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OIG Issues Work Plan for 2012 and Publishes Interactive Map of Medicaid Fraud Control Unit Statistics

The Department of Health and Human Services Office of Inspector General (OIG) published its Work Plan for the 2012 fiscal year. The Work Plan identifies the specific areas that the OIG will focus on for the fiscal year beginning October 1, 2011 through September 30, 2012 and includes OIG compliance concerns from previous years, as well as new OIG initiatives. **Click Here to view the Work Plan.** The OIG also published each state's Medicaid Fraud Control Unit (MFCU) 2010 Fiscal Year statistical data in the form of a new interactive map. This alert highlights aspects of the Work Plan relevant to hospitals, physicians and other health professionals, and features of the MFCU interactive map.

OIG 2012 Work Plan

Hospitals

New areas of focus include the following:

- **Accuracy of Present-on-Admission (POA) Indicators**—The OIG will examine the accuracy of POA indicators reported on hospitals' inpatient claims. These indicators identify which diagnoses were present when the patient was admitted and which developed during the hospital stay. Under the Patient Protection and Affordable Care Act, hospitals with high rates of hospital-acquired conditions will receive lower payments.
- **Payments to Acute Care Hospitals**—The OIG will review payments to hospitals to assess compliance with billing requirements, recommend recovery of overpayments and identify hospitals that routinely submit improper claims.
- **Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care**—The OIG will review inpatient hospital claims where the beneficiary was transferred to a hospice, and will examine the relationship (either financial or common ownership) between the hospital and the hospice. The OIG will also examine how Medicare treats reimbursement for similar transfers from acute-care hospitals to other providers.
- **Medicare Outpatient Dental Claims**—The OIG will review hospital outpatient payments for dental services to determine whether such payments comply with Medicare requirements. Generally, dental services are excluded from Medicare coverage. Recent OIG audits indicate that providers have received significant overpayments in this area.

- In-Patient Rehabilitation Facilities (IRF)—The OIG will review the appropriateness of IRF admissions and the level of therapy provided in IRFs.
- Critical Access Hospitals (CAHs)—The OIG will review CAHs to profile variations in size and services and examine the numbers and types of patients that CAHs treat. Currently, limited information exists about the structure and type of services provided by CAHs.

Areas of focus from previous years that the OIG will continue to monitor include the following:

- Adverse Events—The OIG will review hospitals' incident-reporting systems to assess the data provided in the reporting systems, and to determine the extent to which such systems capture and report adverse health care events to external patient-safety oversight entities.
- Quality Data—The OIG will evaluate whether hospitals have implemented sufficient controls for ensuring the accuracy and validity of the quality of care data that they submit to the Centers for Medicare & Medicaid Services (CMS) for Medicare reimbursement.
- Payments—The OIG will examine hospital inpatient outlier payments and evaluate national trends of such payments to identify the characteristics of hospitals with high or increasing rates of outlier payments. The OIG will also review high-payment claims, payments for graduate medical education to determine whether duplicate or excess payments were made, and payments to critical access hospitals.
- Readmissions—The OIG will continue to examine Medicare claims to determine trends in the number of same-day hospital readmission cases.

Physicians and Other Health Professionals

New areas of focus include the following:

- High Cumulative Part B Payments—The OIG will examine high cumulative Medicare Part B payments (meaning an unusually high payment made to an individual physician or supplier over a specified period of time) to determine if such payments are reasonable and necessary.
- Incident-to-Services—The OIG will evaluate physician billing for "incident-to" services to assess whether payments for such services had a higher error rate than that for non-incident-to services.
- Impact of Physicians Opting out of Medicare—The OIG will review the extent to which physicians are opting out of Medicare and the impact on beneficiaries and whether those physicians who have opted out are submitting claims to Medicare.
- Ambulances—Questionable Billing for Ambulance Services—The OIG will examine Medicare claims data to identify questionable billings such as transports that were potentially not medically reasonable and necessary, and potentially unnecessary billing for Advanced Life Support Services and specialty care transport.
- Ambulatory Surgical Centers (ASC) and Hospital Outpatient Departments (HOPD)—Safety and Quality of Surgery and Procedures—The OIG will evaluate the safety and quality of care for

surgeries and procedures performed at ASCs and HOPDs, and will identify health care adverse events for both ASCs and HOPDs.

- Hospice Marketing Practices and Financial Relationships with Nursing Facilities—The OIG will review hospices' marketing practices and their financial relationships with nursing facilities. Areas of particular concern include aggressive marketing of hospice services to nursing facility residents and compliance with hospice coverage requirements.

Areas of focus from previous years that the OIG will continue to monitor include the following:

- Place-of-Service Coding—The OIG will review physician coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the place of service.
- Review of Payment—The OIG will continue to evaluate the methodology for setting ASC payment rates, and will review payments to sleep disorder clinics to assess compliance with Medicare requirements.
- Part B Imaging Services—Medicare payments for Part B imaging services will be evaluated to determine whether they reflect expenses incurred, and whether the utilization rates reflect industry practices.
- Hospice Services—The OIG will continue to examine general inpatient care claims and hospice beneficiary drug claims to determine whether such claims complied with Medicare reimbursement requirements.

The Work Plan also discusses the OIG's review of other types of health care providers such as DME suppliers, home health agencies and nursing homes.

MFCU Interactive Map

On October 13, 2011, the OIG posted an interactive map which shows each state's MFCU statistical data for the 2010 Fiscal Year. [Click Here to view the interactive map.](#)

While each MFCU maintains statistical data regarding the number of investigations, indictments, convictions, settlements, judgments and civil/criminal monetary recoveries resulting from enforcement actions, the interactive map provides convenient access to this data and also lists the resources (staff and monetary expenditures) utilized by each state. If the OIG continues to publish MFCU statistical data, providers will be able to easily assess the trends in fraud enforcement activities throughout the country.

For questions regarding the Work Plan, or for assistance in bringing your facility or practice into compliance with the areas identified in the Work Plan, please contact any member of the Health Care Department.