



Work Plan

Fiscal Year 2007

Introduction

The project areas described in this Office of Inspector General (OIG) Work Plan reflect what we believe at the beginning of each fiscal year best identifies vulnerabilities of Department of Health & Human Services' (HHS) programs and activities, and promotes improvement in their efficiency and effectiveness.

OIG work planning does not end with publication of the plan. It is a dynamic, year-round process, adjusting to new issues, new information, and shifts in the priorities of Congress, the President, and the Secretary.

To ensure that our studies do not duplicate existing work and to build on that work, we identify and evaluate the audits, inspections, and studies done by others, such as the Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services (CMS), and the Office of Management & Budget Program Assessment and Rating Tool (PART) process. We also undertake projects designed to determine the effectiveness of management actions to correct deficiencies cited in prior studies.

This document is divided into four sections. The first three consist of the ongoing and proposed work relating to each of the major program operating divisions of HHS: (1) CMS; (2) the seven major public health agencies: Agency for Health Care Research & Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), National Institutes of Health (NIH), and Substance Abuse and Mental Health Services Administration (SAMHSA); and (3) Administration for Children & Families (ACF) and Administration on Aging (AoA). The fourth section contains projects that cut across Department programs, including State and local government use of Federal funds, and the functional areas of the Office of the Secretary.

Mission Activities

The work of the OIG is planned and performed by its four direct mission components: the offices of Audit Services (OAS), Evaluation and Inspections (OEI), Investigations (OI), and Counsel to the Inspector General (OCIG).

Program Audits

OAS conducts financial and performance audits of departmental programs and operations to determine whether objectives are being achieved, which aspects of programs need to be performed more efficiently, and to identify systemic weaknesses that give rise to fraud, waste, or abuse. OAS also provides leadership and direction in carrying out the mandates of the Chief Financial Officers Act of 1990 and the Government Management Reform Act of 1994 relating to financial statement audits.

Program Inspections

OEI seeks to improve HHS program effectiveness and efficiency by conducting inspections to provide timely, useful, and reliable information and advice to decision makers. These inspections are program and management evaluations that focus on specific issues of concern to the Department, Congress, and the public. The inspections in this work plan focus on programs with significant expenditures of funds, and in which important management issues have surfaced. The results of these inspections should generate useful information on how well the programs are operating and offer specific recommendations to improve their overall efficiency and effectiveness.

Investigative Focus Areas

OI conducts investigations of fraud and misconduct to safeguard the Department's programs and protect its beneficiaries. OI concentrates its resources on criminal investigations, but its activities are also aimed at deterring fraud and abuse by identifying systemic weaknesses and vulnerabilities that can be mitigated through corrective management actions, regulation, or legislation; and by pursuing criminal convictions and recovering damages and penalties through civil and administrative proceedings.

Legal Counsel Focus Areas

OCIG coordinates OIG's role in the judicial and administrative resolution of fraud and abuse cases involving HHS programs, including the litigation and imposition of administrative sanctions, such as program exclusions and civil monetary penalties and assessments; the global settlement of cases arising under the Civil False Claims Act; and the development and monitoring of corporate integrity agreements for certain providers that have settled their False Claims Act liability with the Federal Government. It also develops and promotes industry-specific voluntary compliance program guidance. OCIG issues special fraud alerts to the public, special advisory bulletins, and advisory opinions regarding the application of OIG's sanction authorities. OCIG is responsible for developing new, and modifying existing, safe harbor regulations under the anti-kickback statute. Finally, OCIG provides general legal services to OIG, including advice and representation on HHS programs and operations, administrative law issues, and criminal procedure.

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Medicare Nursing Homes

Skilled Facility Rehabilitation and Infusion Therapy Services

Through medical review, we will analyze whether rehabilitation and infusion therapy services provided to Medicare beneficiaries in skilled nursing facilities (SNF) were medically necessary, adequately supported, and actually provided as ordered. SNFs provide infusion and rehabilitation therapy services to Medicare beneficiaries for a variety of medical and postsurgical conditions. These services are ordered by a physician and are administered onsite by the SNFs' nursing staff.

(OAS; W-00-04-35110; W-00-04-35130; various reviews; expected issue date: FY 2007; work in progress)

Skilled Nursing Facilities' Involvement in Consecutive Inpatient Stays

We will determine whether SNF care provided to Medicare beneficiaries with consecutive inpatient stays was medically reasonable and necessary. An inpatient hospital stay must precede all SNF stays. This study will focus on beneficiaries who experience three or more consecutive stays, including at least one SNF facility stay. We will also examine the extent and nature of consecutive Medicare hospital inpatient stays.

(OEI; 07-05-00340; expected issue date: FY 2007; work in progress)

Enforcement Actions Against Noncompliant Nursing Homes

We will continue our work in examining the effectiveness of CMS and State enforcement actions taken against noncompliant nursing homes. Under contracts with CMS, States conduct surveys at least every 15 months to certify that nursing facilities meet the required standards for the Medicare and Medicaid programs. We will assess whether CMS and its fiscal intermediaries appropriately process denial of Medicare payment remedies for facilities noncompliant with Federal program standards.

(OEI; 06-03-00390; expected issue date: FY 2007; work in progress)

Skilled Nursing Facility Payments for Day of Discharge

Medicare regulations state that the day of discharge is not a day of billable services for SNFs. We will determine whether Medicare is inappropriately paying SNFs for services on the day of discharge.

(OAS; W-00-06-35194; various reviews; expected issue date: FY 2007; work in progress)

Skilled Nursing Facility Consolidated Billing

We will determine whether controls are in place to preclude duplicate billings under Medicare Part B for services covered under the SNF PPS and assess the effectiveness of Common Working File edits established in 2002 to prevent and detect improper payments. Under the PPS, the SNF has the Medicare billing responsibility for virtually all of the Medicare-covered services that its residents receive. As a result, the outside supplier must receive payment from the SNF, rather than the Medicare Part B carrier. Prior OIG work identified improper payments associated with outpatient hospital, ambulance, laboratory, and radiology services during 1999 and 2000. We will identify any additional improper payments for services during calendar years 2001,

2002, and 2003 and also determine whether the Common Working File edits are effective in detecting and preventing improper payments.

(OAS; W-00-05-35185; W-00-05-35097; various reviews; expected issue date: FY 2007; work in progress)

Nursing Home Residents' Minimum Data Set Assessments and Care Planning

We will examine the type, frequency, and severity of nursing home deficiencies related to Minimum Data Set assessments and care planning. In previous studies, we identified increases in deficiencies related to comprehensive assessments, care planning, and the provision of services in accordance with the care plan. We will also examine methods the State survey agencies use in identifying assessments and care plans that do not address individualized needs of residents.

(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Imaging and Laboratory Services in Nursing Homes

We will determine the extent and nature of any medically unnecessary or excessive billing for imaging and laboratory services provided to nursing home residents. Medicare pays more than \$200 million a year for imaging and laboratory services. We will review a sample of services and examine utilization patterns in nursing facilities.

(OEI; 00-00-00000; expected issue date: FY 2008; new start)

Implementation of Medicare Part D in Nursing Facilities

This review will assess the implementation of Medicare Part D in nursing homes. Prior to the implementation of Part D, nursing homes generally contracted with one long term care pharmacy to provide drugs for all of their residents eligible for both Medicare and Medicaid. As part of this study, we will determine how dual eligible nursing home residents are selecting and enrolling in Medicare prescription drug plans and whether these residents are receiving the drugs they need under Part D.

(OEI; 02-06-00190; expected issue date: FY 2008; work in progress)

Submission of Skilled Nursing Facility No-Pay Bills

This review will determine whether SNFs submit “no-pay bills” as required. No-pay bills are submitted to Medicare without a request for reimbursement to track beneficiaries’ benefit periods. We will also determine the extent to which failure to submit no-pay bills contributes to inappropriate calculations of Medicare SNF eligible benefit periods, as well as the amount of inappropriate Medicare payments due to this practice. Additionally, we will identify whether measures are in place to ensure that no-pay bills are submitted.

(OEI; 00-00-00000; expected issue date: FY 2007; new start)

Inappropriate Psychotherapy Services in Nursing Facilities

This review will determine the extent to which psychotherapy services are provided and medically necessary for Medicare beneficiaries residing in nursing facilities. In a 2001 report, we found that 50 percent of group psychotherapy services reviewed were inappropriate. We will also determine the extent of inappropriate payments for these services.

(OEI; 06-06-00580; expected issue date: FY 2007; work in progress)