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CLIENT ADVISORY

February 5, 2014

Time to Get to Work: The OIG Work Plan for 2014

As promised, The Department of Health and Human Services Office of the Inspector General (OIG) published its Fiscal Year (FY) 2014 Work Plan on January 31, 2014, nearly four months past its usual October release date. Each year, the OIG publishes the Work Plan as a report and roadmap of ongoing and new HHS projects that the OIG intends to pursue. Though the Work Plan pertains to all HHS programs, including the National Institute of Health (NIH), Food and Drug Administration (FDA), the Centers for Disease Control (CDC), and the Administration for Children and Families (ACF), the OIG's primary function is to protect the integrity of the health plans operated under the Centers for Medicare and Medicaid Services (CMS).

The Work Plan provides a unique opportunity for providers to take a look at the issues that the OIG has determined to be most worthy of attention and resources. Thus, providers are always encouraged to review the OIG Work Plan and tailor their own internal compliance program resources to address the identified issues that are applicable to their provider type. Among the many returning initiatives in the OIG's Work Plan, several additions have made the list. Some of the most noteworthy additions are summarized below:

I. New OIG Work Plan Projects

The OIG has identified a number of "new" projects for FY 2014. "New" projects indicate that the OIG will be gathering data, trends and statistics on the identified compliance areas to make recommendations to other agencies on how certain practices should either be changed or enforced. Many OIG projects culminate in a report to Congressional committees, the DOJ or to Medicare policy makers. Therefore, "new" projects on the OIG Work Plan should serve as a guide for providers on how to avoid becoming an OIG statistic in the coming year

A. HOSPITALS

New Inpatient Admission Criteria. In 2014, the OIG will review how the new "Two-midnight" rule for inpatient admissions will impact hospital billing, Medicare payments, and beneficiary payments. A report is expected in 2015; however, recent delays in implementation of the two-midnight rule's financial penalties will likely delay any substantive work that the OIG can accomplish this year.

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 new limits on those allowable costs would 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. Beginning in 2014, the OIG will begin to review physician payment data and compare billing rates for similar services performed in provider-based clinics and free-standing clinics. This comes after the OIG sent an "Information Request" targeting provider-based hospital departments in May, 2013. The report on the review is expected in 2014 and will likely lead to standardized payments for similar services across all providers.

Outpatient E&M Services Billed at the New-Patient Rate. The rate at which Medicare reimburses evaluation and management is generally higher if a patient is identified as either "new" or "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 will review claims data to determine how often "new" patient E&M codes were billed for "established" patients. Based on the review, the OIG will make appropriate

overpayment and retraction recommendations.

Oversight of Pharmaceutical Compounding. In the wake of recent widespread meningitis outbreaks resulting from contaminated compounded drug injections, the OIG will begin reviewing Medicare's role in overseeing on-site pharmaceutical compounding in Medicare-participating acute care hospitals. As a result, hospitals will likely see an increase in accreditation and certification enforcement actions related to pharmacy compounding services.

Oversight of Hospital Privileging. Medicare-participating hospitals are already required to adopt privileging and credentialing programs that ensure that the hospital's medical staff members are adequately assessed and their credentials are verified. Hospitals should review their current policies and procedures for medical staff privileging because starting in 2014, the OIG will be reviewing hospital policies to determine how hospitals are meeting this requirement.

B. LONG TERM/POST-ACUTE CARE PROVIDERS

Medicare Part A Billing by Skilled Nursing Facilities (SNF). The only new initiative fir SNFs on the OIG's Work Plan for 2014 relates to a multi-year review of SNF Part A billing practices. The review stems from prior OIG work that identified that SNFs are increasingly billing for the highest levels of therapy despite the fact that beneficiary characteristics have remained largely unchanged. The prior work suggests that SNFs are up-charging for skilled therapy services. SNFs should take the opportunity to review historical therapy claims to ensure that the levels of therapy services match the patient's documented acuity.

Hospice in Assisted Living Facilities (ALF). Recent analysis has shown that patients receiving hospice care in ALFs tend to have the longest lengths of stay in hospice. Thus, the OIG has determined to closely monitor and examine ALF hospice services to assess the necessity and impact of these long stays.

C. DME SUPPLIERS

Reasonableness of Medicare's Fee Schedule Amounts for Selected Medical Equipment Items. Pricing of certain Medicare -covered supplies and equipment will likely see cuts after the OIG completes its 2014 review. Prior OIG work suggests that Medicare is paying more than non-Medicare payers for the same medical supplies and equipment. Therefore, CMS will be making efforts to more closely align Medicare fee schedules with those of non-Medicare payers.

Nebulizer Machines and Related Drugs—Supplier Compliance with Payment Requirements. In 2014, the OIG will complete a review of 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 Services. The OIG added no "new" objectives to the Work Plan specific to physicians.

Chiropractic Services—Questionable Billing and Maintenance Therapy. Despite recent news and CMS manual guidance clarifying that CMS does not adopt an "improvement standard" for traditional outpatient therapies (OT, PT, SLP), the OIG reiterates that chiropractic therapy services are only covered by Medicare to the extent there is "a reasonable expectation of recovery or improvement of function." Because Medicare does not reimburse for chiropractic maintenance therapy, the OIG will be reviewing claims in 2014 to determine the extent of questionable billing for chiropractic maintenance therapy services.

Mental Health Providers—Medicare Enrollment and Credentialing. The OIG will review standards and offer guidance for Medicare's mental health provider enrollment and credentialing requirements. Ultimately, CMS will be assessing whether various mental health providers are properly qualified to meet Medicare's general provider enrollment standards as well as specific standards for licensure within their states.

E. PRESCRIPTION DRUGS

Manufacturer Reporting of Average Sales Prices (ASP) for Part B Drugs. The OIG has recommended that CMS seek a legislative change that would require all manufacturers of Part B-covered drugs to submit ASP data. Many manufacturers are not already obligated by existing contracts that require such disclosure to CMS. The intent is to collect sufficient data to ensure that Medicare sets appropriate reimbursement levels for Part B-covered 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 will begin reviewing Part B drug use to ensure that any off-label use of Part B-covered drugs is adequately supported by evidence-based literature.

Payment for Compounded Drugs under Medicare Part B. Medicare pays for compounded drugs only when those drugs are produced in accordance with the standards set forth in the Food Drug & Cosmetic Act. This year, the OIG will be reviewing the MAC's policies and procedures to determine how MAC are reviewing and paying compound drug claims to ensure that such drugs have been properly produced and, thus, properly paid.

II. Continuing OIG Work Plan Projects

During the next year, providers can expect the same level of pressure from the OIG as it continues to target questionable billing practices and documentation. Areas where providers can expect to see continued scrutiny in the coming year are described below:

A. HOSPITALS

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.

Long Term Care Hospital (LTCH) Payments for Interrupted Stays. The OIG will continue looking at the frequency of billing errors for interrupted LTCH stays. Prior analysis uncovered vulnerabilities in CMS' ability to detect readmissions and interrupted stays in the LTCH setting. LTCH providers are encouraged to continue reviewing records for interruptions or readmissions that could be subject to billing adjustments.

B. LONG TERM/POST-ACUTE CARE PROVIDERS

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.

HHA Criminal Background Check Enforcement. Nearly all states have laws which prohibit HHAs from hiring employees with prohibited criminal convictions. The OIG has continued to review the extent that HHAs are complying with State background check laws in light of a recent 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 evaluate personnel records for current employee criminal background checks.

C. DME SUPPLIERS

Compliance with Payment Requirements. The Work Plan for DME suppliers historically focuses on reviewing compliance with payment requirements. To that end, projects continuing in FY 2014 include assessing compliance with billing for supplies furnished for diabetes testing, lower limb prostheses, and power mobility devices. As with previous years, when OIG and CMS audits reveal that documentation does not support medical necessity, payments for such supplies will likely be flagged for overpayment and recoupment.

D. PHYSICIANS

Physician Billing Errors. The OIG will continue efforts in 2014 to review and identify issues with physician billing practices. Specifically, the OIG will examine the frequency with which providers are excessively billing Medicare beneficiaries who assign their Part B benefits to their physician. The OIG will also continue to investigate

the incidences of physician billing for the wrong place-service-codes. Physicians and group practice should use this opportunity to review historical claims data to ensure that any payment issues as identified by the Work Plan are corrected before they are scrutinized by the OIG.

As outlined above, the OIG has many "new" and continuing objectives it plans to focus on in 2014. We have included those projects we anticipate will likely have the most impact on providers. Healthcare providers are, nevertheless, encouraged to review the OIG Work Plan in its entirety and utilize it to assist in developing an annual compliance risk assessment and action plan. A full copy of the OIG Work Plan for FY 2014 can be downloaded by visiting the OIG's website at http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf.

If you have questions regarding the Work Plan or need assistance with developing your annual compliance risk assessment, please contact a member of HDJN's Risk Management and Compliance Team:

Mary C. Malone (mmalone@hdjn.com)

Michelle E. Calloway (mcalloway@hdjn.com)

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.