Focus on Risk

COMPLIANCE AND THE 2009 OIG WORK PLAN

By Cindy M. Pittmon, CHBME

The mission of the Office of Inspector General (OIG) is to protect the program integrity of the Department of Health and Human Services (HHS). In fulfilling that mission, the OIG must conduct and supervise audits and investigations; prevent and detect fraud and abuse; promote economy, efficiency and effectiveness; and inform HHS and Congress about deficiencies and problems. That mission leads the OIG to conduct a comprehensive review each year to identify potential problem areas and vulnerabilities in the HHS programs. Those areas deemed most worthy of follow up are then included in their annual Work Plan and used to focus OIG activities.

The Work Plan should be required reading for all compliance officers and others interested in getting an advance look at the feds' playbook. You may find the full report at: www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf.

RISK AREAS

The pertinent risk areas for physicians identified for 2009 are:

- **Hospital ownership of physician practices:** The OIG will investigate the extent to which hospital-owned physician practices received reimbursement under the OPPS without provider-based designation
- **Medicare secondary payer:** Payments for beneficiaries who have other insurance that is primary will be investigated, identified, and resolved.
- **Payments for diagnostic X-rays in hospital emergency departments:** An OIG review of sample claims will be used to determine appropriateness of radiology services provided in hospital emergency departments.
- **Place-of-service errors:** The OIG will review place-of-service coding for facility versus non-facility coding.
- **Evaluation and management services during global periods**: The OIG will review the number of E&M services provided since global periods were established in 1992 to insure that E&M services were not billed separately.
- **Medicare practice expenses incurred by selected physician specialties:** Selected physician specialties will be reviewed to determine if the practice expense component is appropriate.
- **Services provided by clinical social workers:** Since clinical social workers cannot bill for services provided to Medicare Part B inpatients, the OIG will investigate and verify that these services were not billed inappropriately.
- **Outpatient physical therapy services provided by independent therapists:** Focusing on services provided by independent therapists with high utilization, the OIG will ensure that federal guidelines are followed.
- **Medicare payments for colonoscopy services:** The OIG will determine whether payments for these services were properly supported, billed, and paid.
- **Physicians' Medicare services performed by nonphysicians:** "Incident to" services will be reviewed by the OIG to ensure that all services are performed by properly licensed professionals.
- **Appropriateness of Medicare payments for polysomnography:** The OIG will investigate the increased use of this examination to establish adherence to program requirements.
- **Long-distance physician claims requiring a face-to-face visit:** Factors contributing to the submission of long distance evaluation and management codes will be examined by the OIG to ensure that face-to-face visits are performed when necessary.
- **Geographic areas with a high density of independent diagnostic testing (IDTF) facilities:** In areas of high density IDTFs, the OIG will examine service, physician, and beneficiary profiles in addition to billing patterns to ensure compliance with Medicare standards.
- **Patterns related to high utilization of ultrasound services:** In high areas of ultrasound utilization, the OIG will investigate medical necessity. *(continued on page 24)*

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- **Medicare payments for chiropractic services billed with the acute treatment modifier:** The OIG will review chiropractor billings with acute treatment (AT) modifiers to determine whether they comply with Medicare coverage criteria and documentation requirements.
- **Physician reassignment of benefits:** A national sampling of reassignment of physician payments will be performed to insure that reassignment is appropriate.
- **Medicare payments for unlisted procedure codes:** The OIG will review the usage of unlisted procedure codes to insure that there are no existing codes that appropriately identify the services rendered.
- **Laboratory test unbundling by clinical laboratories:** The extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments will be reviewed.
- **Variation of laboratory pricing:** Claims will be reviewed to determine pricing variances between Medicare carriers for the most commonly performed tests.
- **Clotting-factor furnishing fee:** The OIG will determine if payments for clotting-factor furnishing fees were appropriately made.
- **Medicare billings with modifier GY:** The OIG will investigate over-utilization of the GY modifier and resulting billings to beneficiaries for non-covered services.

Every compliance plan should include a requirement to review the annual OIG Work Plan each October as it points to potential risk areas. This review should result in the modification of your compliance focus for the upcoming year. ▲

Cindy M. Pittmon, CHBME, is president of Specialty Group Services, LLC, in Longview, Texas. She can be reached at cindy@sgsmedical.com.