PUBLICATION

OIG's 2014 Work Plan: A Roadmap to Key OIG Fraud and Abuse Priorities [Ober|Kaler]

2014

The Department of Health and Human Services, Office of the Inspector General (OIG) released its Fiscal Year (FY) 2014 Work Plan on January 31, 2014. While the OIG usually releases its work plan in October of each year, in August of 2013, it notified the provider community that release of the 2014 Work Plan was to be delayed by several months.

The Work Plan provides a description of what the OIG will be focusing on in the coming year, giving providers insight into what the OIG believes are areas prone to fraud, waste and abuse. Throughout the year, the OIG will adjust its Work Plan by responding to emerging issues. The OIG submits a Semiannual Report to Congress describing findings and recommendations from recently completed reviews and details significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations.

The Work Plan identifies a number of OIG initiatives that affect hospital, skilled nursing facilities, hospices, home health agencies, durable medical equipment suppliers, physicians, and prescription drugs, among others. Additional OIG initiatives will address the Affordable Care Act (ACA), electronic health records (EHR), and Medicaid. The 2014 Work Plan introduces “new” initiatives that represent a new focus for FY 2014 and revisits “continuing” initiatives that were previously addressed in the FY 2013 Work Plan.

Providers should review the OIG Work Plan to determine whether any areas represent a compliance risk, and update their compliance plans accordingly.

Hospitals

New Initiatives

- *New inpatient admission criteria:* The OIG will determine the impact of new inpatient admission criteria on hospital billing, Medicare payments, and beneficiary payments. The review will also determine how billing varied among hospitals in FY 2014.
- *Comparison of provider-based and free-standing clinics:* The OIG will review and compare Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals' claiming provider-based status for such facilities.
- *Outpatient evaluation and management (E/M) services billed at the new-patient rate:* The OIG will review Medicare outpatient payments made to hospitals for E/M services for clinic visits billed at the new-patient rate to determine whether the service was appropriate.
- *Nationwide review of cardiac catheterization and heart biopsies:* The OIG will review Medicare payments for right heart catheterizations and heart biopsies billed during the same operative session and determine whether hospitals complied with Medicare billing requirements.
- *Indirect medical education payments:* The OIG will review provider data to determine whether hospitals' indirect medical education payments were made in accordance with federal regulations and guidelines.

- *Hurricane Sandy—Case study of hospitals' emergency preparedness and response:* The OIG will assess and describe hospital preparedness and response during Hurricane Sandy. The study will include an assessment of the emergency preparedness of hospitals in selected counties affected, including the hospitals' participation in the Public Health Emergency Preparedness Cooperative Agreements program funded through the Centers for Disease Control and Prevention and the Hospital Preparedness Program funded through the Office of the Assistant Secretary for Preparedness and Response.
- *Oversight of hospital privileging:* The OIG will determine how hospitals assess medical staff candidates prior to granting initial privileges, including verification of credentials and review of the National Practitioner Databank.

Continuing Initiatives

- *Critical access hospitals (CAHs)—Payment policy for swing-bed services:* The OIG will compare reimbursement for swing-bed services at CAHs to the same level of care obtained at traditional skilled nursing facilities (SNF) to determine whether Medicare could achieve cost savings through a more cost effective payment methodology.
- *Long-term-care hospitals (LTCHs)—Billing patterns associated with interrupted stays:* The OIG will identify readmission patterns in LTCHs to determine the extent to which LTCHs readmit patients after a certain number of days, thereby billing Medicare for higher paying new stays and separate payments instead of for interrupted stays. The OIG will also determine the extent to which co-located LTCHs readmit patients from the providers with which they are co-located and the extent to which Medicare made improper payments associated with LTCH readmissions in 2011.
- *Selected inpatient and outpatient billing requirements:* The OIG will review Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements.
- *Duplicate graduate medical education (GME) payments:* The OIG will review provider data from CMS's Intern and Resident Information System (IRIS) to determine whether hospitals received duplicate or excessive GME payments. The OIG will assess the effectiveness of IRIS in preventing duplicate payments for GME costs.
- *Inpatient rehabilitation facilities—Adverse events in post-acute care for Medicare beneficiaries:* The OIG will estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care in inpatient rehabilitation facilities.

Physicians

New Initiatives

- *Chiropractic services—Questionable billing and maintenance therapy:* The OIG will determine the extent of questionable billing for chiropractic services as well as identify trends suggestive of maintenance therapy billing.

Continuing Initiatives

- *Diagnostic radiology—Medical necessity of high-cost tests:* The OIG will continue to review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which utilization has increased for these tests.
- *Evaluation and management (E/M) services—Inappropriate payments:* The OIG will determine the extent to which selected payments for E/M services were inappropriate. The OIG will also review multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities.

- *Imaging services—Payments for practice expenses:* The OIG will review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices.
- *Physicians and suppliers—Noncompliance with assignment rules and excessive billing of beneficiaries:* The OIG will review the extent to which physicians and suppliers participated in Medicare and accepted claim assignment during 2012. The OIG will also assess the effects of their participation and claim assignments on the Medicare program (such as noncompliance with assignment rules) and on beneficiaries (such as excessive billing of beneficiaries' share of charges).

Nursing Homes

New Initiatives

- *Medicare Part A billing by skilled nursing facilities (SNFs):* Prior OIG work found SNFs not only have high billing error rates, but that they are increasingly billing for the highest level of therapy (despite the fact that beneficiary characteristics have remained largely unchanged). As a result, the OIG plans to describe SNF billing practices in selected years and any variation in billing among SNFs in those years.

Continuing Initiatives

- *Questionable billing patterns for Part B services during nursing home stays:* The OIG intends to identify “questionable billing patterns” associated with nursing home and Medicare providers for Part B services provided to residents during stays not paid under Part A (e.g., stays during which benefits are exhausted or the 3-day prior inpatient stay requirement is not met).
- *Hospitalization of nursing home residents for manageable and preventable conditions:* The OIG plans to determine the extent to which Medicare beneficiaries residing in nursing homes are hospitalized as a result of conditions thought to be manageable or preventable in the nursing home setting.

Hospice

New Initiatives

- *Hospice in assisted living facilities (ALFs):* Noting that ALF residents have the longest lengths of stay in hospice care, the OIG intends to review the extent to which hospices serve Medicare beneficiaries who reside in ALFs, and to determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs.

Continuing Initiatives

- *Hospice general inpatient care:* The OIG has stated it will continue to assess the appropriateness of hospices' general inpatient care claims, the content of election statements for hospice beneficiaries who receive general inpatient care, and hospice medical records, in order to address concerns that this level of hospice care is being misused.

Home Health Services

Continuing Initiatives

- *Home health prospective payment information:* A prior OIG report found that one in four HHAs had questionable billing practices. In light of such findings, and CMS's designation of newly enrolling HHAs as high-risk providers, the OIG intends to review compliance with various aspects of the home health prospective payment system, including Medicare documentation requirements.

- *Employment of individuals with criminal convictions:* The OIG will determine the extent to which home health agencies are complying with state requirements for conducting criminal background checks on HHA applicants and employees.

Durable Medical Equipment and Supplies

New Initiatives

- *Reasonableness of Medicare's fee schedule amounts for selected medical equipment items compared to amounts paid by other payers:* The OIG's review will determine the reasonableness of the Medicare fee schedule amount for various medical equipment items, including commode chairs, folding walkers, and transcutaneous electrical nerve stimulators, by comparing Medicare payments for such items to the amounts paid by non-Medicare payers.
- *Power mobility devices (PMD)—Add-on payment for face-to-face examination:* The OIG intends to review Medicare Part B payments for PMD to determine whether the Medicare requirements for a face-to-face examination were met.
- *Nebulizer machines and related drugs—Supplier compliance with payment requirements:* The OIG intends to review Medicare Part B payments for nebulizer machines and related drugs to determine whether medical equipment suppliers' claims for nebulizers and related drugs are in fact medically necessary, and are supported in accordance with Medicare requirements.

Continuing Initiatives

- *Parenteral nutrition—Reasonableness of Medicare payments compared to payments by other payers:* Noting Medicare allowances for parenteral nutrition averaged 45 percent higher than Medicaid prices, 78 percent higher than prices available to Medicare risk-contract health maintenance organizations, and 11 times higher than some manufacturer's contract prices, the OIG intends to asses the reasonableness of Medicare reimbursement rates for parenteral nutrition compared to amounts paid by other payers.
- *Frequently replaced supplies—Supplier compliance with medical necessity, frequency, and other requirements:* The OIG will review claims for frequently replaced medical equipment supplies to determine whether medical necessity, frequency, and other Medicare requirements are met. Prior OIG work determined that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies without current physician orders for refills.

Prescription Drugs

New Initiatives

- *Manufacturer reporting of average sales prices (ASPs) for Part B drugs:* The OIG intends to determine the potential effect on ASP reporting if all manufacturers of Part B-covered drugs were required to submit ASPs to CMS.
- *Part B payments for drugs purchased under the 340B Program:* The OIG will determine how much Medicare Part B spending could be reduced if Medicare were able to share in the savings for 340B-purchased drugs.

Continuing Initiatives

- *Payments for outpatient drugs and administration of the drugs:* The OIG indicated it will review Medicare outpatient payments to providers for certain drugs (e.g., chemotherapy drugs) and the administration of the drugs to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units.

Affordable Care Act

Key, new priority areas include

- *Payment Accuracy:* The OIG intends, among other "payment accuracy" initiatives, to determine the validity of payment amounts and assess the effectiveness of HHS internal controls to pay Advanced Premium Tax Credit and Cost Sharing Reduction subsidy amounts, and evaluate CMS's efforts to ensure accurate reporting and payments in the risk corridors program.
- *Eligibility Systems:* The OIG noted that it will assess the effectiveness of internal controls currently in place to ensure that accurate information is used by a marketplace to determine consumer eligibility for enrollment and subsidy payments.
- *Security of Data and Consumer Information:* The OIG will determine whether information security controls for CMS's Web infrastructure, which hosts the federally facilitated marketplace, have been implemented in accordance with CMS information security standards, recognized industry best practices, and federal information security standards. The OIG indicated it plans to perform a similar assessment for state-based marketplaces.

Adoption of Electronic Health Records

Key, new priority areas include

- *Security of Certified Electronic Health Record (EHR) Technology under Meaningful Use:* The OIG will audit various covered entities receiving EHR incentive payments from CMS and their business associates, such as EHR cloud service providers, to determine whether they adequately protect electronic health information created or maintained by certified EHR technology.

Medicaid

New Initiatives

- *Medicaid eligibility determinations in selected states:* The OIG will review Medicaid eligibility determinations in selected states. The OIG will calculate a Medicaid eligibility error rate.
- *Medicaid managed care reimbursement:* The OIG will review states' managed care plan reimbursements to determine whether managed care organizations are appropriately and correctly reimbursed for services provided.

Continuing Initiatives

- *Home health services—provider and beneficiary eligibility:* The OIG will continue to review HHA claims to State Medicaid programs to determine whether the billing providers met applicable criteria to provide home health services to Medicaid beneficiaries. The OIG will also determine whether the beneficiaries met the criteria to receive such services.

Ober|Kaler's Comments

It is critical that providers review the OIG Work Plan to identify specific compliance risk areas. Additional OIG publications that may inform compliance-risk assessments for the coming year include the OIG's Strategic Plan for 2014 to 2018 [PDF] and the OIG's 2014 budget request to Congress [PDF]. Compliance plans should be updated following such a review.

As evidenced by the OIG Work Plan, and as discussed in its 2014 budget request to Congress, the OIG is currently attempting to adapt its oversight approach to a “changing health care system.” The OIG is not only seeking to address health spending, but also the shift from volume-based to value-based payment, advances in quality measurement, the impact of increased access to care under the ACA, and the growing use of EHRs.