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# The OIG's 2009 Work Plan — What's in it for Long-term Care & Community-based Providers?

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Providers conducting annual updates to their compliance plans should consider, among other available guidance, the Department of Health and Human Services, Office of the Inspector General's (OIG) focus areas set forth in the OIG's fiscal year (FY) 2009 Work Plan.

In a previous issue of *Payment Matters*, we discussed the **release by the OIG of its FY 2009 Work Plan** and, specifically, the provisions within the Work Plan that will affect hospital providers. We now focus on the Work Plan provisions that address perceived issues involving home health agencies, nursing homes, hospice providers, and other providers rendering services in these long-term care settings. These provisions are summarized below.

## Home Health Agencies

### New Initiatives:

- *Physician Referrals for Home Health Agency (HHA) Services*: The OIG will review Medicare payments for HHA services to identify potentially aberrant billing by referring physicians. The OIG notes that HHAs must have a plan of care for each patient that is established and certified by a physician, and home health care claims must also include an attending/referring physician identifier.

- *Medicare Home Health Payments for Insulin Injections*: The OIG will review billing patterns in geographic areas with high rates of home health visits for insulin injections to determine the appropriateness of services billed, including review of outlier payments made under the Medicare home health benefit for such services.

- *Comprehensive Error Rate Testing Program - FY 2008 HHA Claims Error Rate*: The OIG will review a statistical subsample of the HHA claims reviewed under the Centers for Medicare and Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) program. Under the

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Improper Payments Information Act of 2002, federal agencies are required annually to develop a statistically valid estimate of improper payments made under federal programs. The OIG will review the subsample of HHA claims to determine whether payments for services and items, such as skilled nursing, therapy, and medical supplies were appropriately documented, medically necessary and coded properly.

### Continuing Initiatives:

- *Part B Therapy Payments for Home Health Beneficiaries*: The OIG will continue to evaluate Part B payments for therapy services, which are supposed to be included as part of the HHA prospective payments. The OIG will identify Part B payments made to outside suppliers on behalf of beneficiaries in home health episodes and examine the adequacy of controls established to prevent inappropriate payment.

- *Accuracy of Coding and Claims for Medicare Home Health Resource Groups*: The OIG will continue to review Medicare claims submitted by HHAs to determine the accuracy of home health resource group (HHRG) billing codes and whether the HHRG billing code selected is fully supported by documentation in the medical record. The OIG will also evaluate the accuracy of HHRG assignments and look for any potential patterns of upcoding by HHAs.

- *Medicaid HHA Claims*: The OIG will continue to review Medicaid HHA claims to determine whether providers have met the applicable criteria to provide services, including, among other things, minimum staffing levels, proper licensing, review of service plans of care, and proper authorization of services. The OIG will also evaluate whether beneficiaries meet eligibility criteria.

## Nursing Homes

### New Initiatives:

- *Calculation of Medicare Benefit Days*: The OIG will review no-pay bills submitted by Medicare skilled nursing facilities (SNFs) for patients on Part A stays (and related non-covered stays) to determine whether the failure of SNFs to submit no-pay bills contributes to inappropriate calculations of SNF eligibility periods. The OIG will also review CMS' oversight mechanisms for ensuring that no-pay bills are submitted by SNFs.

- *Oversight of Nursing Home Minimum Data Set (MDS) Data*: The OIG will evaluate CMS' mechanisms for ensuring that nursing homes submit accurate and complete MDS data, which is data relating to the resident's physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. MDS-based quality performance information appears on CMS' Nursing Home Compare Website.

- *Nursing Home Residents Aged 65 or Older Who Received Antipsychotic Drugs*: The OIG will review Medicare Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents to determine the extent to which the drugs are being used as inappropriate "chemical restraints," i.e., being prescribed in the absence of conditions approved by the Food and Drug Administration.

- *Medicaid Payments to Nursing Homes While Dual-Eligible Beneficiaries Received Covered Medicare Part A Services*: The OIG

will review Medicaid payments made to nursing homes for dual-eligible beneficiaries while the beneficiaries were receiving Medicare Part A services (e.g., hospital or SNF stays).

- *Transparency Within Nursing Facility Ownership*: Noting that nursing homes are increasingly being purchased by private equity or other for-profit investment firms, the OIG will review the ownership structures at investor-owned nursing homes to determine which entities are benefiting from Medicaid reimbursement and study the effects of ownership changes, including potential reductions in staffing levels and other cost-cutting measures.

- *Plans of Care — Addressing MDS and Resident Assessment Protocols Through Provided Services*: The OIG will review nursing homes' use of federally required MDS and Resident Assessment Protocols to develop nursing home residents' plans of care and to guide the provision of appropriate and necessary care.

- *States' Use of Civil Monetary Penalty (CMP) Funds*: The OIG will review the amounts that States have received from CMP funds and the States' use of CMP funds to determine whether States are appropriately applying CMP funds to programs that protect the health and welfare of nursing home residents.

- *Payments for "Bed Holds"*: The OIG plans to assess the appropriateness of Medicaid payments for "bed holds," including whether CMS and the States have provided appropriate oversight of compliance with bed hold policies and proper reporting of bed hold days.

### Continuing Initiatives:

- *SNF Consolidated Billing*: Continuing prior OIG work, the OIG is determining whether controls are in place to preclude duplicate billings under Medicare Part B for services covered under the SNF prospective payment system and is assessing the effectiveness of Common Working File edits to prevent and detect improper payments.

- *Accuracy of Coding for Medicare SNF Resource Utilization Groups' (RUGs) Claims*: Noting that a 2006 OIG report found that 22 percent of Medicare claims submitted by SNFs were upcoded, the OIG plans to continue evaluating a national sample of Medicare claims submitted by SNFs to determine whether the RUGs included on the claims were accurate and supported by the beneficiaries' medical charts.

- *Part B Services in Nursing Homes*: The OIG is continuing its review of Part B services provided in SNFs for residents whose stays are no longer covered under Part A. The OIG is evaluating the extent of Part B services provided to SNF residents in 2006 and look for patterns of billing by SNFs and other providers. In addition, the OIG is conducting a closer review of several types of Part B services, such as durable medical equipment (DME) and enteral nutrition therapy (ENT), discussed below.

- *ENT*: The OIG will review the medical necessity, adequacy of documentation and coding accuracy of Part B claims submitted for ENT provided to Medicare beneficiaries residing in nursing homes that are not covered under the Part A SNF benefit.

- *Part B Pricing of Enteral and Parenteral Nutrients*: The OIG is comparing Medicare's fee schedule for enteral and parenteral nutrients with prices available to other purchasers, such as nursing homes and

HHAs.

- *DME*: Noting that a previous OIG report found that $210 million was potentially inappropriately paid for DME for beneficiaries residing in nursing home, the OIG will continue its review of Medicare Part B DME payments allowed for items and supplies provided to beneficiaries in nursing homes.

- *Part B Services in Nursing Homes*: Mental Health and Psychotherapy Services: The OIG is continuing its review of the medical necessity, appropriateness of coding and documentation of Medicare Part B payments for psychotherapy services provided to nursing home residents during noncovered Part A stays.

- *Payments for Drugs Under Medicare Part D During Part A Skilled Nursing Stays*: The OIG is continuing to examine the extent to which payments for drugs are being made under Part D while Medicare beneficiaries are covered for such drugs during a Part A SNF stay.

## Hospice Care

### New Initiatives:

- *Physician Billing for Medicare Hospice Beneficiaries*: The OIG will examine payments made for physician services provided to Medicare hospice beneficiaries. Specifically, the OIG will determine the frequency at which such services are billed under both Part A and Part B, and the total expenditures for such services. The OIG anticipates that CMS is being double-billed for hospice services under Part A and Part B.

- *Trends in Medicare Hospice Utilization*: Noting that the number and types of diagnoses associated with hospice utilization have increased, and that longer stays have become more common since Congress eliminated the limitation on coverage days for hospice care in 1997, the OIG plans to examine the characteristics of hospice beneficiaries, geographic variations in utilization and differences between for-profit and non-profit hospice providers.

### Continuing Initiatives:

- *Hospice Payments to Nursing Facilities*: The OIG has determined that nursing home patients receive 46 percent fewer nursing and aide services from hospice staff than home hospice patients, and is concerned about the appropriateness of the arrangements hospices have with nursing facilities. The OIG is conducting a medical record review of a sample of beneficiaries to evaluate the beneficiaries' plans of care and determine whether treatment provided is consistent with the beneficiary's plan of care and whether payments were appropriate.

## Miscellaneous Medicaid Providers

### New Initiatives:

- *Community Transition Services Provided to Medicaid Home- and Community-Based Services (HCBS) Waiver Beneficiaries*: The OIG will analyze the types and costs of community transition services provided by States to Medicaid HCBS beneficiaries. These services assist Medicaid beneficiaries in their transition from institutional care to living

at home or in the community.

## Continuing Initiatives:

- *Community Residence Rehabilitation Services*: The OIG will continue to evaluate Medicaid payments made for beneficiaries who reside in community residences for persons with mental illness to determine whether States improperly claimed federal financial participation (FFP).
- *Targeted Case Management Services*: The OIG is continuing its review of Medicaid payments made for targeted case management services, which are services that assist individuals eligible under the State plan to gain access to needed medical and other services.
- *Medicaid Payments for Personal Care Services*: The OIG will continue to review Medicaid payments made for personal care services to determine whether States have appropriately claimed FFP. Personal care services must be authorized by a physician in accordance with a plan of treatment and is covered only for individuals who are not inpatients or residents of hospitals, nursing homes, or intermediate care facilities.
- *Medicaid Payments for Medicare-Covered Home Health Services*: The OIG will continue to determine in selected States the extent to which both Medicare and Medicaid have paid for the same home health care services.
- *Compliance with States' Requirements for Medicaid-Funded Personal Care Service Attendants*: The OIG will continue to examine whether personal care service attendants have met their State-established qualifications.
- *State and Federal Oversight of HCBS Provided in Assisted Living Facilities*: The OIG will continue to review the extent to which States are complying with federal regulations for HCBS waiver programs, including assuring that necessary safeguards are in place to protect the health and welfare of recipients. The OIG will further evaluate CMS' processes for monitoring the States' compliance with the requirements.
- *Medicaid Adult Health Service Payments for Ineligible and Absent Beneficiaries*: Noting that prior review has revealed that Adult Day Care facilities were billing Medicare for deceased patients, patients who did not require center services, and patients who attended the facility for only a fraction of the time authorized by statute, the OIG will continue to identify whether payments are being improperly made to Adult Day Care facilities on behalf of ineligible individuals.