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OIG Rolls Out its 2009 Work Plan – What Should Hospitals Be Aware Of?

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It's that time of year again when the leaves are changing colors and, with the advent of autumn, the Department of Health and Human Services, Office of the Inspector General (OIG) has released its Fiscal Year (FY) 2009 Work Plan. The OIG Work Plan provides a broad description of the focus areas for the OIG in the coming fiscal year. This is the first in a series of articles addressing potential risk areas that providers should consider addressing in their compliance plans. This article focuses on the Work Plan provisions affecting hospital providers, including both new and continuing OIG initiatives.

New Initiatives for Hospitals:

- *Provider-Based Status for Inpatient and Outpatient Facilities:* The OIG will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. The OIG speculates that free-standing facilities are benefitting from provider-based status, which leads to enhanced disproportionate share hospital (DSH) payments, upper payment limit (UPL) payments, and graduate medical education (GME) payments for which they may not be eligible.

- *Hospital Ownership of Physician Practices:* The OIG will evaluate whether hospital-owned physician practices are meeting the regulatory requirements for provider-based designation, such as the physical location of the entity, patient population served, and the types of controls and governance exhibited by the hospital over the physicians. The OIG plans to also determine the extent to which hospital-owned physician practices, which are not designated as provider-based, are being improperly reimbursed at outpatient prospective payment system (OPPS) levels rather than in accordance with the Medicare Physician Fee Schedule.

- *Coding and Documentation Changes under the Medicare Severity Diagnosis Related Group (MS-DRG) System:* The OIG will evaluate the impact of the October 1, 2007 implementation of the MS-DRG system, which increased the number of DRGs from 538 to 745. Specifically, CMS will review coding trends and patterns and determine whether certain MS-DRGs are prone to potential upcoding.

- *Reliability of Hospital-Reported Quality Measure Data:* The OIG will evaluate whether hospitals have implemented sufficient controls to ensure that they are reporting accurate data relating to quality of care

under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

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- *Additional Part A Hospital Capital Payments for Extraordinary Circumstances:* The OIG will evaluate the appropriateness of additional Medicare capital payments, which are made to hospitals if they incur unanticipated capital expenditures in excess of $5 million due to extraordinary circumstances outside of the hospital's control, such as floods, fires or earthquakes.

- *Inpatient Rehabilitation Facility (IRF) Payments:* The OIG will review IRF claims to determine if the IRF is appropriately coding claims as transfers where the IRF transfers a patient to other IRFs, long-term care hospitals (LTCH), acute inpatient hospitals, or nursing homes.

- *Interrupted Stays at Inpatient Psychiatric Facilities (IPF):* The OIG will evaluate the extent to which interrupted stays at IPFs, i.e., where a patient is discharged and then readmitted to the same or another IPF within 3 days following discharge, are being improperly coded as transfers rather than as one continuous stay.

- *Compliance with the Emergency Medical Treatment and Labor Act (EMTALA):* The OIG will review CMS' oversight of hospitals' compliance with EMTALA by identifying variations among regions in the number of EMTALA complaints and cases referred to the states, examining CMS' methods for tracking complaints and cases, and determining whether required peer reviews have been conducted prior to CMS making a determination about whether to terminate non-compliant providers.

- *Medicare Payments for Colonoscopy Services:* The OIG will review whether payments made to physicians performing colonoscopies are properly supported, billed and paid, in accordance with Medicare requirements.

Continuing Initiatives Affecting Hospitals:

- *Hospital Capital Payments:* The OIG will continue to evaluate whether general Part A capital payments to hospitals are being made at appropriate levels for expenditures associated with acquiring new equipment and facilities.

- *Inpatient Prospective Payment System Wage Indices:* The OIG is continuing its initiative to evaluate Medicare and hospital controls over the accuracy of hospital wage data reported to CMS for purposes of calculating wage indices. Prior review has revealed hundreds of millions of dollars in misreported data.

- *Inpatient Hospital Payments for New Technologies:* The OIG is continuing its review of payments made to hospitals for new devices and technologies to determine whether claims were submitted in accordance with applicable criteria and whether CMS' calculation of the payments was correct.

- *Medicare Disproportionate Share (DSH) Payments:* As an on-going initiative, the OIG is evaluating DSH payments made to hospitals to determine whether they are made in accordance with Medicare criteria. As part of this evaluation, the OIG is assessing the components of the formula used to determine Medicare DSH payments and examining the total amounts of uncompensated care costs hospitals incur.

- *Provider Bad Debts:* The OIG is reviewing claims made by inpatient hospitals, LTCHs, inpatient rehabilitation facilities, inpatient psychiatric facilities, and skilled nursing facilities (SNFs) for Medicare bad debts. Certain unpaid deductibles and coinsurance amounts may be claimed as Medicare bad debts if specific criteria are met. The OIG will evaluate whether recoveries of prior year write-offs were properly used to reduce

the cost of beneficiary services for the appropriate time period.

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- *Medicare Secondary Payer:* The OIG is continuing to evaluate the effectiveness of current procedures for preventing inappropriate Medicare payments to beneficiaries with other insurance coverage under the Medicare Secondary Payer provisions. For example, the OIG will review procedures used to identify and resolve current balance situations where payments from Medicare and other insurers exceed the provider's charges or allowed amount.

- *Serious Medical Errors (Never Events):* The OIG is continuing its study of the incidence, facility response, and payments associated with serious medical errors, known as "never events." The OIG's study focuses on the extent to which the Medicare program paid, denied payment, or recouped payment for never events and CMS' administrative processes to detect such events. As a new initiative, the OIG is also evaluating key issues, policies and practices of hospitals regarding never events and hospital compliance with CMS' requirements for identifying several hospital-acquired conditions using the "Present on Admission" coding system implemented on October 1, 2007.

- *Payments for Diagnostic X-rays in Hospital Emergency Departments:* Noting increased concerns with the rise of imaging expenditures, the OIG plans to continue its review of a sample of paid Medicare Part B claims and associated medical records for diagnostic imaging services provided in hospital emergency departments.

- *Inpatient Psychiatric Facility Emergency Department Adjustments:* The OIG is continuing to evaluate the appropriateness of payment adjustments provided to inpatient psychiatric facilities for operating emergency departments.

- *Organ Procurement Organizations:* The OIG will continue to examine Medicare payments related to organ procurement organizations, which are reimbursed on a cost-related basis, to determine whether payments made are correct and supported.

- *Critical Access Hospitals (CAHs):* The OIG is reviewing payments made to CAHs to determine whether the hospitals meet CAH classification criteria and conditions for participation, and whether payments were appropriate and in accordance with CMS regulations.

- *Financial Status of Hospitals in the New Orleans Area:* The OIG is continuing to examine the financial status of hospitals in the New Orleans area in the aftermath of Hurricane Katrina.

- *Place of Service Errors:* The OIG is investigating whether physicians properly code the place of service on claims for services provided in ambulatory service centers and hospital outpatient departments. Medicare regulations provide higher reimbursement for physician services provided in non-facility settings, such as physician offices.

- *Services Performed by Clinical Social Workers (CSWs):* The OIG is continuing its investigation of payments made under Medicare Part B for services provided by CSWs in hospitals and SNFs. Medicare regulations prohibit billing Medicare Part B for certain services provided by CSWs in inpatient settings.

- *Medicaid Hospitals:* The OIG is conducting several studies and investigations related to Medicaid hospitals, including studies: (1) reviewing the appropriateness of hospital outlier payments; (2) reviewing DSH eligibility, payments, and payment distribution; (3) reviewing whether states have appropriately determined provider eligibility for Medicaid reimbursement; (4) evaluating the appropriateness of the Medicaid inpatient utilization rate used to determine eligibility of Medicaid DSH payments; (5) reviewing the

appropriateness of Medicaid supplemental payments made by states to private hospitals; and (6) evaluating state controls to detect potentially excessive Medicaid payments to hospital providers for inpatient and outpatient services.

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