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## The 2010 OIG Work Plan

CLIENT ADVISORY

The Office of the Inspector General (“OIG”) recently published its 2010 Work Plan. Each year, the OIG identifies Health and Human Services (“HHS”) programs that are vulnerable to fraud, waste or abuse; or that can be improved to further promote economy, efficiency and effectiveness. The OIG then develops a Work Plan that addresses the areas and issues the OIG intends to audit, evaluate and inspect during the upcoming fiscal year. The Work Plan is a useful tool for identifying areas and issues that may evolve into future OIG enforcement activities. Health care providers should consider Work Plan priorities when examining their own operations.

While past Work Plans have focused on addressing long-standing topics, in the 2010 Work Plan, the OIG turns a large share of its attention to more recent and emerging issues. In addition, the Work Plan spotlights the OIG’s investigative and legal capabilities with regard to prevention of fraud and abuse.

Here are some of the 2010 Work Plan highlights.

### **I. New Projects for 2010**

The OIG plans to take the following actions, with respect to each of the following types of providers:

#### ***Hospitals.***

- Analyze the appropriateness of payments for non-physician outpatient services that were provided shortly before or during Medicare Part A-covered stays at acute care hospitals.

- Review Medicare payments for inpatient rehabilitation facilities (“IRFs”) stays in which patient assessments were transmitted to the Centers for Medicare & Medicaid Services (“CMS”) late, and determine whether payments were made correctly. Additionally, the OIG will review IRF claims to determine whether patient assessments were submitted in accordance with Medicare regulations.
- Review Medicare claims to determine the number of inpatient hospital admissions for which certain diagnoses were coded as being present when patients were admitted to the hospitals (referred to as diagnoses present on admission (“POA”)), and determine which of the diagnoses were most frequently coded as POA. Additionally, the OIG will determine which types of facilities are most frequently transferring patients with a POA diagnosis specified by CMS to hospitals, and whether specific providers transferred a high number of patients to hospitals with POA diagnoses.
- Review Medicare claims to determine trends in the number of hospital readmission cases. In addition, the OIG will test the effectiveness of the edit (which providers may override, in certain situations) which combines the original and subsequent stays for a same-day readmission into a single claim, and allows only one diagnosis-related group payment. The OIG will also determine the extent of oversight in readmissions cases.



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- Review CMS's oversight of hospitals' compliance with the Emergency Medical Treatment and Labor Act of 1986 ("EMTALA").
- Review Medicare payments for observation services provided during outpatient visits in hospitals. Additionally, the OIG will assess whether and to what extent hospitals' use of observation services affects the care Medicare beneficiaries receive, and their ability to pay out-of-pocket expenses for health care services.

### ***Home Health Agencies.***

- Review Part B payments for services and medical supplies provided to beneficiaries in home health episodes. The OIG will also determine the appropriateness of payments to outside suppliers for services and medical supplies that are included in the HHA prospective payment.

### ***Nursing Homes.***

- Review CMS's and States' use of enforcement measures to determine their impact on improving the quality of care beneficiaries received in poorly performing nursing homes and the performance of these nursing homes. The OIG will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement plans of correction.

### ***Providers Working with Suppliers of Durable Medical Equipment and Supplies.***

- Determine the allowability of physician self-referrals to durable medical equipment ("DME") suppliers in which physicians hold ownership interests.

### ***Medicaid Hospitals.***

- Review policies adopted by State Medicaid programs related to adverse events, including events designated in CMS's list of hospital-

acquired conditions. The OIG will examine the characteristics and implementation of State policies and explore their potential impact on the Medicaid program and its beneficiaries.

### ***Medicaid Home, Community and Nursing Home Care.***

- Review Medicaid data to identify nursing facilities that may have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions, including those for diagnoses of pressure sores, infections, or both.

## **II. Continuing Projects from Previous Work Plans**

In addition to these new initiatives, the OIG will continue to focus on previously identified priorities with regard to various providers. The OIG plans, with respect to each of the following types of providers, to:

### ***Hospitals.***

- Review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities to determine the appropriateness of the provider-based designation.
- Review payments made to Critical Access Hospitals ("CAHs") to determine whether CAHs have met the CAH designation criteria and have satisfied regulatory conditions of participation; and to determine whether payments made to CAHs were in accordance with Medicare requirements.
- Review provider data from CMS's Intern and Resident Information System ("IRIS") to determine whether duplicate graduate medical education payments have been claimed. In addition, the OIG will assess the effectiveness of IRIS in preventing providers from receiving payments for duplicate graduate medical education costs.
- Review Medicare bad debts



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claimed by acute care inpatient hospitals, long term care hospitals ("LTCH"), inpatient rehabilitation facilities, inpatient psychiatric facilities and skilled nursing facilities ("SNFs") to determine whether they were reimbursable; and whether recoveries of prior year writeoffs were properly used to reduce the cost of beneficiary services for the period in which the recoveries were made.

- Review Medicare payments for beneficiaries who have other insurance to ensure Medicare is billed as the secondary payer where required.
- Conduct various reviews of adverse events, including:
  - Review of adverse health care events among Medicare beneficiaries in inpatient hospital settings to facilitate: estimation of the national incidence of such events; identification of types of adverse events experienced by Medicare beneficiaries in hospital settings; and assessment of the extent to which serious reportable events and other adverse events were preventable as determined by a panel of physicians with expertise in patient safety.
  - Examination of various methods for identifying adverse health care events, including examination of the following methods to assess their utility: medical records reviews by nurses and physicians; administrative data analysis using Agency for Healthcare Research and Quality ("AHRQ") patient safety indicators and POA indicators; hospital incident reports and interviews with Medicare beneficiaries or their representatives.
  - Review of CMS's administrative processes for identifying hospital-acquired conditions and denying higher Medicare reimbursement for related care.
- Review of responses of state survey and certification agencies, State licensure boards, and Medicare accreditors to adverse events in hospitals in order to identify opportunities for Medicare oversight committees to improve the quality of oversight and response to adverse events.
- Review of policies and practices of CMS and selected patient safety organizations for disclosing information about adverse health care events as well as associated protections intended to ensure patient privacy.
- Review a sample of Medicare Part B paid claims and medical records for diagnostic x rays performed in hospital emergency departments to determine the appropriateness of payments.

### ***Nursing Homes.***

- Review Medicare Part B payments for psychotherapy services provided to nursing home residents during noncovered Medicare Part A SNF stays; determine the medical necessity of services, appropriateness of coding and adequacy of nursing home documentation.
- Assess how SNFs have addressed certain Federal requirements related to quality of care. Specifically, the OIG plans to determine the extent to which SNFs: (1) developed plans of care based on assessments of beneficiaries, (2) provided services to beneficiaries in accordance with these plans of care, and (3) planned for beneficiaries' discharges.

- Review SNF claims for Medicare reimbursement to determine the



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accuracy of Resource Utilization Groups (RUG) coding. OIG will also explore other opportunities to improve the accuracy of payments to SNFs.

### ***Providers Working with Suppliers of Durable Medical Equipment and Supplies.***

- Review the appropriateness of Medicare Part B payments to DME suppliers that submitted claims with modifiers.

### ***Medicaid Hospitals.***

- Review whether States appropriately determined provider eligibility for Medicaid reimbursement.

### ***Medicaid Home, Community, and Nursing Home Care.***

- Review ownership structures at investor-owned nursing homes. The OIG will determine which entities are benefiting from Medicaid reimbursement and study the effects of these types of ownership changes on the care received by beneficiaries in nursing homes.

### ***Medicare Providers, Generally.***

- Review CMS's oversight of Recovery Audit Contractors ("RACs") during a 3-year demonstration program to determine the extent to which RACs, which are responsible for identifying Medicare overpayments and underpayments, also identified and reported potential fraud and abuse to CMS.

### **III. Investigative and Legal Activities Related to Centers for Medicare & Medicaid Services, Programs and Operations**

The OIG conducts health care investigations and legal activities that span the Medicare and Medicaid programs. This year, the OIG has described its intentions for implementing these activities in the OIG Work Plan. In 2010, the OIG will continue to focus attention on:

- Investigating individuals, facilities or entities that bill or are alleged to have billed Medicare and/or Medicaid for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts and false claims submitted to obtain program funds.

- Excluding individuals from participation in Medicare, Medicaid and all other Federal health care programs to protect the programs and beneficiaries from providers that pose a risk. Providers are excluded for reasons that include program-related convictions, patient abuse or neglect convictions and licensing board disciplinary actions.

- Encouraging health care providers to promptly self-disclose improper conduct that violates Federal health care program requirements. (The self-disclosure protocol is designed only for providers that believe a violation of law has occurred. Matters exclusively involving overpayments or errors that do not indicate violations of the law should be brought directly to the attention of the entity responsible for claim processing and payment.)

- Working closely with prosecutors from the Department of Justice ("DOJ") to develop and pursue Federal false claims cases against individuals and entities that defraud the Government. The OIG will continue to consider whether to invoke its exclusion authority based on defendants' conduct. When appropriate and necessary, the OIG will require defendants to implement compliance measures, in the form of integrity agreements, aimed at insuring future compliance with Federal health care program requirements.

- Assessing the compliance of providers with the terms of Corporate Integrity Agreements ("CIAs") which they entered as part of settlement of fraud and abuse allegations; and, where warranted,



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imposing sanctions on providers that breach their integrity agreement obligations.

- Responding to requests for formal advisory opinions on the application of the anti-kickback statute and other fraud and abuse statutes to particular business arrangements or practices. The OIG will issue special fraud alerts and advisory bulletins, as warranted, to inform the health care industry more generally of particular practices that the OIG determines are suspect.
- Continuing to pursue Civil Monetary Penalties cases, when supported by appropriate evidence, based on the submission of false or fraudulent claims; the offer, payment, solicitation or receipt of kickbacks in violation of the Social Security Act; violations of EMTALA; and other conduct actionable under the Social Security Act, or other CMP authorities delegated to the OIG.

## More Information

Remember, this advisory does not include every initiative described in the 2010 OIG Work plan, and should not be used as a substitute for reviewing the entire plan. If you have any questions about the information contained in the 2010 OIG Work Plan, or if your organization would like assistance in complying other Medicare and Medicaid program requirements, please contact Mary C. Malone, Emily Towey or Rachel J. Suddarth by telephone at (804) 967-9604 or by email at [mmalone@hdjn.com](mailto:mmalone@hdjn.com), [etowey@hdjn.com](mailto:etowey@hdjn.com) or [rsuddarth@hdjn.com](mailto:rsuddarth@hdjn.com). Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at [www.hdjn.com](http://www.hdjn.com).

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