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Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

OIG's 2013 Work Plan – What Should Hospital and Physician Providers Expect in the Coming Year?

By: Lisa D. Stevenson

The Department of Health and Human Services, Office of the Inspector General (OIG) released its Fiscal Year (FY) 2013 Work Plan [PDF] on October 2, 2012. The OIG Work Plan is released annually and identifies what the OIG will be focusing on in the coming year, providing a roadmap to potential risk areas.

This is the first of two articles highlighting 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 addressed in last year's Work Plan or whether it is a new focus.

Hospitals

New Initiatives

Diagnosis Related Group (DRG) Window: Currently, Medicare bundles all outpatient services delivered 3 days prior to an inpatient hospital admission (known as the "DRG window"). The OIG notes that if the DRG window was expanded from 3 to 14 days CMS could realize significant savings. The OIG plans to analyze claims data to determine exactly how much CMS would save if it increased the DRG window to 14 days.

Non-Hospital-Owned Physician Practice Using Provider-Based Status: In response to the Medicare Payment Advisory Commission's concerns about the financial incentives presented by provider-based status, the OIG plans to analyze whether non-hospital-owned physician practices billing under a provider-based status meet the applicable CMS requirements.

Inpatient Billing for Medicare Beneficiaries: Noting Medicare paid hospitals $100 billion for inpatient stays in 2012, the OIG plans to examine Medicare billing variations of inpatient stays from fiscal years 2008 to 2012. The OIG also plans to look at how hospitals comply with Medicare inpatient billing requirements.

Hospital Compliance With Medicare's Transfer Policy: The OIG will examine payments made to hospitals for beneficiary discharges that should have been classified as transfers and the extent to which these claims were appropriately processed and paid.

Hospital Payments for Discharges to Swing Beds in Other Hospitals: The OIG plans to review CMS's policy related to payment for hospital discharges to swing beds in another hospital. Currently, in order to deter hospitals from discharging patients too early, Medicare pays a smaller amount for shorter stays when beneficiaries are transferred to another prospective payment system hospital. Medicare, however, pays the full DRG amount if the beneficiary is discharged to another hospital's swing bed (beds that can be used interchangeably for either acute care or skilled nursing services).

Payments for Canceled Surgical Procedures: The OIG plans to look at the costs associated with Medicare's payment of inpatient hospital claims for cancelled surgical procedures, particularly where the same hospital received higher payments for rescheduled surgical procedures.

Payments for Mechanical Ventilation: The OIG plans to review Medicare payments for mechanical ventilation to determine whether the DRG assignments and resultant payments were appropriate. Specifically, the OIG plans to review

select Medicare payments to determine whether hospitals provided the minimum 96 hours of mechanical ventilation, required for certain DRG payments to qualify for coverage.

Quality Improvement Organizations' Work With Hospitals: The OIG plans to review the extent to which Quality Improvement Organizations have worked with hospitals to conduct quality improvement projects or provide technical assistance to help improve efficiency, effectiveness, economy, and quality of services.

Hospital Acquisitions of Ambulatory Surgical Centers: The OIG plans to determine how hospitals' acquisition of Ambulatory Surgical Centers and subsequent conversion to outpatient hospital departments impacts reimbursement of services and beneficiary cost sharing.

Critical Access Hospitals — Payments for Swing-Bed Services: The OIG will investigate whether the current swing bed payment policy, which allows critical access hospitals to receive reimbursement equal to 101% of reasonable costs for patient care provided in swing beds, should be adjusted to "a more cost-effective payment methodology" when patients are provided the same level of care at traditional skilled nursing facilities.

Long-Term-Care Hospitals (LTCHs) — Payments for Interrupted Stays: Noting prior OIG work identifying vulnerabilities in CMS's ability to detect readmission and appropriate pay for interrupted stays, the OIG plans to determine the extent to which Medicare made improper payments for interrupted stays in LTCHs, identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay period.

Continuing Initiatives

Hospital Same-Day Readmissions: The OIG will continue to 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.

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.

Medicare Inpatient and Outpatient Payments to Acute Care Hospitals: The OIG will continue to 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.

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: 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.

Duplicate Graduate Medical Education Payments: The OIG will continue to 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: The OIG will continue evaluating the accuracy of data reported by hospitals on the occupational mix of their employees, and determine whether the data complies with Medicare regulations.

Medicare Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices: The OIG will continue 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.

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.

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.

Inpatient Rehabilitation Facilities (IRF) — Appropriateness of Admission and Level of Therapy: The OIG will continue to examine the appropriateness of admissions to IRF as well as the level of therapy being provided in the facilities. The OIG will also 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.

Physicians

New Initiatives

Anesthesia Services — Payments for Personally Performed Services: The OIG will be checking claims submitted with modifier "AA" (used for anesthesia

services personally performed by an anesthesiologist and reimbursed at 100 percent of the physician fee schedule) to determine whether they met Medicare requirements.

Opthalmological Services: The OIG will review Medicare claims data for ophthalmological services during 2011 to identify questionable billing practices.

Improper Use of Commercial Mailboxes: The OIG plans to review 2011 enrollment data to determine the extent to which the practice location addresses of Medicare Part B providers and suppliers were actually commercial mailbox addresses, rather than an address of a physical practice location.

Payments to Providers Subject to Debt Collection: The OIG plans to review providers/suppliers that received Medicare payments after CMS referred them to the Treasury for failing to refund overpayments and determine the extent to which they may have billed under a different Medicare number.

Continuing Initiatives

High Cumulative Part B Payments: Noting previous OIG work showing that unusually high Medicare payments may indicate incorrect billing or fraud and abuse, the OIG plans to continue to review the efficacy of payment systems controls that identify high cumulative Medicare Part B payments to physicians and suppliers.

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

Ambulatory Surgical Centers and Hospital Outpatient Departments: Safety and Quality of Surgery and Procedures: The OIG will continue to review the safety and quality of care for Medicare beneficiaries having surgeries and other procedures in ambulatory surgical centers and Hospital Outpatient Departments.

Part B Imaging Services: Medicare Payments: The OIG will continue its review of Medicare payments for Part B imaging services 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 will continue 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 continue to 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.

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: Incident-To Services: The OIG will continue to 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.

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 and hospital outpatient departments.

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 continue to review the appropriateness of the use of certain claims modifier codes during the global surgery period.

Medicare Payments for Part B Claims with G Modifiers: The OIG will continue to examine the extent to which Medicare improperly paid for claims with a G Modifier (used to indicate that the provider expected that the claim would be denied).

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.

Medical Claims Review at Selected Providers: The OIG plans to continue 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.

Federally Excluded Providers: The OIG will continue to investigate whether States properly terminate providers that have been terminated under Medicare or by another state and the extent to which payments were made for services rendered during periods of exclusion.

Ober|Kaler's Comments

Hospital and physician providers should evaluate their compliance programs to determine if the current program should be modified to incorporate any of the OIG focus areas for 2013.