Office of
Inspector
General

Work Plan

FISCAL YEAR
2010

Department of Health and Human Services
Office of Inspector General

Observation Services During Outpatient Visits

We will review Medicare payments for observation services provided during outpatient visits in hospitals. The Social Security Act, §§ 1832(a) and 1833(t), provides for Part B coverage of hospital outpatient services and reimbursement for such services under the Hospital Outpatient Prospective Payment System (OPPS). CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 4, § 290, provides the billing requirements. We will assess whether and to what extent hospitals' use of observation services affects the care Medicare beneficiaries' receive and their ability to pay out-of-pocket expenses for health care services.
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Coding and Documentation Changes Under the Medicare Severity Diagnosis Related Group System

We will review the impact of the October 1, 2007, implementation of the Medicare Severity Diagnosis Related Group (MS-DRG) system. CMS revised its hospital inpatient reimbursement system to improve recognition of severity of illness and resource consumption, as recommended in a March 2005 MedPAC report. As a result, the number of DRGs has increased from 538 to 745. We will examine coding trends and patterns under the new system and determine whether specific MS-DRGs are vulnerable to potential upcoding.
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Financial Status of Hospitals in the New Orleans Area

We will review the financial status of hospitals in the New Orleans area in the aftermath of Hurricane Katrina to assess the needs of hospitals and options for policymakers as the area rebuilds its health care infrastructure. HHS has played a central role in Katrina recovery efforts, including the funding of provider stabilization grants and workforce supply grants under the authority of section 6201(a)(4) of the DRA 72 Fed. Reg. 9538 (Mar. 2, 2007). Among other things, these grants were intended to compensate health care providers for wage rates that had not yet been reflected in the Medicare reimbursement system methodologies and to help retain and recruit the licensed health care professionals needed to restore access to health care. We will determine whether the grantees were effective in meeting the objectives.
(OAS; W-00-09-35203; various reviews; expected issue date: FY 2010; work in progress)

Home Health Agencies

Part B Payments for Home Health Beneficiaries

We will review Part B payments for services and medical supplies provided to beneficiaries in home health episodes. Most services and nonroutine medical supplies furnished to Medicare beneficiaries during home health episodes are included in the HHA prospective payments. The Social Security Act, §§ 1832(a)(1) and 1842(b)(6)(F), require that in the case of home health services furnished under a plan of care of an HHA, payment for those services be made to the HHA, including payment for services and supplies provided under arrangements by outside suppliers. We will identify Part B payments made to outside suppliers for services and medical

supplies that are included in the HHA prospective payment and examine the adequacy of controls established to prevent inappropriate Part B payments for services and medical supplies. *(OAS; W-00-09-35418; W-00-10-35418; various reviews; expected issue date: FY 2010; new start)*

Home Health Agencies: Accurately Coding Claims for Medicare Home Health Resource Groups

We will review Medicare claims submitted by HHAs to determine the extent to which the billing codes for home health resource groups (HHRG) are used in determining whether payments to HHAs are accurate and supported by documentation in the medical record. The Social Security Act, § 1895, governs the payment basis and reimbursement for claims submitted by HHAs, including a case-mix adjustment using HHRGs. Medicare pays for home health episodes based on a PPS that categorizes beneficiaries into groups, referred to as HHRGs. Each HHRG has an assigned weight that affects the payment rate. We will assess the accuracy of HHRG assignment and identify patterns of miscoded HHRGs.
(OEI; 01-08-00390; expected issue date: FY 2011; work in progress)

Medicare Home Health Payments for Insulin Injections

We will review the incidence of Medicare home health services outlier payments for insulin injections. Insulin is customarily self-injected by a patient or is injected by a family member. However, CMS's "Medicare Benefit Policy Manual," Pub. No. 100-02, ch. 7, § 40.1.2.4.A.2, states that when a patient is either physically or mentally unable to self-inject insulin and no other person is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service under the Medicare home health benefit.
The unit of payment under the home health PPS is a national 60-day episode rate with applicable adjustments. The law requires the 60-day episode to include all covered home health services, including medical supplies. When beneficiaries experience an unusually high level of services in a 60-day period, Medicare systems will provide additional "outlier" payments to the episode payment. Outlier payments can result from medically necessary high utilization of home health services. CMS makes outlier payments when the cost of care exceeds a threshold dollar amount. We will also examine billing patterns in geographic areas with high rates of home health visits for insulin injections.
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Home Health Agency Outlier Payments

We will review CMS's methodology for calculating outlier payments to HHAs to determine whether the methodology reimburses HHAs as intended for high cost episodes. Pursuant to the Social Security Act, § 1895(b)(5), the HHS Secretary may provide outlier payments for episodes of care that incur unusually high costs. In recent years, outlier payments have significantly increased.
(OAS; W-00-09-35107; W-00-10-35107; various reviews, expected issue date: FY 2010; work in progress)

Home Health Prospective Payment System Controls

We will review compliance with various aspects of the home health PPS, including billings for the appropriate location of the services provided. Pursuant to the Social Security Act, § 1895, the home health PPS was implemented in October 2000. Since that time, total payments to

HHAs have substantially increased from $8.5 billion in 2000 to $16.4 billion in 2008. We will also analyze various trends in HHA activities, including the number of claims submitted to Medicare, the number of visits provided to beneficiaries, arrangements with other facilities, and ownership information.
(OAS; W-00-10-35501; various reviews; expected issue date: FY 2010; new start)

Home Health Agency Profitability

We will review cost report data to analyze HHA profitability trends under the home health PPS to determine whether the payment methodology should be adjusted. The Social Security Act, § 1895, added by the Balanced Budget Act of 1997 (BBA), § 4603, requires a PPS for home health services. Since the PPS was implemented in October 2000, HHA expenditures have significantly increased. We will examine various trends, including profitability trends in Medicare and the overall profitability trends for freestanding and hospital-based HHAs.
(OAS; W-00-09-35428; W-00-10-35428; various reviews; expected issue date: FY 2010; work in progress)

Medicare Home Health Payments for Diabetes Self-Management Training Services

We will review Medicare home health payments for diabetes self-management training services. Medicare covers diabetes self-management training services (DSMT) to educate beneficiaries in the successful self-management of diabetes. The Social Security Act, §§ 1861(s)(2)(S) and (qq), permits Medicare coverage of DSMT when these services are furnished by a certified provider who meets certain quality standards. Other conditions for coverage of DSMT are included in 42 CFR pt. 410, subpart H, which includes requirements for plans of care and physician certification. Services include instructions in self-monitoring of blood glucose, diet and exercise education, an insulin treatment plan, and motivation for patients to use the skills for self-management. We will examine billing patterns in geographic areas with high utilization of diabetes self-management training services.
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Oversight of Home Health Agency Outcome and Assessment Information Set Data

We will review CMS's oversight of Outcome and Assessment Information Set (OASIS) data submitted by Medicare-certified HHAs. Federal regulations at 42 CFR § 484.55 require HHAs to conduct accurate comprehensive patient assessments that include OASIS data items and submit the data to CMS. OASIS data reflect HHAs' performance in assisting patients to regain or maintain their ability to function and perform activities of daily living. OASIS data also include measures of physical status and use of services, such as hospitalization or emergent care. CMS has used OASIS data for its HHA PPS since 2000; began posting OASIS-based quality performance information on its Home Health Compare Web site in fall 2003; and started a home health pay-for-performance demonstration based on OASIS data on January 1, 2008. We will review CMS's process for ensuring that HHAs submit accurate and complete OASIS data.
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Nursing Homes

Part B Services in Nursing Homes: Mental Health Needs and Psychotherapy Services

We will review Medicare Part B payments for psychotherapy services provided to nursing home residents during noncovered Medicare Part A SNF stays. Pursuant to 42 CFR § 483.25, certified nursing homes are required to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A previous OIG review found that approximately 31 percent of outpatient claims for Part B mental health services allowed by Medicare did not meet coverage guidelines, resulting in $185 million in inappropriate payments. We will determine the medical necessity of services, appropriateness of coding, and adequacy of nursing home documentation.
(OEI; 06-06-00580; expected issue date: FY 2010; work in progress)

Medicare Requirements for Quality of Care in Skilled Nursing Facilities

We will assess how skilled nursing facilities (SNF) have addressed certain Federal requirements related to quality of care. Specifically, we will determine the extent to which SNFs: (1) developed plans of care based on assessments of beneficiaries, (2) provided services to beneficiaries in accordance with these plans of care, and (3) planned for beneficiaries' discharges. As a part of this study, we will review SNFs' use of the standardized Resident Assessment Instrument (RAI) to develop nursing home residents' plans of care. The Social Security Act, §§ 1819(b)(3) and 1919(b)(3), requires nursing homes participating in the Medicare or Medicaid program to use the RAI to assess each nursing home resident's strengths and needs. Prior OIG reports revealed that approximately one quarter of residents' needs for care, as identified through the RAI, were not reflected in their care plans and that nursing home residents did not receive all psychosocial services identified on care plans.
(OEI; 02-09-00201; expected issue date: FY 2010; work in progress)

Accuracy of Skilled Nursing Facility Resource Utilization Groups Coding

We will review SNF claims for Medicare reimbursement to determine the accuracy of Resource Utilization Groups (RUG) coding. The Social Security Act, § 1888(e), establishes the amount paid to SNFs for all covered services. Medicare pays Part A-covered SNF stays using a PPS that applies a case-mix adjustment based on the resident's RUG, which is an indication of the level of care and resource needs. In 2006, we reported that 22 percent of claims had RUGs associated with higher payment rates than those generated in and supported by patients' medical records. This represented $542 million in potential overpayments for FY 2002. We will also explore other opportunities to improve the accuracy of payments to SNFs.
(OEI; 02-09-00200; expected issue date: FY 2010; work in progress)

Nursing Home Emergency Preparedness and Evacuations During Selected Natural Disasters

We will review nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors to determine the sufficiency of the nursing homes' plans and implementation of the plans. Pursuant to 42 CFR § 483.75(m), Medicare- and Medicaid-certified nursing home facilities must have plans and procedures to meet all potential emergencies and train all employees in these emergency procedures. In 2006, OIG reported that nursing homes in certain

Gulf States had plans that lacked a number of provisions suggested by emergency preparedness experts and that staff did not always follow emergency plans. We will describe the experiences of selected nursing homes, including challenges, successes, and lessons learned, when they implemented their plans during recent disasters.
(OEI; 06-09-00270; expected issue date: FY 2010; work in progress)

Criminal Background Checks for Nursing Facility Employees

We will determine whether and the extent to which nursing facilities have employed individuals with criminal convictions. Pursuant to the Social Security Act, §§ 1819(b)(2) and 1919(b)(2), nursing facilities participating in the Medicare and Medicaid programs are required to provide services that maintain the dignity and well-being of all nursing home residents. Federal regulations at 42 CFR § 483.13(c)(1)(ii) prohibit Medicare and Medicaid long term care (LTC) facilities from employing individuals found guilty of abusing, neglecting, or mistreating residents. We will also categorize the types of crimes, if any are found, for which nursing facilities' employees have been convicted.
(OEI; 07-09-00110; expected issue date: FY 2010; work in progress)

Oversight of Poorly Performing Nursing Homes

We will review CMS's and States' use of enforcement measures to determine their impact on improving the quality of care beneficiaries received in poorly performing nursing homes and the performance of these nursing homes. The Social Security Act, §§ 1819(g) and 1864, established a survey and certification process to ensure that nursing homes meet Federal standards for participation in the Medicare and Medicaid programs. We will examine enforcement measures, such as survey and certification reviews and actions taken by CMS and States. We will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement plans of correction.
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Part B Services in Nursing Homes: Overview

We will review the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Unlike services provided during a Part A SNF stay, which are billed to Medicare directly by the SNF in accordance with consolidated billing requirements, Part B services are provided and billed directly by suppliers and other providers. In repealing consolidated billing provisions that would have applied to non-Part A SNF stays, Congress directed OIG in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313, to monitor these services for abuse. This review will determine the extent of Part B services provided to nursing home residents during 2007 and assess patterns of billing among nursing homes and providers.
(OEI; 06-07-00580; expected issue date: FY 2010; work in progress)

Nursing Home Residents Aged 65 or Older Who Received Antipsychotic Drugs

We will review the extent to which nursing home residents aged 65 or older received selected antipsychotic drugs in the absence of conditions approved by the Food and Drug Administration (FDA). Pursuant to the Social Security Act, §§ 1819 and 1919, SNFs are required to respect certain rights of patients, including the right to be free from chemical restraints administered for discipline or convenience. The regulation at 42 CFR § 483.25(l) defines safeguards to protect nursing home residents from being prescribed unnecessary drugs. We will examine Medicare

Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents and the extent to which these drugs were prescribed and paid for in accordance with Federal regulations.
(OEI; 07-08-00150; expected issue date: FY 2010; work in progress)

Other Part A and Part B Providers Payments

Physician Billing for Medicare Hospice Beneficiaries

We will review the extent of Part B billing for physician services provided to Medicare hospice beneficiaries. The regulations at 42 CFR § 418.304 list the physician services that are already covered by Medicare under the hospice benefit. The regulation provides that for physicians employed by or in an arrangement with the hospice, payments for certain services are reimbursed to the hospice as part of the hospice payment while other services are paid to the hospice under the Part B Medicare Physician Fee Schedule. Physicians may receive reimbursement for hospice services under Medicare Part A or Part B. This study is a followup to recent OIG studies on hospice care. We will determine the frequency of and total expenditures for physician services under Part A and Part B for hospice beneficiaries. We will identify whether physicians double-billed hospice services to Part A and Part B.
(OEI; 02-06-00224; expected issue date: FY 2010; work in progress)

Trends in Medicare Hospice Utilization

We will review Medicare Part A hospice claims to identify trends in hospice utilization. When the hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 122, Medicare did not cover more than 210 days of hospice care per beneficiary. Congress changed the benefit in section 4443 of the BBA, implemented by CMS at 42 CFR § 418.21, to eliminate the limit on the number of days covered by Medicare. Since then, the number and types of diagnoses associated with hospice utilization have increased and longer stays have become more common. We will examine the characteristics of hospice beneficiaries, geographical variations in utilization, and differences between for-profit and not-for-profit providers.
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Medicare Incentive Payments for E-Prescribing

We will review Medicare incentive payments made in 2010 to eligible health care professionals for their 2009 electronic prescribing (e-prescribing) activities. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), § 132, amended the Social Security Act, § 1848(m), to provide for incentive payments to eligible health care professionals for e-prescribing beginning in 2010 and continuing through 2013. Physicians will be eligible for incentive payment if they are "successful electronic prescribers." In its final rule for the calendar year (CY) 2009 Physician Fee Schedule, 73 Fed. Reg. 69726 (Nov. 19, 2008), CMS stated that successful electronic prescribers will be those physicians who report on CMS's e-prescribing quality measure with respect to at least 50 percent of cases in which services are billed to Medicare Part B. We will assess whether, and, if so, the extent to which incentive payments for e-prescribing activities in 2009 were made in error. In addition, if erroneous payments were made, we will assess CMS's actions to remedy erroneous payments and its plans for overseeing