Emerging Compliance Audit Hot Topics

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# OIG Approach to Audits that Internal Audit / Compliance should also utilize.

## Approach

1. The OIG is distributing Internal Controls Questionnaires to the audited hospitals. They have questions inquiring into the following areas:

   **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.

2. The OIG is asking hospitals to produce the following before the audit begins:
   - 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.
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<th><strong>HIPAA Privacy and Security Rules and HITECH</strong></th>
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<td>Make sure hospital is compliant with all applicable provisions of the privacy and security rules, including provisions pertaining to required disclosures and that its privacy and security procedures.</td>
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| Any process in which electronic data is sought, located, secured, and searched with the intent of using it as evidence in a civil or criminal legal case | • Paper  
• Electronic |
| Hybrid Records | • Scanned notes  
• Delayed posting |
| Electronic Source “Records”  
E-signatures | • Administrative (e-mail)  
• Financial  
• Medical  
• EMR’s – (admissions, orders, notes, results, discharges etc....)  
• Digital images (pathology images)  
• Diagnostic images (X-ray, CT, MR, nuclear medicine)  
• Cine (cardiac cath, ultrasound images)  
• Medical transcription files  
• Wave forms (ECG’s, fetal traces, etc.) |
<table>
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<th>Electronic Errors (data/discovery)</th>
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<td>Incompatibility between Multi-Vendor Software Applications or Systems</td>
<td>Incompatibilities which can lead to any of the above</td>
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<td>Use of Information Technology</td>
<td>Ensure that staff has thoroughly assessed all new computer systems and software that impact coding, billing, or the generation or transmission of information related to the Federal health care programs or their beneficiaries.</td>
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<td>Remote computers and servers</td>
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<td>• Defaults</td>
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Submiting incorrect claims for ancillary services because of outdated Charge Description Masters

CDM is current, updated proper use of modifiers, and correct associations between procedure codes and revenue codes.

- For more HCPCS code information see http://www.cms.gov/MedHCPCSGenInfo/
The prohibition against beneficiary inducements at section 1128A(a)(5) of the Act does not apply to incentives offered to promote the delivery of certain preventive care services, if the programs are structured in accordance with the regulatory requirements at 42 CFR 1003.101.

Ensure that a service is a prenatal service or post-natal well-baby visit or a specific clinical service described in the current U.S. Preventative Services Task Force’s Guide to Clinical Preventive Services that is reimbursed by Medicare or Medicaid.

Service is not tied directly or indirectly to the provision of other Medicare or Medicaid services. The incentives may not be in the form of cash or cash equivalents and may not be disproportionate to the value of preventive care provided.

Concern: is whether an arrangement to induce patients to obtain preventive care services intended to induce other business payable by a Federal health care program.

- Relevant factors in evaluating arrangements include, but are not limited to:
  - The nature and scope of the preventive care services
  - Whether the preventive care services are tied directly or indirectly to the provision of other items or services
  - If so, the nature and scope of the other services; the basis on which patients are selected to receive the free or discounted services
  - Whether the patient is able to afford the services
Substandard Care

- Ensure that there were no unnecessary or substandard items or services provided to any patient, even if that patient is not a Medicare or Medicaid beneficiary.

- Continue to measure their performance against comprehensive standards. Hospitals should meet all of the Medicare hospital conditions of participation (COP), including without limitation, the COP pertaining to a quality assessment and performance program at 42 CFR 482.21 and the hospital COP pertaining to the medical staff at 42 CFR 482.22.

- Maintain TJC accreditation. Additionally, develop quality of care protocols and implement mechanisms for evaluating compliance with those protocols.

- Take an active part in monitoring the quality of medical services provided at the hospital by appropriately overseeing the credentialing and peer review of their medical staffs.
Billing Medicare or Medicaid Substantially in Excess of Usual Charges

- Section 1128(b)(6)(A) excludes providers from Federal health care programs if they submit a claim based on costs or charges to Medicare or Medicaid programs that is substantially in excess of its usual charge or cost unless the Secretary finds good cause for the increased charges.

- Ensure that providers are not routinely charge Medicare or Medicaid substantially more than they usually charge others.
No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills.

Make certain that the hospital reflects full uniform charges, rather than the discounted amounts, on its Medicare cost report and make the FI aware that it has reported its full charge.

Make certain that if the hospital forgoes any collection effort aimed at a Medicare patient, the hospital, using its customary methods, can document that the patient is an indigent or medically indigent.

If the hospital also determines that no source other than the patient is legally responsible for the unpaid deductibles and coinsurance, the hospital may claim the amounts as Medicare bad debts.

Hospitals must follow the guidance stated in the Provider Reimbursement Manual.

The hospital should document the method by which it determined the indigency and include all backup information to substantiate the determination.

Medicare requires the efforts to be documented in the patient’s file with copies of the bill(s), follow-up letters, and reports of telephone and personal contacts.
The Referral Statutes

The Physician-Referral Law (the “Stark” law) and the Federal Anti-Kickback Statute

Physician-Referral Law

Prohibits physicians from referring Medicare patients for certain designated health services (DHS) to an entity with which the physician or a member of the physician's immediate family has a financial relationship unless an exception applies. It also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for DHS furnished as a result of a prohibited referral.

- Section 1903(s) (42 U.S.C. 1396b) of the Social Security Act extends this referral prohibition to the Medicaid program.
The Referral Statutes (continued)

The Physician-Referral Law (the “Stark” law) and the Federal Anti-Kickback Statute

**Stark law** and regulatory exceptions are listed in 42 USC §1395nn, available at:

- [http://www.law.cornell.edu/uscode/html/uscode42/usc_sec_42_00001395-nn000-.html](http://www.law.cornell.edu/uscode/html/uscode42/usc_sec_42_00001395-nn000-.html)

- Ensure that the hospital is complying with 42 CFR 411.361, which states that hospitals should retain records concerning financial relationships.

- [http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=8e5f4ac289313e637725e2acd0a927a4&rgn=div8&view=text&node=42:2.0.1.2.11.10.35.9&idno=42](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=8e5f4ac289313e637725e2acd0a927a4&rgn=div8&view=text&node=42:2.0.1.2.11.10.35.9&idno=42)
“The Anti-Kickback Statute set forth at § 1128B of the Social Security Act, (42 U.S.C. § 1320a-7b), makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible “kickback” transaction. For purposes of the anti-kickback statute, “remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. For more information go to http://www.oig.hhs.gov/fraud/safeharborregulations.asp”

Source: https://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf

- To identify arrangements or practices that may present a significant potential for abuse, ask two questions:
  - Does the hospital have a remunerative relationship between itself (or its affiliates or representatives) and persons or entities in a position to generate Federal health care program business for the hospital (or its affiliates) directly or indirectly?
  - With respect to any remunerative relationship so identified, could one purpose of the remuneration be to induce or reward the referral or recommendation of business payable in whole or in part by a Federal health care program?

- An arrangement satisfying both tests requires careful scrutiny. The following questions should also be answered:
  - Does the arrangement or practice have a potential to interfere with, or skew, clinical decision-making?
  - Does the arrangement or practice have a potential to increase costs to Federal health care programs, beneficiaries, or enrollees?
Educational Activities

- Failure to follow Medicare rules regarding payment for costs related to educational activities
- Ensure that the hospital has appropriately calculated the correct number of FTE (full-time equivalent) residents.
- See 42 CFR 413.75-413.83 (GME Requirements) and 42 CFR 412.105 (IME Requirements)
Patient or Quality Care Concerns

- Does the arrangement or practice raise patient or quality of care concerns?
- Safe harbors protect possible problematic arrangements. Safe harbor protection requires strict compliance with all applicable conditions set out in the relevant safe harbor:
  - Investment interests safe harbor, 42 CFR 1001.952(a)
  - Space rental safe harbor, 42 CFR 1001.952(b)
  - Equipment rental safe harbor, 42 CFR 1001.952(c)
  - Personal services and management contracts safe harbor, 42 CFR 1001.952(d),
  - Sale of practice safe harbor, 42 CFR 1001.952(e)
  - Referral services safe harbor, 42 CFR 1001.952(f)
  - Warranties 42 CFR 1001.952(g)
  - Discount safe harbor, 42 CFR 1001.952(h)
  - Employment safe harbor, 42 CFR 1001.952(i)
  - Group purchasing organizations safe harbor, 42 CFR 1001.952(j)
  - Waiver of beneficiary coinsurance and deductible amounts safe harbor, 42 CFR 1001.952(k)
  - Price reductions offered to health plans, 42 CFR 1001.952(m)
  - Practitioner recruitment safe harbor, 42 CFR 1001.952(n)
Patient or Quality Care Concerns (continued)

- Obstetrical malpractice insurance subsidies safe harbor, 42 CFR 1001.952(o),
- Investments in group practices, 42 CFR 1001.952(p)
- Cooperative hospital services organizations safe harbor, 42 CFR 1001.952(q),
- Ambulatory surgical centers safe harbor, 42 CFR 1001.952(r),
- Referral arrangements for specialty services, 42 CFR 1001.952(s),
- Price reductions offered to eligible managed care organizations, CFR 1001.952(t),
- Price reductions offered by contractors with substantial financial risk to managed care organizations, 42 CFR 1001.952(u)
- Ambulance replenishing safe harbor, 42 CFR 1001.952(v)
- Health centers, 42 CFR 1001.952(w)
- Electronic prescribing items and services, 42 CFR 1001.952(x)
- Electronic health records items and services, 42 CFR 1001.952(y)
Joint Ventures

- Chief concern: remuneration from a joint venture might be a disguised payment for past or future referrals to the venture or to one or more of its participants.

- Special Advisory Bulletin is available at http://oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf

- When examining joint ventures, hospitals should look at:
  - The manner in which joint venture participants are selected and retained. If participants are selected or retained in a manner that takes into account, directly or indirectly, the value or volume of referrals, the joint venture is suspect. One of more of the following may suggest a suspect venture:
    - A substantial number of participants are in a position to make or influence referrals to the venture, other participants, or both;
    - Participants that are expected to make a large number of referrals are offered a greater or more favorable investment or business opportunity in the joint venture than those anticipated to make fewer referrals;
    - Participants are actively encouraged or required to make referrals to the joint venture;
    - Participants are encouraged or required to divest their ownership interest if they fail to sustain an “acceptable” level of referrals;
    - The venture (or its participants) tracks its sources of referrals and distributes this information to the participants; or
    - The investment interests are nontransferable or subject to transfer restrictions related to referrals.
  - The manner in which the joint venture is structured. The joint venture is suspect if participant is already engaged in the line of business to be conducted by the joint venture, and that participant will own all or most of the equipment, provide or perform all or most of the items or services, or take responsibility for all or most of the day-to-day operations.
The manner in which the investments are financed and profits are distributed. Any of the following suggests a suspect joint venture:

- Participants are offered investment shares for a nominal or no capital contribution
- The amount of capital that participants invest is disproportionately small, and the returns on the investment are disproportionately large, when compared to a typical investment in a new business enterprise
- Participants are permitted to borrow their capital investments from another participant or from the joint venture, and to pay back the loan through deductions from profit distributions, thus eliminating even the need to contribute cash
- Participants are paid extraordinary returns on the investment in comparison with the risk involved; or
- A substantial portion of the gross revenues of the venture are derived from participant-driven referrals

Structure joint ventures so that they fit into one of the safe harbors designated by 42 CFR 1001.952
Compensation Arrangements with Physicians

Ensure that physician compensation agreements fit into one of the Stark exceptions when possible.

Review physician compensation arrangements. Begin by assessing the risk of fraud and abuse using the following factors:

- Are the items and services obtained from a physician legitimate, commercially reasonable, and necessary to achieve a legitimate business purpose (apart from obtaining referrals)? Does the hospital have multiple arrangements with different physicians, so that in the aggregate the items or services provided by all physicians exceed the hospital’s actual needs (apart from generating business)?

- Does the compensation represent fair market value in an arm’s-length transaction for the items and services?

- Could the hospital obtain the services from a non-referral source at a cheaper rate or under more favorable terms?

- Does the remuneration take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties? Is the compensation tied, directly or indirectly, to Federal healthcare program reimbursement?

- Is the determination of fair market value based upon a reasonable methodology that is uniformly applied and properly documented? If fair market value is based on comparables, the hospital should ensure that the comparison entities are not actual or potential referral sources, so that the market rate for the services is not distorted.

- Is the compensation commensurate with the fair market value of a physician with the skill level and experience reasonably necessary to perform the contracted services?
Compensation Arrangements with Physicians

- Were the physicians selected to participate in the arrangement in whole or in part because of their past or anticipated referrals?
  - Is the arrangement properly and fully documented in writing?
  - Are the physicians documenting the services they provide?
  - Is the hospital monitoring the services?
  - [Note: this is a sample list of questions and should not be deemed to be all inclusive]

- Develop policies and procedures requiring physicians to document, and the hospital to monitor the services or items provided under compensation arrangements.
If the hospital is the referral source for other providers or suppliers, scrutinize carefully any remuneration flowing to the hospital from the provider or supplier to ensure compliance with the anti-kickback statute.

Relationships with Federal Health Care Beneficiaries

Make certain that the hospital is not offering valuable items or services to Medicare and Medicaid beneficiaries to attract their business.

Familiarize themselves with the OIG’s August 2002 Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries available at [http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf](http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf)
Safe harbor protection is available for certain recruitment arrangements offered by hospitals to attract primary care physicians and practitioners to health professional shortage areas (HPSAs). See 42 CFR 1001.952(n).

Provisions include the following:

- The arrangement is set forth in a written agreement signed by the parties that specifies the benefits provided by the entity, the terms under which the benefits are to be provided, and the obligations of each party.
- If a practitioner is leaving an established practice, at least 75 percent of the revenues of the new practice must be generated from new patients.
- The benefits are provided by the entity for a period not in excess of 3 years.
- There is no requirement that the practitioner make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for receiving the benefits.
- The practitioner is not restricted from establishing staff privileges at, referring any service to, or otherwise generating any business for any other entity of his or her choosing.
- The amount or value of the benefits provided by the entity may not vary (or be adjusted or renegotiated) in any manner based on the volume or value of any expected referrals.
- The practitioner agrees to treat patients receiving medical benefits or assistance under any Federal health care program in a nondiscriminatory manner.
- At least 75 percent of the revenues of the new practice must be generated from patients residing in a HPSA or a Medically Underserved Area (MUA) or who are part of a Medically Underserved Population (MUP).
- The payment or exchange of anything of value may not directly or indirectly benefit any person (other than the practitioner being recruited) or entity in a position to make or influence referrals to the entity providing the recruitment payments or benefits of items or services payable by a Federal health care program.
Familiarize self with the discount safe harbor [42 CFR 1000.952(h)].

- Ensure that all discounts (including rebates) are properly disclosed and accurately reflected on hospital cost reports. If a hospital offers a discount on an item or service to a buyer, it should ensure that the discount is properly disclosed on the invoice or other documentation for the item/service.

- In negotiating discounts for items and services paid from a hospital’s pocket, the hospital should ensure that there is no link or connection, explicit or implicit, between discounts offered or solicited for that business and the hospital’s referral of business billable by the seller directly to Medicare or another Federal health care program.
Concern: Certain medical staff credentialing practices may implicate the anti-kickback statute. For example, conditioning privileges on a particular number of referrals or requiring the performance of a particular number of procedures, beyond volumes necessary to ensure clinical proficiency, potentially raise substantial risks under the statute.

Examine credentialing practices to ensure that they do not run afoul of the anti-kickback statute.
Review malpractice insurance subsidy arrangements closely to ensure that there is no improper inducement to referral services. Relevant factors include:

- Whether the subsidy is being provided on an interim basis for a fixed period in a State or States experiencing severe access or affordability problems;
- Whether the subsidy is being offered only to current active medical staff (or physicians new to the locality or in practice less than a year, *i.e.*, physicians with no or few established patients);
- Whether the criteria for receiving a subsidy is unrelated to the volume or value of referrals or other business generated by the subsidized physician or his practice;
- Whether physicians receiving subsidies are paying at least as much as they currently pay for malpractice insurance (*i.e.*, are windfalls to physicians avoided);
- Whether physicians are required to perform services or relinquish rights, which have a value equal to the fair market value of the insurance assistance; and
- Whether the insurance is available regardless of the location at which the physician provides services, including, but not limited to, other hospitals.

The above is an illustrative, not exhaustive, list.
Payments to Reduce or Limit Services: Gain sharing Arrangements

- Hospitals are prohibited from making a payment directly or indirectly to a physician as an inducement to reduce or limit items or services furnished to Medicare or Medicaid beneficiaries under the physician’s direct care.

- The payments need not be tied to an actual diminution in care, so long as the hospital knows that the payment may influence the physician to reduce or limit clinical services to his or her patients.

- Ensure that no hospital incentive plan that encourages physicians to reduce or limit clinical services, which may directly or indirectly violate the statute.

- Check physician compensation for services to reductions or limitations on items or services provided to patients under the physicians’ clinical care.

- Make certain that the hospital does not offer a cost-sharing program with the intent to foster physician loyalty and attract more referrals.
Scrutinize any offers of gifts or gratuities to beneficiaries for compliance with the CMP provision prohibiting inducements to Medicare and Medicaid beneficiaries.

Focus on whether the remuneration is something that the hospital knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier for Medicare or Medicaid payable services. This does not include items or services valued at less than $10 per item or $50 per patient in the aggregate on an annual basis.
Cost-Sharing Waivers

- Waiving owed amounts may constitute prohibited remuneration to beneficiaries under section 1128A(a)(5) of the Act for anti-kickback statute.
- Hospitals may waive cost-sharing amounts on the basis of a beneficiary’s financial need, so long as the waiver is not routine, not advertised, and made pursuant to a good faith, individualized assessment of the beneficiary’s financial need or after reasonable collection efforts have failed.
- Review waiver policies to ensure that the policies and the manner in which they are implemented comply with all applicable laws.
The CMP prohibits offering free transportation to Medicare or Medicaid beneficiaries to influence their selection of a particular provider, practitioner, or supplier.

- Free local transportation offered is of low value (i.e. within the $10 per item and $50 annual limits).
- Exceptions to hospital-based complimentary transportation programs:
  - The program was in existence prior to August 30, 2002, the date of publication of the Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries.
  - Transportation is offered uniformly and without charge or at reduced charge to all patients of the hospital or hospital-owned ambulatory surgical center (and may also be made available to their families).
  - The transportation is only provided to and from the hospital or a hospital owned ambulatory surgical center and is for the purpose of receiving hospital or ambulatory surgery center services (or, in the case of family members, accompanying or visiting hospital or ambulatory surgical center patients).
  - The transportation is provided only within the hospital’s or ambulatory surgical center’s primary service area.
  - The costs of the transportation are not claimed directly or indirectly by any Federal health care program cost report or claim and are not otherwise shifted to any Federal health care program.
  - The transportation does not include ambulance transportation.
- Also see: OIG advisory opinion concerning a complimentary local transportation program for friends and family of residents of a skilled nursing facility - http://oig.hhs.gov/fraud/docs/advisoryopinions/2009/AdvOpn09-01.pdf
Falsification of Information

- False Coding,
- Altered Claims

Questionable Practices

- Up coding,
- Unbundling,
- Cost Shifting,
- Prescribing Practices,
- Clustering,
- Underutilization,
- Invalid Place of Service,
- Non-Contracted Providers

Overutilization or inappropriate utilization

- Medically Unnecessary Diagnostics,
- Office Visit Frequency,
- Unnecessary DME,
- Inappropriate Procedure for Diagnosis
Internal Audit / Compliance Departments should have on their Internal Audit Plans:

- Outpatient claims billed during the DRG payment window.
- Inpatient and outpatient manufacturer credits for replacement of medical devices.
- Post-acute transfers to SNF/HHA/Another Acute Care/Non-Acute Inpatient settings.
- SNF/HHA consolidated billings for outpatient services.
- Outpatient claims billed with modifier 59.
- Inpatient and outpatient claims paid greater than charges.
- Inpatient payments greater than $150,000.
- Outpatient payments greater than $25,000.
- Payments for hemophilia services.
- Payments for inpatient psychiatric facilities interrupted stays.
- One-day stays as acute care.
- MCC and CC (Major Complications and Comorbidities, and Complications and Comorbidities)
- Payments for septicemia services.
Submission of Acute Claims

Outpatient Procedure Coding

• Billing on an outpatient basis for “inpatient-only” procedures
  ◦ Ensure that “inpatient-only” procedures were not billed to outpatients.
  ◦ A complete list of inpatient procedures covered can be found in Addendum E of the OPPS rules See Medicare Claims Processing Manual at: http://www.cms.gov/manuals/downloads/clm104c04.pdf
Submitting claims for medically unnecessary services by failing to follow the Fiscal Intermediary’s local medical review policies [now local coverage determinations].

- Certify that specific conditions were present to render the procedure necessary.
  - A claim that does not fulfill the coverage requirements described above may be given individual consideration based on review of all pertinent medical information.
  - To search existing local policies go to FI/Carrier/ MAC website. Example:

Submitting duplicate claims or otherwise not following the National Coding Initiative guidelines.

- Coding software includes updated NCCI edit files.
- NCCI identifies certain codes that should not be used together because they are either mutually exclusive or one is a component of another. If a hospital uses code pairs that are listed in the NCCI and those codes are not detected by the editing routines in the hospital’s billing system, the hospital may submit duplicate or unbundled claims.

  ◦ More information on the guidelines and acceptable codes: https://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp
When listing procedures, make certain that the procedure codes selected represent the actual services provided, irregardless of the discounting status. CMS handles all of the discounting formulas, the hospital is only responsible for reporting an accurate and undiscounted bill.

- Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

- The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

- Review the annual OPPS rule update to understand more fully CMS’s multiple procedure discounting rule.

  - For updates see http://www.cms.gov/manuals/downloads/clm104c04.pdf
Failing to follow CMS instructions regarding the selection of proper evaluation and management codes.

- Evaluation and management codes are used to describe medical services and follow the published CMS guidelines.
- For example, each medical history should contain some or all of the following elements: chief complaint, history of present illness, review of symptoms, and past, family and/or social history.
  - E/M documentation guidelines can be accessed at http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guid e.pdf
Improperly billing for observation services.

- Make certain that claims for observation services correctly reflect the diagnosis and meet certain other requirements.
  - Be familiar with CMS’s detailed policies for the submission of claims.
  - See Medicare Claims Processing Manual sections:
    - 290 - Outpatient Observation Services
    - 290.1 - Observation Services Overview
    - 290.2 - General Billing Requirements for Observation Services
    - 290.2.1 - Revenue Code Reporting
    - 290.2.2 - Reporting Hours of Observation
Admissions and Discharges

- Failure to follow “same-day rule”
  - Hospital has included all OPPS services provided on the same day at the same hospital as required by OPPS.
  - Review internal billing systems and procedures to ensure that they are not submitting multiple claims for OPPS delivered to the same patient on the same day.
    - See chapter 1, section 50.2 of the Medicare Claims Processing at http://www.cms.gov/manuals/downloads/clm104c04.pdf
Abuse of partial hospitalization payments

- Maintain documentation to support medical necessity of services provided, including beginning and ending time.
- Examples of improper billing include, without limitation: reducing the range of services offered; withholding services that are medically appropriate; billing for services not covered; and billing for services without a certificate of medical necessity.

Same day discharge and readmissions

- Review discharges and admissions carefully to ensure that they reflect prudent clinical decision-making and are properly coded.
Violations of Medicare’s post-acute care transfer policy

- Discharge bill coding is based on the discharge plan. Any changes to the plan result in an adjusted bill.
  - To avoid improperly billing for discharges, attention is paid to CMS’s post-acute care transfer policy, specifics for which is available starting on page 12 at http://oig.hhs.gov/oas/reports/region4/40001220.pdf
  - An accurate list of all designated DRGs subject to that policy is maintained. List is under chapter 3, section 40.2.4 http://www.cms.gov/manuals/downloads/clm104c04.pdf
Improper churning of patients by long-term care hospitals co-located in acute care hospitals

- Improper churning is the inappropriate transfer of a patient between a host hospital and a hospital within a hospital.

- A transfer is appropriate between such hospitals if all of the following apply:
  
  - Separate governing body, separate chief medical officer, separate medical staff, chief executive officer, performance of basic hospital functions, plus certain exceptions.
  
  - Reviewed transfers between long-term care hospitals co-located in acute care hospitals and the transfers were proper and necessary.
  
  - See 42 CFR 412.22(e)
Supplemental Payment Considerations

- *Improper reporting of costs of “pass-through” items.*

- “Pass-through” items are certain items of new technology and drugs for which Medicare will reimburse the hospital based on costs during a limited transitional period.

- Ensure that the costs of “pass-through” items are appropriate.
  - For more information regarding CMS’s APC “pass through” payments, including instructions on how to apply for funds, see [http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp](http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp)
Abuse of DRG Outlier Payments

• Verify that:
  ◦ The admission was medically necessary and appropriate.
  ◦ Services were medically necessary and delivered in the most appropriate setting.
  ◦ Services were ordered by the physician, actually furnished, and not duplicatively billed.
  ◦ The diagnostic and procedural codings are correct.
    • Rules are outlined in detail in 42 CFR 412.84(f)
Improper claims for incorrectly designated “provider-based” entities

- Certain hospital-affiliated entities and clinics can be designated as “provider-based,” which allows for a higher level of reimbursement for certain services.

- Ensure that hospital meets all of the criteria to be designated as provider-based
  - Criteria for determining provider-based status can be found at 42 CFR 413.65
Hospitals that participate in clinical trials should review the requirements for submitting claims for patients participating in clinical trials.

Clinical trial services covered by Medicare must meet both the following requirements:

1. Qualifying Trial. Which includes all of the following: evaluates a Medicare benefit, has a therapeutic intent, enrolls diagnosed beneficiaries, and has desirable characteristics.

2. Routine Costs. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial except:

   a. The investigational item or service, itself unless otherwise covered outside of the clinical trial;

   b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and

   c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

To view Medicare’s National Coverage Decision regarding clinical trials see https://www.cms.gov/DeterminationProcess/, see also:

- https://www.cms.gov/ClinicalTrialPolicies/
Improper claims for organ acquisition costs

- Verify Hospital has satisfied the proper requirements to receive organ acquisition costs.
- Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Hospitals should pay particular attention to when an individual must receive a medical screening exam to determine whether that individual is suffering from an emergent medical condition.

If the patient is suffering from an emergent medical condition, treatment cannot be delayed to inquire into the individual’s method of payment or insurance.

If an ED is on diversionary status, they are still required to provide an evaluation and treatment to a patient who arrives with a medical emergency.

If a patient with a medical emergency is being transferred, ensure that the benefits of the transfer outweigh the risks.

If the hospital receives a phone call from another facility who wants to transfer a patient, the hospital must accept the patient if it has specialized capabilities to treat the patient that the transferring patient does not.

Hospital policies should be clear on how to access the full services of the hospital and all staff should understand the hospital’s policy and obligations to patients under EMTALA.
Ensure that cardiac rehabilitation services are reasonable and necessary.

Medicare coverage of cardiac rehabilitation programs are considered reasonable and necessary only for patients with a clear medical need, who are referred by their attending physician and (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or (2) have had coronary bypass surgery; and/or (3) have stable angina pectoris; (4) heart valve repair/replacement; (5) percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or (6) heart or heart-lung transplant.

- Medicare Claims Processing Manual, Chapter 32 (Billing Requirements for Special Services), Sections 140 (Cardiac Rehabilitation Programs) and 140.1 (Coding Requirements), at http://www.cms.hhs.gov/Transmittals/downloads/R909CP.pdf
Save the Date:
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