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October 27, 2011

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OIG's 2012 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) 2012 Work Plan [PDF] on October 5, 2011. The OIG Work Plan provides an overview of what the OIG will focus on in the coming year. It gives providers insight into the areas that the OIG believes are susceptible 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. It has been divided into "new" and "continuing" initiatives based on whether the issue was previously addressed in the FY 2011 Work Plan or whether it is a new focus.

Hospitals

New Initiatives

Accuracy of Present-on-Admission Indicators Submitted on Medicare Claims: Beginning in FY 2008, CMS required hospitals to submit present-on-admission (POA) indicators with each diagnosis code on Medicare hospital inpatient claims. These indicators help differentiate between conditions that developed during the hospital stay and conditions that were present on admission. Pursuant to the Affordable Care Act, § 3008, hospitals with high rates of hospital-acquired conditions (HAC) will receive reduced Medicare payments. To implement the requirements of the Affordable Care Act, the OIG plans to review the accuracy of POA indicators.

Medicare Inpatient and Outpatient Payments to Acute Care Hospitals: Prior OIG audits, investigations, and inspections have identified areas that are at risk for noncompliance with Medicare billing requirements. In 2012, 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.

Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care: The OIG plans to review Medicare claims for inpatient stays in which the beneficiary was transferred from an acute care hospital to hospice care. The OIG plans to further examine the financial and ownership relationships 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.

Inpatient Rehabilitation Facilities: Inpatient rehabilitation facilities (IRFs) provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program. Regulations stipulate that patients must undergo preadmission screening and evaluation to ensure that they are appropriate candidates for IRF care. 42 CFR § 412.622(a). The OIG has signaled its intention to examine the appropriateness of admissions to IRFs as well as the level of therapy being provided in the facilities.

Critical Access Hospitals: Citing limited information about the structure of critical access hospitals (CAH) and the types of services they provide, the OIG will review CAHs to profile variations in size, services, and distance from other hospitals. The OIG will also study the number and types of patients that CAHs treat.

Continuing Initiatives

Hospital Reporting for Adverse Events: The OIG will continue to review the information that hospitals' internal incident-reporting systems capture about adverse events. Specifically, the OIG is interested in the extent to which these systems captured adverse events and reported the information to external patient-safety oversight entities. The OIG will rely on data collected for a 2010 OIG study of adverse events.

Reliability of Hospital-Reported Quality Measure Data: The Social Security Act, § 1886(b)(3)(B)(vii), requires hospitals to report quality of care measures for a set of 10 indicators established by the Secretary as of November 1, 2003. Noting that the Affordable Care Act expands the existing quality initiative, the OIG plans to review hospitals' controls for ensuring the accuracy and validity of data related to quality of care that they submit to CMS for Medicare reimbursement.

Hospital Admissions With Conditions Coded Present on Admission: The OIG will continue to review Medicare claims to determine which types of facilities most frequently transfer patients with certain diagnoses that were coded as being present on admission. The OIG also plans to investigate whether specific providers transferred a high number of patients with present on admission diagnoses.

Hospital Inpatient Outlier Payments: Trends and Hospital Characteristics: Noting that recent whistleblower lawsuits have resulted in millions of dollars in settlements from hospitals charged with inflating Medicare claims to qualify for outlier payments, the OIG will continue to review hospital inpatient outlier payments, examine trends of outlier payments nationally, and identify characteristics of hospitals with high or increasing rates of outlier payments.

Medicare's Reconciliations of Outlier Payments: In 2012, the OIG will continue its efforts to review Medicare outlier payments. The OIG is seeking to determine whether CMS performed the necessary reconciliations in a timely manner so that Medicare contractors could perform final settlement of the associated cost reports submitted by providers. Outlier payment reconciliations must be based on the most recent cost-to-charge ratio from the cost report to properly determine outlier payments.

Hospital Claims With High or Excessive Payments: Previous OIG studies have revealed that Medicare hospital claims with unusually high payments may be incorrect for various reasons. Consequently, the OIG plans to review three categories of claims to determine whether they were appropriate: Medicare hospital claims with high payments, outpatient claims in which payments exceeded

charges, and selected Healthcare Common Procedure Coding System codes for which billings appear to be aberrant. The OIG will also review the efficacy of the claims processing system edits used to identify excessive payments.

Hospital Same-Day Readmissions: CMS implemented an edit (a special system control) in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. The OIG will review Medicare claims to determine trends in the number of same-day hospital readmission cases, and will also test the effectiveness of the edit. The OIG notes that this work may be helpful to CMS in implementing provisions of the Affordable Care Act.

Duplicate Graduate Medical Education Payments: Medicare pays teaching hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs. Medicare may not count any intern or resident as more than one full-time equivalent employee when calculating payments for DGME and IME costs. The OIG will review provider data from CMS's Intern and Resident Information System (IRIS) to assess whether duplicate or excessive graduate medical education (GME) payments have been claimed.

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 report data on the occupational mix of their employees every three years. These data are used to construct an occupational-mix adjustment to CMS's hospital wage indexes. The OIG plans to continue evaluating the accuracy of the data reported by hospitals, and whether the data comply with Medicare regulations.

Inpatient and Noninpatient Prospective Payment Systems: Hospital Payments for Nonphysician Outpatient Services: Previous OIG studies have revealed a significant number of improper claims for nonphysician outpatient services provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals and non-IPPS hospitals. The OIG plans to continue its scrutiny of these claims in 2012.

Medicare Brachytherapy Reimbursement: Brachytherapy is a form of radiotherapy in which a radiation source is placed inside or next to the area requiring treatment. In 2012, the OIG plans to review Medicare payments for brachytherapy to assess compliance with Medicare requirements.

Medicare Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices: The OIG plans to investigate whether hospitals have complied with Medicare regulations when submitting inpatient and outpatient claims that include procedures for the insertion of replacement medical devices. Medicare is not responsible for the full cost of a replaced medical device when the hospital receives a partial or full credit from the manufacturer under a warranty or due to a recall.

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.

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.

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.

Physicians

New Initiatives

Physicians and Other Suppliers: High Cumulative Part B Payments: Previous OIG work has shown that unusually high Medicare payments may indicate incorrect

billing or fraud and abuse. In 2012, the OIG plans to review the efficacy of payment systems controls that identify high cumulative Medicare Part B payments to physicians and suppliers.

Physicians: Incident-To Services: Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. The OIG believes that incident-to services represent a program vulnerability because they do not appear in claims data, can only be identified by reviewing the medical record, and may expose Medicare beneficiaries to care that does not meet professional standards of quality. In 2012, 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."

Physicians: Impact of Opting Out of Medicare: The OIG plans to review the extent to which physicians are opting out of Medicare. The OIG will also examine whether physicians who have opted out of Medicare are submitting claims to Medicare, and whether specific areas of the country have seen higher numbers of physicians opting out. Finally, the OIG is also interested in the potential impact of opting out on beneficiaries.

Ambulatory Surgical Centers and Hospital Outpatient Departments: Safety and Quality of Surgery and Procedures: The proportion of surgeries and procedures performed in ambulatory surgical centers has increased dramatically over the past decade. CMS and other stakeholders have expressed an interest in the comparative safety and quality of care provided by ambulatory surgical centers and Hospital Outpatient Departments (HOPDs). Consequently, the OIG will review the safety and quality of care for Medicare beneficiaries having surgeries and other procedures in ambulatory surgical centers and HOPDs.

Evaluation and Management Services: Use of Modifiers During the Global Surgery Period: Noting that improper use of modifiers during the global surgery period often results in inappropriate payments, the OIG plans to review the appropriateness of

the use of certain claims modifier codes during the global surgery period. The OIG is seeking to determine whether Medicare payments for claims with modifiers used during the global surgery period were in accordance with Medicare requirements.

Continuing Initiatives

Physicians and Suppliers: 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.

Physicians: 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.

Ambulatory Surgical Centers: Payment System: In 2012, the OIG will continue to review the appropriateness of Medicare's methodology for setting ambulatory surgical center payment rates under the revised payment system.

Evaluation and Management Services: Trends in Coding of Claims: Noting that Medicare paid $32 billion for Evaluation and Management services in 2009, the OIG will continue to review Evaluation and Management claims to identify trends in the coding of these services as well as providers that exhibited questionable billing.

Evaluation and Management Services Provided During Global Surgery Periods: In 2012, the OIG will continue to examine industry practices related to the number of evaluation and management services provided by physicians and reimbursed as

part of the global surgery fee to determine whether the practices have changed since the global surgery fee concept was developed in 1992.

Evaluation and Management Services: Potentially Inappropriate Payments: The OIG will continue to review payments for evaluation and management services. Specifically, the OIG plans to assess the extent to which CMS made potentially

inappropriate payments for these services, and the consistency of medical review determinations.

Part B Imaging Services: Medicare Payments: In 2012, the OIG will continue its review of Medicare payments for Part B imaging services. The OIG seeks to determine whether the payments reflect the expenses incurred and whether the utilization rates reflect industry practices. The OIG will specifically focus on the practice expense components, including the equipment utilization rate, for selected imaging services.

Diagnostic Radiology: Excessive Payments: The OIG plans to review Medicare payments for high-cost diagnostic radiology 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 specialists for the same treatment.

Trends in Laboratory Utilization: Noting that Medicare paid approximately $7 billion for clinical laboratory services in 2008, 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 Part B Claims with G Modifiers: Pursuant to CMS's Medicare Carriers Manual, the GA and GZ modifier are to be used for coding services that providers expect Medicare to deny as not reasonable or necessary. A recent OIG review found that Medicare may be making potentially inappropriate payments for claims with GA or GZ modifiers. The OIG will examine the appropriateness of providers' use of these modifiers and the extent to which Medicare paid claims having such modifiers.

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. The OIG will also examine CMS's

oversight mechanisms to identify and prevent improper payments for services based on orders or referrals by excluded providers.

Medical Claims Review at Selected Providers: The OIG will continue to review Medicare Part A and Part B claims submitted by error-prone providers. The OIG plans to use CMS's Comprehensive Error Rate Testing (CERT) Program data to identify the top error-prone providers, determine the validity of claims submitted by these providers, project the results to each provider's population of claims, and recommend that CMS request refunds on projected overpayments.

Ober|Kaler's Comments

As in the past, hospitals and physicians should use the OIG's workplan as a tool to identify areas that may be appropriate for internal compliance reviews.