

HEALTH LAW

Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Office of Inspector General Fiscal Year 2008 Work Plan

December 10, 2007

Each year, the Office of Inspector General of the Department of Health and Human Services (the “OIG”) issues an annual Work Plan reflecting those areas that the OIG considers vulnerable to fraud and abuse. In essence, the Work Plan provides a road map of the OIG’s expected areas of investigation for the upcoming fiscal year. The Work Plan for fiscal year 2008 (the “2008 Work Plan”) includes proposals to review and investigate over two hundred CMS-related programs. This Health Law Update highlights reviews and investigations (both new and continuing) that are of particular significance to Medicare providers.

Hospitals

Disproportionate Share (DSH) Payments. Payments to acute care hospitals that serve a significantly disproportionate number of low-income Medicare and Medicaid patients, referred to as disproportionate share hospital (DSH) payments, will be scrutinized. Medicare DSH payments have been steadily increasing and previous OIG work has identified overpayments in this area. The OIG will investigate the uncompensated care costs incurred by hospitals and scrutinize various components of the methodology for calculating DSH payments in order to determine whether DSH payments have been made in accordance with Medicare criteria.

Patient Care and Safety in Physician-Owned Specialty Hospitals. Recent patient deaths and other incidents in physician-owned specialty hospitals have led several members of Congress to express concern about patient care in these facilities. The OIG will continue to review indicators of patient care and safety in physician-owned specialty hospitals and will examine policies related to staffing requirements for these facilities.

Payments for Diagnostic X-Rays in Hospital Emergency Departments. The exponentially increasing cost of imaging services for Medicare beneficiaries and the potential overuse of diagnostic imaging have been an area of concern for healthcare policymakers for the last several years. The OIG will review Medicare Part B paid claims and medical records for diagnostic x-rays performed in hospital emergency departments to determine whether the payments for diagnostic x-rays and interpretations were appropriate.

Long term care hospitals (LTCHs) will be the focus of several investigative reviews. The OIG will continue its reviews of payments for beneficiaries discharged from LTCHs with lengths of stay well below the average for their diagnoses related group, referred to as short stay outliers (SSOs), and payments made to LTCHs for interrupted stays. In addition, two new investigations will focus on whether the special payment provisions for (1) patients who are transferred to onsite providers and readmitted to LTCHs, and (2) LTCHs discharging patients to co-located or satellite providers, have been appropriately applied.

Medicare Secondary Payer payments will be reviewed to assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries who have other insurance. For example, the OIG will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amount.

Inpatient Psychiatric Facilities. Some inpatient psychiatric facilities receive an adjusted rate if they maintain a qualifying emergency department. The OIG will review payments made to these facilities to determine if appropriate rate adjustments have been made.

Physicians and Other Health Professionals

Payment for selected physician services, such as surgery, consultation, and home, office, and institutional calls, will be the focus of an OIG study to determine if the services were performed according to Medicare requirements. Medicare reimbursement for physician services is made on the basis of a fee schedule. Payment for these services is precluded unless the provider has furnished information necessary to determine the amounts due.

Medicare "Incident To" Services. The OIG will review the medical necessity, documentation, and quality of care for services furnished "incident to" the professional services of selected physicians.

Business Relationships and the Use of Magnetic Resonance Imaging (MRI). The OIG will examine relationships among physicians, billing providers, and others who work together to provide imaging services, particularly MRI services, and determine whether these relationships affect levels of utilization. The OIG will pay particular attention to financial relationships among the parties involved in providing such services and identify whether such relationships are associated with high use of services.

Ultrasound Services. In this new audit, the OIG will review services and billing patterns in geographic areas with high utilization of ultrasound services in an effort to identify disproportionately high charges and services per beneficiary. In areas of high utilization, the OIG will examine service profiles, provider profiles, and beneficiary profiles.

Independent Diagnostic Testing Facilities ("IDTF"). A new OIG investigation will focus on services and billing patterns in geographic areas with high concentrations of IDTFs. A previous 2006 OIG review found numerous problems with IDTFs, including noncompliance with performance standards and potential improper payments. In areas of high density of IDTFs, the OIG will examine service profiles, provider profiles, beneficiary profiles, and billing patterns.

Physician Reassignment of Benefits. Medicare regulations prohibit a physician who provides services to Medicare beneficiaries from reassigning his or her right to payment for those services to

other individuals or entities, unless a specific exception applies. Previous OIG investigations have revealed schemes in which fraudulent providers obtain identifying information about legitimate physicians and request reassignments on their behalf. The OIG believes that having a large number of reassignments may be indicative of fraudulent or abusive activity. The OIG intends to examine a national sample of physicians to determine the extent to which they reassign their benefits to other entities and to the extent to which the physicians are aware of reassignments requested on their behalf.

Nursing Homes

Previous OIG audits have identified significant improper claims submission and reimbursement for Part B claims submitted for items, supplies, or services provided to patients during Part A Medicare-covered nursing home stays. The OIG intends to continue its review in this area to identify additional overpayments. In addition, the OIG will initiate new investigations to evaluate CMS's oversight of Medicare expenditures contained in nursing facility cost reports and to determine the extent to which Resource Utilization Groups (RUGs) included on skilled nursing facility claims for Medicare reimbursement are accurate and supported by the residents' medical records.

Hospice

The OIG will continue its assessment of beneficiaries' plans of care to determine whether the services they receive are consistent with their plans of care and whether payments are appropriate.

Home Health Agencies (HHAs)

The 2008 Work Plan focuses on three primary areas of concern for Medicare home health agencies. The OIG will review national data on home health agency survey and certification deficiencies to identify trends or patterns of cyclical noncompliance with certification standards and determine whether CMS applies appropriate sanctions to noncompliant facilities. The OIG will also review the extent to which the Home Health Compare website maintained by CMS includes accurate and complete information on Medicare-certified home health agencies and examine how CMS identifies and updates missing and incorrect information in the database. Finally, the OIG will review Medicare claims submitted by home health agencies to determine the extent to which the home health resource groups (HHRGs) used in determining payments to home health agencies are accurate and supported by documentation in the medical record.

Medical Equipment and Supplies

The OIG will initiate many new investigations in fiscal year 2008 focusing on the appropriateness of payments for power wheelchairs, negative pressure wound therapy pumps, blood glucose testing supplies and other durable medical equipment and supplies. In addition, Part B services provided in nursing homes for durable medical equipment and enteral nutrition therapy will be evaluated.

Conclusion

Healthcare companies should assess their risks against the annual OIG Work Plan and tailor their compliance audits based on these risks. If you have any questions about these new investigations, please contact any of the attorneys in our Health Law Practice Area listed below.

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