ALSTON & BIRD LLP

WWW.ALSTON.COM

Health Care ADVISORY ■

FEBRUARY 25, 2014

OIG Issues 2014 Work Plan

Recently, the Office of Inspector General (OIG) of the United States Department of Health and Human Services (HHS) issued its Work Plan for Fiscal Year 2014 ("2014 Work Plan").[1] The 2014 Work Plan outlines the areas of special concern to the OIG and describes those enforcement initiatives the OIG will pursue in FY 2014 in connection with its oversight of the Centers for Medicare & Medicaid Services (CMS) and other agencies of HHS. Companies in the health care industry should be aware of the OIG's initiatives when planning their business strategies and compliance efforts for the year.

New Areas Covered in the 2014 Work Plan

The 2014 Work Plan covers a broad array of projects related to CMS programs, organized by type of provider and federal reimbursement scheme. Highlights of some of the new and expanded projects in the 2014 Work Plan are as follows:

Hospitals

- **New Inpatient Admission Criteria.** The OIG will determine whether new inpatient admission criteria implemented at the start of the 2014 fiscal year (restrict hospital admissions for inpatient care to those patients requiring a minimum of two nights of care) have had an impact on overpayments, inconsistencies in hospital billing procedures and financial incentives to improperly bill Medicare.
- **Medicare Costs Associated with Defective Medical Devices.** The OIG will review Medicare claims to determine the additional cost associated with replacing defective devices and assess the impact of this cost on Medicare.
- **Analysis of Salaries Included in Hospital Cost Reports.** The OIG will identify the salary amounts included in operating cost submissions to Medicare by reviewing data from Medicare cost reports and hospitals. Given that Medicare has not set a cap on the amount of salary that may be reported on hospital cost reports, OIG will then determine the potential impact that limits on reportable salary amounts could have on the Medicare Trust Fund.
- **Impact of Provider-Based Status on Medicare Billing.** The OIG will assess the impact of having subordinate facilities with provider-based status bill as if they were the main provider. Doing so results in additional Medicare payments and higher coinsurance liabilities for beneficiaries. OIG will also consider whether such facilities meet CMS criteria to properly hold provider-based status.

---

[1] http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf

- **Comparison of Provider-Based and Free-Standing Clinics.** The OIG will compare Medicare payments for similar procedures provided at physician office visits in provider-based clinics versus free-standing clinics to assess the potential impact of the higher payments being made for services provided at provider-based clinics.
- **Long-Term-Care Hospitals – Billing Patterns Associated with Interrupted Stays.** The OIG will assess readmission patterns to determine how frequently long-term-care hospitals (LTCH) readmit patients after a certain number of days as higher paying new stays requiring separate Medicare payments, as opposed to interrupted stays. The OIG will also determine how frequently LTHCs readmit patients from providers with which the LTCHs are co-located. Finally, the OIG will determine the extent to which Medicare made improper payments associated with LTCH readmissions in 2011.
- **Outpatient Evaluation and Management Services Billed at the New-Patient Rate.** The OIG will assess Medicare payments for evaluation and management (E/M) services for clinic visits billed at new-patient rates to determine whether it has overpaid for hospitals' provision of evaluation and management services in clinics. Preliminary research indicates that these hospitals billed Medicare at the new-patient billing rate, even when providing these services to existing patients (patients whom hospitals have treated as registered inpatients or outpatients in the last three years). In the event of overpayment, OIG will recommend that CMS recover the excess funds.
- **Nationwide Review of Cardiac Catheterization and Heart Biopsies.** The OIG will assess whether Medicare was properly billed for right heart catheterizations (RHC) and heart biopsies by reviewing Medicare payments. Medicare requires the cost for RHCs to be included in the cost for heart biopsies when the two procedures are performed together. However, previous reports indicate that Medicare may have been improperly billed for RHCs and heart biopsies separately.
- **Payments for Patients Diagnosed with Kwashiorkor.** The OIG will review Medicare payments to determine whether the corresponding documentation in medical records supports Kwashiorkor diagnoses, thus justifying hospitals' billing of Medicare at the substantially higher billing rate assigned to Kwashiorkor diagnoses.
- **Bone Marrow or Stem Cell Transplants.** The OIG will review Medicare payments for bone marrow and stem cell transplants to ensure full compliance with federal billing requirements. Medicare fully covers transplants only for certain diagnoses and previous OIG reports have identified improper billing with respect to these transplants.
- **Indirect Medical Education Payments.** The OIG will review provider data to assess whether reimbursements for hospitals' indirect medical education were properly calculated using the hospital's ratio of resident full-time equivalents to available beds. The OIG has previously found payments in excess of the proper amount.
- **Oversight of Pharmaceutical Compounding.** The OIG will detail how Medicare, as well as state agencies and hospital accreditors, oversee pharmaceutical compounding in acute-care hospitals participating in Medicare.
- **Oversight of Hospital Privileging.** The OIG will review the procedures and criteria hospitals use to vet medical staff candidates when electing to grant initial privileges, including how they verify credentials and review the National Practitioner Databank.

Nursing Homes

- **Medicare Part A Billing by Skilled Nursing Facilities.** The OIG will describe skilled nursing facility (SNF) billing practices and the variations amongst SNFs in specific years. The OIG believes SNFs increasingly bill for the highest level of therapy though beneficiaries' health characteristics have not worsened from year to year.

Hospices

- **Hospice in Assisted Living Facilities.** The OIG will review the level of service provided to Medicare beneficiaries living in assisted-living facilities (ALF), including the length of stay, levels of care received and common terminal illnesses. This information is necessary for CMS to reform the hospice payment system and develop quality measures for hospices pursuant to the Affordable Care Act.

Home Health Services

- **Home Health Prospective Payment System Requirements.** The OIG will review compliance with the home health prospective payment system, including the documentation required to support claims and whether home health claims were paid in compliance with federal laws and regulations. The OIG noted that a prior OIG report found that one in four home health agencies had questionable billing.

Medical Equipment and Supplies

- **Reasonableness of Medicare's Fee Schedule Amounts for Selected Medical Equipment Items Compared to Amounts Paid by Other Payers.** The OIG will assess the reasonableness of the Medicare fee schedule for medical equipment, including commode chairs, folding walkers and transcutaneous electrical nerve stimulators, and will compare Medicare spending on such equipment with that of non-Medicare payers. The OIG will assess the financial impact that conforming the Medicare fee schedule to those of non-Medicare payers would have on the Medicare program.
- **Power Mobility Devices – Lump-Sum Purchase Versus Rental.** The OIG will determine whether Medicare can achieve savings by renting power mobility devices over a 13-month period, as opposed to purchasing them with a lump-sum payment.
- **Power Mobility Devices – Add-on Requirement for Face-to-Face Examination.** The OIG will review Medicare Part B payments for power mobility devices to determine whether Medicare requirements for a face-to-face examination were met.
- **Competitive Bidding for Diabetes Testing Supplies – Mandatory Market Share Review.** Pursuant to the Medicare Improvements for Patients and Providers Act, OIG will determine the market share of different types of diabetic testing strips directly after implementing Round 2 of the Competitive Bidding Program.
- **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 ensure that the claims for which payments were made were medically necessary and were supported as required by Medicare requirements.

Other Part A and Part B Providers

- **Ambulance Service Payments.** The OIG will begin to review previous OIG evaluations, audits, investigations and compliance guides to identify vulnerabilities, inefficiencies and fraud trends in Medicare Part B reimbursements for ambulance services. The OIG will begin to develop recommendations to improve detected vulnerabilities and to minimize inappropriate payments.
- **Anesthesia Services Payments for Personally Performed Services.** The OIG will review claims for personally performed anesthesia services to determine whether the claims were supported in accordance with Medicare requirements. The OIG will also determine whether services with the "AA" service code modifier met Medicare requirements.

- **Physical Therapists – High Utilization of Outpatient Physical Therapy Services.** The OIG will review outpatient physical therapy services provided by independent therapists with high utilization rates to determine whether the services were not reasonable and medically necessary or were not documented properly, as required under the Medicare reimbursement regulations.
- **Portable X-Ray Equipment Supplier Compliance with Transportation and Set-Up Fee Requirements.** The OIG will review Medicare payments for the transportation and set-up of portable x-ray equipment to determine whether payments were correct and supported by proper documentation. The OIG will also assess the qualifications of the technologists and whether the services were ordered by a physician.

Part C – Medicare Advantage

- **Encounter Data – CMS Oversight of Data Integrity.** The OIG will review the extent to which Medicare Advantage (MA) encounter data reflecting the items and services provided to MA plan enrollees are complete and consistent and are verified for accuracy by CMS.
- **Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses.** The OIG will review the medical record documentation to ensure that it supports the diagnoses MA organizations submitted to CMS for use in CMS's risk-score calculations, as well as determine whether the diagnoses submitted complied with federal requirements.

Part D – Prescription Drug Program

- **Savings Potential of Adjusting Risk Corridors.** The OIG will analyze risk-sharing payments between Medicare and Part D sponsors to determine whether cost savings could have been realized had the existing risk corridor thresholds remained at 2006 and 2007 levels.
- **Documentation of Administrative Costs in Sponsors' Bid Proposals.** The OIG will review the sufficiency of Part D sponsors' documentation supporting the administrative costs they included in their annual bid proposals to CMS.
- **Reopening Final Payment Determinations.** The OIG will review CMS's policies, procedures, instructions and processes for reopening final payment determinations and determine the adequacy of sponsor compliance and sponsor-submitted data. This follows CMS's April 2013 announcement that it planned to reopen 2007 and 2008 reconciliations during the 2013 calendar year and would assess at a later time whether it is necessary to reopen 2009, 2010 and 2011 reconciliations.
- **Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts.** The OIG will review data submitted by Part D sponsors for use in calculating the coverage gap discount to assess the accuracy of the data and determine whether beneficiary payments are correct and amounts paid to sponsors are supported.

Prescription Drugs

- **Manufacturer Reporting of Average Sales Prices for Part B Drugs.** The OIG will begin to evaluate the potential effect on average sales price (ASP) reporting if all manufacturers of Part B-covered drugs were required to submit ASPs to CMS. The OIG will also assess whether CMS has followed previous OIG recommendations to improve its process for collecting ASP data.
- **Covered Uses for Medicare Part B Drugs.** The OIG will begin to review the oversight efforts of CMS and its claims processing contractors to ensure that payments for Part B drugs meet the appropriate coverage criteria.

State Medicaid

- **Health-Care-Acquired Conditions.** The OIG will evaluate whether selected states made Medicaid payments for health-care-acquired conditions and provider-preventable conditions and quantify the amount of Medicaid payments for such conditions. Federal regulations prohibit Medicaid payments by states for services related to health-care-acquired conditions and for provider-preventable conditions.
- **Enhanced Federal Medical Assistance Percentage.** The OIG will review Medicaid claims to assess whether states are correctly applying the enhanced Federal Medical Assistance Percentage (FMAP) payment provisions of the Affordable Care Act.
- **National Error Rates for Medicaid Eligibility Enrollment.** For 2014, the OIG will estimate the national enrollment error rates for newly enrolled Medicaid beneficiaries in states participating and those not participating in Medicaid expansion under the Affordable Care Act. The goal of this review is to determine the national error rates for states improperly enrolling individuals in the Medicaid program who did not meet eligibility criteria.
- **Medicaid Eligibility Determinations in Selected States.** The OIG will begin a new review of Medicaid eligibility determinations in selected states with a focus on the determinations for beneficiaries who were newly eligible pursuant to the Affordable Care Act and those who were eligible prior to Medicaid expansion. The OIG will also assess the amount of payments associated with beneficiaries who received incorrect eligibility determinations.
- **State Actions to Address Vulnerabilities Identified During CMS Reviews.** CMS performs a triennial review of each state's Medicaid program integrity functions to evaluate effectiveness and compliance with federal program integrity requirements. The OIG will initiate a review of the corrective actions implemented by the state Medicaid agencies in response to issues identified during the reviews.
- **Provider Payment Suspensions During Pending Investigations of Credible Fraud Allegations.** The OIG will implement reviews of payments to providers with allegations of fraud deemed credible by the state. The OIG will also review the state Medicaid agencies' suspension of payments process.

Medicaid Managed Care Organizations (MCOs)

- **Medicaid Managed Care Reimbursement.** The OIG will conduct a review of Medicaid managed care plan reimbursements to assess whether MCOs are correctly reimbursed for services provided by ensuring that only appropriate data is used to set rates and that payments made under risk-sharing mechanisms and incentive payments are within the limits set forth by federal regulations.
- **Medicaid Managed Care Entities' Identification of Fraud and Abuse.** In response to a prior OIG report, the OIG will begin a review of Medicaid MCOs to determine whether the organizations have identified and addressed potential fraud and abuse incidents.
- **Medicaid Managed Care Beneficiary Grievances and Appeals Process.** The Social Security Act requires states to provide beneficiaries whose Medicaid claims are denied or not promptly acted upon with an opportunity for a fair hearing. The OIG will evaluate how states monitor the Medicaid MCOs' grievance and appeals processes to determine compliance with federal requirements.
- **Oversight of Managed Care Entities' Marketing Practices.** In order to determine compliance with federal requirements, the OIG will review state Medicaid agencies' policies, procedures and activities regarding monitoring of Medicaid MCOs' marketing practices and CMS's activities to ensure the MCOs' compliance with marketing requirements.

340B Program-Related Projects

- **Part B Payments for Drugs Purchased Under the 340B Program.** The OIG will begin to determine how much Medicare Part B could save if Medicare were able to share in providers' savings for drugs purchased under the 340B program. The OIG will calculate the difference between average sales price and 340B prices to estimate potential savings.
- **340B-Covered Entities Access to 340B Ceiling Prices.** In previous OIG Work Plans, the OIG made recommendations to HRSA in an effort to strengthen the 340B program, including a recommendation that HRSA provide covered entities with ceiling prices in order to detect overcharges. The OIG will conduct a review to determine the steps taken by HRSA to address the OIG's previous recommendations regarding 340B ceiling prices and the challenges faced by HRSA in implementing the recommendation. The OIG will also evaluate whether drug manufacturers are overcharging 340B-covered entities.
- **Contract Pharmacy Arrangements in the 340B Program.** The OIG will evaluate the extent to which selected 340B-covered entities and HRSA oversee contract pharmacies' compliance with the 340B Program requirements.

Information Technology Security, Protected Health Information and Data Accuracy

- **Controls Over Networked Medical Devices at Hospitals.** The OIG will begin to evaluate hospitals' security controls of networked medical devices to determine whether they effectively protect associated electronically protected health information and ensure beneficiary safety.

Comment

The above represents just a sampling of the new OIG initiatives for FY 2014 as found in the 2014 Work Plan. The 2014 Work Plan is extensive and touches on numerous issues of concern to the OIG. A careful review of the 2014 Work Plan should be undertaken in conjunction with an annual monitoring of each health care company's and provider's compliance program. Health care providers and companies should pay close attention to those items outlined in the 2014 Work Plan, and seek to update their compliance programs to ensure that they address the issues of particular concern to the OIG. If gaps are detected in a compliance program, it may be necessary to develop additional training for personnel.

If you would like to receive future ***Health Care Advisories*** electronically, please forward your contact information to **healthcare.advisory@alston.com**. Be sure to put "**subscribe**" in the subject line.

If you have any questions, or would like additional information, please contact any of the following:

Donna Bergeson
404-881-7278
donna.bergeson@alston.com

Angie Burnette
404-881-7665
angie.burnette@alston.com

Jennifer Butler
202-239-3326
jennifer.butler@alston.com

Craig Carpenito
212-210-9582
craig.carpenito@alston.com

Dan Elling
202-239-3530
dan.elling@alston.com

Peter Fise
202-239-3842
peter.fise@alston.com

Larry Gage
202-239-3614
larry.gage@alston.com

Joyce Gresko
202-239-3628
joyce.gresko@alston.com

Hannah Heck
404-881-4293
hannah.heck@alston.com

Elinor Hiller
202-239-3401
elinor.hiller@alston.com

Bill Jordan
404-881-7850
bill.jordan@alston.com

Ted Kang
202-239-3728
edward.kang@alston.com

Peter Kazon
202-239-3334
peter.kazon@alston.com

Dawnmarie Matlock
404-881-4253
dawnmarie.matlock@alston.com

Kim McWhorter
404-881-4254
kim.mcwhorter@alston.com

Wade Miller
404-881-4971
wade.miller@alston.com

Rudy Missmar
202-239-3034
rudy.missmar@alston.com

Mitch Mitchelson
404-881-7661
mitch.mitchelson@alston.com

D'Andrea Morning
404-881-7538
dandrea.morning@alston.com

Michael Park
202-239-363
michael.park@alston.com

Earl Pomeroy
202-239-3835
earl.pomeroy@alston.com

Mark Rayder
202-239-3562
mark.rayder@alston.com

Sam Rutherford
404-881-4454
sam.rutherford@alston.com

Thomas Scully
202-239-3459
thomas.scully@alston.com

Gina Sherick
202-239-3383
gina.sherick@alston.com

Bob Siggins
202-239-3836
bob.siggins@alston.com

Carolyn Smith
202-239-3566
carolyn.smith@alston.com

Paula Stannard
202-239-3626
paula.stannard@alston.com

Brian Stimson
404-881-4972
brian.stimson@alston.com

Tim Trysla
202-239-3420
tim.trysla@alston.com

Marilyn Yager
202-239-3341
marilyn.yager@alston.com

ALSTON & BIRD LLP

WWW.ALSTON.COM

ATLANTA: One Atlantic Center ■ 1201 West Peachtree Street ■ Atlanta, Georgia, USA, 30309-3424 ■ 404.881.7000 ■ Fax: 404.881.7777
BRUSSELS: Level 20 Bastion Tower ■ Place du Champ de Mars ■ B-1050 Brussels, BE ■ +32 2 550 3700 ■ Fax: +32 2 550 3719
CHARLOTTE: Bank of America Plaza ■ 101 South Tryon Street ■ Suite 4000 ■ Charlotte, North Carolina, USA, 28280-4000 ■ 704.444.1000 ■ Fax: 704.444.1111
DALLAS: 2828 North Harwood Street ■ 18th Floor ■ Dallas, Texas, USA, 75201 ■ 214.922.3400 ■ Fax: 214.922.3899
LOS ANGELES: 333 South Hope Street ■ 16th Floor ■ Los Angeles, California, USA, 90071-3004 ■ 213.576.1000 ■ Fax: 213-576-1100
NEW YORK: 90 Park Avenue ■ 12th Floor ■ New York, New York, USA, 10016-1387 ■ 212.210.9400 ■ Fax: 212.210.9444
RESEARCH TRIANGLE: 4721 Emperor Blvd. ■ Suite 400 ■ Durham, North Carolina, USA, 27703-85802 ■ 919.862.2200 ■ Fax: 919.862.2260
SILICON VALLEY: 275 Middlefield Road ■ Suite 150 ■ Menlo Park, California, USA, 94025-4004 ■ 650-838-2000 ■ Fax: 650.838.2001
WASHINGTON, DC: The Atlantic Building ■ 950 F Street, NW ■ Washington, DC, USA, 20004-1404 ■ 202.756.3300 ■ Fax: 202.756.3333