OIG 2003 Work Plan Ready For SNFs

The continuing emphasis on quality of care includes several new areas of focus, including medical directors, social services, and MDS reporting.

Quality Of Care Additions

OIG’s continued and increasing focus on quality-of-care issues for SNFs in 2003 is perhaps best evidenced by the following new entries in this year’s work plan:

Nursing facility medical directors

Nursing facilities are required to designate a medical director who is responsible for clinical policies and the coordination of medical care. OIG will be examining more closely how SNFs have implemented the role of medical director and how this affects quality.

Nursing facility quality and deficiency data. As a means of effectively monitoring quality of care in SNFs, OIG will more closely analyze the accuracy of facilities’ online survey, certification, and reporting system (OSCAR) data.

Repeated deficiencies. OIG will examine how states identify SNFs that receive repeated patient-care deficiencies and the effectiveness of state enforcement mechanisms to increase compliance with federal regulatory requirements. OIG will also examine how states track facilities that repeatedly are cited for quality-of-care deficiencies.

Minimum data set (MDS) reporting. OIG will assess nursing facility compliance with MDS reporting requirements—one of the primary oversight mechanisms for regulating quality-of-care issues in SNFs. Medicare requires that MDS information be reported on all patients for quality oversight purposes. Interestingly, this review will focus on non-Part A patients and will involve examining records and other submissions to verify the accuracy of MDS reported data.

Social work services. OIG will examine whether nursing facilities provide the psychosocial services required by Medicare regulations and will review the qualifications of persons providing these services. Medicare regulations require SNFs to provide a level of social services to patients adequate to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each patient. Facilities with more than 120 beds are required to employ a qualified social worker on a full-time basis. This individual must have at least a bachelor’s degree in social work or in a related human services field and have at least one year of supervised social work experience directly with patients in a health care setting.

Trends in deficiencies and ombudsman complaints. OIG will assess trends in quality-of-care problems at nursing facilities by reviewing state survey deficiencies and ombudsman complaints. The focus will be on most frequently cited deficiencies as well as on deficiencies that carry the most serious scope and severity levels.

Staffing requirements. OIG will determine the degree to which staffing levels at SNFs are linked to quality-of-care issues. In this regard, OIG will examine whether there are differences in quality of care provided at facilities with staffing levels that are higher than, equal to, or lower than the levels set forth in regulatory requirements.

Quality-of-care sanctions. OIG will determine whether SNFs are complying fully with sanctions imposed for quality-of-care problems. For example, an assessment will be made regarding whether facilities that were penalized for quality-of-care deficiencies through the imposition of restrictions on the admission of new Medicaid patients during a particular period of time violated the restriction by admitting new patients for whom they received reim-

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Quality-of-care investigations. OIG will increase its investigations of the quality of care provided by SNFs. Due to continuing growth in the elderly population, OIG says it is determined to examine whether the Medicare and Medicaid programs are doing everything possible to ensure a safe environment for all patients, while ensuring that all billings to the programs are appropriate.

Further, in a repeat of an entry from last year, OIG will continue its review of the role and effectiveness of quality assessment and quality assurance committees in ensuring the quality of care in nursing facilities. Such committees must be comprised of the director of nursing, a physician, and at least three other staff members. The committees are required to meet at least quarterly to identify, respond to, and evaluate issues relating to quality of care.

Other New Areas
In addition to the stepped-up focus on quality of care, OIG’s 2003 work plan encompasses other new areas of note to long term care facilities, including:

- Evaluating the effect that the prospective payment system (PPS) has had on access to nursing facility care for Medicare beneficiaries;
- Examining changes in the proportion of Medicare beneficiaries assigned to each resource utilization group (RUG);
- Following up a review of infusion therapy services provided to nursing facility patients;
- Reviewing Part B payments to determine if there has been unbundling, inappropriate services, or aberrant billing patterns, including any duplicate Part B payments, with respect to services covered by the consolidated billing requirement; and
- Examining the appropriateness of Medicaid payments to providers of ancillary services in nursing facilities to ensure that the program, through its per diem rate, is not paying twice for the same services.

Suggestions For Work-Plan Compliance
In order to help demonstrate “effective” compliance with OIG’s 2003 work plan, providers should consider the following five actions:

1.) Compliance committees. Facilities should convene a series of compliance committee meetings as soon as possible to discuss OIG’s 2003 work plan. Emphasis should be placed on new areas of OIG focus that have not yet been reviewed or audited by the facility. It is important to document these efforts by keeping written minutes of all such meetings.

2.) Audits. Providers should initiate internal or external audits of some of the areas of OIG focus—especially those that the facility has not recently audited—to evaluate compliance in these areas. As described in more detail above, some new areas to consider auditing include medical director services, social work services, other quality-of-care areas, MDS reporting, and ancillary service billing. It is important to document these efforts by preparing a written summary of the methodology and results of such audits and any corrective actions taken as a result.

3.) Risk areas. If a facility’s compliance program sets forth risk or audit areas, it should be amended to add new risk areas reflected in the 2003 work plan. All activities involving the discussion and consideration of such amendments should be thoroughly documented and distributed to all relevant staff.

4.) Dissemination to managers. Providers should send copies of the 2003 work plan to all members of their management teams, including a cover memorandum explaining the significance of the material. Facilities may choose to follow a more tailored approach by sending managers select sections of the 2003 work plan, depending on each manager’s area of responsibility. Such efforts should be documented by keeping copies of all cover memoranda and the materials distributed.

5.) Copies to physicians. Physicians who are cognizant of compliance issues in their private practices will also be more aware of compliance issues in the nursing facility setting. Providers should send a copy of the 2003 work plan (or just the section that is directly applicable to physicians, on pages 13-16) to every physician who provides services at the facility, along with an appropriate cover letter explaining the significance of the material. Copies of all such letters should be kept in the compliance officer’s files.

In the event that a facility has not yet developed and implemented a corporate compliance plan, providers still can demonstrate good faith by taking the above-described actions and documenting the efforts.

For More Information
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