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The OIG Work Plan: Does OIG Always Know Best?

Provider Compliance Departments routinely set audit priorities based, in part, on OIG's Work Plan, but what should a provider do if it disagrees with a position that the OIG takes? Providers should be prepared to defend their practices where there is a reasonable dispute about the law by applying traditional analytical tools to decide whether the OIG's position is on solid footing.

It is well known by now that the Office of Inspector General (OIG) recently released its 2015 Work Plan, a document that always sparks significant interest because it often foretells the areas where hospitals can expect to see audit reviews from OIG and others in the coming years. And it's not just the Work Plan that prompts such interest. The OIG's Office of Evaluations and Inspections and the Office of Audit Services conduct evaluations of individual providers or, in some cases, more global practices nationwide that involve potential fraud, waste, and abuse. But just because OIG identifies an item as a risk area, does that make it true? Not necessarily.

Range of Possible Conclusions upon Review

In many Compliance Departments, there is the oft-repeated drill: With the Work Plan in one hand and the published reports in the other, the institution's annual audit protocol is established. Once an audit is conducted, there are three possible outcomes:

- The Compliance Department concludes that the institution is doing exactly what it should be doing.
- The Compliance Department concludes that the institution's checks and balances suffer from the same deficiencies that the OIG expressed concern about in its report, which suggests that there may be significant errors.
- The Compliance Department concludes that the institution's practices do not line up with OIG's views, but the institution still reasonably believes that it billed the Medicare program correctly.

In the first two of these cases, the resolution is clear (though not necessarily easy). In the first case, there is no liability, and thus, the inquiry ends. In the second, an overpayment refund is often required. The scope of that repayment needs to be determined, and management buy-in must be obtained, but the required course is nevertheless clearly understood. The third case, however, requires a deeper look.

What Is the Legal Significance of OIG Pronouncements?

The Work Plan and OIG reports are not the law. The Work Plan is a basic explanation of OIG's review and audit agenda for the coming year, and the reports indicate how OIG interprets the law as applied to a particular provider's facts. The reports are not programmatic guidance documents akin to Medicare manuals, and do not necessarily reflect providers' legal obligations or the "right" way to bill the Medicare program for certain items and

services. Indeed, by law, the OIG is prohibited from creating policy. It is important to recognize the distinction; unlike a policy change in a Medicare manual, a provider is not on notice of legal issues that arise out of the Work Plan or audit reports, nor are providers legally required to comport their conduct to these documents.

Not surprisingly, many providers take issue with the OIG's findings in these reports and articulate their positions in their responses. Some recent examples are instructive. For instance, a recent series of reports suggests that there are discrepant views between OIG and the provider community as to what qualifies for payment as an inpatient admission, rather than observation stay. Other reports have shown that industry and the OIG are not always aligned as to when right heart catheterizations can be performed simultaneous with a heart biopsy, and providers have been able to furnish support as to why they believe the OIG's views are in error.

In addition, the Centers for Medicare & Medicaid Services (CMS) does not always adopt the OIG's recommendations in these reports, and only CMS (or its Medicare Administrative Contractors) can issue overpayment demands based on the OIG's recommendations. In other words, the OIG perspective is the first, not the last, word on a particular topic.

How Should OIG Pronouncements Be Evaluated?

If a provider's billing practices diverge from OIG statements, the provider should be prepared to do a deeper dive. OIG reports commonly (but less so in its Work Plan), provide citations to the legal sources it relies on. Providers should examine each of those sources carefully, decide if there are other sources that were omitted from OIG's analysis, and decide how to weigh each one. This analysis can become complex because of some tried and true administrative law principles that guide how to weigh various legal resources. For instance, it is axiomatic that statutes take precedence over regulations, which take precedence over manual provisions and *Federal Register* preambles. It is also well-established that significant operational obligations must go through notice and comment rulemaking and cannot be implemented through the issuance of subregulatory guidance. Through this analysis, providers may identify nuanced distinctions between governing authorities and OIG's statements. It may thus be determined that OIG has actually exceeded its bounds and is creating policy, rather than simply auditing it.

Throughout this process, the importance of documentation cannot be underscored. Documentation reflects that the organization has truly taken a "kick-the-tires" review of the potential compliance issue. Documenting a provider's analysis can show the government that the provider acted responsibly by taking reasonable steps to determine whether or not an actual problem existed. Thus, even if regulatory authorities later disagree with the provider, it can nevertheless show good faith, which often vitiates a finding of knowing or willful misbilling.

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