Report on
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OIG Work Plan Will Assess Medicare Spending on High-Risk Areas

In its 2013 Work Plan, the HHS Office of Inspector General enters new audit territory, including payments for discharges to swing beds and mechanical ventilation DRGs, and continues work on a host of other risk areas. The Work Plan, released Oct. 2, also gives the industry a preview of Medicare payment cuts it may see sometime down the road.

The Work Plan is an annual roadmap of the OIG's audits, evaluations and other reviews, and helps compliance officers in their risk-assessment planning. There is a familiar ring to many Work Plan items, even the new ones. Some are RAC targets, some stem from the health reform law's crackdown on fraud and abuse and some overlap with the Medicare compliance reviews that OIG has been conducting at hospitals around the country.

OIG also has some interesting new program-integrity projects in the mix, including a review of "Medicare Part A and Part B claims submitted by error-prone providers to determine their validity, project our results to each provider's population of claims, and recommend that CMS request refunds on projected overpayments."

What seemed to raise the most hackles was OIG's plan to analyze how much Medicare could save if hospitals were required to bundle into the MS-DRG payment outpatient services provided up to 14 days before an admission. Expanding the three-day DRG payment window to 14 days potentially means hospitals wouldn't be paid separately for diagnostic and related nondiagnostic services. "It would be a huge cost savings for the government to do it this way, but I don't think it is fair to hospitals," says San Francisco attorney Judy Waltz, with Foley & Lardner. "It would pull in too many unrelated things."

Canceled Surgeries Are New Priority

Another new item on the Work Plan is an audit of payments for canceled surgeries. Although it's labeled a brand-new audit — "a new start" in OIG-speak — OIG sent letters to at least 95 hospitals across the country this summer asking questions about their billing and compliance procedures for cancelled surgeries *(RMC 7/9/12, p. 1)*. In the Work Plan, OIG states that "our preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed by a second, higher PPS payment to the same hospitals for the rescheduled surgical procedure."

Other new hospital targets include changes in inpatient billing since 2008, when CMS adopted severity-based DRGs; same-day readmissions; payments for interrupted stays at long-term care hospitals; and compliance with Medicare's transfer policy.

Waltz says hospitals should keep their eye on the transfer issue, which RACs also are auditing. One angle is compliance with the lower per-diem payments hospitals receive when they transfer patients to post-acute care. RACs are identifying hospital underpayments in connection with hospitals that billed per diems for beneficiaries who did not end up receiving post-acute care, which means the hospital is entitled to the full DRG payment, Waltz says.

Place of Service Codes Trouble Watchdogs

Medicare compliance reviews, the OIG's comprehensive audits of hospitals, are apparently informing the OIG Work Plan, says Boston attorney Larry Vernaglia, also with Foley & Lardner. It includes reviews, for example, of inpatient and/or outpatient billing for medical devices, which are featured in virtually every Medicare compliance review. Other items from Medicare compliance reviews are observation services and outpatient dental claims.

This year, OIG also will tackle a number of hot physician issues. One is place-of-service coding, which was the subject of an Oct. 9 *MLN Matters* article (7631). In a revised national policy on place-of-service coding (CR 7631), CMS states that for all services paid under the Medicare physician fee schedule, the place-of-service code used by the physician will be based on the setting in which the Medicare beneficiary received the face-to-face service, with two exceptions.

Other physician audits on the Work Plan include the error rate in incident-to billing by nonphysician practitioners *(RMC 7/2/12, p. 1);* payments for evaluation and management services; payments for person-

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ally performed anesthesia services; and the use of G modifiers with Part B claims.

Vernaglia says OIG also is looking at market dynamics. A number of Work Plan items are about the impact on Medicare spending. For example, OIG will determine the extent to which hospitals buy ambulatory surgery centers and convert them to outpatient departments, which allows them to bill more for the same procedures. "It's not true [that] when you see growth in spending you will find fraud, waste and abuse," Vernaglia says. But he suggests it may be wise to inform senior leaders and the board that there is a hint that lower reimbursement for on-campus surgeries may be in their future.

There are many more items on the Work Plan, including the Medicaid arena, post-acute care and labs. OIG also plans to assess whether Medicare administrative contractors are implementing system edits to prevent improper payments as well as "the extent to which recovery audit contractors identified overpayments" and made fraud referrals.

To incorporate the Work Plan into her compliance program, WellSpan Health Compliance Officer Wendy Trout reviews each item in detail. She determines which WellSpan entities provide the services subject to OIG's upcoming reviews, how many cases they see per year and how much revenue would be affected. Then she sends an explanation of the Work Plan item to the managers of the relevant departments and asks them to answer the following questions:

◆ ***Do you have any concerns?***

◆ ***How do you think WellSpan would perform*** if selected by OIG for a review of this service?

◆ ***Does WellSpan meet all regulations in this area?***

◆ ***Has your department done any reviews*** of this service to validate compliance?

◆ ***What mechanisms exist to ensure that WellSpan documents and bills properly*** for the services under review?

The information Trout gathers is added to her risk assessment process "to determine if we have a high-enough risk that would warrant a review by compliance." The highlights of the Work Plan are also reviewed with the compliance steering committee to get its thoughts and recommendations. But Trout says her cursory review indicated that Work Plan items were already on WellSpan's risk assessment, are being addressed by its RAC team or don't affect the Pennsylvania health system.

Contact Waltz at jwaltz@foley.com, Vernaglia at lwv@foley.com and Trout at wtrout@wellspan.org. Read the Work Plan at http://go.usa.gov/Y2Cx and view the *MLN Matters* article on place-of-service coding at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7631.pdf. ✧

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