



*An Informational Bulletin Brought To You By Polaris Group*

## OIG Work Plan for Fiscal Year 2010—Nursing Homes

**The OIG has released its work plan for FY 2010. The following are the 17 SNF- related items that will be reviewed.**

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### **1) Part B Services in Nursing Homes: Mental Health Needs and Psychotherapy Services**

The OIG will review Medicare Part B payments for psychotherapy services provided to nursing home residents during non-covered Medicare Part A SNF stays. Pursuant to [42 CFR § 483.25](#), certified nursing homes are required to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A previous OIG review found that approximately 31 percent of outpatient claims for Part B mental health services allowed by Medicare did not meet coverage guidelines, resulting in \$185 million in inappropriate payments. OIG will determine the medical necessity of services, appropriateness of coding, and adequacy of nursing home documentation.

### **2) Accuracy of Skilled Nursing Facility Resource Utilization Groups Coding**

OIG will review SNF claims for Medicare reimbursement to determine the accuracy of Resource Utilization Groups (RUG) coding. The Social Security Act, § 1888(e), establishes the amount paid to SNFs for all covered services. Medicare pays Part A-covered SNF stays using a PPS that applies a case-mix adjustment based on the resident's RUG, which is an indication of the level of care and resource needs. In 2006, they reported that 22 percent of claims had RUGs associated with higher payment rates than those generated in and supported by patients' medical records. This represented \$542 million in potential overpayments for FY 2002. The OIG will also explore other opportunities to improve the accuracy of payments to SNFs.

### **3) Medicare Requirements for Quality of Care in Skilled Nursing Facilities**

The OIG will assess how skilled nursing facilities (SNF) have addressed certain Federal requirements related to quality of care. Specifically, they will determine the extent

to which SNFs: (1) developed plans of care based on assessments of beneficiaries, (2) provided services to beneficiaries in accordance with these plans of care, and (3) planned for beneficiaries' discharges. As a part of this study, they will review SNFs' use of the standardized Resident Assessment Instrument (RAI) to develop nursing home residents' plans of care. The Social Security Act, §§ 1819(b)(3) and 1919(b)(3), requires nursing homes participating in the Medicare or Medicaid program to use the RAI to assess each nursing home resident's strengths and needs. Prior OIG reports revealed that approximately one quarter of residents' needs for care, as identified through the RAI, were not reflected in their care plans and that nursing home residents did not receive all psychosocial services identified on care plans.

### **4) Nursing Home Emergency Preparedness and Evacuations During Selected Natural Disasters**

OIG will review nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors to determine the sufficiency of the nursing homes' plans and implementation of the plans. Pursuant to [42 CFR § 483.75\(m\)](#), Medicare- and Medicaid-certified nursing home facilities must have plans and procedures to meet all potential emergencies and train all employees in these emergency procedures. In 2006, OIG reported that nursing homes in certain Gulf States had plans that lacked a number of provisions suggested by emergency preparedness experts and that staff did not always follow emergency plans. OIG will describe the experiences of selected nursing homes, including challenges, successes, and lessons learned, when they implemented their plans during recent disasters.

### **5) Criminal Background Checks for Nursing Facility Employees**

OIG will determine whether and the extent to which nursing facilities have employed individuals with criminal convictions. Pursuant to the Social Security Act, §§ 1819(b)(2) and 1919(b)(2), nursing facilities participating in the Medicare and Medicaid programs are required to provide services that maintain the dignity and well-being of all nursing home residents. Federal regulations at [42 CFR § 483.13\(c\)\(1\)\(ii\)](#) prohibit Medicare and Medicaid long term care (LTC) facilities



from employing individuals found guilty of abusing, neglecting, or mistreating residents. The OIG will also categorize the types of crimes, if any are found, for which nursing facilities' employees have been convicted.

#### **6) Oversight of Poorly Performing Nursing Homes**

The OIG will review CMS's and States' use of enforcement measures to determine their impact on improving the quality of care beneficiaries received in poorly performing nursing homes and the performance of these nursing homes. The Social Security Act, §§ 1819(g) and 1864, established a survey and certification process to ensure that nursing homes meet Federal standards for participation in the Medicare and Medicaid programs. OIG will examine enforcement measures, such as survey and certification reviews and actions taken by CMS and States. They will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement plans of correction.

#### **7) Part B Services in Nursing Homes: Overview**

The OIG will review the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Unlike services provided during a Part A SNF stay, which are billed to Medicare directly by the SNF in accordance with consolidated billing requirements, Part B services are provided and billed directly by suppliers and other providers. In repealing consolidated billing provisions that would have applied to non-Part A SNF stays, Congress directed OIG in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313, to monitor these services for abuse. This review will determine the extent of Part B services provided to nursing home residents during 2007 and assess patterns of billing among nursing homes and providers.

#### **8) Nursing Home Residents Aged 65 or Older Who Received Antipsychotic Drugs**

OIG will review the extent to which nursing home residents aged 65 or older received selected antipsychotic drugs in the absence of conditions approved by the Food and Drug Administration (FDA). Pursuant to the Social Security Act, §§ 1819 and 1919, SNFs are required to respect certain rights of patients, including the right to be free from chemical restraints administered for discipline or convenience. The regulation at [42 CFR § 483.25\(l\)](#) defines safeguards to protect nursing home residents from being prescribed unnecessary drugs. They will examine

Medicare Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents and the extent to which these drugs were prescribed and paid for in accordance with Federal regulations.

#### **9) Services Performed by Clinical Social Workers**

They will review services furnished by clinical social workers (CSW) to inpatients of Medicare participating hospitals or SNFs to determine whether the services were separately billed to Medicare Part B. Federal regulations at [42 CFR § 410.73\(b\)\(2\)](#) describe services performed by a CSW that may not be billed as CSW services under Medicare Part B when provided to inpatients of certain facilities. They will examine Medicare Part A and Part B claims with overlapping dates of service to determine whether services performed by CSWs in inpatient facilities were separately billed to Medicare Part B.

#### **10) Enteral Nutrition Therapy Services in Nursing Homes**

OIG will review Part B enteral nutrition therapy (ENT), commonly called tube feeding, to assess the medical necessity, adequacy of documentation, and coding accuracy of claims submitted for Medicare beneficiaries during a nursing home stay that is not covered under the Part A SNF benefit. The Social Security Act, § 1861(s) (8), authorizes Medicare Part B coverage of ENT under a prosthetic device benefit provision for beneficiaries residing at home or in nursing facilities when the stays are not covered by Medicare Part A. They will also examine the characteristics of inappropriately allowed claims for ENT.

#### **11) Quality Improvement Organizations' Beneficiary Complaint Process**

OIG will review the extent to which Quality Improvement Organizations (QIO) notify Medicare beneficiaries and/or their representatives of the final outcomes of their quality-of-care complaints to QIOs and determine trends in the receipt and disposition of beneficiary complaints by QIOs. Pursuant to the Social Security Act, § 1154(a)(14), QIOs are required to review complaints about the quality of care Medicare beneficiaries receive and inform beneficiaries and/or their representatives of the final outcome of their complaints. OIG reviews from 1995 and 2001 found issues with the QIO process for reporting the outcomes of their quality-of-care complaints to beneficiaries. Further, in 2002 the



U.S. Court of Appeals for the District of Columbia Circuit found that HHS had not implemented the requirement to notify Medicare beneficiaries and/or their representatives of the final disposition of the quality-of-care complaints they had made to QIOs.

### **12) Recovery Audit Contractors' Referrals of Potential Fraud and Abuse**

The OIG will review CMS's oversight of Recovery Audit Contractors (RAC) during a 3-year demonstration program to determine the extent to which RACs, which are responsible for identifying Medicare overpayments and underpayments, also identified and reported potential fraud and abuse to CMS. Section 306 of the MMA directed the Secretary of HHS to conduct a demonstration project using RACs to identify Medicare underpayments and overpayments. Following the conclusion of the RAC demonstration program, CMS made the RACs a national program. For both the demonstration and national RACs, they will examine the number of cases referred to CMS, CMS's processing of those referrals, CMS's guidance and training to the demonstration RACs to identify and report potential fraud, and CMS's guidance and training to national RACs on appropriately reporting potential fraud.

### **13) Oversight of Nursing Home Minimum Data Set Data**

They will review CMS's oversight of Minimum Data Set (MDS) data submitted by nursing homes certified to participate in Medicare or Medicaid. The Social Security Act, §§ 1819(b)(3)(A)(iii) and 1819(e)(5), and corresponding sections of Title XIX of the Social Security Act require nursing homes to conduct accurate comprehensive assessments for residents using a resident assessment instrument that includes the MDS. Regulations at [42 CFR § 483.20](#) specify the requirements of the assessment instrument. MDS data include the residents' physical and cognitive functioning, health status and diagnoses, preferences, and life care wishes. CMS implemented a SNF PPS based on MDS data in July 1998 and began posting MDS-based quality performance information on its Nursing Home Compare Web site in 2002. Approximately half of the States also use MDS data as the basis of their Medicaid payment systems. OIG will review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data.

### **14) Transparency Within Nursing Facility Ownership**

OIG will review ownership structures at investor-owned

nursing homes. Nursing facilities are increasingly being purchased by private equity or other for-profit investor firms. Prior OIG work showed that after the facility purchase, in some cases, new owners created a complex web of ownership that essentially left the operators of the nursing facility with no assets. Determination of which entity is legally liable for patient care can be made difficult because of the ownership structure. In addition, after the facility purchase, in some cases, new owners have reduced staffing levels and taken other cost-cutting measures that increase profit at the expense of quality of care. They will determine which entities are benefiting from the Medicaid reimbursement and study the effects of these types of ownership changes on the care received by beneficiaries in nursing homes.

### **15) States' Administration and Use of Civil Monetary Penalty Funds in Medicaid Nursing Homes**

The OIG will examine how States administer and use civil monetary penalties (CMP) imposed on nursing homes that fail to meet Medicare and Medicaid health and safety requirements. The Social Security Act, § 1919 (h)(2)(A)(ii), requires that States use the CMP funds they collect to ensure the safety of residents of the penalized nursing homes. They will identify the amounts that States have received as a result of imposing CMPs, determine what policies and procedures States have to ensure that CMP funds are allocated appropriately to meet Federal requirements, and determine how and to what extent CMS oversees States' use of CMP funds.

### **16) Medicaid Nursing Home Patients: Quality of Care**

OIG will review Medicaid data to identify nursing facilities that may have provided substandard care resulting in or contributing to beneficiaries' subsequent hospital admissions, including those for diagnoses of pressure sores, infections, or both. Federal regulations at [42 CFR § 483.25](#) require facilities to provide beneficiaries necessary care and services to attain the highest practicable physical well-being in accordance with comprehensive assessments and plans of care and to ensure, for example, that no pressure sores develop unless such sores are clinically unavoidable. OIG work has identified instances when nursing home residents covered by Medicaid were admitted to hospitals with conditions that reflect poor quality of care.

**17) Medicaid Incentive Payments for Nursing Facility Quality-of-Care Performance Measures**

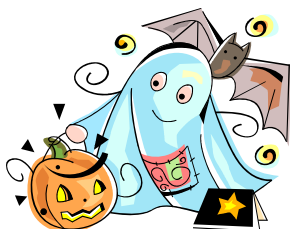
They will review Medicaid incentive payments that States have made to nursing facilities based on the facilities' quality-of-care performance measures. The Social Security Act, § 1919(h)(2)(F), authorizes States to establish programs to reward nursing facilities—through public recognition, incentive payments, or both—that provide the highest quality care to their Medicaid-eligible residents. OIG will determine whether States have sufficient controls to assess nursing facilities' quality-of-care performance measures and determine whether States have made incentive payments in accordance with program requirements.

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**Q & A**  
**“Where No Question Goes Unanswered!”**

Q. Can maintenance therapy minutes be coded in section P1b?

A. No. Once the licensed therapist has designed a maintenance program, and discharged the resident from skilled therapy, the services performed by the therapist and the aide should no longer be reported on the MDS at Item P1b as skilled therapy. The services of the aide may be reported on the MDS as restorative at Item P3, provided they meet the requirements for restorative. RAI Manual 3-189.



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