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OIG's 2009 Work Plan Identifies Potential Compliance Risks

The Office of the Inspector General (OIG) recently issued its annual Work Plan for fiscal year 2009, which identifies the areas that the OIG considers "most worthy of its attention." The OIG is the federal agency within the Department of Health and Human Services (HHS) that, among other things, investigates fraud and misconduct related to HHS programs, including Medicare and Medicaid. The Work Plan describes the activities the OIG plans to initiate or continue in the coming fiscal year, and its selection of issues for the Work Plan can indicate potential compliance risks that Medicare and Medicaid providers should be aware of and safeguard against.

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The OIG Work Plan for Fiscal Year 2009 identifies over 200 areas of concern within programs operated by the Centers for Medicare and Medicaid Services (CMS). Some of these concerns are specific to certain provider types (e.g. hospitals or nursing homes), while others apply more broadly to all Medicare or Medicaid providers. It is worthwhile to read the relevant portions of the Work Plan in their entirety, but the following summary highlights some of the important issues raised in the 2009 Work Plan.[1]

1. Areas of Concern for Hospitals and Health Systems

- **Provider-Based Status for Inpatient and Outpatient Facilities**. The OIG will be reviewing cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. The OIG noted that provider-based status can allow hospitals to receive higher reimbursements and allows freestanding facilities to receive enhanced disproportionate share hospital (DSH) payments, upper payment limits (UPL) payments or graduate medical education payments, which they would not be entitled to in the absence of claiming provider-based status.

- **Hospital Ownership of Physician Practices**. Citing similar concerns, the OIG stated that it will review the appropriateness of Medicare reimbursement to hospital-owned physician practices that are designated as provider-based. The provider-based designation allows

hospitals to receive Medicare reimbursement for outpatient services at a higher level than Medicare would pay if the physician practice lacked the provider-based designation. The OIG will determine whether hospitals have met the requirements to claim provider-based status and will assess the impact of higher Medicare reimbursement resulting from provider-based physician practices.

- **Inpatient Hospital Payments for New Technologies**. The OIG will examine Medicare payments to hospitals for new services and technologies. To qualify for these payments, a hospital must demonstrate that the services and technologies qualify as new under 42 C.F.R. § 412.87 and would otherwise receive insufficient payment under the diagnosis-related group (DRG) system.

- **Reliability of Hospital-Reported Quality Measure Data**. The OIG will review whether hospitals are adequately ensuring that the data they submit to CMS regarding quality of care is accurate. Hospitals that do not report the quality measures are subject to reduced Medicare payments.

- **Payments for Diagnostic X-Rays in Hospital Emergency Departments**. Noting general concerns with the potential overuse of diagnostic imaging services, the OIG stated it will sample Part B claims and medical records for diagnostic x-rays performed in hospital emergency departments to determine whether payments were proper.

- **EMTALA Compliance**. To address concerns that CMS has performed insufficient oversight of the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), the OIG will review CMS's oversight of hospitals' compliance with this law. The OIG specifically noted potential problems in CMS's delay in investigating complaints and inadequate feedback provided to hospitals on alleged violations.

- **Coding and Documentation Changes Under MS-DRGs**. The OIG will examine coding trends and patterns under the new Medicare Severity Diagnosis Related Group (MS-DRG) system. The OIG hopes to discover whether specific MS-DRGs are vulnerable to upcoding.

- **Serious Medical Error (Never Events)**. The OIG will review key issues, policies and practices regarding "never events" that occur in hospitals. The OIG will also use the Present on Admission coding system, which became effective on October 1, 2007, to identify several hospital-

acquired conditions and determine hospitals' compliance with CMS's policy regarding never events. CMS recently expanded the list of hospital-acquired conditions for which Medicare will not make payment.

- **Security of Portable Devices Containing Personal Health Information**. The OIG will review the security controls hospitals have implemented to prevent the loss of protected health information stored on portable devices and media, such as laptops, jump drives, backup tapes and equipment considered for disposal. The OIG will assess and test hospitals' policies and procedures for protecting, accessing, storing and transporting electronic health information.

2. Areas of Concern for Long Term Care Providers

- **SNF Consolidated Billing**. Observing that prior work has identified a significant amount of improper claims and reimbursement in this area, the OIG will continue to examine whether providers and suppliers are complying with the consolidated billing rules. Specifically, the OIG will review Part B claims submitted by suppliers for items, supplies or services provided during nursing home stays covered by Part A.
- **Accuracy of Coding for Medicare SNF RUG Claims**. The OIG will review a national sample of SNF claims to assess whether the Resource Utilization Groups (RUG) included on the claims are accurate and supported by the residents' medical records. In a 2006 report, the OIG found that 22% of claims were upcoded.
- **Calculation of Medicare Benefit Days**. To ensure that beneficiaries' benefit periods are properly tracked, the OIG will review whether SNFs are submitting no-pay bills as required. SNFs must submit a bill to Medicare for a beneficiary who has started a spell of illness under the Part A benefit for every month of the related stay, even though no benefits may be payable for those months. SNFs must also submit no-pay bills for beneficiaries who previously received Medicare-covered skilled care and subsequently dropped to a noncovered level of service, but who continue to reside in Medicare-certified areas of the facility.
- **Nursing Facility Ownership**. The OIG plans to review ownership structures at investor-owned nursing homes. The OIG noted that nursing facilities are increasingly being purchased by private equity or other for-

profit investor firms, which may implement complex ownership structures leaving the operators of a nursing facility with no assets. The OIG is also concerned that the new owners may reduce staffing levels and take other cost-cutting initiatives to increase profit at the expense of quality of care. The OIG seeks to determine which entities benefit from Medicaid reimbursement and study effects on the quality of care when nursing home ownership changes to an investor firm.

3. Areas of Concern for Hospices

- **Hospice Care for Nursing Home Residents**. Continuing its concern regarding hospice services provided to nursing home residents, the OIG stated that it will conduct medical record reviews to assess whether nursing home residents receive hospice services that are consistent with their plans of care and whether payments are appropriate.
- **Physician Billing for Medicare Hospice Beneficiaries**. The OIG will review the extent of Part B billing for physician services provided to beneficiaries who have elected the Medicare hospice benefit. The OIG intends to identify whether physicians double-billed hospice services to Part A and Part B.

Medicare and Medicaid providers face a vast array of regulations governing all aspects of reimbursement, the services they provide and their business arrangements. In addition to knowing the substance of these laws, it is important for providers to understand how these laws are enforced, and the particular areas that may present high compliance risks. In addition to other OIG reports and compliance guidelines, the OIG Work Plan offers providers a view of some of the current issues that the OIG perceives as risks and intends to address. By reviewing the government's enforcement policies and actual practices, providers can understand the current enforcement climate and avoid traps for the unwary. If you have any questions regarding the issues raised in the 2009 OIG Work Plan, or other health care compliance issues, please feel free to contact one of Reinhart's health care attorneys.

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