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HEALTH LAW
FOULSTON SIEFKIN ISSUE ALERT

OIG 2005 Work Plan Identifies Government Enforcement Priorities

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On October 12, 2004, the Office of Inspector General for the U.S. Department of Health and Human Services (OIG) released its Fiscal Year 2005 Work Plan. The Work Plan provides a brief description of over 150 audits, evaluations, and investigations the OIG intends to initiate or continue during the upcoming year to protect the Medicare and Medicaid programs from fraud, waste, and abuse.

The OIG's audits, evaluations, and investigations are aimed at all sectors of the health care industry, including hospitals, physician practices, nursing homes, home health agencies, clinical laboratories, pharmaceutical companies, DME suppliers, ambulance services, and mental health providers. The 2005 Work Plan is available at http://oig.hhs.gov/publications/workplan.html.

The Work Plan is an essential self-assessment tool for health care providers to use in evaluating their compliance efforts. In our review of the document, we found the following items of particular interest.

Reporting of rebates on hospital cost reports. The 2005 Work Plan lists a number of new projects relating to hospitals. First, the OIG intends to visit several large vendors to determine if hospitals are accurately reporting rebates received from vendors on their Medicare cost reports. Hospitals should take appropriate measures to ensure accurate reporting of rebates given the OIG's new interest in this area.

DRG coding. The OIG also will examine DRGs with a history of aberrant coding to determine whether some hospitals exhibit irregular coding patterns. Although the Work Plan does not identify any specific codes, the fact the OIG has chosen to focus on DRG coding this year illustrates the need for hospitals to conduct routine audits of their coding practices.

Provider-based entities. The OIG intends to evaluate whether facilities designated as "provider-based" comply with the requirements for receiving this designation. The OIG notes that Medicare and its beneficiaries may be paying excessive amounts for services inappropriately billed as provider-based. Hospitals should maintain documentation demonstrating how those facilities designated as provider-based facilities satisfy the applicable criteria.

Coronary artery stents. Although this item was listed in the 2004 Work Plan, the OIG identifies this project as a "new start," presumably because work on this review of claims involving arterial stent implantation did not get underway last year. The OIG intends to conduct medical reviews to determine whether these services were medically necessary and supported by adequate documentation. In particular, the OIG will review claims for beneficiaries who had stent implantations during multiple procedures to determine if the implantations should have been performed simultaneously.

Other new projects relating to hospitals. During the upcoming year, the OIG also will examine the medical necessity of inpatient psychiatric stays; review payments made to inpatient rehab hospitals when they fail to transmit admission and discharge assessments in a timely manner; assess the early experiences of Medicare Quality Improvement Organizations in resolving beneficiary complaints; determine the appropriateness of payments to hospitals in connection with dental and podiatry residents and nursing and allied health students; and evaluate hospitals' compliance with beneficiary notification requirements for "lifetime reserve days," a non-renewable Medicare benefit created by the Medicare Modernization Act of 2003.

On-going projects relating to hospitals. Approximately one-half of the projects relating to hospitals for the upcoming year are carry-overs from the 2004 Work Plan. Ongoing interests include inpatient and outpatient outlier payments, sequential stays at different hospitals, post acute care transfers, payments to long-term care hospitals, outpatient cardiac rehabilitation services, and reporting of restraint-related deaths.

Billing companies. The 2005 Work Plan includes several new projects focusing on physicians. First, the OIG intends to review relationships between physicians and billing companies to determine the impact of these arrangements on physicians' billings. Physician practices and other health care providers who utilize

billing companies should review their written agreements, as well as their ongoing relationships with such companies, to identify and remedy any potential problems.

Physician services at skilled nursing facilities. Medicare rules provide that a physician may bill only the professional component of the physician's services for skilled nursing facility patients; the technical component is covered under the patient's Part B stay in the facility. The OIG will examine whether improper payments have been made to physicians and/or skilled nursing facilities for the technical component of physician services.

Billing for services provided for inpatients. The OIG will examine the extent to which improper Part B payments have been made for the technical component of radiology and clinical lab services and ambulance services provided for beneficiaries during the course of a hospital inpatient stay.

Physician pathology services. Given that Medicare pays over $1 billion annually to physicians for pathology services, the OIG intends to review the relationships between physicians who furnish pathology services in their offices and outside pathology companies.

Cardiography and echocardiography services. The OIG will examine whether physicians who perform interpretations of tests performed by other health care providers appropriately bill for those services with a 26 modifier.

Coding of evaluation and management services. In 2005, the OIG plans to enter into a new phase of its ongoing review of physician coding of evaluation and management services, having previously found that inaccurate coding has resulted in large overpayments. The OIG intends to examine patterns of physician coding, presumably focusing on whether certain physicians bill for a higher level of service as compared to national statistics. Physicians should consider comparing their levels of service with national averages to determine whether they are a possible target for allegations of up-coding.

"Long-distance" physician claims. The OIG will review Medicare claims for face-to-face physician encounters where the practice setting and the beneficiary's location are separated by a significant distance to confirm that services were provided and accurately reported. The OIG suspects claims for services provided to persons with ongoing illnesses requiring skilled care are not accurate because such individuals are unlikely to travel long distances from home.

Ongoing projects relating to physicians. The 2005 Work Plan identifies 15 projects relating to physicians for the upcoming year, nine of which are carry-overs from the 2004 Work Plan. Ongoing interests include Medicare payments to VA physicians, payment for care plan oversight for home health and hospice patients, physical and occupational therapy services, Part B mental health services, wound care services, and use of modifiers.

Contractual arrangements with suppliers. Both hospitals and physician practices should take note of a new project identified in the 2005 Work Plan relating to contractual arrangements with suppliers (e.g. clinical labs, DME suppliers) pursuant to which the supplier agrees to operate the service on behalf of the hospital or physician practice. Providers who have entered into such arrangements should review them carefully for compliance with applicable program requirements.

Other providers. In addition to those projects relating to hospitals and physicians, the 2005 Work Plan also identifies projects for home health (all of which are carry-overs from the 2004 Work Plan); nursing homes (including new projects focused on the quality of patient care and residents' rights); clinical labs (including a new project addressing proficiency testing); IDTFs (a carry-over project addressing medical necessity of services provided in these facilities); CORFs (a carry-over project addressing these facilities' billings for PT, OT, and speech therapy services); ambulance services (a new project addressing compliance with new Medicare reimbursement regulations and a carry-over project addressing reimbursement for air ambulance services); and dialysis facilities (a new project focused on quality of care and proper oversight).

Medicare Drug Reimbursement. Finally, the 2005 Work Plan includes descriptions of a number of projects relating to Medicare's new coverage for prescription drugs. These projects focus on the drug discount card program, the impact of employer subsidies for drug coverage, and the manner in which drug sales prices are determined.

For Further Information

Foulston Siefkin's health care lawyers maintain a high level of expertise regarding federal and state regulations affecting the health care industry. The firm devotes significant resources to ensure our attorneys remain up-to-date on daily developments. At the same time, the relationship of our health care law practice group with Foulston Siefkin's other practice groups, including the taxation, general business, labor and employment, and commercial litigation groups, enhances our ability to consider all of the legal ramifications of any situation or strategy. For additional information, contact **Gary Ayers** at (316) 291-9530, or gayers@foulston.com. For more information on the firm, please visit our website at **www.foulston.com.**

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