COMPLIANCE ALERT:
HIGHLIGHTS OF THE OIG'S 2011 WORK PLAN FOR HOME HEALTH AGENCIES

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This Compliance Alert is one in a series of articles focusing on compliance issues of interest to home health care agencies.

On October 1, 2011, the OIG released its work plan for fiscal year 2011. Updated annually at the start of each fiscal year, the OIG's work plans describe the investigative, enforcement, and compliance activities that the OIG is pursuing or plans to initiate in the year ahead. The OIG's annual work plans are significant, not only because they describe the OIG's focus areas for the year, but also because state Medicaid Inspector Generals and third-party contractors and fiscal intermediaries refer to them in setting their own audit and investigatory priorities.

The OIG's 2011 Work Plan, which is available at http://oig.hhs.gov/publications/workplan/2011/, addresses several matters of interest to home health agencies. These include the following:

Medicare Program Initiatives

- Part B Payments for Home Health Beneficiaries -- The OIG will identify Part B payments to outside suppliers for services and medical supplies that are included in HHA prospective payment and examine the adequacy of controls established to prevent inappropriate Part B payments for services and medical supplies.
- HHA Claims for Medicare Home Health Resource Groups -- The OIG will assess the accuracy of HHRGs submitted for Medicare home health claims in 2008 and identify characteristics of miscoded HHRGs.
- Oversight of HHA Outcome and Assessment Information Set Data -- The OIG will review CMS's oversight of Outcome and Assessment Information Set ("OASIS") data submitted by Medicare-certified HHAs, including CMS's process for ensuring that HHAs submit accurate and complete OASIS data.
- Home Health Prospective Payment System Controls -- OIG claims that, following the implementation of the home health Prospective Payment System, total payments to HHAs increased from $8.5 billion in 2000 to $16.4 billion in 2008. The OIG will review compliance with various aspects of the home health PPS, including billings for the appropriate location of the services provided, and analyze various trends in HHA activities, including the number of claims submitted to Medicare, the number of visits provided to beneficiaries, arrangements with other facilities, and ownership information.
- HHA Profitability -- The OIG will review cost report data to analyze HHA profitability trends under the home health PPS to determine whether the payment methodology should be adjusted. Since the implementation of PPS for home health services in October 2000, HHA expenditures have significantly increased. The OIG will examine trends, including

profitability trends in Medicare and the overall profitability trends for freestanding and hospital-based HHAs.

- Medicare HHA Enrollment -- The OIG will review the program integrity efforts of CMS, its contractors, and State agencies during the HHA enrollment process to determine whether these efforts identify and prevent the enrollment of questionable HHA applicants.
- Medical Equipment and Supplies
  - The OIG will review the appropriateness of Medicare Part B payments to DME suppliers of power mobility devices (e.g., scooters), hospital beds and accessories, oxygen concentrators, and enteral/parenteral nutrition by identifying DME suppliers in selected geographic areas with high-volume claims and reimbursement and determining whether the payments were proper.
  - The OIG will review the compliance of suppliers of durable medical equipment, prosthetics, orthotics, and supplies with Medicare requirements for frequently replaced DME supplies, specifically including the automatic shipment of continuous positive airway pressure system and respiratory-assist device supplies without having a physician order for refills in effect.
  - The OIG will review documentation for payments to DME suppliers for standard and complex rehabilitation power wheelchairs to determine whether the claims were medically necessary and whether the suppliers maintained documentation, consistent with that of the ordering physicians, supporting medical necessity.
  - The OIG will review the appropriateness of Medicare Part B payments to DME suppliers that submitted claims with modifiers, which indicate the maintenance of appropriate documentation on file, to confirm that the necessary documentation is on file to support the claims.

Medicaid Program Initiatives

- Medicaid HHA Claims -- The OIG will review HHA claims to determine whether providers have met applicable criteria to provide services and whether beneficiaries have met eligibility criteria under the federal regulations at 42 CFR § 440.70 and 42 CFR pt. 484, such as the minimum number of professional staff, proper licensing and certification, review of service plans of care, and proper authorization and documentation of provided services, including a doctor's determination that the beneficiary needs at-home medical care, which must include intermittent (not full-time) skilled nursing care and may include physical therapy or speech-language pathology services.
- Medicaid Payments for Personal Care Services -- The OIG will review Medicaid payments for personal care services to determine whether States have appropriately claimed the FFP only for those individuals who are not inpatients or residents of hospitals, nursing facilities, institutions for mental diseases, or intermediate care facilities for those with mental retardation and that the personal care services are authorized by a physician or (at the option of the State) otherwise authorized in accordance with a plan of treatment, provided by someone who is qualified to render such services and who is not a

member of the individual’s family (except after January 1, 2007 for self-directed personal assistance services), and furnished in a home or other location.

- Health Screenings of Medicaid Home Health Care Workers -- The OIG will review health screening records of Medicaid home health care workers to determine whether the workers were screened in accordance with Federal and State requirements at 42 CFR § 440.70, 441.15, and 441.16 and 42 CFR pt 484, and applicable state/local regulations.

Medicare/Medicaid Program Integrity Initiatives

- Payments for Services Ordered or Referred by Excluded Providers -- The OIG will review the nature and extent of Medicare payments for services ordered or referred by excluded providers.
- Medicare Services Billed with Dates of Service after Beneficiaries’ Dates of Death -- The OIG will review Medicare claims with dates of service after beneficiaries’ dates of death to assess controls to preclude or identify and recover improper FFS payments.
- Payments to Terminated and/or Excluded Medicaid Providers and Suppliers -- The OIG will review the nature and extent of Medicaid payments to providers and suppliers during periods of termination or exclusion from the Medicaid program.
- Medicaid Claims with Inactive or Invalid Physician Identifier Numbers -- The OIG will review Medicaid claims to assess controls to identify claims associated with inactive or invalid unique physician identifier numbers, including claims for services alleged to have been provided after the dates of the referring physicians’ deaths.
- Third-Party Liability Payment Collections -- The OIG will review States’ procedures for identifying and collecting third-party payments for services provided to Medicaid beneficiaries to determine the extent to which States’ efforts have improved since its last review in 2006.
- Medicaid Credit Balances -- The OIG will review providers to determine whether there are Medicaid overpayments in patient accounts with credit balances.

This is just a summary and does not include all of the areas that the OIG plans to review. Please review the complete OIG 2011 Work Plan for more information.

In New York, compliance programs have been mandatory since October 2009 for Medicaid providers subject to the provisions of Articles 28 and 36 of the New York Public Health Law and for other specified providers. The federal health reform legislation enacted in March 2010 requires health care providers to adopt compliance programs, by March 2013 for skilled nursing facilities and by a date not yet specified for other providers and suppliers.

One element of an effective compliance program is a system for the routine identification of compliance risk areas specific to the provider type and for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits. Health care providers may find it useful to take guidance from the annual OIG work plans as they identify risk areas and determine the focus for their compliance activities in the coming year.

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