OIG Work Plan Monthly Updates (November-December 2018, January-February 2019)

Feb 27 2019

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von Briesen continues to monitor the United States Department of Health and Human Services, Office of Inspector General (the "OIG") Work Plan to provide insight into emerging legal trends in health care. Health organizations are advised to use the Work Plan to identify the OIG's areas of interest and enforcement priorities, and to review and update policies and procedures accordingly.

This *Legal Update* summarizes some of the significant OIG Work Plan updates released for November 2018, December 2018, January 2019, and February 2019.

Assessing Inpatient Hospital Billing for Medicare Beneficiaries (December 2018)
Upcoding, or the practice of miscoding in order to increase Medicare payment, is an ongoing concern for both the Centers for Medicare & Medicaid Services ("CMS") and the OIG. Since inpatient hospital stays account for 17% of all Medicare payments, the OIG aims to assess inpatient billing to identify the extent to which hospitals use incorrect codes for these services. The OIG will begin their review by analyzing Medicare claims data to parse out billing trends and changes, as well as, variations among hospitals. Then, using the data, the OIG will target specific hospitals and codes. Providers should review their own billing code trends in order to reduce coding errors.

Medicare Outpatient Outlier Payments for Claims with Credits for Replaced Medical Devices (January 2019)
CMS requires hospitals to adjust their charges to reflect full or partial credits that the hospital has received for replacement medical devices. The OIG has already found that hospitals under-report the full and/or partial credits they receive. See, OIG Report Update: Cardiac Device Credits for more information. In addition, CMS makes additional payments for hospital outpatient services that exceed a fixed multiple of the normal Medicare payment ("outlier payment"). In this audit, the OIG will analyze outpatient claims that include both an outlier payment and a reported medical device credit to determine whether both the medical device credits and the outlier payments adhered to the Medicare requirements. Providers should review their procedures to make sure that medical device credits are being properly reported and that the calculation of outpatient outlier payments is accurate when it includes such a credit.

Follow-up Review on Inpatient Claims Subject to the Post-Acute-Care Transfer Policy (January 2019)
Medicare has two different inpatient payment methodologies which depend on whether the beneficiary is discharged "to home" or to a post-acute care setting. A prior OIG analysis found that hospitals transferred patients to post-acute care settings but improperly claimed the higher reimbursement associated with discharges "to home." The OIG determined that some of these overpayments resulted from the failure of edits in CMS's common working file. The OIG previously recommended corrections to CMS and to recover identified overpayments. The OIG will now review to determine if the recommendations have been implemented and are working properly to prevent the previous problems. Providers should review their designation of Medicare beneficiaries' discharge status to ensure proper coding of inpatient claims.

Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid (January 2019)
Home Health Agencies (HHAs) are responsible for providing all services (either directly or under arrangement) to Medicare/Medicaid beneficiaries while under a home health plan of care. Medicare makes the payment for beneficiaries who are eligible under both Medicare and Medicaid ("dual eligible"). The OIG will conduct an analysis to determine whether states have improperly made Medicaid payment to HHAs for dual eligible beneficiaries. Home health providers should review claims for dual eligible beneficiaries to ensure that claims are not inappropriately submitted to Medicaid.

Nursing Facility Staffing: Reported Levels and CMS Oversight (February 2019)
CMS mandates that nursing facilities provide sufficient licensed nursing staff 24-hours a day and have a registered nurse present for at least 8 consecutive hours a day, 7 days a week. Staffing data is submitted to CMS's Payroll-Based Journal. CMS uses this data to analyze staffing patterns and to populate staffing information in the Nursing Home Compare website. The OIG will produce two reports about this data. The first report will be a data brief that describes nursing staffing levels reported by facilities. The second report will examine the efficacy of CMS's efforts to ensure the self-report data's accuracy and improve quality of care. Long term care providers should review their self-reported staffing information to ensure its accuracy.

Characteristics of Part D Beneficiaries at Serious Risk of Opioid Misuse or Overdose (February 2019)
A previous OIG data brief identified that approximately 71,000 Part D beneficiaries were at risk for serious opioid misuse or overdose. The OIG will conduct a new study with the goal of: (1) identifying the characteristics of at-risk beneficiaries; (2) the beneficiaries' utilization of opioids; and (3) the extent of adverse health effects related to a beneficiaries' opioid use and opioid overdoses. In light of the OIG's continued focus on opioid prescribing, providers should continue to implement measures to monitor prescribers who issue high levels of opioid prescriptions.

Other areas of focus of the OIG in November, December, January, and February are as follows:

- The OIG will release an analysis of the top 25 laboratory tests by Medicare Part B expenditure for 2018 (the first year payments were subject to the Protecting Access to Medicare Act of 2014);
- The OIG will analyze the extent to which states are complying with federal requirements to investigate and take enforcement actions against nursing homes which make inappropriate involuntary transfers and discharges;
- Pursuant to the broad goal of protecting Medicare hospice beneficiaries from harm, the OIG will use survey reports to produce a study identifying instances of poor-quality care and other vulnerabilities that resulted in harm to beneficiaries; and
- To ensure the integrity of the NIH grant process, the OIG will evaluate the NIH policies and procedures to ensure that grants are free of financial conflicts of interest and other potential sources of bias.