OIG PUBLISHES 2013 WORK PLAN

The Office of the Inspector General (OIG) has published their annual Work Plan for 2013. The Work Plan continues to identify compliance risk areas that subject Medicare and Medicaid providers to audit and enforcement initiatives. The Work Plan specifically targets skilled nursing facilities (SNFs), hospices, and home health agencies (HHAs). For all types of providers, the main goal of this Work Plan is to focus on measuring and quantifying the cost and quality of care. A brief overview of the OIG's target areas for each provider type is listed below.

NURSING FACILITIES

Adverse Events in Post-Acute Care: The OIG will continue to work to identify the incidents of adverse and temporary harm events in SNFs, and determine the extent to which the events were preventable. Additionally, the OIG will work to estimate the cost to Medicare for such events.

Quality of Care Requirements: The OIG will continue to examine the extent of residential assessment instruments (RAIs) usage in SNFs to develop care plans that are tailored to individual residents in accordance with their plan of care.

State Agency Verification of Corrections: This is a new initiative of the OIG, which will determine whether state agencies actually verified corrective action plans for survey deficiencies. This initiative was designed after discovering certain state agencies did not always verify corrected deficiencies in accordance with Federal requirements.

Oversight of Poorly Performing Facilities: The OIG will continue to monitor poorly performing facilities, as measured by enforcement activities, to improve overall nursing facility performance.

Use of Antipsychotic Drugs: As part of a recent onslaught of legislative and regulatory action aimed at curbing the use of antipsychotics in SNFs, the OIG has created this new initiative to assess SNFs' administration of atypical antipsychotic drugs. This initiative will include the percentage of residents receiving these drugs and the types of drugs most commonly administered. The OIG will describe the characteristics associated with facilities that frequently administer such drugs.

Questionable Billing Patterns for Part B Services: Congress directed the OIG to monitor Part B expenditures in SNFs for potential for abuse. The OIG plans to institute a series of studies on podiatry, ambulance, laboratory, and imaging services.

Oversight of the Minimum Data Set: The OIG will work to determine whether and the extent to which CMS and the states oversee the accuracy and completeness of the minimum data set (MDS) data submitted by SNFs.

HOSPICES

Marketing Practices and Financial Relationships with SNFs: The OIG will continue to examine hospices' marketing materials and practices and their financial relationships with SNFs. A recent report discovered 82% of hospice claims for beneficiaries in nursing facilities did not meet the Medicare coverage requirements. The OIG will focus their review on hospices that have a high percentage of their beneficiaries in nursing facilities.

General Inpatient Care: The OIG will review the use of hospice general inpatient care in 2011. This also will include an evaluation as to the appropriateness of the care claims. The OIG will review hospice medical records to address concerns that this level of care is being abused.

HOME HEALTH AGENCIES

Face-to-Face Requirements: The OIG will determine the extent to which HHAs are complying with the requirement that physicians, or other permitted practitioners, who certify beneficiaries as eligible have face-to-face encounters with the beneficiaries.

Employment of Aides with Criminal Convictions: This is a new initiative the OIG is undertaking to determine the extent to which HHAs are complying with state requirements that criminal background checks be conducted with respect to HHA applicants and employees.

States' Survey and Certification- Timeliness, Outcomes, Follow-up, and Medicare Oversight: The OIG will review the timeliness of HHA certification and complaint surveys conducted by state survey agencies and accreditation organizations. Additionally, the OIG will review the

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outcome of those surveys and the follow-up of complaints against the HHA.

Missing or Incorrect Patient Outcome and Assessment Data: The OIG will review HHAs' outcome and assessment information set (OASIS) data to identify payments for episodes for which OASIS data were not submitted or for which the billing codes on the claims are inconsistent with OASIS data.

Medicare Administrative Contractors' Oversight of Claims: The OIG will review the activities that CMS and its contractors performed to identify and prevent improper home health payments from January through October 2011.

Home Health Prospective Payment System Requirements: The OIG will review compliance with various aspects of the home health prospective payment system (PPS), including the documentation required in support of the claims paid by Medicare.

Trends in Revenues and Expenses: The OIG will review cost report data to analyze HHA revenue and expense trends under the home health PPS to determine whether the payment methodology should be adjusted.

In summary, the OIG will be focusing their efforts on reviewing potential areas to discover fraud, quality issues, and costs. All provider types should expect ongoing pressures to improve quality measures in the face of stagnant or diminishing reimbursements.

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