What It Is, Why It Is and How We Get Through It

Michele Parr, MS, CCEP, FAACVPR

No financial disclosures that would be considered a conflict of interest.

OIG Audit

What, or better yet who is the OIG?

Office of the Inspector General for Health and Human Services

Mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

Established in 1976

HHS OIG is the largest inspector general’s office in the Federal Government.

Approximately 1,600 employees whose main goal is to combat fraud, waste and abuse and to improve the efficiency of HHS programs.

A majority of OIG’s resources goes toward the oversight of Medicare and Medicaid — programs that represent a significant part of the Federal budget and that affect this country’s most vulnerable citizens.

What is An Audit?

an official inspection of an individual’s or organization’s accounts, typically by an independent body.

a systematic review or assessment of something.
The OIG Work Plan

Sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG’s Office of Audit Services and Office of Evaluation and Inspections.

Updated monthly.

Projects listed in the Work Plan span the Department and include the Centers for Medicare & Medicaid Services (CMS), public health agencies such as the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), and human resources agencies such as Administration for Children and Families (ACF) and the Administration on Community Living (ACL) and other issues.

How They Plan Their Work

They assess relative risks in HHS programs and operations to identify those areas most in need of attention and, accordingly, to set priorities for the sequence and proportion of resources to be allocated.

Audits and evaluations may be cancelled based on OIG staff availability, changes in the environment, legislation that affects the issue, or similar recent studies that provided definitive results.

In evaluating potential projects to undertake, they consider a number of factors such as mandatory requirements for OIG reviews, as set forth in laws, regulations, or other directives requests made or concerns raised by Congress, HHS management, or the Office of Management and Budget.

Be aware that the OIG does not necessarily follow through on all audits included in the Work Plan but you need to be prepared.

So Why Cardiac and Pulmonary Rehab?

Medicare Part B covers outpatient cardiac and pulmonary rehabilitation services. For these services to be covered, however, they must be medically necessary and comply with certain documentation requirements.

Previous OIG work identified outpatient cardiac and pulmonary rehabilitation service claims that didn’t always comply with Federal requirements.

So now, they will assess whether Medicare payments for outpatient cardiac and pulmonary rehab services were allowable in accordance with Medicare requirements and determine whether potential risks in these programs continue to exist.

Announced or Revised
<table>
<thead>
<tr>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
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<tr>
<td>May 2018 Centres for Medicare &amp; Medicaid Services</td>
<td>Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services</td>
<td>Office of Audit Services</td>
<td>W-00-18-35808</td>
<td>2019</td>
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Although the work plan doesn’t cite a specific report, concerns regarding appropriate payment for these services cropped up in a number of reports from the past several years.

A previous OIG audit of cardiac and pulmonary rehabilitation claims, was conducted in 2015 and reviewed one hospital in New Jersey.

Claim period January 2012 through December 31, 2013
6,569 outpatient cardiac and pulmonary rehabilitation
Total amount of claims $417,944
Random sample of 100 claims (68 cardiac and 32 pulmonary) were reviewed

Findings

Significant number of deficiencies in both CR and PR programs
54 of 100 — properly claimed
46 (16 cardiac and 30 pulmonary) — improperly claimed
Of the 30 pulmonary rehabilitation services claims, 13 contained more than 1 deficiency.

Results-based on the sample

The institution had to pay back $115,000 to the Federal Government
Implement written policies and procedures to ensure that outpatient cardiac and pulmonary rehabilitation services are provided and documented in accordance with Medicare requirements.

There was another audit in 2017.

7,500 claims from 376 providers
321 providers responded
198 appealed or challenged

RAC (Recovery Audit Contractor) audits.

ADR request for 20 patients at each facility. Send in entire chart for the month requested.

My approval rate was 100% and we did not have to do anything further.

National results were as follows:

Final denial rate-38% lack of documentation, ITP signatures missing or not within 30 days of last review, no psychosocial component, criteria, outcomes, etc.

Did these results prompt them even more to put this on their work plan?
How do we get through it?

Supervisor or Entire Department Responsibility?

**BOTH**

- Supervisor
  - Educate your staff
  - Know who is in charge of compliance in your medical records department
  - Who creates the skills and sends them in?
  - Introduce yourself, let them know that there may be an audit of DR and PA services and give them your contact info.
  - Have them reach out to you with any requests for CR or PR charts. Paper chart to EMR. Document partial charts are sent in and you didn’t even know there was a request for information. Half of your documentation is still in your department until they finish the program.
  - Communicate with everyone to not send out anything regarding claims in your department without your final review.
  - Prepare your staff with the tools they need.
  - Chart audits
  - Follow instructions

- Department
  - Review the IPP as you do them every 30 days - modeling reality action.
  - Chart audit each other
  - If something is missing, fix it, get it, find it!
  - Know what is required (referrals, exercise prescription, physician signatures, documentation of medical necessity, psychosocial assessment).
  - Know your LCD and keep it in a convenient place.
  - Signatures legible?
  - Charges reconciled?
  - Don’t let anything “slide”
  - Work as a team

If you spend a little more time on the front end and ensure your charts are compliant, then you will spend a lot less time and worry in the appeal process.

We have been through this as a state before and we were the first to come off of the audit out of our MAC.

WE CAN DO IT AGAIN!!!