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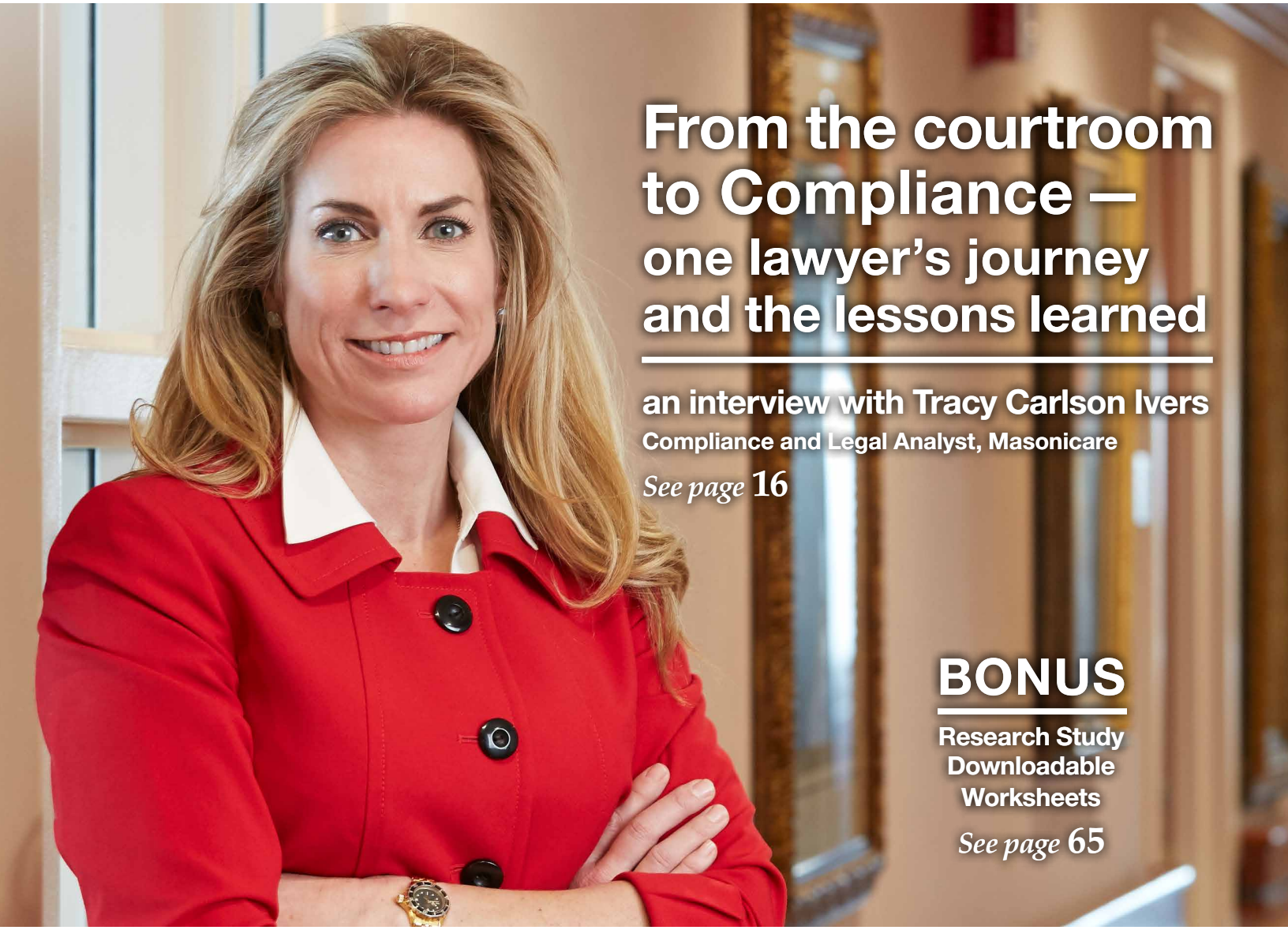

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by Cindy Hart, LPN, CPA, CGMA, CPC, CHC; Walter E. Johnson, MSA, CHC, CRCMP; Adam K. Weinstein, FACHE; and Frank Ruelas

Compliance 101

The seven essential elements, Part 4: Auditing & Monitoring

» Aligning your risk areas with the OIG's focus areas helps your organization to prove adherence to regulations.
» OIG has developed a series of voluntary compliance program guidance documents.
» The single biggest risk area for hospitals is the preparation and submission of claims.
» Functions common to all healthcare organizations should be monitored for compliance.
» Auditing and monitoring may identify risk areas that prompt discussions between the Compliance department and legal counsel.

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Now that you are getting settled and more comfortable in your role as the compliance officer (CO), it is time to develop an audit plan and begin monitoring the processes you have put in place to mitigate risk. The Work Plan published by the Office of the Inspector General (OIG) of the Department of Health and Human Services (DHHS) is a good place to start when developing your audit plan. Aligning your risk areas with the OIG's focus areas helps your organization to prove adherence to regulations. In addition, you should review program guidance documents for your specific segment of healthcare.


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The OIG has developed a series of voluntary compliance program guidance (CPG) documents directed at various segments of the healthcare industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.[1] The CPG supplement offers a set of guidelines that providers are encouraged to consider when developing and implementing a new compliance program or evaluating an existing one.

Perhaps the single biggest risk area for hospitals is the preparation and submission of claims or other requests for payment from the federal healthcare programs.[2] Effective auditing and monitoring plans will help hospitals avoid the submission of incorrect claims to federal healthcare program payers. Hospitals should develop detailed annual audit plans designed to minimize the risks associated with improper claims and billing practices. As described in the Federal Register (Vol. 70, No. 19, January 31, 2005), some factors hospitals may wish to consider in developing their audit plans include the following:

- Annual re-evaluation of the audit plan to address areas of concern identified through the findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high-volume services;
- Assessment of billing systems and claims accuracy to identify root causes of billing errors;
- Clearly established roles for auditors, and assurance that coding and audit personnel are independent and qualified with requisite certifications;
- Ability of Audit department to conduct unscheduled reviews;
- Mechanism that allows the Compliance department to request additional audits or monitoring if the need arises;
- Evaluation of error rates identified in annual audits;
- Additional investigation into other aspects of the hospital compliance program to determine hidden weaknesses and deficiencies when error rates do not decrease; and
- Review of all billing documentation, including clinical documentation in support of the claim.

The OIG states: "The best evidence that a provider's compliance program is operating effectively occurs when the provider, through its compliance program, identifies problematic conduct, takes appropriate steps to remedy the conduct and prevent it from recurring, and makes a full and timely disclosure of the misconduct to appropriate authorities." To identify the problem areas, use of internal and external audits is the key. A good compliance plan that uses both internal and external auditors shows your facility's desire to operate within the guidelines.[3] The OIG strongly recommends that a hospital conducts an external compliance effectiveness review of its compliance program at least every three years.[4]

Common audits and methods

Certain functions common to all healthcare organizations should be monitored for compliance, such as Stark violations; Anti-Kickback Statute; record retention; bad debts, credit balances, and cost reports; marketing; background checks and excluded individuals; security breaches; Health Insurance Portability and Accountability Act (HIPAA) violations; and claim submissions.

Stark and Anti-Kickback audits

Your organization should have a policy that explicitly prohibits remuneration for referrals and requires disclosure of financial conflicts. Your compliance team should periodically conduct audits to ensure this policy is followed. During your annual compliance training, ask about referrals and conflicts. Each year, all employees should read the policy and sign a statement signifying their understanding and compliance. The CO should use the questioning method to elicit responses and make a determination of risk. Develop a question set and meet with individual physicians and other employees to review the questions. A good tool to use during an

audit is a conflict-of-interest questionnaire. The CO may elect to use a confidential survey to promote honesty. It is also important to include patients in your audit. Ask patients about their experience, their referral source, and if they felt compelled to see a particular physician or patronize a certain facility.

Record retention, background checks, excluded individuals audits

Record retention and destruction laws vary by state. The CO should be aware of the laws for each state in which your organization operates. Read all sections pertaining to retention and destruction, paying close attention to differences for minors and types of records. Some states suggest destruction every 10 years, except for pathology reports which must be kept in perpetuity. The compliance team should periodically audit for compliance by randomly selecting cases that are approaching and beyond the destruction date. Very old records may not have been converted to electronic media and may actually be in storage at a separate location. Visit the location to determine safety from fire, water, and vandalism.

Record retention and destruction laws vary by state. The CO should be aware of the laws for each state in which your organization operates.

Background checks and checks for excluded individuals should be conducted at least yearly. Many large organizations contract with a vendor who conducts monthly background checks. Continuous monitoring enables your organization to become aware of changes in a timely manner and address the issue immediately. Background checks should be conducted on all new hires, all employees who come in contact with patients, Accounting and Finance personnel, Human Resources personnel, vendors, contractors, and volunteers. In addition, employees who are promoted should have a background check completed. A check for excluded individuals is conducted for physicians, non-physician providers, referring physicians, and vendors. Although background and excluded-individuals checks are time-consuming and tedious, some smaller organizations prefer to perform the checks internally to eliminate the expense of a vendor. The audit method typically used is investigation via database searches.

Bad debts, credit balances, cost report audits

Financial audits are conducted by external accounting firms that attest to management's assertions regarding bad debts, credit balances, and cost report data. Your role as CO may require you to review the financial audit report, participate in the exit meeting with Finance and the accounting firm, and report to the executive compliance committee or the board of directors. The chief financial officer (CFO) is typically responsible for reporting the board. However, the CO should be aware of any qualified reports, notes to the financial statements, and/or excessive journal entries, and recommended corrective actions.

Marketing, security breaches, HIPAA audits

Marketing is another business function that requires auditing. Although an organization's primary focus is to ensure marketing materials capture the attention of the target audience, there are potential risks when marketing materials do not meet regulatory standards. It is essential for organizations to obtain

compliance guidance for marketing functions. As CO, establishing and auditing internal controls for marketing processes helps to reduce risk. Marketing products such as websites, brochures, posters, and other customer-facing materials are subject to audit. Each product may include verbiage that requires editing as regulations change. Regulatory requirements can vary from broad to specific verbiage and include specific font type/sizes. Participating in the development process will help the CO to determine the type and frequency of marketing audits.

Similarly, auditing and monitoring are vital when assessing compliance in areas where non-compliance can have devastating effects. One such example is protecting the privacy and security of patient information. Organizations have invested significant resources to set up effective compliance programs. Some organizations fail to meet HIPAA guidelines. This can be avoided by implementing auditing and monitoring to assess workforce performance in activities that directly contribute to HIPAA compliance. Consequently, if processes are not monitored and work performance is not audited, the organization cannot assess its workforce, thereby exposing the organization to risks.

There are areas within an organization where auditing and monitoring should be considered integral to policy and procedure implementation. The associated training and education should be codified in the policy and procedure.

Claim submission or bill audits

Once you determine what areas to audit, decide whether you will conduct a retrospective or a concurrent audit. You, as the CO, should determine which method is best for your organization and be prepared to explain your rationale to your executive team and board of directors. A retrospective audit is conducted on claims that have already been submitted to payers for reimbursement and often have already been paid. If you use the retrospective audit method, be aware that your organization is required to report errors and refund overpayments to the government. Therefore, the retrospective audit is not the preferred method.

A concurrent audit is conducted prior to claim submission. Therefore, corrections can be made before the claims are submitted, providing a greater level of confidence in the accuracy of claims. The challenge with the concurrent audit method is the need to "hold the bill" until the service has been audited and approved, thereby delaying revenue.

Regardless of the method you employ, if you discover serious infractions (e.g., fraud, abuse, waste, negligence, disregard, misconduct), you should immediately notify your legal counsel, who will make the determination whether to proceed under attorney-client privilege and will properly notify your fiscal intermediary. A CO who holds a law degree should not assume the role of legal counsel for the organization. Rather, remain within the scope of your position and enlist counsel for legal matters.

Other audits

Another area that you may deem necessary for audit is eligibility for healthcare benefits. Select a sample of employees and review their dependents listed on the policy for current eligibility. Employees are not always aware that changes are required in the event of divorce, death of dependent, or when dependents reach 26 years of age. Your insurance carrier may restrict coverage for step-children in the event of a second divorce.

Audits for phantom employees may be needed. Although challenging, it may be prudent for an organization to conduct an audit every couple of years to reduce the risk of phantom employees. One method is to have

every employee pick up their payroll check for a certain pay period at a specific location. Direct deposit makes this method a bit more difficult. However, work with department heads to put a hold on direct deposits for that pay period.

"How to" and auditing fundamentals

Once the decision to conduct an audit is made, the next challenge is to determine the parameters that will be used to design the sample size. A sample is used when the universe (i.e., total size of the audit area) is large. The size of the audit depends on your decision to perform a statistically valid sample or not. Statistically valid samples are based on a percentage and depict a true representation of your organization's activities. Statistically valid samples require results to be extrapolated across your universe, and refunds are made to payers based on the extrapolated amount. Internal audits are usually random, but not statistically valid, with a pre-determined number of cases or records making up the sample size.

After the random sample is reviewed, generalities can be drawn based on the findings. A distinct upside to random sampling is that it generates very useful results without placing too much of an administrative burden on the auditors.

Consider three types of audits commonly referred to in OIG and Centers for Medicare and Medicaid Services (CMS) publications that help make auditing more efficient: probe audits, discovery audits, and full audits.

Probe audits

Probe audits are the smallest in terms of the number of elements that are reviewed. Probe audits generally involve sampling 20–40 elements. Probe audits are often conducted to determine if the findings may indicate the need for a more in-depth review. If the findings indicate a need to gather more information, the CO may decide to expand the audit if a process or procedure is not performing at an acceptable level.

Discovery audits

Discovery audits represent the next level, or more in-depth type of audits. Discovery audits typically use a sample size of 50 elements. It is important to note that when moving from a probe audit to a discovery audit, an entirely different sample must be randomly selected. For example, if a probe audit was done using 40 elements, a discovery audit would require selecting 50 new elements at random, not simply selecting 10 more elements to increase the sample size to 50. The reason for this is that sample sizes must be drawn so all elements have the same probability of being selected. This concept is known as equi-probability and is a very important principle when selecting samples.

Full audits

The most comprehensive type of audit involves the largest sample size. Often referred to as "full" audits, sample sizes are derived from mathematical formulas that take into account the confidence level desired and the associated confidence interval. Fortunately, publicly available software (such as RAT-STATS, a statistical software package available from the OIG) can assist practitioners in conducting these three types of audits.[5]

Evolve the auditing program

It is not uncommon to read articles that share a position stating auditing and monitoring may be the weakest element within a compliance program.[6] Too often, the new compliance professional discovers that auditing and monitoring has not occurred recently. To overcome this weakness, the new CO embarks on an aggressive approach, attempting to tackle all types of audits at once. Although ambitious, this approach can cause significant frustration. The CO should take a step back and review

the existing compliance program. Apply the KISS (Keep It Simple Sam) principle by using the existing program as a base and building out the audit process from there.

Start with an audit that is simple and meaningful. Identify one risk area that lends itself to a straightforward analysis. Use the results to recommend mitigating actions for risk reduction. As the CO gains audit experience, self-confidence increases, and he/she begins to feel more comfortable in the position. The CO can now move forward with more complex audit areas.

Auditing and monitoring program overview

Once established, it is essential to document the entire auditing and monitoring program for the organization. The written overview of the entire program must be easily accessible by the CO. This program overview differs from the dashboard regularly shared with senior leadership and presented to the board of directors. The dashboard serves as a snapshot of compliance activities. At a minimum, the auditing and monitoring program overview serves as a master document that should include the title of all auditing and monitoring activities, designated operational area, frequency, and sample size. The auditing and monitoring program overview document may include an appendix consisting of all the results for the previous 12 months. Sharing findings with operational leaders, prior to reporting to the compliance committee, is appropriate.

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3. Marcia Vaqar: "The Importance of Internal Audits." RMC Compliance Connections, vol. 2, issue 1, 1st Quarter 2011. Available at http://bit.ly/1wR8Jbe
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5. Office of Inspector General: RAT-STATS-Statistical Software. Available at http://oig.hhs.gov/compliance/rat-stats
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