

## *Something Old and Something New in Healthcare Compliance: The OIG Issues Its 2010 Work Plan*

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Recently the Office of Inspector General of the Department of Health and Human Services ("OIG") released its "areas most in need of attention" for the 2010 fiscal year. As those familiar with past OIG Work Plans may note, this year's Work Plan involves a great deal of follow-up with respect to previous reviews and initiatives, as well as new areas of focus. As a guidepost to the OIG's current and future audit initiatives, the 2010 Work Plan is essential reading for compliance officers and provider administrators charged with setting audit priorities for their internal corporate compliance programs and the legal counsel who advise them. As described by the OIG, a healthy compliance program is constantly identifying new risk areas for investigation and audit. The OIG issues the Work Plan as a catalog of risk areas designed to guide hospitals and other healthcare providers and suppliers in the operation of their individual compliance plans.

In the 2010 Work Plan, the OIG's audit priorities for Centers for Medicare and Medicaid Services ("CMS") programs – including the Medicare and Medicaid programs – covers several dozen pages of densely written text. A recitation of all the priorities is beyond the scope of this Client Alert and is better left to a review of the Work Plan itself. However, the following is an abridged review of some areas of particular interest to certain healthcare providers and suppliers in the Work Plan.

### **Payments for Diagnostic X-Rays in Hospital Emergency Departments**

The OIG will continue to 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. As noted last year, there appear to be different motivating factors for this particular emphasis. For instance, the Medicare Payment Advisory Commission ("MedPAC") reported in its previous testimony before Congress about concerns regarding the increasing costs of imaging services for Medicare beneficiaries and the potential overuse of diagnostic imaging services. As noted by the OIG in its 2009 Work Plan, approximately 4.7 million diagnostic X-rays were performed in Medicare-certified hospitals with emergency departments in 2004, amounting to a 9.6 percent increase within three years and resulting in nearly \$50 million in Medicare spending in 2004. The increase in such spending has only continued since that time. According to the OIG, Medicare reimbursed physicians approximately \$207 million for imaging interpretations performed in emergency departments. Such increases are likely to incentivize the OIG to continue to scrutinize such services on a heightened basis.

### **Reliability of Hospital-Reported Quality Measure Data**

The OIG indicated that it intends to refocus on a review of hospital controls pertaining to the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement. Section 1886(b)(3)(B)(vii) of the Social Security Act requires that hospitals report quality measures for a set of ten prescribed indicators. Those hospitals that do not report the prescribed quality indicators are subject to a reduction in payments (recently increased to a two percent reduction effective at the beginning of fiscal year 2007). Further, the OIG will determine whether hospitals have implemented sufficient controls to ensure that their quality measurement data are valid.

### **Provider-Based Status for Inpatient and Outpatient Facilities**

The OIG appears to be maintaining a higher level of scrutiny pertaining to provider-based entities consistent with the heightened scrutiny it signaled it would engage in last year. Consistent with its focus last year, the OIG once again stated that it will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. The OIG noted that hospitals with provider-based entities may receive higher reimbursement when they include the costs of a provider-based entity on their cost reports. The OIG also noted that freestanding facilities may also benefit from enhanced disproportionate share hospital ("DSH") payments, upper payment limit payments or graduate medical education payments for which they would not normally be eligible. Moreover, according to the OIG, provider-based status for outpatient clinics may increase coinsurance liability for Medicare beneficiaries. As a result, the OIG will continue to determine the potential impact on both the Medicare program and its beneficiaries of hospitals improperly claiming provider-based status for inpatient and outpatient facilities.

### **Oversight of Hospitals' Compliance With the Emergency Medical Treatment and Labor Act**

CMS is responsible for evaluating Emergency Medical Treatment and Labor Act of 1986 ("EMTALA") complaints and referring to state-licensing agencies cases that warrant investigation. CMS can terminate facilities' participation in Medicare if investigations identify EMTALA violations. As noted last year, the OIG previously raised concerns about CMS's EMTALA's oversight, specifically regarding long delays to investigate complaints and inadequate feedback provided to hospitals on alleged violations. As a result, the OIG stated that it intends to review and identify variations among different regions in the number of EMTALA complaints and cases referred to states, examine CMS's methods for tracking complaints and cases, and determine whether required peer reviews have been conducted prior to CMS making a determination about whether to terminate noncompliant providers from the Medicare program.

### **Part A Inpatient Prospective Payment System Wage Indices**

The OIG indicated that it will continue its review of hospital and Medicare controls over the accuracy of the hospital wage data used to calculate wage indices for the Inpatient Prospective Payment System ("IPPS"). Hospitals must accurately report wage data for CMS to properly calculate the wage index in accordance with the Social Security Act, Section 1886(d)(3). According to the OIG, it had determined previously that hundreds of millions of dollars were misreported in the wage data. The OIG intends to determine whether hospitals have complied with Medicare requirements for wage data and determine the effect on the Medicare program of incorrect diagnosis-related group ("DRG") reimbursement

caused by inaccurate wage data. The OIG further intends to assess the appropriateness of using hospital wage indices for other provider types.

### **Adverse Events**

The term “adverse event” describes harm to patients as a result of medical care. The terms “never events” or “serious reportable events” are subcategories of adverse events. The OIG signaled that it will review adverse events among Medicare beneficiaries in inpatient hospital settings to better understand the national incidence of such events and to assess the extent to which serious reportable events and other adverse events were preventable. Moreover, the OIG will examine various methods for identifying adverse healthcare events by reviewing medical records and administrative data and by reviewing CMS's administrative processes for indentifying hospital-acquired conditions and denying higher Medicare reimbursement for related care.

Related to the above, the OIG indicated that it will devote resources to reviewing various state Medicaid programs that pertain to adverse events and explore how various state policies are impacting or may impact the Medicare program and its beneficiaries.

### **Hospital Outlier Payments**

The OIG indicated that it will follow up regarding previous reviews of Medicaid outlier payments. According to the OIG and as it has stated in the past, it is concerned about some state Medicaid payments for hospital outliers because they may be based upon certain past Medicare hospital outlier payment methodologies with which certain vulnerabilities had been detected. Consistent with previous efforts, the OIG is trying to determine whether certain state Medicaid programs for calculating inpatient hospital cost outlier payments incorporated some of the same vulnerable characteristics of the previously indentified Medicare payment methodologies.

### **Ambulatory Surgical Center Payment System**

The OIG will continue its review of the appropriateness of the methodology for setting ambulatory surgery center (“ASC”) payment rates under the revised ASC payment system. It did not elaborate upon whether there were any particular aspects of the payment methodology or other aspects of ASC payments that would receive particular scrutiny.

### **Quality of Care in Skilled Nursing Facilities**

The OIG will assess how skilled nursing facilities address certain federal requirements related to quality of care, including, but not limited to: (1) development of plans of care based upon appropriate assessments; (2) whether those plans of care were actually followed and executed; and (3) discharge plans. Part of the motivation for this focus appears to be certain prior OIG findings, including the finding that approximately one quarter of skilled nursing home residents’ needs for care were not addressed in the care plans. Related to the above, the OIG indicated that it will review skilled nursing facility use of the standardized Resident Assessment Instrument in preparing plans of care for residents.

### **Criminal Background Checks for Nursing Facility Employees**

The OIG will assess to what extent nursing facilities are employing or have employed persons with criminal convictions. Federal regulations at 42 C.F.R. § 483.13(c)(1)(ii) prohibit long-term care

facilities that treat Medicare or Medicaid residents from employing individuals who were convicted of offenses relating to abuse, neglect or mistreatment of residents.

### **Physician Billing for Medicare Hospice Beneficiaries**

As a follow-up to previous studies, the OIG indicated that it will review the extent to which Medicare Part B is billed for physicians providing services to Medicare hospice beneficiaries. Federal regulations at 42 C.F.R. § 418.304 list physician services that are already covered by Medicare under the Medicare Part A hospice benefit. Apparently, it is suspected that some physicians may have double-billed hospice services to both Medicare Part A and Part B.

### **Duplicate Drug Claims for Hospice Beneficiaries**

According to the OIG, it is in the process of reviewing certain drug claims for individuals who are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. Generally, prescription drugs related to the beneficiaries' terminal illnesses are covered in Part A payments for hospice services. As a result, the OIG is concerned that Medicare may be paying for some drugs under the Part A (or possibly Part B) payment, and again under Medicare Part D.

### **Medicare Incentive Payments for E-Prescribing**

The OIG intends to review Medicare incentive payments made in 2010 to eligible healthcare professionals for electronic prescribing activities in 2009. The Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") provides for incentive payments to eligible healthcare professionals for electronic prescribing starting in 2010 and continuing through 2013. Physicians will be eligible if they are "successful electronic prescribers." According to guidance from Medicare, physicians are "successful electronic prescribers" if they report Medicare's electronic prescribing quality measure with respect to at least 50 percent of cases in which services are billed to Medicare Part B. The OIG indicated that it will assess the extent to which incentive payments for electronic prescribing activities in 2009 were made in error. Importantly, the OIG further indicated that this review will lay a foundation for future evaluations of the integrity of payments authorized by the American Recovery and Reinvestment Act of 2009, including incentive payments by CMS to providers that implement electronic health records.

### **Physician Self-Referral for Durable Medical Equipment Services**

The OIG will refocus on Medicare payments for Durable Medical Equipment Services ("DME") services to assess their permissibility in the context of the federal physician self-referral prohibitions (i.e., the Stark Law). It would be prudent for physicians who have financial relationships or ownership interests in DME companies to which they make referrals to engage qualified healthcare counsel to review these relationships for compliance purposes.

### **Ambulance Services Used to Transport End-Stage Renal Disease Beneficiaries**

The OIG signaled that it will review the extent to which ambulance services are used to transport End-Stage Renal Disease ("ESRD") beneficiaries to and from dialysis facilities. Currently, the bundled prospective payment system for ESRD services generally does not provide for ambulance services. According to the OIG, payments in the year 2005 for ambulance services between beneficiaries' homes and hospital-based or freestanding ESRD centers amounted to approximately \$262 million. The OIG intends to compare and assess ambulance utilization rates and the feasibility of contracting by

freestanding facilities with ambulance suppliers in determining how to proceed with payments for these services in the future.

*It may be wise for healthcare providers and suppliers to reassess or refocus the priorities and quality of their compliance programs in light of the publication of the 2010 Work Plan. In light of the current heightened focus on healthcare reform and the potential passage of major healthcare reform legislation, it may be prudent to give added focus to areas pertaining to potential fraud and duplication of payment. Although it is not practical or realistic to expect that one could implement internal investigations relating to all the Work Plan's audit priorities, the Work Plan, along with operational experience, may assist providers and suppliers to thoroughly assess their respective compliance plans' priorities.*



*If you have any questions concerning these developing issues, please do not hesitate to contact:*

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