

## SUMMARY OF THE OIG 2012 WORK PLAN

### EXECUTIVE SUMMARY

On October 5, 2011, the Office of Inspector General ("OIG") published its proposed Work Plan for Fiscal Year ("FY") 2012 ("Plan"). The Plan, which is published annually and describes the OIG's new and ongoing audit and enforcement priorities for the upcoming year, is helpful in identifying corporate compliance risk areas and providing focus for providers' ongoing efforts relating to their compliance program activities, audits and policy development. Compliance Officers should carefully review the Plan when preparing their own organization's annual audit work plan to ensure it includes the risk areas identified by the OIG.

Although there is significant overlap between the FY 2012 Plan and the OIG's previous Work Plan activities, there are several new areas of focus. In particular, some of the significant new hospital focus areas include, but are not limited to: Medicare inpatient and outpatient payments to acute care hospitals, accuracy of present-on-admission indicators submitted on Medicare claims, acute-care hospital inpatient transfers to inpatient hospice care, Medicare outpatient dental claims and inpatient rehabilitation facilities. Significant new focus areas for other types of providers/suppliers include, but are not limited to: physician "incident-to" services, the use of modifiers during the global surgery period, nursing home compliance plans, billing patterns during non-Part A nursing home stays and hospice marketing practices and financial relationships with nursing facilities.

A complete copy of the Plan may be accessed on the OIG's website at <http://www.oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>. A summary of the OIG's key FY 2012 hospital audit areas and other activities is provided below.

### NEW MEDICARE HOSPITAL AUDIT ACTIVITIES

Significant new hospital risk areas that the OIG will focus on during FY 2012 include the following:

- *Medicare Inpatient and Outpatient Payments to Acute Care Hospitals.* The OIG will review Medicare payments to hospitals to determine compliance with selected billing requirements. The OIG will use the results of these reviews to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations and inspections have identified areas that are at risk for noncompliance with Medicare billing requirements. Based on computer matching and data mining techniques, the OIG will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same data analysis techniques, the OIG will also identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. The OIG will then review the hospitals' policies and procedures to compare the compliance practices of these two groups of hospitals. The OIG also intends to survey or interview the hospitals' leadership and Compliance Officers to provide contextual information related to the hospitals' compliance programs and controls in place to mitigate these compliance risks.

We note that these reviews appear to be substantially similar to the hospital compliance audits of error-prone billing issues that we discussed in previous Health Law News alerts from May and July of this year. The appearance of this initiative in the 2012 Work Plan seems to confirm that additional hospitals across the country will be targeted.

- *Accuracy of Present-on-Admission ("POA") Indicators Submitted on Medicare Claims.* The OIG will review the accuracy of POA indicators submitted on inpatient claims submitted by hospitals nationally in October 2008. Hospitals do not receive additional payment for certain conditions that were not present when the patient was admitted. Beginning in FY 2008, the Centers for Medicare & Medicaid Services ("CMS") required hospitals to submit POA indicators with each diagnosis code on Medicare hospital inpatient claims. These indicators identify which diagnoses were present at the time of admission and those conditions that developed during the hospital stay. Recent law provides that hospitals with high rates of hospital-acquired conditions will receive reduced payments. Accurate POA indicators are needed for CMS to implement these legal requirements.
- *Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care.* The OIG will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care and examine the relationship, either financial or common ownership, between the acute-care

hospital and the hospice provider and how Medicare treats reimbursement for similar transfers from the acute-care setting to other settings.

- *Medicare Outpatient Dental Claims.* The OIG will review Medicare hospital outpatient payments for dental services to determine whether payments for dental services were made in accordance with Medicare requirements. Dental services are generally excluded from Medicare coverage, with a few exceptions. Based on current OIG audits, providers received Medicare reimbursement for noncovered dental services that resulted in significant overpayments.
- *In-Patient Rehabilitation Facilities ("IRF").* The OIG will examine the appropriateness of admissions to IRFs. The OIG will also examine the level of therapy being provided in IRFs and how much concurrent and group therapy IRFs are providing. IRFs provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve their ability to function. Patients must undergo preadmission screening and evaluation to ensure that they are appropriate candidates for IRF care.

## **CONTINUING MEDICARE HOSPITAL AUDIT ACTIVITIES**

In FY 2012, the OIG will also continue to examine several compliance risk areas that have been the focus of previous years' work, including the following:

- Hospital Reporting for Adverse Events
- Reliability of Hospital-Reported Quality Measure Data
- Hospital Admissions with Conditions Coded Present on Admission
- Observation Services During Outpatient Visits
- Hospital Same-Day Readmissions
- Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices
- Medicare Brachytherapy Reimbursement
- Hospital Inpatient Outlier Payments
- Medicare's Reconciliations of Outlier Payments
- Hospital Payments for Non-physician Outpatient Services Under the Inpatient Prospective Payment System
- Hospital Claims with Higher or Excessive Payments
- Medicare Payments for Beneficiaries with Other Insurance Coverage
- Duplicate Graduate Medical Education Payments
- Hospital Occupational-Mix Data Used to Calculate Inpatient Hospital Wage Indexes
- IRF Transmission of Patient Assessment Instruments



## OTHER NEW PROVIDER/SUPPLIER AUDIT AREAS

The OIG Work Plan identifies enforcement priorities not only for hospitals, but also for other types of providers/suppliers, including physicians, home health agencies, skilled nursing facilities and medical equipment suppliers. Some of the significant new focus areas that the OIG identified for these providers/suppliers during FY 2012 include the following:

- *Physicians' "Incident-To" Services.* The OIG will review physician billing for "incident-to" services to determine whether payment for such services had a higher error rate than that for non-incident-to services. The OIG will also assess CMS's ability to monitor services billed as "incident-to." Medicare Part B pays for certain services billed by physicians that are performed by non-physicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians to bill for more than 24 hours of services in a day, half of the services were not performed by a physician. The OIG also found that unqualified non-physicians performed 21 percent of the services that physicians did not perform personally. "Incident-to" services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. "Incident-to" services may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality.
- *Evaluation and Management ("E/M") Services. Use of Modifiers During the Global Surgery Period.* The OIG will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during the global surgery period were in accordance with Medicare requirements. Prior OIG work has shown that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period.
- *Nursing Home Compliance Plans.* The OIG will review Medicare and Medicaid-certified nursing homes' implementation of compliance plans as part of their day-to-day operations and whether the plans contain elements identified in the OIG's compliance program guidance. The OIG will assess whether CMS has incorporated compliance requirements into the Medicare Requirements of Participation and whether CMS oversees provider implementation of plans. The Affordable Care Act requires nursing homes to operate a compliance and ethics program to prevent and detect criminal, civil and administrative violations and promote quality of care. The Affordable Care Act requires CMS to issue regulations by 2012 and SNFs to have plans that meet such requirements on or after 2013.
- *Questionable Billing Patterns During Non-Part A Nursing Home Stays.* The OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Part B services provided during a non-Part A stay must be billed directly by suppliers and other providers. Congress directed the OIG to monitor these services for abuse. Specifically, the OIG will examine podiatry, ambulance, laboratory and imaging services in this context.
- *Hospice Marketing Practices and Financial Relationships with Nursing Facilities.* The OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. In a recent report, the OIG found that a high percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also noted that many hospices aggressively market their services to nursing facility residents. The OIG will focus its review on hospices that have a high percentage of their beneficiaries in nursing facilities.

## CONCLUSION

As indicated above, the Plan is useful in giving providers a preview of many of the OIG's enforcement priorities planned for FY 2012. Providers should take advantage of this opportunity to consider how to effectively focus their compliance program activities over the ensuing twelve months.

If you would like additional information, please contact your regular Hall Render attorney or Scott W. Taebel or Leia C. Olsen via email at [staebel@hallrender.com](mailto:staebel@hallrender.com) and [lolsen@hallrender.com](mailto:lolsen@hallrender.com) or by telephone at (414) 721-0442   at the Milwaukee, Wisconsin office of Hall Render.