Health and Human Services Office of Inspector General Work Plan

I. Work Plan for Fiscal Year 2013

On October 2, 2012, the U.S. Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) published its Work Plan for Fiscal Year 2013 (“Work Plan”), summarizing the new and ongoing activities that it plans to engage in during the 2013 fiscal year.¹

OIG is responsible for detecting, investigating and preventing fraud for over 300 HHS programs that are administered by agencies such as the Centers for Medicare & Medicaid Services (“CMS”), National Institutes of Health (“NIH”), Food and Drug Administration (“FDA”), Centers for Disease Control and Prevention (“CDC”), and Administration for Children and Families (“ACF”). Audits and enforcements, compliance projects and program reviews are carried out by its Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General, with some reviews required by statute, including the audit of HHS’ financial statements under the Government Management Reform Act.

The Work Plan describes OIG’s audit and enforcement priorities for many of these HHS programs, including its activities for more than 240 Medicare and Medicaid initiatives. Some of its expected activities concerning these Medicare (and several related Medicaid) initiatives, as set forth in the Work Plan, are briefly summarized below.

A. Hospitals

1. Non-Hospital Owned Physician Practices Using Provider-Based Status

OIG will review the impact on non-hospital owned physician practices billing Medicare as provider-based physician practices and the extent to which these practices meet the Medicare

¹ The Work Plan is one of OIG’s three core publications. The Semiannual Report to Congress summarizes OIG’s most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. The annual Compendium of Unimplemented Recommendations describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.
provider-based rules. OIG will also determine the extent to which hospitals acquiring ambulatory surgery centers and converting them to hospital outpatient surgery departments impacts both Medicare payments and beneficiary costs.

2. Patient Transfers and Discharges

OIG will review 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. A hospital discharging a Medicare beneficiary is entitled to the full diagnosis related group (“DRG”) payment amount, while a transferring hospital is entitled to a per diem rate. OIG will scrutinize both the processing and payments for Medicare beneficiary discharges and the effect of Medicare Contractors’ claims processing edits to distinguish between transfers and discharges.

3. Payments for Interrupted Stays

OIG will review 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.

4. Billing Compliance for Specific Payment Areas

OIG will examine certain areas of payment, including payments for canceled surgical procedures and payments for mechanical ventilation. OIG will continue to review Medicare payments for inpatient and outpatient services to determine billing compliance, inpatient outlier payments to identify characteristics of hospitals with high or increasing rates of outlier payments, reconciliation by CMS of outlier payments and duplicate graduate medical education payments.

Additionally, OIG will continue to scrutinize:

- Hospital admissions with conditions coded present on admission;
- Hospital readmissions;
- Inpatient outliers and other charge-related issues;
- Observation services during outpatient visits;
- Improper payments to providers under the Medicare secondary payor rules; and
• Whether certain states made Medicaid payments for healthcare acquired and provider-preventable conditions.

B. Nursing Homes

1. Adverse Events and Hospitalization

OIG will determine and review the incidence of adverse and temporary harm events for Medicare beneficiaries receiving post-acute care in skilled nursing and inpatient rehabilitation facilities, 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.

2. Use of Atypical Antipsychotic Drug

OIG will assess nursing home administration of atypical antipsychotic drugs, the types of drugs most commonly used, and the number of residents receiving such drugs.

3. Oversight of Minimum Data Set Submitted by Long-Term Care Facilities

OIG will review CMS’ oversight of Minimum Data Set (“MDS”) data to determine how CMS assesses the data for accuracy and completeness.

C. Hospices


OIG will review hospices’ marketing practices and their relationships with nursing facilities, following up on a 2009 report finding that 82 percent of hospice claims for beneficiaries in nursing homes did not meet Medicare coverage requirements.

2. General Inpatient Care

OIG will examine general hospice inpatient care, reviewing medical records to address concerns of improper levels of hospice care.
D. **Home Health Services**

1. **Home Health Face-to-Face Requirement**

OIG will examine the extent to which home health agencies (“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 start of the home health services.

2. **Employment of Home Health Aides with Criminal Convictions**

OIG will determine whether HHAs are complying with State requirements that HHAs perform criminal background checks on HHA applicants and employees, in light of a previous OIG review that estimated 82 percent of nursing homes employed at least one individual with a criminal conviction.

E. **Medical Equipment and Supplies**

1. **Reliability of Service Code Modifiers on Medical Equipment Claims**

Based on previous 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.

2. **Supplier Compliance with Payment Requirements**

OIG will review Medicare payments for claims submitted by medical suppliers for lower limb prosthetics and power mobility devices (“PMDs”) to determine whether applicable CMS policies and regulations were followed.

3. **Continuous Positive Airway Pressure (“CPAP”) Supplies**

OIG will review the extent to which Medicare’s supply replacement related to CPAP machines vary from those of other government payers and adopt alternative schedules to avoid wasteful spending.
4. **Diabetes Testing Supplies**

OIG will determine the extent to which suppliers improperly billed Medicare for non-mail-order diabetes test strips in Competitive Bidding Areas in 2011 and the extent to which suppliers conducted “inappropriate” activities such as waiving copayments, contacting beneficiaries, or sending unsolicited test strips in 2010-2011. Since Medicare reimbursements are higher for non mail order supplies, there is a concern that suppliers provide incentives to beneficiaries not to use mail order test strips. OIG will also determine whether Part B payments for non mail order diabetes testing supplies were made according to Medicare requirements.

OIG will also determine whether opportunities exist for lowering payments for home blood-glucose testing strips provided under the Medicaid program through a reduction in payments through rebates, competitive bidding, or other means. OIG will review Medicare Part B payments for home diabetes testing supplies, and will determine the appropriateness of billings for blood glucose testing strips and lancet supplies. Lastly, OIG will assess the effectiveness of Medicare’s claims processing edits in preventing inappropriate payments to multiple suppliers of home diabetes testing supplies.

5. **Competitive Bidding - Mandatory Review**

OIG will research the potential cost savings for Medicare and Medicaid that could result from expanded use of competitive bidding for medical equipment and supplies.

**F. Prescription Drugs**

1. **Conflicts of Interest Involving Prescription Drug Compendia**

OIG will observe how drug compendia monitor and mitigate conflicts of interest.

2. **Off-Label Use of Medicare Part B Drugs**

OIG will review off-label and off-compendia use of certain Medicare Part B prescription drugs and determine the extent to which specified compendia provide support for coverage.
3. **Prescription Drug Shortages**

Research the impact of prescription drug shortages on physicians, hospitals, and manufacturers, focusing on patient safety and quality of care. Specifically, OIG will assess the extent to which providers of selected Part B covered drugs report having difficulty acquiring those drugs, the behavior of providers and hospitals when facing a drug shortage, and any effect on pricing, quality of care, and market availability. OIG will also measure the effect of drug shortages on manufacturer sales and the extent to which demand and sales prices changed when there was an alleged shortage.

4. **Potential Savings from Manufacturer Rebates for Part B Drugs**

OIG will analyze the possible government savings associated with implementing manufacturer rebates for Part B drugs. While pharmaceutical manufacturers are required to remit rebates for prescription drugs paid under Medicaid, a comparable rebate program does not yet exist under Medicare Part B.

5. **Payments for Immunosuppressive Drug Claims with KX Modifiers**

OIG will review supplier compliance with Medicare Part B documentation requirements for immunosuppressive drugs billed with a “KX” modifier. Medicare rules require suppliers that furnish immunosuppressive drugs, used when a beneficiary receives an organ transplant, to submit the claim using a “KX” modifier to signify that the supplier retained appropriate documentation of the transplant date and date of service.

6. **Payments for Multiuse Vials of the Drug Herceptin**

OIG will review 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.

7. **Beneficiary Use of Manufacturer Copayment 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.

8. **Voluntary Reporting of Fraud, Waste, and Abuse by Plan Sponsors**

OIG will review the extent to which plan sponsors have voluntarily reported Part D anti-fraud activity to CMS.

9. **Part D Sponsors’ Oversight of Pharmacy benefit Managers’ Administration of Plan Benefits**

OIG will review the Part D sponsors’ abilities to oversee the ways in which pharmacy benefit managers (“PBM”) carry out their responsibilities to administer their formularies and manage prescription drug use in accordance with Federal regulations and CMS guidance.

10. **Claims for and Use of Atypical Antipsychotic Drugs Prescribed to Children in Medicaid**

OIG will determine the extent to which children ages 18 and younger had claims for atypical antipsychotic drugs during a selected timeframe, including the extent to which such drugs were prescribed for off-label use.

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The remaining sections of the Work Plan describe OIG’s audit and enforcement priorities for Medicaid, its legal and investigative activities related to Medicare and Medicaid, and its Public Health, Human Services, and other HHS-related reviews. The Work Plan also includes descriptions of OIG’s reviews related to the Patient Protection and Affordable Care (“Affordable Care Act”), and OIG’s oversight of the funding that HHS received under the American Recovery and Reinvestment Act of 2009 (“Recovery Act”).


*This Committee Update provides general information and not legal advice or opinions on specific facts*