

SUMMARY OF THE OIG 2013 WORK PLAN

EXECUTIVE SUMMARY

On October 2, 2012, the Office of Inspector General ("OIG") published its Work Plan for Fiscal Year ("FY") 2013 ("Plan"). The Plan, which is published annually and describes the OIG's new and ongoing audit and enforcement priorities for the upcoming year, is helpful in identifying corporate compliance risk areas and providing focus for providers' ongoing efforts relating to their compliance program activities, audits and policy development. Compliance Officers should carefully review the Plan when preparing their own organization's annual compliance audit priorities to ensure they include the pertinent risk areas identified by the OIG.

Although there is significant overlap between the FY 2013 Plan and the OIG's previous Work Plan activities, there are several new areas of focus. In particular, some of the significant new hospital focus areas include, but are not limited to, compliance with Medicare's transfer policy, payments for discharges to swing beds in other hospitals, payments for canceled surgical procedures, payments for mechanical ventilation and payments for interrupted stays. Significant new focus areas for other types of providers/suppliers include, but are not limited to, nursing home use of atypical antipsychotic drugs, compliance with the home health face-to-face requirement, payments for personally performed anesthesia services, rural health clinic compliance with location requirements and Medicare payments for Part B claims with G modifiers.

A complete copy of the Plan may be accessed on the [OIG's website](#). A summary of the OIG's key FY 2013 hospital audit areas and other activities is provided below.

NEW MEDICARE HOSPITAL AUDIT ACTIVITIES

Significant new hospital risk areas that the OIG will focus on during FY 2013 include the following:

- Compliance with Medicare's Transfer Policy. The OIG will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers. The OIG will determine whether such claims were appropriately processed and paid. The OIG will also review the effectiveness of the Medicare Administrative Contractors' claims processing edits used to identify claims subject to the transfer policy. Pursuant to federal regulations, a hospital discharging a beneficiary is paid the full Diagnostic Related Group ("DRG") payment amount. In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate, not to exceed the full DRG payment that would have been made if the beneficiary had been discharged without being transferred.
- Payments for Discharges to Swing Beds in Other Hospitals. The OIG will review Medicare payments made to hospitals for beneficiary discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services. As previously noted, a hospital discharging a beneficiary is paid the full DRG payment amount. In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another prospective payment system ("PPS") hospital. This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted for additional care in other clinical settings. However, Medicare does not pay the reduced graduated per diem rate if that patient was discharged to a swing bed in another hospital. If appropriate, the OIG will recommend that the Centers for Medicare and Medicaid Services ("CMS") evaluate its policy related to payment for hospital discharges to swing beds in other hospitals.
- Payments for Canceled Surgical Procedures. The OIG will determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures. The OIG's preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed by a second, higher PPS payment to the same hospitals for the rescheduled surgical procedure. For these claims, the canceled surgical procedure was the principal reason for the initial hospital admission. For these short-stay claims, few, if any, inpatient services (i.e., laboratory or diagnostic tests) were provided by the hospitals because the surgical procedure was canceled. Medicare makes two payments to hospitals that generate two bills unless the patient is readmitted to the hospital on the same day, in which case a single payment is made. The OIG's analysis also identified inpatient claims with canceled surgical procedures for stays of less than two days that were not followed by subsequent

inpatient admissions to the same hospitals for the rescheduled surgical procedures. Current Medicare policy does not preclude payment for these claims.

- Payments for Mechanical Ventilation. The OIG will review Medicare payments for mechanical ventilation to determine whether the DRG assignments and resultant payments were appropriate. The OIG will review selected Medicare payments to determine whether patients received fewer than 96 hours of mechanical ventilation. Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient. For certain DRG payments to qualify for Medicare coverage, a patient must receive 96 or more hours of mechanical ventilation.
- Payments for Interrupted Stays. The OIG will determine the extent to which Medicare made improper payments for interrupted stays in long-term care hospitals ("LTCHs") in 2011. The OIG will also identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. LTCHs are generally defined as inpatient acute care hospitals with an average length of stay greater than 25 days. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days. Interrupted stays in LTCHs cause an adjustment in Medicare payments. Prior OIG work has identified vulnerabilities in CMS's ability to detect readmissions and appropriately pay for interrupted stays.

CONTINUING MEDICARE HOSPITAL AUDIT ACTIVITIES

In FY 2013, the OIG will also continue to examine several compliance risk areas that have been the focus of previous years' work, including the following:

- Hospital Same-Day Readmission
- Acute-Care Inpatient Transfers to Inpatient Hospice Care
- Hospital Admissions with Conditions Coded Present on Admission
- Inpatient and Outpatient Payments to Acute Care Hospitals
- Hospital Inpatient Outlier Payments
- Medicare's Reconciliations of Outlier Payments
- Duplicate Graduate Medical Education Payments
- Hospital Occupational-Mix Data Used to Calculate Inpatient Hospital Wage Indexes
- Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices
- Outpatient Dental Claims
- Outpatient Observation Services During Outpatient Visits
- Critical Access Hospital Variations in Size, Services and Distance from Other Hospitals
- Transmission of Patient Assessment Instruments in Inpatient Rehabilitation Facilities
- Appropriateness of Admissions and Level of Therapy in Inpatient Rehabilitation Facilities

OTHER NEW PROVIDER/SUPPLIER AUDIT AREAS

The OIG Work Plan identifies enforcement priorities not only for hospitals but also for other types of providers/suppliers, including home health agencies, skilled nursing facilities, medical equipment suppliers and physicians. Some of the significant new focus areas that the OIG identified for these providers/suppliers during FY 2013 include the following:

- Nursing Home Use of Atypical Antipsychotic Drugs. The OIG will assess nursing homes' administration of atypical antipsychotic drugs, including the percentage of residents receiving these drugs and the types of drugs most commonly received. The OIG will also describe the characteristics associated with nursing homes that frequently administer atypical antipsychotic drugs. Nursing homes must comply

with federal quality and safety standards, including requiring the monitoring of the prescription drugs prescribed to its residents. Federal requirements also require that nursing home residents' drug regimens be free from unnecessary drugs.

- Home Health Face-to-Face Requirement. The OIG will determine the extent to which home health agencies ("HHAs") are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries. The encounters must occur within 120 days, either within the 90 days before beneficiaries start home health care or up to 30 days after care begins. The OIG work conducted before the Affordable Care Act mandate went into effect found that only 30% of beneficiaries had at least one face-to-face visit with the physicians who ordered their home health care.
- Payments for Personally Performed Anesthesia Services. The OIG will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. The OIG will also determine whether Medicare payments for anesthesiologist services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed or medically directed. The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, and the "QK" modifier is used for medical direction of two, three or four concurrent anesthesia procedures by an anesthesiologist. The QK modifier limits payment at 50% of the Medicare-allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due.
- Rural Health Clinic Compliance with Location Requirements. The OIG will determine the extent to which Rural Health Clinics ("RHCs") do not meet basic location requirements. The Balanced Budget Act of 1997 permitted CMS to remove clinics that do not meet location requirements from the RHC program. In 2005, the OIG recommended that CMS promulgate regulations implementing the Balanced Budget Act of 1997. CMS has yet to promulgate the final regulations allowing for the removal of RHCs. As a result, RHCs that no longer meet eligibility requirements continue to receive enhanced Medicare reimbursement. The OIG will determine the extent to which such reimbursements are occurring.
- Medicare Payments for Part B Claims with G Modifiers. The OIG will determine the extent to which Medicare improperly paid claims from 2002 to 2011 in which providers entered GA, GX, GY or GZ service code modifiers, indicating that Medicare denial was expected. Providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary pursuant to CMS's Claims Processing Manual. They may use GX or GY modifiers for items or services that are statutorily excluded. A recent OIG review found that Medicare paid for 72% of pressure-reducing support surface claims with GA or GZ modifiers, amounting to \$4 million in potentially inappropriate payments.

CONCLUSION

As indicated above, the Plan is useful in giving providers a preview of many of the OIG's enforcement priorities planned for FY 2013. Providers should take advantage of this opportunity to consider how to effectively focus their compliance program activities over the ensuing 12 months.

If you would like additional information, please contact your regular Hall Render attorney or Scott W. Taebel, Leia C. Olsen or Stephane P. Fabus via email at staebel@hallrender.com, lolsen@hallrender.com and sfabus@hallrender.com or by telephone at (414) 721-0442 at the Milwaukee, Wisconsin office of Hall, Render, Killian, Heath & Lyman, P.C.