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OIG Hospital Compliance Audits: Is Your Number Up? Are You Ready?



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In its Work Plan for Fiscal Year 2012, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) announced it would begin reviews of Medicare payments to hospitals to determine compliance with selected billing requirements.

Over the past three years, following these compliance audits, the OIG has increasingly been using the results of these reviews to recommend recovery of overpayments and identify providers that routinely submit improper claims.

Unfortunately, through the use of an extrapolation process which is often ill suited to this process, the results of these audits are often ''overpayment'' claims which are far beyond what appears reasonable, or based on sound methodology, resulting in overpayment demands in the millions. Many of these audit findings are now the subject of administrative appeals.

Many hospitals which have gone through the audit process have objected to them as being redundant and burdensome. The American Hospital Association weighed in with a letter last year to the HHS Secretary lobbying for a change in the process. But the audit notice letters keep on coming. If your hospital or hospital client has not yet undergone such an audit, it is only because, as one OIG agent explained, your ''number has not yet come up''.

The OIG explained in its 2012 Work Plan announcement both how a hospital will be picked for audit and the probable subject matters of the audit. Based on computer matching and data mining techniques the OIG identifies areas ''at risk'' for noncompliance with Medicare billing requirements and from this data analysis the OIG selects hospitals for focused reviews of claims.

Using the same data analysis techniques, the OIG identifies hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky.

If your hospital is selected for audit, you will receive a letter notifying the hospital of the upcoming audit.

The Audit Process

The OIG's audit notice letter outlines the audit process. The OIG auditors can be helpful in explaining their requests and claims decisions.

It is always a good idea, however, to get a head start in preparing for an audit and to hear from others who have gone through the process.

The authors' goal in writing this article is to share our experiences and insight into the audit process. Other in-

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formation about these audits can be found by reviewing the audit reports published on the OIG's website or by speaking with representatives of hospitals which have faced these audits.

The OIG's stated objective in hospital compliance audits is to determine whether the hospital complied with Medicare requirements for billing inpatient and outpatient services. The OIG has identified ''risk areas'' for inpatient and outpatient claims reviews. These risk areas have changed through the years.

In its most recent audits, the OIG has been focusing on:

- inpatient claims with manufacturer credits for medical devices;
- inpatient claims billed with high severity level diagnosis related group codes;
- inpatient claims paid in excess of charges;
- inpatient cancelled surgeries;
- outpatient claims with manufacturer credits for medical devices;
- outpatient bypass modifiers (modifier-59); and
- outpatient claims with payments greater than a stated dollar amount (e.g., $25,000 or $100,000).

Other risk areas identified for review have included short hospital stays, same day discharge and readmission, transfers to post-acute care providers or to inpatient hospice care, outpatient services billed during inpatient stays, outpatient surgeries, and outpatient services billed during skilled nursing facility stays.

The list of identified ''risk areas'' has grown since the original list referenced in the 2012 Work Plan and new areas are identified in each new annual Work Plan.

Taken from its identified list of ''risk areas,'' the OIG will specify the ''initial review areas'' for the audit of a particular hospital. To identify these areas, the OIG uses data analysis to identify ''highly vulnerable'' claims submitted by that hospital. In most instances the OIG will select up to 200 inpatient and 200 outpatient claims for review.

In its initial audit letter, the OIG explains that it intends to look at statistically sampled claims for the identified review areas. The denial/disallowance findings may be projected to all claims in the sampling frame.

The OIG may also, using its discretion, select certain specific types of claims (such as claims with manufacturer credits for medical devices) and perform a review of billing and medical record documentation on these claims.

The OIG auditors will make an initial site visit to review claims. The auditors will often work with hospital representatives to clarify the scope of an audit request, and are typically flexible in terms of scheduling and arranging for review of the documents. The on-site visits generally range from several days to up to two weeks.

The OIG conducts the audit as an ''internal controls audit'' which requires the hospital to evaluate and disclose its analysis of claims to the OIG auditors as they review the claims. This type of audit process results in discussions and active ''negotiations'' on each claim determination as the on-site visit takes place. It includes interviews with managers for admission, care management, medical records and coding to determine the ''internal control environment''.

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The audit process does not extend only to claims; the OIG also conducts a type of due diligence review of the hospital's policies and procedures on billing practices by asking for copies of all internal audits and by conducting selected interviews of hospital personnel. This can cause the OIG to look at new issues which may have been identified in prior internal audits of the hospital or as a result of these interviews.

The Role of Legal Counsel

Hospitals should take an OIG audit very seriously. The OIG has authority to make referrals for civil or criminal investigation. The broad and expansive scope of an OIG compliance audit, coupled with its enforcement and referral authority, make it appropriate for a hospital undergoing the audit to engage legal counsel at the inception of the process.

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Legal counsel should actively participate in reviewing questions arising during the audit, including questions relating to production of documents requested by the OIG auditors. Upon receipt of the draft audit report, legal counsel should review and assist the hospital in preparing its response to OIG Audit report.

At the completion of the OIG auditor's onsite visit, the OIG will send Internal Control Questionnaires (ICQ) on each of the reviewed ''areas'' for completion by the hospital. The hospital will submit its written responses to the ICQs. Following receipt and consideration of the hospital responses, the OIG will finalize its findings, a process that can take weeks to months. The OIG will return to the hospital for an exit conference to present its findings. The OIG findings will also be included in a draft report which will be given to the hos-

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pital. The hospital will have 30 days to submit its written formal response to the draft findings.

The response to the draft report is important. It sets the stage for the factual and legal arguments the hospital will want to preserve, and advance at different levels of administrative appeal, if necessary. In its response, the hospital identifies the OIG's claims decisions with which it is in agreement and which decisions or disallowances with which it disagrees and will appeal. The hospital's response is included in the Final Audit Report issued by the OIG.

In its final report, the OIG makes ''recommendations'' of claims overpayments which should be repaid, and forwards these recommendations to a HHS action official. The action official will make a final determination as to actions taken. The hospital's legal counsel should contact the action official during this time period to address any issues in the final report.

In preparation for the delivery of claims information requested by the OIG auditors and the first site visit by the OIG auditors, the hospital should form a team to respond to and participate in discussions with the OIG auditors.

In-house and usually outside legal counsel should be involved in those discussions, which, in addition to enabling counsel to identify and prepare for the legal issues likely to be involved, also establishes the basis for an attorney-client privilege for the discussions. In addition, the hospital should engage legal counsel to direct its audit response team on any legal matters that arise during the audit process.

One decision the hospital and its audit response team will need to make early on is whether it needs the assistance and consultation of a coding expert. If so, legal counsel should engage the consultant.

The expert consultant can conduct a ''shadow'' audit of the claims identified for audit by the OIG auditors. This audit should be a real-time audit done before and during the time these claims are being reviewed by the OIG auditors. The consultant's audit findings can assist legal counsel in advising the hospital audit response team on formulating responses to OIG auditors relating to claims reviewed, but also establishes a basis for challenging the most significant part of an audit overpayment recommendation: extrapolation. In our experience, the extrapolation process used by the OIG is often subject to attack on a variety of grounds.

Legal counsel can also assist the hospital's audit response team during the audit process by, in some cases, helping to prepare the team members for questions that are likely to arise during the auditor's interviews.

Just as it is important for a witness preparing for a deposition to be fully prepared to give truthful and accurate testimony in a litigated matter, it is important for hospital representatives interviewed during an audit to understand the importance of the matter, and to be prepared to answer questions raised during the process accurately and completely.

If the hospital needs the assistance of a coding consultant during the audit, legal counsel should consider engaging the expert coding consulting firm which can advise and assist legal counsel in advising its client, in order to preserve applicable privileges.

Legal counsel should also consider engaging, early in the process, a statistician to assist counsel in rendering legal advice to the hospital client. The statistician expert can assist legal counsel in the review of the OIG's statistical sampling of claims, and assist in any challenge to the OIG's sampling methodology.

Communication Plan

The hospital should develop a communication plan for managing the exchange of documents and information during the audit process. The plan should include the identification of a contact person and spokesperson for the hospital. This person can be the hospital's compliance officer, its in-house legal counsel or another officer of the hospital.

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In addition, the hospital should create an audit response team which will gather requested documents; identify and review policies and procedures responsive to the auditor's questions and requests; develop the format for responses; and review and approve responses.

In order to effectively control the information exchange, the hospital audit response team, in conjunction with in-house and/or outside counsel, should establish a shared file area with controlled access; maintain a record of documents produced and responses given to OIG auditors and prepare and circulate a weekly summary of audit requests and responses. The team will need to meet weekly to discuss and respond to OIG requests and to discuss errors identified by OIG auditors and determine weaknesses/problems in procedures and practices.

Maintaining attorney-client and other applicable privileges during this process is important.

The audit response team, along with legal counsel, should keep the hospital, its officers and its board informed of the scope of the audit and the responses by the hospital team. There may be instances when the audit response team will need to reach out to officers and department heads of the hospital to assist in formulating its responses to specific questions.

In addition, members of the team, along with legal counsel, may need to interview individual department heads or managers to obtain guidance and information needed to formulate responses to the auditor's questions. Certain individuals may be identified either by the OIG auditors or by the audit response team to be interviewed by the OIG auditors. Members of the audit response team will need to assist these individuals in their preparation for these interviews.

Upon receipt of the OIG's draft report, the hospital's audit response team, with assistance from legal counsel and its experts, will prepare the hospital's response. This will require the hospital to determine whether it agrees or disagrees with the OIG's decision that a claim should be disallowed. The response will identify the areas of disagreement and the hospital will state its intent to appeal the denials of claims.

Appeals Process

If an overpayment is assessed, the matter will be sent to the hospital's Medicare contractor. The Medicare contractor will subsequently issue a demand letter to the hospital outlining the hospital's appeal rights.

The Medicare appeals process includes the following five levels of review:

- Level One: Redetermination.
- Level Two: Qualified Independent Contractor Reconsideration (QIC).
- Level Three: Administrative Law Judge (ALJ).
- Level Four: Medicare Appeals Council.
- Level Five: Federal Court.

The Redetermination and QIC level appeals are decided by Medicare contractors ''on the record'' and do not allow for an actual hearing.

The first actual hearing takes place before an administrative law judge (ALJ).

It is vitally important that the hospital maintain all of its rights during the appeals process. A Medicare contractor is prohibited by law from recouping or offsetting any portion of an overpayment through the first two levels of appeal if the hospital meets established appeal timeframes. Specifically, if a hospital files a redetermination appeal within 30 days of the demand letter and files a QIC appeal within 60 days of the redetermination decision, no offset or recoupment may take place until the QIC decision is issued.

If a contractor attempts to recoup or offset during this time period, a hospital should vigorously demand that the recoupment or offset be refunded immediately.

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A hospital, working with legal counsel, should submit relevant documentation and make a strong case at all appeal levels. Early submission of additional evidence and analysis from experts is critical because recoupment or offset of payments can begin after the QIC decision.

Further, new evidence submitted at the ALJ level may be excluded from consideration unless the hospital can demonstrate good cause as to why the evidence was not submitted during the earlier appeals.

Currently, there are significant delays in scheduling ALJ hearings. As a result, unfavorable QIC determinations may result in significant repayment obligations for the hospital while waiting for the case to be heard.

Actively appealing claim denials and challenging the sampling methodology is especially important when extrapolation is involved because each claim denial represents a larger extrapolated overpayment across a broader universe of claims.

For example, the overpayment might involve 50-100 denied claims. While the actual overpayment may be relatively minimal, the extrapolated overpayment could amount to hundreds of thousands or possibly millions of dollars.

Conclusion

The OIG hospital compliance audit process, at least in practice, is shifting from a true compliance enforcement program into a thinly disguised effort to control hospital costs through recoupment of substantial funds on highly technical grounds.

This process is exacerbated significantly by the use of statistical sampling techniques to extrapolate large financial penalties, often on the basis of highly questionable extrapolation formulas. Hopefully, the objections to the reach and scope of these audits as outlined by the American Hospital Association will result in a more measured approach, if not an overhaul of the process entirely.

For the time being, however, hospitals must assume that the audit program will not only continue, it will assume increasing importance as a billing enforcement tool by the federal government.

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