The 2003 OIG Work Plan: An analysis of this year’s projects.

A supplement to Opus Communications publications
Dear reader:

HCPro is pleased to present this 12-page special report on the 2003 Office of Inspector General (OIG) Work Plan. The government’s studies on improper payments, coding concerns, medical necessity, and other issues that lead to fraud, waste, and abuse provide a host of hints on how to fine tune your compliance efforts.

This report is designed to serve as a reference guide and resource as you work to make sure you are coding and billing all of your services appropriately and accurately. With that in mind, we have included information about auditing, specific coding areas to keep an eye on, why some projects stay in the report year after year, and more.

We look forward to continuing to provide you with timely, pertinent information and tools to help you with your compliance efforts.

Sincerely,

Melissa Chapdelaine, Managing Editor

Beth Easley, MA, Managing Editor

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15 new focus areas for hospitals in the 2003 Work Plan

The OIG appears to be changing its focus areas for reviewing hospital compliance with Medicare regulations.

Fifteen of the 25 items listed on the OIG’s 2003 Work Plan for hospitals are new this year, while 15 other items from last year didn’t make the cut. Physicians will see eight new focus areas, four projects carried over, and five missing areas from last year.

Hospitals

New
- Hospital quality oversight
- Inpatient capital payments
- Long-term care hospital payments
- Certification of heart transplant centers
- Organ donation at transplant hospitals
- Medical necessity of inpatient psychiatric stays
- Medical necessity of inpatient rehabilitation facility stays
- Prospective payment system (PPS) for inpatient rehabilitation facilities
- Critical access hospitals
- Update on diagnosis-related group (DRG) coding
- Medicare hospital outlier payments
- Potentially excessive payments for inpatient and outpatient services
- Diagnostic testing in emergency rooms
- External oversight of hospital outpatient departments
- Outpatient cardiac rehabilitation services

Old favorites
- Medical education payments
- Hospital privileging activities
- Consecutive inpatient stays
- DRG payment limits
- Uncollected beneficiary deductibles and coinsurance
- Expansion of DRG payment window
- Hospital reporting of restraint-related deaths
- Outpatient PPS (OPPS)
- Outlier payments under OPPS
- Procedure coding of outpatient physician services

Gone
- Medicare payment error prevention program
- One-day hospital stay
- Hospital discharges and subsequent readmissions
- Payments to acute care PPS hospitals
- Implementation of critical access hospital program
- Satellite hospitals
- PPS transfers during hospital mergers
- Outlier payments for expanded services
- Periodic interim payments
- DRG payment window—Part B providers
- Reporting of restraint and seclusion use in psychiatric hospitals
- Outpatient services on same day as discharge and readmission
- Outpatient pharmacy services at acute care hospitals
- Outpatient medical supplies at acute care hospitals
- Peer review organization sanction authority

Physician

New
- Coding of Medicare physician services
- Coding of evaluation and management services
- Coding of physician evaluation of dialysis
- “Long distance” physician claims
- Billing for chiropractic care
- Cataract surgery comanagement
- Financial arrangements between physicians and ambulatory surgery centers
- Medicare payments to nonphysician practitioners

Old favorites
- Consultations
- Bone density screening
- Services and supplies incident to physicians’ services
- Reassignment of benefits

Gone
- Beneficiary access to preventive services
- Advance beneficiary notices
- Physicians at teaching hospitals
- Billing for residents’ services
- Inpatient dialysis services
OIG will focus on new initiatives and old favorites

Move over evaluation and management coding: You’ve got company. The Office of Inspector General (OIG) will start paying more attention to consults, referrals, dialysis, “long distance” claims, and bone density—the so-called nuts and bolts of reimbursement, according to analysis by Theodore Sanford Jr., MD, of the agency’s 2003 agenda. Despite this narrower focus and the OIG’s emphasis on quality and oversight, fraud and abuse investigations will remain a priority, says Sanford.

“All of this oversight is looking at fraud and abuse in claims made for government reimbursement. However, to help providers, the OIG is trying to appear to be more helpful in developing guidelines to remove some of the ambiguity of [Medicare and Medicaid] regulations,” says Sanford, chief compliance officer for professional billing at Michigan Medical Center in Ann Arbor.

Few sections in the Work Plan are very surprising, says Lisa Murtha, JD, chief audit and compliance officer for Children’s Hospital in Philadelphia. The OIG speaks on these same issues frequently at conferences. Next year’s key focus areas for compliance officers are documentation, coding, and the accuracy of claims. In addition, compliance officers must also focus on the Health Insurance Portability and Accountability Act of 1996, clinical research, and educating clinicians on areas the OIG lists as suspicious practices in its compliance guidance for pharmaceutical manufacturers, says Murtha.

Hospital quality oversight
The OIG will examine the current status of accreditation, Medicare certification, and the Centers for Medicare & Medicaid Services’ (CMS) activities for improving hospital oversight. This should catch the eye of all compliance officers, says Sanford. CMS is expected to issue a detailed plan for improving hospital oversight of quality. There’s the potential, says Sanford, for disaccreditation of a hospital’s participation in the Medicare program.

Medical education payments
The OIG plans to continue its reviews to evaluate the efficiency of controls over Medicare payments for medical education and controls over resident counts. To do this, the OIG will visit fiscal intermediaries (FI) and providers to determine the validity of claims for these payments. OIG investigators must ensure that, when they audit for full-time equivalents (FTE), they establish very clear calculation guidelines, says Sanford.

However, this isn’t always the case. For example, FI-hired auditors recently visited a graduate medical education (GME) program to examine the claims for GME payments. But the program, says Sanford, encountered problems because the auditors had their own idea of what constituted FTE training. “Because of this, the FI denied many of the claims and demanded repayment,” he says.

Privileging
In the context of the Medicare Conditions of Participation (COP), the OIG will review the process by which a hospital determines the scope of allowable practice for each hospital physician. This review probably won’t mean much to hospitals since the COP haven’t changed substantially and most hospitals know what they have to abide by, says Beverly Pybus, CMSC, a senior consultant with The Greeley Company and principle of the Beverly Group in Georgetown, MA.

However, some hospitals without strong privileging criteria may run into problems if the OIG decides to conduct random checks. Hospitals should make sure their privileging criteria requires more from physicians than just board certification, says Pybus.

DRGs
The OIG has three projects specifically targeted to diagnosis-related groups (DRGs): expansion of the DRG payment window, DRG payment limits, and DRG coding abuses.

• Window: The OIG is considering expanding the DRG payment window to 14 days, which would have a significant impact on hospital reimbursement. Currently, CMS treats all services rendered within three days of a hospital admission as inpatient services. This prohibits hospitals from receiving separate payment for certain pre-admission services rendered to a patient within that three-day period. In last year’s Work Plan, the OIG outlined a goal to determine whether to increase the payment window from three days to seven.
• Payment limits. The OIG will assess how well Med-
icare contractors are limiting payments to hospitals for patients who are discharged from prospective payment system (PPS) hospitals and admitted to one or several post-acute care settings.

- Abuses: The OIG will also examine DRGs that have a history of aberrant coding to determine coding payment error rates. Results of a recent review by quality improvement organizations will be incorporated in the OIG’s examination, according to a recent “Law Watch” from Foley and Lardner, authored by Charles Oppenheim, a partner in the Los Angeles office.

Medicare hospital outlier payments
The OIG will review whether contractors are appropriately reimbursing hospitals for beneficiary stays with charges exceeding a preset limit under the PPS. Based on pilot reviews, the OIG found that these outlier payments posed a high risk of being incorrect, leading to many Medicare overpayments for outliers, Oppenheim says.

Medical necessity
In two separate projects, the OIG will assess the extent of improper Medicare payments to inpatient psychiatric stays and inpatient rehabilitation facility stays. Medicare paid $6.8 billion for these PPS-exempt services. In 1995, quality improvement organizations, formerly known as peer review organizations, stopped medical reviews of PPS-exempt services. The OIG will now determine the adequacy of controls to detect improper payments for both services.

Diagnostic testing in emergency rooms
The OIG will study whether Medicare payments for diagnostic tests performed in the emergency room were medically necessary. The OIG will also determine whether hospitals interpreted those tests contemporaneously with the patient’s treatment.

Uncollected beneficiary deductibles and coinsurance
Under current law, the Medicare program may reimburse uncollected deductibles and coinsurance amounts. The OIG will continue to review the logic of Medicare payments to inpatient and outpatient hospital providers that fail to collect these patient liabilities. The OIG will also assess the impact of these payments and evaluate the effectiveness of existing controls to ensure their validity, says Oppenheim.

Medicaid hospital patient transfers
Medicaid only pays one hospital the full payment amount when a patient is transferred under the PPS. Medicaid pays the first (transferring) hospital a per diem rate and pays the receiving hospital a DRG payment based on the final discharge code. The OIG will review the extent of overpayments made by Medicaid for incorrectly reported transfers.

Consecutive inpatient stays
The OIG will analyze claims to identify questionable patterns of acute and post-acute care. While Medicare allows care in different facilities depending on the beneficiary’s needs, it may deny payment if a hospital uses one or multiple stays to circumvent the PPS.

Inpatient capital payments
The OIG will perform a series of reviews examining Medicare inpatient hospital capital payments.

The OIG will examine the accuracy and appropriateness of the CMS process for updating the capital rates and analyze the effects of excess capacity on those rates. The OIG will also examine capital payments in relation to a hospital’s financial status.

LTC hospital payments
The OIG will determine the extent to which long-term care (LTC) hospitals operate as satellite units and “hospitals within hospitals.” The OIG will determine whether the following conditions have been met:

- To retain prospective payment system exempt status, LTC satellite units are required to have average stays of more than 25 days
- The first stay may be denied if more than 5% of discharges from a hospital within a hospital to its host hospital result in subsequent readmission to the hospital within a hospital

Potentially excessive payments
The OIG will evaluate controls to detect potentially excessive Medicare payments to institutional providers for inpatient and outpatient services. In the past, the OIG has identified simple clerical billing errors that generated significant excessive payments.

The OIG will now assess the adequacy and extent of actions taken on the recommendations of its prior report, as well as potentially excessive inpatient and outpatient payments during subsequent years.

Editor’s note: For more about the OIG’s projects for hospital coding, go to p. 6.
The 2003 Work Plan, released by the Office of Inspector General (OIG) on October 2, includes many projects we’ve seen before but with new twists, says Sue Prophet Bowman, RHIA, director of coding and classification for the American Health Information Management Association.

“Every year it seems like they fine tune it a little more,” says Cindy Parman, CPC, CPC-H, principal for Coding Strategies, Inc., in Dallas, GA. “Before, they said ‘we’re going to look at a particular issue.’ Now, they publish monetary amounts. Every year they’re gaining a little more knowledge of what they want to look for.”

Aberrant coding
Many of the projects in this year’s report, however, say the agency will be looking at “aberrant coding patterns.” Some previous Work Plan projects remain, but the OIG expanded on the thought, says Bowman. For example, this year’s plan says the agency will be looking at “diagnosis-related groups [DRGs] that have a history of aberrant coding patterns.”

“It’s not like the OIG hasn’t been looking at DRGs before now,” she says. “But instead of starting with certain diagnoses or a particular investigation, they’re actually looking at trend data, which might provide a clue for an area that requires further investigation,” says Bowman.

Expansion of DRG payment window
The possible expansion of the DRG payment window from three to 14 days for all admission-related services should be particularly interesting to health information management directors.

All related services provided prior to an admission are supposed to be bundled into the DRG payment. The report says that prior OIG work has shown growth in nonphysician outpatient services rendered four to 14 days before an inpatient admission.

“That’s quite a jump, and it’s interesting that they are focusing specifically on 14 days,” Bowman says. “They are looking at preadmission testing being done outside the three-day window. But at a lot of organizations, you can only have certain services done so many days ahead of time or they’re not worth anything anyway. Lab values and the like can change so they become basically useless.”

Bowman also wonders how many of the services that the OIG would consider related to an admission are actually related to the reason for the admission rather than the admission itself.

For example, if a patient has an ongoing condition, he or she will most likely undergo a variety of procedures. The results of one of those might lead to the admission.

PPS
The Work Plan lists several projects related to the new inpatient rehabilitation prospective payment system (PPS). “Whenever they implement a new PPS, it has potential risks for errors and fraud and complexity of reimbursement,” Bowman says.

“We’re not crying wolf by telling you that the OIG could come knocking on your door for [outpatient PPS]-related billing and coding questions,” says Jugna Shah, president of Nimitt Consulting, in St. Paul, MN. “It has made it clear that this area needs review,” she says.

“Given the number of reviews related to the inpatient PPS [DRG] system that the OIG continues to do, we would be foolish not to keep our guard up, particularly in the areas they outlined as targets. The OIG may or may not come, but it’s better to be safe than find yourself being fined for noncompliance.”

Shah advises that the government is watching. “The OIG is out there, and it’s only a matter of time before OPPS becomes the theme of a work plan, not just a chapter.”

We’re not crying wolf by telling you that the OIG could come knocking on your door for OPPS-related billing and coding questions.”
— Jugna Shah
Also returning: Procedure coding
A coding project carried over from earlier Work Plans is procedure coding of outpatient and physician services.

The OIG’s previous review found that 23% of cases were inconsistent between hospital outpatient department procedure coding and physician procedures coding for the same outpatient service. This year, the project adds billing for ambulatory service centers into the mix.

“They’re saying they want to find out whether there’s any value in using NCCI edits in Medicaid as well as Medicare,” Bowman says.

Medical necessity
This is something all providers are struggling with, says Parman.

“Local medical review policies try to take medical necessity down to a payable diagnosis list and so many places use those lists. The thing is, all of a sudden, everything becomes payable,” she says. “You have to code the diagnosis in the medical record.”

When it comes to outpatient laboratory testing or radiology testing, staff sometimes have trouble getting medical necessity information. “The report might say ‘rule out aneurysm,’ but nothing about the real signs and symptoms. There’s no way to code a ‘rule out,’” says Parman.

Correct Coding review
The OIG will take a look at whether carriers are appropriately applying edits required by Medicare’s National Correct Coding Initiative (NCCI). The agency wants to find out whether physicians were improperly paid for claims that the NCCI should have rejected.

This is a key issue, Bowman says, because the Work Plan mentions the NCCI in another project, in which it plans to see whether Medicaid can save money by eliminating duplicate physician services.

“You have read the National Correct Coding Initiative and you’re falling into a deep sleep. But not to worry, the handsome prince of compliance will wake you with a kiss just in time for your next 12-hour shift.”

Illustration by Dave Harbaugh
Take a hint

The Work Plan gives you an idea of the Office of Inspector General’s (OIG) focus areas—the areas you might want to audit.

“You might want to look at what an expanded [diagnosis-related group] payment window would do to your facility,” says Sue Prophet Bowman, RHIA, director of coding and classification for the American Health Information Management Association. “How many admission services are you providing?”

Although the report says the Office of Investigations will not allocate resources to investigate facilities or practices that make errors or mistakes on claims, “there are many instances when there are allegations and you cannot determine whether the conduct was fraud or an innocent mistake until you investigate,” says Howard Young, Esq., an attorney with Arent Fox in Washington, DC. “At the end of the day, the OIG is going to have to investigate allegations,” he says. Continue to be vigilant in following your policies and maintaining compliance programs, especially in billing and coding, Young recommends.

“There’s some relief in that the OIG is interested in reading between the lines. It is trying to strike a balance and send a message that it’s in the fraud-fighting business, not the mistake-fighting business.” However, Young points out that the OIG’s mission is not only to fight fraud.

“When they do these studies, they’re not only looking for fraud but also for waste and abuse. Waste could be a Medicare program. Or they could say your policies are foolish and you need to accomplish something a different way. That’s the classic definition of waste.”

The OIG has always been pushing for proactive steps from providers, Bowman says. “You should use this information to solve your own problems before the OIG comes out and says, ‘You have a compliance problem that’s been in our plan for the past five years but you haven’t even looked at it.’ ”

“You don’t have an excuse to ignore it when the OIG is pretty public about what they’re focusing on,” Bowman says. “Everybody needs to step up to the plate and look at these issues.”

Four steps you can take toward better compliance

You can start your own 2003 work plan toward better compliance by implementing the following four steps, recommended by Jugna Shah, president of Nimitt Consulting, in St. Paul, MN:

Educate staff—Make sure health information management and clinical staff work in the same direction. They need to communicate their needs, share their expertise, and recognize that each component is an important piece of the overall picture. Everything they do affects reimbursement.

Document everything—Let this be your mantra: If it isn’t written in the record, it didn’t happen. If it didn’t happen, we can’t bill for it.

Audit yourself—Conduct audits on a regular basis and analyze the results. When you discover weak spots in your processes, take corrective action.

You may want to audit some of the areas highlighted in the OIG’s 2003 Work Plan, such as checking the accuracy of outlier payments or reviewing physician and facility claims for matching diagnosis codes.

Ask for feedback—But don’t just ask for it, act on it. Talk to staff. Ask them what problems they have and then help find solutions. Share positive feedback. Nothing makes people feel good more than being told they do a great job.

If you can’t give rewards in the form of pay raises or bonuses, take a worthy staff member to lunch or give a gift certificate for an afternoon at a local spa.
Clinical trials: OIG will focus on Medicare billing, adverse event reporting, and child protections

Recent fraud settlements in the clinical research arena have pushed clinical trial compliance even further into the spotlight. In November, the Department of Justice settled with seven hospitals for $40 million for false claims billing.

This year’s Work Plan reiterates the Office of Inspector General’s (OIG) focus on clinical research compliance. The OIG plans to focus on the following areas involving clinical trials:

Medicare payments for clinical trials
The OIG will examine whether Medicare payments to clinical trials were made in accordance with program specifications. The OIG will also examine whether the current Medicare billing systems can accurately monitor the “appropriateness of these payments.”

In order to be eligible for Medicare coverage, a clinical trial involving a medical device must be the subject of an investigational device exemption. If you have a qualified category B device, you can move on to the next step, contacting the carrier medical director to get authorization for the study, says Linda Bentley, an attorney at the Boston firm of Mintz Levin Cohn Ferris Glovsky and Popeo, PC.

Once you have received approval from your medical director, be sure to closely follow the billing guidance in the Centers for Medicare & Medicaid Services’ Medicare Carrier Manual to ensure that you are following all regulations for claims submissions, says Charmaine Munt, director of reimbursement for AbbeyMoor Medical Inc in Miltona, MN.

Human subject protections for children
The OIG will look at the role of institutional review boards (IRB) in overseeing clinical research projects involving children.

The Office for Human Research Protection and the Food and Drug Administration, the two departmental agencies that oversee clinical research, have regulations to protect children enrolled in clinical trials. Both rely on IRBs to monitor and carry out these regulations.

IRBs should pay careful attention to research involving children, especially since children don’t have the comprehension necessary to make informed decisions and they can be easily swayed, says Adil Shamoo, PhD, a professor at the University of Maryland School of Medicine.

Once the IRB has determined whether a particular protocol involving children can go forward, it must make sure that researchers have each of the following:

1. The assent of the child
2. Permission of the parents or legal guardian
3. Assurances that there are adequate safeguards to protect the child

Be certain when your IRB is reviewing a protocol involving children that you have IRB members who are knowledgeable about issues related to children, says Cynthia Kenny, CMSC, CP, CIM, president and chief executive officer of IRB Specialists Inc.—or the IRB should consult experts who are knowledgeable in this area.

Also be sure that the researchers conducting the study are trained to deal with children, “including the evaluation and management of potential pediatric adverse events,” Kenny says.

Monitoring adverse events in clinical research
The OIG will also be looking to see that the National Institutes of Health practices are adequate to ensure that grantees are complying with adverse event reporting and monitoring in clinical trials regulations.

The OIG will review the use of data safety monitoring boards, which provide scientifically based reviews vital to the safety of subjects.

The NIH requires these for later stage clinical trials. These boards analyze adverse event reports during clinical trials to determine whether the trials are safe enough to continue.
Focus your audits around the OIG’s hot spots

Next year’s Office of Inspector General (OIG) Work Plan seems to have moved away from broad reaching False Claims Act projects, such as audits to detect pneumonia upcoding and violations of the 72-hour rule, in favor of more individualized assignments, according to James Kopf, the OIG’s former director of program investigation and now senior vice president of Health Care Oversight, a consulting firm, in New York City. Hospital and physician relationships are two new targets in the 2003 Work Plan that represent this shift.

To keep track of the OIG’s auditing and investigative plans for the coming year—and to decide where to focus your time and money—follow the government’s target areas.

Start by reviewing the entire OIG Work Plan to determine which areas apply to your organization’s opera-

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**Six steps for audits in the emergency room**

**Guidelines for auditing Work Plan items**

The Office of Inspector General (OIG) listed 25 hospital projects for next year. One potential risk area: diagnostic testing in the emergency room. The OIG will assess whether hospitals bill Medicare appropriately for these diagnostic tests.

The agency will focus on whether these tests are medically necessary and whether they are interpreted contemporaneously with the patient’s treatment.

Before starting an audit of a new area to your organization’s audit process, conduct a baseline audit to determine risk areas and to determine where employees need more education.

Also, review all fraud alerts, bulletins, and other guidance on the OIG’s Web site when beginning preliminary audits.

To conduct your own audit of diagnostic testing in the emergency room, follow these six steps:

1. Identify all diagnostic tests for which the Centers for Medicare & Medicaid Services (CMS) issued a national coverage decision. Also review any local medical review policies that CMS, your fiscal intermediary, or your carrier has issued.

2. Run a volume report for Medicare patients for all procedure codes identified. Include total charges and reimbursement.

3. If possible, run a separate report for the same procedure codes, then identify all medical necessity denials that forced your hospital to write off a charge.

4. Choose the procedure you will audit based on an analysis of denial patterns/volume. Audit procedures with a high denial rate that resulted in a large dollar amount in write offs.

As a result of your audit findings, you may be able to earn additional reimbursement based on the corrective actions you’ve implemented. Also, audit the high-volume procedures that generate the most revenue—these are often the highest risk areas.

5. If you identify issues through the audit, educate staff and implement corrective action. Establish a monitoring process and follow up with additional audits to ensure that corrective measures were successful. Reevaluate the issue and reeducate if necessary.

6. If you identify a problem, schedule periodic audits until audits show that the problem is resolved. -

Source: Stacie Buck, RHIA, LHRM, president of Health Information Management Associates in North Palm Beach, FL.
tions; then, conduct a baseline audit of those areas to determine whether each is in compliance, says Stacie Buck, RHIA, president, Health Information Management Associates of North Palm Beach, FL.

Billing, documentation, and reimbursement issues remain staples of the 2003 Plan, Kopf says. “Auditors should remain cognizant of documentation—it has been shown to be many hospital’s Achilles heel. Without proper documentation, providers could be seen as billing for services not rendered. Consider conducting audits of the following OIG Work Plan targets:

- Hospital and physician relationships for Stark and kickback issues
- Evaluation and management (E/M) coding
- Diagnostic testing in emergency rooms
- Hospital privileging activities
- Consecutive inpatient stays
- Diagnosis-related group payment limits

How to use the OIG’s roadmap
Before beginning your audits, identify and familiarize yourself with the Centers for Medicare & Medicaid Services’ guidance for each Work Plan element, says Buck.

If you identify an error in any of these audits, educate all parties involved about it and then conduct another audit after you’ve taken corrective measures. If you continue to identify errors in a particular area, make this area, like diagnostic testing in the emergency room, part of your regular audit plan, Buck says.

Don’t fall into the trap of limiting your audit plan only to the issues identified on the OIG’s agenda. Look to other sources to identify potential issues, such as Medicare claims denials, says Buck. Also, do not feel that you must conduct audits for all Work Plan items.

“Ideally, it would be wonderful to audit all risk areas identified by the OIG,” Buck says. “However, this is not practical given the hectic schedules that compliance officers and auditors face each day. Carefully choose those areas that you feel could create the greatest risk of exposure for your organization.” Be careful when choosing your sampling methodology and selection criteria, Buck advises. Each sample should be a “snap shot” that adequately represents what is occurring within your organization. Take care in choosing an appropriate sample size. Audit at least 5% or 30 records, whichever is greater. However, auditors can modify this to suit the purpose of the audit and the organization’s needs.

Déjà vu?
Many of the projects listed in the Office of Inspector General’s Work Plan go on for several years, which explains why it may seem like you see the same thing year after year.

“Some of these initiatives are rather complex. For example, following the implementation of something like inpatient rehab prospective payment system, there’s not one specific thing you can study. There are a lot of variables so it’s not at all strange that it would be a multi-year project,” says Sue Prophet Bowman, RHIA, director of coding and reimbursement for the American Health Information Management Association.

In fact, some of the projects’ expected issue dates aren’t until sometime in fiscal year 2004, “so I’m sure we’ll see them in next year’s report as well,” she adds.

“There’s quite a bit of carry-over. Keep in mind that the Work Plan lists what they hope and plan to work on, not what they hope and plan to complete,” says Howard Young, an attorney with Arent Fox, PLLC, in Washington, DC.

“I can certainly understand that when we see the same projects year after year it may appear to be inaction and may suggest no concern. But, I would submit that some of these studies take years to finalize.” Don’t forget that the Work Plan addresses not just fraud, but also waste and abuse. “Waste could be an entire Medicare program,” says Young. “They could tell you that your policies are foolish, do it a different way. That doesn’t mean there’s fraud—that’s the classic definition of waste.”

And, just because the project makes it into the Work Plan doesn’t mean the government will come knocking on your door to investigate. “Not everything listed means the OIG is going to pursue these matters as fraud,” he adds.
On the physician side—changes to two familiar projects

E/M coding
The Office of Inspector General’s (OIG) review of evaluation and management (E/M) coding is not a new initiative, but the OIG’s focus has changed. Last year, the agency examined whether physicians were adhering to documentation guidelines appropriately, says Sue Prophet Bowman, RHIA, director of coding and classification for the American Health Information Management Association. This year, investigators will focus on E/M coding problems of all kinds.

“Of course, there’s all kinds of confusion over which guidelines to use, but now there’s a new set under development,” says Bowman.

“The OIG] took all references to that out of this year’s description of the project and just focused on aberrant coding patterns. Regardless of which guidelines physicians use, there still could be a problem with coding if physicians are consistently coding to a higher level.”

Not surprisingly, the Work Plan says that the OIG wants to look at physicians who charge disproportionately high volumes of high-level E/M codes for greater reimbursement.

Consultations
On average, Medicare pays about $40 more for a consultation than they do for another type of E/M service, says Cindy Parman, CPC, CPC-H, of Coding Strategies, Inc, Dallas, GA. “[The OIG] wants to make sure there really is physician to physician interaction.”

In her experience working with practices, she has found that many doctors say ‘I’m a specialist so I always get to charge for a consultation.’ That is incorrect and fraudulent.

In addition, if a physician agrees in advance to accept a patient’s care from another doctor, that’s not a consult, it’s a referral, she says. “There’s a lot of criteria here that physicians are not reading through.”

The Work Plan project on consultations says the agency wants to determine the primary reasons for inappropriate billings because in 2000, allowed Medicare charges for consultations totaled $2 billion.

Using the plan
“I think everybody’s going to take something different out of the Work Plan,” says Parman. For some issues, facilities may already have policies. On the other hand, facilities may not know whether they have a problem because they’ve never done any kind of review.

It’s important to read the whole thing, Parman says. “Sometimes those little odds and ends found in such sections as legal and program integrity may not be in another section but it still is relevant to your practice.”

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