OIG Work Plan Monthly Updates (September, October, and November 2017)

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As previously explained in von Briesen's *Legal Update* OIG Work Plan Moves from Annual to Monthly Updates, the United States Department of Health and Human Services, Office of Inspector General (the "OIG") has decided to update its Work Plan monthly. Health organizations are advised to use these monthly updates to review and update policies and procedures based on the OIG's areas of interest and enforcement priorities.

This *Legal Update* summarizes some of the significant OIG Work Plan updates released for September, October, and November 2017.

Review of Part B Medicare Payments to Hospitals for Services Provided During Inpatient Stays (Added September 2017)
Durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS") claims for beneficiaries who received DMEPOS items while in an inpatient hospital stay should not be billed to Medicare separately. Hospitals are reimbursed for DMEPOS provided to inpatients via the inpatient prospective payment system under Part A, so submission of separate claims results in overpayments. The OIG will review Part B claims made for services provided during inpatient stays to assess compliance. Hospitals should protect against overlapping claims, especially where a beneficiary is an inpatient of one hospital and then sent to another hospital to obtain outpatient services that are not available at the originating hospital. Claims for services or supplies provided on an outpatient basis that are usually reimbursable under Part B may be inappropriate based on a patient's inpatient status at another hospital.

Review of Bariatric Surgery Payments and Documentation of "Morbid Obesity" (Added October 2017)
Bariatric surgical treatments for obesity alone are not covered. Medicare Parts A and B cover certain bariatric procedures if the beneficiary has (1) a body mass index of 35 or higher, (2) at least one comorbidity related to obesity, and (3) been previously unsuccessful with medical treatment for obesity. The Centers for Medicaid and Medicare Services ("CMS") found that nearly all improper payments for bariatric surgical procedures lacked sufficient documentation to support the procedure. The OIG will review supporting documentation to determine whether the bariatric services performed meet the conditions for coverage and are supported in accordance with federal requirements.

Audit of Covered Entities Receiving EHR Incentive Payments to Assess Health Information Security (Added October 2017)
In a July 2017 Work Plan update, the OIG planned to assess calculations in determining Electronic Health Record ("EHR") incentive payments and recommended that CMS recover past overpayments. In order to receive EHR incentive payments, providers have to show that they are "meaningfully using" their EHRs by meeting certain objectives. One objective is to protect electronic health information created or maintained by certified EHR technology. The OIG will perform audits of various covered entities receiving EHR incentive payments from CMS to determine whether they adequately protect electronic health information created or maintained by EHR technology. Covered Entities receiving EHR incentive payments should review the results of their mandatory security risk analyses of EHR technology to determine potential inadequacies and address them accordingly.

Review of Intensity-Modulated Radiation Therapy Billing (Added October 2017)
Intensity-modulated radiation therapy ("IMRT") is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. The OIG has identified hospitals as incorrectly billing for IMRT services. The OIG will review Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with federal requirements. Facilities providing IMRT services should carefully review their billing practices to ensure compliance with Medicare payment rules.

Review Inpatient SNF Payments for Compliance with 3-Day Hospital Stay Rule (Added October 2017)
In order for Medicare beneficiaries to be eligible for skilled nursing facility ("SNF") services (under the prospective payment system), they must have been an inpatient of a hospital for at least 3 consecutive days. Furthermore, the beneficiary is required to be admitted to the SNF either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. The OIG will review SNF claims made under the prospective payment system for compliance with requirements related to the 3-day inpatient hospital stay rules. SNFs should ensure procedures are in place to adequately assess whether potential patients qualify for Medicare reimbursement for SNF services.

Review Supporting Documentation for Diagnoses Submitted by Medicare Advantage Organizations (Added October 2017)
Payments to Medicare Advantage ("MA") organizations are risk adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk adjustment data to CMS. In general, MA organizations receive higher payments for sicker patients. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted. The OIG will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submit to CMS for use in CMS's risk score calculations and determine whether the diagnoses submitted complies with federal requirements. MA organizations should ensure all diagnoses submitted for risk adjustment purposes have adequate supporting documentation.

Review Medicaid Payments for Adult Day Health Care Services (Added October 2017)
Adult day health care programs provide in-home and community-based health, therapeutic, and social services to program enrollees, which are reimbursable under Medicaid. The OIG will review Medicaid payments by states for adult day health care services to determine whether providers complied with federal and state requirements. Providers should ensure that enrollees meet eligibility requirements for the specific programs in which they are enrolled and that each enrollee has a plan of care that is updated as care progresses.

Determine Accuracy of Graduate Medical Education Payments to Hospitals (Added October 2017)
Medicare pays teaching hospitals for direct graduate medical education ("DGME") and indirect medical education ("IME") costs. CMS created the Intern and Resident Information System ("IRIS") to assist hospitals in collecting and reporting information on medical residents. The OIG will review provider data from IRIS to determine whether hospitals received duplicate or excessive DGME payments, and to assess the effectiveness of IRIS in preventing duplicate payments. Hospitals should review compliance with DGME and IME reporting requirements and ensure that no medical resident is being counted by Medicare as employed more than one full-time equivalent.

Examine Assignment of Beneficiaries to Accountable Care Organizations and Related Shared Savings Payments (Added October 2017)
In a June 2017 Work Plan update, the OIG stated it would review Accountable Care Organizations' ("ACOs") participation in the Medicare Shared Savings Programs (the "MSSP"). Under the October update, the OIG explains it will examine the MSSP to determine whether CMS properly assigned beneficiaries to ACOs and made shared savings payments for assigned beneficiaries in compliance with federal requirements. ACOs should ensure that there is no duplication of shared savings payments for the same beneficiaries by other savings programs or initiatives.

Determine Nursing Home Compliance with Updated Life Safety and Emergency Preparedness Requirements (Added October 2017)
CMS recently updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long term care ("LTC") facilities. These updates include requirements that facilities install expanded sprinkler and smoke detector systems to protect residents from the hazards of fire and develop an emergency preparedness plan that facilities must review, test, update, and train residents on annually. The plan must include provisions for sheltering in place and evacuation. The OIG will determine whether LTC facilities that received Medicare or Medicaid funds complied with new federal requirements for life safety and emergency preparedness for the period May 4, 2016, through November 15, 2017. Such facilities should review compliance with the life safety and emergency preparedness updates and maintain documentation of the required improvements.

Review Hospital Claims Indicating "Severe Malnutrition" (Added November 2017)
Hospitals are allowed to bill for the treatment of malnutrition on the basis of the severity of the condition – mild, moderate or severe – and whether it affects patient care. Severe malnutrition is classified as a major complication or comorbidity ("MCC"). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher diagnosis related group. The OIG will determine whether providers are complying with Medicare billing requirements when assigning diagnosis codes for the treatment of severe types of malnutrition on inpatient hospital claims. Hospitals should review their billing of treatment for malnutrition to ensure the proper level of severity is being used. Units with elderly patients, especially those with severe illnesses, will likely receive particular attention because they have increased likelihood of serving malnourished patients.

Additional Areas of Focus
Other areas of focus of the OIG in September, October, and November are as follows:

- Assessment of Controls Over Opioid Treatment Programs and Review Receipt of Opioid by Medicaid Beneficiaries Amid Concerns of Extreme Use and Questionable Prescribing in Selected States;
- Review of the Availability of Behavioral Health Services in Medicaid Managed Care;
- Medicaid Health Home Services for Beneficiaries with Chronic Conditions;
- Review of Medicare and Medicaid Payments for Telehealth Services (this was also a July 2017 update we covered in the *Legal Update* OIG Work Plan Moves from Annual to Monthly Updates);
- Determination of Incorrect Medical Assistance Days Claimed by Hospitals;
- Comparison of Provider-Based and Freestanding Clinics;
- Evaluation of Home Health Prospective Payment System Compliance with Medicare Requirements;
- Assessment of Reconciliation of Outlier Payments;
- Evaluation of the Number and Nature of Financial Relationships Reported to the Open Payments Program;
- Assessment of Medicare Part C and D Payments for Service Dates After Individuals' Dates of Death.
