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OIG Work Plan For Fiscal Year 2013

The Office of the Inspector General's (OIG) 2013 Work Plan (collectively the "Work Plan") describes the OIG's enforcement priorities for the upcoming year. This article highlights some of the aspects of the Work Plan that may be of interest to the provider community. Access a complete copy of the Work Plan here.

PART I: MEDICARE PART A AND PART B

Part I of the Work Plan focuses on Medicare billing and payment practices. In addition to hospital focused reviews, the OIG will audit home health service agencies, medical equipment and supply companies, and other providers as part of the Work Plan.

Hospital Reviews

- **Payments for Canceled Surgical Procedures**: A preliminary analysis by the OIG demonstrated many occurrences of an initial Prospective Payment System (PPS) payment to hospitals for a canceled surgical procedure followed by a second, higher PPS payment to the same hospital for the rescheduled surgical procedure. The OIG will evaluate the costs incurred to Medicare due to inpatient hospital claims for canceled surgical procedures.
- **Compliance with Medicare's Transfer Policy**: The OIG will review payments made to hospitals for beneficiary discharges that should have been coded as transfers. The OIG plans to determine whether such claims were appropriately processed and paid and will review the effectiveness of the Medicare Administrative Contractor's claims processing edits that were used to identify the claims that were subject to the transfer policy.
- **Acquisition of Ambulatory Surgical Centers (ASCs)**: The OIG will determine the extent to which hospitals acquire ASCs and convert them into hospital outpatient departments. This review will evaluate whether Medicare reimburses outpatient surgical services performed in hospital outpatient departments at a higher rate than similar services performance in ASCs.
- **Quality Improvement Organizations' Work with Hospitals**: The OIG will review the extent to which Quality Improvement Organizations (QIOs) worked with hospitals and any barriers that QIOs encountered while engaging with hospitals. The purpose of the

review is to evaluate whether QIOs provide proper guidance and promote the efficiency, effectiveness, economy, and quality of services that hospitals perform.

Home Health Services Reviews

- **Home Health Face-to-Face Requirement**: The OIG will determine the extent to which home health agencies (HHAs) are complying with the statutory requirement under the Patient Protection and Affordable Care Act of 2010 (PPACA) that physicians have face-to-face encounters with beneficiaries within 120 days after certifying beneficiaries Medicare eligibility (either 90 days before beneficiaries start home health care or up to 30 days after care begins).
- **Employment of Home Health Aides with Criminal Convictions**: Due to a previous review finding that 92 percent of nursing homes employed at least one individual with at least one criminal conviction, the OIG will now determine the extent to which HHAs are complying with state requirements of conducting criminal background checks for HHA applicants and employees.

Medical Equipment and Supplies Reviews

- **Quality Standards - Accreditation of Medical Equipment Suppliers**: The OIG will review the requirements accreditation organizations use to grant accreditation in order to ensure that medical equipment suppliers meet each of Medicare's quality standards.

Other Provider Reviews

- **Non-Hospital Owned Physician Practices Using Provider-Based Status**: The OIG plans to determine the impact and the extent to which provider practices that are using the provider-based status have met the billing requirements established by the Centers for Medicare and Medicaid Services (CMS).
- **Payments for Medical Ventilation**: The OIG will review the appropriateness of payments made for the use of ventilators to take over active breathing for a patient. The OIG will focus on whether Medicare coverage criteria requiring a minimum of 96 hours of ventilation were met in the cases to be reviewed.
- **Payments for Swing Bed Services**: The OIG will review whether or not they are able to achieve cost savings through a more effective payment method for swing beds that can be used interchangeably for acute care or skilled nursing services. The OIG will compare the reimbursement for swing beds at Critical Access Hospitals to the reimbursement paid to skilled nursing facilities for the same level of care.

PART II: MEDICARE PART C AND PART D

Part II of the Work Plan focuses on Medicare Parts C and D. The reviews planned in Part II of the Work Plan have a strong focus on program integrity and payment practices. Upcoming reviews include the following:

- **Beneficiary Appeals**: The OIG plans to review denied requests for payments by Medicare Advantage (MA) organizations to evaluate whether the notices explained beneficiaries' right to appeal.
- **Program Integrity for Part D**: The OIG will review beneficiary use of manufacturer copayment coupons, and voluntary reporting of fraud, waste, and abuse by plan

sponsors.

- **Encounter Data - CMS Oversight of Data Integrity**: Following prior audits that showed vulnerabilities in the accuracy of data reported by MA organizations, the OIG will review the extent to which MA encounter data is complete, consistent, and verified for accuracy by CMS.

PART III: MEDICAID REVIEWS

Part III of the Work Plan focuses on Medicaid reviews. The Medicaid Reviews planned by the OIG include reviews for home health services, and nursing facilities. Below are some of the key reviews planned for the 2013 fiscal year.

Home Health Services Reviews

- **Duplicate Payments by Medicare and Medicaid**: The OIG will review Medicaid payments for Medicare-covered home health services in order to determine the extent to which both Medicare and Medicaid have paid for the same services. Medicaid is a payer of last resort that pays only after all other third-party sources have met their legal obligation to pay.

Nursing Facility Reviews

- **Communicable Disease Care**: The OIG will review claims by nursing facilities for communicable disease care to ensure compliance with federal and state coverage requirements.
- **State Management of Medicaid**: The OIG has planned new reviews of the state management of Medicaid including: the extent to which states incorrectly use the Federal Medical Assistance Percentage for Federal Share Adjustments; state Medicaid payments for Medicare deductibles and coinsurance; state cost allocations that deviate from acceptable practices; state recovery audit contractor performance and results; and state determinations of hospital provider eligibility and program participation.

AFFORDABLE CARE ACT REVIEWS

The OIG plans to review the newly initiated programs created by PPACA as well as how the already existing Health and Human Services' operations and programs relate both directly and indirectly to PPACA provisions. Some PPACA provisions being examined include coverage of pre-existing conditions; the early retiree reinsurance program; the health insurance web portal; and insurance exchanges. In addition, some of the reviews of PPACA as related to Medicare include supplier compliance with payment requirements regarding power mobility devices; program integrity of onsite visits for Medicare provider and supplier enrollment and reenrollment; and state health insurance assistance programs' provision of Medicare fraud information.

RECOVERY ACT REVIEWS

Part of the American Recovery and Reinvestment Act of 2009 (Recovery Act) allowed for Medicare and Medicaid incentive payments to be made to health care professionals and hospitals that become meaningful users of electronic health records (EHR). The OIG plans to

review the Medicare incentive payment data from 2011 to identify if any payments were made to providers who did not demonstrate meaningful use and thereby were not entitled to receive such a payment. Additional Recovery Act reviews include examining Medicare and Medicaid information systems and data security, examining Public Health Programs, and investigating the integrity of Recovery Act expenditures.

Review Reports

Each review in the Work Plan should result in a report posted to the OIG website in either the 2013 or 2014 fiscal years. This depends on when each review is initiated during the year as well as the complexity and scope of the review conducted.

Please contact any member of Robinson & Cole's Health Law Group if you have any questions with respect to any portion of the Work Plan.

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