OIG Releases FY 2010 Work Plan

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On October 1, 2009, the Office of the Inspector General ("OIG") released its Fiscal Year 2010 Work Plan (the "Work Plan"). Providers should carefully review the areas of the Work Plan pertinent to their areas of service, because the plan shows what areas the OIG will be targeting in its enforcement activities for the upcoming year. Most areas concern topics near and dear to providers' hearts: providing quality care and accurately billing for it. After reviewing these risk areas, providers should update their corporate compliance plans, prioritize their compliance activities, and educate their staff accordingly. The areas I find noteworthy include the following:

FOR HOSPITALS:

- **Hospital admissions with Conditions Coded Present-On-Admission ("POA")**: The OIG will review the number of inpatient hospital admissions for which certain diagnoses were coded as being present when patients were admitted to hospitals, as well as the diagnoses most frequently coded as POA, and the types of facilities most frequently transferring patients with a POA diagnosis.
- **Hospital Readmissions**: The OIG will look at trends in readmissions and determine whether the hospital services met professional standards of care.
- **Adverse Events**: The OIG will review adverse events, as well as "never events" that the National Quality Forum deemed "should never occur in a health care setting", such as surgery on the wrong patient. The OIG will review various adverse events.
- **Inpatient Rehabilitation Facility ("IRF") Submission of Patient Assessment Instruments**: The OIG will review IRF stays in which patient assessments were transmitted to CMS late to determine whether payments were correctly made and whether the assessments were submitted in accordance with the Medicare regulations.

FOR HOME HEALTH AGENCIES ("HHAS"):

- **Continued Interest in Part B Payments for Home Health Beneficiaries**: The OIG will continue to investigate Part B payments made to outside suppliers for services and medical supplies that are included in the HHA prospective payment and controls to prevent inappropriate Part B payments.
- **HHA outlier payments**: Outlier payments have significantly increased in recent years. Therefore, the OIG will review CMS's methodology for calculating outlier payments to HHAs to determine whether the HHAs are being reimbursed as intended for high cost episodes.
- **Overview of OASIS data**: The OIG will review CMS's process for ensuring that HHAs submit accurate and complete OASIS data.

FOR NURSING HOMES:

- **Medicare Requirements for Quality of Care in Skilled Nursing Facilities ("SNFs")**: The OIG will determine the extent to which SNFs: (1) developed plans of care based on assessments of beneficiaries, (2) provided services to beneficiaries in accordance with the plans of care, and (3) planned for beneficiaries' discharges per the federal regulations. It will also review SNFs' use of the Resident Assessment Instrument ("RAI") to develop plans of care for their residents.
- **Criminal Background Checks for Nursing Facility Employees**: The OIG will review the extent to which nursing facilities have employed individuals with criminal convictions, as well as the types of crime for which they were convicted.
- **Oversight of Poorly Performing Nursing Homes**: The OIG will review enforcement measures take by CMS and States and also the extent to which they followed up to ensure poorly performing nursing homes implemented plans of correction.
- **Continued Interest in Part B Services**: The OIG will review the extent of Part B services provided to nursing home residents and assess patterns of billing among nursing homes and providers.
- **Mental Health Needs, Psychotherapy Services, and use of Antipsychotic Drugs**: These areas of concern will continue to be scrutinized.

FOR HOSPICES:

- **Continued Interest in Physician Billing for Medicare Hospice Beneficiaries**: The OIG will look at Part B billing for physician services provided to Medicare hospice beneficiaries, and specifically whether physicians are double-billing hospice services to Part A and Part B.
- **Continued Interest in Trends in Medicare Hospice Utilization**: Trends in this area include the fact that the number and types of diagnoses associated with hospice utilization have increased and longer stays have become more common. OIG will also, interestingly, look at differences between for-profit and not-for-profit providers.
- **Continued Interest in Duplicate Drug Claims for Hospice Beneficiaries**: The OIG will review whether payments made under Part D drug plans are correct, supported, and not duplicated in hospice per diem amounts. It will also determine the extent of duplication between Part D payments and Part A hospice payments and identify controls to prevent duplicate drug payments.

OTHER:

- **Medicare Incentive Payments for E-Prescribing**: The OIG will review Medicare incentive payments made in 2010 to eligible health care professionals for their 2009 e-prescribing activities, and whether any such payments were made in error.
- **Payments for Services Ordered or Referred by Excluded Providers**: The OIG will review the extent to which this is occurring.
- **In General**: Upcoding, duplicate billing, and wrongful billing for poor quality and unnecessary care continue to be hot topics.