

# Office of Inspector General's (OIG) 2012 Work Plan

*An overview of the new projects identified by  
the OIG for Fiscal Year 2012*

Faith M Jones MSN, RN, NEA-BC  
Clinical Services Consultant

# OIG Core Values

The Office of the Inspector General's core values are:

- Integrity: Acting with independence and objectivity.
- Credibility: Building on a tradition of excellence and accountability.
- Impact: Yielding results that are tangible and relevant.

# How Tangible??

In fiscal year 2010, the OIG's "contributions to safeguards" were:

- \$3.8 billion in expected investigative receivables that were court ordered or agreed to be paid through civil settlements that resulted from cases developed by OIG investigators;
- \$1.1 billion in audit receivables that were agreed to be pursued by HHS program managers as a result of OIG audit disallowance recommendations;
- a ratio of \$16.7 to \$1 expected return on investment

# What is the OIG Work Plan?

The work plan is a document that is published at the beginning of each federal fiscal year that “provides brief descriptions of activities that the OIG plans to initiate or continue with respect to the programs and operations of the Department of Health & Human Services”.

# What can you Learn from the OIG's work plan?

The OIG *Work Plan* outlines the OIG's focus areas and states

- The primary objectives of each review
- Expected report dates on the review
- A review designated as “work in progress” will result in reports issued in FY 2012
- A review slated to begin in FY 2012 (“new start”) could result in FY 2012 or FY 2013 reports, depending upon when the assignments are initiated during the year and the complexity and scope of the examinations

# Programs the Work Plan Covers

- Medicare Part A and Part B
- Medicare Part C and Part D
- Medicaid Reviews
- Legal and Investigative Activities
- Public Health Reviews
- Human Services Reviews
- Other HHS-Related Reviews
- Affordable Care Act Reviews
- Recovery Act Reviews

# Medicare Part A and Part B

Areas include:

- Hospitals
- Home Health Agencies
- Hospices
- Nursing Homes
- Other Providers and Suppliers
- Medical Equipment and supplies
- Part B Payments for Prescriptions

# Number of Projects

Total Projects Addressed =	109
• Hospitals	23
• Home Health Agencies	9
• Hospices	2
• Nursing Homes	8
• Other Providers and Suppliers	34
• Medical Equipment and supplies	14
• Part B Payments for Prescriptions	11



# What's New for 2012?

New Projects =	37
• Hospitals	6
• Home Health Agencies	5
• Hospices	1
• Nursing Homes	3
• Other Providers and Suppliers	13
• Medical Equipment and supplies	4
• Part B Payments for Prescriptions	5

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# Why Do You Care?

An effective compliance program should have a auditing and monitoring component

Reviewing the OIG work plan will assist in developing monitoring and auditing projects

Let's Look at some of the new projects that the OIG will be starting this year

# Hospitals

# Accuracy of Present-on-Admission Indicators Submitted on Medicare Claims

The OIG will review the accuracy of POA indicators submitted on inpatient claims by hospitals in October 2008.

# Medicare Inpatient and Outpatient Payments to Acute Care Hospitals

OIG will review Medicare payments to hospital to determine compliance with selected billing requirements.

Sample of hospitals that broadly rank as least risky across compliance areas and those broadly ranked as most risky and compare P&Ps and interview leadership.

# Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care

OIG will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care and examine the relationship, wither financial or common ownership between the two entities and how Medicare treats reimbursement for similar transfers from the acute care to other settings.

# Medicare Outpatient Dental Claims

OIG will review Medicare hospital outpatient payments for dental services to determine whether payments for dental services were made in accordance with Medicare requirements. Dental services are generally excluded with a few exceptions.



# In-Patient Rehabilitation Facilities

OIG will examine the appropriateness of admissions to IRFs and ensure the multidisciplinary approach to care.

# Critical Access Hospitals

OIG will review CAHs to profile variations in size, services, and distance from other hospitals. Also examine the numbers and types of patients that CAHs treat.

There are approximately 1350 CAHs but limited information exists about their structure and the type of services they provide.

# Home Health/Hospice

# **States' Survey and Certification of Home Health Agencies: Timeliness, Outcomes, Follow up, and Medicare Oversight**

OIG will review the timeliness of home health agency standard and complaint surveys conducted by state survey agencies and accreditation organizations and the follow up from the surveys.

HHAs must be surveyed at least every 36 months.

# Missing or Incorrect Patient Outcome and Assessment Data

OIG will review HHAs OASIS data to identify payments for episodes for which OASIS data were not submitted or for which the billing code on the claim is inconsistent with OASIS data.

# Questionable Billing Characteristics of Home Health Services

OIG will review HHA claims to identify questionable billing in 2010 for potential fraud.

HHAs were originally intended for short term, post-hospital recovery for homebound beneficiaries but it has been expanded to include other types of homebound beneficiaries.

# Medicare Administrative Contractors' Oversight of Home Health Agency Claims

OIG will review fraud and abuse prevention and services performed by the Home Health benefit MACs and any reduction of payment errors by MACs.

The OIG believes that the pattern of utilization growth has not been related to clinical or patient characteristics.

# Wage Indexes Used To Calculate Home Health Payments

OIG will determine whether Medicare Home Health payments were calculated using incorrect wage indexes and evaluate the adequacy of controls to prevent such inaccuracies.

Ensure that the wage index corresponds to the beneficiary's site of service.



# Hospice Marketing Practices and Financial Relationships with Nursing Facilities

OIG will review hospices' marketing materials and practices and their financial relationships with nursing facilities.

Recent OIG report found that 82 % of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.

Look for inappropriate enrollment and compensation.

# Nursing Homes

# Safety and Quality of Post-Acute Care for Medicare Beneficiaries

OIG will review the quality of care and safety of Medicare beneficiaries transferred from acute care hospital to post acute care. They will evaluate the transfer process and identify rates of adverse events and preventable hospital readmissions from post acute care settings.

Focus will be SNFs, IRFs and Long term care hospitals

# Nursing Home Compliance Plans

OIG will review Medicare and Medicaid certified nursing homes' implementation of complained plans as part of their day-to-day operations.

Affordable Care Act requires that nursing homes have a compliance and ethics program in place on or after 2013.

# Questionable Billing Patterns During Non-Part A Nursing Home Stays

OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit.

Part B services provided during a non-Part A stay must be billed directly by suppliers and other providers.

# Providers and Suppliers

# Diabetic Supplies

- Effectiveness of edits to prevent payments to multiple suppliers of home blood-glucose testing supplies
- Questionable billing for Medicare Diabetic testing supplies (must meet utilization guidelines)

# Ambulances: Comparison of Medicare Fee Schedule Amounts to Other Payers

OIG will compare reimbursements by other payers for ambulance services to Medicare fee scheduled amounts for similar services to determine whether Medicare amounts exceed the reimbursements by other payers

Medicare gets the best price.



# Ambulances: Questionable Billing for Ambulance Services

OIG will examine relationships between ambulance companies and other providers as well as review Medicare claims data to identify questionable billing such as:

- transports that were potentially not medically reasonable and necessary
- Unnecessary billing for advanced Life support Services and Specialty care transport

# Physicians and Other Suppliers

- OIG will review payment system controls that identify High cumulative Part B payments.
- OIG will determine the extent to which physician owned distributors provide spinal implants purchased by hospitals.
- OIG will review the extent to which physicians are opting out of Medicare and ensuring that those who have are no longer billing.
- OIG will review appropriate use of modifiers during the global surgery period

# Physicians: Incident-To Services

OIG will review physician billing for “incident-to”

- Amount of services billed in any one day by a provider - not reporting it as “incident to”
- Unqualified non-physician personnel performing the services which lead to decrease in quality of care
- Overutilization of “incident to”

# Ambulatory Surgical Centers and Hospital Outpatient Departments: Safety and Quality of Surgery and Procedures

OIG will review and compare the safety and quality of care for Medicare beneficiaries having surgeries and procedures in ambulatory surgical centers, hospital outpatient departments and other healthcare settings such as a physician's office.

The proportion of surgeries and procedures performed in ASC has risen substantially

# Part B Payments for Prescription Drugs

# Part B Payments for Prescription Drugs

- OIG will review payments for ESRD drugs under the new bundled rate system effective Jan 1, 2011
- OIG will compare payments for commonly used physician-administered drugs to determine whether changes in the reimbursement methodologies will result in savings.
- OIG will review the extent of off-label and off compendia use of Medicare and Medicaid funded prescription drugs.

# Medicare Payments for the Drug Herceptin

- OIG will review payments for Herceptin to determine whether they were appropriate.
- Drug claims involving a single-use vial or package, if a provider must discard the remainder of a single-use vial after administering a dose/quantity of the drug, CMS pays for the drug administered and wasted
- However, multiuse vials such as those used for supplying Herceptin are not subject to payment for discarded amounts of the drug.

# Medicare Outpatient Payments for Drugs

- OIG will review payments for certain drugs and the administration of those drugs (e.g. chemotherapy) to determine whether CMS overpaid providers because of incorrect coding or overbilling of units.
- Certain drugs, particularly chemotherapy drugs, are vulnerable to incorrect coding.



# What to Monitor?

- Assess your organizational risks
- Develop a monitor to check compliance
- Correct systems for ongoing compliance
- Move on to new areas of risk
- Conduct reassessments periodically
- Once a system is in place – be ok with discontinuing the monitor

# Resource for Compliance Education

Compliance videos available on a variety of topics made available on the OIG website.

[http://oig.hhs.gov/newsroom/video/2011/heat\\_modules.asp](http://oig.hhs.gov/newsroom/video/2011/heat_modules.asp)