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2014 Compliance Institute

Review of the OIG 2014 Work Plan For Post-Acute Providers

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2

What is an OIG Work Plan?

- Provides an indication of OIG enforcement activities for the coming year.
- Don't--

- What happened in the previous year???

OIG Recoveries FY 2013

- > $5.8 billion expected recoveries
  - ~ $850 million in audit receivables
  - ~$5 billion in investigative receivables
- ~ $19.4 billion in savings on the basis of prior- period legislative, regulatory, or administrative actions based on OIG recommendations

OIG FY 2013 Actions

- 3,214 exclusions of individuals and entities
- 960 criminal actions of individuals and entities
- 472 civil actions

Investigative Letters: Medicare MAC

Dear Compliance Officer:

As the Medicare Administrative Contractor (MAC)…regularly monitors billing and claim submission data for unusual patterns and data aberrancies…As such, the enclosed data are intended to provide you with information based on your facility's claim submissions, and to serve as an educational tool to assist you in the evaluation of your billing patterns.

A recent OIG data analysis on SNF RUG billing trends from 2006 to 2008 indicates that

(1) SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged.

(2) For-profit SNFs were far more 'likely than nonprofit or government SNFs to bill for higher paying RUGs.

Based on these findings, OIG recommended that MACs strengthen monitoring of the SNF billing and conduct additional reviews of SNFs that bill high paying RUGs excessively.

…We identified claims with the high paying RUG codes from your facility. Enclosed is a summary of the RUG claims billed by your facility as compared to the J12 average…Though we recognize that not all of these claims may represent payment errors, we are asking, in, light of the OIG findings, for you to review the data closely and conduct a self audit of the associated claims. If you determine any claims were paid in error, you should submit the appropriate refund…

OIG Outlook (2/6/2014)

- Goal: promote quality, safety and value
  - Key focus on quality and care of nursing homes & how often beneficiaries are harmed during their stay
- Compliance work in home health agencies
- Office of Evaluations & Inspections' focus
  - Quality of care, accuracy of payments & access to care

OIG Outlook 2014

- Adverse events in SNFs
  - Preventable?
  - Medicare cost impact
- Data analytics
  - Trends, spikes, decreases
- Home health & personal care services
  - Are services delivered, are they necessary, are patients homebound, kickbacks

OIG Outlook 2014

- Office of General Counsel
  - Proposed regulations on civil money penalties (CMPs), exclusions and safe harbors
  - New guidance for health care boards of directors

OIG Work Plan (WP): Focus on Providers

Hospitals

- New hospital inpatient admission criteria (new)
  - Focus on impact of new inpatient admission criteria on hospital billing, Medicare payments, and beneficiary payments; variations among hospitals
  - 2 day inpatient stay/observation stays
- Analysis of salaries included in hospital cost reports (new)
- Compare reimbursement for swing bed at Critical Access Hospitals to the same level of care at SNFs

LTCHs

- Long-term-care hospitals (LTCHs)—Billing patterns associated with interrupted stays
  - Focus on readmission patterns to determine the extent of new stays instead of interrupted stay billings,
  - Extent to which co-located LTCHs readmit patients from the providers with which they are co-located
  - Extent of improper LTCH payments for readmissions in 2011

Hospitals

- Selected inpatient and outpatient acute care billing requirements (ongoing)
  - Determine hospitals' compliance with selected billing requirements and recommend recovery of overpayments
  - *Survey or interview hospitals' leadership and compliance officers to provide contextual information related to hospitals' compliance programs*

Hospitals

- Hospital participation in projects with quality improvement organizations (QIOs) (ongoing)
  - Focus on extent and nature of hospitals' participation in quality improvement projects with QIOs
  - Extent to which QIOs' quality improvement projects in hospitals overlap with projects offered by other entities
  - CMS spending $1.3 billion for current 3 year QIO contract

IRFs

- Inpatient rehabilitation facilities (IRFs)—Adverse events in post-acute care for Medicare beneficiaries
  - Adverse and temporary harm events
  - Factors contributing to events
  - Preventable?
  - Medicare cost impact
- IRFs provide 11 % of post acute facility care
  - $7 billion annually

Nursing Homes

- SNF Medicare Part A billing facilities (new)
  - Describe SNF billing practices in selected years & variation in billing among SNFs in those years
  - Prior OIG work found SNFs increasingly billed for highest level of therapy even though beneficiary characteristics remained largely unchanged
  - OIG also found SNFs billed one-quarter of all 2009 claims in error, resulting in $1.5 billion in inappropriate Medicare payments
  - Quality of care on-going focus

Nursing Homes

- Questionable billing patterns for Part B services during nursing home stays
  - Focus on questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to residents during stays not paid under Part A
  - Series of studies examining several broad categories of services, such as foot care
  - Congress explicitly directed OIG to monitor Part B billing for abuse during non-Part A stays

Nursing Homes

- State agency verification of deficiency corrections
  - Determine whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.
  - Prior OIG review found one State survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with Federal requirements

Nursing Homes

- Program for national background checks for long-term-care employees
  - Review procedures implemented by participating States for long-term-care facilities or providers to conduct background checks on prospective employees and providers who would have direct access to patients and determine the costs of conducting background checks
  - Determine outcomes of States' programs and determine whether the programs led to any unintended consequences.
  - Mandated by Affordable Care Act, § 6401

Nursing Homes

- Hospitalizations of nursing home residents for manageable and preventable conditions
  - Determine hospitalization rates of SNF residents as a result of conditions thought to be manageable or preventable in the nursing home setting
  - 2013 OIG review found that 25% of Medicare beneficiaries were hospitalized for any reason in FY 2011.
  - Premise: hospitalizations of SNF residents are costly to Medicare and may indicate quality-of-care problems in the nursing homes

Hospices

- Hospice in assisted living facilities (ALFs)(new)
  - Focus: extent to which hospices serve Medicare beneficiaries who reside in ALFs
  - Length of stay, levels of care received, and common terminal illnesses.
  - Goal: provide HHS with data to support payment reform and quality measures pursuant to ACA § 3132
  - Concern: ALF residents have the longest lengths of stay in hospice care
  - Medicare Payment Advisory Commission has said that these ALF long stays bear further monitoring and examination

Hospices

- Hospice general inpatient care (GIP)
  - Focus on use of hospice GIP
  - Assess appropriateness of GIP claims and the content of election statements for hospice beneficiaries who receive GIP
  - Review hospice medical records to address concerns that GIP is being misused

Home Health Services

- Home health prospective payment system requirements
  - Review compliance with various aspects of the home health prospective payment system (PPS), including the documentation required
  - Determine whether home health claims were in paid in accordance with Federal laws and regulations.
  - Prior OIG report found that one in four HHAs had questionable billing.
  - CMS designated newly enrolling HHAs as high-risk providers, citing their record of fraud, waste, and abuse
  - Since 2010, ~ $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit

Home Health Services

- Employment of individuals with criminal convictions
  - Determine extent to which home health agencies (HHAs) are complying with State requirements for conducting criminal background checks on HHA applicants and employees
  - Prior OIG review found that 92 % of nursing homes employed at least 1 individual with at least 1 criminal conviction but review could not determine whether the nursing home employees should have been disqualified from working in nursing homes
  - Nearly all states have laws prohibiting certain health-care-related entities from employing individuals with prohibited criminal conviction

Ambulances

- Ambulance services—Portfolio report on Medicare Part B payments (new)
  - Analyze and synthesize OIG evaluations, audits, investigations, and compliance guidance related to Medicare Part B ground ambulance transport services
  - Identify vulnerabilities, inefficiencies, and fraud trends and offer recommendations to improve detected vulnerabilities and minimize inappropriate payments for ambulance services
  - Prior OIG work identified fraud schemes and trends indicating overutilization and medically unnecessary payments
  - Premise: ambulance services are covered "where the use of other methods of transportation is contraindicated by the individual's condition...." when a beneficiary's medical condition at the time of the transport is such that using other means of transportation would endanger the beneficiary's health.

Ambulances

- Ambulance services—Questionable billing, medical necessity, and level-of- transport
- Examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports that potentially never occurred or potentially medically unnecessary transports to dialysis facilities
- Determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements
- Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports

Lab Tests

- Laboratory tests—Billing characteristics and questionable billing
  - Review billing characteristics for Part B clinical laboratory (lab) tests and identify questionable billing
  - Lab payments in 2008 represented an increase of 92 % over payments in 1998
  - In 2010, Medicare paid ~ $8.2 billion for lab tests, 3 % of all Medicare Part B payments
  - Premise: Medicare should pay only for those lab tests that are ordered by a physician or qualified nonphysician practitioner who is treating a beneficiary

Physical Therapists

- Physical therapists—High utilization of outpatient physical therapy services
  - Review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations
  - Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or medically necessary or were not properly documented
  - Focus is on independent therapists who have a high utilization rate for outpatient physical therapy services

Portable X-Ray

- Portable x-ray equipment—Supplier compliance with transportation and setup fee requirements (new)
  - Review Medicare payments for the transportation and setup of portable x-ray equipment to determine whether payments were correct and were supported by documentation
  - Assess the qualifications of the technologists who performed the services and determine whether the services were ordered by a
  - Prior OIG work found that Medicare improperly paid portable x-ray suppliers for return trips to nursing facilities (i.e., multiple trips to a facility in 1 day) and for services ordered by nonphysicians that are not covered by Medicare

Prescription Drugs

- Covered uses for Medicare Part B drugs (new)
  - Review the oversight actions CMS and its claims processing contractors take to ensure that payments for Part B drugs meet the appropriate coverage criteria
  - Identify challenges contractors face when making coverage decisions for drugs.
  - Premise: If Part B MACs do not have effective oversight mechanisms, Medicare and its beneficiaries may pay for drugs with little clinical evidence of the drugs' safety and effectiveness
  - Part B may also cover drugs when an "off-label" use of the drug is supported in major drug compendia or when an off-label use is supported by clinical evidence in authoritative medical literature

Medicaid Home Health Services

- Home health services—provider and beneficiary eligibility
  - Review Medicaid HHA claims to determine whether the billing providers met applicable criteria to provide home health services to Medicaid beneficiaries
    - Minimum number of professional staff, proper licensing and certification, review of service plans of care, and proper authorization and documentation of provided services
  - Determine whether the beneficiaries met the criteria to receive such services

Medicaid Adult Day Services

- Adult day health care services
  - Review Medicaid payments for adult day care services to determine whether the providers complied with Federal and State requirements
    - Beneficiaries enrolled must meet eligibility requirements
    - Services must be furnished in accordance with a plan of care

Medicaid Home Health

- Home health services—Screenings of health care workers
  - Review health-screening records of Medicaid HHA health care workers to determine whether they were screened in accordance with Federal and State requirements
    - Health screenings for home health care workers include vaccinations such as those for hepatitis and influenza

Medicaid Payments for Health-Care-Acquired Conditions

- Health-care-acquired conditions—Prohibition on Federal reimbursements
- Determine whether selected States made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions
  - As of July 1, 2011, Federal payments to States are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions. (Social Security Act, § 1903, and Affordable Care Act, § 2702.) Federal regulations prohibit Medicaid payments by States for services related to health-care-acquired conditions and for provider-preventable conditions

OIG WP: Integrity Activities

Integrity Contractors

- Medicare benefit integrity contractors' activities (new)
  - Review and report the level of benefit integrity activity performed by Medicare benefit integrity contractors in calendar years 2012 and 2013
  - Activities include analyzing data to identify aberrant billing patterns, conducting fraud investigations, responding to requests for information from law enforcement, and referring suspected cases of fraud to law enforcement for prosecution
  - Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs) carry out benefit integrity activities for Medicare Parts A and B, and a Medicare Drug Integrity Contractor (MEDIC) carries out benefit integrity activities for Medicare Parts C and D

ZPICs & PSCs

- ZPICs and PSCs—Identification and collection status of Medicare overpayments (new)
  - Determine the total overpayments that ZPICs and PSCs identified and referred to claims processors in 2013 and the amount of these overpayments that claims processors collected
  - Review procedures for tracking collections on overpayments identified by ZPICs and PSCs
  - OIG has issued several reports critical of tracking and collection of
  - CMS has added reporting requirements that would improve overpayment tracking among the claims processors and ZPICs and PSCs
  - ZPICs and PSCs required to detect and deter fraud and abuse in Medicare Part A and/or Part B in their jurisdictions
    - Conduct investigations; refer cases to law enforcement; and take administrative actions, such as referring overpayments to claims processors for collection and return to the Medicare program

Provider Eligibility

- Enhanced enrollment screening process for Medicare providers
  - Determine extent to which and the way in which CMS and its contractors have implemented enhanced screening procedures for providers pursuant to ACA § 6401
  - Collect data on and report number of initial enrollments and enrollment revalidations approved and denied by CMS before and after the implementation of the enhanced screening procedures
    - Automated screening
    - Finger printing
    - Background checks

Provider Eligibility

- Idle Medicare provider records (new)
  - Identify active Medicare providers who have not billed Medicare for more than 1 year
  - Previous OIG work suggested many providers have active Medicare records but have not submitted any claims for more than 1 year
  - Providers enrolled solely to refer items and services for beneficiaries (ordering and referring providers) and certain provider specialty types are excluded from this deactivation process

Provider Eligibility

- Payments to providers subject to debt collection
  - Review providers and suppliers that received Medicare payments after CMS referred them to the Department of the Treasury (Treasury) for failure to refund overpayments
  - Determine the extent to which they ceased billing under one Medicare provider number but billed Medicare under a different number after being referred to Treasury
  - The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer eligible delinquent debt to Treasury for appropriate action

Medicaid Exclusions

- State terminations of providers terminated by Medicare or by other States
  - Review States' compliance with requirement that they terminate their Medicaid program providers that have been terminated under Medicare or by another State Medicaid program
  - Determine whether such providers are terminated by all State Medicaid programs in which they are enrolled
  - Assess the status of the supporting information-sharing system
  - Determine how CMS is ensuring that States share complete and accurate information
  - Identify obstacles States face in complying with the termination requirement
  - ACA § 6501

Ownership Information

- State collection and verification of provider ownership information
  - Determine extent to which States and CMS collect and verify required ownership information for provider entities enrolled in Medicare and Medicaid
  - Review States' and CMS's practices for collecting and verifying provider ownership information and determine whether States and CMS had comparable provider ownership information for providers enrolled in both Medicaid and Medicare
  - Premise: Federal regulations require Medicaid and Medicare providers to disclose ownership information, such as the name, address, and date of birth of each person with an ownership or control interest in the provider entity

Enhanced Provider Screening

- States' experiences with enhanced provider screening
  - Review States' progress toward rescreening or revalidating all Medicaid providers by 2016
  - Assess how States are complying with mandate to conduct enhanced screening; determine how many providers are enrolled in both Medicare and Medicaid; and determine whether States can use screenings from Medicare, other State Medicaid programs, and CHIP

Medicaid Provider Payment Suspensions

- Provider payment suspensions during pending investigations of credible fraud allegations (new)
  - Review payments to providers with allegations of fraud deemed credible by States and States' suspension of payments processes
  - Review select Medicaid State agencies for compliance with new federal provisions:
    - Federal financial participation in the Medicaid program is not available for items or services furnished by an individual or entity when the State has failed to suspend payments during a period when there is a credible allegation of fraud
    - Upon determinations that allegations of fraud are credible, States must suspend all Medicaid payments to the providers, unless the States have good cause to not suspend payments or to suspend payment only in part
    - States are required to make fraud referrals to MFCUs or to appropriate law enforcement agencies in States with no certified MFCUs

MCO Program Integrity

- Medicaid managed care entities' identification of fraud and abuse
  - Determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents
  - Describe how States oversee MCOs' efforts to identify and address fraud and abuse
  - Prior OIG report revealed that over a quarter of the MCOs surveyed did not report a single case of suspected fraud and abuse to their State Medicaid agencies in 2009
  - All MCOs are required to have processes to detect, correct, and prevent fraud, waste, and abuse. However, the Federal requirements surrounding these activities are general in nature (42 CFR § 438.608) and MCOs vary widely in how they deter fraud, waste, and abuse

Legal Activities

- Exclusions
- CMPs
- False Claims Act cases and Corporate Integrity Agreements (CIAs)
- Provider compliance with CIAs
- Advisory opinions and other guidances
- Provider compliance trainings

Legal Activities

- Provider self-disclosure
  - Protocol was updated in April 2013
  - Must admit fault
  - No guarantees

Investigative Activities

- Medicare & Medicaid fraud & abuse
- Failure of care cases
- Medicare Fraud Strike Force Teams
- Collaboration with Federal Bureau of Investigation (FBI), the United States Postal Inspection Service, the Internal Revenue Service (IRS), and State Medicaid Fraud Control Units (MFCU)

Investigative Activities

- Strike Force operations work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets
  - Quality-of-care and failure-of-care issues in nursing facilities, institutions, community-based settings, and other care settings and instances in which Federal programs may have been billed for services that were medically unnecessary, not rendered or not rendered as prescribed, or the care was so deficient that it constituted “worthless services”

OIG WP:

Focus on Protected Health Information (PHI)

Security of Portable Devices

- Security of portable devices containing personal health information (PHI)
  - Review security controls implemented by Medicare and Medicaid contractors and at hospitals to prevent the loss of PHI stored on portable devices and media, such as laptops, jump drives, backup tapes, and equipment considered for disposal
  - Assess and test contractors' and hospitals' policies and procedures for electronic health information protections, access, storage, and transport

Networked Medical Devices

- Controls over networked medical devices at hospitals (new)
  - Determine whether hospitals' security controls over networked medical devices are sufficient to effectively protect associated electronically protected health information (ePHI) and ensure beneficiary safety
  - Premise: Computerized medical devices, such as dialysis machines, radiology systems, and medication dispensing systems that are integrated with EMRs and the larger health network, pose a growing threat to the security and privacy of personal health information
  - Medical device manufacturers provide Manufacturer Disclosure Statement for Medical Device Security (MDS2) forms to assist health care providers in assessing the vulnerability and risks associated with ePHI that is transmitted or maintained by a medical devices

OIG WP: Focus on Payment Issues

Medicare Part C

- Risk adjustment data—Sufficiency of documentation supporting diagnoses
  - Review medical record documentation to ensure that it supports the diagnoses MA organizations submitted to CMS for use in CMS's risk-score calculations and determine whether the diagnoses submitted complied with Federal requirements
  - Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to CMS by the MA organizations)
  - Premise: Payments to MA organizations are adjusted on basis of the health status of each beneficiary, so inaccurate diagnoses may cause CMS to pay MA organizations improper amounts

Provider Taxes

- State use of provider taxes to generate Federal funding
  - Review State health-care-related taxes imposed on various Medicaid providers to determine whether the taxes comply with applicable Federal requirements
  - Focus on the mechanism States use to raise revenue through provider taxes and determine the amount of Federal funding generated
  - Prior OIG work raised concerns about States' use of health-care-related taxes

Certified Public Expenditures

- State compliance with Federal Certified Public Expenditures (CPE) regulations
  - Determine whether States are complying with Federal regulations for claiming CPEs, which are normally generated by local governments as part of their contribution to the coverage of Medicaid services
  - States may claim CPEs to provide the States' shares in claiming Federal reimbursement as long as the CPEs comply with Federal regulations and are being used for the required purposes

Medicaid Credit Balances

- Recovering Medicaid overpayments—Credit balances in Medicaid patient accounts
  - Review providers' patient accounts to determine whether there are Medicaid overpayments in accounts with credit balances
  - Previous OIG work found Medicaid overpayments in patients' accounts with credit balances

Medicaid MCOs

- Medicaid managed care reimbursement (new)
  - Review States' managed care plan reimbursements to determine whether MCOs are appropriately and correctly reimbursed for services provided
  - Ensure that the data used to set rates are reliable and include only costs for services covered under the State plan as required by or costs of services authorized by CMS
  - Verify that payments made under a risk-sharing mechanism and incentive payments made to MCOs are within the limits set forth in Federal regulations
  - Previous GAO work found that CMS's oversight of States' rate setting required improvement and that States may not audit or independently verify the MCO reported data used to set rates.

Preparing for the Audits

Resources

- HHS/DOJ Health Care Fraud and Abuse Control Program Report for Fiscal Year 2013: http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf
- OIG Outlook 2014: http://oig.hhs.gov/newsroom/outlook/index.asp
- OIG Strategic Plan 2014-2018: http://oig.hhs.gov/reports-and-publications/strategic-plan/files/OIG-Strategic-Plan-2014-2018.pdf
- OIG Work Plan for Fiscal Year 2014: http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf

Resources

- Selected recent OIG reports focused on post-acute providers:
  - Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring, OEI-06-0040, (Nov. 2013), http://oig.hhs.gov/oei/reports/oei-06-11-00040.pdf
  - Frequency of Medicare Recertification Surveys for Hospices Is Unimproved, OEI-06-13-00130, (Aug. 2013), http://oig.hhs.gov/oei/reports/oei-06-13-00130.pdf
  - Some States Improperly Restrict Eligibility for Medicaid Mandatory Home Health Services, OEI-07-13-00060, (July 2013), http://oig.hhs.gov/oei/reports/oei-07-13-00060.pdf
  - Medicare Hospice : Use of General Inpatient Care, OEI-02-1 0-00490, (May 2013), http://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf
  - Medicare Could Save Millions By Implementing A Hospital Transfer Payment Policy For Early Discharges To Hospice Care, A-01-12-00507, (May 2013), http://oig.hhs.gov/oas/reports/region1/11200507.pdf
  - Skilled Nursing Facilities Often Fail To Meet Care Planning And Discharge Planning Requirements, OEI-02-09-00201, (Feb. 2013), http://oig.hhs.gov/oei/reports/oei-02-09-00201.pdf
  - Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement—A Portfolio, OIG-12-12-01, (Nov. 2012), http://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf
  - Inappropriate Payments To Skilled Nursing Facilities Cost Medicare More Than A Billion Dollars In 2009, OEI-02-09-00200, (Nov. 2012), http://oig.hhs.gov/oei/reports/oei-02-09-00200.pdf
  - Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation, 0EI-07-1 0-004 22, (Oct. 2012), http://oig.hhs.gov/oei/reports/oei-07-10-00422.pdf
  - Nursing Facility Assessments And Care Plans For Residents Receiving Atypical Antipsychotic Drugs, OEI-07-08-00151, (July 2012), http://oig.hhs.gov/oei/reports/oei-07-08-00151.pdf
  - Gap S Continue To Exist In Nursing Home Emergency Preparedness And Response During Disasters: 2007–2010, OEI-06-09-00270, (April 2012), http://oig.hhs.gov/oei/reports/oei-06-09-00270.pdf
  - Nationwide Program for National and State Background Checks for Long-Term-Care Employees -Results of Long-Term-Care Provider Administrator Survey, OEI-07-10-00421, (Jan. 2012), http://oig.hhs.gov/oei/reports/oei-07-10-00421.pdf
  - Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011, OEI-02-09-00204, (July 2011), http://oig.hhs.gov/oei/reports/oei-02-09-00204.pdf
  - Medicare Hospices That Focus On Nursing Facility Residents, Oei-02-10-00070, (July 2011), http://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf
  - Payments/or Medicare Part B Services During Non-Part A Nursing Home Stays in 2008, OEI-06-07-00580, (July 2011), http://oig.hhs.gov/oei/reports/oei-06-07-00580.pdf
  - Medicaid Services Provided In An Adult Day Health Setting, OEI-09-07-00500, (July 2011), http://oig.hhs.gov/oei/reports/oei-09-07-00500.pdf
  - Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents, OEI-07-08-00150, (May 2011), http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf
  - Questionable Billing By Skilled Nursing Facilities, OEI-02-09-00202, (Dec. 2010), http://oig.hhs.gov/oei/reports/oei-02-09-00202.pdf

QUESTIONS????

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