Hot Spots in the 2002 OIG Work Plan

by Sue Prophet, RHIA, CCS, CHC

Organizational compliance programs are never static. Rather, they must continually be refined and updated to respond to changes in healthcare delivery and system vulnerabilities. The 2002 Work Plan of the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) provides excellent insight into the major initiatives that it intends to audit, evaluate, or investigate in a given year.

While HHS expects to report on all the projects described in the Work Plan in fiscal year 2002, the focus and timing of many of these projects can evolve in response to new information, new issues, and shifting priorities of Congress, the president, and the secretary and may be altered over time. The work plan is an invaluable resource for identifying new or hot risk areas to be incorporated into an organization's compliance program, as the OIG projects pinpoint areas that have been identified nationally as being particularly vulnerable to fraudulent or abusive practices.

Each organization should review the annual OIG Work Plan, identify those target areas that are relevant to its business operations, prioritize them, and update its compliance program to include these risk areas in the auditing process.

The following are highlights of the OIG's 2002 Work Plan. It can be downloaded in its entirety from the OIG Web site: www.oig.hhs.gov.

Medicare Payment Error Prevention Program

The progress of the Medicare peer review organizations' Payment Error Prevention Program (PEPP) in reducing hospital payment errors will be under scrutiny by the OIG. It will identify the nature of payment errors, the actions taken by peer review organizations, and the extent of recoupment by fiscal intermediaries.

One-day Hospital Stays

The OIG will evaluate controls designed to ensure the reasonableness of Medicare inpatient hospital payments for beneficiaries discharged after spending only one day in the hospital. This review will concentrate on the adequacy of controls to detect and deny inappropriate payments for one-day stays and the Centers for Medicare and Medicaid Services (CMS) program integrity studies in this area.

Hospital Discharges and Subsequent Readmissions

The OIG will conduct a series of reviews to examine Medicare claims for beneficiaries who were discharged and subsequently readmitted relatively soon to the same or another acute care Prospective Payment System (PPS) hospital. In addition to determining if these claims were appropriately paid, they will also review claims-processing procedures to determine the effectiveness of existing system edits used to identify and review diagnosis and time-related admissions.

Consecutive Inpatient Stays

The extent to which Medicare beneficiaries receive acute and post acute care through sequential stays with different providers will be under examination. As part of this review, the OIG will assess CMS instructions for identifying and evaluating consecutive beneficiary stays, including those in skilled nursing facilities, long-term care hospitals, and PPS-exempt units.

Payments to Acute Care PPS Hospitals

The OIG will examine DRGs that have a history of abusive coding to determine whether some PPS hospitals continue to exhibit abnormal coding patterns. This study will incorporate the results of a review by PEPP on DRGs with significant patterns of coding errors.

Diagnosis-Related Group Payment Limits

The ability of Medicare contractors to limit payments to hospitals for patients who are discharged from a PPS hospital and admitted to one of several post acute care settings will continue to be assessed by the OIG. This limitation applies to certain DRGs.

Outlier Payments for Expanded Services

The OIG will continue to examine the financial impact of outlier Medicare payments made in unusual cases for inpatient care.

Diagnosis Related Group Payment Window—Part B Providers

The OIG will determine the extent of duplicate claims submitted by Part B providers for services such as ambulance, laboratory, or x-ray services provided to hospital inpatients. Separate payments for non-physician services rendered within 72 hours of a hospital admission are not allowed.

Expansion of Diagnosis Related Group Payment Window

The extent of pre-admission services rendered outside the current 72-hour DRG payment window and the amount of savings that can be achieved by expanding the payment window will be studied by the OIG.

Outpatient Prospective Payment System

The OIG will evaluate the effectiveness of internal controls intended to ensure that services are adequately documented, properly coded, and medically necessary. Controls over “pass-through” costs will also be reviewed.

Outlier Payments Under OPPS

The appropriateness of outlier payments under the OPPS will be determined and any outlier payments paid in error will be identified. Significant overpayments can result if providers submit claims with clerical errors that result in overstated charges for services.

Outpatient Services on Same Day as Discharge and Readmission

Outpatient services provided on the same day that a beneficiary was discharged and readmitted to the same PPS hospital will be under review. This review will determine whether beneficiaries were discharged from a PPS hospital, transported to another PPS hospital for outpatient services, and readmitted to the first hospital on the same day. It will also determine the appropriateness of the Medicare reimbursement for the outpatient services.

Procedure Coding of Outpatient and Physician Services

The procedure coding of outpatient services billed by a hospital and a physician for the same service will be reviewed. Previously, the OIG identified a 23 percent national rate of inconsistency between hospital outpatient department procedure coding and physician procedure coding for the same service. The current review will determine whether these coding differences continue and how they affect the Medicare program.

Home Health Payment System Controls

The OIG will monitor implementation of the new PPS used to pay home health agencies for providing care to Medicare beneficiaries. It will evaluate the adequacy of controls intended to ensure that services are provided only to homebound

individuals and are adequately documented, properly coded, and medically necessary. It will also monitor controls over advance payments to providers.

Coding of Home Health Resource Groups

The OIG will conduct a review to determine whether home health agencies classified their patients in the appropriate case-mix category. It will assess whether home health agencies received higher payments than warranted due to miscoding.

Quality Assessment and Assurance Committees

The role and effectiveness of quality assessment and assurance committees in ensuring quality of care in nursing homes will be under examination.

Consolidated Billing Requirements

CMS' efforts to determine the extent of overpayments made during 2000 for certain Part B services subject to the consolidated billing provisions of the PPS for skilled nursing facilities will be monitored by the OIG.

Advance Beneficiary Notices

The OIG will examine the use of advance notices to Medicare beneficiaries and their financial impact on beneficiaries and providers. The OIG believes that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to non-covered laboratory services.

Physician Evaluation and Management Codes

The OIG will determine whether physicians correctly coded evaluation and management services in physician offices and effectively used documentation guidelines. It will also assess whether carriers identified any instances of incorrect coding and what corrective actions they took.

Consultations

The appropriateness of billings for physician consultation services and the financial impact on the Medicare program from any inaccurate billings will be reviewed. The OIG will determine the primary reasons for inappropriate billings.

Inpatient Dialysis Services

This review will determine whether Medicare payments for inpatient dialysis services met the billing requirements of Medicare Part B. Medicare requires that the physician be physically present with the patient at some time during the dialysis session and that the medical record document this in order for the physician to be paid on the basis of dialysis procedure codes. If the physician visits the patient on a dialysis day, but not during the dialysis treatment, physician services are billable under the appropriate hospital visit codes.

Medicare Billings for Cholesterol Testing

The OIG will determine whether cholesterol tests billed to Medicare are medically necessary and accurately coded. Although total cholesterol testing can be used to monitor many patients, Medicare claims reflect a prevalence of claims for lipid panels, which include HDL cholesterol and triglycerides. Medicare claims will be examined for the frequency of testing and the medical necessity of lipid panels.

Utilization Service Patterns for End-stage Renal Disease

The utilization of healthcare services by end-stage renal disease beneficiaries will be examined and the medical necessity and accuracy of coding of selected categories of services provided outside the composite rate will be assessed.

Medicare Mental Health National Error Rate

A national payment error rate for Medicare fee-for-service mental health claims will be developed by the OIG. Medical reviews of a sample of claims will be reviewed to determine medical necessity, coding accuracy, coverage, and setting of care.

Medicaid Hospital Patient Transfers

The propriety of Medicaid claims for hospital-patient transfers in states that use prospective payment principles in reimbursing hospitals for inpatient admissions will be examined.

Mutually Exclusive Procedure Codes (Medicaid Services)

The OIG will determine the extent of potential overpayments or savings that could accrue to the federal and state governments under the Medicaid program if edits were implemented to identify and deny payments for procedure codes that CMS has identified as mutually exclusive.

Provider Education and Training

The OIG will examine Medicare carriers' provider education and training efforts and identify any promising practices. These efforts, required and funded by CMS, include training providers and their staff on the complexities of submitting claims (such as coverage, payment, and billing policy), answering providers' requests for guidance on coverage, reimbursement, and medical necessity policy, and identifying providers that habitually submit claims that create processing problems and targeting them for training.

Medicare Comprehensive and Component Procedure Codes

The adequacy of fiscal intermediary and carrier procedures and controls to prevent inappropriate Medicare payments for comprehensive and component procedure codes will be determined. CMS has identified coding combinations and has developed related computer edits to preclude improper payments. These coding combinations involve "comprehensive and component" procedures for services provided to the same beneficiary by the same provider during the same session.

Improper Medicare Fee-for-service Payments

The OIG will determine whether fiscal year 2001 Medicare fee-for-service benefit payments were furnished by certified Medicare providers to eligible beneficiaries, made in accordance with Medicare laws and regulations, medically necessary, accurately coded, and sufficiently documented. They will review a sample of claims and patient medical records and use statistical sampling techniques to project results nationwide and compute a national error rate.

Healthcare Fraud Investigations

The OIG's Office of Investigations will investigate individuals, facilities, or entities that bill the Medicare or Medicaid program for services not rendered, claims that manipulate payment codes in an effort to inflate reimbursement amounts, and other false claims submitted to obtain program funds. Special focus areas include pharmaceutical fraud and quality of care issues for beneficiaries residing in care facilities. Business arrangements that violate anti-kickback statutes will also be investigated. The Office of Investigations will not allocate resources to conduct investigations of individuals, facilities, or entities that committed errors or mistakes on claims submitted to the Medicare or Medicaid program.

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