provide the agency with a complete understanding of the hospital's admission process. All of this was for the purpose of ultimately understanding how each service was coded and billed to Medicare from admission to discharge.

OIG Audit Work

In addition to the completed self-audit workbook, the data gathered during the course of the entrance conference, staff interviews, and the documentation of the hospital's internal controls, the OIG demanded a list of all doctors that had admitting privileges at the hospital, the complete medical record for each claim in the sample, the UB-04 and remittance advice for each sampled claim, and the coding summary for each claim. Based upon all of this information, the OIG audit staff performed its own review of the sampled claims.

This audit process was a back and forth process with the hospital. The OIG repeatedly submitted questions to the hospital regarding the claims in the audit workbook, asking for more and more explanation of why claims were coded with one DRG versus another or one HCPCS code versus another

and more documentation to support the payments made.

Once this process is completed, but prior to issuing the final report, the OIG provides the hospital with its audit findings and an Internal Controls Questionnaire. The OIG's audit findings are organized by risk area, and the Initial Control Questionnaire has four sections of questions for each risk area.

In Section 1, the OIG sets out the claims that it has determined were incorrectly billed by the provider, as well as the legal authority to support its determination. The statement of legal authority is very general. In Section 2, the report requires the provider to describe the key internal controls that it had in place during the period under review to avoid billing to the identified risk area in question incorrectly. Section 3 requires the provider to describe why the key controls did not prevent the claims in the sample from being billed incorrectly. Lastly, Section 4 requires the provider to describe the tentative corrective measures that the provider will be taking to address the types of errors identified in Section 1. Although this report is described as the tentative audit report, these findings are final.

Going Forward

This new audit expands the type of reviews beyond the more common pre-payment and post-payment reviews that most hospitals have experienced over time. In addition to a review of the paid claims, the OIG is looking at the systems that hospitals have in place to make sure that the entire process, from admission to discharge, is designed to result in a bill for payment that correctly reflects the services rendered and Medicaid rules.

The OIG put significant emphasis on how orders get input into the computer system and how these services ultimately are coded and billed. They were looking to see whether the services coded were adequately documented in the medical records, and supported the DRG assigned, and coded properly.

One interesting and unexpected item that arose in a number of audits was lack of signed admission orders. It is not uncommon for patients to start out with an outpatient procedure but, for a variety of reasons, are converted to inpatient status. This is frequently done with verbal orders. The OIG has taken the position that without a signed order reflecting the changed status, all payments made must be recouped. Just like the RAC take backs for one-day stays, it is quite possible that this issue may result in significant losses to hospitals across the country.

Overall, hospitals can evaluate whether the identified risk areas are putting them at risk. This can be used as a template to determine whether they are submitting claims that do not comply with Medicare rules in the identified areas. And, if they are not in compliance, actions can be taken to rectify their internal systems to prevent future errors. It also is an indication that the OIG will be looking at hospital quality controls to assure that future billings are performed correctly. ■

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