# OIG Work Plan Update

**Presented by:**
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*Tenacious about results.*

# Mary Devine

## Vice President of Revenue Integrity

Mary Devine is VP of Revenue Integrity at BESLER. Mary has over twenty-five years of experience in healthcare financial management and possesses extensive knowledge of all components within the revenue cycle.

Prior to BESLER Mary worked for a revenue cycle outsourcing company as Vice President of Operations. In that role, Mary had responsibility for the accounts receivable for multiple hospitals. Mary was also the Assistant Vice President of Patient Financial Services for Kennedy Health System in New Jersey where she oversaw hospital, physician and home health care billing and collections.

Mary is a registered nurse with acute-care and long-term care clinical experience. Mary holds a bachelor's in accounting from The Pennsylvania State University.

# Agenda

- What You should know about the OIG
- Highlights from the semi-annual report from the OIG to Congress
- Highlights from Annual Report of the Departments of Health and Human Services and Justice U.S. Department of Justice Health Care Fraud and Abuse Control Program FY 2020
- Workplan updates for 2022 specific to CMS
- Workplan Updates relating to COVID-19
- Transfer DRG Work Plan items
- Workplan Updates for Medicare Advantage
- Action items and next steps

# Objectives

- Review important updates to the work plan
- Highlight important updates in the OIG issued reports
- Provide action steps
  - Understand what the audit means to you
  - What you should be doing to avoid Medicare take backs from an OIG audit

# What You should know about the OIG

# The OIG Work Plan

- OIG operates by providing independent and objective oversight that promotes economy, efficiency, and effectiveness in the programs and operations of HHS (Not just CMS)
- The mission is to protect the integrity of HHS programs and the health and welfare of the people served by those programs through a nationwide network of audits, investigations, and evaluations, as well as outreach, compliance, and educational activities

# The OIG Strategic Plan

1. Fight fraud, waste, and abuse
2. Promote quality, safety, and value in HHS programs and for HHS beneficiaries
3. Advance excellence and innovation.

# COVID-19 Response Strategic Plan

1. Protect people

2. Protect funds

3. Protect infrastructure

4. Promote effectiveness of HHS programs—now and into the future

# The OIG

Office of Audit Services (OAS)

Office of Evaluation and Inspections (OEI)

Office of Investigations (OI)

Office of Counsel to the Inspector General (OCIG)

Mission Support and Infrastructure (MSI)

- What Do They Do:
  - Advanced data analytics and modeling
  - Criminal, civil, and administrative investigations
  - Compliance guidance and education
  - Technical expertise on program integrity issues
  - Cyber security oversight
- Why Do They Do it:
  - Achieve systemic improvements
  - Improved compliance
  - Successful enforcement actions
  - Recovery of misspent funds

# OIG Reports

*Semi-Annual Report to Congress*

*Healthcare Fraud and Abuse Report*

# OIG Semi Annual Report to Congress

- April – September 2021
- OIG issued 87 audit reports and 26 evaluation reports.
- Audits identified $220.82 million in expected recoveries and $934.21 million in questioned costs (questioned as unnecessary or unreasonable).
- Audits identified $318.91 million in potential savings for HHS if audit recommendations are implemented
- OIG made 276 new audit and evaluation recommendations for positive change in HHS programs.
- HHS implemented 238 prior OIG recommendations, leading to positive impact for HHS programs and beneficiaries.

# OIG Semi Annual Report to Congress

- The OIG detects, investigates, and prosecute fraud through a coordinated and data-driven approach.
- Their investigative work led to $1.61billion in expected investigative recoveries
- 311 criminal actions during April-Sept
- OIG took civil actions, against 417 individuals and entities, and excluded 654 individuals and entities from Federal health care programs, Medicare and Medicaid

# OIG Semi Annual Report to Congress

- Other Highlights in the Report
  - Responding to the COVID-19 Pandemic and Other Emergencies
    - Evaluations and Inspections
    - Corrective action
  - Health and Safety of Children
    - Oversight efforts
    - Tool kits provided
  - Preventing and Treating Opioid Misuse
    - Prioritize oversight and enforcement activities to protect beneficiaries from prescription drug abuse
    - Their work helped improve access to medication-assisted treatment (MAT)

# OIG Healthcare Fraud and Abuse Report

- The HIPAA of 1996 established a Healthcare Fraud and Abuse Control Program under HHS and is part of the OIG
- It is designed to coordinate federal, State and local law activities targeted at Healthcare Fraud and Abuse
- Approach is to identify and prosecute egregious healthcare fraud and to prevent future fraud while adding money back to the Federal Government funds
- This report is their findings for 2020 and reported on in 2021

# OIG Healthcare Fraud and Abuse Report

- 2020 Findings
  - $1.8 billion in healthcare fraud settlements
  - $3.1 billion was returned due to prior year settlements in 2020
    - $2.1 was transferred to the Medicare trust fund
    - $128.2 million was transferred to the Federal Medicaid Fund
  - 1,148 new criminal healthcare fraud investigations were opened
  - 1,079 new Civil healthcare fraud investigations were opened
  - 407 FBI investigations halted operations due to criminal fraud
  - 2,148 individuals and entities were excluded from the Medicare and Medicaid programs

# 2022 OIG Work Plan Updates

*Recent additions and completions*

# OIG Work Plan Updates

- Assess risks in HHS programs and operations
- Identify areas in need of attention and, set priorities for the sequence and resources to be allocated
- Planned work
  - Required by Law
  - Areas of concern
  - Previously Implemented changes
- Workplan is reviewed and updated monthly
- Completed reports can be found on OIG's What's New page

# Items on the Work Plan

- 120 active items on the work plan with the Centers for Medicare and Medicaid Services (CMS) as of the March update
- 30 items were added in FY 2022 so far
- 94 items expected to be reported on this year
- There are 60 items that were either partially completed, completed or removed

# Open Work Plan items by year

| Year | Items |
|---|---|
| 2016 | 2 |
| 2017 | 0 |
| 2018 | 2 |
| 2019 | 1 |
| 2020 | 10 |
| 2021 | 31 |
| 2022 | 16 |
| Revised – 58 Items | |

# 2022 Additions

## Office of Audits

- Nationwide Review of Hospice Beneficiary Eligibility
  - Hospice benefits are based on clinical judgment of the hospice medical director or physician
  - Focus on hospice beneficiaries that haven't had an inpatient hospital stay or an emergency room visit in certain periods prior to their start of hospice care

# 2022 Additions

## Office of Audits

- Follow up Audit on CMS's Use of Medicare Data To Identify Instances of Potential Abuse or Neglect
  - A prior audit identified 34,664 Medicare claims containing diagnosis codes that indicated Medicare beneficiaries were treated for injuries possibly caused by abuse or neglect
  - Follow up audit to see if data was used to determine where abuse occurred in if authorities were contacted.

# 2022 Additions

## Office of Audits

- Medicare Administrative Contractor Cost Report Oversight - Contract Review
  - MACs are responsible for accepting, auditing, and settling provider Medicare cost reports CMS has identified problems with upcoding
  - MAC performs desk reviews of all cost reports to determine accuracy, completeness
  - Audit for the number of desk reviews completed
  - Did provider implement the recommendations and take corrective action
  - Examine CMS's oversight of the MAC cost report desk reviews/audits

# 2022 Additions

## Office of Audits

- Medicare Payments for Inpatient Claims With Mechanical Ventilation
  - MS-DRG assignments that require mechanical ventilation
  - Beneficiary must have received more than 96 hours of mechanical ventilation
  - Previous audits found hospitals inappropriately billed for beneficiaries who did not receive at least 96 hours of mechanical ventilation.

# 2022 Additions

## Office of Evaluation and Inspections

- Biosimilar Trends in Medicare Part B
  - Biologic drugs with complex molecules produced in a living system are among the most expensive drugs on the U.S. market
  - Biosimilar drugs have no clinically meaningful difference and are less expensive
  - Providers do not have strong financial incentives to use less expensive biosimilars
  - Audit to see how much more Providers and beneficiaries paid more for Biologic drugs

# 2022 Additions

## Office of Evaluation and Inspections

- Toolkit for Identifying Adverse Events Through Medical Record
  - OIG has found that patient harm is common among Medicare beneficiaries in a range of inpatient health care settings
  - Federal regulations require hospitals and other health care facilities identify adverse events (harm) and work to reduce these events
  - Created tools and guidance material to identify harm
  - Determine if these tools are being used and if patients with indications of adverse effects were identified and helped

# 2022 Additions

## Office of Evaluation and Inspections

- Adverse Events: Disparities Among Hospitalized Medicare
  - Research on disparities in patient safety and adverse events is limited
  - This study will add to the information specific to health outcome disparities
  - Utilize detailed information about adverse events experienced by a random sample of 770 hospitalized Medicare patients
  - The audit will help medical providers and researchers identify and address the underlying issues that contribute to inequities in the delivery of health care

# 2022 Completions

- Medicare Part B Payments for Laboratory Services–
  - Focused on overpayments and use of modifiers
- Home Health Compliance with Medicare Requirements–
  - HHAs were paid $18 billion in 2020, $9.4 billion was found to be in error
- Medicare Payments Made Outside of the Hospice Benefit –
  - Identified  separate payments that should have been covered under the per diem payments made to hospice

# Open items help:

- Fight Fraud, Waste and Abuse
- Maintain Quality for Beneficiaries
- Advance Excellence

# Fraud and Abuse

- Medicare Part D Payments During Covered Part A SNF Stay (January 2021)
  - Medicare Part A covers most services, including drugs provided by the SNF for use in the facility for the care and treatment of beneficiaries
  - Medicare Part D should not pay for drugs related to posthospital SNF care these drugs were included in the payment for Part A SNF stay
  - Determine whether Medicare Part D paid for drugs that should have been paid under Part A SNF stays

# Fraud and Abuse

- Medicare-Related Capital Costs Reported by New Hospitals (May 2021)
  - Hospitals are paid through Medicare Part A for Medicare-related capital costs
  - New hospitals can be exempted from the IPPS and be paid on a cost basis for their first 2 years of operation
  - Determine whether new hospitals claimed Medicare-related capital costs in accordance with Federal regulations

# Fraud, Abuse and Waste

- Duplicate Payments Made by Medicare and the Department of Veterans Affairs' Veterans Community Care Program
  - The VA allows non-VA providers to provide hospital care and medical services to eligible veterans with non-VA providers
  - Duplicate claims may be paid by both Medicare and the VCCP if claims for services are billed to both programs
  - The payments associated with these claims are considered overpayments

# Fraud or Abuse

- Audit of Independent Organ Procurement Organizations' Organ Acquisition Overhead Costs
  - Review Medicare payments made to independent organ procurement organizations
  - Medicare reimburses OPOs under 42 CFR § 413.200 costs for the procurement
  - We will determine whether payments to OPOs for selected overhead costs complied with Medicare requirements and guidance

# Quality for Beneficiaries

- Audit of Medicare Part B Opioid-Use-Disorder Treatment Services Provided by Opioid Treatment Programs
  - CMS established a new Medicare Part B benefit for OUD treatment services furnished by OTP in 2020
  - Review OUD treatment services for Medicare beneficiaries in nonresidential OTPs to determine whether the services were allowable in accordance with Medicare requirements

# Fraud or Abuse

- Duplicate Medicare Professional Fee Billing by Both the Critical Access Hospital and the Health Care Practitioner to Medicare Part B
  - Critical Access Hospitals (CAHs) are paid under the Standard Payment Method unless they elect to be paid under the Optional (Elective) Payment
  - Under the Optional Payment CAH submits Part B services for Outpatient services
  - If a physician assigns his/her rights to bill to the CAH; physician can't submit bills

# Duplicate Billing by CAH and the Practitioner

- Determine whether both the CAH and physician billed and were paid by the MAC for the same outpatient professional services
- Determine whether the beneficiary paid coinsurance amounts to both the CAH and physician or other practitioner
- Determine whether CMS has an edit in place to ensure that duplicate payments for beneficiary outpatient professional services are not made.

# Fraud

- Accuracy of Place-of-Service Codes on Claims for Medicare Part B Physician Services
  - The amount Medicare pays physician service providers can vary based on where the service is provided and is indicated on the bill with a two-digit code
  - Non-facility rates are higher than facility rates
  - 2018 and 2019 audits determine providers were paid at Non facility rate
  - Review place of service to determine if providers were overpaid in 2020 and 2021

# Fraud and Abuse

- Follow up Review on Medicare Claims for Outpatient Services Provided During Inpatient Stays
  - Prior audit found 129,792 claims should not have been paid because the inpatient facilities were responsible for payments
  - Beneficiaries paid $14.3 million unnecessary deductibles and coinsurance
  - Edits in FISS were not correct
  - This revised audit will audit the outpatient services paid during inpatient services AND the FISS edits corrected

# Fraud, Abuse and Waste

- Results of UPICs' Benefit Integrity Activities (November 2020)
  - Unified Program Integrity Contractors (UPICs) are the only benefit integrity contractors that safeguard both the Medicare and Medicaid programs from fraud, waste, and abuse
  - Medicare and Medicaid provide health coverage to over 100 million
  - OIG's will examine the results from Integrity contractors' identification and investigation of fraud, waste, and abuse

# Quality for Beneficiaries

- Background Checks for Nursing Home Employees
  - Federal regulation 42 CFR 483.12(a)(3) provides beneficiaries who rely on long-term care services with protection from abuse, neglect
  - National Background Check Program was enacted by legislation in 2010
  - Audit to determine whether Medicaid beneficiaries in nursing homes in selected States were adequately safeguarded from caregivers with a criminal history of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property

# Advance Excellence and Quality

- Race and Ethnicity Data for Medicare Beneficiaries
  - Accurate, complete, and appropriately detailed race and ethnicity data for Medicare beneficiaries are critical to identifying and mitigating health disparities
  - Review the extent to Medicare's race and ethnicity data for beneficiaries are complete and accurate and compare data to data from other sources.
  - Also determine the extent the Medicare beneficiary race and ethnicity data align with Federal data standards

# Fraud, Abuse and a little bit of Quality

- Audit of Medicare Emergency Dept Evaluation and Management
  - Medicare reimburses physicians based on a patient's documented needs at the time of a visit
  - All evaluation and management (E/M) services reported to Medicare must be adequately documented so that medical necessity is clearly evident
  - Determine in Medicare payments to providers for emergency department E/M services were appropriate, medically necessary, and paid in accordance with Medicare requirements.

# COVID-19

*OIG Work Plan items*

# COVID-19 Highlights

- All items were added in 2020
- Originally added to gather intelligence
  - Treatment
  - Comorbidities
  - High risk
- Only 3 items were added in 2022
  - Focused on information gathering
  - Focused on treatment
- Items were added in 2021 regarding payment

# COVID-19 Treatment (Added in 2022)

- Telehealth Services in Select Federal Health Care Programs
  - Use of telehealth has been critically important
  - helped ensure access to care while reducing the risk of community spread of the virus
  - Determine how telehealth can best be used to meet the needs of beneficiaries in the future
  - Utilize data to produce a report describing telehealth services available for the future, to include the expanded pandemic services

# COVID-19 Treatment (Added in 2022)

- Nursing Home Capabilities and Collaboration to Ensure Resident Care During Emergencies
  - To protect residents and prevent disruption of care during emergencies, nursing homes must develop and maintain an emergency preparedness program
  - Recent emergencies have exposed weaknesses in nursing home emergency preparedness
  - This audit will focus on the challenges and capabilities during an emergency

# COVID-19 Treatment (Added in 2022)

- COVID-19 Vaccination Status of Nursing Homes
  - Data identified that COVID-19 infections among nursing home residents were higher in nursing homes with lower vaccination coverage among staff
  - CMS requires that nursing home staff be fully vaccinated against COVID-19 and report status
  - This audit will determine if nursing homes are complying with vaccinations and reporting

# COVID-19 Treatment

## Revised

- Audits of Medicare Part B Laboratory Services During the COVID-19 Pandemic
  - Initial analysis has shown that the number of non-COVID-19 tests billed for Medicare Part B beneficiaries during the COVID-19 pandemic has decreased
  - Follow up audit  to focus on the effect of the pandemic on non-COVID-19 testing
  - The series of audits will also focus on aberrant billing of COVID-19 testing during the pandemic

# COVID-19 Treatment Revised

- Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency
  - Phase one - did EM, opioid use disorder, end-stage renal disease, and psychotherapy meet Medicare requirements
  - Phase two did virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits meet Medicare requirements

# COVID-19 Treatment

## Potential Overpayments

- Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency
  - Waiver expanded telehealth to services such as PT, OT and Speech
  - Waiver does not allow for payment of telehealth services on home health claims
  - Evaluate services provided during PHE to determine which services were furnished via telehealth
  - Were services were administered and billed in accordance with Medicare requirements
  - Report any overpayments

# COVID-19 Treatment

## Potential Overpayments

- Audit of Medicare Payments for Inpatient Discharges Billed by Hospitals for Beneficiaries Diagnosed With COVID-19
  - Section 3710 of the Coronavirus Aid, directs the Secretary to increase the weighting factor that would otherwise apply to the assigned diagnosis-related group by 20 percent
  - Audit payments made by Medicare for COVID-19 inpatient discharges billed by hospitals complied with Federal requirements.

# Transfer DRG Work Plan items

*Remains an open item and focus*

# Transfer DRG Work Plan items

## Continued Focus

- Medicare hospital payments for claims involving the Acute and Post Acute Care Transfer policies
  - Remains on the workplan
  - Review Medicare hospital discharges paid a full DRG payment when the patient was transferred to a facility covered by the acute and post-acute transfer policies where Medicaid paid for the service

# Transfer DRG Work Plan items

## Continued Focus

- Medicare hospital payments for claims involving the Acute and Post Acute Care Transfer policies
  - These hospital inpatient stays should have been paid a reduced amount
  - Review policies to prevent cost shifting

# Transfer DRG

## Increased Focus

- Increased payments for Transfer claims with outliers
  - Opened in 2018
  - Transfer rule reduces payments
  - Outlier payments can result in such payments being higher than what would have been paid in a non-transfer case

# Transfer DRG

## Remains Open

- Increased payments for Transfer claims with outliers
  - The application of the outlier methodology at 42 CFR Sec. 412.80(b) can result in an increase in the outlier payment in transfer cases
  - Report describing the extent to which additional Medicare outlier payments negate the reduction in DRG, DSH, and IME payments of transfer claims

# Medicare Advantage Work Plan items

# Medicare Advantage Work Plan items

## 2022 Additions

- Identifying Denied Claims in Medicare Advantage Encounter Data
  - CMS requires Medicare Advantage organizations (MAOs) to submit records of all services provided to beneficiaries to CMS's Medicare Advantage (MA) Encounter Data, including denials
  - Audit will determine MA encounter data contained potentially denied claims and identify any challenges to MA program oversight that result from the lack of a denied claim indicator on services in the MA encounter data.

# Medicare Advantage Work Plan items

## 2022 Additions

- Availability of Behavioral Health in Medicare Fee-For-Service, Medicare Advantage, and Medicaid Managed Care
  - Medicare and Medicaid beneficiaries often have unmet behavioral health needs and face difficulty accessing appropriate services
  - Auditing ratio of beneficiaries to providers, providers available for new patient and providers that provided services

# Medicare Advantage Work Plan

## Open items

- Ineligible Providers in Medicare Part C and Part D
  - Federal law prohibits Medicare payments for services provided or prescriptions written by individuals or entities who are excluded ineligible providers
  - Determine whether Part C and Part D sponsors complied with Federal requirements on preventing ineligible providers from rendering services to Medicare beneficiaries based on payments made

# Medicare Advantage Work Plan

## Open items

- Inappropriate denial of services and payment in Medicare Advantage
  - Attempt to increase profits for managed care plans
  - Conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare

# Medicare Advantage Work Plan

## Open items

- Inappropriate denial of services and payment in Medicare Advantage
  - To the extent possible, determine the reasons for any inappropriate denials and the types of services involved.
  - CMS does not get involved unless patient care is impacted
  - Report was issued on April 28, 2022
    - Confirmed denials caused delay
    - Met Medicare coverage rules

# OIG Work Plan Wrap-up

*Things to consider*

*Actions and next steps*

# OIG Work Plan wrap-up

- In place to protect CMS, providers and beneficiaries
- Stop Fraud, Abuse and Waste
- Provides intelligence to advance excellence
- So much data!
- Patient care and provider reimbursement

# Things to consider

- Review the OIG Work Plan regularly
  - Check new additions
  - Check completed items
  - Review reports
  - How does your facility measure to the reports?
- Initiate internal audits based on new items
- Revisit items that remain open to ensure compliance

# Action steps – Auditing services

- Make sure Telehealth services are meeting requirements
- Continue to monitor for coding optimization and not maximization
- Ensure outpatient services are included in the inpatient claim based on CMS regulations
- Make sure you return any overpayments

# Action steps – COVID-19

- Review Inpatient charts for appropriate diagnosis
- Review telemedicine notes and outcomes

# Action steps – Transfer DRG

- Perform retrospective review on accounts impacted by the Transfer Rule
- Audit for underpayments and overpayments
- Review outlier payments
- Return overpayments identified!

# Action steps – Medicare Advantage

- Ensure Medicare Advantage claims have ordering providers information
- Report properly to CMS
- Fight for service coverage!

# Questions?

BESLER offers a suite of contingency-based services to ensure optimal post-bill recovery

Underpayment/validation services can be performed even if you have an existing vendor or internal process in place.

Little IT involvement to get started

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*HFMA staff and volunteers determined that Revenue Integrity Solutions has met certain criteria developed under the HFMA Peer Review Process. HFMA does not endorse or guarantee the use of this service.

# Thank you

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