



The U.S. Department of Health & Human Services (HHS) released the Office of Inspector General (OIG) 2015 Work Plan on October 31, 2014. The OIG Work Plan summarizes the objectives for HHS planned areas of focus for investigation and enforcement activities. The majority of the items in the report are ongoing reviews with just a few new activities the Office of Inspector General (OIG) will pursue in the coming year and beyond. In FY 2015 and beyond, the OIG will continue to focus on emerging payment, eligibility, management, and IT systems security vulnerabilities in health care reform programs, such as the health insurance marketplaces. One of the major changes in the OIG Work Plan for 2015 is the absence of physician Evaluation and Management (E&M) coding review, which had been an OIG focus for a number of years. We have highlighted a few OIG projects below. The full OIG Work Plan can be downloaded by following the link: <http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf>

#### **Outpatient evaluation and management services billed at the new-patient rate**

The OIG will review Medicare outpatient payments made to hospitals for evaluation and management (E/M) services for clinic visits billed at the new-patient rate to determine whether they were appropriate and will recommend recovery of overpayments. Preliminary work identified overpayments that occurred because hospitals used “new”-patient codes when billing for services to established patients. The rate at which Medicare pays for E/M services requires hospitals to identify patients as either new or established, depending on previous encounters with the hospital. According to Federal regulations, the meaning of “new” and “established” pertains to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past 3 years.

#### **Questionable billing patterns for Part B services during nursing home stays**

The OIG will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents during stays not paid under Part A (for example, stays during which benefits are exhausted or the 3-day prior-inpatient-stay requirement is not met). A series of studies will examine several broad categories of services, such as foot care. Congress directed OIG to monitor Part B billing for abuse during non-Part A stays to ensure that no excessive services are provided.

#### **Physicians—Place-of-service coding errors**

The OIG will review physicians’ coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service. Prior OIG reviews determined that physicians did not always correctly code non-facility places of service on Part B claims submitted to and paid by Medicare contractors. Federal regulations provide for different levels of payments to physicians depending on where services are performed. Medicare pays a physician a higher amount when a service is performed in a

non-facility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC.

### **Risk Assessment of CMS' Administration of the Pioneer Accountable Care Organization Model (new)**

The OIG will conduct a risk assessment of the Pioneer Accountable Care Organization (ACO) Model. An ACO is a group of providers and suppliers of services (e.g., hospitals and physicians and others involved in patient care) that will work together to coordinate care for the Medicare fee-for-service beneficiaries they serve. The Centers for Medicare & Medicaid Innovation was created to test innovative care and service delivery models and is administering the Pioneer ACO Model. The OIG will conduct a risk assessment of internal controls over administration of the Pioneer ACO Model.

### **Medicare incentive payments for adopting electronic health records**

The OIG will review Medicare incentive payments to eligible health care professionals and hospitals for adopting EHRs and the Centers for Medicare & Medicaid Services (CMS) safeguards to prevent erroneous incentive payments. The OIG will review Medicare incentive payment data from 2011 to identify payments to providers that should not have received incentive payments (e.g., those not meeting selected meaningful use criteria).

The OIG will also assess CMS's plans to oversee incentive payments for the duration of the program and corrective actions taken regarding erroneous incentive payments. Medicare incentive payments are authorized over a 5-year period to physicians and hospitals that demonstrate meaningful use of certified EHR technology. Incentive payments were scheduled to begin in 2011 and continue through 2016, with payment reductions to health care professionals who fail to become meaningful users of EHRs beginning in 2015. As of August 2014, Medicare EHR incentive payments totaled more than \$16 billion.

### **Medicaid incentive payments for adopting electronic health records**

The OIG will review Medicaid incentive payments to Medicaid providers and hospitals for adopting electronic health records (EHRs) and CMS safeguards to prevent erroneous incentive payments. The OIG will determine whether incentive payments to Medicaid providers to purchase, implement, and operate HER technology were claimed in accordance with Medicaid requirements; assess CMS's actions to remedy erroneous incentive payments and its plans for securing the payments for the duration of the incentive program; and determine whether payments to States for related administrative expenses were appropriate. The law authorizes 100 percent Federal financial participation for allowable expenses for eligible Medicaid providers to purchase, implement, and operate certified EHR technology. The section also provides a 90-percent Federal match for State administrative expenses for the adoption of certified EHR technology by Medicaid providers. As of August 2014, Medicaid EHR incentive payments totaled more than \$8 billion. Incentive payments will continue through 2021.

### **Security of certified electronic health record technology under meaningful use**

The OIG will perform audits of various covered entities receiving EHR incentive payments from CMS and their business associates, such as EHR cloud service providers, to determine whether

they adequately protect electronic health information created or maintained by certified EHR technology. A core meaningful-use objective for eligible providers and hospitals is to protect electronic health information created or maintained by certified EHR technology by implementing appropriate technical capabilities. To meet and measure this objective, eligible hospitals, including critical access hospitals, must conduct a security risk analysis of certified EHR technology as defined in Federal regulations and use the capabilities and standards of Certified Electronic Health Record Technology. Furthermore, business associates that transmit, process, and store EHRs data for Medicare and Medicaid providers are playing a larger role in the protection of electronic health information. Therefore, audits of cloud service providers and other downstream service providers are necessary to ensure compliance with regulatory requirements and contractual agreements.

If you have questions or would like to comment on the OIG work plan for FY 2015 please contact Brian Outland in Health Policy and Regulatory Affairs at [boutland @acponline.org](mailto:boutland@acponline.org).

Updated: 7-Apr-15