A New Year Ahead With New Priorities: The OIG Issues Its 2007 Work Plan

By Paul A. Gomez and Kenneth Yood

Recently, the Office of Inspector General of the Department of Health and Human Services (“OIG”) released its “areas of special concern” for the 2007 fiscal year. As a guidepost to the OIG’s current and future audit initiatives, the 2007 Work Plan is essential reading for compliance officers and provider administrators charged with setting audit priorities for their internal corporate compliance programs. 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 2007 Work Plan, the OIG’s audit priorities for CMS programs – including the Medicare and Medicaid programs – covers 53 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 areas of particular interest in the Work Plan.

Medical Appropriateness and Coding of Diagnosis Related Group Services

The OIG will analyze inpatient hospital claims to identify providers who exhibit high or unusual patterns for selected DRGs. Moreover, the OIG will also determine the medical necessity, the appropriate level of coding and reimbursement for a sample of services billed by these providers. According to the OIG, in 2005, Medicare reimbursed hospitals approximately $110 billion for inpatient care. Further, the OIG reports that the DRG system is vulnerable to abuse by providers who wish to increase reimbursement inappropriately through upcoding.

Physician Pathology Services

The OIG will determine whether the billings for pathology services comply with Medicare Part B requirements. In particular, it will focus on pathology services performed in physicians’ offices. The OIG is specifically interested in identifying and reviewing the relationships between physicians who furnish pathology services in their offices and outside laboratory companies. The OIG reports that Medicare pays more than $1 billion annually to physicians for pathology services.

Advanced Imaging Services in Physician Offices

The OIG will examine the appropriateness of imaging services provided in physician offices. The OIG reports that utilization of advanced imaging services such as MRI, PET and CT scans has grown on average by 20 percent per year from 1999 to 2005. Moreover, Medicare allowed charges of over $7 billion for these services in 2005. The OIG will retrospectively examine the nature of the growth of these services over this period including examination of billing patterns in certain geographic areas and practice settings.

Part B Mental Health Services

The OIG will determine whether Medicare Part B mental health services provided in physicians’ offices were medically necessary and billed in accordance with Medicare requirements. According to the OIG, payments for mental health services provided in the physician office setting accounted for approximately 55 percent of the $1.3 billion in Medicare payments for Part B mental health services in 2002. Further, in a prior report, the OIG found that Medicare allowed $185 million in 1998 for inappropriate mental health services in the outpatient setting.

Violations of Assignment Rules by Medicare Providers

The OIG will examine the extent to which providers are billing beneficiaries in excess of the Medicare allowed amount. The OIG will also assess beneficiary awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines. Providers must accept Medicare’s
payment and beneficiary co-payment (the Medicare allowed amount) as payment in full for all covered services.

**Cardiography and Echocardiography Services**

The OIG will review Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and technical components of the services.

**Physical and Occupational Therapy Services**

The OIG will review Medicare claims for therapy services provided by physical and occupational therapists to determine whether the services were reasonable and medically necessary, adequately documented, and properly certified by a physician.

**Payment to Providers of Care for Initial Preventive Physical Examination**

The OIG will evaluate the impact of the initial preventive physical examination (IPPE) on Medicare payments and physician billing practices. Section 611 of the Medicare Modernization Act provides for coverage under Part B of an IPPE, including a screening electrocardiogram (EKG) for new Medicare beneficiaries, effective January 1, 2005.

**Wound Care Services**

The OIG will determine whether claims for wound care services were medically necessary and billed in accordance with Medicare requirements. From 1998 to 2002, wound care services billed by physicians increased from $98 million to $147 million. The OIG intends to examine the adequacy of controls to prevent inappropriate payments for wound care services.

**Evaluation of “Incident to” Services**

The purpose of the OIG’s study is to evaluate the appropriateness of Medicare services performed “incident to” the professional services of physicians. The OIG will identify services performed “incident to” the physicians’ professional services and will determine the extent to which the services met Medicare standards for medical necessity, documentation and quality of care.

**Place of Service Errors**

The OIG’s review will determine whether physicians properly coded the site of service on claims for services provided in ambulatory surgery centers and hospital outpatient departments. Medicare regulations provide for different levels of payments to physicians depending on where the service is performed. Medicare makes higher payments for physician office services.

**Billing Service Companies**

The OIG will identify and review the relationships between billing companies and physicians and other Medicare providers who use their services. They will further identify the types of arrangements that physicians and other Medicare providers have with billing services and determine the impact of these arrangements on physicians’ billings.

**Inpatient Hospital Payments for New Technologies**

The OIG will review payments made to hospitals for new services and technologies. New technology payments consist of payments for new medical services and technologies meeting the clinical definition of “new” that are demonstrated to be inadequately paid otherwise under the DRG system. Further, the OIG will examine the costs associated with new devices and technologies to determine whether the reimbursement is appropriate.

**Unbundling of Hospital Outpatient Services**

The OIG will determine the extent to which hospitals and other providers have been submitting claims for services that should be bundled into outpatient services. The unbundling of services could lead to inappropriate Medicare expenditures.

**Oversight of Specialty Hospitals**

The OIG will assess CMS oversight of physician-owned specialty hospitals to ensure patient safety and quality of care at these hospitals. Staffing requirements at these hospitals will be reviewed also. Congress imposed an eighteen month moratorium on the construction of new physician-owned specialty hospitals in the Medicare Prescription Drug Improvement and Modernization Act of 2004, amid concerns over the growth of specialty hospitals.

**Skilled Nursing Facility Consolidated Billing**

The OIG will determine whether controls are in place to preclude duplicate billing under Medicare Part B for services covered under the skilled nursing facility PPS and assess the effectiveness of Common Working File edits established in 2002 to prevent and detect improper payments.
Medicare Part D Drug Benefit Payments

CMS established new policies and procedures, as well as new computerized payment systems, to implement the new Part D drug benefit. The OIG will sample Part D beneficiaries’ claims files to determine whether controls have been implemented and are working to ensure that (1) the benefits are paid on behalf of eligible beneficiaries and (2) Medicare and beneficiaries are paid appropriate amounts for drug coverage.

Disproportionate Share Hospital Payments

The OIG will review several States’ disproportionate share hospital payments to selected hospitals to verify that the States calculated the payments according to their approved State plans and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act of 1993.

The publication of the OIG Work Plan is an opportune time for healthcare providers and suppliers to reassess the quality of their compliance programs. Although no one can implement internal investigations relating to all the Work Plan’s audit priorities, the Work Plan, along with operational experience, may help a compliance officer look for that needle in the haystack. If you have any questions, please do not hesitate to contact:

Paul A. Gomez 213-683-6132
paulgomez@paulhastings.com

Kenneth Yood 213-683-6110
kennethyood@paulhastings.com