Just Released 2002 OIG Work Plan
Know where the risks may lie

The HHS Office of Inspector General (OIG) released its annual Work Plan for fiscal year 2002 on October 1, 2001. In this document, the OIG lists those areas on which the agency will be placing a special focus by conducting an audit or evaluation and issuing a separate report. Typically, these are areas that the government has noted a problem related to reimbursement, claims processing, quality of care, Medicare/Medicaid program oversight, etc.

We have reviewed the Medicare/Medicaid portions of the Work Plan. As in the past, there are many planned audits and investigations that are “holdovers” from previous Work Plans; however, there are many new areas of focus. For instance, for fiscal year 2002, the OIG appears to be particularly concerned about issues involving outpatient reimbursement, medical education, and Medicaid. In fact, the plan has a completely new section focusing solely on Medicaid Hospitals.

The following is the table of contents from the Work Plan. We have identified, with an underline, those entries that are new to the 2002 plan. See inside for additional information about some of these new entries.
Department of Health and Human Services
Office of Inspector General Work Plan
Fiscal Year 2002
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS, formerly HCFA)

Table of Contents

MEDICARE HOSPITALS
Medicare Payment Error Prevention Program
Medical Education Payments
Hospital Privileging Activities
One-Day Hospital Stays
Hospital Discharges and Subsequent Readmissions
Consecutive Inpatient Stays
Payments to Acute Care Prospective Payment System Hospitals
Implementation of Critical Access Hospital Program
Satellite Hospitals
Prospective Payment System Transfers During Hospital Mergers
Diagnosis-Related Group Payment Limits
Outlier Payments for Expanded Services
Periodic Interim Payments
Uncollected Beneficiary Deductibles and Coinsurance
Diagnosis-Related Group Payment Window — Part B Providers
Expansion of Diagnosis-Related Group Payment Window
Hospital Reporting of Restraint-Related Deaths
Reporting of Restraint and Seclusion Use in Psychiatric Hospitals
Outpatient Prospective Payment System
Outlier Payments Under Outpatient Prospective Payment System
Outpatient Services on Same Day as Discharge and Readmission
Outpatient Pharmacy Services at Acute Care Hospitals
Outpatient Medical Supplies at Acute Care Hospitals
Procedure Coding of Outpatient and Physician Services
Peer Review Organization Sanction Authority

HOME HEALTH
Oversight of Home Health Care Quality
Home Health Compliance Programs
Home Health Payment System Controls
Coding of Home Health Resource Groups

NURSING HOME CARE
Quality Assessment and Assurance Committees
Nurse Aide Training
Family Experience With Nursing Home Care
Three-Day Stay Requirement
Consolidated Billing Requirements
Survey and Certification Process
Use of Penalties

HOSPICE CARE
Plans of Care
Hospice Payments to Nursing Homes

PHYSICIANS
Beneficiary Access to Preventive Services
Advance Beneficiary Notices
Physicians at Teaching Hospitals
Billing for Resident’s Services
Physician Evaluation and Management Codes
Inpatient Dialysis Services
Bone Density Screening Services and Supplies Incident to Physicians’ Services
Reassignment of Benefits

MEDICAL EQUIPMENT AND SUPPLIES
Medical Necessity of Durable Medical Equipment
Medicare Pricing of Equipment and Supplies

LABORATORY SERVICES
Clinical Laboratory Improvement
Amendments Certifications
Medicare Billings for Cholesterol Testing
Clinical Laboratory Proficiency Testing

END STAGE RENAL DISEASE
Utilization Service Patterns of Beneficiaries
Medicare Payments for EPOGEN Method II Billing

DRUG REIMBURSEMENT
Medicare Coverage of Prescription Drugs
Drug Prices Paid by Medicare Versus Other Sources
Medicare Billings for Nebulizer Drugs

OTHER MEDICARE SERVICES
Beneficiaries’ Experiences With Medigap Insurance
Rural Health Clinics
Medicare Payments for Clinical Trials
Medicare Mental Health National Error Rate

MEDICARE MANAGED CARE
Adjusted Community Rate Proposals
General and Administrative Costs
Cost-Based Managed Care Plans
Enhanced Managed Care Payments
Managed Care Organization Profits
Managed Care Additional Benefits
Educating Beneficiaries About Medicare+Choice
Physician Perspectives on Managed Care Organizations

MEDICAID HOSPITALS
Medicaid Graduate Medical Education Payments
Hospital-Specific Disproportionate Share Payment Limits
Medicaid Hospital Patient Transfers
Outpatient Clinical Diagnostic Laboratory Services Under Ambulatory Procedure Group Systems
Credit Balances in Inpatient Accounts

Underlined items are entries that are new to the 2002 plan.
## Table of Contents

**MEDICAID MANAGED CARE**
- Marketing and Enrollment Practices
- Public-Sponsored Managed Care Health Plans
- Managed Care Payments as Part of the Fee-for-Service Upper Payment Limit Calculation
- Medicaid Fee-for-Service and Managed Care Duplicate Payments
- Pharmacy Benefit Managers
- HIV/AIDS Antiretroviral Drug Therapy
- Cost Containment of Medicaid Mental Health Drugs

**MEDICAID/STATE CHILDREN’S HEALTH INSURANCE PROGRAM**
- Adolescent Enrollment in Medicaid/State Children’s Health Insurance Program
- Educating Families of Children Newly Enrolled in Medicaid Managed Care
- Disenrollment from State Children’s Health Insurance Program

**OTHER MEDICAID SERVICES**
- Mutually Exclusive Procedure Codes
- Payments for Services to Dually Eligible Beneficiaries
- Medicaid Fee-for-Service Payments for Dually Eligible Medicare Managed Care Enrollees
- Upper Payment Limit Calculations
- Intergovernmental Transfers
- Nursing Facility Administrative Costs
- Medicaid Services for the Severely Mentally Ill
- Medicaid Benefits for the Homeless Mentally Ill
- Claims for Residents of Institutions for Mental Diseases
- Payments for Inmates of Public Institutions
- Restraints and Seclusion in Residential Treatment Centers
- Discharge Planning: Intermediate Care Facilities/Institutions for the Mentally Retarded
- Durable Medical Equipment Reimbursement Rates
- Follow-up on Clinical Laboratory Services
- Average Wholesale Drug Prices Reported to Medicaid
- Medicaid Outpatient Prescription Drug Pricing
- Medicaid Drug Rebate Program
- Medicaid Rebates for Physician-Administered Drugs
- Collection of Medicaid Drug Rebates
- Medicaid Coverage for the Poor Working Disabled
- School-Based Health Services
- Payments for Services to Deceased Beneficiaries
- Escheated Warrants

**MEDICARE CONTRACTOR OPERATIONS**
- CMS Oversight of Contractor Evaluations
- Program Safeguard Contractors
- Contractor Fraud Control Units
- Information System Controls
- Provider Education and Training
- Medicare Comprehensive and Component Procedure Codes
- Payments for Incarcerated Persons
- Payments for Deported Individuals
- Bankrupt Providers
- Contractors’ Administrative Costs
- Medicare Data Center Claim Processing Costs
- Unfunded Pensions
- Pension Segmentation/Costs Claimed
- Pension Termination

**GENERAL ADMINISTRATION**
- Government Information Security Reform Act
- Improper Medicare Fee-for-Service Payments
- Medicare Secondary Payer
- Group Purchasing Organizations
- Corporate Integrity Agreements
- Joint Work With Other Federal and State Agencies

**INVESTIGATIONS**
- Health Care Fraud
- Provider Self-Disclosure

**LEGAL COUNSEL**
- Compliance Program Guidance
- Corporate Integrity Agreements
- Advisory Opinions and Fraud Alerts
- Anti-Kickback Safe Harbors
- Patient Anti-Dumping Statute Enforcement
- Program Exclusions
- Civil Monetary Penalties

*Underlined items are entries that are new to the 2002 plan.*
Transferring, Discharging, and Readmitting Patients

For years, there have been reimbursement issues related to whether a patient is discharged or transferred from a PPS hospital. In general, a patient is considered discharged if the patient dies in the hospital, is discharged to home, or is transferred to a non-PPS facility or PPS-excluded distinct unit. In these cases, the discharging hospital receives the full DRG for that patient. A patient is considered to be transferred if he or she is moved to another PPS hospital. The transferring hospital receives a graduated per diem for the time the patient was there. The reimbursement philosophy is that the transferring hospital spends fewer resources on that patient than the receiving hospital and, thus, does not deserve the full DRG.

Earlier investigations by the OIG found that hospitals were inappropriately coding a patient who was transferred as being discharged for Medicare reimbursement purposes to receive the higher payment. Compounding the situation, the 1997 Balanced Budget Act changed the rule to state, among other things, that a patient is also considered to be transferred for reimbursement purposes if he or she is moved to a non-PPS facility or nursing facility, or is discharged to home with a plan of care calling for home health within 3 days of that discharge and is classified in one of 10 specific diagnosis codes.

In FY 2002, the OIG will expand its investigation of discharges, transfers, and readmissions to evaluate whether: 1) there are appropriate edits to the system; 2) existing instructions are effective; and 3) claims are being appropriately paid. The OIG also plans to investigate whether hospitals are releasing patients to outpatient facilities, then readmitting the patient, again, to maximize reimbursement.

Outpatient Reimbursement

Now that the Outpatient Prospective Payment System has been in place for a while, the OIG is beginning to investigate whether providers are adhering to the rules, whether these rules are appropriate, and whether reimbursement is adequate. In particular, the OIG will evaluate whether outlier payments for outpatient services are necessary. As described above, the OIG will also investigate occurrences in which a patient is discharged from the hospital, transported to another hospital to receive outpatient services, and then readmitted into the original hospital. In this scenario, the hospital submits claims for the discharge and re-admission and the outpatient also submits claims for its services which may result in inappropriate duplicate payments. In addition, the OIG plans to investigate other potential duplicate payments caused by claims submitted by the outpatient facility and the treating physician for the same services.

Medical Education

There continue to be issues related to reimbursement for medical education. These issues include accurately computing full-time equivalents for interns and residents and ensuring that Medicare is only billed for residents who are licensed physicians and moonlighting. The OIG also plans to review the coordination of Medicare and Medicaid GME payments for those states in which CMS has approved Medicaid payments.
OIG Work Plan Summary

As with previous Work Plans, it is unlikely that the OIG will complete all of the audits and investigations planned; some will be listed on the next fiscal year plan. Nevertheless, the areas identified in the Work Plan should serve as a “red flag” to healthcare providers as areas deserving additional attention in the course of a compliance review. It is always more advantageous to discover the problem and take corrective action before the government finds it.

Operating When Disaster Hits —
A Planning Primer for Healthcare Entities

Much of these last few weeks have been spent trying to make sense out of the East Coast tragedy. Most of us in the Rocky Mountain region were insulated from the immediate disaster and trauma. Our main exposure was through the media. Nevertheless, as we all begin to resume some semblance of normalcy, the spectra of these events still looms large. Because, as we unfortunately witnessed, no one is immune from the potential for such a disaster, it is important to put these events in perspective and to take appropriate preventive actions. These preventive measures are essential to decrease your liability in the aftermath of a disaster.

A great deal has been written about disaster planning. Many healthcare organizations have provided guidance documents targeted at a particular healthcare provider type. While this detailed information is helpful, for those entities just beginning the process, we wanted to provide a few thoughts to get you started in the planning process.

Disaster planning should be part of your overall compliance program. As with compliance programs, there should be a process to revise disaster-planning protocols as needed. More importantly, as with compliance programs, all staff should be aware of the protocols.

Disaster drills should be conducted. If these drills are not conducted, you may not know if there are any “glitches” to your protocols until it is too late. You cannot know that your plan is effective until you test it. That test should not occur during a “real” emergency.

Identify the Nature of the Emergency

Different emergencies will activate different responses. A biochemical emergency, for example, will involve a different response than a fire, earthquake, or building collapse. Create protocols appropriate for each emergency.

Identify who is Responsible During an Emergency

Identify individuals responsible for coordinating responses and activities. This includes identifying who is responsible for communicating both inside and outside of the facility. Appoint “back ups.” Create a decision-making “tree.” If the CEO is unavailable, who is in charge? Make sure similar “trees” are in place at the department level. This will create an orderly flow of activity throughout the facility.

If your facility's assistance is needed outside of building, identify the appropriate personnel capable of fulfilling a particular need. Do not wait until a need arises to make the determination.

Communication

When an emergency that is the magnitude of a disaster occurs, communication is vital. Links should be pre-established between the entity's previously designated “point person” and:

- Staff;
- Visitors (medical, volunteers, family members);
- Outside emergency personnel;
- Law enforcement;
- Other healthcare entities in the surrounding area.

Remember that a building’s public address system may fail. Alternative methods to communicate throughout the building should be established. Telephone, including cellular telephone, service may also be disrupted. Again, alternatives should be created. Interestingly, the Internet was a vital communication link during the East Coast emergency.

Working with the Community

Have protocols in place to accept patients from other facilities or to transfer your patients to those facilities if needed. In addition to the actual move, you will also need to protect the patient's medical record. Pertinent medical information should accompany the patient to ensure an adequate continuum of care. Protocols should be in place to ensure smooth transitions.
**Medical Record Safety**

With the passage of the privacy and confidentiality provisions in the Health Insurance Portability and Accountability Act (HIPAA), providers are increasingly conscious of the need to protect patient records. Protection in the event of an emergency takes on a different perspective. Medical records should be maintained in a fire-safe area. If the records are maintained electronically, there should be a “back up” system in case the original record is deleted or otherwise destroyed. Ideally, that “back up” system should be stored in a different location.

**Government Resources**

The Federal Emergency Management Administration (FEMA) has an “Emergency Preparedness Checklist” which is available from its web site (http://www.fema.gov/pte/emprep.html.) This checklist is not specific to healthcare entities, but provides general information. Other checklists are also available on the FEMA site.

The Occupational Safety and Health Administration (OSHA) has several documents specific to healthcare disaster planning that are helpful. Go to http://www.osha-slc.gov/Publications/OSHA3152/osha3152.html. Within this document is a list of federal regulatory standards applicable to disaster planning, such as Hazard Communication, Employee Emergency Plans and Fire Prevention Plans, Personal Protective Equipment, and Respiratory Protection. OSHA also published guidelines addressing “work place violence.” These can be found at http://www.osha-slc.gov/SLTC/workplaceviolence/guideline.html.

While not providing checklists, per se, the Department of Health and Human Services (HHS) has several documents that may provide guidance when formulating a plan. See, for example, a January 2001 press release outlining the department’s role in responding to emergencies (http://www.hhs.gov/news/press/2001pres/01fsemergencyresponse.html).

Bioterrorism has, thankfully, not been an issue, thus far; however, the Centers for Disease Control and Prevention established protocols in the event of such an event. Go to http://www.bt.cdc.gov/EmtContact/Protocols.asp. See also “Bioterrorism Readiness Plan: A Template for Healthcare Facilities” (http://www.cdc.gov/ncidod/hip/Bio/13apr99APIC-CDCBioterrorism.PDF), a document prepared by the CDC Hospital Infections Program Bioterrorism Working Group and the APIC (Association for Professionals in Infection Control and Epidemiology) Bioterrorism Task Force. Finally, see an August 2001 press release from HHS outlining the government’s plans to respond to the threat of bioterrorism (http://www.hhs.gov/news/press/2001pres/01fsbioterrorism.html).

**Other Issues to Consider**

Of course, all the planning in the world will not necessarily help if, like those on the East Coast, you are at “ground zero.” However, an effective plan will be invaluable if you are outside “ground zero.” An effective plan will help you use any amount of time you have to respond to an emergency of that magnitude much more efficiently.

It is important to remember that you are responsible for the well being of your patients, your staff, and anyone else who may have a relationship, however tangential, to your facility at the time of an emergency. While many things may be out of your control, it is important to maintain as much control as possible. A disaster plan gives you the ability to maintain that control. Once the dust settles, it is likely that anyone injured will look to you for recovery. Developing and implementing a disaster plan may decrease your culpability and subsequent liability.
HIPAA Tidbit

While we are all focused on the East Coast events, another part of returning to “normalcy” is to focus on existing federal requirements. In particular, it will take a great deal of effort to implement the privacy rules published earlier this year. Covered entities have until April 14, 2003, to come into compliance with federal standards. Covered entities are defined as health plans, healthcare clearinghouses, and healthcare providers who transmit health information electronically. Small health plans, those with annual receipts of $5 million or less, have an extra year—April 14, 2004—to comply with the rule. Look to Holland & Hart’s Health Care Group for additional information in the future about these requirements and how to implement them.

CMP Alert

The Centers for Medicare and Medicaid Services (CMS) published a final rule outlining its implementation of new Civil Monetary Penalties (CMPs) and new CMP maximums for certain billing improprieties. Specifically, a CMP will be imposed if a provider knowingly and willfully fails to accept assignment and bill accordingly for outpatient therapy services or comprehensive outpatient rehabilitation services or for ambulance services. The maximum CMP for failing to bill on an assignment-related basis was increased to $10,000 for each violation. The maximum was originally $2,000. A CMP will also be imposed if a physician or nonphysician provider fails to furnish diagnostic codes for items or services furnished. Finally, a provider must respond within 30 days to a Medicare beneficiary’s request for an itemized statement of the Medicare items or services furnished or face a $100 CMP. These new penalties, published in the September 28, 2001, Federal Register, implement changes enacted by the 1997 Balanced Budget Act. They are effective October 29, 2001. Comments on the rule will be accepted until November 27, 2001.

Note to our clients and friends: The information contained in this newsletter does not constitute legal advice, nor does it create an attorney-client relationship where none has previously existed. You are receiving this newsletter because you are either a present or former client of Holland & Hart LLP, or have requested to be placed on this mailing list. If you would prefer to not receive these newsletters, please let us know and we will delete you from our list. In addition, we plan to send future newsletters electronically. If you would like to receive the newsletter electronically, please send your email address to kbmiller@hollandhart.com. For comments about the newsletter content, please contact Robbi-Lynn Watnik at rwatnik@hollandhart.com. © Copyright 2001 Holland & Hart Health Care Group
Just Released - 2002 OIG Work Plan

Operating When Disaster Hits -
A Planning Primer for Health Care Entities

HIPAA Tidbit & CMP Alert

October 2001