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Alerts

2011 OIG Work Plan Targets New Risk Areas for Hospitals

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Health Care Alert

The U.S. Department of Health and Human Services' Office of Inspector General (OIG) is responsible for deterring fraud and abuse by identifying systemic weaknesses and vulnerabilities that can be mitigated through corporate compliance programs. The OIG also pursues criminal convictions and recovers damages and penalties through civil and administrative proceedings from individuals and entities that commit fraud or abuse.

Each year, the OIG publishes a work plan to identify and prioritize specific projects for future implementation. The OIG creates the work plan after completion of comprehensive financial and performance audits that identify systemic weaknesses that give rise to fraud, waste and abuse. The OIG Work Plan for Fiscal Year 2011 (2011 OIG Work Plan) identifies risk areas that the OIG will study, audit and/or investigate in fiscal year 2011, and provides valuable guidance for identifying high-risk compliance areas that apply to specified types of health care organizations. Health care organizations can mitigate their risk of False Claims Act or other fraud and abuse liability by assessing their operations in the context of current government priorities and identifying and correcting deficiencies in legal compliance. Listed below are summaries of the most significant new OIG Medicare Advantage Plan projects that will be implemented in 2011.

Provider-Based Status for Inpatient and Outpatient Facilities

The OIG will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. The OIG will also determine the appropriateness of the provider-based designation and the potential impact on the Medicare program and its beneficiaries of hospitals improperly claiming provider-based status for inpatient and outpatient facilities.

Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System

The OIG 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.

Noninpatient Prospective Payment System Hospital Payments for Nonphysician Outpatient Services

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The OIG 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 non-Medicare Prospective Payment System (PPS) hospitals.

Part A Hospital Capital Payments

The OIG will determine whether capital payments to hospitals are appropriate.

Critical Access Hospitals

The OIG will review payments to critical access hospitals (CAH). Pursuant to Sections 1814(l)(1) and 1834(g) of the Social Security Act, the OIG will determine whether CAHs have met the CAH-designation criteria in Section 1820(c)(2)(B) of the Social Security Act, and conditions of participation (CoP) at 42 CFR pt. 485, subpart F, and whether payments to CAHs were in accordance with Medicare requirements.

Medicare Disproportionate Share Payments

The OIG will review Medicare Disproportionate Share (DSH) payments to hospitals and examine the total amounts of uncompensated care costs that hospitals incur. The OIG will determine whether DSH payments were in accordance with Medicare methodology in Section 1886(d)(5)(F)(v-vii) of the Social Security Act.

Duplicate Graduate Medical Education Payments

The OIG will review provider data from CMS's Intern and Resident Information System (IRIS) to determine whether duplicate graduate medical education payments have been claimed. If duplicate payments were claimed, the OIG will determine which payment was appropriate.

Hospital Occupational Mix Data Used to Calculate Inpatient Hospital Wage Indexes

The OIG will determine whether hospitals' reported occupational–mix data (used to calculate inpatient wage indexes) is in compliance with Medicare regulations.

Medicare Secondary Payer/Other Insurance Coverage

The OIG will review Medicare payments for beneficiaries who have other insurance. Pursuant to Section 1862(b) of the Social Security Act, Medicare payments for such beneficiaries are required to be secondary to certain types of insurance coverage.

Reliability of Hospital-Reported Quality Measure Data

The OIG will review hospitals' controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement. The OIG will determine whether hospitals have implemented sufficient controls to ensure that their quality measurement data is valid.

Medicare Brachytherapy Reimbursement

The OIG will review payments for brachytherapy — a form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment — to determine whether the payments are in compliance with Medicare requirements.

Payments for Diagnostic Radiology Services in Hospital Emergency Departments

The OIG will review Medicare Part B-paid claims and medical records for interpretations and reports of diagnostic radiology services (X-rays, CTs, and MRIs) performed in hospital emergency departments to determine the appropriateness of payments. It will also determine whether diagnostic radiology interpretations and reports contributed to the diagnoses and treatment of beneficiaries receiving care in emergency departments.

Hospitals' Compliance With Medicare Conditions of Participation for Intensity-Modulated and Image-Guided Radiation Therapy Services

The OIG will review hospitals' compliance with Medicare requirements concerning the safety and quality of intensity-modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services.

Medicare Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices

The OIG will determine whether hospitals submitted inpatient and outpatient claims that included procedures for the insertion of replacement medical devices in compliance with Medicare regulations.

Observation Services During Outpatient Visits

The OIG will review Medicare payments for observation services provided during outpatient visits in hospitals. It will also assess whether and to what extent hospitals' use of observation services affects the care that Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for health care services.

Hospital Inpatient Outlier Payments

The OIG will review hospital inpatient 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. The OIG will examine trends of outlier payments nationally and identify characteristics of hospitals with high or increasing rates of outlier payments.

Inpatient Rehabilitation Facility Transmission of Patient Assessment Instruments

The OIG will determine whether inpatient rehabilitation facilities (IRF) received reduced payments for claims with patient assessment instruments that were transmitted to CMS's National Assessment Collection Database more than 27 days after the beneficiaries' discharges.

Recovery Act Compliance Reviews

OIG recovery act compliance reviews will review: (1) Medicare incentive payments to eligible hospitals for adopting electronic health records to prevent erroneous incentive payments; and (2) DSH payments to determine whether the expenditures claimed met Medicaid requirements.

Compliance Activities That Hospitals Should Undertake

Health care organizations should ensure that newly identified OIG projects contained in the 2011 OIG Work Plan receive priority in establishing future compliance efforts. In order to demonstrate that your compliance program is "effective" and is being updated to address new regulatory issues, we recommend that health care organizations take the following actions:

- **Compliance Committee.** Convene a compliance committee meeting to discuss the 2011 OIG Work Plan, with particular emphasis on risk areas that impact your health care organization. Document these efforts by keeping written minutes of such meeting.
- **Compliance Program Amendments.** Carefully review your compliance program to consider whether amendments to it should be made. New risk areas identified in the 2011 OIG Work Plan should be added to risk or audit areas set forth in the compliance program. All such compliance program amendments should be documented.
- **Develop a Compliance Risk Assessment.** One of the key components of an effective compliance program is that hospitals should conduct a comprehensive routine risk assessment, under the direction of the compliance officer, that identifies and prioritizes the compliance and business risks that the health care organization may experience in its daily operations and should serve as the basis for the written policies and procedures that the health care organization should develop. The risk assessment should: (1) identify the health care organization's key compliance risks; (2) evaluate compliance program control activities and the level of risk mitigation; (3) rank risk areas and risk concern level; and (4) incorporate risk assessment results in the compliance program work plan. It is important to note that targeted risk assessments that may have false claims act implications should be done under the direction and supervision of outside legal counsel so that the attorney-client privilege attaches.
- **Develop a Compliance Work Plan.** Upon completing a compliance risk assessment, the next step is to create a compliance work plan detailing various compliance monitoring and auditing activities for the upcoming year. The

objective of the work plan is to plan for the provision of compliance, monitoring and audit services to those areas of greatest health care organization risk and management concern. The planning process should be broad-based, taking into consideration existing and emerging strategic, financial, operational, compliance and overall risks associated with the health care organization's operations. Resources to consider in preparing a work plan include: the 2011 OIG Work Plan; state and federal laws, licensing, accreditation, and certification requirements; OIG advisory opinions; OIG audit services and investigation reports; local Medical review policies; local coverage decisions; Medicare bulletins and CMS updates; and peer review organization activities. Elements of a compliance program work plan should include audits, investigations, consulting services, training and education, and compliance services.

- **Auditing and Monitoring.** Initiate internal and/or external monitoring and audits of the areas of the 2011 OIG Work Plan that impact your medical group to evaluate your compliance in those areas. "Monitoring" is a process involving ongoing checking and measuring to ensure quality control. It involves daily, weekly, or other periodic checks to verify that essential functions are being adequately performed and that processes are working effectively. The results of the monitoring process may indicate the need for a more detailed audit. "Auditing" is a systematic and structured approach to analyzing a compliance process. It is a formal review that usually includes planning, identifying risk areas, assessing internal controls, sampling of data, testing of processes, validating information, and formally communicating recommendations and corrective action measures to both management and the board of directors. Document these efforts by preparing a written summary of the methodology and results of such audits, and any corrective actions taken as a result.

  Where potential fraud or False Claim Act liability might be involved, the auditing decisions should be discussed with internal or outside legal counsel. The Patient Protection and Affordable Care Act of 2010 (PPACA) provides that retaining a known overpayment creates potential False Claim Act liability. Therefore, auditing activities that involve the sampling of data and the identification of specific overpayment claims should be directed by legal counsel.
- **Educate Personnel.** Educate management, professionals and staff with respect to new risk areas and the need to develop mechanisms to reduce the risk of noncompliance. New policies and procedures should be developed to address new risk areas identified by the 2011 OIG Work Plan, and the new policies and procedures should be coordinated with training and educational programs. Document all efforts in connection with any educational program or seminar offered regarding compliance issues.

Conclusion

Hospitals should regularly review and update the implementation and execution of their compliance programs to ensure the programs' effectiveness. An effective compliance program demonstrates a good faith effort to comply with applicable statutes, regulations, and other federal health care program requirements, and may significantly reduce the risk of unlawful conduct and corresponding sanctions. Hinshaw attorneys have assisted numerous health care organizations with the development, implementation and operation of corporate compliance plans, internal investigations, and responding to governmental investigations.

For further information, please contact Michael A. Dowell or your regular Hinshaw attorney.

This alert has been prepared by Hinshaw & Culbertson LLP to provide information on recent legal developments of interest to our readers. It is not intended to provide legal advice for a specific situation or to create an attorney-client relationship.

Hinshaw & Culbertson LLP is Pleased to Announce its 2010 Health Care Conference

Wednesday, November 10, 2010
9:00 a.m. to 4:00 p.m.

Hilton Lisle/Naperville
3003 Corporate West Drive
Lisle, Illinois

Now in its sixth year, the Conference will offer both plenary and breakout sessions. Join Senior Management, Board Members and In-House Counsel of Hospitals and Health Systems as our presenters examine and analyze current issues and strategies affecting the health care industry.

Plenary Sessions

- Perspectives on Health Care Reform
- Round Three: Anti-Fraud Statutes Within Health Care Reform

Breakout Sessions

- RAC & MIC – Effectively Managing Audits and Appeals
- Managed Care Contracting After Health Care Reform
- Tax Exemption After Health Care Reform and Provena
- Provider-Based Status and the Physician Supervision Requirements of 2010
- Social Media Concerns for the Employer
- The Impact of Health Care Reform on Physicians, Group Practices and Hospital/Physician Arrangements

Hinshaw is an accredited CLE provider in Illinois. Illinois attorneys can earn 4.25 general CLE credit hours for attending the conference.

There will be a $95 non-refundable fee to attend this conference.