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CLIENT ADVISORY

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OIG Identifies New Enforcement Priorities in FY 2016 Work Plan

On November 2, 2015, the U.S. Department of Health & Human Services Office of Inspector General ("OIG") released its Work Plan for Fiscal Year 2016 ("Work Plan"). The Work Plan highlights the OIG's new and ongoing enforcement and program integrity priorities for the coming year. The OIG will continue to focus on many of the priorities listed in last year's Work Plan, which we summarized in a previous Client Advisory. Providers and suppliers would be well advised to target their compliance resources on outstanding risk areas mentioned in the 2015 Work Plan. In addition, providers and suppliers should assess compliance risks in the below-listed areas, which will be subject to the OIG's attention as we head into the new year.

I. New and Expanded Areas of Enforcement and Oversight

Hospitals

Oversight of provider-based status. The OIG will continue its oversight of hospitals' compliance with the provider-based requirements. The agency continues to express concern regarding higher Medicare payments to hospitals, the resulting increase in beneficiary coinsurance obligations, and the financial incentives presented by provider-based status. The OIG will determine the number of provider-based facilities that hospitals own and assess the extent to which hospitals satisfy the provider-based requirements at 42 C.F.R. § 413.65 and CMS Transmittal A-03-030. The agency will also examine CMS's ability to effectively oversee provider-based billing and whether challenges exist with the provider-based attestation review process.

Medicare payments during MS-DRG payment window. In response to prior OIG enforcement and review activity indicating a risk for noncompliance with the Medicare billing requirements, the agency will review hospitals' billing of certain outpatient claims under Part B during an inpatient stay and determine whether payment was allowable under the inpatient prospective payment system ("PPS"). Certain items, supplies, and services furnished to inpatients are covered under Part A and should not be billed separately to Part B during the payment window period.

Credits for replaced medical devices. Previous OIG reviews have indicated that Medicare has made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices. Federal regulations require reductions in Medicare payments for the replacement of defective or recalled devices. The OIG intends to determine whether Medicare payments for replaced medical devices were made in accordance with Medicare requirements.

Post-Acute Providers and Hospice

SNF PPS requirements. Based on previous reviews finding that Medicare payments for therapy greatly exceeded SNF costs and that SNFs have increasingly billed for the highest level of therapy despite minimal changes in key beneficiary characteristics, the OIG will focus on compliance with SNF PPS requirements, including documentation to support claims. All documentation requirements at 42 C.F.R. § 483.20 must be satisfied to ensure that SNF care is reasonable and necessary. This includes a physician order upon admission, a comprehensive assessment, and a comprehensive care plan prepared by an interdisciplinary team of providers.

Hospice general inpatient care. The OIG will continue to review use of the general inpatient care level of the Medicare hospice benefit. The OIG is concerned that hospices are billing for inpatient levels of care when such care is not medically necessary. The agency reiterated that hospice care is palliative rather than curative. The agency will examine claims and the content of election statements for hospice beneficiaries receiving general inpatient care. It will also review medical records and care plans to determine whether all requirements are satisfied.

DMEPOS Suppliers

Payment rates and medical necessity for orthotic braces. The OIG will assess the fee schedule amounts for orthotic braces relative to rates paid by other payers. The agency will also review Part B payments to determine whether durable medical equipment, prosthetics, orthotics, and supplies ("DMEPOS") suppliers' claims are medically necessary and supported by adequate documentation.

Increased billing for ventilators. The OIG will examine the increase in ventilator billing, specifically for HCPCS code E0464 (a pressure support ventilator with volume control mode and a noninvasive interface (e.g., mask)). The agency believes suppliers may be inappropriately billing for ventilators for beneficiaries with non-life threatening conditions, which would not meet the medical necessity criteria for ventilators and might be more appropriately billed to codes for respiratory assist devices or continuous positive airway pressure devices.

Other Providers and Suppliers

Quality oversight of ambulatory surgery centers. The OIG will closely review Medicare's quality oversight as it relates to ambulatory surgery centers ("ASCs"). Previous OIG reviews identified problems with Medicare's oversight of ASCs. These shortcomings included finding spans of five or more years between certification surveys, poor CMS oversight of State survey agencies and ASC accreditors, and little public information on the quality of ASCs.

Documentation of physician DME orders/referrals and certain E&M visits. The OIG will review select Medicare services, supplies, and DME referred or ordered by physicians and non-physician practitioners ("NPPs") to determine whether payment was made in accordance with Medicare requirements, notably the requirement that a Medicare-enrolled physician or NPP ordered the item or service and was legally eligible to do so. The agency will also review payments to physicians for evaluation and management ("E/M") home visits and payments for prolonged E/M services. The OIG will ensure that physicians adequately document the medical necessity of a home visit in lieu of an office or outpatient visit and that payments for prolonged E/M services were reasonable and in compliance with Medicare requirements.

Open Payments program reporting. The OIG will ensure CMS is adequately overseeing manufacturers' and group purchasing organizations' compliance with data reporting requirements and whether the required data for physician and teaching payments is valid.

HIPAA Covered Entities

Office for Civil Rights oversight of health information security. The OIG will review the adequacy of the Office for Civil Rights' ("OCR") oversight of the security of electronic protected health information ("ePHI"). The OIG is concerned that OCR has not assessed the risks, established priorities, or implemented controls for its HITECH Act requirement to provide for periodic audits of Covered Entities and Business Associates.

II. Practical Takeaways

The FY 2016 Work Plan contains several new enforcement and oversight initiatives that will impact most providers and suppliers participating in the Medicare program. As in previous years, the OIG remains concerned with improper payments stemming from noncompliance with the Medicare billing requirements across all

provider and supplier types. Providers and suppliers should analyze their documentation practices and ensure they are minimizing their reimbursement risk in the face of expanded OIG reviews. In addition, HIPAA Covered Entities should anticipate continued audit activity from OCR as it faces increased pressure to audit for compliance with the Security Rule.

For more information about the OIG's FY 2016 Work Plan and actions your organization can take to minimize future compliance risks, please contact Mary Malone (mmalone@hdjn.com), Michelle Calloway (mcalloway@hdjn.com), or Corbin Santo (csanto@hdjn.com) by email or 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.