

most hospitals (and even many health systems) to invest in information systems that can monitor and trend billing data, allowing them to target specific types of bills for denials. It is clear that a good denials management program is a hugely important element in revenue cycle management and can pay significant dividends in the reduction of billing denials.

Denials Management: Fraud and Abuse Issues Related to Billing

Issues of fraud and abuse in billing for services are multifaceted and complex. The Medicare and Medicaid programs want to be sure that they are paying only for the services required and used by their beneficiaries. On an annual basis, the Office of Inspector General (OIG), which is an arm of the Department of Health and Human Services, creates a work plan of what it believes are the biggest areas of fraud and abuse in claims processing. The areas targeted for substantial review in 2013 are summarized in exhibit 5.1.

EXHIBIT 5.1. OFFICE OF INSPECTOR GENERAL WORK PLAN: SELECTED AREAS FOR REVIEW IN BILLING AND CLAIMS PROCESSING, FISCAL YEAR 2013

Area for Review	Action and Intent
Same-Day Readmissions	OIG will review Medicare claims to determine trends in the number of same-day hospital readmission cases. On the basis of prior OIG work, CMS implemented an edit (a special system control) in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. If a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one DRG payment and should combine the original and subsequent stays into a single claim. (CMS's <i>Medicare Claims Processing Manual</i>, Pub. No. 100-04, ch. 3, § 40.2.5.) Providers are permitted to override the edit in certain situations. We will test the effectiveness of the edit. This work may also be helpful to CMS in implementing provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). (OAS; W-00-13-35439; various reviews; expected issue date: FY 2013; new start; Affordable Care Act)

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practices billing Medicare as provider-based physician practices. OIG will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities.

In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OIG: 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)

OIG will review Medicare claims to determine whether specific acute care hospitals are frequently transferring patients with certain diagnoses that were coded as being present when patients were admitted (referred to as "present on admission," POA) to another acute care hospital. Medicare requires acute care hospitals to report on their claims which diagnoses were present when patients were admitted. (Social Security Act, §1886(d)(4)(D), and CMS's *Change Request* 5679, Pub. 100-20, One-Time Notification, Transmittal 289.) (OAS: W-00-12-35500; various reviews; expected issue date: FY 2013; work in progress)

OIG will review Medicare payments to hospitals to determine compliance with selected billing requirements. Results of these reviews will be used to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations, and inspections have identified areas at risk for noncompliance with Medicare billing requirements. Using computer matching and data mining techniques, OIG will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same techniques, OIG will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. OIG will then review the hospitals' policies and procedures to compare the compliance practices

Hospital-Owned Physician Practices Using Provider-Based Status

Admissions with Conditions Coded Present on Admission

Inpatient and Outpatient Payments to Acute Care Hospitals

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of these two groups of hospitals. OIG will also survey or interview hospitals' leadership and compliance officers to provide contextual information related to hospitals' compliance programs. (OAS; W-00-11-35538; W-00-12-35538; various reviews; expected issue date: FY 2013; work in progress)

Inpatient Outlier
Payments: Trends and
Hospital Characteristics

OIG will review hospital inpatient outlier payments, examine trends of outlier payments nationally, and identify characteristics of hospitals with high or increasing rates of outlier payments. Medicare typically reimburses hospitals for inpatient services based on a predetermined per-discharge amount, regardless of the actual costs incurred. Medicare pays hospitals supplemental payments, called outlier payments, for patients incurring extraordinarily high costs. (Social Security Act, §1886(d)(5)(A)(ii).) In 2009, outlier payments represented about 5 percent of total Medicare inpatient payments, or about \$6 billion per year. Recent whistleblower lawsuits have resulted in millions of dollars in settlements from hospitals charged with inflating Medicare claims to qualify for outlier payments. (OE; 06-10-00520; expected issue date: FY 2013; work in progress)

It is pretty obvious that the government is serious about fraud and abuse in billing. The table is not comprehensive, and some of the areas listed are given more weight than others. It is not known which of these areas is considered most heavily weighted, but some supposition can be gleaned from the OIG's work in the recent past and the probability of a greater monetary return for the government (Gardner 1998). Since the appearance of Gardner's article, the OIG has continued to bring charges against many health care providers and contractors. In fact, on February 11, 2013, Attorney General Eric Holder and Health and Human Services Secretary Kathleen Sebelius released a new report showing that for every dollar spent on health care-related fraud and abuse investigations in the previous three years, the government recovered \$7.90. This is the highest three-year average return on investment in the sixteen-year history of the Health Care Fraud and Abuse (HCFAC) Program.

The government's health care fraud prevention and enforcement efforts recovered a record \$4.2 billion in taxpayer dollars in FY 2012, up from nearly \$4.1 billion in FY 2011, from individuals and companies who attempted

to defraud federal health sought payments to which the administration's enforcement from \$6.7 billion over the Program has returned more

Additionally, new programs HHS and CMS have been activity in health care. In 1.5 million Medicare-environmental Screening system, fraudulent providers and of data for revalidation of 2012, more than 400 requirements and nearly eliminated from Medicare requirements and other

It is principally because government's focus on care billing issues, will Services also established 2012 to improve health innovation, and help re Medicaid. The RCD are be aware of all the bill operation. Several are The first is upcoding of emergency department ment than is deserved the claim. This is unlikely where improved docu

Upcoding achieved in early 1997 highlighting much money. In a number the codes needed to and guidelines fill two extremely difficult to providers often downcode issues entail (Lagnad

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