OIG releases its 2014 work plan

February 25, 2014

On January 31, 2014, the Department of Health & Human Services, Office of Inspector General (OIG) released its 2014 Work Plan. The Work Plan sets forth the OIG's initiatives and priorities for the 2014 federal fiscal year that it will pursue through audits, investigations, inspections, industry guidance (including advisory opinions) and enforcement actions (including actions to impose civil monetary penalties, assessments and administrative sanctions, such as exclusions).

In addition to the audits already underway, some of the new OIG audits and inspections scheduled to begin in 2014 and 2015 that will affect hospitals, physicians and other health care providers, nursing homes and Medicaid managed care organizations (MCOs) include:

New Hospital Initiatives

New inpatient admission criteria. Determine the impact of new inpatient admission criteria on hospital billing, Medicare payments and beneficiary payments. The OIG will also determine how billing varied among hospitals in FY 2014. Beginning in FY 2014, new criteria state that physicians should admit for inpatient care those beneficiaries who are expected to need at least two nights of hospital care (the “two-midnight” rule). Beneficiaries whose care is expected to last less than two nights should be treated as outpatients unless they are receiving a procedure on the Medicare inpatient-only list. The criteria represent a substantial change in the way hospitals bill for inpatient and outpatient hospital stays.

Medicare costs associated with defective medical devices. Review Medicare claims to identify the costs resulting from additional utilization of medical services associated with defective medical devices and determine the impact of the cost on the Medicare trust fund. The Centers for Medicare & Medicaid Services (CMS) has previously expressed concerns about the impact of the cost of replacement devices, including ancillary cost, on Medicare payments for inpatient and outpatient services.

Analysis of salaries included in hospital cost reports. Review data from Medicare cost reports and hospitals to identify salary amounts included in operating costs reported to and reimbursed by Medicare. The OIG will also determine the potential impact on the Medicare trust fund if the amount of employee compensation that could be submitted to Medicare for reimbursement on future cost reports had limits.

Comparison of provider-based and freestanding clinics. Review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals claiming provider-based status for such facilities.

Review of selected inpatient and outpatient billing requirements. Review Medicare payments to acute care hospitals to determine hospital compliance with selected billing requirements and recommend recovery of overpayments. The OIG will also survey or interview hospital leadership and compliance officers to provide contextual information related to hospital compliance programs. Based on this item’s appearance on the 2014 Work Plan as a new start, we expect to see more of these dreaded Medicare compliance reviews in the upcoming year.

Nationwide review of cardiac catheterization and heart biopsies. Review Medicare payments for right heart catheterizations and heart biopsies billed during the same operative session and determine whether hospitals complied with Medicare billing

requirements.

Medicare payments for bone marrow or stem cell transplants. Review Medicare payments made to hospitals for bone marrow or stem cell transplants to determine whether Medicare payments were paid in accordance with federal rules and regulations. The OIG is looking for potential unbundling of any of the steps in the transplantation process.

Indirect medical education payments. Review provider data to determine whether hospitals' indirect medical education (IME) payments were made in accordance with federal regulations and guidelines. The OIG will also determine whether the IME payments were calculated properly.

New Initiatives for Physicians and Other Health Care Practitioners and Entities

Physicians and suppliers—Noncompliance with assignment rules and excessive billing of beneficiaries. Review the extent to which physicians and suppliers participated in Medicare and accepted claim assignment during 2012. The OIG will also assess the effects of their participation and claim assignments on the Medicare program (such as noncompliance with assignment rules) and on beneficiaries (such as excessive billing of beneficiaries' share of charges).

Physicians—Place-of-service coding errors. Review physician coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service.

Anesthesia services—Payments for personally performed services. Review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. The OIG will also determine whether Medicare payments for anesthesiologist services reported on a claim with the "AA" service code modifier (indicating the services were personally performed) met Medicare requirements.

New Home Health Agency Initiatives

Home health prospective payment system requirements. Review compliance with various aspects of the home health prospective payment system, including the documentation required in support of the claims paid by Medicare. The OIG will also determine whether home health claims were paid in accordance with federal laws and regulations.

New Medicaid Managed Care Initiatives

Completeness and accuracy of managed care encounter data. Determine the extent to which complete Medicaid managed care encounter data is included in Medicaid Statistical Management Systems (MSIS). The OIG will also identify factors that enable state and Medicaid managed care entities to collect and report MSIS encounter data or prevent them from performing these functions and assess CMS' oversight of the reporting of MSIS encounter data.

Medicaid managed care entities' identification of fraud and abuse. Determine whether Medicaid MCOs identified and addressed potential fraud and abuse incidents. Describe how states oversee MCOs' efforts to identify and address fraud and abuse.

Oversight of managed care entities' marketing practices. Review state Medicaid agencies' oversight policies, procedures and activities to determine the extent to which states monitor Medicaid MCOs' marketing practices and compliance with federal and state contractual marketing requirements. Determine the extent to which CMS ensures that states comply with federal requirements involving Medicaid MCO marketing practices.

New Equipment and Supplies Initiatives

Reasonableness of Medicare's fee schedule amounts for selected medical equipment items compared to amounts paid by other payers. Determine the reasonableness of the Medicare fee schedule amount for various medical equipment items, including commode chairs, folding walkers and transcutaneous electrical nerve stimulators. The OIG will compare Medicare payments made for various medical equipment items to the amounts paid by non-Medicare payers, such as private insurance companies and the Department of Veterans Affairs, to identify potentially wasteful spending.

Power mobility devices – Lump-sum purchase versus rental. Determine whether potential savings can be achieved by Medicare if certain power mobility devices are rented over a 13-month period rather than acquired through a lump-sum purchase.

Nebulizer machines and related drugs – Supplier compliance with payment requirements. Review Medicare Part B payments for nebulizer machines and related drugs to determine whether medical equipment supplier claims are for nebulizers and related drugs that are medically necessary and are supported in accordance with Medicare requirements.

Frequently replaced supplies – Supplier compliance with medical necessity, frequency and other requirements. Review claims for frequently replaced medical equipment supplies to determine whether medical necessity, frequency and other Medicare requirements are met.

New Initiatives Regarding Other Providers and Suppliers

Physical therapists–High utilization of outpatient physical therapy services. Review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations.

Portable X-ray equipment–Supplier compliance with transportation and setup fee requirements. Review Medicare payments for the transportation and setup of portable X-ray equipment to determine whether payments were correct and were supported by documentation. Also assess the qualifications of the technologists who performed the services and determine whether the services were ordered by a physician (e.g., doctor of medicine or doctor of osteopathy).

New Prescription Drug Initiatives

Payments for immunosuppressive drug claims with KX modifiers. Determine whether Part B payments for immunosuppressive drugs that were billed with a service code modifier "KX" met Medicare documentation requirements.

New Information Technology Security, Protected Health Information and Data Accuracy Initiatives

Controls over networked medical devices at hospitals. Determine whether hospital security controls over networked medical devices (computerized medical devices, such as dialysis machines, radiology systems and medication dispensing systems that are integrated with EHRs and the larger health network) are sufficient to effectively protect associated electronically protected health information and ensure beneficiary safety.

New Medicaid Prescription Drug Initiatives

Medicaid payments for multiuse vials of Herceptin. Review state claims for the federal share of Medicaid payments for the drug Herceptin, which is used to treat breast cancer, to determine whether providers properly billed the states for the drug. Determine whether provider claims to states were complete and accurate and were billed in accordance with the regulations of the selected states.

New Initiatives Regarding Other Medicaid Services, Equipment and Supplies

Health care-acquired conditions – Prohibition on federal reimbursements. Determine 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.

Authors