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OIG Publishes 2016 Work Plan

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Health Care Alert

Each November, the U.S. Department of Health and Human Services Office of Inspector General ("OIG") publishes its Work Plan for the coming fiscal year. The Work Plan describes OIG's new and ongoing audit and enforcement priorities for the upcoming year and gives providers of health care insight into assessing what the OIG believes may be problematic and systemic weaknesses in the Medicare and Medicaid system. A thorough review of the Work Plan is helpful in identifying compliance risk areas and giving providers the ability to determine those compliance program activities and audits that need to occur.

The Work Plan published in early November applies to Medicare Part A and B, and Medicare Part C and D, as well as the Medicaid Program. Entities covered by the Work Plan include hospitals, nursing homes, hospices, home health services, medical equipment suppliers and other providers. The Work Plan can be found here.

The Work Plan includes several interesting statistics reflecting the enforcement activities of the OIG:

- Approximately seventy-six percent of the OIG's total funding is directed towards oversight of the Medicare and Medicaid programs
- The OIG is expected to recover more than $3 billion, consisting of nearly $1.13 billion in audit receivables and $2.22 billion in investigative receivables, in fiscal year 2015.
- In fiscal year 2015 there were exclusions of 4,112 individuals and entities from participating in federal health care programs, with 925 criminal actions against individuals or entities and 682 civil actions, which include false claims and unjust enrichment lawsuits filed in federal district court, CMP settlements and administrative recoveries related to provider self-disclosure matters.

With the number of potential investigations, and the dollars involved, providers are well advised to review the Work Plan to determine those issues that the OIG has indicated are important to it.

Among the Work Plan elements that are of particular significance to hospitals are the following:

- The OIG will review Medicare claims to identify the impact on beneficiary safety and quality of care, as well as cost to Medicare, resulting from

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additional use of medical services associated with defective medical devices. The OIG is concerned about the impact of the cost of replacement devices, including ancillary costs and Medicare payments.

- The OIG will also review data from the Medicare Cost Reports to identify salary amounts, including the operating costs reported to and reimbursed by Medicare. Employee compensation can be included as allowable provider cost, only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the hospital.
- The OIG will determine the extent to which provider-based facilities meet the applicable federal requirements at 42 CFR, Section 413.65. The OIG is concerned that provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments, resulting in higher Medicare payment for services furnished through provider-based facilities, and possibly increasing beneficiaries' co-insurance.
- In addition, the OIG will review the following types of Medicare payments to determine if they were made in accordance with Medicare requirements:
  - visits to physician offices, provider-based clinics, and freestanding clinics, to determine the difference in payments made to clinics for similar procedures, and to assess the impact of hospitals claiming provider-based status.
  - right heart catheterizations ("RHCs") and endomyocardial biopsies billed during the same operative session.
  - bone marrow or stem cell transplants. Bone marrow or peripheral blood stem cell transplantation includes mobilization, harvesting and transplant of bone marrow or peripheral blood stem cells, and the administration of high dose chemotherapy or radiotherapy before the actual transplant.
  - replaced medical devices.
- The OIG will review Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays were allowable in accordance with inpatient perspective payment systems.
- The OIG will determine the extent to which hospitals comply with contingency planning requirements of the Health Insurance Portability and Accountability Act ("HIPAA"). They will compare hospitals' contingency plans with government and industry-recommended practices.

With regard to nursing homes, the OIG will review, among other matters, the following:

- The implementation, status and early results of the National Background Check Program for long-term care employees from the first four years of the program. The Affordable Care Act requires that the Secretary of Health and Human Services carry out a nationwide program for states to conduct national and state background checks for prospective employees of nursing facilities and other long-term care providers.
- The compliance with new aspects of skilled nursing facility prospective payment system, including the documentation required in support of claims paid by Medicaid.

Other providers should note the OIG will review:

- The use of general inpatient care levels of the Medicare hospice benefit to assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
- Home health service providers' compliance with the various aspects of the home health prospective payment system ("PPS"), including the documentation required in support of the claims paid by Medicare. OIG has indicated that a prior report found that one in four home health agencies have questionable billing practices. The OIG indicated that since 2010, nearly $1 billion in improper Medicare payments and fraud had been identified related to home health benefits.

There are a number of equipment and supplies initiatives underway for policies and practices, and billing and payment. A few of those are as follows:

- For orthopedic braces, the reasonableness of what Medicare pays compared to amounts paid by other payors will be assessed.

- The OIG will also review power mobility devices, nebulizer machines and related drug supplier compliance with payment requirements, as well as systems in place to prevent inappropriate payment for blood glucose test strips and lancets to multiple suppliers of diabetes testing supplies.

Health care providers should review the 2016 Work Plan to determine which of the government's initiatives might affect them. Those initiatives should be given priority in any compliance efforts for Fiscal Year 2016. Health care organizations should, at least on an annual basis, review their compliance program to add elements of the Work Plan that may affect them. The elements of the Work Plan that may affect the provider should form the basis of any new or revised written policies and procedures that the health care provider may need to implement. Those revised policies and procedures should be done after there has been an assessment of the health care organization's compliance risks, an evaluation of the current compliance program's ability to mitigate those risks, and any revisions to current policies and procedures in order to best ensure compliance with those risks.

The above elements are necessary for an effective compliance program which demonstrates a good faith effort to comply with applicable statutes, regulations and other federal health care program requirements. This activity may significantly reduce the risk of unlawful conduct and potential sanctions.

For further information please contact your regular Hinshaw attorney or Roy M. Bossen.