



## The Office of Inspector General Work Plan A USEFUL COMPLIANCE TOOL

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A health care compliance program is designed to ensure avoidance, identification, and mitigation of real and/or potential compliance risks. An important tool in the identification of potential risks is a close review and analysis of the annual Office of Inspector General (OIG) Work Plan. The OIG was established to protect the integrity and provide oversight for the Department of Health & Human Services (HHS) programs, such as, the Centers for Medicare and Medicaid Services (CMS). The OIG is “dedicated to combating fraud, waste and abuse, and to improving the efficiency of the HHS Programs.”

One proactive approach is to review the focus of the work plan annually to assess, address, and correct issues and/or identified risks. Each year the published work plan outlines new and ongoing reviews and activities planned by the OIG for the Department of Health & Human Services programs. The work plan includes the primary objective for each planned evaluation, audit, and other ongoing initiatives.

### FY 2015 Work Plan

The OIG Work Plan for FY 2015 includes sections for each part of Medicare A-D. This article will focus on those areas of the work plan that most directly impact health information management compliance risks. A review of the entire work plan is also recommended.

■ **The Two Midnight Rule:** The OIG will focus on the impact of the Two-Midnight Rule admission criteria on hospital billing for inpatient care in FY 2014. The OIG had previously identified millions of dollars in hospital overpayments for short inpatient stays that should have been billed as outpatients.

**Recommendation:** Review discharges with short length-of-stay (LOS) to ensure compliance with documentation requirements for the Two-Midnight Rule.

■ **Inpatient claims for mechanical ventilation:** The OIG will review medical record documentation for MS-DRGs 003, 004, 207, 870,

927, and 933 to ascertain whether the patient received 96 hours or more of continuous mechanical ventilation. Previous OIG reviews found overpayments made to hospitals for beneficiaries who did not receive 96 or more hours of mechanical ventilation.

**Recommendation:** Run a report for the above MS-DRGs for calendar year (CY) 2014 to look for any patient with a LOS of less than 96 hours and assignment of ICD-9-CM procedure code 96.72, continuous invasive mechanical ventilation for 96 consecutive hours or more.

■ **Outpatient dental claims:** Medicare generally does not cover hospital outpatient dental procedures. The OIG hospital outpatient dental procedures to determine whether billing of these services was in compliance with Medicare requirements. Previous audits indicated hospitals received significant overpayments from

Medicare for non-covered dental services.

**Recommendation:** Review all hospital inpatient and outpatient claims with dental procedures to ensure compliance with Medicare documentation requirements.

■ **Nationwide review of cardiac catheterizations and endomyocardial biopsies:** When a right cardiac catheterization (RHC) is performed in conjunction with endomyocardial biopsies, only the biopsies may be coded and billed. Previous OIG reviews identified unbundling of these two procedures, resulting in hospital overpayments. The RHC services are already included in payments for endomyocardial biopsies.

**Recommendation:** Run a report for hospital outpatient endomyocardial biopsies with either a primary or secondary procedure of a RHC during the same operative episode to ensure unbundling did not occur.

- **Payments for patients diagnosed with kwashiorkor:** Kwashiorkor is a type of severe protein malnutrition generally found in children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. It is typically not found in the United States. Prior OIG reviews have identified inappropriate payments to hospitals for claims with a Kwashiorkor diagnosis. The OIG will review Medicare payments made to hospitals for claims that include a diagnosis of Kwashiorkor to determine whether the diagnosis is adequately supported by documentation in the medical record.
- **Bone marrow or stem cell transplants:** These services are only covered by Medicare for specific diagnoses. Diagnoses must meet specified criteria for the bone marrow or peripheral blood stem cell transplantation procedures performed (mobilization,

harvesting, and transplant of bone marrow or peripheral blood stem cells and the pre-transplant administration of high-dose chemotherapy or radiotherapy). Previous reviews have identified incorrect billing for bone marrow or stem cell transplants.

- **Inpatient rehabilitation facilities (IRF) and Long-term Care Hospitals (LTCH)—Adverse events in post-acute care for Medicare beneficiaries:** The OIG plans to review data related to the incidence of adverse and temporary harm events that occur in the IRF and LTCH settings and identify factors that contribute to these events. The goal is to determine to what extent these events may have been preventable and estimate the associated costs to Medicare.
- **Hospice general inpatient care:** The OIG plans to assess the appropriateness of hospices' general inpatient care claims, the

content of election statements for hospice beneficiaries who receive general inpatient care, and review hospice medical records to address concerns that this level of hospice care is being misused.

- **Ambulatory surgical centers (ASC)—Payment system:** The OIG will also determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings.
- **Diagnostic radiology—Medical necessity of high-cost tests:** High-cost diagnostic radiology tests are under review to determine whether the tests were medically necessary and to determine the extent to which use has increased for these tests.

see [The OIG Work Plan page 22](#)

■ **Medicare Advantage (MA) Organizations Compliance with Part C Requirements:**

**Encounter data** - CMS oversight of data integrity: MA encounter data will be reviewed to determine the extent to which it reflects the items and services provided are complete, consistent, and verified for accuracy. Prior CMS and Office of Inspector General (OIG) audits indicated vulnerabilities in the accuracy of risk adjustment data reporting by MA organizations.

**Risk adjustment data** - Sufficiency of documentation supporting diagnoses: Medical record documentation will be reviewed to ensure that it supports the diagnoses that MA organizations submit to CMS for use in risk-score calculations and will determine whether the diagnoses submitted complied with federal requirements. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to CMS by MA organizations. Inaccurate diagnoses may cause CMS to overpay MA organizations.

**Summary**

The annual OIG Work Plan provides health care organizations a tool to use in evaluating compliance with CMS documentation, coding, and billing requirements. Use of data analytics will provide additional insight into potential compliance risks. A full review of the work plan is an essential component of a Health Information Management Compliance program.

**References**

OIG on the Web: [oig.hhs.gov](http://oig.hhs.gov).

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## SEPTEMBER

### ICD-10-PCS Fundamentals

- 1 Walnut Creek
- 2 Ontario

### CDI Program in Place, Now What?

- 9 Newport Beach
- 10 Dublin

### ICD-10 GoLive Reality - It's Here

- 22 Live Webinar

## OCTOBER

### ICD-10-CM Fundamentals

- 28 Walnut Creek
- 29 Ontario

## NOVEMBER

### Confidentiality and the Release of Information in California

- 18 Garden Grove
- 19 Concord

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### DECEMBER

2016 CPTs Updates and Big Data

### JANUARY

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