

## HHS-OIG Work Plan

By Daniel Brewer, Jennifer Breuer and Scott Coffina

Last week, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its Work Plan for Fiscal Year 2013 highlighting the new and ongoing activities that OIG plans to pursue during the next fiscal year. OIG is the principal organization charged with detecting, investigating and preventing fraud for all HHS programs, including Medicare and Medicaid. Some of the services that OIG will scrutinize in 2013 include:

### Hospitals

- > Patient Transfers and Discharges: Reviewing Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers; and payments for discharges to swing beds in other hospitals.
- > Payments for Mechanical Ventilation: Reviewing Medicare DRG payments to determine whether beneficiaries received less than the requisite 96-hours of mechanical ventilation to be eligible for certain DRG payments.
- > Outlier Payments: OIG continues to have an interest in examining inpatient outlier payments, which they estimate amount to \$6 billion per year and which have been the basis for millions of dollars in settlements of whistleblower lawsuits.
- > Duplicate Graduate Medical Education Payments: The primary purpose of this review would be to determine whether interns or residents have been improperly counted as more than one full-time employee, resulting in overpayments of allowable costs.
- > Payments for Interrupted Stays: Determining the extent to which Medicare made improper payments to long-term care hospitals when patients are discharged to pursue other treatment, and then readmitted after a certain number of days.

## Hospices

- > Hospice billing and financial relationships: Following up on a 2009 report finding that 82 percent of hospice claims for beneficiaries in nursing homes did not meet Medicare coverage requirements, and on concerns about aggressive marketing by hospices to nursing homes, OIG will focus its review on these activities by hospices with a high percentage of beneficiaries in nursing homes.
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## Nursing Homes

- > Adverse Events and Hospitalization. As Medicare expenditures to SNFs have doubled to \$28 billion over the past decade, OIG will determine the incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care, as well as the extent to which the events were preventable. OIG also will continue to look at the hospitalization of nursing home residents to determine whether they result from quality of care problems.
  - > Use of atypical antipsychotic drugs. Assessing nursing home administration of atypical antipsychotic drugs, and the types of drugs most commonly used. In the Work Plan, OIG reminds SNFs that they must monitor the prescription drugs prescribed to residents and that such regimens must be free from unnecessary drugs.
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## Home Health Agencies

- > Face-to-Face Requirement: Examining the extent in which HHAs are complying with statutory requirements that physicians who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries within 90 days before, or 30 days after, the home health services are begun.
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## Medical Equipment Suppliers

- > Service Code Modifiers: Building upon past reviews of suppliers finding insufficient documentation to support claims for medical equipment, OIG will determine the appropriateness of Part B payments that Medicare made on the basis of specific service code modifiers that suppliers entered on the claims.
- > Specific Medical Equipment: Reviewing supplier compliance with payment requirements for the following specific items:
  - > lower limb prosthetics (building upon a prior national review that showed frequent instances of questionable billing characteristics, such as an absence of documentation of amputation or missing limbs)
  - > power mobility devices (issues of medical necessity)

- > diabetes testing supplies (questionable billing with respect to blood glucose test strips and lancets; diabetes test strips and billing for non-mail-order test strips that actually were provided via mail order to obtain higher reimbursement)Anesthesia Services
- > Reviewing Medicare Part B claims for personally performed services and use of the appropriate modifier for “personally provided” versus “directed the provision of” anesthesia services.

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## Ophthalmological Services

- > Reviewing claims to identify questionable billing for ophthalmological services during 2011. OIG noted that Medicare allowed over \$6.8 billion for services provided by ophthalmologists in 2010.

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## Electrodiagnostic Testing

- > Reviewing questionable billing practices, such as needle electromyograms and nerve conduction studies, which OIG describes as a “growing vulnerability.”

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## Prescription Drug Manufacturers

- > Conflicts of Interest Involving Prescription Drug Compendia: Building on the increased attention paid to reported conflicts of interest and related disclosures in pharmaceutical research studies, OIG will examine how drug compendia monitor and mitigate conflicts of interest
- > Herceptin: Reviewing claims for the breast cancer drug Herceptin, and payments for multi-use vials. Medicare pays for discarded excess product in single use vials, but not for multi-use vials.
- > Off-label Use of Antipsychotics in Children: Following a number of substantial investigations, settlements, litigation and media attention on the off-label prescription of antipsychotics for children, OIG will continue to scrutinize such claims.
- > Manufacturer Co-Payment Coupons: Based on a survey indicating that beneficiaries are using copayment coupons to obtain brand name drugs instead of less expensive generics, OIG will review what safeguards pharmaceutical manufacturers have in place to prevent the use of copayment coupons by beneficiaries to obtain prescription drugs paid for by Medicare Part D, which OIG claims implicates the Anti-Kickback Act.

## Conclusion

The OIG Work Plan provides a good roadmap to areas of likely law enforcement interest, and an opportunity to guide the use of providers' compliance resources. If a provider believes it may have vulnerability in any of the areas highlighted by the OIG in its work plan, it may be advisable to conduct a review or investigation into those activities in order to stay ahead of the law enforcement curve. However, in light of the Affordable Care Act provisions creating False Claims Act liability for the failure to report and return Medicare and Medicaid overpayments within 60 days of identifying them, self-reviews need to be carefully considered, designed and executed.

For more information on any of the activities focused upon by the OIG, or assistance with uncovering and addressing any areas of concern, please contact your usual Drinker Biddle & Reath contact or a member of the Firm's White Collar Defense and Corporate Investigations or Health Care teams:

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