OIG Work Plan for 2008

The following areas have been targeted by the Office of Inspector General for audits in their 2008 work plan. Reviews will be conducted of:

- **diagnostic x-rays** performed in hospital emergency departments to determine the appropriateness of payments; There has been an increasing cost of imaging services for Medicare beneficiaries and potential overuse of diagnostic imaging services.
- **physician coding of place of service** on claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Different levels of payments to physicians are made depending on where the services are performed. The OIG wants to be sure no overpayments were made based on claims submitted with the incorrect place of service.
- **industry practices related to the number of evaluation and management (E&M) services** provided by physicians and reimbursed as part of the global surgery fee. Since the average number of E&M services provided in the global period was determined in 1992, the OIG will determine if the number of visits for which payment is allocated is still appropriate.
- **psychiatric services** for a determination of medical necessity
- **Licensed Clinical Social Worker (LCSW) services** when provided in the hospital or Skilled Nursing Facility environment to determine whether the services were separately billed to Medicare Part B. Services performed by an LCSW cannot be billed under Medicare Part B when provided to inpatients of certain facilities.
- **Physician services** such as surgery, consultations, and home, office, and institutional calls to insure there is proper documentation of the services.
- “incident to” services and the qualifications and appropriateness of the staff who perform them. Incident to a physician’s professional services means that the services or supplies are furnished by ancillary personnel as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.
- the appropriateness of Medicare payments for polysomnography. Medicare payments for polysomnography increased from $62 million in 2001 to $170 million in 2004.
- Medicare Physician Fee Schedule payments for Magnetic Resonance Imaging (MRIs) and the relationships among physicians, billing providers, and others who work together to provide imaging services to determine whether these relationships affect levels of utilization with particular emphasis on the financial aspect of the relationships.
- **interventional pain management** procedures and the medical necessity and appropriateness of these services
- geographic areas with high utilization of ultrasound services to determine the medical appropriateness for the services.
- payment for chemotherapy drug administration services that occur without corresponding chemotherapy administration drug claims. Medicare Payment Advisory Commission (MedPAC) found that Medicare payments for chemotherapy drug administration services increased 217 percent between 2003 and 2004, while payments for chemotherapy drugs increased only 4 percent. The MedPAC is an independent federal body established to advise the U.S. Congress on issues affecting the Medicare program.
- **dialysis services** paid by Medicare to hospitals for admissions for observation status versus an inpatient stay for dialysis services. This review will determine if the patient was admitted as observation or formally admitted to the hospital. Reimbursement differs depending on the patient’s status.
- **inpatient laboratory services**: laboratory services furnished to hospital inpatients are generally included in hospitals’ Medicare Part A payments. The OIG will determine whether Part B payments for laboratory services rendered during inpatient stays were appropriate.
- **Medicaid Laboratory Tests**: The OIG will determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts authorized by Medicare for the same tests or were duplicated; identify tests that were not grouped together (bundled into a panel or profile) for payment purposes; and determine whether the tests were properly supported by physicians’ orders.

The entire report can be found at: http://www.oig.hhs.gov/publications/workplan.
IN THE NEWS

Stratford, CT Lab Enters into Another Civil Settlement

Dianon Systems, Inc. has agreed to a $1.5 million dollar settlement with the federal government to resolve allegations that the company submitted false claims to Medicare and Tricare. The issue involved billing for flow cytometry services which were either not rendered or were not medically necessary. The case was prompted by a pathologist who had worked at Dianon and who will receive $300,000 as the whistleblower’s share of the settlement.

This is not Dianon Systems first run in with the law. In 2002, Dianon paid $4.8 million to settle another false claims case with the OIG for allegations involving billing for unnecessary or investigational lab work. In the current case, the OIG has not determined whether Dianon Systems will be excluded from participation in federal health care programs.

Recover Audit Contractors Halted

In our February 2007 “Alert”, we reported that the Recovery Audit Contractors (RACs) also known as ‘compliance bounty hunters’ were conducting postpayment reviews of claims paid by Medicare. The RACs are paid commissions of between 25 percent and 30 percent of the money they collect from reviewing and rejecting Medicare claims as far back as five years. Medicare officials have declared a temporary “pause” in this controversial auditing program after dozens of California rehabilitation hospitals were forced to surrender tens of millions of dollars on allegations that the care they provided to elderly patients was medically unnecessary. At the third level of appeal, judges are reversing many, if not all, of those decisions on grounds that it is impermissible under departmental rules for the auditors to call up cases more than a year old without good cause. The Center for Medicare and Medicaid Services (CMS) plans to roll out the audit program nationally by 2010.

Training Alert!!

All billing physicians and non-physician practitioners must complete their one-hour of medical billing compliance training by December 31, 2007 or their billing numbers will be suspended. To check your training status, visit http://www.yale.edu/training/.

The training requirement may be met by attending a compliance session on December 4th or December 18th at 5:30 pm in Fitkin Amphitheater or by taking the online training at http://learn.med.yale.edu/cms/caslogin.asp.

Holiday Gift Giving?

During this holiday season it is important to remember that the Yale School of Medicine seeks to manage its relationships with external vendors in a fair and reasonable manner, consistent with all applicable laws and good business practices. Vendors may attempt to cultivate relationships with providers in a position to generate business for them through a variety of practices, including gifts and entertainment. These activities have the potential to violate fraud and abuse laws and historically have generated a substantial number of anti-kickback convictions. As you may be aware, if remuneration is intended to generate any federal health care business, it potentially violates the Federal Anti-Kickback Statute.

In light of the obvious risks inherent in these arrangements, we ask that you take the time to review the University gift policy “Policy 2201 Gifts From External Parties to Employees” located at: http://www.yale.edu/ppdev/policy/2201/2201.pdf

This policy was written to assist faculty and staff to preserve and protect Yale University’s reputation and to avoid the appearance of impropriety.

Happy Holidays!

Compliance Quiz Question

Question: When my patients are hospitalized, a hospitalist will round on that patient. Can I include the hospitalist’s medical record documentation with my own to determine the level of visit to bill?

Answer: No. Since the hospitalist is employed by the hospital, you cannot link your medical record documentation to theirs to determine the level of visit to bill.