OIG FY 2017 Year in Review & Work Plan Highlights
OIG FY 2017 Year in Review

1. **881** criminal actions

2. **826** civil actions

3. **$4B+** in expected recoveries

4. Exclusion of **3,244** individuals & entities


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OIG FY 2017 Highlights

1. **Largest takedown of health care fraud in July 2017**
   - $1.3 billion in false billings, 412 defendants, 41 judicial districts
   - Medicare and Medicaid fraud schemes

2. **eClinicalWorks charged, forced $155 million to settle false claims act allegations for misrepresenting functions of its electronic health records software**
   - 1st civil settlement that OIG has had with an EHR vendor

3. **Released a data brief on extreme user and questionable prescribing of opioids prescribing patterns**

4. **Released an early alert of neglect and abuse at skilled nursing facilities (SNF’s)**

Curbing the Opioid Epidemic
Federal takedown of improperly prescribing clinicians

- Federal takedown included opioid related charges against 120 individuals; defendants included 27 physicians
- OIG identified concerns about extreme use of and questionable prescribing of opioid epidemics
- In 2016, 500,000 beneficiaries received high amounts of opioids, and almost 90,000 of them were at serious risk of opioid misuse or overdose
- 400 prescribers had questionable prescribing patterns for the beneficiaries at serious risk
- Fraudulent medical practice and pharmacy co-conspirators sentenced, ordered to pay $10.7 million in restitution

Source: Semiannual Report to Congress – April 1, 2017, through September 30, 2017

OIG Work Plan: Recently added items (January 2018)

<table>
<thead>
<tr>
<th>Announced</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
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</thead>
<tbody>
<tr>
<td>January 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Financial Impact of Health Risk Assessments and Chart Reviews on Risk Scores in Medicare Advantage</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-03-17-00470</td>
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<td>January 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>OIG Toolkit to Identify Patients at Risk of Opioid Misuse</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-02-17-00560</td>
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<tr>
<td>January 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Potential Abuse and Neglect of Medicare Beneficiaries</td>
<td>Office of Audit Services</td>
<td>W-00-18-35805</td>
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<tr>
<td>January 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Questionable Billing for Off-the-Shelf Orthotic Devices</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-07-17-00390</td>
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<td>January 2018</td>
<td>Administration for Children and Families</td>
<td>States’ Monitoring of Subrecipients to Ensure Program Integrity Within the Child Care Development Fund Block Grant Program</td>
<td>Office of Evaluation and Inspections</td>
<td>OEI-03-17-00500</td>
</tr>
</tbody>
</table>
Changes to Medicare Inpatient Only (IPO) list

Changes to Medicare’s IPO List effective January 1, 2018

On November, 1 2017 CMS issued Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System and Quality Reporting Programs Changes for 2018 (CMS-1678-FC).

The Medicare IPO list includes procedures that are typically provided in the inpatient setting and therefore are not paid under the OPPS. Each year, CMS uses established criteria to review the IPO list and determine whether or not any procedures should be removed from the list. For CY 2018, CMS is removing total knee arthroplasty from the IPO list as well as five other procedures. CMS is also adding one procedure to the IPO list in response to public comments.

In addition, CMS is precluding the Recovery Audit Contractors from conducting "site of service" reviews of outpatient total knee arthroplasty procedures for a period of two years.

Five CPT codes were removed from the IPO list:
• 27447  Total Knee Arthroplasty
• 55866  Laparoscopic and Robotic Prostatectomy
• 43282  Laparoscopic procedures on the Esophagus
• 43772  Laparoscopic Bariatric Surgery (removal of gastric band)
• 43773  Laparoscopic Bariatric Surgery (removal and replacement of gastric band)
• 43774  Laparoscopic Bariatric Surgery (removal of adjustable gastric band and port)

Procedure added to CMS inpatient only list:
• 92941  Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction

Source: 1) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01.html
Payment system and quality reporting programs changes for 2018

Response to comments by CMS:

**CMS-1678-FC 666 – Inpatient Admission for Total Knee Arthroplasty (TKA)**

- Do not expect to create or endorse specific guidelines or content for the establishment of providers’ patient selection protocols.
  - The “2-midnight” rule continues to be in effect and was established to provide guidance on when an inpatient admission would be appropriate for payment under Medicare Part A, IPPS (80 FR 70539).
  - For stays for which the physician expects the patient to need less than 2 midnights of hospital care, an inpatient admission is payable under Medicare Part A on a case-by-case basis if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care.
    - This documentation and the physician’s admission decision are subject to medical review, which is discussed in greater detail below (80 FR 70541).
  - The 2-midnight rule does not apply to procedures on the IPO list

**CMS-1678-FC 667**


OPPS impact on Drug Pricing Program (340B)
The 340B market today

The size and scope of the 340B program has grown significantly in recent years. Entities made newly eligible under the Affordable Care Act have increased the numbers of covered entities, while overall drug spending has increased with the availability of specialty and biologic drugs for cancer, autoimmune conditions, and others.

Drivers of growth include

- Newly eligible provider categories
  - Affordable Care Act added rural referral centers, sole community hospitals, critical-access hospitals, and freestanding cancer centers
- Guidance allowing largely multiple contract pharmacy arrangements
- Overall trends in drug spending

Changes to Part B payments for 340B drugs

Under the 2018 Outpatient Prospective Payment Final Rule, CMS will no longer reimburse most 340B-purchased drugs at the standard Part B rate of Average Sales Price (ASP) plus 6%, and instead will pay a rate of ASP minus 22.5%.

Standard Medicare Part B Rate

\[ \text{ASP} + 6\% \]

Medicare Part B for 340B

\[ \text{ASP} - 22.5\% \]
Projected impact on 340B and Medicare Part B
With a lower payment rate, Part B beneficiaries without additional coverage will see a reduction in coinsurance. Budget neutrality requires that any savings to one part of Medicare B be redistributed across the program.

340B Covered Entities

$1.6 billion in drug payment reductions

All Part B Providers

3.2% increase in non-drug OPPS rates

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Exceptions
Certain drug classes and certain covered entities are exempt from the new payment policy

Exempted Drug Categories

- Drugs that are not separately payable
- Vaccines
- Drugs on “pass-through” status
  - Certain newer drugs
  - Certain cancer drugs
  - Certain biologics and radiopharmaceuticals
  - Orphan drugs

Exempted Entity Types

- Sole community hospitals (SCHs)
- Children’s hospitals
- Prospective Payment System (PPS) exempt cancer hospitals
- New (non-excepted) off-campus hospital outpatient departments that are no longer paid under OPPS

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Several factors go into the financial implications of this policy change.

**Operational and compliance considerations**

**Coding Requirements**

The 2018 OPPS Final Rule requires that all 340B drug claims under Medicare Part B must contain a modifier to identify them as such. There will also be an informational modifier for use by providers who will be exempt from the 340B payment reduction.

**Group Purchasing Organizations (GPOs)**

Payment arrangements such as the 340B Prime Vendor Program can secure discounts well below the 340B ceiling price. Depending on the particulars, GPO participation can greatly change the financial calculus of an affected hospital.

**Current and Projected Drug Spending Patterns**

The Government Accountability Office (GAO) estimates 340B discounts from market pricing in the 20%–50% range. Depending on the actual discounts of particular drugs purchased by a given entity under Part B, the financial outlook can look very different.

**340B Program Compliance Costs**

Significant time and resources go into participation in the 340B program. Covered entities are subject to manufacturer audits, develop parallel drug inventory tracking systems, and engage in extensive reporting to federal administrators.

**OPPS and 340B reference materials**

**Regulatory**

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule
- OPPS Final Rule Fact Sheet
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements, and Medicare Diabetes Prevention Program

**Deloitte Publications**

- CMS finalizes changes to payment policy under the 340B drug discount program
- CMS moves forward with implementation of MACRA, other policy changes in Physician Fee Schedule Update
# OIG and RAC update

## OIG Medicare

Billing, reimbursement, and payment related reviews

<table>
<thead>
<tr>
<th>Review type</th>
<th>Review subject</th>
<th>Audit period</th>
<th>Financial impact</th>
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<tbody>
<tr>
<td>Medical device claims data</td>
<td>CMS</td>
<td>10-year period ending December 2014</td>
<td>N/A</td>
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<tr>
<td>Reimbursements for portable x-ray services</td>
<td>Health administrative services company</td>
<td>January 2012 – June 2014</td>
<td>Findings: $2,000 overpaid by CMS Extrapolated: $900,000</td>
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<tr>
<td>Payments to acute-care hospitals for outpatient services</td>
<td>CMS</td>
<td>January 2013 – August 2016</td>
<td>Recover $51.6 million in improper payments; Refund beneficiaries up to $14.4 million</td>
</tr>
<tr>
<td>Hospital outlier payments</td>
<td>CMS and Medicare contractors</td>
<td>October 2003 – March 2011</td>
<td>N/A</td>
</tr>
<tr>
<td>Immunosuppressive drug claims</td>
<td>CMS</td>
<td>FFY 2014</td>
<td>Findings: $4,000 overpaid by CMS Extrapolated: $4.6 million</td>
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<tr>
<td>Reimbursement for outpatient therapy services</td>
<td>Therapy provider</td>
<td>July 2013 – June 2015</td>
<td>Findings: $8,000 overpaid by CMS Extrapolated: $29.9 million</td>
</tr>
</tbody>
</table>

Sources: 1) OIG A-02-15-00504; 2) OIG A-02-15-01003; 3) OIG A-09-16-00202; 4) OIG A-07-14-02800; 5) OIG A-08-15-00301; 6) OIG A-02-16-01004
Medicare RACs

**Medicare Fee-for-Service RAC Regions**

![Map of Medicare Fee-for-Service RAC Regions]


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### Performant Recovery, Inc. – Region 1

**Recent CMS approved audit topics**

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date posted to Performant’s website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient service overlapping or during an inpatient stay</td>
<td>10/26/2017</td>
</tr>
<tr>
<td>Critical care billed on the same day as emergency room services</td>
<td>10/19/2017</td>
</tr>
<tr>
<td>Excessive units - untimed therapy</td>
<td>9/20/2017</td>
</tr>
<tr>
<td>Arthroscopic limited shoulder debridement</td>
<td>9/11/2017</td>
</tr>
<tr>
<td>Hospital readmission same day as discharge billed with condition code B4*</td>
<td>9/8/2017</td>
</tr>
<tr>
<td>Excessive units of nursing facility services</td>
<td>9/8/2017</td>
</tr>
<tr>
<td>Inpatient psychiatric facility services*</td>
<td>9/8/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.

Source: [https://performantrap.com/search-issues/?order=desc&filter=date_approved](https://performantrap.com/search-issues/?order=desc&filter=date_approved)

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### Performant Recovery, Inc. – Region 5

**Recent CMS approved audit topics**

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<thead>
<tr>
<th>Issue name</th>
<th>Date posted to Performant’s website</th>
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<tbody>
<tr>
<td>Complex positive airway pressure (PAP) devices for the treatment of obstructive sleep apnea*</td>
<td>9/8/2017</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) continuous PAP (CPAP) without obstructive sleep apnea diagnosis</td>
<td>9/2/2017</td>
</tr>
</tbody>
</table>

Source: [https://performantrap.com/search-issues/?order=desc&filter=date_approved](https://performantrap.com/search-issues/?order=desc&filter=date_approved)
### Medicare RACs

**Recent CMS approved audit topics (cont’d)**

#### Cotiviti, LLC – Regions 2 and 3

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date approved</th>
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<tbody>
<tr>
<td>Initial hydration, infusion and chemotherapy administration</td>
<td>10/10/2017</td>
</tr>
<tr>
<td>Outpatient service overlapping or during an inpatient stay</td>
<td>10/5/2017</td>
</tr>
<tr>
<td>Critical care billed on the same day as emergency room services</td>
<td>10/5/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.


### Medicare RACs

**Recent CMS approved audit topics (cont’d)**

#### HMS Federal Solutions – Region 4

<table>
<thead>
<tr>
<th>Issue name</th>
<th>Date posted to HMS’ website</th>
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<tbody>
<tr>
<td>Complex medical necessity sacral neurostimulation*</td>
<td>10/24/2017</td>
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<tr>
<td>Initial hydration infusion and chemotherapy administration – excessive units</td>
<td>10/5/2017</td>
</tr>
<tr>
<td>Critical care billed on the same day as emergency room services</td>
<td>10/6/2017</td>
</tr>
<tr>
<td>Outpatient services overlapping or during an inpatient stay</td>
<td>10/5/2017</td>
</tr>
<tr>
<td>Inpatient psychiatric facility services*</td>
<td>9/21/2017</td>
</tr>
<tr>
<td>Evaluation and management (E/M) review of excessive units of professional services in nursing facilities</td>
<td>9/19/2017</td>
</tr>
<tr>
<td>Excessive units of critical care</td>
<td>9/12/2017</td>
</tr>
</tbody>
</table>

* Denotes a complex review. All others are automated reviews.

Source: [https://racinfo.hms.com/Public1/NewIssues.aspx](https://racinfo.hms.com/Public1/NewIssues.aspx)
Inpatient Psychiatric Facility Services

As of September 8, 2017, one of the recent CMS approved audit topics includes Inpatient Psychiatric Facility Services - Complex Review. Inpatient hospital services furnished in an inpatient psychiatric facility will be reviewed to assess whether services were medically reasonable and necessary. Further, Inpatient Psychiatric Facility Outlier Payments were a new addition to the 2017 OIG Workplan.
Inpatient psychiatric facilities – Medicare requirements overview (cont’d)

Why are inpatient psychiatry requirements different from general inpatient requirements?

The purpose of Inpatient Psychiatric Facility (IPF) Medicare Requirements is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage.

IPFs are certified under Medicare as inpatient psychiatric hospitals and their documentation/content requirements are different from general inpatient documentation requirements because the care furnished in inpatient psychiatric facilities is often purely custodial and thus not covered under Medicare.

For purposes of payment for IPF under Medicare Part A, required conditions of payment requirements (including admission order, certification, recertification(s) (where required)) must be met.

Medicare Part A pays for inpatient services in an IPF only if a physician (not a mid-level practitioner) certifies and recertifies the need for services consistent with the Medicare requirements for inpatient services of inpatient psychiatric facilities. Medical record documentation must support the physician’s certification / recertification.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff.

Inpatient psychiatric facilities – Medicare conditions of payment

Admission Order

Requirements:
The inpatient admission order must state that the beneficiary should be formally admitted for hospital inpatient care, and must be furnished at or before the time of the inpatient admission by a physician or other qualified practitioner*.

Timing and Signature Requirement:
Verbal/Telephone admission order must identify the ordering practitioner and must be authenticated (countersigned) by the ordering practitioner prior to discharge.

* A “qualified practitioner” is someone who is licensed, has admitting privileges at the hospital as permitted by State law, is knowledgeable about the patient’s hospital course, medical plan of care, and current condition; and acts in accordance with scope-of-practice laws, hospital policies, and medical staff bylaws, rules and regulations.
Inpatient psychiatric facilities – Medicare conditions of payment (cont’d)

<table>
<thead>
<tr>
<th>Initial Certification</th>
<th>Recertification*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Content Requirements:</strong></td>
<td><strong>Content Requirements:</strong></td>
</tr>
<tr>
<td>The physician must certify -</td>
<td>The recertification must indicate that -</td>
</tr>
<tr>
<td>(1) That inpatient psychiatric services were required for treatment that could reasonably be expected to improve the patient’s condition, or for diagnostic study.</td>
<td>(1) Inpatient services furnished since the previous certification or recertification were, and continue to be, required for treatment that could reasonably be expected to improve the patient’s condition or for diagnostic study; and</td>
</tr>
<tr>
<td>(2) That the inpatient psychiatric services were provided in accordance with requirements outlined in §412.3 for inpatient admissions.</td>
<td>(2) The hospital records show that the services furnished were Intensive treatment services, Admission and related services necessary for diagnostic study, or Equivalent services.</td>
</tr>
</tbody>
</table>

(3) The patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

<table>
<thead>
<tr>
<th>Timing and Signature Requirements</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Certification is required at the time of admission or as soon thereafter as is reasonable and practicable and must be completed and documented in the medical record prior to discharge.</td>
<td>The first recertification is required as of the 12th day of hospitalization. Subsequent recertification(s) are required at intervals established by the Utilization Review Committee, but no less frequently than every 30 days after the prior recertification.</td>
</tr>
</tbody>
</table>

* A legitimate reason for any delayed / lapsed recertification must be documented in the medical record and a delayed / lapsed recertification may not extend past discharge.

Source: Code of Federal Regulations, Condition of Participation 42 CFR Section 412.3 Parts A, B, and C and 482.24(c)(2); Section 482.61 (a)(3); Center for Medicare & Medicaid Services, Transmittal 234 Clarification of Admission Order and Medical Review Requirements, March 10, 2017; Medicare Benefit Policy Manual, Chapter 2, Section 20: Admission Orders; Code of Federal Regulations, Conditions for Medicare Payment 42 CFR Section 424.14, Parts A – D.
Kelly J. Sauders, CPA, MBA

Experience: Over twenty years of experience providing regulatory, compliance and related services

Education: MBA in Health Systems Administration, Union College
            B.S. in Accounting, State University of New York College at Plattsburgh

Kelly is a Partner with Deloitte & Touche LLP who has over 20 years of experience in the health care industry. She specializes in providing regulatory compliance and risk services in the health care industry. Kelly has led numerous regulatory compliance program assessments, HIPAA/privacy program assessments, implementation projects and responses to government investigations. Many of these have involved documentation, coding or billing matters. This experience includes coding and billing for hospitals, physician groups, skilled nursing facilities, home health and hospice. She has also been involved in many enterprise-wide risk assessment and ERM program development projects. In these roles she works frequently with boards of directors and executive teams.

This experience has given Kelly both a broad and deep understanding of health care (e.g. academic and community hospitals, physician/clinic, SNF/HH, outpatient, etc.) and the impact of changing regulations not only on health care organizations but on large employers and companies in related industries. Kelly has also served several academic medical center and health system clients as an interim chief compliance officer and as an interim director of internal audit. She has assisted numerous clients with CIA-readiness, government investigations, OIG audits, and self-disclosures regarding documentation, coding and billing matters and has led a number of Independent Review Organization (IRO) engagements. Kelly has also served as an expert witness on a billing dispute between a medical practice and a hospital. She is a frequent national speaker on compliance programs, ERM, coding and billing matters, internal controls and other regulatory topics.

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Associations: Member of HCCA and HFMA

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