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Client Alert

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HHS Work Plan Provides Blueprint for Likely Government Investigations and Enforcement

On October 2, 2012, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its 2013 Work Plan. On its face, the Work Plan provides brief descriptions of the activities the OIG plans to undertake or to continue from the previous year. In the context of the Government's increasing emphasis on health care fraud, however, the Work Plan also is a plausible projector of the types of health care investigations we can expect the Justice Department to focus on in the next two to five years.

The emphasis on program fraud that defines the OIG's work, coupled with the development of predictive models for identifying where fraud is likely to occur, give added purpose to OIG reports and findings. In the long term, even an OIG report that focuses on vulnerabilities in CMS policies or in the states' health care systems provides a basis for scrutinizing providers and suppliers who may have fraudulently exploited the systemic weaknesses identified in the report. The Government's proactive approach to hunting out fraud using OIG findings to initiate investigations has been made easier by the expanded use of joint task forces, enhanced information sharing across wider groups of stakeholders, and the rise in parallel investigations. The rise in parallel investigations, in particular, strengthens the likelihood that, even without having engaged in criminal fraud, providers and suppliers will still have to defend their billings against civil fraud liability.

With these circumstances in mind, the 2013 Work Plan provides the following information about the OIG's priorities and concerns, as well as specific programs and billings that the OIG believes are vulnerable to fraud and abuse. In all of these, the Government's underlying interest is the extent to which billings under the higher-paying reimbursement codes account for a disproportionate share of the providers' and suppliers' total billings – and whether that effect is a function of a deliberate policy to increase revenues, rather than of meeting legitimate patient needs.

Hospitals:

The OIG is sharpening its focus on Diagnosis Related Groups (DRG's) for inpatient stays, with planned reviews of how hospital billing for inpatient stays changed from FY 2008 to FY 2012. In particular, the OIG will be looking at outpatient services delivered prior to an inpatient hospital admission. While the ostensible purpose of the review is to determine whether the current

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"DRG window" of three days for bundling the outpatient services with the inpatient hospital admission should be expanded to fourteen days, it inevitably will raise questions whether hospitals intentionally scheduled outpatient services to take place more than three days before a scheduled admission in order to maximize their billings.

The Work Plan also includes several planned reviews directed at possible abuses of the admissions, transfers, and discharges policies for Medicare reimbursements. Hospitals should expect scrutiny of their billings for: same-day readmissions; transfers that were coded and paid for as discharges; transfers to other PPS hospitals that were coded and paid for as discharges to swing beds; acute care inpatient transfers coded and paid for as discharges to inpatient hospice care; and admissions/discharges for canceled and rescheduled surgical procedures, all of which are the subjects of specific 2013 reviews.

In conjunction with these reviews of hospitals' discharge and transfer practices, the OIG will also be looking at whether hospitals have acquired or entered into relationships with other facilities in order to maximize billings for procedures that would otherwise be reimbursed at lower levels. Specifically, the OIG plans to determine the extent to which hospitals have acquired (lower paying) Ambulatory Surgical Centers and converted them to (higher paying) hospital outpatient departments - for the purpose of increasing their reimbursements for the same services.

Long-Term-Care Hospitals, Nursing Homes, Hospice, and Home Health Agencies:

Expanding on lengths of stay and readmissions issues involving hospitals, the OIG further plans to review the extent to which improper Medicare payments were made for interrupted stays at long-term-care hospitals. Reviewers will identify readmission patterns in order to determine the extent to which patients were readmitted directly following the interrupted stay periods. Long-term-care facilities should expect to answer whether they manipulated and scheduled readmissions of patients who were discharged for treatment and services not available at the facility in order to maximize claims for payments for long-term-care services.

In response to a specific directive from Congress, the Work Plan includes several projects based on previous studies that identified questionable billing patterns suggesting that nursing homes are billing Medicare for Part B services that are required to be billed directly by suppliers and other providers. While this investigative scenario obviously poses concerns for nursing homes, it also raises the possibility of duplicate billings involving the particular providers as well. Reading the Work Plan closely, it is clear that the providers and services within the OIG's sights include providers of **podiatry, ambulance, laboratory, and imaging services** who serve nursing home residents.

Nursing homes will also face scrutiny of their relationships with hospice care facilities. Specifically, the OIG will review hospices' marketing materials and practices – as well as their financial relationships with nursing facilities. The Work Plan particularly notes that a recent OIG report "found that 82 percent of hospice claims

for beneficiaries in nursing facilities *did not meet Medicare coverage requirements*.," (Emphasis added). The Work Plan further states that the independent congressional agency, MedPAC, has noted that "hospices and nursing facilities may be involved in inappropriate enrollment and compensation," and has highlighted "instances in which hospices aggressively marketed services to nursing facility residents." The review will focus on hospices with a high percentage of their beneficiaries in nursing facilities – and, given the inquiry into marketing and compensation practices - is likely to heighten prosecutors' interests in this area.

Hospice care, already under review in the context of acute care inpatient transfers (see above), will be subject to further assessments to determine the appropriateness of general inpatient care claims. The OIG plans to study hospice medical records in response to concerns that this level of hospice care is being misused to allow for greater billings to Medicare.

A number of significant studies are directed at home health agencies. In particular, the OIG will determine whether agencies have complied with the statutory requirement that beneficiaries who have been certified as eligible for Medicare home health services have had face-to-face visits with physicians (or certain practitioners working with physicians). The Work Plan pointedly notes that previous OIG work found that "only 30 percent of beneficiaries had at least one face-to-face visit with the physicians who ordered their home health care."

Sharpening the focus on home health care abuses, the OIG will review the work that CMS and its contractors performed to identify and prevent improper home health payments from January to October 2011. The Work Plan further states that previous OIG and Department of Justice investigations "indicate that the home health benefit may be susceptible to fraud." In particular, the Work Plan includes a review of states' Medicaid payments for Medicare-covered home health services to determine the extent to which Medicare and Medicaid have paid for the same services. Duplicate payments, which are extremely likely throughout the country, will inevitably result in claims for overpayments, if not questions about the knowledge and intent of the home health agencies that submitted the overlapping claims.

Medical Equipment Suppliers:

Government scrutiny of medical equipment suppliers and purchases is certainly not new. The Work Plan, however, offers considerable insight into the kinds of medical equipment purchases that are currently believed to be vulnerable to fraud and abuse. Thus, in addition to reviewing generally whether suppliers have complied with requirements to maintain supporting documentation for their reimbursement claims, the OIG will review specific types of medical equipment purchases.

These include:

1. reviews of payments for lower limb prostheses (based on prior OIG work that identified 267 suppliers with questionable billings);

2. a series of reviews related to power mobility devices;
3. at least six different reviews of payments for blood glucose/diabetes test strips; and
4. comprehensive review of Medicare Part A and Part B claims submitted by (previously identified) "top error-prone providers."

In a further indication of the ongoing concern to detect fraud by medical equipment suppliers, the Work Plan also mandates a study to determine the extent to which Medicare Part B providers and suppliers had practice locations that matched their commercial mailbox addresses during 2011, or whether they were, in fact, mailbox companies.

Medical Services and Tests:

As with claims for medical equipment, the Work Plan also focuses on certain specific medical services that have caught the OIG's attention. These include planned reviews of:

1. utilization patterns of outpatient physical therapy services provided by independent therapists;
2. payments for sleep study services, as well as utilization patterns for sleep testing procedures;
3. utilizations of orthopedic implant devices in spinal fusion procedures;
4. whether anesthesia services that were billed as having been personally performed by a physician were, in fact, medically directed (which would have produced a 50% lower reimbursement);
5. questionable billing patterns for ophthalmological services, as well as the geographic locations of providers who submitted questionable billings in 2011;
6. whether payments for Partial Hospitalization Programs and Community Mental Health \ Centers were appropriate;
7. questionable billings for electrodiagnostic testing;
8. whether high cost diagnostic tests were medically necessary; and
9. billing characteristics and questionable billings for clinical laboratory tests.

Pharmaceuticals:

While any reviews of off-label uses of any pharmaceutical products are likely to interest the Department of Justice's prosecutors and consumer protection lawyers, this year's Work Plan includes several new projects with implications for future legal actions involving pharmaceutical companies. Among these are:

1. examination of the extent to which the Prescription Drug Compendia oversees conflicts of \ interest through its reporting requirements – and the number and nature of these conflicts;
2. using FDA records and CMS data to determine the extent to which demand and average sales

prices of drugs changed when the drugs were reportedly in shortage;

3. identifying whether pharmaceutical manufacturers have safeguards in place to ensure that beneficiaries do not use copayment coupons to obtain prescription drugs paid for by Medicare Part D (and specifically noting that "the use of copay coupons in Federal health programs implicates the anti-kickback statute");
4. reviewing Part D drugs billed in 2009 – to identify the presecribers and beneficiaries associated with atypically high billing;
5. identifying the pharmacies, prescribers, and beneficiaries associated with questionable Part D billing for HIV drugs; and
6. examining Medicaid billings for generic drugs from large chain pharmacies to determine whether they are billing the usual and customary charges for drugs provided under their retail discount generic programs – a review that is virtually certain to result in future claims for overpayments.

Universities and Other Grantees:

While not traditionally viewed as of interest to federal Inspector Generals, universities and other grant-receiving institutions are increasingly under scrutiny for their management of, and spending on, federal grant programs – and HHS, especially through NIH and the CDC, is one of the largest sources of these grants. As a result, the Work Plan includes a number of new projects directed at grantees' use of funds, among them:

1. whether CDC's oversight of HIV/AIDS prevention and research grants was conducted in accordance with regulations and HHS policies;
2. whether costs claimed by CDC grantees through the National Center for Chronic Disease Prevention and Health Promotion were for allowable purposes – and, specifically, whether they were misused for impermissible lobbying;
3. whether NIH grantees that received extramural construction grants under the American Recovery and Reinvestment Act of 2009 complied with appropriate bidding procedures and whether their expenditures were allowable;
4. whether NIH grantees' equipment purchases complied with the terms and conditions of the American Recovery and Reinvestment Act and federal requirements – reviews that will be conducted as specific selected educational institutions;
5. whether selected colleges and universities receiving NIH grants have complied with OMB cost principles;
6. whether educational institutions have improperly made extra compensation payments (to faculty in particular) and impermissibly charged them against NIH contracts;
7. whether university faculty members working on NIH grants were inappropriately drawing salaries from multiple universities; and
8. whether universities are properly meeting cost sharing requirements – or whether they are improperly charging indirect costs (clerical salaries, postage, memberships, subscriptions, telephone charges, and office supplies) as direct costs.

Conclusion:

The OIG's plans for FY 2013 will significantly affect a broad spectrum of providers, manufacturers, community health organizations, and educational institutions. While many of the issues the Work Plan is concerned with have been a focus of interest for some time, the Work Plan also includes a number of new projects directly based on prior work that identified fraud and abuse, as well as public reports of fraud and abuse in particular areas, and even specific directives from Congress. Many of the projects described in the Work Plan can be expected to be followed by (targeted) proactive audits, claims for overpayments, and eventual criminal prosecutions. The Work Plan provides valuable insight into the areas that are most likely to attract future Government action, and is a useful manual for providers looking to avoid further scrutiny.