Case Management Monthly

OIG Work Plan for 2017 contains warning areas for case management

Learning objective:

At the completion of this educational activity, the learner will be able to:

- *Identify the items in the 2017 OIG Work Plan that may affect case management and learn how to prepare for them.*

The 2017 OIG *Work Plan* is out, and there are a few areas that may affect case management, particularly with regard to the 2-midnight rule, skilled nursing facilities (SNF), ambulance services, and home health agencies (HHA).

Regardless of the changes in each year's *Work Plan,* the document as a whole should remind case managers that they need to comply with the rules, says **Stefani Daniels, RN, MSNA, CMAC, ACM,** managing partner at Phoenix Medical Management, Inc., in Pompano Beach, Florida.

It's important to ask the following questions about your compliance efforts:

- Have hospital executives given the chief compliance officer the resources to ensure activities are compliant with the statutes, rules, and regulations?
- Have chief financial officers supported the work of patient financial services to ensure claim submissions are accurate?
- Are there robust access management processes in place to ensure high-cost hospital services are being used by "eligible" patients?

The annual *Work Plan* should help hospitals review systems to ensure not only that they are complying with the new year's focus areas, but that compliance programs are appropriate overall.

The following is a rundown of the areas of focus for 2017 and what you can expect as a result.

The 2-midnight rule. Regulators and auditors have concentrated heavily on the 2-midnight rule, and the OIG is no different. The 2017 *Work Plan* states that it will:

Determine how hospitals' use of outpatient and inpatient stays changed under Medicare's two-midnight rule by comparing claims for hospital stays in the year prior to and the year following the effective date of that rule. We will also determine the extent to which the use of outpatient and inpatient stays varied among hospitals.

In the same vein, the OIG also says it will review selected inpatient and outpatient billing requirements. "This review is part of a series of hospital compliance reviews that focus on hospitals with claims that may be at risk for overpayments," states the *Work Plan.* "Prior OIG reviews and investigations have identified areas at risk for noncompliance with Medicare billing requirements. We will review Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements and recommend recovery of overpayments. Our review will focus on those hospitals with claims that may be at risk for overpayments."

The 2-midnight rule, first implemented in October 2013, was designed to address hospital use of short inpatient stays and long outpatient stays.

To ensure compliance, **Janet L. Blondo, MSW, LCSW-C, LICSW, CMAC, ACM, CCM, C-ASWCM, ACSW,** manager of case management at Washington Adventist Hospital in Takoma Park, Maryland, says organizations should focus on which patients are in observation vs. inpatient status and make sure the necessary supporting documentation is available to prove a patient's stay is valid and withstand audit scrutiny. Keeping the focus on patient status will help hospitals avoid one-day inpatient stays and observation stays of longer than 48 hours.

SNF reimbursement. SNFs must periodically assess patients using a tool known as the Minimum Data Set, which helps the SNF classify each patient into a resource utilization group for payment.

"Medicare payment for SNF services varies based on the activities of daily living score and the therapy minutes received by the beneficiary and reported on the Minimum Data Set. The more care and therapy the patient requires,

the higher the Medicare payment," states the *Work Plan.*

The OIG goes on to say that reviews have revealed some SNFs are billing for a higher level of therapy than appropriate. "We will review the documentation at selected SNFs to determine if it meets the requirements for each particular resource utilization group," states the *Work Plan.*

So how does the OIG's focus affect case management? It may mean providing more documentation than in the past. "Expect nursing homes to request all rehab notes for patients," says Blondo. "SNFs may be more selective in who they accept as a Medicare skilled patient for rehab. Be prepared with a backup transition plan in case the patient is not accepted at the SNF using the Medicare benefit, or obtain a level of care if the patient has Medicaid."

Ambulance services. OIG states in the *Work Plan* that it will look more closely to ensure Medicare payments for emergency and nonemergency ambulance services are appropriate. Medicare currently pays for these services when a patient's physical condition makes it dangerous for him or her to travel by other means.

"Medicare pays for different levels of ambulance service, including basic life support, advanced life support, and specialty care transport," states the *Work Plan.* "Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports."

With this in mind, case managers should review criteria to determine who qualifies for advanced life support ambulance transport under Medicare, says Blondo. "Pay attention to documentation and medical necessity," she says. "Expect the patient or your facility to get a bill for the transport if you do not prove medical necessity in your documentation for transport."

HHAs. This year's *Work Plan* places particular emphasis on HHAs. The OIG has taken aim at improper home health Medicare billing, stating that "previous OIG work has shown that the home health program is prone to fraud, waste, and abuse." That and other information included in the document send a pretty clear signal that HHAs need to be on guard.

One target area outlined in the *Work Plan* looks specifically at fraud related to patients who were defined as homebound when they didn't qualify for or need HHA skilled services.

"OIG notes in a study that of the $18 billion paid in 2014 for Medicare home health services, CMS determined that 51.4% of claims were paid improperly," **Neville M. Bilimoria, Esq.,** partner in the Chicago office of Duane Morris, LLP, told **CMM**'s sister publication **Homecare Direction.** "That's about $9.4 billion worth of fraudulent or improper claims in the home health arena. This study signals a significant target for OIG and the high potential for fraud and abuse prosecution against home health agencies."

Furthermore, the OIG also says it believes that CMS surveys of HHAs need to be looked at more carefully and should include the provider's Medicare claims history, says Bilimoria. "According to OIG, certain HHAs are leaving out certain patients from information provided to survey agencies—these omitted patients may indicate fraudulent or improper billing," he says. "OIG wants surveyors in 2017 to tie patient information received in a survey to Medicare claims data to ferret out fraud. Increased surveyor scrutiny of HHAs is going to be critical in 2017 for CMS and OIG."

So what does this mean for case managers? Because case managers regularly work with HHAs, they must take some extra precautions. HHAs must be in compliance with Medicare requirements, case managers should expect agencies to be strict about not accepting patients for services until the face-to-face form is signed by the physician and received. "Patients may also need physician documentation of homebound status," says Blondo.

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