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SUMMARY OF THE OIG 2014 WORK PLAN

EXECUTIVE SUMMARY

On January 31, 2014, the Office of Inspector General ("OIG") published its Work Plan for Fiscal Year ("FY") 2014. Normally, the OIG issues its Work Plan in early October to coincide with the beginning of its October 1 Fiscal Year. The Work Plan, which is published annually and describes the 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 Work Plan when preparing their own organization's annual compliance audit priorities to ensure they include the pertinent risk areas identified by the OIG.

Although there is significant overlap between the FY 2014 Work Plan and the OIG's previous Work Plan activities, there are several new areas of focus. In particular, some of the significant new hospital focus areas include, but are not limited to: 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. Significant new focus areas for other types of providers/suppliers include, but are not limited to: Medicare Part A billing by skilled nursing facilities ("SNFs"), hospice in assisted living facilities, Medicare Part B payments for ambulance services, chiropractic services billing and payment and mental health provider enrollment and credentialing.

A complete copy of the Work Plan may be accessed on the OIG's website. A summary of the OIG's key FY 2014 hospital audit areas and other activities is provided below.

NEW MEDICARE HOSPITAL AUDIT ACTIVITIES

Significant new hospital risk areas that the OIG will focus on during FY 2014 include the following:

- New Inpatient Admission Criteria. The 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. The 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. The Centers for Medicare and Medicaid Services ("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 Freestanding Clinics. The 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. The 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. The 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. The 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. The 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. The 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. The 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.

CONTINUING MEDICARE HOSPITAL AUDIT ACTIVITIES

In FY 2014, the 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;
- Impact of Provider-Based Status on Medicare Billing;
- Critical Access Hospitals - Payment Policy for Swing-Bed Services;
- Critical Access Hospitals - Beneficiary Costs for Outpatient Services;
- Long-Term Care Hospitals - Billing Patterns Associated with Interrupted Stays;
- Inpatient Claims for Mechanical Ventilation;
- Review of Selected Inpatient and Outpatient Billing Requirements;
- Duplicate Graduate Medical Education Payments;
- Outpatient Dental Claims;
- Hospital Participation in Projects with Quality Improvement Organizations; and
- Inpatient Rehabilitation Facilities - Adverse Events in Post-Acute Care for Medicare Beneficiaries.

OTHER NEW PROVIDER/SUPPLIER AUDIT AREAS

The OIG Work Plan identifies enforcement priorities not only for hospitals, but also for other types of providers/suppliers, including SNFs, hospices, ambulance suppliers and individual practitioners, including chiropractors and mental health providers. Some of the significant new focus areas that the OIG identified for these providers/suppliers during FY 2014 include the following:

- Medicare Part A Billing by SNFs. The OIG will review SNF billing practices in selected years and describe variation in billing among SNFs in those years. Prior OIG work found that SNFs increasingly billed for the highest level of therapy even though beneficiary characteristics remained largely unchanged. The OIG also found that SNFs billed one-quarter of all 2009 claims in error, resulting in $1.5 billion in inappropriate Medicare payments.

- Hospice in Assisted Living Facilities. The OIG will review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities ("ALFs"). The OIG will determine the length of stay, levels of care received and common terminal illnesses of beneficiaries

who receive hospice care in ALFs. The OIG's work is intended to provide the U.S. Department of Health and Human Services ("HHS") with information needed for HHS to reform the hospice payment system and develop quality measures for hospices, as required under the Affordable Care Act. Since ALF residents have the longest lengths of stay in hospice care, the Medicare Payment Advisory Commission has suggested that these long stays bear further monitoring and examination.

- Ambulance Services – Portfolio Report on Medicare Part B Payments. The OIG will analyze and synthesize OIG evaluations, audits, investigations and compliance guidance related to ground ambulance transport services paid by Medicare Part B to identify vulnerabilities, inefficiencies and fraud trends and offer recommendations to improve detected vulnerabilities and minimize inappropriate payments for ambulance services. Prior OIG work identified fraud schemes and trends indicating overutilization and medically unnecessary payments for ambulance services. Ambulance services are covered under Medicare Part B only when the use of other methods of transportation is contraindicated by the beneficiary's condition.

- Chiropractic Services Reviews. The OIG will review and perform various analyses related to billing and payments for chiropractic services. The OIG indicated that it will use relevant data to identify trends in payment, compliance and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities. The OIG will also review the payment data for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements. Medicare Part B pays only for a chiropractor's manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuro-musculoskeletal condition for which manual manipulation is appropriate treatment. Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable by Medicare.

- Mental Health Providers – Medicare Enrollment and Credentialing. The OIG will review and describe Medicare's mental health provider enrollment and credentialing requirements and assess CMS's oversight efforts to verify the qualifications of mental health service providers. The OIG will determine whether selected providers have the required federal and state qualifications to bill Medicare for mental health services.

CONCLUSION/PRACTICAL TAKEAWAY

As indicated above, the Work Plan is useful in giving providers a preview of many of the OIG's enforcement priorities planned for FY 2014. Providers should take advantage of this opportunity to consider how to effectively focus their compliance program activities over the ensuing 12 months.

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