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CLIENT ADVISORY

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What a Treat: The OIG Releases the FY 2015 Work Plan

As October came to a close, many were left wondering whether this year's OIG Work Plan would be delayed until January as it was last year. The wait ended, however, on October 31, 2014 when the OIG posted the FY 2015 Work Plan. Despite its release ominously coinciding with Halloween, providers will see that this year's Work Plan is more "treat" than "trick" as the OIG has included only a handful of "new" initiatives. What this means is that providers can continue to work through some of the older initiatives and focus additional efforts on identifying their own internal risk areas.

I. New OIG Work Plan Projects for Hospitals

There are a few important additions to the FY 2015 Work Plan. These additions are for Medicare participating hospitals and include the following:

Review of hospital wage data used to calculate Medicare payments. Based on some prior work, the OIG has identified hundreds of millions of dollars of incorrectly reported wage data. Because hospital wage data is used to calculate wage index rates for prospective payments, incorrect wage data can lead to inaccurate Medicare payments. The OIG is specifically looking at the reporting of "deferred compensation" arrangements in light of recent policy changes. However, providers should review all compensation arrangements to ensure that they are accurately reporting wage data.

Long-term-care hospitals – adverse events in post-acute care for Medicare beneficiaries. Like many other initiatives focused on quality improvement in hospitals, the OIG has identified the need to review incidents of adverse and harmful events in long-term-care hospitals (LTCHs). As the OIG explains, LTCHs care for complex patients who are at a higher risk of adverse events. The OIG intends to review the incidents of adverse events, their causes, and whether these events are preventable.

Hospital's Electronic health record system contingency plans – The Health Insurance Portability and Accountability Act (HIPAA) has traditionally required covered entities, including hospitals, to develop a contingency plan that establishes policies and procedures for responding to an emergency or other occurrence that damages systems that contain protected health information. Concerned that hospitals may not have adequate plans in place, this year the OIG will conduct a review to determine the extent to which hospitals are complying with the contingency planning requirements. Hospitals' contingency plans will also be compared with government- and industry-recommended best practices. Hospitals should review their plans to ensure that they are adequately addressing these concerns or create policies and procedures if a contingency plan has not yet been developed.

II. Continuing OIG Work Plan Projects

While new initiatives are typically the predominant focus when the Work Plan is released, it is important not to overlook the OIG's older initiatives on the Work Plan that may still "haunt" providers. Many of these are highlighted below:

A. HOSPITALS

New inpatient admission criteria. In 2014, the OIG reviewed how the "Two-midnight" rule for inpatient admissions began to impact hospital billing, Medicare payments, and beneficiary payments. Many hospitals also saw increased Recovery Audit Contractor payment denials based on the two-midnight rule for services provided before the rule even took effect. Now, many providers are appealing these denials or taking advantage of a settlement option. The OIG was originally planning to release a report on the rule's impact in 2015. Due to the rule's implementation delay, that report is now expected in 2016.

Analysis of salaries included in hospital cost reports. Currently, "employee compensation may be included in allowable provider costs only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and furnished in connection with patient care." (*CMS's Provider Reimbursement Manual, Part 1, Pub. No. 15-1, Ch. 9 § 902.2.*) The OIG intends to review and analyze the data from cost reports to determine the impact that limits on those allowable costs have on the Medicare Trust Fund.

Comparison of provider-based and free-standing clinics. In 2011, 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. In 2014, the OIG began to review physician payment data and compared billing rates for similar services performed in provider-based clinics and free-standing clinics. The report on the review is expected in 2015.

Outpatient evaluation and management (E&M) services billed at the new-patient rate. The rate at which Medicare reimburses E&M is generally higher if a patient is identified as either "new" rather than "established." A patient should only be identified as "new" if the patient has not received professional services from the physician or physician group within the last three years. Starting in 2014, the OIG sought to determine how often "new" patient E&M codes were billed for "established" patients. Based on its continuing review, the OIG will make appropriate overpayment and retraction recommendations for providers that have still not corrected billing practices.

Oversight of pharmaceutical compounding. In the wake of a 2012 meningitis outbreak resulting from contaminated compounded drug injections, the OIG will continue to review Medicare's role in overseeing on-site pharmaceutical compounding in Medicare-participating acute care hospitals. Hospitals have seen an increase in accreditation and certification enforcement actions related to pharmacy compounding services. This year, the OIG will examine whether that oversight has addressed the best practices for pharmacy compounding.

Oversight of hospital privileging. Medicare-participating hospitals are already required to adopt privileging and credentialing programs that ensure medical staff members are adequately assessed and their credentials are verified. In anticipation of OIG scrutiny, hospitals should review their current policies and procedures on medical staff privileging to ensure compliance with applicable requirements.

Compliance with selected billing requirements. The OIG will also continue to determine hospitals' compliance with selected billing requirements. The Work Plan does not specifically mention which billing practices the OIG will select but providers are encouraged to read periodic reports published on the OIG's Office of Audit Services website (https://oig.hhs.gov/reports-and-publications/oas/cms.asp) for additional guidance.

B. LONG-TERM/POST-ACUTE CARE PROVIDERS

Medicare Part A billing by skilled nursing facilities (SNF). Prior OIG work identified that SNFs were increasingly billing for the highest levels of therapy despite the fact that beneficiary characteristics had remained largely unchanged. This suggests that SNFs are up-charging for skilled therapy services. SNFs should take the opportunity to review historical therapy claims to ensure that the level of therapy provided matches the patient's documented acuity.

State agency monitoring of deficiency corrections. The OIG will continue to assess whether state agencies are adequately and accurately monitoring deficiency corrections following on-site surveys. CMS requires state agencies to perform periodic on-site surveys of Medicare participating nursing homes to review compliance with Medicare Conditions of Participation. If deficiencies are cited during a survey, the nursing home must submit an acceptable plan of correction. Previous OIG investigations revealed that some state agencies do not follow-up with nursing homes to ensure that the nursing home has taken the corrective actions outlined in the plan of correction.

Hospice in assisted living facilities ("ALFs"). Recent analysis has shown that patients receiving hospice care in ALFs tend to have the longest lengths of stay. The OIG plans to continue to closely monitor and examine ALF hospice services to assess the necessity and impact of these long stays.

Home Health Agency ("HHA") criminal background check enforcement. Nearly all states have laws that prohibit HHAs from hiring employees with prohibited criminal convictions. The OIG has continued to review the extent to which HHAs are complying with State background check laws, particularly in light of a study which suggested that nearly 92% of nursing homes retained employees with criminal convictions of some kind. It is important that HHAs strengthen policies related to hiring practices and annually review personnel records for current employee criminal background checks.

C. DME SUPPLIERS

Nebulizer machines and related drugs—supplier compliance with payment requirements. In 2015, the OIG will continue to review claims for nebulizers and related inhaled drugs. The OIG suggests that suppliers are not following local coverage determinations and are being overpaid by approximately $46 million for these items and related drugs.

D. OTHER PROVIDERS

Physician billing errors. The OIG will continue efforts in 2015 to review and identify issues with physician billing practices. Specifically, the OIG will investigate incidences where and examine the frequency with which providers are incorrectly using facility-based Place of Service codes when patients are actually treated in nonfacility settings. Physicians and group practice should use this opportunity to review historical claims data to ensure that any payment issues noted in the Work Plan are corrected before they are scrutinized by the OIG.

Chiropractic services—questionable billing and maintenance therapy. As it has in previous years, the OIG will continue to review chiropractic claims to determine if chiropractors are providing covered services. This includes billing for services for which there is a reasonable expectation of recovery or improvement of function.

E. PRESCRIPTION DRUGS

The OIG intends to focus on comparisons between the Average Sales Price (ASP) of Part B drugs and the Average Manufacturer Price (AMP). Although Part B drugs are currently reimbursed at the ASP, the enabling statue allows CMS to disregard the ASP when the AMP is more than 5% lower than the ASP. This review will likely end in some further cuts to reimbursement for Part B drugs.

Part B payments for drugs purchased under the 340B program. The OIG is looking to assess how much savings could be realized by pulling back on how much money providers get to keep under the 340B drug program. Right now, providers keep all of the difference between the discounted 340B purchase price and the full ASP-based Medicare reimbursement rate. This initiative suggests that Medicare is looking to start sharing in the savings, ultimately reducing the benefit to individual providers.

Covered uses for Medicare Part B drugs. Although providers are permitted to, and often do, prescribe FDA-approved drugs for "off-label" uses, Medicare Part B only covers "off-label" use drugs when such use is supported in major drug compendia or when "off-label" use is supported by clinical evidence in authoritative medical literature. Thus, the OIG plans to review Part B drug use to ensure that any off-label use of Part B-covered drugs is adequately supported by evidence-based literature.

Despite the lack of new initiatives, the OIG will continue to scrutinize providers on previously released initiatives. As 2014 comes to an end, providers should review the progress they have made over the last year and develop next year's risk assessment and action plans that will guide compliance activity in the coming year.

If you have questions regarding the Work Plan or need assistance with developing your annual compliance risk assessment and action plans, please contact a member of HDJN's Compliance Team: Mary C. Malone (mmalone@hdjn.com), Michelle E. Calloway (mcalloway@hdjn.com), and Thomas E. Miller (tmiller@hdjn.com). They can be reached by phone at (866) 967-9604. Additional information about Hancock, Daniel, Johnson & Nagle, P.C., is available on the firm's website at www.hdjn.com.