HCCA Audio Conference
2013 OIG Work Plan – Hospital

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Presenters

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OIG Organization

- Immediate Office (IO)
- Office of Audit Services (OAS)
- Office of Evaluation and Inspections (OEI)
- Office of Investigations (OI)
- Office of Counsel to the Inspector General (OCIG)
- Office of Management and Policy (OMP)

OIG Overview

- Mission
  - To protect the integrity of HHS programs and the health and welfare of the beneficiaries of those programs
- Statutory Mandate
  - The Inspector General Act of 1978, as amended
- OIG Activities
  - Audits, evaluations, investigations, enforcement, and compliance
OIG Work Plan Process

- OIG Work plan
  - Process
  - Considerations
    - Stakeholder input
    - Review of prior work (OIG and others)
    - Latest news and events
    - Risk assessment
    - Draft to HHS and OMB for comment
  - Published in October

Other “Enterprise Risk” Assessment Tools

- “Semiannual Report to Congress”
- “Top Management and Performance Challenges”
- “Compendium of Unimplemented Recommendations”
- “Medicaid Program Integrity Report”
- “Health Care Fraud and Abuse Control Program Report”
- Compliance program guidance and fraud alerts
- Testimony and speeches of OIG and DOJ officials
- Press releases

www.oig.hhs.gov
OIG Priorities and Focus Areas

- Implementation of Affordable Care Act
- Improper payments
- Prescription drugs
- Program integrity
- Patient safety and quality of care
- Provider outreach

Notable Work Plan Elements - Evaluations
Inpatient Billing for Medicare Beneficiaries – *New* (OEI)

  - Review variations in inpatient billing in FY12 among different types of hospitals
  - Review how hospitals ensure compliance with Medicare requirements for inpatient billing
- Determining effect of MS-DRG’s
- Compliance considerations:
  - Compliance controls on Clinical Documentation Improvement (CDI) programs
  - Monitoring and assessing risk

Diagnosis Related Group Window – *New* (OEI)

- Analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to 14 days to an inpatient hospital admission into the DRG
- Prior work by the OIG identified improper payments within the current 3 day window
- Compliance Considerations:
  - Continued issues with 3 day window
  - Can we handle increasing to 14 days?
  - Multiple locations
Non-Hospital-Owned Physician Practices Using Provider-Based Status

– New (OEI)

• Study to determine the impact of non-hospital-owned physician practices billing Medicare as provider-based
• Evaluate the extent to which these practices met CMS billing requirements
• 2011, Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives for provider-based status
  – Provider-based services have grown about 40% from 2004 – 2010
  – Increase in cost to Medicare approximately $21.2M
  – Continued growth could cost $10B over 10 years
  – Noted that higher payments for provider-based departments are appropriate due to the increased costs hospitals incur
  – MedPac proposed Medicare payment for the hospital outpatient E&M be reduced to the practice component payment rates under physician fee schedule

Non-Hospital-Owned Physician Practices Using Provider-Based Status

– New (OEI)

• Compliance Considerations
  – Inventory of on and off-campus facilities
  – Are the provider-based departments operated under the same license as the hospital (except where state requirements require separate license)?
  – Are the departments clinically integrated with the hospital?
  – Are department and hospital financially integrated? Is the department held out to the public as part of the hospital?
  – Are physician services provided using the correct site of service (hospital outpatient)
  – Are Medicare beneficiaries treated the same as any other hospital outpatient for billing purposes (registered as hospital outpatient, billed a facility fee, etc.)
  – Are the 3-day payment window provisions applied to services received in the department?
  – Are physician supervision requirements satisfied?
Inpatient Outlier Payments (OEI)

- Review hospital inpatient outlier payments
- Examine trends of outlier payments nationally
- Identify characteristics of hospitals with high or increasing rates of outlier payments
- Recent whistleblower lawsuits have resulted in millions of dollars in settlements from hospitals charged with inflating Medicare claims to qualify for outlier payments

Reconciliations of Outlier Payments (OAS)
- Determine whether CMS performed the necessary reconciliations in a timely manner
- Examine whether MACs referred all providers that meet the criteria for reconciliations to CMS

Inpatient Outlier Payments (OEI)

- Compliance Considerations
  - Difficult issue to track
  - Audit and identify outliers
  - Determine how arrived at the dollars
  - Work closely with cost report staff
Quality Improvement Organizations’ Work with Hospitals – New (OEI)

- Study to determine the extent to which Quality Improvement Organizations (QIO) worked with hospitals to:
  - Conduct quality improvement projects
  - Provide technical assistance to hospitals
- Purpose of QIO – improve efficiency, effectiveness, economy, and quality of services
- $1.1B spent for each 3-year QIO contract
- Compliance Consideration
  - Extent to which your QIO is working with hospital

Outpatient Observation Services (OEI)

- Trend the use of observations services from 2008-2011
- Describe the characteristics of beneficiaries receiving observation services in 2011
- Determine how much Medicare and beneficiaries paid for observation and related services
- Determine the extent to which hospitals inform beneficiaries about observation services
Outpatient Observation Services (OEI)

• Compliance Considerations
  – Observation continues to be a challenge
  – Processes and education are key
  – Documentation
  – Bring physicians on board

Acquisitions of Ambulatory Surgical Centers – *New* (OEI)

• Determine the extent to which hospitals acquire ASC and convert them to hospital outpatient departments
• Determine the effect on Medicare payments and beneficiary cost sharing

• Compliance Considerations
  – Compliance role in business development and due diligence
Critical Access Hospitals (OEI)

- Profile CAHs for variations in size, services, and distance from other hospitals
- Examine the types of patients that are treated by CAHs
  - Compliance Considerations
    - Has been designated by the State as a CAH
    - Is located in a rural area or treated as rural
    - Is located more than 35-mile drive from any other hospital or CAH (15 miles if mountainous)
    - Maintains no more than 25 inpatient beds
    - Maintains average length of stay of 96 hours per patient for acute inpatient care
    - Maintains emergency care services 24/7
    - Complies with all CAH Conditions of Participation

Inpatient Rehabilitation Facilities (OEI)

- Examine the appropriateness of admission
- Examine the level of therapy provided and how much concurrent and group therapy the IRF provides

- Compliance Considerations
  - Tracking PAI submission (27 days...25%)
  - Audit for appropriate preadmission screening (RAC dollars)
  - Appropriate level of care
Long-Term-Care Hospitals – Payment for Interrupted Stays – New (OEI)

- Examine the extent to which Medicare made improper payments for interrupted stays in 2011
- Identify readmission patterns and determine the extent to which LTCHs readmit patients directly following interrupted stay periods
- Prior OIG work identified vulnerabilities in CMS’s ability to detect readmissions and appropriately pay for interrupted stays.
- Compliance Considerations
  - Determine what the processes are for tracking interrupted stays
  - Audit the documentation of interrupted stays
  - Audit a randomly selected number of bills to validate readmissions are appropriately indicated

Notable Work Plan Elements - Audits
Same-Day Readmissions (OAS)

- Added to the work plan because OIG noted an increase in the number of readmission cases during the past several years, despite the required use of the condition code
- Same-day readmissions is one of the issues in the OIG hospital compliance initiative
- Compliance Considerations
  - Hospitals reviewed to data do not consistently understand the billing and review requirements
  - Audit for condition code on all same-day readmissions
  - Billing vs. clinical review of readmission
  - Lack of training to appropriate hospital staff

Transfers (OAS)

- Compliance with Medicare’s Transfer Policy (New)
  - Audit payments made for discharges that should have been coded as transfers
  - Review the effectiveness of the MAC’s claim processing edits
- Payments for Discharges to Swing Beds in other Hospitals (New)
  - Review Medicare payments for discharges that were coded as discharges to a swing bed in another hospital
  - Swing beds are inpatient beds that can be used interchangeably for acute care or skilled nursing services
- Acute-Care Inpatient Transfers to Inpatient Hospice Care
  - Review extent to which acute care hospitals discharge patients after short stay to Hospice
  - Data analysis of claims data show significant occurrences of a discharge after a short stay immediately followed by hospice
Transfers (OAS)

• Compliance Considerations
  – Audit short stays for both admission status appropriateness and for discharge status appropriateness
  – Review RAC denials – particularly automated denials
  – Trend discharges to Swing Bed and Hospice

Payments for Canceled Surgical Procedures – New (OAS)

• Determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures
• Preliminary analysis of claims data show significant occurrence of an initial PPS payment to hospitals for a canceled surgical procedure followed by second, higher, PPS payment to the same hospitals for the rescheduled surgical procedure.
• Compliance Consideration
  – How many cancelled surgical procedures do you have?
  – Is patient later readmitted?
  – Keep abreast of CMS activity
Payments for Mechanical Ventilation – *New* (OAS)

- Audit Medicare payments for mechanical ventilation to determine whether the DRG assignment is appropriate
- Review whether patients received fewer than 96 hours of mechanical ventilation
- Compliance Consideration
  - RACs validated claims with MS DRGs 003, 004, 207, 870, 927, and 933, which require ventilator support of 96 or more hours, have been billed though documentation does not support 96 hours
  - Focus audit on above MS DRGs for documentation (including start and stop times) supporting 96 or more hours
  - Focus pre-payment MAC reviews

Accuracy of POA Indicators

- POA data important as it determines whether Medicare pays for certain Hospital-Acquired Conditions
- CMS began requiring hospitals to report POS data in 2008
- Per ACA, hospitals with high rates of HACs will received reduced payments

- Compliance consideration
  - Validate a process in place to document Present on Admission
  - Audit to verify POA process is followed
  - Verify HACs are correct
Medicare Inpatient and Outpatient Payments to Acute Care Hospitals (OAS)

– Section 6401 of the Patient Protection and Affordable Care Act requires healthcare providers to have a compliance program in place.

– OIG believes this hospital compliance initiative is an effective measurement of hospital performance.

– Reports on OIG webpage explain how compliance risks are identified.

Medicare Inpatient and Outpatient Payments to Acute Care Hospitals (OAS)

– Selecting hospitals for review

  • Using CMS claims data, OIG identifies claims for each compliance issue
  • Analyze the raw claims data and consider the materiality of the risks at individual hospitals
  • Consider prior OIG work at the hospital
  • Discuss with Medicare contractors and Quality Improvement Organizations
  • Broad coverage of multiple compliance issues

  • Based on our analysis, hospitals are assigned to a risk-based tier
Medicare Inpatient and Outpatient Payments to Acute Care Hospitals (OAS)

- Reports issued to date on OIG website.
- Each report identifies the compliance areas reviewed.
- Each of those reports, as well as the OIGs prior single issue reports, explain the steps we took to identify overpayments. See the methodology section of each report.
- Compliance Consideration
  - Compliance program effectiveness
  - Compliance program risk assessment

Replacement of Medical Devices (OAS)

- Relatively new area for OAS. OIG is working with hospitals, FDA, CMS and manufactures to identify ways to mitigate risks.
- Issued several reports dealing specifically with medical devices. The reports are on OIG webpage.
- The methodology section of each report explains the steps we took to identify overpayments.
- This is also one of the hospital compliance issues.
Replacement of Medical Devices (OAS)

- Hospitals need to ensure a methodology is in place to identify the credits received for device replacement.
- OIG noted there is often a lack of coordination between ordering physician groups, hospital purchasing departments, and hospital billing/accounting departments.
- OIG expects their continuing work will identify best practices to mitigate the risks of overpayments.
- Compliance Considerations
  - Validate a process for identifying replacement medical devices
  - Process for notifying the appropriate people
  - Audit appropriate billing for credited replaced medical device

Duplicate Graduate Medical Education Payments

- Review provider data from CMS’s Intern and Resident Information System (IRIS) to determine if duplicate or excessive graduate medical education payments have been claimed
- Assess the effectiveness of IRIS in preventing providers from receiving payments for duplicate GME costs
- Compliance Consideration
  - Count no more than one full time FTE
  - Become familiar with Resident assignments
  - Audit to validate appropriate counting
Program Integrity – Medical Review of Part A/B claims submitted by Top Error-Prone Providers (OAS)

- Review claims submitted from error-prone providers to determine their validity
  - Project results to provider’s population of claims
  - Identify refunds on projected overpayments
- Uses Comprehensive Error Rate Testing (CERT)
- Selects providers who consistently submitted claims found to be in error over a 4-year period
- Will conduct a medical review on a sample of claims
- Compliance Consideration
  - Know your error rate and implement corrections (including disclosure if necessary)

Connecting the Dots...

- Be familiar with the entire work plan
- Compliance Program Effectiveness
  - Seven elements
  - Program maturity
  - Perception of effectiveness among board, management, staff
  - Metrics
- Compliance Risk Assessments
  - Substantive areas of concern
  - Understand your risk position (audits/monitors)
  - Understand vulnerabilities
    - Process complexity
    - History of failure
  - Monitor your control environment
QUESTIONS