OIG's 2012 Work Plan for Hospitals: An Overview

The 2012 OIG Work Plan for hospitals highlights 23 areas of focus, seventeen repeating or carrying over from 2011 (and earlier) and six new areas. The plan is a helpful map of Medicare enforcement priorities. It is interesting to note its evolution from year to year; the influence of data mining capability and healthcare reform are two discernible trends this year.

Carryover Areas of Focus from the 2011 OIG Work Plan

A review of the seventeen "carryover" projects reflects some longstanding issues of concern, such as (1) "outlier payments," the subsidies to the Prospective Payment System (PPS) for super-expensive patient cases that have been viewed as a vehicle for hospital fraud and abuse for nearly a decade. Medicare continues to scrutinize outlier payments, and will increasingly rely on data mining to identify suspicious inflations of Medicare claims that are submitted to qualify for outlier payments. In addition, OIG will review (2) whether the Center for Medicare and Medicaid Services (CMS) and the various contractors are performing the necessary reconciliations to verify the outlier payment formula. OIG will also focus generally on (3) hospital claims with unusually high payments for possible overpayments, such as outpatient claims and particular Healthcare Common Procedure Coding System (HCPCS) coding errors.

Carryover project areas that flow from healthcare reform include (4) Same-Day Hospital Readmissions. Historically, hospitals have profited from patients who were discharged and returned to the hospitals in short order based on the PPS system and the Diagnosis Related Group (DRG) payments. In recognition that the same-day readmission is a reflection of sub-optimal patient management (i.e. premature patient discharge), Medicare will verify that hospitals are not receiving DRG payments for multiple hospital stays with a re-admitted patient. (This issue was supposed to have been addressed years ago, but OIG has reason to believe the practice is continuing). OIG is also continuing to focus on (5) whether observation services provided by hospital outpatient departments in the discharge process are being billed inappropriately.

A distinct area of healthcare reform-driven focus is the continued OIG examination of (6) data on adverse events to ensure that hospitals are reporting internal medical errors. Adverse event data simultaneously enables Medicare to avoid paying for care that could have been prevented and to improve safety by addressing recurring problems and holding error-prone physicians accountable. The focus on establishing reliable patient safety data is evident in the carryover focus on (7) ensuring the accuracy and validity of hospital quality measure data, which predates but was significantly expanded by the Affordable Care Act (ACA). OIG will also continue to focus on (8) conditions that are coded as Present on Admission (POA) in an effort to root out payments for hospital-acquired conditions (HAC's).

The influence of greater access to data mining is also reflected in carryover issues such as (9) medical device replacement, where OIG seeks to ensure it is not paying for replacement devices that should be covered by manufacturers, and (10) beneficiaries with other insurance coverage. Medicare continues to seek to ensure that it is not overcompensating patients or providers who are also receiving coverage from private payors. Medicare will continue to scrutinize (11) graduate medical education (GME) payments to teaching hospitals to avoid duplicative payments. Medicare will also look to (12) penalize hospitals whose inpatient rehabilitation facilities (IRF's) were late in submitting patient assessment data, which is due within 27 days of patient discharge.

Other carryover project areas include review of (13) hospitals reporting of occupational-mix data used to calculate inpatient wage indexes and (14/15) payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals. The only hospital-based clinical therapy targeted for review on the "carryover" list was (16) brachytherapy, a form of radiation oncology using "seeds" or source devices. Finally, (17) Critical Access Hospitals (CAH's) were singled out for scrutiny of whether all CAH's (which receive additional cost subsidies) truly met the necessary requirements.

New Areas of Hospital Focus from the 2012 OIG Work Plan

Like the "carryover" issues, the six new hospital areas of focus also highlight the ACA and the turn towards

data-mining. Specifically, the area of focus are as follows:

(1) Accuracy of Present on Admission (POA) Indicators Submitted on Medicare Claims. OIG, through its Office of Evaluations and Inspections (OEI), intends to review the accuracy of POA indicators submitted on inpatient claims. As noted above, the ACA provides for reductions in payments to hospitals with high HAC rates. OIG will review hospital records to ensure hospitals are providing accurate POA information, so that HAC's can be better identified.

(2) Medicare Inpatient and Outpatient Payments to Acute Care Hospitals. OIG, via the Office of Audit Services (OAS), will be reviewing Medicare payments to hospitals to determine compliance with selected billing requirements. OIG will use "computer matching and data mining techniques" to identify and review high- and low-compliance risk hospitals and will compare the compliance practices of the two groups.

(3) Inpatient Transfers to Inpatient Hospice Care. OIG, via the OAS, will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care. As to these claims, OIG will examine the financial or common ownership relationship between the acute-care hospital and the hospice provider, and how Medicare treats reimbursement for similar transfers from the acute care setting to other settings. Medicare will apparently be considering whether hospitals are receving excessive reimbursement for inpatient hospice care.

(4) Medicare Outpatient Dental Claims. With limited exceptions, dental services are generally excluded from Medicare coverage. OIG will review hospital outpatient payments for dental services to determine whether payments for dental services were made in accordance with Medicare requirements. OIG will examine whether hospitals are billing for noncovered dental services, resulting in significant overpayments.

(5) Inpatient Rehabilitation Facilities. OIG, via the OEI, will examine the appropriateness of admissions to inpatient rehabilitation facilities (IRF's). IRF's provide rehabilitation services for patients who require a hospital-level of care to improve their ability to function, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve their ability to function. OIG will review the pre-admission screening and evaluation to filter out inappropriate candidates, the level of therapy, and how much concurrent group therapy is provided.

(6) Critical Access Hospitals. OIG, via the OEI, will review CAH's to weed out hospitals that have been incorrectly designated as CAH's. CAH-designation is supposed to be limited to qualifying small (25 or fewer bed-) facilities in rural areas that give limited outpatient and inpatient hospital services. OIG suspects that many of the over 1,300 CAH's are inappropriately designated as such.

While OIG's regulatory enforcement efforts are not bounded by the Work Plan, it is helpful in flagging particular areas where hospitals should direct attention in their own compliance efforts. The 2012 Work Plan highlights that, while some parts of health care reform may be at risk of judicial or political undoing, data-mining will continue to play a more and more prominent role in identifying overpayments, fraud, and abuse.

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