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SUMMARY OF THE OIG 2016 WORK PLAN

EXECUTIVE SUMMARY

On November 2, 2015, the Office of Inspector General ("OIG") published its Work Plan for Fiscal Year ("FY") 2016 ("Plan"). 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 corporate compliance risk areas and providing focus for providers' 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.

There are several new and revised areas of focus in the FY 2016 Plan. In particular, the new hospital focus areas include medical device credits for replaced medical devices, Medicare payments during an MS-DRG payment window and the Centers for Medicare & Medicaid Services' ("CMS's") validation of hospital-submitted quality reporting data. In addition, OIG will continue to review Medicare's oversight of provider-based status. Significant new focus areas for other types of providers/suppliers include, but are not limited to, the general inpatient care level of the Medicare hospice benefit, skilled nursing facility ("SNF") prospective payment system requirements, increased billing for ventilators, quality oversight of ambulatory surgical centers, the referring/ordering of Medicare services and supplies by physicians, the reasonableness of physician home visits and the reasonableness of prolonged physician evaluation and management services. OIG also notes that it will expand its focus on delivery system reform and the effectiveness of alternate payment models, coordinated care programs and value-based purchasing in FY 2016 and beyond.

A complete copy of the Plan may be accessed on OIG's website here.

A summary of OIG's key FY 2016 hospital audit areas and other activities is provided below.

MEDICARE HOSPITAL AUDIT ACTIVITIES

Significant new and revised hospital risk areas that OIG will focus on during FY 2016 include the following:

- Medical device credits for replaced medical devices (New). OIG will determine whether Medicare payments for replaced medical devices were made in accordance with Medicare requirements. Federal regulations require reductions in Medicare payments for the replacement of implanted devices. Prior OIG reviews have determined that Medicare Administrative Contractors have made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices.
- Medicare payments during MS-DRG payment window (New). 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 and in accordance with the Inpatient Prospective Payment System. Prior OIG audits, investigations and inspections have identified this area as at risk for noncompliance with Medicare billing requirements.
- CMS validation of hospital-submitted quality reporting data (New). OIG will determine the extent to which CMS validated hospital inpatient quality reporting data. Accuracy and completeness of this data is important because CMS uses it for the Hospital Value-Based Purchasing Program and the Hospital-Acquired Condition Reduction Program.
- Medicare oversight of provider-based status (Revised). OIG will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. OIG will also determine the extent to which provider-based facilities meet requirements described in 42 CFR § 413.65 and CMS Transmittal A-03-030 and whether there were any challenges associated with the provider-based attestation review process. Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries' coinsurance liabilities.

OTHER CONTINUING MEDICARE HOSPITAL AUDIT ACTIVITIES

In FY 2016, OIG will also continue to examine several compliance risk areas that have been the focus of previous years' work, including the following:

- Reconciliations of outlier payments;
- Hospitals' use of outpatient and inpatient stays under Medicare's two-midnight rule;
- Medicare costs associated with defective medical devices;
- Analysis of salaries included in hospital cost reports;
- Comparison of provider-based and freestanding clinics;
- Inpatient claims for mechanical ventilation;
- Selected inpatient and outpatient billing requirements;
- Duplicate graduate medical education payments;
- Indirect medical education payments;
- Outpatient dental claims;
- Nationwide review of cardiac catheterizations and endomyocardial biopsies;
- Payments for patients diagnosed with kwashiorkor;
- Bone marrow or stem cell transplants;
- Review of hospital wage data used to calculate Medicare payments;
- Intensity-modulated radiation therapy;
- Inpatient rehabilitation facilities - adverse events in post-acute care for Medicare beneficiaries;
- Long-term care hospitals - adverse events in post-acute care for Medicare beneficiaries;
- Hospital preparedness and response to high-risk infectious diseases; and
- Hospitals' electronic health record system contingency plans.

OTHER PROVIDER/SUPPLIER AUDIT ACTIVITIES

The Plan identifies enforcement priorities not only for hospitals but also for other types of providers/suppliers, including skilled nursing facilities, hospices, ambulance suppliers and individual practitioners, including chiropractors and mental health providers. Some of the significant new and revised focus areas that OIG identified for these providers/suppliers during FY 2016 include the following:

- Skilled nursing facility prospective payment system requirements (New). OIG will review compliance with various aspects of the SNF prospective payment system, including the documentation requirement in support of the claims paid by Medicare. Prior OIG reviews have found that Medicare payments for therapy greatly exceeded SNFs' costs for therapy. In addition, OIG has found that SNFs have increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. OIG will determine whether SNF claims were paid in accordance with federal laws and regulations. All documentation requirements specified in 42 CFR § 483.20 must be met to ensure that SNF care is reasonable and necessary.
- Increased billing for ventilators (New). OIG will describe billing trends for ventilators, respiratory assist devices ("RADs") and continuous positive airway pressure ("CPAP") devices from 2011-2014, as well as examine factors associated with the increase in ventilator claims. CMS and its contractors have expressed concerns about the increase in billing for ventilators, specifically HCPCS code E0464. Suppliers may be inappropriately billing for ventilators for beneficiaries with non-life-threatening conditions, which would not meet the medical necessity criteria for ventilators and might instead be more appropriately billed to codes for RADs or CPAPs.
- Ambulatory surgical centers - quality oversight (New). OIG will review Medicare's quality oversight of ASCs. Previous OIG work found problems with Medicare's oversight system, including finding spans of five or more years between certification surveys for some ASCs, poor CMS oversight of state survey agencies and ASC accreditors and little public information on the quality of ASCs.

- Physicians - referring/ordering Medicare services and supplies (New). OIG will review select Medicare services, supplies and durable medical equipment ("DME") referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid.
- Anesthesia services - non-covered services (New). OIG will review Medicare Part B claims for anesthesia services to determine whether they were supported in accordance with Medicare requirements. Specifically, OIG will review anesthesia services to determine whether the beneficiary had a related Medicare service.
- Physician home visits - reasonableness of services (New). OIG will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit.
- Prolonged services - reasonableness of services (New). OIG will determine whether Medicare payments to physicians for prolonged evaluation and management ("E/M") services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. The necessity for prolonged services is considered to be rare and unusual.
- Hospice general inpatient care (Revised). OIG will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. OIG will also review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary, including reviewing beneficiaries' plans of care to determine whether they meet key requirements. In addition, OIG will determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

OTHER NEW AND CONTINUING PROVIDER/SUPPLIER AUDIT ACTIVITIES

OIG will also focus on the following areas in FY 2016, many of which have been the focus of previous years' work:

- Orthotic braces - reasonableness of Medicare payments compared to amounts paid by other payers (New);
- Osteogenesis stimulators - lump-sum purchase versus rental (New);
- Orthotic braces - supplier compliance with payment requirements (New);
- Histocompatibility laboratories - supplier compliance with payment requirements (New);
- National Background Check Program for long-term care employees;
- Home health prospective payment system requirements;
- Power mobility devices - lump-sum purchase versus rental;
- Competitive bidding for medical equipment items and services - mandatory post-award audit;
- Power mobility devices - supplier compliance with payment requirements;
- Nebulizer machines and related drugs - supplier compliance with payment requirements;
- Diabetes testing supplies effectiveness of system edits to prevent inappropriate payments for blood glucose test strips and lancets to multiple suppliers;
- Access to durable medical equipment in competitive bidding areas;
- Ambulatory surgical centers - payment system;
- End-stage renal disease facilities-payment system for renal dialysis services and drugs;
- Ambulance services - questionable billing, medical necessity and level of transport;

- Anesthesia services - payments for personally performed services;
- Chiropractic services - Part B payments for non-covered services;
- Chiropractic services - portfolio report on Medicare Part B payments;
- Imaging services - payments for practice expenses;
- Selected independent clinical laboratory billing requirements;
- Annual analysis of Medicare clinical laboratory payments;
- Physical therapists - high use of outpatient physical therapy services;
- Portable x-ray equipment - supplier compliance with transportation and setup fee requirements;
- Sleep disorder clinics - high use of sleep-testing procedures; and
- Inpatient rehabilitation facility payment system requirements.

PRACTICAL TAKEAWAY

As indicated above, the Plan is useful in giving providers a preview of many of OIG's enforcement priorities planned for FY 2016. Providers should take advantage of this opportunity to consider how to effectively focus their compliance program activities over the ensuing twelve months.

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