2017 OIG Work Plan summary

November 21, 2016

Each fall, the Department of Health and Human Services Office of Inspector General (OIG) publishes its Work Plan for the upcoming fiscal year to summarize new and ongoing OIG reviews and initiatives. On November 10, 2016, the OIG's2017 Work Plan was posted to its website.

The OIG's Work Plan sets forth its initiatives and priorities for the 2017 federal fiscal year (FFY), which the OIG 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). The 2017 OIG Work Plan includes the audits begun in years past that will continue into FFY2017 as well as new audits scheduled to begin in FFY2017.

There are a number of new starts for OIG audits and other reviews included in the 2017 OIG Work Plan. We have highlighted a number of those below.

New Hospital Initiatives

Incorrect medical assistance days claimed by hospitals

To address the risk of overpayment under the Medicare disproportionate share hospital payments, OIG will determine whether, with respect to Medicaid patient days, Medicare administrative contractors properly settled Medicare cost reports in accordance with federal requirements.

Comparison of provider-based and freestanding clinics

The OIG will 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. The OIG will also assess the potential impact on Medicare and beneficiaries of hospitals' claiming provider-based status for such facilities. While this review was also included in the 2016 OIG Work Plan and has not been revised, we have included it here to remind hospitals that provider-based status remains a hot topic for government regulators like the OIG.

New Medicare Billing/Payment Initiatives

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Hyperbaric oxygen therapy services — provider reimbursement in compliance with federal regulations

In order to address concerns from prior OIG reviews regarding noncompliance with hyperbaric oxygen (HBO) treatment requirements described in CMS Publication 100-03, National Coverage Determinations Manual, Ch. 20, Sec. 20.29(A), the OIG will determine whether Medicare payments related to HBO outpatient claims were reimbursed in accordance with federal requirements.

Inpatient psychiatric facility outlier payments

Due to a 28 percent increase in the number of inpatient psychiatric facility claims with outlier payments from FY2014 to FY2015, the OIG will determine whether Inpatient Psychiatric Facilities nationwide complied with Medicare documentation, coverage and coding requirements for stays that resulted in outlier payments.

Case review of inpatient rehabilitation hospital patients not suited for intensive therapy

After physician reviewers found a small number of cases in which inpatient rehabilitation hospital patients appeared to be unsuited for intensive therapy, the OIG will conduct a study to assess a sample of rehabilitation hospital admissions to determine whether the patients participated in and benefited from intensive therapy. For patients who were not suitable candidates, the OIG will identify reasons they were not able to participate and benefit from therapy.

Medicare payments for transitional care management

In this review, the OIG will determine whether payments for transitional care management services (services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital or skilled nursing facility/nursing facility to the patient's community setting) were in accordance with Medicare requirements.

Medicare payments for chronic care management

In this review, the OIG will determine whether payments for chronic care management services (non-face-to-face services provided to Medicare beneficiaries who have multiple significant chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline where the significant chronic conditions are expected to last at least 12 months or until the death of the patient) were in accordance with Medicare requirements.

Medicare payments for service dates after individuals' dates of death

In order to establish policies and implement claim edits as required under Section 502 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the OIG

will review CMS' policies and procedures that ensure that payments are not made for Medicare services ostensibly rendered to deceased individuals.

Management review — CMS's implementation of the Quality Payment Program

The OIG will describe the timelines and key milestones CMS has established for implementing the Quality Payment Program provisions of MACRA and will identify the key challenges and potential vulnerabilities CMS is facing during implementation.

New Physician Initiative

Data brief on financial interests under the Open Payments program

The OIG will analyze 2015 data extracted from the Open Payments website to determine the number and nature of financial interests (payments as well as ownership or investment interests) that physicians had with drug and medical device manufacturers and group purchasing organizations. The OIG will also determine how much Medicare paid for drugs and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) ordered by physicians who had financial relationships with manufacturers and group purchasing organizations. Finally, the OIG will determine the volume and total dollar amount associated with drugs and DMEPOS ordered by these physicians in Medicare Parts B and D for 2015.

New Skilled Nursing Facility and Nursing Home Initiatives

Nursing home complaint investigation data brief

Based on a 2006 OIG report that state agencies did not investigate some of the most serious nursing home complaints (i.e., immediate jeopardy and actual harm) within the 2- and 10-day required timeframe, the OIG will determine to what extent state agencies investigate the most serious nursing home complaints within the required timeframes.

Skilled nursing facilities — unreported incidents of potential abuse and neglect

The OIG will assess the incidence of abuse and neglect of Medicare beneficiaries receiving treatment in skilled nursing facilities and determine whether these incidents were properly reported and investigated in accordance with applicable federal and state requirements. The OIG will also interview state officials to determine if each sampled incident was reported, if required, and whether each reportable incident was investigated and subsequently prosecuted by the state, if appropriate.

Skilled nursing facility reimbursement

Following up on previous OIG findings (and, likely, the large settlements we have seen recently in this area) indicating that skilled nursing facilities are billing for higher levels of therapy than were provided or were reasonable or necessary, the OIG will review the documentation at selected skilled nursing facilities to determine if their

documentation meets the requirement for each particular resource utilization group.

Skilled nursing facility adverse event screening tool

The OIG review will describe the purpose, use and benefit of the SNF adverse event trigger tool with the goal of disseminating practical information about the tool for use by those involved with the skilled nursing industry.

New Initiatives for Medical Equipment and Supplies

Part B services during non-Part A nursing home stays: Durable medical equipment

The OIG will conduct a study to determine the extent of inappropriate Medicare Part B payments for DMEPOS provided to nursing home residents during non-Part A stays in 2015. The OIG will also determine whether CMS has a system in place to identify inappropriate payments for DMEPOS and recoup payments from suppliers.

Medicare market share of mail-order diabetic testing strips: April 1 through June 30, 2016 — mandatory review

Pursuant to requirements of the competitive bidding program, section 1847(b)(10)(B) of the Social Security Act), the OIG will review and report the market share of diabetic testing strips to help CMS determine how the National Mail Order Recompete may impact shifts in the market.

Positive airway pressure (PAP) device supplies — supplier compliance with documentation requirements for frequency and medical necessity

The OIG will review claims for frequently replaced PAP device supplies to determine whether documentation requirements for medical necessity, frequency of replacement and other Medicare requirements are met.

Power mobility devices equipment

In this review, the OIG will compile the results of prior OIG audits, evaluations and investigations of power mobility device equipment paid by Medicare to identify trends in payment, compliance and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities.

New Hospice and Home Health Initiatives

Medicare hospice benefit vulnerabilities and recommendations for improvement

The OIG will create a portfolio summarizing the OIG's evaluations, audits and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

Review of hospices' compliance with Medicare requirements

To ensure that federal regulations regarding Medicare conditions of payment and limitations on payments for hospice services in 42 CFR Part 418, Subpart G are being

followed, the OIG will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Hospice home care — frequency of nurse on-site visits to assess quality of care and services

Medicare requires that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the interdisciplinary group meet the patient's needs (42 CFR § 418.76(h)(1)(i)). The OIG will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

Comparing home health agency survey documents to Medicare claims data

The OIG will determine whether home health agency surveys are accurately providing patient information to state agencies for recertification surveys.

New Laboratory Initiative

Monitoring Medicare payments for clinical diagnostic laboratory tests — mandatory review

The OIG will analyze Medicare payments for clinical diagnostic laboratory tests performed in 2016 and monitor CMS' implantation of the new Medicare payment system for these tests.

New Prescription Drugs Initiatives

Medicare Part D rebates related to drugs dispensed by 340B pharmacies

In this review, the OIG will determine the upper bound of what could be saved if pharmaceutical manufacturers paid rebates for drugs dispensed through Medicare Part D program at 340B covered entities and contract pharmacies.

Questionable billing for compounded topical drugs in Part D

Following a 3,400 percent increase in Part D spending for compounded topical drugs between 2006 and 2015, the OIG will describe billing for topical compounded drugs under Part D and identify pharmacies with questionable Part D billing for these drugs and any associated prescribers.

Medicare Part D payments for service dates after individuals' dates of death

In this review, the OIG will determine whether prospective payments made to Part D sponsors after beneficiaries' date of death were in accordance with Medicare requirements.

Drug waste of single-use vial drugs

The OIG will determine the amount of waste for the 20 single-use-vial drugs with the highest amount paid for waste as identified by the JW modifier and provide specific examples of where a different size vial could significantly reduce waste.

New Part C Medicare Advantage Initiatives

Medicare Part C payments for service dates after individuals' dates of death

The OIG will determine whether prospective payments made after beneficiaries' date of death were in accordance with Medicare requirements.

Extent of denied care in Medicare Advantage and CMS oversight

The OIG will examine national trends and oversight by CMS of denied care within Medicare Advantage (MA). The OIG will determine the extent to which services were denied, appealed and overturned in MA from 2013 to 2015. The OIG will also compare rates of denials, appeals and overturns across MA plans and evaluate CMS's efforts to monitor and prevent inappropriate denials of care in MA.

New Medicaid Initiatives

States' managed care organization (MCO) Medicaid drug claims

A drug manufacturer must have a rebate agreement with CMS to have its outpatient drugs covered under Medicaid (Section 1927(a)(1) of the Social Security Act). The OIG will determine whether MCO capitation payments included reimbursement for drugs that are not covered under the Medicaid program.

Data brief on fraud in Medicaid personal care services

The OIG will issue a data brief that provides an overview of personal care services (PCS) statistical data collected since 2012. The data brief will provide information on state and federal investigations, indictments, convictions and recoveries involving fraud and patient abuse or neglect in Medicaid PCS.

Delivery System Reform Incentive Program

Delivery system reform incentive payments are incentive payments made under section 1115 waivers to hospitals and other providers that develop programs or strategies to enhance access to healthcare, increase the quality and cost-effectiveness of care, and increase the health of patient and family served. The OIG review will ensure that select states adhered to applicable federal and state requirements when they made incentive payments to providers.

Accountable care in Medicaid

The OIG will review selected accountable care models in Medicaid for compliance with relevant State and Federal requirements.

Third-party liability payment collections in Medicaid

The OIG will determine if states have taken action to ensure that Medicaid is the payer of last resort by identifying whether a third-party payer exists and if the state correctly reports the third-party liability to CMS.

Medicaid overpayments reporting and collections

For OIG audits in which CMS concurred with recommendations to collect Medicaid overpayments from a state, the OIG will determine whether the overpayments have been recouped and properly reported to CMS.

Health-care related taxes: Medicaid MCO compliance with hold-harmless requirement

The OIG will determine if health-care-related tax programs for MCOs meet federal hold-harmless requirements in 42 CFR Sec. 433.68 by examining the tax programs in large states that tax MCOs.

Health-care-acquired conditions — Medicaid MCOs

The Affordable Care Act Sec. 2702, and implementing regulations at 42 CFR § 447.26 prohibit Federal payments for provider preventable conditions. Because the OIG found problems with states making fee-for-service payments associated with provider preventable conditions in prior reviews, the OIG is expanding its review now to managed care arrangements. The OIG will determine whether Medicaid MCOs have continued to make payments to providers for inpatient hospital services related to treating certain provider preventable conditions.

Overview of states' risk assessments for Medicaid–only provider types

Section 6402 of the Affordable Care Act requires enhanced screening for providers and suppliers seeking initial enrollment, reenrollment or revalidation in Medicare, Medicaid and CHIP according to risk. The OIG will review states’ assignment of Medicaid–only providers to the federally designated risk categories of high, moderate, and limited and any challenges states face in screening Medicaid-only provider types.