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OIG Holds Hospital Boards Accountable on Fraud Audits

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Facilities are now faced with audits from many sides. Audits overlap one another and duplicate requests for the same files can be overwhelming. There are currently 16 different fraud audits in effect. I've listed some recent developments in the Medicare and Medicaid fraud and abuse arena and provided several insightful tips from our firm on dealing with the tangled layers of fraud audits your facility may encounter. There is now a new focus particularly on CAH, Rural Health and IHS facilities.

The OIG

The Office of Inspector General (OIG) has released its compliance guide directed at Boards of health care entities. Increased scrutiny at the Board level will determine whether there are processes in place to effectively monitor compliance issues. Boards may now be held personally accountable for their decisions. For example, in New York, a State Attorney General forced a hospital to replace the entire Board as part of the Plan of Correction in a fraud audit case.

The OIG's work plan includes a high focus on cost reports and fraud audits associated with cost reports. In addition to the base payments, issues such as disproportionate share, sole community provider status, bad debt, CAH designation and provider based clinic designation will be under additional review, and overpayments and underpayments on claims may deem your cost report fraudulent. Hospitals should regularly monitor and utilize the OIG work plan each year in order to see where the government's concentration will be.

In Florida, the OIG, CMS, and the DOJ have leveraged all of their resources for Operation Whack-a-Mole (WAM) to prevent, identify, and prosecute health care fraud. To date the project has recovered over $11 million and leveled over 43 indictments. This initiative is expanding to other states.

RAC Audits

Health Data Insights (HDI) will be the RAC contractor for Region D which includes Alaska, Washington, Oregon, Montana, Wyoming, South & North Dakota, Utah and Arizona. With Region D's low contingency fee rate of 9.49%, expect HDI to overcompensate by intensity to find more fraudulent claims. Unlike the pilot program, a facility cannot rebill on an outpatient basis any inpatient claims denied by the RAC. This is an additional reason to do your own audits and rebill correctly.

RAC's apply the data found in their data mining software to find areas of fraud and abuse. Your facility can beat the auditors to the punch by auditing your own processes to detect and correct improper claims.

Be aggressive with your appeals

The results released from RAC contractor Connolly Consulting Associates in region C demonstrate the need for providers to appeal the result of their audit findings.

A hospital in Southern California received a RAC audit where 2,103 medical charts were requested and reviewed. Connolly modified 1,148 claims and requested paybacks of $9,743,897. The provider appealed 808 claims. Many of the claims were denied during the first and second level appeals. The provider persisted and appealed to the third level. The provider's dollars

on overturned claims repaid on appeal was $2,458,677 with more claims still in the appeal process. The appeals at the third level of appeal process had an 81% chance of being overturned, versus a 37.5% chance at the first level of appeal.

Recommendations

- Develop a Fraud Audit Response Team to include Case Management, Business Office, Compliance Officer, Billing Cycle Management, Medical Records, Nursing Administrator, and a Consulting Physician
- Write a plan with a checklist and tracking mechanisms
- Designate a point of contact person for fraud audits
- Conduct internal or external fraud audits regularly
- Evaluate the 2009 OIG work plan high risk areas for overpayments
- Review the top 20 risk areas in the PEPPER report and the top underpayment areas
- Establish fraud protocols, dashboards, and reports and share with your Board, management, Response Team, and physicians
- On audit requests, number all pages, and keep three copies of everything prepared. Include a checklist to accompany all patient records. Back up your records electronically. Send all documentation certified mail, return receipt
- Document all communication (emails, etc.) with intermediary and audit contractors
- Be sure the individual handling Medicare remits notifies the point of contact for fraud audits at your facility when recoupments occur
- Differentiate regular recoupment from fraud audit recoupment

A full year of net income can be wiped out with one bad fraud audit. The average RAC recovery per hospital was about $500,000. Investing in a compliance plan now can help reduce your RAC contingency fees later.

Donna Herbert is the founder of Financial Consultants of Alaska & Washington (FCAW). Since 1979, she has provided advice and counsel to health care providers in both Alaska and Washington concerning all aspects of budget, finance, and preparation of third-party cost reports. She can be reached at 907-790-1026 or by email at fcaw@fcawreimbursement.com

Provider appeals of RAC overpayments
January 1, 2008 – June 30, 2008

Claim RAC	Claims with Overpayment Determinations	# appealed (all levels)	% appealed (all levels)	% favorable to provider
Connolly	110,635	8,125	7.3%	57.4%
HDI	239,205	65,963	27.6%	41.8%
PRG	175,293	28,617	16.3%	12.6%
All RACs	525,133	102,705	19.6%	34.9%

Source: RAC files, Includes all completed appeals.

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