CLIENT ALERTS & INSIGHTS

OIG Work Plan 2012: Hospitals

NOVEMBER 15, 2011

On October 5, 2011, the U.S. Department of Health and Human Services Office of the Inspector General ("OIG") released its Work Plan for 2012. The OIG releases its work plan for each year in advance of the coming year. The work plan provides stakeholders in the health care industry with a broad overview of the OIG's activities in the coming year as they relate to its enforcement priorities and issues it will review and evaluate during that fiscal year. The OIG's activities relating to hospitals for 2012 are focused on a variety of both new and ongoing enforcement initiatives.

New Initiatives

The OIG announced the following new hospital initiatives for 2012:

- **Accuracy of Present-on-Admission (POA) Indicators Submitted on Medicare Claims.** The OIG will use certified coders to review the accuracy of POA indicators submitted on hospital inpatient claims in October, 2008. POA indicators identify which diagnoses were present at the time of admission and those that developed during the hospital stay. The purpose of the review is to enable CMS to implement certain requirements of the Deficit Reduction Act (DRA) and the Affordable Care Act (ACA). Section 501 of the DRA provides that hospitals do not receive additional payment for certain conditions that were not present when the patient was admitted. Section 3008 of the ACA provides that hospitals with high rates of hospital-acquired conditions will receive reduced payments. Accurate POA indicators are needed to implement these requirements.
- **Medicare Inpatient and Outpatient Payments to Acute Care Hospitals.** The OIG will review Medicare payments to determine compliance with selected billing requirements and use the results to recommend recovery of overpayments and identify providers that routinely submit improper claims. Hospitals will be selected for review based on computed matching and data mining techniques that are used to identify at-risk areas for noncompliance with billing requirements. Using these techniques, the OIG will also identify the "least risky" and "most risky" hospitals across various compliance areas and analyze such hospitals' policies and procedures to compare their compliance practices.
- **Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care.** The OIG will review Medicare inpatient claims for which the beneficiary was transferred to hospice care and examine the financial and ownership arrangement between the acute-care hospital and the hospice provider. The OIG will also examine how Medicare treats reimbursement for similar transfers from the acute-care setting to other settings.

- **Medicare Outpatient Dental Claims.** The OIG will review Medicare outpatient dental payments to determine compliance with Medicare requirements. Claims for dental services are only paid by Medicare in limited, specific situations (such as for the extraction of teeth to prepare the jaw for radiation treatment). Current OIG audits have uncovered significant overpayments for noncovered dental services.
- **In-Patient Rehabilitation Facilities.** Admissions to and the level of therapy being provided in in-patient rehabilitation facilities (IRFs) will be examined. IRF admission is only appropriate for patients who require a hospital level of care and patients should only be admitted after undergoing appropriate preadmission screening and evaluation.
- **Critical Access Hospitals.** The OIG will examine variations in size and service among critical access hospitals (CAHs), as well as the distances between hospitals and the numbers and types of patients they treat. A hospital can only be designated as a CAH if it is located in a rural area, furnishes 24-hour emergency services, provides no more than 25 inpatient beds and has an average annual length of stay of 96 hours or less. Currently, only limited information exists about the structure of the 1,350 CAHs in operation nationwide and the type of services they provide.

Ongoing Initiatives

The following is a sampling of the OIG's ongoing hospital initiatives.

- **Hospital Reporting for Adverse Events.** The OIG will review the type of information captured by hospitals' internal incident-reporting systems about adverse events to determine the extent to which such events were captured and reported to external patient-safety oversight entities. Data will be used from a 2010 OIG study that examined the national incidence of adverse events among hospitalized Medicare beneficiaries.
- **Reliability of Hospital-Reported Quality Measure Data.** The OIG will review hospitals' controls for ensuring the accuracy and validity of quality care data, which must be reported to Medicare for reimbursement purposes. The DRA provides for a 2 percent reduction in payments to hospitals that fail to report established quality measures and the ACA recently expanded the quality initiative that relies on such data.
- **Hospital Claims With High or Excessive Payments.** Hospital claims with high payments will be reviewed for appropriateness, along with the effectiveness of the claims processing system edits used to identify excessive payments. Focus will be placed on certain outpatient claims in which payments exceeded charges and selected codes for which billings appear to be aberrant. The OIG’s prior work has shown that claims with unusually high payments may be incorrect for various reasons.
- **Medicare Payments for Beneficiaries With Other Insurance Coverage.** The OIG will assess the effectiveness of procedures that are intended to prevent inappropriate Medicare payments for services to beneficiaries who have other types of insurance coverage. Specifically, procedures for identifying and resolving credit balance situations that occur when Medicare and other insurers make concurrent payments that exceed charges or the allowed amounts will be evaluated.

- **Duplicate Graduate Medical Education Payments.** Data will be reviewed to determine whether duplicate or excessive graduate medical education (GME) payments have been claimed. CMS's Intern and Resident Information System (IRIS) is meant to ensure that no intern or resident is counted as more than one full time employee for purposes of paying teaching hospitals for direct graduate medical education and indirect medical education costs. In addition to reviewing whether duplicate or excessive GME payments were claimed, the OIG will evaluate the effectiveness of IRIS in preventing duplicative payments.

For more information on the OIG's Work Plan for 2012, please contact a member of Benesch's Health Care Department.

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