

Healthcare Auditing Strategies

NEWSLETTER FOR THE HEALTHCARE AUDIT RESOURCE CENTER

CMS stops payment for eight HACs; more to come

Beginning in October, hospital staff members need to be more conscious of patients' conditions at admission.

In 2007, CMS proposed to stop paying for eight hospital-acquired conditions (HAC) previously included in the higher-weighted DRG in the inpatient prospective payment system (IPPS), including:

- Foreign objects retained after surgery
- Air embolisms
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma in the hospital
- Catheter-associated urinary tract infections
- Vascular catheter-associated infections
- Surgical site infections

In April, CMS proposed adding nine more conditions to the HAC initiative for fiscal year 2009, according to a report on CMS' Web site. They are:

- Surgical site infections for specific surgeries, such as total knee replacements
- Legionnaire's disease
- Glycemic control
- Ventilator-associated pneumonia
- Iatrogenic pneumothorax
- Delirium
- Deep vein thrombosis/pulmonary embolisms
- Septicemia
- *Clostridium difficile*-associated diseases

CMS' criteria for choosing HACs

Caroline Piselli, RN, MBA, FACHE, program manager of performance management at 3M Health Information Systems in Wallingford, CT, says CMS selected these conditions for its HAC initiative, based on three criteria:

- Are these conditions high-cost, high-volume, or both?
- Are these conditions considered complicating?
- Are there evidence-based guidelines to determine whether the medical staff can prevent the condition from occurring?

"This documentation shouldn't be an additional burden. It should be something they should incorporate into their normal process."

—June Bronnert, RHIA, CCS, CCSP

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HCP Pro

The growing HAC initiative is expected to affect present on admission (POA) regulation, Piselli says.

In October 2007, Medicare required facilities to submit POA documentation on its claim form, using five POA indicators:

- Y = The diagnosis was present at the time of inpatient admission

Eight HACs

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- N = The diagnosis was not present at the time of inpatient admission
- U = Documentation was insufficient to determine whether the condition was POA
- W = The condition is clinically undetermined
- I = The code is not reported/used and is exempt from POA reporting

Since then, many hospitals have created interdisciplinary steering committees to make sure staff members

complied with POA mandates, Piselli says. Hospitals can form these types of committees by focusing on the following three areas:

- **Accurate documentation and coding.** POA documentation requires a thorough recording of the patient's symptoms and medical history during the admission process.

The HACs make clinical documentation all the more important, Piselli says. Physicians documenting patient care "need to make it crystal clear whether the patient came in with [a specific] condition or not," she says, adding that physicians need to draw "a sharper line as to what the patient came in with versus what happened when the patient came in to the hospital."

Staff members must work closer together to ensure clear documentation. For example, physicians need to review their documentation to make sure coders can understand the patient's condition. Conversely, coders must ensure that clinical staff members (i.e., a nurse practitioner or physician) understand the importance of the DRG.

One tricky aspect with documentation for determining POA indicators is that it must come from the physician. "That's been one of the biggest challenges," says **June Bronnert, RHIA, CCS, CCSP**, director of clinical data standards at the American Health Information Management Association in Chicago.

For example, a nurse might write a dazzling report about a patient's pressure ulcer, but if a physician does not refer to it or acknowledge it in his or her report, the nurse's information cannot be used to determine a POA indicator.

"Coders have to go by the physician's documentation," Bronnert says. "If the documentation is clear, it should be pretty easy" for coders to assign POA indicators.

A physician champion can help with this process by serving as a liaison between physicians and coders. Physician champions can help their peers understand why it is important for them to be thorough with their

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documentation, Bronnert says. "It helps a lot of times to have that peer-to-peer communication. If there's one physician talking to another physician, sometimes the information is received better," she says. "This documentation shouldn't be an additional burden; it should be something they should incorporate into their normal process."

➤ **Clinical quality improvement.** Clinical staff members need to check and double check their work to guarantee the best quality of care.

A mistake such as leaving a wad of gauze in a patient might seem unlikely, but it happens. Such actions result in a HAC, which means reduced Medicare reimbursement for the facility.

Stringent policies on sterilization, hospital safety, evidence-based documentation, and patient history documentation can also improve the quality of care and prevent HACs from occurring.

Thus, for example, surgical staff members may have to change their habits to prevent these occurrences, Piselli says. "They may have to change their checklist or change their work flow," she says.

➤ **Financial and operational modeling.** Conducting analyses to reveal where and why HACs occur helps hospital staff members change their practice and prevent costly mistakes, Piselli says.

"Where are these things happening today, and how do I work on the most important aspects to prevent

these things?" she says. With data analysis, hospital staff members are "able to really look at all the data from the whole organization. This allows a hospital to look at what really stands out as a problem and to go look at that area first."

Piselli also advises hospitals to review their HAC prevention costs and make sure it's not putting them in financial debt.

"Don't have your prevention process model cost more than if you didn't get paid for these things. Do it smartly," Piselli says. ■

Illustration by David Harbaugh



"While you were out, the OIG called to audit our facility. Whoever answered your phone said, 'No thanks.' "

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Medicaid enforcement

A four-step approach to a risk management plan

In an attempt to reduce government spending, state and federal agencies are taking a fine-tooth comb to organizations that receive Medicaid funding. That means having an effective compliance policy is more important than ever.

The escalation of Medicaid costs—an expected \$204 billion in fiscal year (FY) 2008 and \$400 billion in 2009—raised red flags in Congress, said **Michael F. Mangano**, a former principal deputy and acting inspector general in the OIG and senior vice president at Strategic Management in Alexandria, VA.

Mangano spoke during the February 20 HCPro audioconference, “Medicaid Enforcement: Prepare Your Compliance Program for Government Scrutiny.” (For information, visit www.hcmarketplace.com/prod-6185.html.)

To address that concern, the federal government promised CMS millions for the enforcement of Medicaid regulations.

In FY 2008, CMS received \$50 million from the federal government and will get \$75 million for each subsequent year to complete its five-year plan of eliminating fraud and abuse of the Medicare and Medicaid programs. So far, CMS has spent money to hire 100 additional staff members in order to complete its goal.

How the DRA changed Medicaid enforcement

“The biggest change for Medicaid enforcement has been the Deficit Reduction Act of 2005 [DRA],” Mangano said.

The DRA gave CMS the authority to audit health-care providers suspected of abuses. Under its supervision, CMS formed the Medicaid Integrity Group (MIG)

to find potential targets for audits and hire contractors to conduct those audits.

The DRA also gave states a bigger incentive to implement their own false claims acts (FCA).

Prior to the DRA, any monies recovered due to fraud or abuse of a state Medicaid program were shared between the state and federal governments, each according to its share of the program’s cost. For example, if a state pays 40% of the Medicaid program costs, it will receive 40% of the recovery.

Now, states that adopt their own FCA and have it approved by the OIG receive an additional 10% of the recovered money. So far, Hawaii, Illinois, Massachusetts, New York, Nevada, Tennessee, Texas, and Virginia have OIG-approved FCAs.

The DRA also enacted the 60-day rule, which requires states to pay the federal government for any abuses within 60 days, regardless of whether they recovered the money.

“That will put a great incentive on the states to go back and recover this money,” Mangano said. “There will be many state and federal agencies looking over your shoulder with data mining resources for both Medicaid and Medicare services. The need to be careful is important.”

What the government looks for

The first thing the OIG examines is the facility’s compliance program. Often, the organization’s policy looks good on paper. But staff members rarely follow the policy, Mangano said.

A good compliance policy includes:

- Executive involvement in oversight
- Clear, written guidance
- A well-developed and attended education and training program
- Employees who bring potential compliance issues to the compliance officer

Questions? Comments? Ideas?

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- Coordination with other departments (e.g., legal and HR)
- Annual auditing/monitoring of compliance risks
- Evidence of identification, follow-up, and resolution
- Effective internal communication

How to approach a Medicaid risk management program

A structured, four-step approach involving the entire hospital is the best way to identify and reduce potential compliance risks, said **Dave Butler**, president of Strategic Management, who also spoke at the audioconference. These steps are:

1. Risk identification. To start, have all departments attend a meeting to identify the probability and the effect of risks, ranging from low to high, in every possible department. Identify the risks based on OIG, MIG, CMS, and other government agency–targeted items.

High-risk areas include:

- Lack of written guidance for staff members
- Enrollment abuses
- Doctored birth certificates
- Giving bad information to beneficiaries
- Billing errors
- Denying services through rationing of services

2. Risk assessment. Next, narrow down your facility's greatest potential risks to 15. Base this on the newness of the policy, any recent training, internal controls, and other factors. Use key players in each department to assess and prioritize the risk list, Butler said.

3. Risk strategy plan. Determine a plan for when and how you will address each risk area. Start with the most critical risk and work down. Develop a chart to organize when each risk will be addressed. List each risk area down the left side of the chart with a calendar across the top. Use color-coded boxes to show when each risk area will be reviewed. "I think [a work plan] communicates well to the executives that will be overseeing this process as to where you are and how this process works," Butler said.

4. Risk remediation. Review existing policies and procedures and develop new ones where needed.

To help visualize your organization's deficiencies, make a matrix comparing FCA regulations and your organization's current policy. This makes it easy to determine whether your organization effectively meets your top risks.

If changes to policy must be made, train and test your staff members based on the new compliance criteria. All training should be documented in HR records.

After training, conduct an internal audit to see whether the new policies and procedures effectively address the risk areas. If not, make the appropriate changes and reassess your success.

How to keep up with changes

All compliance policies and procedures should remain active and should always include the most recent information. Your organization should keep an eye on any changes to the FCA.

To make sure the organization is up to date on all the most recent regulations, it's a good idea to do an annual internal audit, as well as an external review of your compliance procedures every three years.

Since the DRA encourages each state to develop its own FCA, it is important that your organization's attorneys understand the legal landscape for your particular area, said **Sarah Kay Wheeler**, a partner specializing in health and hospital law at King & Spaulding, LLP, in Atlanta, who also spoke during the audioconference.

For example, some states require that providers certify compliance with employee education provisions in order to get reimbursement. In those states, a person of appropriate authority needs to attest to the fact that employees received adequate education. ■

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Methods of issuing IM on discharge appeal rights vary

Hospital staff members have a few choices when deciding how to distribute the Important Message from Medicare (IM) regarding discharge appeal rights. However, the hospital operational staff should find the method that best suits the size of the hospital and the roles of the staff members. In 2007, CMS required hospitals to give Medicare inpatients a revised version of the IM to explain beneficiaries' hospital discharge appeal rights.

Beneficiaries receive the notice twice, according to the regulations. The first time should be "up to seven days before or within two calendar days of admission," according to CMS. At that time, the hospital "must obtain the signature of the beneficiary or his or her representative and provide a copy" to the patient. The hospital gives the patient his or her signed notice a second time "as far in advance of discharge as possible, but not more than two calendar days before discharge," CMS states.

Distributing the notice

Hospital staff members can easily distribute the IM the first time during patient admission, says **Kimberly Hoy, JD, CPC**, regulatory specialist at HCPro, Inc., in Marblehead, MA.

The second distribution is a little trickier because it is difficult to predict the time of a patient's discharge, Hoy says. CMS prohibits hospitals from having a routine policy to hand the patient the notice on the day of discharge, which further complicates the process. Also, hospitals must ensure that a qualified staff member, such as a case manager, hands the patient the IM and answers any questions he or she might have, Hoy says. However, case managers generally do not work weekends.

Deciding on a method

Some hospitals adopted an organized method, designating a qualified person, such as a case manager, to hand out the IM every Monday, Wednesday, and Friday in case patients should be discharged in the ensuing two days. Since this duty would take a case manager away from

discharge planning, this process would probably work best for larger hospitals that can afford to assign a case manager solely for this purpose, Hoy says.

"When you have the volume that some of the larger hospitals have, you need a systematic process," she says, adding that this method ensures the designated person delivering the notices is qualified to answer patients' questions.

Unit clerks play a major role in distributing the IM at Mercy Health Partners' (MHP) five hospitals in Ohio. At MHP hospitals, registration staff members give the patient the IM at admission, and the unit clerks hand it out the second time prior to discharge, says **Beth Hickman**, MHP's regional director of corporate responsibility.

Unit clerks generally perform nonclinical administrative tasks in a hospital unit. Their duties vary, so this method may not work at all hospitals, depending on what roles unit clerks play, Hickman says.

"The unit clerks get a list of all the Medicare patients, and they consult with the nurses to find out when the patient is expected to go home," she says. Then they determine whether the patient can sign the form or who can sign it if the patient is unable.

Because unit clerks work near patient rooms all day, they can see whether a patient's family visits. This makes it easy for them to get a signature from the patient's healthcare proxy, Hickman says. "That's how we've done it. It's actually worked out pretty well for us," she says. The process gives unit clerks added job responsibilities and a chance to interact with the patients.

Although unit clerks can distribute the IM, Hoy says, whoever hands it out needs to be qualified to answer a patient's questions regarding his or her discharge. Patients might want to know why they no longer need inpatient care or what kind of care they will need after discharge.

Preventing appeals

Medicare beneficiaries have the right to appeal the discharge decision by calling the affiliated quality

improvement organization (QIO). The telephone number is printed on the IM.

However, some appeals pose financial harm for hospitals. For example, if a patient makes the call to the QIO to appeal on a Friday night, he or she will likely leave a message on an answering machine. By the time the QIO processes the appeal and gives its decision, it is noon on Tuesday. The patient does not have to pay for his or her care between the time of appeal and the time the hospital discharged the patient on Tuesday, resulting in a loss of money and resources, Hoy says.

To avoid the appeals process, Hoy suggests a premeditated strike of sorts.

Hospitals have the opportunity to provide a patient with a detailed notice of discharge (DND) in addition to the IM. Hospitals are required to provide the patient with the DND after the patient appeals his or her discharge. However, the DND can also be given out prior to a possible appeal. If a nurse or case manager feels that a patient is likely to appeal, they should distribute a DND, along with applicable Medicare policies and documentation showing why the patient no longer meets inpatient care criteria, Hoy says.

The more information the facility provides to patients regarding discharge planning and ensuring that patients have an appropriate place to go, "the safer they're going to feel leaving the hospital," Hoy says.

Electronic medical records can aid in auditing IMs

Auditors and compliance officers can easily audit their hospital's IM distribution practices, Hickman says. Some of MHP's facilities have electronic medical records, which make the auditing process a cinch. They use document imaging to scan the signed IM into the patient's medical record.

"I can go in from my desk, pull a record, and look to see whether I've got a signed IM in that electronic health record," Hickman says. "It's really very nice."

Some of MPH's facilities do not have electronic medical records; however, auditing is still fairly simple, Hickman says. She suggests multitasking.

"It doesn't take that much time to go in and look for it when you're looking at records for other things," she says. "It's a matter of being cognitive of the fact that it's one more thing you're going to need to audit for." ■

OIG's SDP 'Open Letter'

A proactive approach to self-disclosure

by Sujata Sahgal, MHSA

The cost to healthcare organizations that do not comply with federal healthcare laws and regulations can be enormous, resulting in large fines and penalties and possibly corporate integrity agreements (CIA) and/or certification of compliance agreements (CCA).

Ultimately, CMS can exclude an organization from working with federal healthcare programs. This affects the financial viability of an organization and its reputation within its community.

The OIG expects all healthcare providers to regularly audit and monitor facility activities to identify organizational weaknesses that may result in improper claims.

For claims processing systems, this means establishing quality control reviews to consistently monitor claims and ensure accuracy.

Compliance officers should review referral arrangements and carefully revise them as needed to ensure compliance. These arrangements include lease agreements, advisory agreements, recruitment contracts, and joint venture agreements, all of which could implicate the anti-kickback statute and/or Stark Law violations. There are a host of factors that should be addressed with these types of arrangements, particularly as they relate to determining fair market value and commercially reasonable standards.

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Self-disclosure

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Analyze a problem as soon as it is found

Let's say these proactive measures uncovered a compliance concern. Now what? Before reaching for the OIG's self-disclosure protocol (SDP) guidelines, analyze the situation and determine the scope and depth of the problem and, if necessary, disclose it to the proper person. The OIG clearly states in its April 15 "Open Letter to Health Care Providers" ("Open Letter") that it is interested in violations of law or regulations, not simply errors resulting in overpayment. According to the OIG, it relies on providers' good-faith determination that the matter under investigation "implicates potential fraud against the federal healthcare programs."

Matters disclosed that simply turn out to be cases of billing errors or overpayments significantly inhibit the OIG investigation process by reducing the government resources available to investigate actual instances of fraud and abuse.

In its letter, the OIG cautions against disclosing matters that do not "potentially violate criminal law, civil law, or administrative laws for which exclusion and civil monetary penalties are authorized" and says it will remove an organization from the SDP if it determines that the disclosure of information was not made in good faith. Providers should contact the appropriate claims processing entity or Medicare contractor directly to resolve all cases.

Decide whether the error was intentional

Once the facility determines who to report the problem to, the next step is for the organization to determine the cause of the problem and whether it was simply a matter of error or the result of process design. If evidence indicates the error was the result of design or intent, the potential violation must be disclosed to the OIG. At this point, the hospital should immediately take steps to correct the problem so it does not submit any further deficient claims. Implement a process for corrective action related to any systemic problems. Ensure that there are no weaknesses within the system that could lead to a pattern of error.

Developing and implementing the proper policies and procedures within your facility can help detect future inconsistencies or patterns that may lead to other investigations. The provider must return any overpayments to the federal government as soon as it discovers the error, regardless of the cause.

Disclose when necessary

If the hospital administration and its legal counsel determines that self-disclosure is the proper avenue to follow, the provider should submit the case to the SDP and provide all necessary and required information in an efficient manner. When providing information for acceptance into the SDP, hospitals need to review the new guidelines governing the submission process as set forth in the OIG's "Open Letter."

The "Open Letter" discusses four new submission requirements for healthcare providers:

- A complete description of the conduct being disclosed
- A description of the provider's internal investigation or a commitment regarding when it will be completed
- An estimate of the damages to the federal healthcare programs, the methodology used to calculate that figure, or a commitment regarding when the provider will complete the estimate
- A statement of the laws potentially violated by the conduct

Failure to submit this information within the designated time frame will result in a denial. If denied, the OIG will require the facility to resubmit all information for consideration into the SDP.

In addition, the "Open Letter" states that the facility must complete the internal investigation and damages assessment within 90 days from acceptance into the SDP. This poses a significant obstacle for hospitals that want to disclose but whose internal audit and assessment process requires more time due to the complex nature of the issue under investigation.

The OIG's reasoning behind this mandate is to ensure providers disclose information within an appropriate time frame, allowing the OIG to resolve a protocol case in approximately nine months after submission, according to an American Health Lawyers Association's June audioconference, "Open Letter to Providers—What You Need to Know Before Self-Disclosing."

To meet this goal, OIG attorneys and special agents assigned to protocol cases will set deadlines for provider responses to requests for additional information.

The OIG pledged to streamline its internal processes to review all submitted information according to the same deadlines the agency imposed on the organization. However, any deadlines not met by the provider will result in the organization's removal from the SDP.

Positive aspects of the SDP

Aside from the newly imposed submission requirements and process time frames, there is good news for providers that choose to self-disclose and are accepted into the SDP. The "Open Letter" states that "a provider's submission of a complete and informative disclosure, quick response to OIG's requests for further information, and performance of an accurate audit are indications that the provider has adopted effective compliance measures."

Further, the OIG states in the "Open Letter" that it will generally "not require the provider to enter into a CIA or CCA" when the above conditions are met.

The OIG makes it clear in its "Open Letter" that it is serious about improving the efficiency of the SDP and providing benefits for healthcare organizations that identify and disclose unlawful conduct through a proactive approach.

However, for each individual healthcare organization, the decision to disclose warrants careful analysis by the organization's senior leadership and compliance team regarding the legal issues that surround the case, according to an article, "OIG Improves the Viability of the Self-Disclosure Protocol," in McDermott Will & Emery's April newsletter.

Further, inclusion into the SDP does not eliminate the OIG's authority to impose sanctions on an organization since the OIG's "Open Letter" does not speak for the DOJ, which continues to weigh the merits of each case on the totality of the information presented. The DOJ, in its authority, is not bound by the decisions of the OIG. ■

Editor's note: Sahgal conducts policy and regulatory research and analysis at Strategic Management, a management consulting firm focused on compliance and ethical solutions in the healthcare business sectors. She provides assistance to clients in the development of corporate compliance and risk assessment audit tools to ensure adherence to OIG guidelines and other federal regulations. Contact her at ssahgal@strategicm.com or 703/683-9600, Ext. 439.

Tips and techniques

Conducting an internal investigation interview

When conducting an internal investigation interview, don't try to mimic the television show *Law and Order's* interrogation style. Compliance officers conduct interviews, not interrogations, says **Michael Johnson, Esq.**, former DOJ attorney and copresident of Global Compliance's Brightline Learning Division, based in Charlotte, NC. Approach the interview more like a journalist than a prosecutor.

Aggressive and accusatory tones do not produce good information. Rather, it puts the interviewee on the defensive.

Planning the interview

To obtain reliable information, create a casual interview environment, says **John Beattie CPA, CFE**,

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Investigation interview

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managing director at Parente Randolph Healthcare Consulting group in Mechanicsburg, PA.

An interviewer can create that environment by breaking the interview into five segments:

1. Introduction. Briefly explain the reason for the inquiry. Keep the explanation general and try not to reveal the specific topic of the investigation.

2. Rapport. Ask simple conversational questions about the weather, the trip to the meeting, etc. It is also wise to ask questions that may seem relevant, but in reality are benign, such as employment history. Developing good rapport puts interviewees at ease, making them more forthcoming with information.

Rapport also helps establish a baseline for how interviewees answer questions, what their mannerisms are, cadence of speech, etc. Noting these behaviors will help you determine whether interviewees are being honest. Do not move on to the next step without establishing a good rapport, Beattie says.

3. Question. Use the funnel approach when questioning. Begin with general, narrative-style questions, and gradually request more detailed information. Narrative questions uncover inconsistencies in a fabricated story. They also provide relevant information to help you ask detailed follow-up questions.

4. Summary. Repeat the information offered by interviewees to make sure everything is accurate. Give them an opportunity to add information.

5. Close. Both parties should leave on a positive note. If interviewees admitted to wrongdoing, now is not the time to pass judgment or talk about consequences. Remember, this is not an interrogation. Thank interviewees for their cooperation, shake hands, and exchange business cards.

Detecting deception with verbal and nonverbal indicators

Sometimes there is no hard evidence to identify the responsible party for an abuse. Situations of “he said,

she said” pit one person’s word against another. By conducting an effective interview and picking up on subtle clues of dishonesty, you can make a reasonable determination of who might be mistaken in their testimony.

People don’t have to tell a lie to be deceptive, Johnson says. Most people would rather avoid telling the truth than tell an outright lie. For example, if you ask your friend Bill, “How many drinks did you have at the bar last night?” he might say, “I usually have two beers when I go to the bar.” He didn’t lie, but he didn’t answer the question you asked either.

Another verbal indicator of dishonesty is the use of contractions. There is 60% statistical correlation between dishonesty and not using contractions, Beattie says.

In addition, when people lie, they tend to pause longer between statements. That is why it is important to get a feel for an interviewee’s cadence in the rapport stage to compare when the sensitive questions are asked.

One of the most reliable ways to detect dishonesty is to look someone in the eye, says **Lawrence Schoen, PhD**, chief compliance officer at Wedge Medical Center in Philadelphia. Schoen’s doctorate in cognitive psychology taught him how to detect the nonverbal clues that show when someone is being dishonest.

People have a physiological response when they are excited or aroused. “When people lie, their pupils dilate, and you can see it,” Schoen says. “If you learn to look for this, you will spot it every time.”

This response is an adaptation that allows humans to survive life-threatening situations by letting more light into the eye. The adaptation also produces a boost of energy. That means when people are lying, they typically begin to fidget or move around. Experienced liars compensate for this tick by crossing their arms. So look at the interviewee’s feet to see whether they tap excessively.

“Don’t ever take the response to one question or one action as the whole picture,” Beattie says. “That’s not the whole picture. You have to look at clusters, patterns, and

trends. That is one of the big problems with interviewing. A lot of people will look at one thing and say, 'He's guilty because he didn't use contractions.' "

Demeanor is not the only factor when determining whether someone is dishonest, Johnson says. Other factors to take into account are:

- Plausibility of the story
- Past record
- Motive to lie
- Corroboration

Sensing dishonesty

If you think an interviewee is dishonest, don't beat the desk and shout for the truth, like Lt. Daniel Kaffee in the movie *A Few Good Men*. Instead, use your suspicion of dishonesty to explore that specific area in more detail after the interview. But during the interview, calmly and respectfully probe the interviewee and keep asking questions.

In the earlier example, Bill avoided answering how many beers he had the previous night. In that situation,

an investigator might politely say, "I understand that you typically have two drinks, but I asked how many beers you had last night?"

If the person still avoids the question or continues to be untruthful, the investigator should document that the interviewee didn't answer the question.

Getting it wrong

Investigations often lead to punitive actions. Sometimes, the compliance officer incorrectly identifies the guilty party. Be aware that although the compliance officer can be sued—even if thorough due diligence was performed and the accused was afforded an opportunity to refute allegations—he or she is not liable.

That is why Johnson encourages compliance officers to take disciplinary action even if there is no smoking gun. Lack of internal investigations and appropriate punitive responses send the wrong message to potential whistleblowers, Johnson says. It sends the message to not bother reporting potential problems since the organization won't bother investigating. ■

CMP may serve as solution to patient status concerns

Editor's note: This article is the second in a two-part series on patient status.

Developing clear patient status indicators helps improve quality of care. Creating a case management protocol (CMP) based on these clinically approved indicators helps clinical and admissions staff members determine the appropriate patient status, which in turn helps reduce admissions claims denials.

"I can't imagine that hospitals wouldn't want to get their auditing strengthened and use something like a case management protocol to determine the correct patient status," says **Suzanne K. Powell, BSN, RN, MBA, CPHQ, CCM**, of Florida's Quality Improvement Organization (FQIO). A recent study, coauthored by Powell, demonstrated reductions in unnecessary Medicare

hospital admissions for chest pain through the use of CMPs in participating Arizona and Florida hospitals.

The FQIO study supports the use of CMPs to appropriately identify, and subsequently bill for, patient status. As a result of applying the chest pain guidance tool, participating hospitals in Florida reduced projected admissions denials by 67% for patients assigned a DRG of 143, chest pain. Participating Arizona hospitals reduced the number of one-day inpatient admissions for chest pain by 90%.

FQIO's CMP process relies on two-way communication between case managers and physicians. It recommends that facilities have utilization review (UR) management, case management, and other key members of the medical staff approve the protocol prior to implementation.

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Status concerns

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Participating hospitals found the FQIO's CMP and the chest pain admission guidance tool fairly flexible. Some adapted the tool and CMP to their specific needs. For example, a few hospitals did not allow for a hold status—a time frame of two to six hours that allows time for case management/UR staff members to assess the admitted patient.

However, these hospitals defined a patient's status when presenting as inpatient or observation within the CMP and adopted a default-to-observation status if a patient's status was not defined within 12 hours.

One Arizona hospital began a chest pain unit, and another, a clinical decision unit within their emergency departments to determine patient status.

How does a CMP work?

Once the treating physician determines a patient needs treatment in the hospital setting, the physician initiates the CMP used by the FQIO by signing the order "Assign Status Per CMP."

Case management/UR management staff members then have 12 hours to make the initial assignment of the patient's status using a clinical decision support system, such as Interqual. Some hospitals may resist using CMPs.

"A hospital has to define roles and responsibilities of medical personnel. This is a critical but often neglected task," Powell says. Nevertheless, "case management is widely used to determine patient status and is becoming more common since the development of the CMP," she says.

FQIO stated that case managers were not "telling physicians who to admit" under the CMP, but that the protocol requires a physician to sign the order once the physician and case manager agree on the patient's status.

To get physicians to follow the protocol, FQIO members used physician champions to explain how a chest pain admissions guidance tool, as part of a CMP, can help improve quality of care.

The tool consisted of severity of illness criteria and a decision tree that classifies a patient's condition and justifies inpatient or observation status-level care. Other important factors of the program were monthly chart reviews, teleconferences, and physician education. Participating hospitals also gave operational definitions of patient status, clinical status, and level of care to case managers and physicians to avoid confusion and potential claims denial.

RAC program's role in CMP drive

The Recovery Audit Contractor (RAC) program (piloted in March 2005 in New York, Florida, South Carolina, and California) identified \$375.1 million in improper Medicare payments during fiscal year 2007, according to a CMS press release.

Medicare is aggressively reviewing cases retrospectively, says **Robert Corrato, MD**, president and CEO of Executive Health Resources in Newtown Square, PA. Such examinations mean "providers will see a more frequent and critical assessment of their admission status determinations," Corrato says.

CMS states that it expects to complete the rollout of its nationwide RAC program by January 1, 2010.

"I think the No. 1 push for hospitals to use CMPs would be the incoming [RAC] program," Powell says.

OIG offers further impetus for CMP

The OIG imposed use of CMP requirements for case manager training and certification at Saint Joseph's Hospital in Atlanta in a corporate integrity agreement (CIA). The CIA was part of a settlement regarding a recent false claims case in which the hospital inappropriately billed Medicare for short stays.

The hospital soon made changes to its admissions review process, including documentation to validate first- and second-tier review for medical necessity by a physician advisor. The CMP will enable case managers to make admissions decisions with the final disposition of physicians. ■