SUMMARY OF THE OIG 2015 WORK PLAN

EXECUTIVE SUMMARY

On October 31, 2014, the Office of Inspector General ("OIG") published its Work Plan ("Plan") for Fiscal Year ("FY") 2015. The Plan, which is published annually and describes OIG's new and ongoing audit and enforcement priorities for the upcoming year, is helpful in identifying provider compliance risk areas and providing focus for their ongoing efforts relating to their compliance program activities, audits and policy development. Compliance Officers should carefully review the Plan when preparing their own organization's annual compliance audit priorities to ensure they include the pertinent risk areas identified by OIG.

In the FY 2015 Plan, OIG identifies only a couple new focus areas for hospitals and instead continues much of its focus on areas that were identified in the FY 2014 Plan. This could be explained by the fact that OIG delayed publication of the FY 2014 Plan until January 2014, while OIG traditionally publishes the Plan for the upcoming FY in October of each year. The two new areas of focus for hospitals relate to the review of hospital wage data and adverse events in long-term care hospitals. The areas of focus that OIG will also continue from FY 2014 include, but are not limited to, the following: new inpatient admission criteria, Medicare costs associated with defective medical devices, comparison of provider-based and freestanding clinics, outpatient evaluation and management services billed at the new-patient rate, review of cardiac catheterization and heart biopsies, indirect medical education payments and oversight of hospital privileging.

OIG likewise identifies in the FY 2015 Plan only one new targeted issue for non-hospital provider/supplier types - billing by independent clinical laboratories - while remaining focused on a number of areas identified in the FY 2014 and earlier Plans.

A complete copy of the FY 2015 Plan may be accessed on OIG's website here. A summary of OIG's key FY 2015 hospital audit areas and other activities is provided below.

MEDICARE HOSPITAL AUDIT ACTIVITIES

In FY 2015, OIG adds two new compliance risk areas and continues to examine several other areas that were identified in the FY 2014 Plan, including the following:

- Review of Hospital Wage Data *(New).* OIG will review hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments. Prior OIG work in this area identified hundreds of millions of dollars in incorrectly reported wage data, resulting in policy changes by the Centers for Medicare & Medicaid Services ("CMS") with regard to how hospitals report deferred compensation costs. Hospitals must accurately report wage data to CMS annually to develop wage index rates.
- Adverse Events in Long-Term Care Hospitals *(New).* OIG will examine the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving care in long-term care hospitals ("LTCHs"). OIG will identify factors contributing to these events, determine the extent to which the events were preventable and estimate the associated costs to Medicare. LTCHs are inpatient hospitals that provide long-term care to clinically complex patients, such as those with multiple acute or chronic conditions, and account for nearly 11% of Medicare costs for post-acute care.
- New Inpatient Admission Criteria. OIG will determine the impact of new inpatient admission criteria on hospital billing, Medicare payments and beneficiary payments. This review will also determine how inpatient billing varies among hospitals in FY 2014. Prior OIG work found overpayments for short inpatient stays, inconsistent billing practices among hospitals and financial incentives for billing Medicare inappropriately. Beginning in FY 2014, new Medicare inpatient admission criteria state that physicians generally should admit patients for inpatient care when those patients are expected to require care that crosses at least two midnights. Conversely, patients who are expected to require care for less than two midnights generally should be treated as outpatients.
- Medicare Costs Associated with Defective Medical Devices. OIG will review Medicare claims to identify the costs resulting from additional utilization of medical services due to defective medical devices and determine the impact of those costs on the Medicare Trust Fund. CMS previously expressed concerns about the impact of the cost of replacement devices, including ancillary cost, on Medicare payments for inpatient and outpatient services.

- Comparison of Provider-Based and Free-Standing Clinics. OIG will review Medicare payments for physician office visits rendered in provider-based clinics compared to payments for physician office visits rendered in freestanding clinics to determine how payments to these clinics differ for similar services rendered. OIG will use this data to assess the potential impact on the Medicare program of hospitals claiming provider-based status for clinic facilities, which often results in higher payments for services rendered.
- Outpatient Evaluation and Management Services Billed at the New-Patient Rate. OIG will review Medicare outpatient payments made to hospitals for new patient evaluation and management services to determine whether such payments were appropriate and to recommend recovery of overpayments as appropriate. OIG's preliminary work identified overpayments that occurred because hospitals used new patient codes when billing for services provided to established patients. According to applicable federal regulations, the meaning of "new" and "established" pertains to whether the patient was registered as an inpatient or outpatient of the hospital within the past three years.
- Nationwide Review of Cardiac Catheterization and Heart Biopsies. OIG will review Medicare payments for right heart catheterizations ("RHC") and heart biopsies billed during the same operative session and determine whether hospitals complied with applicable Medicare billing requirements. Previous OIG reviews identified inappropriate payments when hospitals received separate payment for RHC procedures when the services were already included in payments for heart biopsies.
- Indirect Medical Education Payments. OIG will review provider data to determine whether hospitals' indirect medical education ("IME") payments were calculated properly and made in accordance with federal regulations and guidelines. Prior OIG reviews indicated that hospitals received excess reimbursement for IME costs. Teaching hospitals with residents in approved graduate medical education programs receive additional payments for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to those of non-teaching hospitals. The additional payments, known as IME adjustments, are calculated using the hospital's ratio of resident full-time equivalents to available beds.
- Oversight of Hospital Privileging. OIG will determine how hospitals assess medical staff candidates prior to granting initial privileges, including verification of credentials and review of the National Practitioner Databank. The Medicare Conditions of Participation for hospitals require that a participating hospital have an organized medical staff that periodically conducts appraisals of its members. A hospital's governing body must ensure that the members of the medical staff, including physicians and other licensed independent practitioners, are accountable for the quality of care provided to patients.

OTHER CONTINUING MEDICARE HOSPITAL AUDIT ACTIVITIES

In FY 2015, OIG will also continue to examine other compliance risk areas that have been targeted in earlier Plans, including the following:

- Reconciliations of Outlier Payments;
- Analysis of Salaries Included in Hospital Cost Reports;
- Medicare Oversight of Provider-Based Status;
- Critical Access Hospitals - Payment Policy for Swing-Bed Services;
- Inpatient Claims for Mechanical Ventilation;
- Review of Selected Inpatient and Outpatient Billing Requirements;
- Duplicate Graduate Medical Education Payments;
- Outpatient Dental Claims;
- Payments for Patients Diagnosed with Kwashiorkor;
- Bone Marrow or Stem Cell Transplants;
- Hospital Participation in Projects with Quality Improvement Organizations;
- Oversight of Pharmaceutical Compounding; and

- Inpatient Rehabilitation Facilities - Adverse Events in Post-Acute Care for Medicare Beneficiaries.

OTHER PROVIDER/SUPPLIER AUDIT ACTIVITIES

The Plan identifies enforcement priorities not only for hospitals but also for other types of Medicare providers and suppliers, including laboratories, skilled nursing facilities, hospices, ambulance suppliers and individual practitioners. For these provider and supplier types, OIG identified only one new focus area for FY 2015:

- Selected Independent Clinical Laboratory Billing Requirements *(New)*. OIG will review Medicare payments to independent clinical laboratories to determine laboratories' compliance with selected billing requirements. The results of the reviews will be used to identify clinical laboratories that routinely submit improper claims. OIG will recommend recovery of overpayments, as appropriate. Prior OIG audits, investigations and inspections have identified independent clinical laboratory areas at risk for noncompliance with Medicare billing requirements. Payments to service providers are precluded unless the provider has, and furnishes upon request, the information necessary to determine the amounts due.

In FY 2015, OIG will also continue to examine several other provider and supplier compliance risk areas that have been the focus of previous years' work, including, but not limited to, the following:

- Medicare Part A Billing by Skilled Nursing Facilities;
- Questionable Billing Patterns for Part B Services During Nursing Home Stays;
- Hospice in Assisted Living Facilities;
- Hospice General Inpatient Care;
- Home Health Prospective Payment System Requirements;
- End-Stage Renal Disease Facilities - Payment System for Renal Dialysis and Drugs;
- Ambulance Services - Questionable Billing, Medical Necessity and Level of Transport;
- Anesthesia Services - Payments for Personally Performed Services;
- Diagnostic Radiology - Medical Necessity of High-Cost Tests;
- Physicians - Place-of-Service Coding Errors;
- Physical Therapists - High Use of Outpatient Physical Therapy Services; and
- Sleep Disorder Clinics - High Use of Sleep-Testing Procedures.

CONCLUSION

As indicated above, the Plan is useful in giving providers a preview of many of OIG's enforcement priorities planned for FY 2015. Providers should take advantage of this opportunity to consider how to effectively focus their compliance program auditing and monitoring activities over the ensuing twelve months.

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