Best Practices for Overseeing an Internal Audit

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This presentation provides attorneys with background and insights into the hospital auditing process.

**Why should you care about auditing?**
- Issues identified in audits can result in large overpayments.
- The general counsel's office and often outside counsel will be brought in eventually to advise on the audit results.
- Often there are inherent problems with the structure of the audit that cost time and money to address.
- The general counsel's office will be viewed as responsible for any interpretation of the laws that underlie the audit.

**What you don’t know won’t hurt you.**
- True
- False

**Why Audit?**

Audits can raise issues. These issues might lead to new and expensive problems that must be dealt with immediately. So, why should you even do them?

**Audits do the following:**
- Serve as a part of an effective compliance plan
- Identify and correct issues
- Find issues before they get worse
- Provide an opportunity to educate
- Improve financial performance
- Improve quality of care
- Preempt a RAC review or other government audits
- Reduce whistleblower risk
Scheduled Internal or Compliance Audit
- Annual compliance work plan
- Internal audit work plan
- DRG validation audits

Unscheduled Internal or Compliance Audit
- Hotline call
- Part of diligence in an acquisition
- Pending government investigation

CODING RULES
- E&Ms
- Diagnosis Coding
- Medical Necessity
- Certified Coder

BILLING RULES
- Non-physician Supervision
- Orders and CMNs
- Provider-Based Rules
- Audit or Compliance Staff

COMPLIANCE PROGRAM
- Structure
- Policies
- Effectiveness
- Outside Auditors or Attorneys

PRIVACY AND SECURITY
- Policies
- Effectiveness
- Breech Protection
- Audit or Compliance Staff

FRAUD AND ABUSE
- Leases
- Medical Directors
- Recruitment
- Non-attorney w/ Attorney Input

Principal Focus

Types and Focus of Audits

Types and Focus of Audits

Types and Focus of Audits
# STRUCTURE OF AUDITS

## Planning

Decide what and when to audit

## Objective

Purpose of the audit  
e.g. Determine if clinics in the health system billing as outpatient departments are compliant with the provider-based rules

## Audit Protocol

Tool used to guide the audit and record compliance

## Method

Conduct interviews, review records or policies or even make observations.

## Reporting

Orally review findings, make refinements, produce draft and final reports. Make presentations of findings.
How To Find Audit Topics

**Risk Assessments**

**PRO:** Chance to listen to administrators and staff issues

**CON:** Administrators and staff don’t know which regulatory requirements are important.

**Other Provider Investigations**

**PRO:** Something the government cares about now.

**CON:** Your provider might not have a similar issue of the same magnitude.

**RAC Issues**

**PRO:** Reduce future government investigation risk

**CON:** The RAC may move on to a different area of audit.

**OIG Work Plans**

**PRO:** Identifies many issues

**CON:** Doesn’t identify whether an issue is important

**The Bottom Line**

**PRO:** Changes can assist fiscally

**CON:** May miss high risk issues

**Hotline Calls and Questions**

**PRO:** Reduce qui tam potential

**CON:** Might not be a widespread issue

**Agency Issuances**

**PRO:** Agency thinks it’s a concern, so it must be.

**CON:** Agencies have many concerns that sometimes get too much coverage by the legal and consulting industries.

HOW TO FIND AUDIT TOPICS
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<th><strong>AGE OF RULE: How long has the rule been around?</strong></th>
<th>Rating</th>
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<tbody>
<tr>
<td>NEW 1 2 3 4 5 OLD</td>
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<tr>
<th><strong>DIFFICULTY: How hard is the rule to understand?</strong></th>
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<td>EASY 1 2 3 4 5 HARD</td>
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<th><strong>MONEY: How much government money is involved?</strong></th>
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<th><strong>QUALITY IMPACT: How is quality impacted?</strong></th>
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<td>LESS 1 2 3 4 5 MORE</td>
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<th><strong>FREQUENCY: How often is the rule cited?</strong></th>
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**TOTAL RISK SCORE:** Add the individual ratings. Use to compare relative risk.
RISK
What is the risk? – Focus the audit and save limited resources by choosing topics that pose the greatest potential for risk.

DOCUMENTATION
Focus on documentation as it can be the reason for half or more of RAC payments and is the basis for showing care was needed (i.e., orders, certifications).

“Q” PRINCIPAL
The “Q Principal” - when deciding between competing topics, chose “Q”uality based topics and traditional compliance topics that allow for incorporating quality messages through a patient interaction or discussion.

Accept that resources and time might not allow coverage of all topics. It’s worse to plan something and not do it. Look for outside resources to augment your program that you can afford or get for free.
Issues

Minimize territorial disputes between auditing and compliance by having clearly defined roles.

Understand that auditors and coders are disinterested third parties with better auditing skills and deep knowledge, but may lack the ability to judgment and experience to assess and quantify risks.

Decide whether the audit will be done under attorney-client privilege and ensure that the attorney is sufficiently involved in the audit to warrant invoking of the privilege.

Regardless of whether attorney-client privilege is used, educate staff as to how to be sensitive to the fact that their communications can be taken out of context and misinterpreted.

Use outside counsel effectively to provide an unbiased opinion and expertise in reducing risk associated with auditing by reviewing the audit protocol.
Well drafted audit protocols are key to reducing audit risk.

Poor drafting can:

- Just like poorly drafted policies, create standards that are higher than what is legally required. An example is using the term “referred to observation” instead of “admit to observation.” There are similar examples on the private payer and Medicare Advantage side.

- Create a problematic record when the health system later goes back to review the audit findings.

- Create gulfs between administrative types and clinicians who challenge the requirements.

- Open the organization up to whistleblower claims by its own auditors and compliance people who strictly interpret guidance from for example a MAC that contradicts the CMS regulations or where coding guidance is unclear.

Steps to better drafting:

1. Legal review of all “source documents” for the audit and a short statement on what the key requirements and best practices would be. See example for non-physician supervision review.

2. Meet with auditors and compliance personnel to discuss what is actually required and what is a best practice. Use outside legal counsel to reduce tension. Create an actual process whereby audits of compliance related issues are more thoughtfully constructed.

3. Attorneys need not draft the protocol but can suggest language changes that provide flexibility if needed. See provider-based rules and non-physician supervision audit protocols.
Audit Protocols should be carefully worded.

Regulations and interpretations of regulations can change. Single words could even be the subject of court cases. Using “should” is a strong word and in some dictionaries, no different than “will,” but leaves flexibility for a different interpretation.

When discussing a regulation, be sure to cite the regulation. If the agency interpretation is inconsistent with the regulation, or if you make a mistake in description, you could create a higher standard for your organization.

**This diagram illustrates what should never happen inadvertently: provider guidance that extends beyond the requirements of a regulation and its interpretation.**
The need to refund overpayments within 60 days of discovery should not impact the carefulness of the audit.

First step is to train compliance, auditing and billing personnel that all billing and fraud and abuse issues need to be investigated.

Second, in both scheduled and unscheduled audits, the audit profile should explain the process of finding and calculating errors. Probe audits are recommended before engaging in a wider audit.

Considerations: size of probe audit and whether to execute multiple probe, what percentage triggers an issue, whether to move to outside auditors if a wider audit is needed, whether to make the wider audit statistically significant so the errors can be extrapolated to the claims universe.

Findings concerning overpayments should be made at the end of the audit either through a full claims review or statistical extrapolation. There are significant legal issues with only refunding claims in the probe unless the probe
Wording here is significant. Audit findings will often need further legal review to determine if there is an historical repayment issue or simply risk of a violation warranting a change in practice.

Original:

Our concern is that CPT xxxxx includes xxxxx and thus not recognizing this inclusion led to excessive reporting of CPT xxxxx. We encourage xxxxx to adopt these recommendations.

Refined:

Our concern is that CPT xxxx could include and thus not recognizing this inclusion could have led to excessive reporting of CPT xxxxx.

Original:

The recruiting arrangement does not comply with the Stark Law and needs to be restructured.

Refined:

The recruiting arrangement may need to be restructured to comply with the Stark Law.
Present to Committee of the Board first to minimize confusion and worry over audit results.

Legal counsel should be involved in providing advice as to the findings and recommended action steps.

Provide a PowerPoint based presentation. Collect any materials provided and consider pre-drafting a resolution and description of the meeting. Providing attachments to Board minutes is not advisable.

It’s better to have analyzed the legal issues and come with a repayment recommendation, if needed, than leave it to the Board to decide. It is very risky to have the Board debating the various legal rules relating to, for example, a coding issue.

For example, you don’t want board minutes that state: “Board discussed whether the organization should have provider-based clinics as the extra reimbursement seems risky.”

Better minutes would read: “The Board discussed the provider-based clinics and recommended further analysis.”

Outside legal counsel can provide an important third party perspective that reassures the Board.
Not following up on findings can cause serious issues even greater than what hasn’t been audited. It increases the risk of the government finding your compliance program is ineffective.

Encourage your system to take on high risk issues that it has the capacity to impact.

*Incentives should include safeguards to show improved care.
The best way to document an effective compliance plan is to tie the major activities of auditing and education together.

This is done by choosing fewer issues and taking a more concerted attempt to show improvement through auditing combined with education efforts throughout several quarters.
Input of both outside and inside legal counsel before and during the audit process is key to creating a sound audit that reduces, rather than increases, the organization’s risk.

Steps to a Better Audit Process:

1. Meet with compliance and internal audit to develop a task force for improved compliance audits.

2. Seek the help of outside experts to discuss the risks associated with auditing.

3. Develop an audit protocol that includes feedback early in the process from legal counsel.

4. Identity subject matter experts from outside legal counsel.

5. Consider partnership opportunities with other systems or within associations to develop best practices audit materials.
NON-PHYSICIAN SUPERVISION

When a physician or mid-level bills the traditional Medicare program, non-physicians may provide part of the service if the non-physician is supervised.

The physician or mid-level that bills for the service should be in the office and immediately available. Being available by pager or phone is not sufficient.

If another physician or mid-level in the group supervises the services, then the bill goes out under their name and not the ordering physician or mid-level.

The billing physician or mid-level also should participate in the management of the course of treatment. New problems should be treated by them.

The regulations apply only when the physician or mid-level is billing for someone else’s services. NPs, PAs and dieticians can also bill on their own.

The regulations never apply to radiology and lab services that have their own supervision rules.

Source Medicare Benefit Policy Manual, Chapter 15, 60.1 to 60.3
Audit Protocol
Non-Physician Supervision
Physician Clinic (non-hospital setting)

First Level – Initial Review

Determine what non-physician practitioners at the practice see patients for purposes of exams and treatment.

Determine whether the NPs or PAs in the practice bill independently or “incident to.”

Review twenty medical records where it is documented that a NP, PA or other non-physician provided services and the services were billed “incident to”.

Review the date and time of the medical record against the supervising physician or physician in the group’s other medical record entries or schedules to verify that they were in the office suite at the same time that the services were provided.

Determine if possible through the record review, if a non-physician was seeing patients for new complaints without the patient seeing a physician in the group during that same visit.

Review the records to determine if the medical record documents the physician or member of his or her group was involved in the course of treatment.

Interview non-physician practitioners to see if they are aware of the requirement that: (1) the physician be in the office suite; and (2) that they address new complaints.

Interview physicians to see if they are aware of the requirement that the physician or other physician in the group be in the office suite; and (2) that they address new complaints.

Second Level Claim Review

Additional probe audits or statistically significant audits if needed.

Check the claims for the services in question to see if the name of the supervising physician is on the bill and whether the name of non-physician is identified as well.

(Education Purposes Only).
**Not meeting a few of the examples cited by CMS wouldn’t necessary mean that the entity is not provider-based. However, going forward, it would be prudent to consider why examples and not met and then meet as many as possible so payment to the main provider will not be questioned.

**PROVIDER BASED RULES AUDIT PROTOCOL**

This simple audit is useful for hospital-based entities, departments and remote locations. The provider-based rules are not applicable to ASCs, HHAs, CORFs, SNFs, labs and ESRD facilities.

1. **Operating Under the Same License**

Do the entities operate under the same license (unless otherwise required by the state)?

Yes_____ No_____

2. **Financial Integration**

Is there shared income and expenses between the entities? Yes_____ No_____

Are the costs of the provider-based entity reported in a cost center of the main provider? Yes_____ No_____

Is the provider-based entity easily identifiable in the main provider’s trial balance? Yes_____ No_____

3. **Clinical Integration**

Do the entities have an integrated medical staff? Yes_____ No_____

Do the entities have integrated medical records? Yes_____ No_____

Is quality monitoring the same? Yes_____ No_____

Do patients at the provider-based facility have access to the main provider services? Yes_____ No_____

4. **Public Awareness**

Is the main provider name included on:

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Outside signage</td>
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<tr>
<td>Advertising</td>
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<td>Patient Bills</td>
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<td>Registration Forms</td>
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<td>Medical Records</td>
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Additional Rules For Off-Campus Providers (located 250 yards from main buildings)

1. Ownership

Is the provider-based entity 100% owned by the main provider (if not, must be located on main campus of the provider that bills for its services)?

Yes______ No______

2. Control**

Do the entities have the same governing body?

Yes_____ No_____

Do the entities have common bylaws?

Yes_____ No_____

Does the main provider’s governing body have final approval over administrative decisions, contracts and personnel policies?

Yes_____ No_____

2. Administration and Supervision**

Is the provider-based entity under the same monitoring and oversight as any other department of the main provider?

Yes_____ No_____

Does the provider-based director maintain a reporting relationship to the main provider and accountability to the governing body just like any other department?

Yes_____ No_____

Do the entities share, contract out together or have the main provider manage the provider-based entities:

- Billing services
  - Yes_____ No_____
- Records
  - Yes_____ No_____
- Human resources
  - Yes_____ No_____
- Payroll
  - Yes_____ No_____
- Employee salary structure
  - Yes_____ No_____
- Employee benefit package
  - Yes_____ No_____
- Purchasing services
  - Yes_____ No_____

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3. **Location**

   a. Does the main provider have a disproportionate share adjustment of greater than 11.75%, and is it owned or operated by: (a) a unit of state/local government; (2) a public or non-profit corporation granted governmental power; or (3) a private entity with a state/local contract that includes operating the off-campus clinic?  
      Yes _____  No _____

   b. Is the main provider a children’s hospital that: (1) has intensive care units that accept newborn infants; (2) is in a rural area at least 35 miles from other neonatal intensive care units; and (3) is located within a 100-miles of the hospital-based clinic?  
      Yes _____  No _____

   c. Is the provider-based clinic a rural health clinic and does the main hospital have fewer than 50 beds and is it located in a rural area?  
      Yes _____  No _____

   **IF NONE OF THE ABOVE:**

   During a 12-month period are 75% of the provider-based entities patients from the same zip code as 75% of the main provider’s patients?  
      Yes _____  No _____

   During a 12-month period did 75% of the provider-based entities patients that needed inpatient care receive it from the main provider?  
      Yes _____  No _____

   If the provider-based entity was not in operation for 12 months, is it in the same zip code area as at least 75% of the patients served by the main provider?  
      Yes _____  No _____

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