

PUBLICATION

OIG's 2015 Work Plan Highlights Departmental Priorities [Ober|Kaler]

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Each year the Department of Health and Human Services, Office of the Inspector General (OIG) issues its Work Plan to identify for the provider community the key fraud and abuse issues on which it will focus on in the coming year, though the OIG may adjust its Work Plan during the year to respond to emerging issues. The OIG released its [Fiscal Year \(FY\) 2015 Work Plan](#) on October 31, 2014. In the 2015 Work Plan, the OIG recognized a number of topics that relate to hospitals, nursing homes, hospices, home health agencies, durable medical equipment (DME) suppliers, and prescription drugs, among others. Many issues in the 2015 Work Plan are continuations of issues identified in prior years. Providers may utilize this information, together with other available guidance, to develop effective and targeted compliance.

Hospitals

New Initiatives

- *Medicare oversight of provider-based status:* The OIG plans to evaluate the extent to which provider-based facilities actually meet the CMS rules for such facilities.
- *Review of hospital wage data used to calculate Medicare payments:* The OIG will assess the level of hospital control over the reporting of wage data, which is used to calculate wage indexes for Medicare payments. In prior reviews, the OIG identified hundreds of millions of dollars in incorrectly reported wage data.
- *Long-term-care hospitals—Adverse events in post-acute care for Medicare beneficiaries:* The OIG will review adverse and temporary harm events to estimate the national incidence of, and costs to Medicare associated with, such events. The OIG plans to identify factors that contribute to those events, and to determine whether the events were preventable.

Continuing Initiatives

- *Inpatient admission criteria:* After previous examinations discovered millions of dollars of overpayments to hospitals for short inpatient stays, the OIG plans to dedicate time and resources to study both hospital billing variances from FY 2014 and the effect the “two midnight rule” has on beneficiary copayments, Medicare payments, and hospital billing.
- *Reconciliation of outlier payments:* The OIG will analyze Medicare outlier payment data to determine whether necessary reconciliations were performed in a timely manner. In addition, the OIG will evaluate whether Medicare contractors refer for consideration all outlier-qualifying hospitals.
- *Selected inpatient and outpatient billing requirements:* The OIG will assess acute care hospital compliance with selected billing requirements. This analysis may result in an effort to recover overpayments.
- *Duplicate graduate medical education (GME) payments:* Using data from CMS's Intern and Resident Information System (IRIS), the OIG will determine whether hospitals received duplicate or excessive GME payments. The OIG will analyze IRIS's ability to prevent duplicate payments.
- *Indirect medical education (IME) payments:* The OIG will determine whether IME payments were properly calculated, and whether they were made in accordance with published regulations and guidelines.

- *Outpatient dental claims:* Recent OIG audits indicated that hospitals are receiving Medicare reimbursement for dental services, which are generally excluded from Medicare coverage. In 2015, the OIG plans to further review hospital outpatient payments for dental services.
- *Outpatient evaluation and management (E/M) services billed at the new-patient rate:* The OIG plans to assess whether payments made for E/M services provided during clinic visits and billed at the new patient rate were appropriate, or whether the services should have been identified as services for established patients. This review may result in the OIG recommending recovery of overpayments.
- *Nationwide review of right heart catheterizations (RHC) and endomyocardial biopsies:* The OIG will review payments for RHCs and endomyocardial biopsies to assess whether hospitals complied with the associated billing requirements.
- *Payments for patients diagnosed with kwashiorkor:* The OIG will analyze whether payments made to hospitals related to a kwashiorkor diagnosis were sufficiently supported by medical record documentation.
- *Participation in projects with quality improvement organizations (QIOs):* The OIG will assess hospital participation in QIOs and will determine the extent to which QIO projects overlap with similar initiatives offered by non-QIO entities.
- *Oversight of pharmaceutical compounding:* In light of the 2012 meningitis outbreak stemming from contaminated injections, the OIG plans to evaluate Medicare's oversight of compounding in acute care hospitals, and whether it addresses suggested practices.
- *Oversight of hospital privileging:* The OIG will review how hospitals assess potential medical staff members before granting initial privileges. Its review will address the processes hospitals use to verify credentials and to check the National Practitioner Databank.
- *Inpatient rehabilitation facilities—Adverse events in post-acute care for Medicare beneficiaries:* The OIG will study adverse and temporary harm events for Medicare beneficiaries receiving care at inpatient rehabilitation facilities (IRFs). The OIG plans to approximate the incidence of such events, identify contributing factors, determine whether the events were preventable, and estimate the related Medicare costs.

Nursing Homes

Continuing Initiatives

- *Medicare Part A billing by skilled nursing facilities (SNFs):* After discovering that SNFs billed a fourth of all 2009 claims in error, the OIG intends to identify changes in SNF billing practices from 2011 to 2013.
- *Questionable billing patterns for Part B services during nursing home stays:* Through a series of studies, the OIG will detect questionable billing patterns tied to nursing homes and Medicare providers of Part B services provided to nursing home residents during stays not reimbursed through the Part A benefit.
- *State agency verification of deficiency corrections:* Following prior OIG reviews that discovered a lack of verification, the OIG will assess whether state survey agencies actually verified correction plans for deficiencies identified during nursing home recertification surveys.
- *Program for national background checks for long-term-care employees:* The OIG will review the background check procedures for prospective employees and providers who could have direct access to patients. In addition, the OIG will evaluate both the cost and the outcomes of those procedures.
- *Hospitalizations of nursing home residents for manageable and preventable conditions:* The OIG will analyze the extent to which Medicare beneficiaries are hospitalized as a result of manageable or preventable conditions from their nursing homes.

Hospices

Continuing Initiatives

- *Hospices in assisted living facilities:* To assist CMS in its efforts to reform the hospice payment system, the OIG will examine how hospices serve Medicare beneficiaries residing in assisted living facilities (ALF). Specifically, the OIG will review the length of stay and level of care received, and will identify the common terminal illnesses of those beneficiaries who receive hospice care in an ALF.
- *Hospice general inpatient care:* Given that hospice care is palliative and not curative in nature, the OIG plans to assess the use of hospice general inpatient care. In its assessment, The OIG will review medical records, claims, and hospice election statements to determine whether the use of hospice general inpatient care was appropriate.

Home Health Services

Continuing Initiatives

- *Home health prospective payment system requirements:* In light of the identification of questionable billing practices and of nearly \$1 billion in improper payments and fraud since 2010 in the home health context, the OIG plans to closely evaluate whether home health claims were paid in accordance with federal laws and regulations. In addition, the OIG will analyze the degree of compliance with the home health prospective payment system and the related documentation requirements.
- *Employment of individuals with criminal convictions:* The OIG will examine how often HHAs employ individuals with criminal convictions, and will review the potentially disqualifying convictions of selected employees.

Medical Equipment and Supplies

Continuing Initiatives

- *Competitive bidding for medical equipment items and services—Mandatory post award audit:* The OIG will review the process CMS used to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program.
- *Competitive bidding for diabetes testing supplies—Market share review:* The OIG will determine the market share of different types of diabetes test strips for the three-month period from October through December 2013 because CMS has requested the study to potentially use the results for program analysis purposes and for evaluating the effect of the competitive bidding program on test strip choice.
- *Power mobility devices—Supplier compliance with payment requirements:* The OIG will review Medicare Part B payments for suppliers of PMDs to determine whether such payments comply with Medicare requirements (at 42 C.F.R. § 410.38) and are medically necessary.
- *Power mobility devices—Add-on payment for face-to-face examination:* The OIG will review Medicare Part B payments for PMDs 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 will 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.
- *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.

- *Diabetes testing supplies—Supplier compliance with payment requirements for blood glucose test strips and lancets:* The OIG's previous reviews determined that suppliers of diabetic-related supplies have not always complied with the federal requirements for coverage. The OIG will review Medicare Part B payments for home blood glucose test strips and lancet supplies to determine their medical appropriateness.
- *Diabetes testing supplies—Effectiveness of system edits to prevent inappropriate payments for blood glucose test strips and lancets to multiple suppliers:* Prior OIG work has found that inappropriate payments were made to multiple suppliers of test strips and lancets that which were dispensed to the same beneficiaries with overlapping service dates. The OIG will review Medicare's claims processing edits, which are designed to prevent payments to multiple suppliers of home blood glucose test strips and lancets, and determine whether the edits are effective in preventing inappropriate payments.

Other Providers and Suppliers

New Initiatives

- *Selected independent clinical laboratory billing requirements:* The OIG will review Medicare payments to independent clinical laboratories to determine whether the laboratories have complied with certain billing requirements. The OIG will then use these reviews to identify clinical laboratories that have routinely submitted improper claims and, if improper claims exist, will recommend recovery of overpayments.

Continuing Initiatives

- *Ambulatory surgical centers—Payment system:* The OIG will review the appropriateness of Medicare's methodology for determining ambulatory surgical center (ASC) payment rates under the revised payment system. The OIG will also determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings.
- *End-stage renal disease (ESRD) facilities—Payment system for renal dialysis services and drugs:* The OIG will review Medicare payments for utilization of renal dialysis services and related drugs under the new bundled ESRD prospective payment system (PPS). The OIG will then compare the ESRD facilities' acquisition costs for certain drugs to inflation-adjusted cost estimates and determine how the costs for the drugs have changed.
- *Ambulance services—Questionable billing, medical necessity, and level of transport:* The OIG has found that Medicare has made inappropriate payments for advanced life support emergency transports. The OIG will review Medicare claims data to assess the extent of questionable billing for ambulance services, e.g., transports that potentially never occurred or potentially were medically unnecessary transports to dialysis facilities. Further, the OIG will determine whether Medicare payments for ambulance services were made in accordance with the applicable Medicare requirements.
- *Ambulance services—Portfolio report on Medicare Part B payments:* Prior OIG work identified fraud schemes and trends indicating overuse and medically unnecessary payments related to ground ambulance transport services paid by Medicare Part B. The OIG plans to synthesize its evaluations, audits, investigations, and compliance guidance related to these ground ambulance transport services to identify vulnerabilities, inefficiencies, and fraud trends.
- *Anesthesia services—Payments for personally performed services:* The OIG will review Medicare Part B claims for personally performed anesthesia services to determine whether the services met

Medicare requirements. The OIG will also determine whether Medicare payments for anesthesia services reported on a claim with the “AA” service code modifier met Medicare requirements.

- *Chiropractic services—Part B payments for non-covered services:* Previously, the OIG determined that inappropriate payments were made for chiropractic services. The OIG will review Medicare Part B payments for chiropractic services to determine whether such payments met Medicare requirements.
- *Chiropractic services—Questionable billing:* The OIG will determine the extent of questionable billing for chiropractic services as well as identify trends suggestive of maintenance therapy billing.
- *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.
- *Physicians—Place-of-service coding errors:* The OIG will review physicians' coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether the claims were properly coded for places of service. Prior OIG reviews revealed that physicians did not always correctly code non-facility places of service on submitted Part B claims.
- *Physical therapists—High use of outpatient physical therapy services:* The OIG will review outpatient physical therapy services provided by independent therapists to determine whether the services complied with Medicare reimbursement regulations. Previous work by OIG found that therapy services claims provided by independent physical therapists were not: reasonable, properly documented, or medically necessary.
- *Portable x-ray equipment—Supplier compliance with transportation and setup fee requirements:* The OIG will review Medicare payments for portable x-ray equipment services to determine whether payments were correct and were supported by documentation. Further, the OIG will assess the qualifications of the technologists who performed the services. Prior OIG work found that Medicare may have improperly paid portable x-ray suppliers for return trips to nursing facilities such as multiple trips to a facility in one day.
- *Sleep disorder clinics—High use of sleep-testing procedures:* The OIG previously analyzed Medicare payments in CY 2010 for Current Procedural Terminology (CPT) codes 95810 and 95811, and the results showed high utilization of these procedures. The OIG will review Medicare payments made to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures. The OIG will assess whether the Medicare payments for the previously mentioned CPT codes were appropriate and determine whether the payments met Medicare requirements.

Prescription Drugs

Continuing Initiatives

- *Comparison of average sales prices to average manufacturer prices:* The OIG will review Medicare Part B drug prices by comparing average sales prices (ASPs) to average manufacturer prices (AMPs) and identify drug prices that exceed a designated threshold. The OIG is required to compare ASPs and AMPs pursuant to 42 U.S.C. 1395w3a(d)(2)(B).
- *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.
- *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.

Other Part A and Part B Program Management Issues

New Initiatives

- *Risk assessment of CMS's administration of the Pioneer Accountable Care Organization Model:* The OIG will conduct a risk assessment of the Pioneer Accountable Care Organization (ACO) Model and specifically focus on internal controls over administration of the Pioneer ACO Model.

Medicaid

Continuing Initiatives

- *States' use of Medicaid drug utilization review to reduce the inappropriate dispensing of opioids:* States have promulgated education and enforcement actions due to information generated by their drug utilization review (DUR) programs, which determine whether there has been inappropriate dispensing and potential abuse of prescription opiates. The OIG will review the education and enforcement actions that states have taken. Additionally, the OIG will review state oversight of Managed Care Organizations' DUR programs and any resulting actions related to inappropriate dispensing of opiates.
- *States' collection and reporting of rebates:* The OIG will ascertain the amount of offset rebates, that is the amount of drug manufacturer rebates attributed to the increase in Medicaid rebates under the Affordable Care Act, as reported by states. The OIG will also determine the amount of supplemental drug rebates that the states have collected during certain periods of time.
- *Dental services for children—Inappropriate billing:* The OIG will review the states' Medicaid payments for dental services to determine whether states have properly claimed federal reimbursement. Prior investigation by the OIG has indicated that some dental providers may have inappropriately billed for dental services.

Ober|Kaler Comments

It is critical that providers review the OIG Work Plan to identify specific compliance risk areas. In 2015, the OIG will be particularly interested in reducing waste in Medicare Parts A and B, while ensuring the quality of care and that appropriate payments were made. The OIG continues to focus its efforts on reducing improper payments, improving quality and access, and fostering economical payment policies. The OIG plans to expand its work regarding changes to Medicare programs designed to improve efficiency and quality of care and to promote program integrity and transparency.

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 2015 budget request to Congress \[PDF\]](#). We encourage providers to update their compliance plans in accordance with this report.