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The OIG's Hospital Compliance Initiative

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Payments for inpatient and outpatient hospital services account for roughly 30 percent of the $515 billion spent on Medicare. Given these significant program outlays, the Department of Health and Human Services Office of Inspector General has recently deployed audit significant resources toward testing and ensuring the 3,600 acute care hospitals compliance with program requirements.[1]

In the past, OIG's hospital audits typically focused on one specific area of risk (e.g., unbundling of services,

[1] Testimony of Lewis Morris, Chief Counsel, Office of Inspector General, U.S. Department of Health and Human Services, ''Harnessing Technology and Innovation to Cut Waste and Curb Fraud in Federal Health Programs,'' before the U.S. Senate Committee on Homeland Security & Governmental Affairs' Subcommittee on Federal Financial Management, Government information, Federal Services and International Security (July 12, 2011).

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inpatient same-day discharges and readmissions, and credits for medical devices), and audited claims exclusively related to that issue.

In part, the OIG had narrowly focused its audits due to limits on its capacity to store and match data. As a consequence of increased data storage, computer matching, and data analytic capabilities, the OIG is now more quickly and efficiently analyzing a vast array of hospital data to simultaneously identify multiple compliance risks.[2]

The OIG targets multiple risk areas simultaneously during its ongoing Hospital Compliance Initiative. The OIG tests hospitals against 27 risk areas that its prior audit and enforcement experience indicate are error-prone.[3] The list of audit issues is not currently published. For the most part, however, the audit issues can be identified through the OIG's previous work plans and audit reports.

Here are some of the audit areas that have been identified to date:

- Inpatient same-day discharges and readmissions
- Inpatient one-day stays
- Inpatient short stays
- 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 and outpatient claims paid in excess of charges
- Inpatient and outpatient claims involving manufacturer credits for medical devices
- Outpatient services billed during skilled nursing facility stays
- Outpatient surgeries billed during diagnosis-related group payment windows
- Outpatient claims billed with modifier -59
- Outpatient claims for evaluation and management services billed with surgical services
- Outpatient claims billed during diagnosis-related group payment windows
- Outpatient claims for intensity modulated radiation therapy planning services
- Outpatient claims billed during an inpatient stay

To better focus its testing, the OIG also analyzes other hospital information, such as provider overpayment, Medicare exclusions, and law enforcement databases. Collectively, these data provide a comprehensive picture of how a hospital is performing and where compliance problems may exist.

Using computer matching and data mining techniques, the OIG then identifies potential problem areas, selects claims for testing, and conducts hospital site visits to perform comprehensive reviews of billing and medical record documentation. The OIG has completed several such audits and has 40 more planned or underway.[4]

The OIG initiates the audit process by sending a letter to the hospital providing notice of its intention to conduct a hospital compliance audit. The stated objective is to determine whether the hospital complied with Medicare requirements for billing selected claims. The audit may span several years, such as 2008 through 2010.

The OIG will review known areas of noncompliance identified during past OIG reviews of hospitals. The letter includes a list of examples of potential audit areas.[5]

The letter states the OIG's authority for the review and access to the necessary records. It also points out that HHS may deny payment to any provider of services unless there is furnished such information as may be necessary to determine the amounts due to the provider. It also gives assurances relating to HIPAA concerns.[6]

The OIG has distributed Internal Controls Questionnaires to the audited hospitals. The questionnaires include questions inquiring into the following areas:[7]

- General Controls
  - The roles and responsibilities of departments and employees involved in claims billing and processing.
  - Any contracts the hospital has for processing payments and any billing related services provided by outside consultants.
  - Current or previous audits performed by the hospital or outside agencies regarding the audited issues.
- Process Controls
  - Billing processes, internal controls and quality controls for inpatient claims.
  - Billing processes, internal controls and quality controls for outpatient claims.
- Specific Controls
  - Key internal controls and common edits for the audited issues, throughout the audit period.

In addition, the OIG is asking hospitals to produce the following before the audit begins:[8]

- Organizational charts for compliance and claims processing.
- Procedures manuals for claims processing.
- A list of common edits related to the audit areas.
- Flow charts for claims processing.

The OIG holds an entrance conference, at which time it explains the process and the timing. It also provides a list of documents that will be required to conduct the review. During the review, the OIG may need additional documents and records that go beyond the initial request. The OIG selects a judgmental sample[9] of claims for detailed review, and reviews the itemized bills and medical record documentation provided by the hospital to support the sampled claims. The OIG requests the hospital to conduct its own review of the sampled claims to determine whether the services were billed correctly. The OIG also reviews the hospital's procedures for assigning HCPCS codes and submitting Medicare claims.

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[2] Id.

[3] The OIG has developed a list of errors that it commonly sees through its audits, whistleblower cases, investigations and self-disclosures.

[4] Note 1, Supra.

[5] ''More About OIG's Intensive Hospital Audits –Required Reading,'' The Healthcare Compliance Blog (http://www.thecomplianceblog.com/2011/05/more-about-oigs-intensive-hospital.html.

[6] Id.

[7] Id.

[8] Id.

[9] Judgemental sampling (as opposed to random sampling) is notable because it means that the government cannot extrapolate from the sample findings.

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The OIG then discusses the incorrectly billed and/or coded claims with hospital personnel to determine the underlying cause of noncompliance with the Medicare requirements, and discusses the result of the audit with hospital officials. Hospitals are required to return any identified overpayments and are expected to implement necessary internal controls to prevent future improper billing. The audits are accomplished as intensive, four-week, on-site reviews.[10]

South Shore Hospital Audit

In the South Shore Hospital[11] audit, the OIG reported on:

- inpatient same-day discharges and readmissions
- inpatient one-day stays
- inpatient claims paid in excess of charges
- outpatient surgeries billed during diagnosis-related group payment windows
- outpatient claims paid in excess of charges
- outpatient services billed during skilled nursing facility stays
- outpatient manufacturer credits for medical devices

The audit covered claims for the two-year period from Jan. 1, 2008, through Dec. 31, 2009. In all, 87 inpatient claims and 302 outpatient claims were audited, and the OIG identified 35 inpatient and 214 outpatient claims errors, leading to claimed overpayments of $167,894 for the inpatient claims and $179,139 for the outpatient claims.

The overall amount of reimbursement represented by the audited claims was $1,891,118, such that the OIG found that about 18% of the audited reimbursement was in error. To place this in context, the hospital reportedly had $163 million in Medicare reimbursement over the two years, based on 18,773 inpatient and 126,078 outpatient claims.[12]

The OIG recommended that the hospital repay $341,033, which it did. It also recommended that the hospital ''strengthen controls to ensure full compliance with Medicare requirements.'' The hospital indicated that it will monitor the audited issues and strengthen controls as indicated.

The hospital also noted that the vast majority of the outpatient claims errors were attributed to a defective hospital software upgrade. Lastly, the hospital indicted that it would continue to monitor all of the audited areas and would update its controls as necessary.[13]

Fletcher Allen Health Care Audit.

In the Fletcher Allen Health Care[14] audit, the OIG reported on:

- inpatient same-day discharges and readmissions
- inpatient one-day stays
- inpatient claims with payments greater than $150,000
- inpatient claims for blood clotting factor drugs
- outpatient claims billed with modifier -59
- outpatient claims for evaluation and management services billed with surgical services
- outpatient claims billed during diagnosis-related group payment windows
- inpatient and outpatient claims paid in excess of charges
- inpatient and outpatient claims involving manufacturer credits for medical devices

Fletcher Allen Health Care, Inc. (the Hospital), complied with Medicare billing requirements for 162 of the 202 claims the OIG reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims in other areas.

Specifically, of the 202 sampled claims, 40 claims had errors in overpayments totaling $234,000 for calendar years 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims and did not fully understand Medicare billing requirements.[15]

The OIG recommended that the hospital repay $234,000, which it did. It also recommended that the hospital ''strengthen controls to ensure full compliance with Medicare requirements.'' To strengthen hospital compliance efforts and address the issues raised by the audit findings, the hospital implemented several measures, including the following:

- Modified edits in the billing system for outpatient services that should be combined with an inpatient stay;
- Corrected assigned revenue codes in areas where errors occurred;
- Conducted additional coding education and auditing; and
- Revised the case management process for determining whether or patient is an inpatient or not.[16]

Cape Cod Hospital Audit

In the Cape Cod Hospital audit, the OIG reported on:

- inpatient short stays
- inpatient same-day discharges and readmissions
- inpatient claims with payments greater than $150,000
- inpatient hospital-acquired conditions and present on admission indicator reporting
- outpatient claims for intensity modulated radiation therapy planning services
- outpatient claims billed with modifier -59
- outpatient claims billed during an inpatient stay
- outpatient claims for evaluation and management services billed with surgical services
- inpatient and outpatient claims paid in excess of charges
- outpatient claims involving manufacturer credits for medical devices[17]

Cape Cod Hospital (the Hospital) complied with Medicare billing requirements for 178 of the 382 claims we reviewed. However, the Hospital did not fully comply with Medicare billing requirements for selected inpatient and outpatient claims in other areas.

Specifically, of 382 sampled claims, 204 claims had errors in overpayments totaling $379,000 for calendar years 2008 and 2009. Overpayments occurred primarily because the Hospital did not have adequate controls to

[10] Id.
[11] http://oig.hhs.gov/oas/reports/region1/11000521.asp
[12] Id.
[13] Id.
[14] http://oig.hhs.gov/oas/reports/region10/11000527.asp.
[15] Id.
[16] Id.
[17] http://oig.hhs.gov/oas/reports/region10/11000530.asp.

prevent incorrect billing of Medicare claims and did not fully understand Medicare billing requirements[18]

The OIG recommended that the hospital repay $379,000, which it did. It also recommended that the hospital ''strengthen controls to ensure full compliance with Medicare requirements.''

As a result of the audit, Cape Cod Hospital implemented several measures, including the following:

- Provided education to the one certified coder who was not utilizing Modifier -59 appropriately;
- Provided education to staff in certain outpatient areas about the identified errors pertaining to selecting charges that are appropriate for the service rendered.;
- Established a new process across the hospital's clinical and financial operations to more effectively communication decisions about the complicated relationship between a patient's discharge and then readmission on the same day when the symptoms on readmission are related to or for evaluation and management of the patient's medical condition at the time of his/her original discharge from the hospital; and
- Changed certain administrative processes to make sure there are appropriate written physician orders and correctly completed claims pertaining to certain neurosurgical procedures for which Medicare requires the patient to be admitted to the hospital as an inpatient prior to the surgery.[19]

Conclusion

According to the OIG audit reports, the common causes of many of the Medicare billing errors related to staff misunderstanding of the proper billing and coding rules, lack of sufficient record and claim review processes, and human error.

Hospitals should consider the above-referenced and other published OIG audit reports to evaluate their own internal controls and compliance with the applicable billing and coding requirements. Hospital compliance departments should implement strategies to prevent such errors from occurring in the future.

Prudent hospitals will take steps now to mitigate their exposure to any potential audit. Hospitals should develop strategies, with the appropriate use of attorney-client privilege and work product protection, to address the audit risk areas and to prevent additional exposure.

In the event of a government investigation at a hospital, experienced health care compliance counsel can be instrumental in orchestrating the hospital's response and can oversee and provide feedback regarding any necessary remedial action.

Counsel can also direct the follow-up communications with the government to clarify or limit the scope of the investigation, and oversee the hospital's corrective action plan and minimize the likelihood that the investigation expands and includes other areas.

[18] Id.

[19] Id.

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