OIG Issues 2014 Work Plan

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On January 31, 2014, the Department of Health and Human Services Office of Inspector General (OIG) released the long-awaited 2014 Work Plan, describing the new studies it will initiate, as well as studies from previous years that it plans to continue or complete this year. As always, the OIG's primary focus – especially with respect to hospitals – is on looking for ways to lower costs, whether by identifying and recovering overpayments, standardizing reimbursements for similar services, or revising requirements for reimbursements. Below are brief summaries of the new and continuing reviews the OIG will be conducting this year:

The OIG plans to initiate the following new audits and reviews for hospitals:

New inpatient admission criteria: Beginning in FY 2014, new admissions criteria require that patients admitted for inpatient care are expected to need at least 2 nights of hospital care, Beneficiaries whose care is expected to last less than 2 nights will be treated as outpatients.

Medicare costs associated with defective medical devices: Responding to Centers for Medicare & Medicaid's (CMS) concerns about the impact of replacement devices costs on payments for inpatient and outpatient services, the OIG will review Medicare claims to identify the costs for additional medical services associated with defective medical devices, and determine the impact of these costs on the Medicare Trust Fund.

Analysis of salaries included in hospital cost reports: The OIG plans to identify the salary amounts that are included in hospitals operating costs in order to determine the potential impact of limiting these reimbursements on the Medicare Trust Fund.

Comparison of provider-based and free-standing clinics: The OIG will compare Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments for similar procedures and assess the potential impact on the Medicare program of hospitals' claiming provider-based status for such facilities.

Outpatient evaluation and management services billed at the new-patient rate: Having found that hospitals use the higher-paying new-patient codes when billing for services to established patients, the OIG will review Medicare outpatient payments for evaluation and management (E/M) services for clinic visits billed at the new-patient rate to determine whether they were appropriate.

Nationwide review of cardiac catheterization and heart biopsies: Medicare payments for heart biopsies include payments for right heart catheterizations (RHC) performed during the same operative session. Expanding on previous reviews that found hospitals were paid separately for RHC procedures performed during heart biopsies, the OIG will review these payments on a nationwide basis.

Payments for patients diagnosed with Kwashiorkor: A severe protein malnutrition that generally affects children in tropical and subtropical parts of the world during periods of famine, Kwashiorkor is typically not found in the United States. Diagnoses of Kwashiorkor on hospital claims substantially increases Medicare reimbursements, and the OIG has previously found inappropriate payments for claims with this diagnosis. The OIG will review payments for claims that include the

diagnosis to determine whether the diagnosis is adequately supported by documentation in the medical record.

Bone marrow or stem cell transplants: Medicare coverage for bone marrow or peripheral blood stem cell transplantation includes all necessary steps in the process. Prior OIG reviews have identified hospitals that have incorrectly billed for bone marrow or stem cell transplants under separate transplant procedure codes, resulting in higher payments from Medicare.

Indirect medical education payments: Teaching hospitals with graduate medical residents receive additional payments for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals. The OIG will review provider data to determine whether hospitals' indirect medical education (IME) payments are made in accordance with federal regulations and guidelines, and whether they are calculated properly.

Oversight of pharmaceutical compounding: Citing the recent meningitis outbreak linked to contaminated injections of compounded drugs, the OIG plans to study Medicare's oversight of pharmaceutical compounding in acute care hospitals, and how state agencies and hospital accreditors assess such pharmacy services in hospitals.

Hurricane Sandy—Case study of hospitals' emergency preparedness and response: The OIG will assess the emergency preparedness of hospitals in selected counties affected by Hurricane Sandy, including the hospitals' participation in the Public Health Emergency Preparedness Cooperative Agreements program funded through the Centers for Disease Control and Prevention, and the Hospital Preparedness Program funded through the Office of the Assistant Secretary for Preparedness and Response.

Oversight of hospital privileging: The OIG will determine how hospitals assess medical staff candidates prior to granting initial privileges, including verification of credentials and review of the National Practitioner Databank.

The OIG will continue the following audits and reviews already in place for hospitals:

Reconciliations of outlier payments: The OIG is reviewing Medicare outlier payments to determine whether CMS has performed reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals' associated cost reports, and to determine whether Medicare contractors referred all hospitals that meet the criteria for outlier reconciliations to CMS.

Impact of provider-based status on Medicare billing: In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives in provider-based status, stating that payments should be similar for similar services. The OIG is reviewing the effects of having subordinate hospital facilities bill Medicare as being hospital-based (provider-based) and whether such facilities meet CMS's criteria for being provider-based.

Critical access hospitals—Payment policy for swing-bed services: The OIG has been studying reimbursements for swing-bed services at critical access hospitals (CAHs) in relation to the same services provided at traditional skilled nursing facilities (SNFs) to determine whether a more cost effective payment methodology would produce greater savings for Medicare.

Critical access hospitals—Beneficiary costs for outpatient services: The OIG is reviewing the costs to Medicare beneficiaries of receiving outpatient services at CAHs, where beneficiaries pay coinsurance amounts that are computed on the basis of CAHs' submitted charges, rather than on the basis of the services costs.

Long-term-care hospitals—Billing patterns associated with interrupted stays: The OIG will determine the extent to which long-term care hospitals (LTCHs) readmit patients after a certain number of days, billing Medicare for higher paying new stays instead of for interrupted stays, as well as the extent to which LTCHs readmit patients from co-located providers. As part of this study, the OIG is reviewing payments for readmissions to LTCHs in 2011.

Inpatient claims for mechanical ventilation: The OIG is reviewing Medicare payments for inpatient hospital claims with Diagnosis Related Group (MS-DRG) assignments that require mechanical ventilation to determine whether they are appropriate. Previous OIG reviews identified inappropriate billings for beneficiaries who did not receive 96 or more hours of mechanical ventilation.

Selected inpatient and outpatient billing requirements: The OIG is reviewing acute care hospital billings to determine their compliance with selected billing requirements and to recover overpayments. As part of this review, the OIG is also reviewing hospitals' compliance programs.

Duplicate graduate medical education payments: Using data from CMS's Intern and Resident Information System (IRIS), the OIG will determine whether hospitals received duplicate or excessive graduate medical education (GME) payments, as well as the effectiveness of IRIS in preventing duplicate payments for GME costs.

Outpatient dental claims: Current OIG audits have indicated that hospitals received Medicare reimbursement for noncovered dental services, resulting in significant overpayments, and the OIG is reviewing those payments

Participation in projects with quality improvement organizations: The OIG is studying the extent and nature of hospitals' participation in quality improvement projects with Quality Improvement Organizations (QIO), as well as the extent to which QIOs' quality improvement projects in hospitals overlap with projects offered by other entities.

Inpatient rehabilitation facilities—Adverse events in post-acute care for Medicare beneficiaries: The OIG will estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care in inpatient rehabilitation facilities (IRF), the factors contributing to these events, the extent to which the events were preventable, and the associated costs to Medicare.

Conclusion and Recommendations

Since the OIG's audits frequently result in subject matter investigations in future years, hospitals should review the 2014 Work Plan proactively and conduct their own internal reviews of the same areas that the OIG has singled out for scrutiny. With the government's increased emphasis on enforcement and the recovery of "misspent" healthcare funds, hospitals and healthcare providers in general should institute strict internal controls and monitor their billings and reimbursements for possible overpayments - before CMS and/or the OIG do it for them.

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