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OIG: Compliance Audits Are Based on Risk Assessment, Which Drives Early Claim Reopening

By Nina Youngstrom

Medicare administrative contractors (MACs) are reopening hospital claims based on information from the HHS Office of Inspector General (OIG) before there's an overpayment finding, an OIG official said.

"MACs have now started reopening claims when we initiate an audit," said Michael Ira Joseph, an OIG senior counsel. "They do this relying on our risk assessment." The risk assessment includes a Hospital Compliance Dashboard that helps OIG choose hospitals for a compliance audit.[1] "We have data for all the hospitals and we can see where a hospital may be an outlier with respect to certain types of claims," he said at the HCCA Compliance Institute April 17. "There's a reason why we choose hospitals to audit, and MACs are now relying on that and issuing reopening notices to providers when we begin an audit."

Joseph and two other OIG officials explained the audit process and their responses to complaints from hospitals about some aspects of provider audits, including the use of an independent medical reviewer and extrapolation.

Hospitals may encounter two types of audits, said Truman Mayfield, assistant regional inspector general. One is an audit specific to the provider that covers multiple risk areas at the same time from a list of 32 potential inpatient and outpatient risk areas. The other type is an issue-specific audit, with OIG focusing on CMS or one of its contractors, although the hospital could be contacted, and an issue-specific audit could lead to a provider-specific audit.

Hospital compliance audits, which started in 2010, have identified $90 million in actual overpayments and $304 million in extrapolated overpayments, Mayfield said. They're a "significant portion of our Medicare Part A workload" and "will continue to be in the future."

The methodology for selecting a hospital audit target has evolved, said Scott Perry, an OIG senior auditor. "Back then it was up to the audit team to select the hospital. Now that wouldn't fly," he said. "We use a risk assessment to determine which hospitals are considered high risk and good candidates for an audit."

A number of factors go into the risk assessment. They include:

- OIG's Hospital Compliance Dashboard.
- Data from the comprehensive error rate testing (CERT) contractor.
- Analysis of PEPPER reports.
- Results of recovery audit contractor reviews.
- Consultations with other parts of OIG, such as the Office of Investigations and Office of Counsel.
- Input from CMS.

The Hospital Compliance Dashboard is a hospital selection and analysis tool used in coordination with the IT department "to automate much of the risk assessment process," Perry said. "Because the dashboard allows review of risk areas over time by one hospital and also across hospitals, it gives audit teams a much better idea of risks associated with their selected provider." The dashboard has compliance trends that can be researched by hospitals, with dollar amounts spent on risk areas compared to the state and national averages. For example, outpatient claims with bypass modifiers (XU, XE, XS, XP) "are the highest risk area billed nationwide at $53 billion," Perry said, and the dashboard shows the number of claims and total claim amount at every hospital with bypass modifiers.

If a hospital is selected for a provider audit, OIG gets a download from CMS's NCH database of all paid claims that were submitted during a specific time frame. "We perform computer matching and data analysis" to identify claims from 32 risk areas that will be included in the universe of claims. From there, OIG develops a sample frame of high-risk claims and selects a stratified random sample of 100 claims for the audit.

Hospital Pushback on Independent Medical Reviews

OIG has gotten pushback about its use of independent medical reviewers and statistical sampling and extrapolation in provider audits, and Joseph explained OIG's responses to these and other complaints.

In terms of medical review, he said, "OIG auditors are very smart, highly educated and well trained in performing audits but they aren't clinicians and they aren't coders so we contract out with clinicians and coders to perform that part of hospital compliance audits that we don't have the expertise to do in-house." The independent medical review contractor reviews documentation to determine whether services were reasonable and necessary and to validate coding.

"We have heard quite often that our medical review contractor is substituting their judgment for that of the physicians who provided the service and that we can't question the claim because we can't do that," Joseph said. But medical reviewers are not obligated to defer to treating physicians, he contended. "There's no legal presumption that hospital claims are correct. All claims are subject to audit," whether it's by OIG, the MAC or other contractors.

"We understand where hospitals and their counsel are coming from," Joseph said. "It's the clinicians in the hospital who have hands on the patient, who talk to the patient and make the diagnoses and decide what treatment to provide, but that doesn't mean we can't question claims. The roles are different." Physicians exercise their judgment in diagnosing and treating patients, but they also have a legal obligation to document their findings, while medical reviewers exercise their judgment in deciding whether the hospital met Medicare requirements based on the documentation, he noted. "This is where compliance officers can make a very big difference and impress upon the physicians in your hospitals that they must well document the care they are providing because if it's not well documented, the claim based on that care could be questioned."

Also, with almost every hospital compliance audit, OIG hears from the hospital or its counsel that "we can't extrapolate our overpayment finding because we have not found a sustained or high level of overpayment or errors or there was a failure of educational intervention before we found overpayments," Joseph said. While the Social Security Act and *Medicare Program Integrity Manual* have that limitation, it applies to Medicare contractors, not OIG, he said. "We do statistical sampling and extrapolation when it's appropriate" with the use of RAT-STATS statistical software.

And there's confusion about the recovery and appeals process. For one thing, OIG doesn't order hospitals to pay money back. OIG sends a copy of the audit report to CMS and recommends the hospitals refund the money, Joseph said. The MACs determine whether the hospital was overpaid and if so, how much, and "they will reopen claims

as necessary and issue a demand letter," he explained. The five-level appeal process kicks in when the MAC sends the demand letter.

MACs have a year to reopen claims for any reason and four years for good cause, but there's no deadline for "payment procured by fraud or similar fault."

According to 42 C.F.R. § 405.980, "a reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or underpayment, even though the binding determination or decision may have been correct at the time it was made based on the evidence of record." But Joseph said MACs are now reopening claims when OIG begins the audit based on data from its risk assessments.

That doesn't sit well with attorney David Glaser. It sounds to him like MACs have figured out a way to start looking back at claims from earlier dates of service than they would otherwise. "They're trying to stop the statute of limitations from running," said Glaser, with Fredrikson & Byron.

Common Errors in Hospital Audits

Perry cited some of the common findings of hospital compliance audits:

- Inpatient rehabilitation facility (IRF) billing: Admissions that weren't reasonable and necessary. Although he acknowledged IRF audits tend to generate a lot of disagreement between OIG and hospitals, "what could be easily fixed are areas related to documentation requirements."
- Inpatient high-severity level DRG codes: "This is a broad area that will be included in every hospital compliance audit," he said. "We find all kinds of errors in this area," including upcoding.
- Two-midnight rule: Among other things, OIG has found conflicting orders and patients who should be billed as observation.
- Post-acute care transfer policy: OIG has found incorrect discharge status codes and conflicts in the medical records (e.g., patients are documented as discharged home but claims data shows they received home health care). "This can be easily fixed with improved internal controls," Perry said.
- Outpatient bypass modifiers.

Contact Perry, Mayfield and Joseph through the OIG press office at public.affairs@oig.hhs.gov and Glaser at dglaser@fredlaw.com.

1 Nina Youngstrom, "Excerpts of OIG's Hospital Compliance Dashboard," *Report on Medicare Compliance* 33, no. 23 (April 24, 2024).