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OIG'S 2011 Work Plan - What's In It For Hospital and Physician Providers?

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The Department of Health and Human Services, Office of the Inspector General (OIG) released its Fiscal Year (FY) 2011 Work Plan on October 1, 2010. The OIG Work Plan provides a description of what the OIG will be focusing on in the coming year, giving providers insight into what the OIG believes are areas prone to fraud, waste and abuse. This is the first of two articles summarizing OIG Work Plan provisions that providers should consider addressing in their compliance plans.

This article focuses on the Work Plan provisions that affect hospital and physician providers and has been divided into "new" and "continuing" initiatives based on whether the issue was previously addressed in the FY 2010 Work Plan or whether it is a new focus.

Hospitals

New Initiatives

Hospital Occupational Mix Data Used to Calculate Inpatient Hospital Wage Indexes: Pursuant to the Social Security Act, § 1886(d)(3)(E), hospitals are required to accurately report data on the occupational mix of their employees every 3 years, which is used to calculate inpatient hospital wage indexes under the Medicare prospective payment system. In 2011, the OIG plans to determine whether hospitals have been compliant with this requirement and the effect on the Medicare program of inaccurate reporting of occupational-mix data.

Medicare Excessive Payments: Noting that claims with unusually high payments are often incorrect for various reasons, the OIG will review Medicare claims with high payments and determine the effectiveness of the claims processing edits used to identify excessive payment. The OIG will also review outpatient claims in which payments exceeded charges and selected HCPCS codes for which billings appear aberrant.

Medicare Outlier Payments: The OIG will review Medicare outlier payments to determine whether CMS appropriately reconciled the payments using the most recent cost-to-charge ratio from hospitals' cost reports.

Hospital Reporting for Restraint- and Seclusion- Related Deaths: Pursuant to the Patient's Rights Hospital Conditions of Participation rule at 42 CFR § 482.13(g), hospitals are required to report deaths that occur while a patient is in restraint or seclusion, as well as deaths that occur within 24 hours after the patient has been removed from restraint or seclusion. Noting a 2006 report finding problems with the restraint- and seclusion- reporting process, the OIG will review hospital-reported restraint and seclusion-related deaths to determine the volume of reports and the outcome of State investigations.

Medicare Brachytherapy Reimbursement: Medicare pays for bracytherapy, a form of radiotherapy used in the treatment of certain forms of cancer. The OIG will review payments for brachytherapy to determine whether the payments are in compliance with Medicare requirements.

Hospitals' Compliance with Medicare Conditions of Participation for Intensity Modulated and Image-Guided Radiation Therapy Services: Pursuant to Medicare Conditions of Participation, hospitals must ensure that therapeutic radiologic services, including intensity modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services, meet professionally approved standards for safety and personnel qualification. The OIG will review hospitals' compliance with these requirements and assess CMS's oversight of IMRT and IGRT services provided at hospitals.

Medicare Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices: The OIG will determine whether hospitals submitted inpatient and outpatient claims that included procedures for the insertion of replacement medical devices in compliance with Medicare regulations which require that hospitals use modifiers on their inpatient and outpatient claims when they receive credit from the manufacturer of 50 percent or more for a replacement device.

Hospital Inpatient Outlier Payments: Noting that outlier payments represent $6 billion per year, the OIG will examine trends of outlier payments nationally and identify characteristics of hospitals with high or increasing rates of outlier payments.

Noninpatient Prospective Payment System Hospital Payments for Nonphysician Outpatient Services: Payments to non-IPPS hospitals for inpatient claims should include diagnostic services and other services related to admission provided during 1 day immediately proceeding the date of the patient's admission. Thus, the submissions of additional claims to Part B for outpatient diagnostic services and admission-related nondiagnositc services rendered up to 1 day before and on the date of admission is prohibited. The OIG will evaluate appropriateness of payments for non-physician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at non-IPPS hospitals.

Continuing Initiatives

Hospital Readmissions: The OIG will continue to review Medicare claims to evaluate trends in the number of hospital readmission cases and evaluate the extent of CMS's oversight of hospital readmission cases.

Hospital Admissions with Conditions Coded Present-on-Admission (POA): The OIG will continue to evaluate Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being POA. As part of this review, the OIG will determine which diagnoses are most frequently coded as POA, the types of facilities that are most frequently transferring patients with a POA diagnoses and whether specific providers are transferring a high number of patients to hospitals with POA diagnoses.

Observation Services During Outpatient Visits: The OIG will continue to review Medicare Part B payments for observation services provided during outpatient visits in hospitals, including an evaluation of whether and to what extent the hospitals' use of observation services affects the care beneficiaries receive and their ability to pay out-of-pocket expenses for such services.

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.

Provider-Based Status for Inpatient and Outpatient Facilities: The OIG will continue to review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities.

Medicare DSH Payments: The OIG will continue to evaluate DSH payments made to hospitals to determine whether they are made in accordance with Medicare criteria.

Duplicate Graduate Medical Education Payments: The OIG continues to review provider data submitted from CMS's Intern and Resident Information System (IRIS) to determine whether any duplicate payments for either direct or indirect graduate medical education have been made. As part of this review, the OIG will look at whether any interns or residents have been improperly counted as more than one full-time equivalent.

Medicare Secondary Payer: The OIG will continue to evaluate the effectiveness of current procedures for preventing inappropriate Medicare payments to beneficiaries with other insurance coverage under the Medicare Secondary Payer provisions.

Reliability of Hospital-Reported Quality Measure Data: The OIG will continue to 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 program.

Adverse Events: The OIG is continuing to conduct various studies of "adverse events," including: evaluation of early implementation of CMS's hospital-acquired conditions (HAC) policy for identifying hospital-acquired conditions and denying higher Medicare reimbursement for related care; and responses of state survey and certification agencies, state licensure boards, and Medicare accreditors to adverse events, including evaluation of any potential overlaps, conflicts and gaps in responses. The OIG will also review the type of information hospitals' internal incident-reporting systems capture about adverse events and by evaluating 2010 data, determine the extent to which hospital systems captured adverse events and reported the information to external patient-safety oversight entities.

Payments for Diagnostic X-rays in Hospital Emergency Departments: The OIG will 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 and determine whether diagnostic radiology interpretations and reports contributed to the diagnoses and treatment of beneficiaries.

Inpatient Rehabilitation Facility (IRF) Submission of Patient Assessment Instruments: The OIG will continue to review Medicare payments for IRF stays to determine whether patient assessments supporting the stay and payment amount were properly encoded and timely submitted.

Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System (IPPS): The OIG will continue to evaluate for appropriateness Part B claims submitted for nonphysician outpatient services provided to beneficiaries shortly before or during a Medicare Part A-covered stay at an acute care hospital. IPPS payments for inpatient stays are considered payment in full for inpatient stays and the Social Security Act prohibits submission of additional claims to Part B for services provided to inpatients by entities under arrangements with the hospital. Moreover, separate payments for outpatient diagnostic services and admission-related nondiagnostic services rendered up to 3 days before admission are prohibited.

Critical Access Hospitals (CAHs): The OIG will continue to review 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.

Comprehensive Error Rate Testing Program (CERT): FY 2010 Error Rate Oversight: Noting that the CERT program's national estimated improper payments for FY 2009 were $24.1 billion, the OIG will continue to review certain aspects of the CERT Program to evaluate CMS's efforts to ensure the accuracy of the FY 2010 error rate and to reduce improper payments.

Medicaid Hospitals: The OIG continue conducting several studies and investigations related to Medicaid hospitals, including the following: (1) reviewing the appropriateness of hospital outlier payments; (2) reviewing whether states have appropriately determined provider eligibility for Medicaid reimbursement; (3) reviewing the appropriateness of Medicaid supplemental payments made by states to private hospitals; and (4) evaluating state controls to detect potentially excessive Medicaid payments to hospital providers for inpatient and outpatient services.

Physicians

New Initiatives

Coding of Evaluation and Management Services: Noting that Medicare paid $25 billion for Evaluation and Management services in 2009, in the coming year the OIG will review Evaluation and Management claims to determine whether coding patterns vary by provider type.

Payments for Evaluation and Management Services: Noting that Medicare contractors have seen an increased frequency of medical records with identical documentation across services and providers' responsibility to select the code for the service based upon the content of the service and maintain documentation that supports the level of service reported, the OIG plans to review the extent of potentially inappropriate payments for Evaluation and Management services.

Excessive Payments for Diagnostic Tests: The OIG plans to review Medicare payments for high-cost diagnostic tests to determine whether they were medically necessary. The OIG will also determine the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialist for the same treatment.

Trends in Laboratory Utilization: Noting that approximately $7 billion was paid by Medicare for clinical laboratory services, the OIG will review the number and types of laboratory tests ordered by physicians and examine how physician specialty, diagnosis, and geographic difference in the practice of medicine affect laboratory test ordering.

Medicare Payments for Claims Deemed Not Reasonable and Necessary: The Medicare Claims processing manual states that providers may use GA or GZ modifiers on claims they expect Medicare to deny. Yet, according to a recent OIG study, Medicare paid for 72 percent of pressure-reducing support surface claims with GA or GZ modifiers. As a result, the OIG plans to review all Medicare payments for 2009 Part B claims with modifiers GA and GZ to determine the extent to which Medicare paid these claims and assess the policies and practices that Medicare contractors have in place with regard to these claims.

Error-Prone Providers: Medicare Part A and Part B: Targeting providers with high error rates, the OIG will conduct a medical review on a sample of claims of top error-prone providers to determine their validity and request refunds on projected overpayments.

Continuing Initiatives

Evaluation and Management Services During Global Surgery Periods: Since 1992 physicians have been required to bill a single fee for all services that are usually associated with a surgical procedure and related Evaluation and Management services provided during the global surgery period. The OIG will continue to review industry practices related to the number of Evaluation and Management services provided by physicians and reimbursed as part of the global surgery fee and determine whether it has changed since the global surgery fee concept began.

Place-of-Service Errors: The OIG will continue to investigate whether physicians properly code the places of service on claims for services provided in ambulatory surgical centers (ASC) and hospital outpatient departments.

Medicare Payments for Part B Imaging Services: The OIG will continue to review Medicare payments for Part B imaging services to determine whether Medicare payments reflect the expenses incurred and whether the utilization rates reflect industry practices.

Medicare Providers' Compliance With Assignment Rules: The OIG will continue to review the extent to which providers comply with assignment rules and determine whether and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.

Payments for Services Ordered or Referred by Excluded Providers: The OIG will continue to review the nature and extent of Medicare payments for services ordered or referred by excluded providers and examine CMS's oversight mechanisms to identify and prevent improper payments for services based on orders or referrals by excluded providers. The OIG will also review Medicaid payments to physicians for services provided during periods of termination or exclusion from the Medicaid program.

Medicare Services Billed With Dates of Service After Beneficiaries' Dates of Death: Pursuant to 42 CFR § 407.27(a), Medicare beneficiaries' entitlement to Part B benefits ends on the last day of the month in which the beneficiary dies. The OIG will review Medicare claims with dates of service after beneficiaries' dates of death to identify and recover improper payments.

Medicaid Claims With Inactive or Invalid Physician Identifier Numbers: Noting prior reviews that found instances in which Medicare had paid DME claims with inactive or invalid UPINs for the referring physicians, the OIG plans to continue to review Medicaid Claims to determine the extent to which State agencies have controls in place to identify claims associated with inactive or invalid unique physician identifier numbers, including claims for services alleged to have been provided after the dates of the referring physicians' deaths.