A Review of the 2011 OIG Workplan – Risk Areas For Everyone!

An Analysis of Identified Medicare Risk Areas for Outpatient Providers, ASCs, SNFs, and HHAs

Learning Points

• Target areas for elevated enforcement for 2011
• How to identify if you are a potential post-payment target
• Recommendations for reducing post-payment risk associated with each risk area
OIG MISSION

OIG’s operational mission is to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws. We carry out our mission by conducting audits, evaluations, and investigations; providing guidance to industry; and, when appropriate, imposing civil monetary penalties, assessments, and administrative sanctions. We work closely with HHS and its Operating and Staff Divisions; the Department of Justice (DOJ) and other agencies in the executive branch; Congress; and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds.

Work Plan is Dynamic

- While the OIG Workplan details the specific audits/evaluations underway or planned for the year, OIG advises that work planning is an ongoing and dynamic process.
- Adjustments to the plan can and do occur throughout the year to respond to emerging issues.
Workplan – Major Parts

- **PART I** – Medicare Part A and B
- **PART II** – Medicare Part C and D
- **PART III** – Medicaid Reviews
- **PART IV** – Legislative and Investigative Activities
- **PART V** – Public Health Reviews
- **PART VI** – Human Services Reviews
- **PART VII** – Department-wide Issues

Part B – Home Health Agencies

- OIG will focus on claims to verify that patients are
  - Homebound;
  - Need intermittent skilled nursing care, physical or speech therapy, or occupational therapy;
  - Are under the care of a physician; and
  - Be under a plan of care that has been established and periodically reviewed by a physician.

42 C.F.R. §409.42
Part B – Home Health Agencies

- OIG will also focus on Outcome and Assessment Information Set (OASIS) Data
  - HHAs are required to conduct accurate comprehensive patient assessments that include OASIS data items.
  - OASIS data must reflect the HHA’s performance in helping patients to REGAIN or maintain their ability to function and perform ADLs.
  
  42 C.F.R. §484.55

Part B – Home Health Agencies

- OIG will Review Compliance with Payment Systems Controls
  - OIG will analyze HHA profitability and potentially adjust payment methodology
  - OIG notes that HHA expenditures have increased from $8.5B in 2000 to $16.4B in 2008
  - OIG will monitor trends in HHA Activities
    - Number of claims submitted
    - Number of visits provided to beneficiaries
    - Arrangements
    - Ownership Information
Part B – Nursing Facilities

- Medicare Requirements for Quality of Care in SNFs
  - OIG will review the extent to which SNFs
    - Developed plans of care based on assessment of beneficiaries;
    - Provided services in accordance with plans of care; and
    - Planned for discharge of the beneficiary.
  - OIG data suggests that 25% of SNF residents needs for care, as assessed through the Resident Assessment Instrument (RAI), were not reflected in the plans of care.
- OIG will perform closer oversight or poorly performing SNFs.
  - OIG will examine enforcement decisions resulting from defects identified during the SNF survey and certification process.

Part B – Nursing Facilities

- Hospitalizations of Nursing Home Residents
  - OIG will review the extent to which hospitalization was due to poor nursing home care on the basis that a 2007 OIG study found this to be the case for 35% of the hospitalizations.
  - OIG will target Nursing Homes with high rates of hospitalization.
- Criminal Background Checks for NH Employees
  - SSA §§1819(b)(2), 1919(b)(2) require NH participating in Medicare/Medicaid to provide services that maintain the dignity and well being of all NH residents.
  - OIG will evaluate the extent to which NH employs persons convicted of crimes and will categorize the types of crimes committed by NH employees to evaluate conformance with this provision of the SSA.
Part B – Other Providers - ASCs

• Place of Service Errors
  – OIG will review physician coding of place of service on Medicare Part B claims for services performed in ASCs and hospital outpatient departments.
  – Different payment amounts exist based on place of service. See 42 C.F.R. §414.32

• ASC Payment System
  – Based on requirements of the Medicare Modernization Act, OIG will review appropriateness of methodology used to set ASC payment rates under revised ASC payment system.

Part B – Other Providers – E/M

• The Perpetual Risk Area
  – $25B or 19% of all Medicare Part B payments are for E/Ms

• Coding of E/M Services
  – Type, setting, complexity. See Medicare Claims Processing Manual, IOM Pub 100-4, Ch. 12, §30.6.1.

• Payment of E/M Services
  – OIG Notes a concern regarding an increased frequency of medical records with identical documentation across services.
  – Multiple E/M services for the same providers/beneficiaries for EHR documentation practices leading to improper payments.

• E/M During Global Period
  – See Medicare Claims Processing Manual, IOM Pub 100-4, Ch. 12, §40.
  – OIG will review industry practices related to number of E/M services provided during global period to see if this has changed since the global fee concept was originated in 1992
Part B – Other Providers – Imaging

• Medicare Payments for Part B Imaging Services
  – OIG intends to analyze the practice expense component of imaging services
  – For selected services, OIG will focus on actual expenses as well as utilization rates to determine whether the utilization rates reflect industry practices.

Part B – Other Providers – PT

• Outpatient PT Services Provided by Independent Therapists
  – Medical Necessity
    • Medicare will evaluate necessity of care focusing heavily on conformance with the documentation standards outlined in the Medicare Benefit Policy Manual, IOM Pub 100-2, Ch. 15, §220.1.3.
    • Documentation compliance is deemed a proxy for determining whether services are medically necessary.
  
• Questionable Billing for Medicare Outpatient Therapy
  – OIG will focus on high utilization counties after comparison of each county with national averages.
  – Therapists with high utilization rates will be evaluated to determine if therapy services met Federal Requirements
Part B – Other Providers – Sleep

• Appropriateness of Medicare Payments for Polysomnography
  – Sleep studies reimbursable only for patients with certain conditions (sleep apnea, narcolepsy, impotence, or parasomnia). See Medicare Benefit Policy Manual, IOM Pub 100-2, Ch. 15, §70.
  – Medicare payments for sleep studies increased from $62M in 2001 to $235M in 2009.

• Medicare Payments for Sleep Testing Provided at Sleep Disorder Clinics
  – OIG will focus on the necessity of these studies. See Medicare Benefit Policy Manual, IOM Pub 100-2, Ch. 15, §70.
  – Preliminary review by OIG revealed improper payments due to failure to report certain modifiers.

Part B – Other Providers – Diagnostic Testing

• Excessive Payments for Diagnostic Tests
  – Focus on high cost diagnostic tests.
  – OIG will evaluate whether tests were medically necessary.
  – OIG will determine the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment (redundant tests).
Part B – Other Providers – Lab

- Laboratory Test Unbundling by Clinical Laboratories
  - OIG will evaluate the extent to which labs are unbundling laboratory profile or panel tests in order to maximize Medicare payments.
  - Payment for individual tests “must not exceed” the lower of the profile/panel price or the total price of all of the individual tests when bundled.
  - OIG will also look at a form of unbundling where different specimens are drawn on sequential days.
- Medicare Part B Payments for Glycated Hemoglobin A1C Tests
  - No more than once every 3 months for a patient with controlled diabetes. See the Medicare National Coverage Determinations Manual, IOM Pub 100-3, Ch. 1, pt. 3, §190.21.
- Trends in Laboratory Utilization
  - $7B in 2008, which is an increase of 92% from the amount in 1998. Nearly $10B in 2009.
  - OIG will look at how physician specialty, diagnosis, and geography impacts utilization of lab services.

Part B – Other Providers – IDTFs

- Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
  - Those in areas with a high density of IDTFs will face increased scrutiny.
  - OIG identified noncompliance with Medicare standards and potential overpayments of $71.5M in 2006. IDTFs received approximately $860M in payments in 2009.
- IDTF Compliance with Medicare Standards
  - IDTFs must certify on enrollment that they comply with 17 different standards including compliance with all Federal and State licensing and regulatory requirements, provide accurate and complete information on applications, and have on duty properly credentialed technical staff to perform the tests. 42 C.F.R. §410.33
Part B – Other Providers – CORFs

• Comprehensive Outpatient Rehabilitation Facilities
  – $61M for 35,000 Bene’s in 2009
  – OIG Identified that CORF services did not meet Medicare standards Not medically necessary
    • Lacked documentation that services were provided
    • Potentially inappropriate rental arrangements between CORFs and landlords.
    • Failed to provide safe and sufficient space for scope of services offered. (42 C.F.R. §485.62)
  – OIG to conduct site visits to evaluate compliance with Medicare standards

Part B – Other Providers – Assignment Rules

• Medicare Provider’s Compliance With Assignment Rules
  – OIG will evaluate the extent to which beneficiaries are inappropriately billed in excess of amounts allowed by Medicare requirements.
  – Assignment agreements must be written.
  – OIG will also direct efforts to ensure patients understand their rights.
Part B – Other Providers – Modifier GY

- Medicare Billings with Modifier GY
  - Service not statutorily covered.
  - Providers not obligated to give beneficiaries advance notice of charges for services that are excluded from Medicare by statute. See Medicare Claims Processing Manual, IOM Pub 100-4, Ch. 1, §60.1.1.
    - This includes services that are not medically necessary since non-medically necessary care is not covered under the Medicare statute.
  - Providers are only required to report covered services to Medicare. See 42 U.S.C. §1395w-4(g)(4)(A)

Part B – Other Providers – Excluded Providers

- Payments for Services Ordered or Referred by Excluded Providers
  - OIG will focus on oversight mechanisms employed by CMS to identify services ordered, referred or provided by excluded providers.
Part B – Other Providers – Error Prone Providers

• Error-Prone Providers: Medicare Part A and Part B
  – Expect increased scrutiny if:
    • the CERT program has determined that your specialty is error prone (provider types that consistently submitted erroneous claims over a 4 year analysis period); and
    • You are a top error prone provider by comparison of the total dollar amount of your claims paid and the National Claims History file.

Contractor Operations

• Zone Program Integrity Contractors’ Identification of Potential Fraud and Abuse
• Vulnerabilities Identified by Medicare Benefit Integrity Contractors
• Identification and Recoupment of Improper Payments by Recovery Audit Contractors
• Variation in Coverage of Services and Medical Expenditures Due to Local Coverage Determinations
• Provider Education and Training: Medicare Affiliated Contractors’ Progressive Correction [sic] Action
Legal Activities

- Exclusions from Program Participation
  - In 2009, 2,556 individuals or entities were excluded from Medicare.
- Civil Money Penalties
  - False or fraudulent claims,
  - Solicitation or receipt of Kickbacks
  - Violations of EMTALA
  - Poor Quality of Care (pattern of medically unnecessary care?)
  - Other conduct actionable under the SSA §1128A
- Resolution of False Claims Act Cases and Negotiation of Corporate Integrity Agreements
- Provider Compliance with Corporate Integrity Agreements

Legal Activities

- Advisory Opinions and Other Industry Guidance
- Provider Self-Disclosure
  - Self disclosure protocol only appropriate for violations of Federal law. Matters exclusively involving overpayments or errors that do not indicate violations of the law are brought directly to the attention of the entity responsible for claim processing and payment.
- Investigative Activities
  - OIG Investigative Outcomes provides a summary of OIG investigative activity. Semiannually to Congress. See http://www.oig.hhs.gov/publications.asp
- Health Care Fraud
  - Billing services not performed
  - Claims that manipulate payment codes to inflate reimbursement amounts
  - Improper business arrangements (STARK/AKB)
  - Quality of Care (nursing facilities, institutions, and community-based settings), billing for a pattern of medically unnecessary care, or substandard care that is so deficient that it constitutes "worthless services."
  - Drug benefit issues
  - DME