OIG Work Plan Monthly Updates (June-December 2019)

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Practice Area: Health Law & Healthcare Billing and Collection & Regulatory Compliance and Fraud and Abuse

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 June 2019, July 2019, August 2019, September 2019, October 2019, November 2019, and December 2019.

Overturned Denials in Medicaid Managed Care (June 2019)
Managed Care Organizations ("MCOs") contract with state Medicaid agencies to provide services to Medicaid beneficiaries. These MCOs then bear the financial risk for the cost of care of the Medicaid beneficiaries as the state Medicaid agencies pay the MCOs at a flat rate per-beneficiary. This has the potential to create an incentive for MCOs to improperly deny access to covered services. Continuing previous evaluations, the OIG will conduct a review of denied services and payments that were overturned on appeal to help monitor this potential for abuse.

Comparison of Provider-Based and Freestanding Clinics (June 2019)
Certain facilities can be treated as "provider-based" if they meet the requirements of 42 C.F.R. §413.65(d). This is often seen as advantageous as provider-based facilities can receive higher reimbursement for some services than freestanding clinics. Given this important distinction, the OIG will review and compare Medicare payments made to provider-based clinics and freestanding clinics in order to assess the potential impact on beneficiaries and the clinics receiving provider-based status.

Involuntary Transfer and Discharge in Nursing Homes (June 2019)
When discharging or transferring a resident, skilled nursing facilities must follow certain formalities required by state and federal regulations. CMS estimates that as many as one-third of all residents are involuntarily discharged—many of which are discharged improperly. The OIG will determine the extent to which long-term care ombudsmen address involuntary transfers and discharges and the extent to which state survey agencies investigated and took enforcement actions against nursing homes for inappropriate involuntary transfers or discharges. In light of this heightened scrutiny from the OIG on state regulators, skilled nursing facilities should review discharge policies and take caution to document compliance with requisite discharge procedures.

Use of Telehealth to Provide Behavioral Health Services in Medicaid Managed Care (August 2019)
Telehealth technology has proliferated to a great extent in the last decade. Payers are increasingly likely to reimburse for medical services provided through telehealth technology. Every state currently provides at least some Medicaid coverage for telehealth services. The OIG has very little information, however, on the utilization of telehealth for behavioral health services. Therefore, the OIG will review a selection of states to determine (i) how MCOs use telehealth to provide behavioral health services; (ii) the policies in place for state oversight of behavioral health services delivered through telehealth technology; and (iii) how to maximize the benefits of utilizing telehealth for behavioral health services.

Medicare Part B Services to Medicare Beneficiaries Residing in Nursing Homes During Non-Part A Stays (August 2019)
Part B services provided to residents of skilled nursing facilities are not subject to consolidated billing and, as a result, individual Part B providers may submit separate claims to Medicare for these residents. However, for decades, the OIG has identified issues with Part B payments for services provided to skilled nursing facility residents because these facilities provide access to a significant population of Medicare beneficiaries and because the skilled nursing facility may not be aware of the services the Part B providers bill directly to Medicare. The OIG will determine whether Part B payments for services rendered to residents were appropriate and whether facilities have effective compliance programs and adequate controls over the care provided to their residents. For this reason, skilled nursing facilities should review their compliance programs to ensure the facility maintains adequate control over the care provided to residents.

Medicaid Assisted Living Services (August 2019)
In many states, Medicaid beneficiaries eligible for placement in a nursing home can elect to be placed in a less restrictive, home and community-based setting to receive treatment and have those services reimbursed through the Medicaid program. In Wisconsin, these services, including assistance with activities of daily living and therapy services, are most often rendered in an assisted living facility through the Family Care program. The Government Accountability Office released a report in 2018 indicating more significant federal oversight is required in these settings. The OIG will determine whether assisted living providers are meeting quality-of-care requirements and whether providers properly claimed Medicaid reimbursement for services. Medicaid certified assisted living providers should review internal policies and procedures to ensure compliance with not only state regulatory requirements, but also federal home and community-based settings requirements.

Review of Medicare DRG Window (August 2019)
If an outpatient services falls within the diagnosis-related group (DRG) window of a hospital admission, per CMS's policy, these services are to be considered a part of the inpatient treatment and are not separately payable by Medicare. Services that fall within the DRG window are typically provided up to three days prior to inpatient admission, are diagnostic or admission related, and provided by the admitting hospital or wholly owned subsidiary or entity operated by the admitting hospital. The OIG will be conducting an analysis of admission or diagnostic services that did not fall within the DRG window and determine how many of these services would have qualified had the window been extended or had other ownership structures been included in the types of facilities included in the DRG window. The OIG will also determine how much money Medicare and its beneficiaries would have saved had those services been included in the DRG window. In addition to the OIG's review, CMS will identify alternative payment models and solutions that could pay for these outpatient services. Providers should be aware that CMS may update the DRG window definitions and payment models and be prepared to update their billing strategies and procedures in response to any changes.

Review of Medicare Facet Joint Procedures (August 2019)
Facet joint injections are a commonly used to diagnose and treat back pain. During previous reviews, the OIG identified significant billing errors related to these injections. The OIG will investigate whether Medicare payments for these procedures are billed in compliance with federal requirements. Providers should review their policies and procedures for billing facet joint injections for compliance with the federal requirements and remedy any billing deficiencies that are discovered during their self-review.

Review of Medicare Part B Urine Drug Testing Services (October 2019)
Medicare covers clinical laboratory services such as urine drug testing ("UDT,"or sometimes referred to as urine drug screens) under Part B. Physicians use UDT to monitor for the presence (or absence) of certain drugs in patient urine samples for a variety of reasons such as when providing treatment for substance use disorders or to track patient compliance with their medication regimen or to detect potential diversion. Medicare fee-for-service data from 2018 showed laboratory testing, including UDT, had an improper payment rate of almost 30 percent and the overpayment rate for definitive drug testing for twenty-two or more drug classes was 71.7 percent. The OIG plans to review UDT services for Medicare beneficiaries with substance-use-disorder-related diagnoses to determine if claims were allowable under Medicare requirements.

Medicaid Concurrent Eligibility (November 2019)
MCOs contract with state Medicaid agencies for the MCOs to provide services to Medicaid beneficiaries. As the state Medicaid agencies pay the MCOs at a flat rate per-beneficiary, the MCOs then bear the financial risk for the cost of care of each Medicaid beneficiary. However, The OIG suspects that those per-beneficiary payments may not be entirely accurate for beneficiaries who move to a new state in a given year and become the responsibility of a different state agency. The OIG will review whether state Medicaid agencies have made any improper payments Medicaid MCO members who have changed residency.

The Opioid Crisis
The OIG continues to focus on how to remedy the opioid crisis and assist those individuals affected by the crisis. Since June 2019, the OIG has focused on identifying at-risk individuals through efforts such as providing state targeted response grants to fund opioid treatment service and releasing a data analysis toolkit to help identify patients who are at risk of misuse or overdose.

Additionally, the OIG is examining Substance Abuse and Mental Health Services Administration's (SAMHSA) buprenorphine waiver program. This program allows providers to prescribe this drug, which helps ease withdrawal symptoms, to their patients in a medical office rather than at a treatment facility. With its review, the OIG hopes to identify the effectiveness of the waiver program and ensure that these programs are reaching the areas with the greatest need.

The OIG also proposed a review of the utilization and pricing trends of naloxone, the lifesaving overdose treatment drug, in Medicaid. With this review, the OIG looks to determine how to cost-effectively increase access to naloxone.

The Rundown
Other areas of focus of the OIG in June, July, August, September, October, November and December are as follows:

- The OIG plans to review the Department of Health and Human Services's (HHS) contingency plans to ensure that HHS is able to continue its mission and the provision services even during a disaster or major disruptive event.
- The OIG will assess the Food and Drug Administration's surveillance efforts in the post market for medical devices in an effort to safeguard individuals from receiving unsafe or ineffective medical devices.
- In order to be eligible for Medicare reimbursement a treatment must be considered "reasonable and necessary." Positive airway pressure (PAP) devices for the treatment of sleep apnea are only reasonable and necessary if prescribed after a sleep study has been conducted. The OIG will examine whether Medicare payments were made only for PAP devices prescribed after a sleep study was conducted.
- The OIG will examine whether or not the National Institute of Health's electronic health records system complies with Federal requirements and what interoperability challenges may exist with the system.
- The OIG will conduct a review to determine the extent to which states are self-certifying to the Administration for Children and Families that a trained guardian ad litem is being appointed for children suffering abuse, and any compliance issues that the states are experiencing.
