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OIG FY 2013 Work Plan (Part 1): What Hospitals Can Look Forward To

Each year, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) publishes its Work Plan for the upcoming fiscal year ("FY"), which lists activities and reviews that the agency plans to pursue during that year. On October 2, 2012 the OIG published its Work Plan for FY 2013 in which it announced the OIG will initiate 11 new and continue 14 ongoing activities and reviews affecting hospitals. Notable throughout the FY 2013 Work Plan is the potential for major changes to Medicare's payment policies impacting hospitals. This article is the first in a series in which we will report on what healthcare providers should expect during the upcoming year based on the OIG FY 2013 Work Plan.

New Items Affecting Hospitals

The OIG plans to undertake 11 new reviews that will likely impact hospitals and the payments they receive under Medicare Parts A and B. These are briefly summarized below:

- Inpatient Billing for Medicare Beneficiaries. Noting that the Centers for Medicare & Medicaid Services (CMS) substantially changed the inpatient prospective payment system (PPS) in FY 2008, the OIG announces that it will examine how hospital inpatient billing has changed from FY 2008 to FY 2012, how inpatient billing in FY 2012 varied among different types of hospitals, and how hospitals ensure compliance with Medicare inpatient billing requirements.

- Diagnosis Related Group Window. The OIG plans to analyze claims data to see how much CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the diagnosis related group (DRG) payment. The current "DRG window," when Medicare does not pay separately for preadmissions services in the hospital setting, is three days and has been the subject of recent OIG enforcement activity. The OIG has previously concluded that considerable program savings could be realized by expanding the DRG window from three to 14 days.

- Non-Hospital-Owned Physician Practices Using Provider-Based Status. The OIG plans to look at the impact of non-hospital-owned physician

practices billing Medicare as provider-based, as well as the extent to which practices billing as provider-based have complied with applicable CMS billing requirements. This review will follow concerns expressed by the Medicare Payment Advisory Committee (MedPAC) in 2011 over financial incentives associated with medical practices seeking provider-based status, as this can increase both Medicare payments and beneficiaries' coinsurance liabilities.

- Compliance with Medicare's Transfer Policy. When a hospital discharges a Medicare beneficiary, it is paid the full DRG amount. When it transfers the beneficiary to another facility, it is paid a graduated, per-diem rate, which is usually less than the full DRG payment. The OIG plans to review Medicare payments to hospitals for discharges that should have been coded as transfers.

- Payments for Discharges to Swing Beds in Other Hospitals. Swing beds are inpatient beds that can be used for either acute care or skilled nursing services. Unlike when a beneficiary is transferred to another PPS hospital, Medicare does not pay the reduced graduated per-diem rate if the beneficiary is discharged to a swing bed in another hospital. The OIG plans to review Medicare payments to hospitals for beneficiary discharges coded as discharges to other hospitals' swing beds. This may lead to a reevaluation of current swing-bed payment policy.

- Payments for Canceled Surgical Procedures. The OIG plans to look at program costs associated with cancelled and rescheduled surgical procedures. The OIG states that it has identified significant occurrences of initial PPS payments to hospitals for cancelled surgical procedures, where few if any inpatient services may have been provided, followed by second, higher payments to the same hospitals when beneficiaries are readmitted for the rescheduled surgical procedures. This review may lead to a reevaluation of the CMS policy that currently permits such billing.

- Payments for Mechanical Ventilations. To qualify for Medicare coverage, certain DRG payments require that a patient receive at least 96 hours of mechanical ventilation. The OIG plans to sample Medicare payments to determine the extent to which this requirement has been met.

- Quality Improvement Organizations' Work with Hospitals. The OIG plans to determine the extent to which Quality Improvement Organizations (QIOs) have worked with hospitals, either in conducting quality improvement projects or providing technical assistance. The OIG also plans to investigate barriers experienced by QIOs when engaging hospitals.

- Acquisition of Ambulatory Surgical Centers: Impact on Medicare Spending. Outpatient surgical services are paid at higher rates when performed in a hospital outpatient department rather than in a physician-owned ambulatory surgery center (ASC). The OIG plans to review the extent to which hospitals acquire ASCs and convert them into hospital outpatient departments and determine how this affects Medicare payments and beneficiary cost sharing.

- Payments for Swing Beds (Critical Access Hospitals). The Medicare Prescription Drug, Improvement, and Modernization Act of (2003) has allowed Critical Access Hospitals (CAHs) to receive up to 101 percent of reasonable costs and have up to 25 inpatient beds that can be used for acute care or swing-bed services, without length-of-stay limits for swing-bed utilization. In contrast, skilled nursing facilities (SNFs) are reimbursed under a PPS through case-mix, adjusted per-diem prospective payments that represent payment in full for all costs in furnishing skilled nursing services to Medicare beneficiaries. The OIG plans to compare payment for swing-bed services at CAHs to same-level care at SNFs to determine the potential here for program cost savings.

- Payments for Interrupted Stays (Long-Term-Care Hospitals). Long-Term-Care Hospitals (LTCHs) are acute care hospitals that have average lengths of stay greater than 25 days. An interrupted stay is where a patient is discharged from an LTCH for services not available at the LTCH and is readmitted after a specific number of days. This causes an adjustment in Medicare payments. The OIG plans to determine the extent to which improper payments for interrupted stays in LTCHs were made in 2011. The OIG indicates that it has previously found vulnerabilities in CMS' ability detect readmissions and adjust for interrupted stays.

Carryover Items Affecting Hospitals

As indicated above, the OIG intends to continue a number of reviews and activities during FY 2013 affecting hospitals. Briefly, these are as follows:

- Same-Day Readmissions. In the case of a same-day readmission for symptoms related to—or for the evaluation or management of the medical condition resulting in—the prior stay, a hospital is entitled to only one DRG payment and should combine both stays into a single claim. The OIG will study trends in the number of same-day readmission cases and the effectiveness of CMS' system controls to reject claims for same-day readmissions.

- Acute-Care Inpatient Transfers to Inpatient Hospice Care. Medicare pays the full PPS rate to hospitals that discharge beneficiaries for hospice care. However, Medicare pays a reduced payment to hospitals for shorter lengths of stay when beneficiaries are transferred to other PPS hospitals or, for certain DRGs, to post-acute care settings such as SNFs. The OIG will review the extent to which hospitals discharge beneficiaries after a short stay to hospice facilities. According to the OIG, Medicare claims data shows "significant occurrences" of short-stay discharges followed by hospice care. This review may lead to a reevaluation of this payment policy.

- Admissions with Conditions Coded Present on Admission. Medicare rules require acute care hospitals to report on claims diagnoses that are present upon patient admission. The OIG will review Medicare claims to see if certain acute care hospitals are frequently transferring patients with such "present on admission" diagnoses.

- Inpatient and Outpatient Payments to Acute Care Hospitals. Using computer matching and data mining techniques, the OIG will review Medicare payments to hospitals to assess Medicare billing compliance in areas that the OIG has identified as being at risk for non-compliance. For hospitals identified at high risk, the OIG intends to review compliance policies and interview the hospital's senior management and compliance officer. The OIG intends to use the results of this review to recommend overpayment recovery and identify providers that routinely submit improper claims.

- Inpatient Outlier Payments: Trends and Hospital Characteristics. In addition to predetermined per-discharge payment amounts, Medicare provides supplemental payments to hospitals for patients incurring extraordinarily high costs. These supplemental payments are called "outlier payments" and, according to the OIG, in 2009 represented approximately five percent of total Medicare inpatient payments. The OIG will review inpatient outlier payments and national trends in order to identify characteristics of hospitals that receive high or increasing rates of outlier payments. The OIG notes that recent qui tam actions have led to millions of dollars in settlements from hospitals charged with inflating claims to qualify for outlier reimbursement.

- Reconciliations of Outlier Payments. Outlier payment reconciliations are to be based on the most recent cost-to-charge ratios from the cost report to properly determine outlier payments. The OIG will review outlier payments to see if CMS performed the necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlements of cost reports. The OIG will also determine whether MACs have referred all providers to CMS that met the criteria for reconciliation.

- Duplicate Graduate Medical Education Payments. Medicare pays teaching hospitals for direct graduate medical education and indirect medical education costs. In calculating such payments, no intern or resident should be counted as more than one full-time-equivalent employee. The OIG will review provider data in CMS' Intern and Resident Information System (IRIS) to see whether duplicate or excessive graduate medical education payments have been made.

- Occupational-Mix Data Used to Calculate Inpatient Hospital Wage Indexes. CMS uses data from occupational-mix surveys to determine occupational-mix adjustments to its hospital wage indexes. The OIG will determine whether hospitals have reported such data accurately and the effect on Medicare of inaccurate data reporting.

- Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices. Medicare does not pay the full cost of a replaced medical device if the hospital receives a full or partial credit from the manufacturer, such as where the manufacturer recalls the device or where the device is covered under warranty. Hospitals are required to include certain modifiers in inpatient and outpatient claims when the manufacturer provides a credit of 50 percent or more for a replacement device. The OIG will review hospitals claims to determine whether hospitals have complied with these billing requirements.

- Outpatient Dental Claims. Generally speaking, Medicare does not cover dental services. One exception, however, is for the extraction of teeth to prepare the jaw for radiation treatment. The OIG will review hospital outpatient payments for dental services to see if these have complied with Medicare requirements. According to the OIG, audits have found that significant overpayments have resulted from Medicare reimbursement for noncovered dental services.

- Outpatient Observation Services During Outpatient Visits. The OIG will describe the use of observation services from 2008 to 2011 and the characteristics of beneficiaries who received such services in 2011. The OIG will also look at how much Medicare and beneficiaries paid for observation and related services in 2011, as well as the extent to which hospitals inform beneficiaries of the impact of the observation services. According to the OIG, beneficiaries may be subject to high cost sharing through improper application of observation services.

- Critical Access Hospitals—Variations in Size, Services, and Distances from Other Hospitals. The OIG will profile the nation's 1,350 CAHs for variations in size, services, and distances from other hospitals. The OIG will also look at the numbers and types of patients treated at CAHs.

- Inpatient Rehabilitation Facilities—Transmission of Patient Assessment Instruments. A patient assessment instrument is used to gather data to determine Medicare payment for each beneficiary admitted to an Inpatient Rehabilitation Facility (IRF). Federal regulations provide for reductions in IRF payments where patient assessments are not encoded and transmitted within specified time limits. Where an IRF transmits the instrument more than 27 days after the date of discharge, the IRF's payment should be reduced by 25 percent. The OIG will determine if IRF payments have been reduced in such instances.

- Inpatient Rehabilitation Facilities—Appropriateness of Admissions and Level of Therapy. IRFs provide rehabilitation for patients who require a hospital level of care. This includes a "relatively intense" rehabilitation program and a multidisciplinary team approach to improving patient functionality. This requires preadmission screening and evaluation to determine whether a patient is appropriate for IRF care. The OIG will examine the appropriateness of IRF admissions. The OIG will also examine the level of therapy provided in IRFs and the amount of concurrent and group therapy provided in such settings.

Conclusion

The OIG has ambitious plans for FY 2013 with respect to hospital-related reviews and investigations. Among other things, a number of these may have important cash-flow implications for hospitals. It is interesting to note the use of data mining tools and the impact of health reform, as well as the continued focus on issues of longstanding concern, such as same-day hospital readmissions. While the OIG's enforcement efforts

are not limited by the scope of the Work Plan, it is helpful in guiding a hospital's compliance focus for the coming year. Additionally, industry leadership should evaluate the impact of potential reimbursement changes, such as expansion of the three-day window for inpatient billed charges to 14 days.

Click here for OIG Work Plan for FY 2013.[1]

1 https://oig.hhs.gov/reports-and-publications/workplan/index.asp