JONES DAY

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HHS-OIG ISSUES FISCAL YEAR 2010 WORK PLAN

On October 1, 2009, the Department of Health and Human Services Office of Inspector General ("HHS-OIG") released its Work Plan for the 2010 fiscal year ("2010 Work Plan"). The 2010 Work Plan highlights the areas in which the HHS-OIG intends to focus in the fiscal year that began on October 1, 2009. This year is no different from prior years, in that the HHS-OIG has identified several "new start" areas along with several "work in progress" areas.

The 2010 Work Plan serves as an important compliance tool for all types of providers and should be reviewed carefully. This *Commentary* provides an overview of noteworthy items relating to hospitals and certain other Part A and Part B providers, but it is not an exhaustive listing of all of the focus areas identified by the HHS-OIG.

HOSPITALS

"New Start" Items Identified in the 2010 Work Plan	
Hospital Payments for Nonphysician Outpatient Services under the Inpatient Prospective Payment System ("IPPS")	Under the IPPS, hospitals are typically paid in full for inpatient stays and hospitals do not receive additional payments for nonphysician services. Further, separate payments are not made for outpatient diagnostic services and admission-related nondiagnostic services rendered up to three days before the dates of admission. The HHS-OIG intends to review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries before or during Medicare Part A-covered hospital stays. In the 2010 Work Plan, the HHS-OIG indicated that previous HHS-OIG work in this area "identified significant numbers of improper claims."

Reliability of Hospital-Related Quality Measure Data	Hospitals are required to submit quality data for a set of indicators to the Centers for Medicare and Medicaid Services ("CMS") or risk a reduction in payments. The HHS-OIG intends to review hospitals' controls related to the accuracy of such data.
Hospital Admissions with Conditions Coded Present-on-Admission	For Medicare claims, acute care hospitals are required to report which diagnoses were present when a patient was admitted to the hospital. For some diagnoses, the hospital receives a lower payment if specific conditions were acquired in the hospital. The HHS-OIG intends to review Medicare claims to determine the number of inpatient hospital admissions for which diagnoses were coded as present-on-admission and which types of facilities most frequently transferred patients with a present-on-admission status to other providers.
Hospital Readmissions	If a same-day readmission occurs for symptoms related to, or for evaluation or management of, the prior stay's medical condition, the hospital is entitled to only one diagnosis-related group payment, except in limited circumstances. This issue dates back to 2004 when CMS initiated an edit to reject subsequent claims for same-day readmission. The HHS-OIG intends to determine the extent of the exceptions used and the extent of oversight of readmission cases.
Oversight of Hospitals' Compliance with the Emergency Medical Treatment and Labor Act ("EMTALA")	CMS is responsible for overseeing hospitals' compliance with EMTALA standards. The HHS-OIG intends to identify any variations in EMTALA complaints and cases referred to States, how CMS tracks these complaints and cases, and whether required peer reviews have taken place before CMS has decided whether to terminate noncompliant providers from participation in the Medicare program.
Observation Services During Outpatient Visits	The HHS-OIG intends to assess whether, and to what extent, a hospital's use of observation services affects the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for the services. The results of this action item might lead to changes in observation standards.
Coding and Documentation Changes Under the Medicare Severity Diagnostic Related Group ("DRG") System	After CMS revised its hospital inpatient reimbursement system to improve recognition of severity of illness and resource consumption, the number of DRGs increased from 538 to 745. The HHS-OIG intends to review coding trends under the new system to assess whether the additional DRGs are susceptible to potential upcoding.
"Work in Progress" Items Continued from Fiscal Year 2009	
Part A Hospital Capital Payments	Capital payments are made to hospitals to reimburse them for assets such as equipment and facilities. The HHS-OIG intends to review whether capital payments are appropriate and will assess the appropriateness of the payment levels.

Provider-Based Status for Inpatient and Outpatient Facilities	Many healthcare providers have taken advantage of provider-based regulations and in turn receive higher reimbursement. The HHS-OIG intends to assess the appropriateness of provider-based designations and the impact this designation has on the Medicare program and its beneficiaries if hospitals improperly claim provider-based status.
Part A IPPS Wage Indices	In order for CMS to calculate the wage index for IPPS, hospitals must accurately report wage data. The HHS-OIG intends to determine the impact of incorrect DRG reimbursement caused by inaccurate wage index on the Medicare program and the appropriateness of using the hospital wage index for other types of providers. The HHS-OIG noted that it has historically identified "hundreds of millions of dollars in misreported wage data."
Payments to Organ Procurement Organizations ("OPO")	Generally, Medicare reimburses OPOs based on a cost basis method. The HHS-OIG intends to review whether payments made to OPOs are correct and supported by appropriate documentation.
Inpatient Rehabilitation Facility ("IRF") Submission of Patient Assessment Instruments	IRF stays are reimbursed based on a prospective payment system, and payments for IRF stays are to be reduced if patient assessments are not encoded and transmitted within defined time limits. The HHS-OIG intends to determine whether Medicare payments for IRFs were correct in cases where the patient assessments were transmitted to CMS after the defined period.
Critical Access Hospitals ("CAHs")	Generally, CAHs are paid 101 percent of the reasonable costs of providing CAH services. The HHS-OIG intends to review whether CAHs meet the CAH designations and conditions of participation, and whether payments are made appropriately per Medicare requirements.
Medicare Disproportionate Share ("DSH") Payments	DSH payments are made to acute care hospitals that serve a disproportionate number of low-income patients. The HHS-OIG intends to review the Medicare methodology for DSH payments and examine the total amount of uncompensated care that the hospitals incur. DSH and upper payment limit ("UPL") payments have been the subject of a number of government audit reports, alleged abusive behaviors, and even whistleblower cases.
Duplicate Graduate Medical Education	Teaching hospitals receive payments for both direct graduate medical education and indirect medical education costs. However, for these payments, a hospital may not count a resident or intern as more than one full-time equivalent employee. The HHS-OIG intends to review data from CMS' Intern and Resident Information System to assess whether hospitals have improperly claimed duplicate graduate medical education payments.
Interrupted Stays at Inpatient Psychiatric Facilities ("IPFs") Payments	Because CMS adjusts payments to IPFs based on the number of days that have elapsed since the IPF admitted a patient, if a patient is discharged and then readmitted to the same or another IPF within three days following discharge, the treatment is considered one continuous stay. The HHS-OIG intends to review IPFs' claims for Medicare reimbursement where there is a transfer from the IPF to the same or a different IPF.

Provider Bad Debts	If certain conditions are met, Medicare bad debt may be claimed for uncollectable debts related to unpaid deductible and coinsurance amounts. The HHS-OIG intends to determine whether bad debt payments were appropriate and whether recoveries of prior year write offs were properly used to reduce the cost of beneficiary services.
Medicare Secondary Payer	Generally, if a Medicare beneficiary has other insurance in addition to Medicare, Medicare payments are required to be secondary to the other insurance. The HHS-OIG intends to review Medicare payments for beneficiaries who have other insurance and assess the effectiveness of current procedures used to prevent inappropriate Medicare payments for beneficiaries with other insurance coverage. In particular, the HHS-OIG intends to focus on credit balances and "procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amounts."
Adverse Events: Various Reviews	In its continuing focus on quality, the HHS-OIG intends to review issues related to adverse events. For example, the HHS-OIG intends to review incidence of adverse events at hospitals, methods hospitals employ to identify adverse events, CMS' processes for identifying hospital-acquired conditions, and public disclosure of adverse event information.
Payments for Diagnostic X-Rays in Hospital Emergency Departments	The HHS-OIG intends to review a sample of Medicare Part B paid claims and medical records to determine the appropriateness of the payments for diagnostic x-rays and interpretations in hospital emergency departments. In 2007, CMS reimbursed physicians approximately $207 million for imaging interpretations in emergency departments.
Financial Status of Hospitals in the New Orleans Area	In response to the aftermath of Hurricane Katrina, HHS helped in the recovery efforts for the New Orleans area by funding provider stabilization grants and workforce supply grants. One of the goals of the grants was to compensate healthcare providers and recruit licensed healthcare workers to the area. The HHS-OIG intends to determine whether the objectives of the grants were met.
Medicaid Hospital Outlier Payments	Similar to Medicare payments for hospital outliers, some States make supplemental Medicaid payments for hospital outliers. The HHS-OIG intends to review Medicaid payments for hospital outliers to see if similar vulnerabilities exist as they do for Medicare hospital outlier payments.
Provider Eligibility for Medicaid Reimbursement	The HHS-OIG intends to review whether States appropriately determined provider eligibility for Medicaid reimbursement. The HHS-OIG noted that it has "previously identified significant unallowable Medicaid payments made to hospitals that did not meet Medicare program eligibility requirements as part of the DSH program."

Medicaid DSH Payment Distribution	In order for hospitals to be deemed eligible to receive Medicaid DSH payments, they must have an inpatient utilization rate of not less than one percent. The HHS-OIG intends to review Medicaid inpatient utilization rates used to determine eligibility for Medicaid DSH payments to evaluate the appropriateness of this threshold and to evaluate whether any changes should be made to the DSH program.

OTHER PART A AND PART B PROVIDERS

"New Start" Items Identified in the 2010 Work Plan	
Trends in Medicare Hospice Utilization	Since the hospice benefit was created, longer hospice stays have become more common, and the number and types of diagnoses associated with hospice care have increased. The HHS-OIG intends to review common characteristics of hospice beneficiaries, whether there are geographical variations in utilizations, and assess whether there are differences between not-for-profit providers and for-profit providers.
Medicare Incentive Payments for E-Prescribing	The Medicare Improvement for Patients and Providers Act of 2008 provides for incentive payments to eligible healthcare professionals for e-prescribing beginning in 2010 and continuing through 2013. The HHS-OIG intends to review Medicare incentive payments made in 2010 to eligible healthcare professionals for their 2009 e-prescribing activities. The HHS-OIG states that "[t]his review will lay a foundation for our future evaluations of the integrity of payments authorized by the American Recovery and Reinvestment Act of 2009. . . ."
Medicare Payments for Part B Imaging Services	Physicians are paid for services based on the Medicare physician fee schedule, which includes practice expenses. The HHS-OIG intends to determine whether, for selected imaging services, the Medicare payment reflects the actual expenses a physician incurs and whether the utilization rate corresponds to current industry practices.
Outpatient Physical Therapy Services Provided by Independent Therapists	Previous work by the HHS-OIG has identified that some claims for therapy services provided by independent physical therapists were not reasonable, medically necessary, or properly documented. The HHS-OIG intends to review whether independent therapists with high utilization rates for outpatient physical therapy services billed Medicare in accordance with the Federal requirements.
Appropriateness of Medicare Payments for Polysomnography	Sleep studies are only reimburseable for patients with certain conditions. Medicare payments for polysomnography have dramatically increased from $62 million in 2001 to $215 million in 2005. The HHS-OIG intends to examine why there has been this increase and assess provider compliance with the Federal program requirements.

Laboratory Test Unbundling by Clinical Laboratories	The HHS-OIG intends to review whether clinical laboratories have inappropriately unbundled laboratory profile or panel tests and the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.
Medicare Billings with Modifier GY	The modifier GY is used for coding services that are statutorily excluded or do not meet the definition of a covered service. The HHS-OIG intends to examine patterns and trends for physicians' and suppliers' use of modifier GY.
Enrollment Standards for Independent Diagnostic Testing Facilities ("IDTFs")	The HHS-OIG intends to review IDTFs enrolled in Medicare to determine whether the IDTFs meet Medicare's enrollment standards. In 2007, IDTFs received payments of approximately $1 billion.
Medicare Providers' Compliance with Assignment Rules	Physicians may agree to accept assignment for items and services furnished to Medicare beneficiaries if there is a written agreement between beneficiaries, their physicians or suppliers, and Medicare. The HHS-OIG intends to examine providers' compliance with the assignment rules and determine if, and to what extent, beneficiaries are billed in excess of amounts allowed by the Medicare requirements.
Payments for Services Ordered or Referred by Excluded Providers	The HHS-OIG intends to examine the nature and extent of Medicare payment for services ordered or referred by excluded providers. In addition, it will review CMS' oversight mechanisms currently in place to identify and prevent improper payments based on these activities.
Ambulance Services Used to Transport End-Stage Renal Disease ("ESRD") Beneficiaries	In calendar year 2005, there were approximately $262 million in payments for ambulance services between beneficiaries' residences and hospital based or freestanding ESRD facilities. The HHS-OIG intends to review factors related to this process, including the percentage of the population using ambulance services, the coverage policies of other health insurance programs, and the feasibility of freestanding facilities to contract with ambulance suppliers.
"Work in Progress" Items Continued from Fiscal Year 2009	
Physician Billing for Medicare Hospice Beneficiaries	Some physician payments are reimbursed to the hospice as part of the hospice payments, but some are paid to the hospice under the Part B Medicare Physician Fee Schedule. The HHS-OIG intends to determine the frequency and total expenditures for physician services under Part A and Part B for hospice beneficiaries and whether physicians double-billed any of these services.
Place-of-Service Errors	Physicians' reimbursement varies based on where services are performed. The HHS-OIG intends to review whether physicians properly coded the places of service on claims for services provided in hospital outpatient departments and ambulatory surgery centers ("ASCs").

ASC Payment System	The HHS-OIG intends to review the appropriateness of the methodology for setting ASC payment rates. Further, it intends to review the revised ASC payment system and the rate-setting methodology used to calculate ASC payment rates.
Evaluation and Management Services during Global Surgery Periods	Global billing provides for physicians to bill a single fee for all services related to a surgical procedure during a global surgery period. The HHS-OIG intends to review whether industry practices have changed since the global surgery fee concept was developed in 1992.
Medicare Payments for Transformational Epidural Injections	Transformational epidural injections are used as an interventional technique to treat or diagnose back pain. The HHS-OIG intends to determine whether there are policies and safeguards in place to prevent inappropriate payments for these types of injections.
Medicare Services Billed with Date of Service after Beneficiaries' Date of Death	The HHS-OIG intends to review Medicare claims for services with a date of service after the beneficiary's date of death to determine if CMS has the appropriate controls in place to prevent or identify and recover any improper fee-for-service payments.
Geographic Areas with a High Density of IDTFs	In 2006, an HHS-OIG review found that there were many noncompliance issues with IDTFs and potential improper payments of $71.5 million. The HHS-OIG intends to review services and billing patterns in high-density IDTF areas.
Physician Reassignment of Benefits	The HHS-OIG intends to review the extent that physicians reassign their benefits and the extent to which physicians are aware of their reassignments.

RECOVERY ACT WORK PLAN

A noteworthy addition to the 2010 Work Plan is found in a new section titled the "Recovery Act Work Plan." The Recovery Act Work Plan sets forth activities that the HHS-OIG intends to review related to the American Recovery and Reinvestment Act of 2009 ("ARRA"). With respect to hospitals and physicians, some of the significant activities the HHS-OIG intends to review as part of the Recovery Act Work Plan include the following items:

- **Medicare incentive payments for electronic health records ("EHRs"):** ARRA contains incentives for Medicare providers to purchase, implement, and operate certified EHR technology. The HHS-OIG intends to review Medicare incentive payments to assess whether any payments were made in error.
- **Medicaid high-risk providers:** The HHS-OIG intends to review claims from providers that have a high risk of claiming improper Medicaid payments. Providers will be identified based on the HHS-OIG's prior work and error rates reported under CMS' Payment Error Rate Measurement program.
- **Breach notification and medical identity theft in Medicare:** ARRA contains breach notification requirements for personally identifiable information. The HHS-OIG intends to examine CMS' procedures related to breach notification requirements.

CONCLUSION

The 2010 Work Plan provides a detailed look at the HHS-OIG's intended areas of emphasis for the coming year. Quality, proper coding and documentation, and cost containment are recurring themes. Providers would be well advised to review the 2010 Work Plan and to incorporate these issues into their compliance activities, as appropriate.

LAWYER CONTACTS

For further information or more details on these matters, please contact your principal Firm representative or one of the lawyers listed below. General email messages may be sent using our "Contact Us" form, which can be found at www.jonesday.com.

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