OIG Mobilizes for 1999

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently presented its Work Plan for Fiscal Year 1999. The Work Plan discusses endeavors the OIG plans to undertake in 1999 (or shortly thereafter), including a listing of areas targeted for investigation, and a brief description of why and how each project will be scrutinized.

Following are a few areas the OIG has stated it plans to examine in 1999.*

Hospital Quality Oversight

We will assess the Health Care Financing Administration's (HCFA's) oversight of private accreditation and state certification activities, as well as the role of private accreditation and state licensure. In order for hospitals to receive Medicare payments, they must be certified by Medicare (through federally reimbursed state surveys) as meeting Medicare requirements or they must be accredited by a recognized accrediting association. Of the 6200 hospitals currently participating in the Medicare program, over 70 percent are accredited: about 4700 through the Joint Commission on Accreditation of Healthcare Organizations and 144 through the American Osteopathic Association.

Prospective Payment System Transfers

We will continue to support the Department of Justice's assistance to the [OIG] in seeking recovery of Medicare overpayments to prospective payment system (PPS) hospitals that incorrectly reported PPS transfers. The transfer payment policy stipulates that when a Medicare patient is transferred between PPS hospitals, the first (transferring) hospital receives a per diem payment limited to the length of stay, while the hospital receiving the transferred patient is paid a diagnosis-related group (DRG) payment based on the final discharge code. Incorrect reporting of these transfers allows both hospitals to receive the full payment amount. We also plan to issue a report recommending recovery of overpayments from hospitals that are not covered by the Justice Department's project.

Monitoring Diagnosis-related Group Coding

We will assess the extent and quality of HCFA's monitoring of DRG coding by hospitals. In a medical record abstraction of 1996 hospital discharges done by the data abstraction contractors, the contractors found a variation of 8 to 10 percent between initial hospital coding and the data abstraction contractor coding. The OIG also found significant coding error rates in a recent sample of hospital medical records. This current study will explore reasons why these errors are occurring and what HCFA does to monitor and correct the errors.

Nursing Home Implementation of Consolidated Billing

We will examine the early implementation of consolidated billing in nursing homes. The Balanced Budget Act legislated a new billing method for all Part B services provided to Medicare beneficiaries residing in nursing homes, effective July 1, 1998. For nursing home stays not paid by Medicare Part A, nursing facilities will be responsible for submitting bills to Medicare contractors for most Part B services. Outside entities will no longer be able to directly bill the program. This is known as consolidated billing. We will examine nursing homes' response to the consolidated billing requirements and the guidance HCFA provided to nursing homes on implementing consolidated billing.

Accuracy and Carrier Monitoring of Physician Visit Coding

We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. In 1992, Medicare began using new visit codes that were developed by the American Medical Association for reimbursing physicians for evaluation and management services.

Generally, the codes represent the type and complexity of services provided and patient status, such as new or established. Previous work by the OIG has found that physicians do not accurately or uniformly use visit codes. Our analysis will build upon this previous work and add more definitive data on the accuracy of physician visit coding.

Pneumonia DRG Upcoding Project

This cooperative effort with the Department of Justice focuses on information that hospitals have upcoded the DRG for pneumonia claims from viral to bacterial pneumonia. By doing this, the hospitals obtained almost $2500 extra per claim in reimbursement. The OIG is looking at both civil and criminal implications.

**Projects are excerpted from the OIG Work Plan. A copy of the Work Plan can be found at http://www.hhs.gov/progorg/oig. Go to the OIG reading room and select Health Care Financing Administration projects.*

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