HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

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COMPLIANCE ALERT 10-8

OIG 2010 Work Plan: Hot Compliance Areas for Hospitals Announced

Each year the Office of the Inspector General (OIG) presents a Work Plan for the fiscal year that describes activities that the OIG plans to initiate or continue with respect to the programs and operations of the Department of Health and Human Services. The Work Plan's purpose is to detect and prevent waste, fraud and abuse, to identify opportunities to improve program economy and efficiencies, and to hold accountable those who violate Federal laws and/or don't meet program requirements.

The OIG uses the Work Plan to conduct audits, reviews, investigations, and evaluations. Then the Work Plan is used to provide industry guidelines and suggest changes in program implementation. This year's Work Plan includes carryover projects from the 2009 Work Plan in addition to new thrusts of interest.

Specific NEW Areas of Hospital Focus: The 2010 OIG Work Plan has several new areas for Hospitals that it plans to review, investigate, and/or audit. They include:

- *Part A of the Inpatient Prospective Payment System (IPPS).* The OIG will review hospital and Medicare controls over the accuracy of the hospital wage data used to calculate the wage indexes for the IPPS. Prior work identified hundreds of millions of dollars in misreported wage data.

- *Reliability of Hospital-Reported Quality Measure Data.* The Work Plan will look at hospitals' controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement. They will be determining whether hospitals have implemented sufficient controls to ensure that their quality measurement data are valid. Overall, "quality" is a key focus for the 2010 OIG Work Plan.

- *Hospital Admissions with Conditions Coded as Present-on-Admission (POA).* This review will look at the number of patients admitted using various POA diagnoses and the subsequent coding. The

review will also look at the documentation used for POA assignments.

- *Hospital Readmissions.* The OIG will look at the number of readmission cases (readmission is defined as less than 31 days after being admitted) to determine if the correct DRG was used.

- *Compliance with EMTALA.* The OIG will review CMS's oversight of hospital compliance with EMTALA requirements.

- *Observation Services During Outpatient Visits.* The Work Plan will assess whether hospitals' use of observation services affects the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for health care services.

- *Coding and Documentation Changes Under the Medicare Severity Diagnosis Related Group System (MS-DRG).* On October 1, 2007 the MS-DRG system was implemented. This audit will examine coding trends and patterns under the new system and determine whether specific MS-DRGs are vulnerable to potential upcoding.

In addition to these seven areas, the OIG will review CMS's oversight of the RAC process to look at whether the RAC process goes too far or not far enough in uncovering potential fraud. The OIG will also look at CMS's compliance with the new data breach notification requirements in HITECH. The Work Plan also includes an examination of Medicare Incentive payments made to eligible health care professionals and hospitals for adopting electronic health records.

Continuing Focus Areas from Previous Work Plans. The 2010 OIG Work Plan includes several on-going efforts from previous Work Plans that include:

- *Medicare inpatient capital payments.* These are payments that reimburse a hospital's expenditures for assets such as equipment and facilities. The OIG will be investigating appropriateness of these payments.

- *Hospital Payment for Nonphysician Outpatient Services Under the IPPS.* The Work Plan will review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-Covered stays at acute care hospitals. The Social Security Act prohibits submissions of any additional claims to Part B for nonphysician services provided to inpatients by entities under arrangements with the hospitals. It is also prohibited to submit separate payments for outpatient diagnostic services and admission-related nondiagnostic

services rendered up to three (3) days before the dates of admission.

- *Inpatient Rehabilitation Facility (IRF) Submission of Patient Assessment Instruments*. Medicare payments for IRF stays in which patient assessments were transmitted to CMS late will be reviewed.

- *Interrupted Stays at Inpatient Psychiatric Facilities (IPF) Payments.* Interrupted stays in which a patient is discharged and then readmitted to the same or another IPF within three (3) days must be treated as one continuous stay so the OIG will be looking for improper claims. These types of claims will be examined.

- *Provider-based Status for Inpatient and Outpatient Facilities*. The OIG will review cost reports of hospitals claiming provider-based status. Currently, the criteria for qualifying as a provider-based off-site facility is subject to some interpretation so the OIG will look at clarifying this issue.

- *Critical Access Hospitals (CAH).* Payments to CAHs will be reviewed as will be the criteria and conditions for participation for CAH designation.

- *Duplicate Graduate Medical Education Payments.* OIG will make sure that no intern or resident as reimbursed by the Medicare Program is counted as more than one FTE. The Work Plan will also assess the effectiveness in prevent providers from receiving payments for duplicate graduate medical education costs.

- *Provider Bad Debts.* The Work Plan will focus on Medicare bad debts claimed by acute care inpatient hospitals, long-term care facilities, IRF, and IPG to determine if they were reimbursable.

- *Medicare Secondary Payer.* OIG will review Medicare payments for beneficiaries who have other insurance. It will look at whether hospitals are asking the correct questions to determine if there are other primary payers that should pay before Medicare.

- *Payments for Diagnostic X-rays in Hospital Emergency Departments*. The 2010 Work Plan will review Medicare Part B claims for diagnostic x-rays performed in emergency departments to determine the appropriateness of payments. Radiology services furnished by physicians are reimbursed by Medicare provided certain conditions are met. CMS is concerned about the increasing reimbursements and potential overuse of diagnostic imaging services.

Key Continuing OIG Focus Area: Adverse Events. One of the key on-going areas of focus this year is previously designated "never events." Now, re-labeled "adverse events," the OIG will conduct reviews in five major areas of hospital-acquired conditions (HAC) that include:

2. National incidence among Medicare beneficiaries of these adverse events to determine their prevalence and to determine if the events were preventable.

3. Methods to identify adverse events including policies in place, medical record review, administrative data analysis, hospital incident reports, and interviews with Medicare beneficiaries or their representatives.

4. Investigating Medicare's policy for HACs including how Medicare identifies these HACs and denies reimbursement for the related care.

5. Response to adverse events in hospitals by state survey and certification agencies, licensure boards, and Medicare accreditors.

6. Looking at how various agencies disclosed adverse event information and protected patient privacy.

This Compliance Alert summarizes the major thrusts for Hospital focus. A previous Compliance Alert 10-7 summarized ongoing efforts (continued in the 2010 Work Plan) to review payments for prescription drugs. Other areas of focus in the 2010 OIG Work Plan include nursing homes, home health agencies, Part A & B Provider Payments, DME providers, and Medicaid. A summary of Work Plan foci for these areas will be provided in a subsequent Compliance Alert.

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