

2010 OIG Work Plan – Implications for Rehab, Skilled Nursing, and Psychiatric Providers

By:

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Introduction

On October 1, 2009, the Department of Health and Human Services' Office of Inspector General (OIG) released its Work Plan for fiscal year 2010 (Work Plan). The Plan was effective beginning October 1, 2009 and it describes new and ongoing audit and enforcement priorities of the OIG.

The Work Plan addresses the areas and issues the OIG intends to audit, evaluate and inspect during fiscal year 2010. The Work Plan also provides some insight into the areas and issues that may evolve into future OIG enforcement activities. Therefore, health care providers and suppliers should carefully consider the Work Plan in relation to their strategic operations.

The Plan is helpful in shaping compliance programs and identifying compliance risk areas upon which providers should focus ongoing efforts over the next 12 months.

New OIG Work Plan Activities Overview

Although there is significant overlap between the FY 2010 and FY 2009 OIG Work Plan activities, there are several new areas; many of which focus on the quality of care provided to Medicare beneficiaries.

In particular, new hospital focus areas include: conditions present on admission, hospital readmissions, adverse events, payments for nonphysician outpatient services under the Inpatient Prospective Payment System, inpatient rehabilitation facility submission of patient assessment instruments, and observation services during outpatient visits. New focus areas for other types of providers/suppliers include, but are not limited to, home health agency outlier payments, quality of care in skilled nursing facilities and payments for services ordered or referred by excluded providers.

Hospital Activities

A vast majority of the 2010 OIG work plan focuses on hospital activities. In previous years, many of the OIG's planned reviews were on topics with a long history of consideration including bad debt, Medicare secondary payer, and wage indices. Some of the new hospital risk areas that the OIG will focus on during FY 2010 include the following:

Hospital Readmissions

According to CMS guidance found in the Medicare Claims Processing Manual, 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 DRG payment and should combine the original and subsequent stays into a single claim. Hospital readmissions present not only a quality of care concern, but also a hospital efficiency problem.

CMS previously implemented a coding edit in 2004 to reject subsequent claims when beneficiaries are readmitted to the same hospital on the same day. In addition, the OIG will now test the effectiveness of this edit. Quality Improvement Organizations are also required to review cases in which a beneficiary is readmitted to a hospital less than 31 days after being discharged from the hospital. The OIG will review the extent of oversight of these readmission cases.

Hospital Admissions with Conditions Coded Present-On-Admission ("POA")

Section 1886(d)(4)(D) of the Social Security Act requires acute care hospitals to report on their Medicare claims when diagnoses are present when patients are admitted to hospitals. For certain diagnoses specified by CMS, hospitals receive lower payment amounts if the specified diagnoses are acquired in the hospital. The OIG will review claims to determine the number of inpatient hospital admissions for which certain diagnoses are coded as being POA and the conditions that are most frequently coded as POA. The OIG will also determine which types of facilities are most frequently transferring patients with a POA diagnosis specified by CMS to hospitals and whether specific providers transferred a high number of patients to hospitals with POA diagnoses.

Adverse Events

An "adverse event" is any event that causes harm to a patient as a result of medical care. Adverse events include, but are not limited to, "never events" which are events that should never occur in a health care setting. The OIG is expanding its review beyond never events and will review the following:

- The national incidence of adverse events among Medicare beneficiaries in inpatient hospital settings;
- The methods for identifying adverse events (including medical record reviews, administrative data analysis and interviews with beneficiaries);
- CMS administrative processes for identifying hospital-acquired conditions and denying higher Medicare reimbursement for related care;
- Responses of State survey and certification agencies, State licensure boards, and Medicare accreditors to adverse events in hospitals; and
- Policies and practices related to the public disclosure of adverse event information.

Observation Services During Outpatient Visits

The OIG will also review Medicare payments for observation services provided during outpatient visits in hospitals. Specifically, the OIG will assess whether and to what

extent hospitals' use of observation services affects the care Medicare beneficiaries' receive and their ability to pay out-of-pocket expenses for health care services. The OIG plans to determine whether the observation services are delivered according to CMS guidelines.

New Key Areas Identified in OIG 2010 Work Plan			
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Hospitals	Rehabilitation Providers	Skilled Nursing Facilities	Inpatient Psychiatric
<ul style="list-style-type: none"> ✓ Present-on-Admission Conditions ✓ Hospital Readmissions ✓ Oversight of EMTALA Compliance ✓ Observation Services During Outpatient Visits ✓ Hospital Payments for Nonphysician Outpatient Services under IPPS ✓ Review of Hospital-Related Quality Measure Data 	<ul style="list-style-type: none"> ✓ Outpatient PT Services provided by Independent Therapists ✓ Submission of Patient Assessment Instruments for Inpatient Rehabilitation Facilities ✓ Review Appropriateness of Payments by Medicaid for PT & OT 	<ul style="list-style-type: none"> ✓ SNFs' Use of the Resident Assessment Instruments (RAI) ✓ Criminal Background Checks on Employees ✓ Monitoring Part B Payments 	<ul style="list-style-type: none"> ✓ Interrupted Stays at Inpatient Psychiatric Facilities Payments
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Rehabilitation Specific Activities

In addition to the hospital specific issues above, the OIG has also released rehabilitation focused areas of review including the following:

IRF Submission of Patient Assessment Instruments

The IRF Prospective Payment System provides that if patient assessments are not encoded and transmitted within defined time limits, payments are to be reduced. The OIG will review Medicare payments for IRF stays in which patient assessments were transmitted to the Centers for Medicare and Medicaid Services ("CMS") late to determine whether payments were correctly made. The OIG will also review IRF claims to determine whether patient assessments were submitted in accordance with Medicare regulations.

Outpatient Physical Therapy Services Provided by Independent Therapists

The OIG will review outpatient physical therapy services provided by independent therapists to determine whether they are in compliance with Medicare regulations. According to the OIG, previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary or properly documented. Focusing on independent therapists with high utilization rates for outpatient physical therapy services, the OIG will determine whether the services billed to Medicare were in accordance with Federal requirements.

Medicaid PT and OT Services: Appropriateness of Payments

The OIG will also review the appropriateness of payments for Medicaid physical and occupational therapy services. Pursuant to 42 CFR § 440.110, states may provide physical and occupational therapy services to Medicaid beneficiaries. Previous OIG studies found that some physical and occupational therapy services provided under Medicare were medically unnecessary, were billed incorrectly, or were rendered by unqualified providers. Through a medical review, the OIG will determine whether Medicaid has similar program integrity issues.

Skilled Nursing Facility Specific Activities

The OIG's review of services provided to beneficiaries in SNFs focuses mainly on quality issues such as oversight of poorly performing facilities, the SNFs' adherence to quality of care requirements, and the appropriateness of mental health treatments. The Plan calls for a continuation of payment reviews of psychotherapy services and of antipsychotic drugs. In addition, the OIG will continue its examination of the accuracy of SNF Resource Utilization Groups (RUG) coding. Other areas to be reviewed by the OIG include:

SNFs' Use of the Resident Assessment Instruments (RAI)

SNFs that participate in Medicare and Medicaid are required to use standardized RAI to develop residents' plans of care. The OIG will look at the extent to which SNFs have based plans of care on RAIs, provided services in accordance with the plans of care, and planned for beneficiaries' discharges. In the past, as many as one quarter of residents' needs identified in RAIs were not reflected in plans of care.

Criminal Background Checks

In addition to the prohibition against employing an individual who has been excluded from participation in the federal health care programs, federal regulations prohibit long-term care facilities from employing individuals found guilty of abusing, neglecting, or mistreating residents. The OIG plans to scrutinize SNFs to determine whether individuals with such criminal convictions are being employed.

Part B Services in Nursing Homes

Congress has directed the OIG to monitor payments made for Part B services in SNFs based on the potential for abuse. Part B services, unlike services provided during a Part A SNF stay, are billed directly by suppliers and other providers. The review will assess the extent to which Part B services are provided in SNFs and the billing patterns among SNFs and other providers.

Psychiatric Facility Specific Activities

The OIG states that it will be reviewing inpatient psychiatric facility claims related to transfers from one IPF to another IPF or within the same IPF. CMS reimburses inpatient psychiatric services based on the number of days that have elapsed since admission. The earlier days of admission are reimbursed at higher per diem rates.

The OIG is concerned with the practice of discharging a patient and then readmitting that patient in order to secure the higher rate of reimbursement that is payable during the earlier portion of the stay and has targeted that area for review. Under the rules, if a patient is discharged from a facility and then readmitted to the same or another facility within 3 days of discharge, both admissions are treated as one continuous stay and the higher reimbursement rates for the early portions of the second admission are not applicable.

The OIG states that it will be reviewing claims where discharge and readmission occur to be certain that it is not overpaying for the services of the second admission. Psychiatric facilities may want to consider auditing their procedures where discharges and readmission occur or where readmission is accepted from another facility to be certain that the readmission is properly coded to comply with the single stay rule.

Conclusion

Providers should use the 2010 OIG Work Plan when considering how to effectively identify and structure their compliance program activities throughout the remainder of the year. In today's environment, which demands transparency and accountability, it is more important than ever for healthcare providers to continually review and monitor federal and state directed compliance. Policies, procedures and practices should be reviewed and updated annually to ensure full conformity with new regulations and areas of heightened CMS and OIG focus.

About the Author:

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