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# OIG 2015 Work Plan, Part 1: Do fewer projects mean a sharper focus?

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*This is Part 1 of a 2-part article. Part 1 addresses Medicare Parts A and B. Part 2 will address Medicare Parts C and D, Medicaid, and public health and department reviews, and will appear in our next issue.*

At the beginning of each new fiscal year, the Office of Inspector General (OIG) at the Department of Health & Human Services (HHS) issues its Work Plan, setting forth the compliance and enforcement projects and priorities OIG intends to pursue in the coming year. The 2015 Work Plan contains only 11 new projects that affect providers, suppliers, and payers, as well as Part C, Part D, and Medicaid (a significant decrease from the 47 new projects in 2014), plus eight other new projects such as public health reviews and department-specific reviews, and 13 new projects related to the Affordable Care Act (ACA).<sup>1</sup>



Lacktman

Compared with last year's Work Plan, the 2015 Work Plan reflects a narrowed scope of projects, possibly attributable to budgetary concerns or increased coordination among agencies, or both. Compelling new projects include a review of the accuracy of hospital wage data reporting, and payments made to independent clinical laboratories with respect to those laboratories' compliance with billing requirements. OIG's summary suggests that "suspect" laboratories may have already been identified by prior OIG audits, investigations, and inspections, and that it will focus on independent clinical laboratories with claims "that may be at risk of overpayments."

## Background on OIG Work Plan

The Work Plan reflects (in large part) two aspects of the work of OIG: (1) projects originating within the Office of Audit Services (OAS), which conducts financial, billing, and performance audits of HHS programs; and (2) projects originating within the Office of Evaluations and Inspections (OEI), which provides management reviews and evaluations of HHS program operations. Except by providing general statistics, the Work Plan does not detail the work of the

Office of Investigations or the Office of Counsel to the Inspector General in investigating and litigating matters involving specific individual providers and suppliers.

Like many to-do lists, OIG's plan is aspirational and, as a result, many projects are carried over from year to year as priorities shift and projects planned in the beginning of the fiscal year are set aside. The fact that a project has not been carried over does not suggest that OIG is no longer interested in that area. If a project is carried over (rather than cancelled), it typically means OIG continues to remain interested in it, notwithstanding its changing priorities.

There is a significant decrease in the number of new Medicare/Medicaid projects—particularly those focused on providers—as well as the total number of projects this year. The number of projects is limited by the funding appropriations allocated to OIG, but is also impacted by the changing areas of fraud and abuse focus. With far fewer new projects this year, OIG will have a narrowed focus, and this might contribute to deeper analysis or greater attention on the projects listed in the 2015 Work Plan.

With respect to forecasting future areas of examination, OIG will continue to focus on emerging payment, eligibility, management, and IT systems security vulnerabilities in healthcare reform programs, such as the health insurance marketplaces. Other forward-looking areas include quality of care in the Medicare and Medicaid programs; continued examination of the appropriateness of Medicare and Medicaid payments; the integrity of the food, drug, and medical device supply chains; security of electronic data; the use and exchange of health information technology; and emergency preparedness and response efforts.

Below is an overview of some of the major projects from the 2015 Work Plan, with particular emphasis on new projects. The summaries

also indicate which OIG office has primary responsibility for the project. Providers and suppliers relying on the Work Plan to influence their own compliance agendas for the upcoming year should review the Work Plan in full, or speak with their compliance professionals and legal counsel about specific projects that affect their businesses.

## Hospitals

The 2015 Work Plan identifies 22 projects targeting hospitals (down from 23 last year). Of these, only two projects are new this year. Unlike last year's Work Plan, OIG is not initiating a high number of new projects. OIG will continue reviews related to areas such as reconciliations of outlier payments, the impact of provider-based status on Medicare billing, and critical access hospitals payments and costs. The new OIG hospital projects are:

### **Review of hospital wage data used to calculate Medicare payments (OAS)**

OIG will review hospital reporting of wage data. Pursuant to SSA § 1886(d)(3), annually hospitals must accurately report wage data to CMS for the development of wage index rates for Medicare payments. OIG previously identified hundreds of millions of dollars in incorrectly reported wage data, resulting in CMS changing how hospitals report deferred compensation cost.

### **Long-term-care hospitals— Adverse events in post-acute care for Medicare beneficiaries (OEI)**

OIG will estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries who receive care in long-term-care hospitals (LTCHs). After skilled nursing facilities and independent rehabilitation facilities, LTCHs are the third most common type of post-acute care facility. OIG will also identify contributing factors,

determine the extent to which the events were preventable, and calculate associated costs to Medicare.

### **Physicians and non-physician providers**

The 2015 Work Plan includes 16 projects targeting physicians and other Medicare Part B Provider/Suppliers (nine are covered herein and the other seven follow). Of these, only one project (clinical lab billing) is new this year. Notable continuing projects include:

#### **Ambulatory surgery centers— Payment system (OAS)**

OIG will review Medicare's methodology for setting payment rates for ambulatory surgery centers (ASCs), and will determine whether a payment disparity exists between ASC and hospital Outpatient department payment rates for similar surgical procedures.

#### **Physicians—**

##### **Place-of-service coding errors (OAS)**

OIG will review physician coding for Medicare Part B claims for services performed in ASCs or hospital Outpatient departments to determine whether they properly coded the place of service.

#### **Ophthalmologists—**

##### **Inappropriate and questionable billing (OEI)**

OIG will review Medicare claims data to identify inappropriate or questionable billing for ophthalmology services during 2012.

#### **Anesthesia services—**

##### **Payments for personally performed services (OAS)**

OIG will review personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements, and whether Medicare payments for anesthesia services reported on a claim with the AA service code modifier

(which indicates that the services were personally performed by an anesthesiologist) met Medicare requirements.

### **Skilled nursing facilities**

The 2015 Work Plan identifies five projects targeting nursing homes, all of which were named in last year's Work Plan. No new projects were listed this year, and OIG continues its review of skilled nursing facilities that have high rates of hospitalizations, questionable billing patterns for Part B services, and national background checks for long-term care employees.

### **Durable medical equipment and supplies**

The past two years have seen a decrease in DME projects (16 in 2013 and 12 in 2014), and the 2015 Work Plan's 10 projects continues that trend. None of the projects are new. OIG will continue its attention on DME billing and payments issues, including power mobility devices and diabetes testing supplies. Notable continuing projects include:

#### **Power mobility devices—**

##### **Lump-sum purchase versus rental (OAS)**

OIG will determine whether cost savings can be realized by Medicare if certain power mobility devices are rented over a 13-month period rather than acquired through a lump-sum purchase.

#### **Power mobility devices—**

##### **Add-on payment for face-to-face exam (OAS)**

Medicare requires the treating physician to conduct a face-to-face exam of the beneficiary to determine medical necessity for power mobility devices, and the physician may bill Medicare for an E/M service, receiving an add-on payment for this work. OIG will review Part B payments for power mobility devices to determine if the face-to-face exam requirements were met.

### **Nebulizer machines and related drugs— Supplier compliance with payment requirements (OAS)**

Prior OIG work contended DME suppliers were overpaid \$6 million for nebulizer inhalation drugs on the grounds the drugs were not medically necessary. Under this project, OIG will review Part B payments for nebulizer machines and drugs to assess medical necessity.

### **Diagnostic testing and imaging**

OIG identified four projects for the 2015 Work Plan, none of which is new. One item from last year (questionable billing for electrodiagnostic testing) has been deleted from this year's Work Plan.

First, OIG will review payments under the Physician Fee Schedule for select imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, OIG will focus on the practice expense component of the resource-based value scale payment system as applicable to such services, and that it accurately reflects the costs (such as office rent, wages, and equipment.) incurred in delivering such services.

Second, OIG will review payments for high-cost diagnostic radiology tests, in effort to determine whether such tests were medically necessary and to determine the extent to which use has increased for these tests. Unlike last year, OIG did not say that for FY 2015 it will investigate the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment.

Third, OIG will review Medicare payments for the transportation and setup of portable x-ray equipment to determine whether payments were correct and were supported by documentation. OIG will also assess the qualifications of the technologists who performed the services and determine whether the services were ordered by a physician. Prior OIG work found that Medicare improperly paid portable x-ray suppliers for return trips to nursing facilities (i.e., multiple trips to a facility in one day) and for services ordered by non-physicians that are not covered by Medicare. Medicare generally reimburses for transportation and setup of portable x-ray equipment if the conditions for coverage are met.

Fourth, OIG will examine Medicare payments to physicians, hospital Outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures. OIG will assess the appropriateness of Medicare payments for high-use sleep-testing procedures and determine whether they were in accordance with Medicare

requirements. An OIG analysis of calendar year (CY) 2010 Medicare payments for CPT codes 95810 and 95811, which totaled approximately \$415 million, showed high utilization associated with these sleep-testing procedures. To the extent that repeated diagnostic testing is performed on the same beneficiary and the prior test results are still pertinent, repeated tests may not be reasonable and necessary.

### **Laboratory**

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scrutiny of clinical laboratories appears relatively limited and will continue work on only one project this year. The new project is:

### **Selected independent clinical laboratory billing requirements (OAS)**

OIG will review payments to independent clinical laboratories with respect to those laboratories' compliance with [unspecified] selected billing requirements to identify laboratories that routinely submit improper claims and recommend recovery of overpayments. OIG's summary suggests that "suspect" laboratories may have already been identified by prior OIG audits, investigations, and inspections, and that it will focus on independent clinical laboratories with claims "that may be at risk of overpayments."

### **Home health services**

Both projects outlined in the 2015 Work Plan are works in progress from last year. OIG's review of prospective payment system requirements will determine whether home health claims were paid in accordance with federal laws and regulations, including documentation required in support of the claims paid by Medicare. OIG will also continue to review the extent to which home health agencies (HHAs) are complying with state requirements for conducting criminal background checks on HHA applicants and employees.

### **Hospices**

The 2015 Work Plan includes only two hospice projects, neither of which is new this year. OIG will continue the following hospice projects:

### **Hospices in assisted living facilities**

Initiated in the 2014 Work Plan, the OIG will continue to review the length of stay, level of care received, and common terminal illnesses of beneficiaries who receive care in assisted living facilities (ALF). This review will assist CMS in the implementation of the Affordable

Care Act requirement which directs that CMS reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. In addition, this review reflects and advances a MedPAC recommendation to

monitor and examine the long stays that ALF residents have in hospice care.

### **Hospice general inpatient care**

In the 2011 Work Plan, the OIG expressed interest in assessing the appropriateness of hospices' general inpatient care claims. Since that 2011 Work Plan, the OIG has expanded its review targeted at hospice general inpatient care to include an assessment of the content of election statements for hospice beneficiaries who receive general inpatient care and the appropriateness of these claims. OIG will continue to review hospice medical records to address the concern of misuse of general inpatient hospice care. As the OIG has previously stated, this review is premised on the notion that hospice care is intended to be palliative rather than curative.

### **Ambulance services**

The 2015 Work Plan includes two projects focusing on ambulance services. First, OIG will examine Medicare claims data to assess the extent of questionable billing for ambulance services, such as transports that were

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medically unnecessary. In particular, OIG will likely focus on unnecessary transports to dialysis facilities. OIG will further scrutinize ambulance claims data to determine whether providers have billed and been paid at the appropriate level of service (e.g., advanced life support vs. basic life support).

For OIG's second project involving ambulance services, it will analyze and synthesize prior OIG evaluations, audits, investigations, and compliance guidance related to ambulance transport services paid by Part B to identify vulnerabilities, inefficiencies, and fraud trends. OIG will offer recommendations to improve detected vulnerabilities and minimize inappropriate payments for ambulance services.

### Prescription drugs

The 2015 Work Plan discusses seven projects related to Part B payments for prescription drugs, only one of which is new (one of these projects is under the ACA reviews). OIG will continue to compare the average sales prices (ASPs) of Part B drugs to average manufacturer prices (AMPs). If the ASP for a drug exceeds the AMP by 5%, OIG will notify the Secretary who may disregard the ASP and apply a price substitution policy when setting reimbursement amounts. OIG will also determine whether Medicare can share in the savings for 340B drugs by calculating the difference between the current ASP-based payments and 340B prices and estimating potential savings.

In the billing and payments category, OIG will continue to determine whether Part B

payments for immunosuppressive drugs that were billed with the service code modifier KX met documentation requirements. Additionally, in response to certain drugs' vulnerability to incorrect coding, particularly chemotherapy drugs, OIG will review outpatient payments to providers as well as the administration of these drugs to determine whether Medicare overpaid providers due to incorrect coding or overbilling.

To avoid Medicare payments for drugs with little clinical evidence of safety and effectiveness, OIG will review oversight actions that CMS and its claims processing contractors take to ensure that payments for Part B drugs meet the appropriate coverage criteria. OIG will also determine the extent to which publishers of authoritative prescription drug compendia recognized by CMS have transparent processes for evaluating anticancer drug therapies and identifying conflicts of interest.

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to scrutiny of potential duplicate discounts for 340B purchased drugs. The Affordable Care Act (ACA) prohibited duplicate discounts for 340B purchased drugs paid through Medicaid managed care organizations. OIG will assess the risk of duplicate discounts and describe states' efforts to prevent them, because

existing processes to prevent duplicate discounts may not be sufficient (according to OIG).

### Part A & B Medicare Administrative Contractors, IT, and program management issues

The number of projects addressing Medicare Administrative Contractors (MACs) has

continued to decline, as has the number of new projects. There are seven projects this year (down from eight last year and 12 in 2013), none of which are new. OIG expects to complete the following notable projects this year:

**Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs)—Identification and collection status of Medicare overpayments (OEI)**

This project will determine the total amount of overpayments that ZPICs and PSCs identified and referred to claims processors in 2013 and the amount of these overpayments that claims processors have collected. This project resulted from OIG reports regarding the tracking and collection of the overpayments and CMS responses related to additional reporting requirements it is implementing to improve overpayment tracking.

**Medicare Benefit Integrity Contractors' activities (OEI)**

OIG will review and report the level of benefit integrity activity performed by Medicare benefit integrity contractors in calendar years 2012 and 2013. These contractors include the PSCs, ZPICs, and the Medicare Drug Integrity Contractors (MEDICs). Some of the activities they perform include identifying aberrant billing patterns, conducting fraud investigations, and referring suspected fraud for prosecution.

In the information technology area, OIG has two projects, including OIG's annual report to Congress on Medicare contractor information systems security programs. The other project is:

**Controls over networked medical devices at Hospitals (OAS)**

OIG will review CMS oversight of hospitals' security controls over computerized medical

devices, such as dialysis machines, radiology systems, and medication dispensing systems that are integrated with hospitals' EHR systems and other networks. OIG is concerned about whether controls are in place to protect electronic PHI. OIG notes that protection of PHI is a condition for hospital participation in federal healthcare programs.

OIG also announced two additional Medicare Part A and B projects related to program management issues, one new and one continuing:

**Enhanced enrollment screening process for Medicare providers (OEI)**

OIG is reviewing CMS's implementation of the enhanced enrollment screening procedures mandated by the ACA. As part of the review OIG will analyze enrollment data pre- and post- these ACA mandated changes.

**Risk assessment of CMS's administration of the Pioneer Accountable Care Organization (ACO) Model (OAS)**

This new audit project will involve a risk assessment of CMS's internal controls related to the Pioneer ACO Model.

**Conclusion**

The 2015 Work Plan represents a notable narrowing the breadth of new OIG projects compared to prior years. With fewer projects, OIG will have a narrowed focus, and possibly a greater attention on those projects listed. Ultimately, healthcare providers and suppliers are advised to keep in mind the OIG projects related to their line of business, because it can help shed light on those areas of compliance which the OIG believes to be important. 

1. Department of Health and Human Services, Office of Inspector General: FY 2015 Work Plan. Available at <http://1.usa.gov/113zaLV>