New Items in the OIG’s Work Plan Update - August 2019

The Office of Inspector General (OIG) has published the latest additions to its Work Plan. PYA offers insights on six noteworthy items related to overprescribing, telehealth for behavioral health services, facet joint procedures, Medicaid assisted living services, Medicare Part B services for nursing homes, and obstructive sleep apnea.

Background

Each month, the OIG publishes the most recent additions to its Work Plan. The work plan development process is dynamic and requires adjustments throughout the year to meet the OIG’s “priorities and to anticipate and respond to emerging issues with resources available.” With a goal of transparency, the OIG updates its Work Plan website monthly, outlining recently added information. The following is a summary of the latest additions, the agencies affected, and what they mean for compliance leaders in healthcare organizations.

Opioids in Medicaid: Review of Extreme Use and Overprescribing in the Appalachian Region (CMS)

According to the OIG Work Plan update:

Opioid abuse and overdose deaths remain at crisis levels in the United States and the Appalachian region. In 2017, opioids were involved in nearly 48,000 overdose deaths nation-wide, and the opioid overdose death rate was 72 percent higher in Appalachian counties than non-Appalachian counties. These issues are of concern for Medicaid beneficiaries, who are more likely to have chronic conditions and comorbidities that require pain relief, especially those beneficiaries who qualify through a disability. Consistent with previous OIG work in Medicaid and Medicare Part D, we will identify beneficiaries who received extreme amounts of opioids through Medicaid, beneficiaries who appear to be doctor or pharmacy shopping, and prescribers associated with these beneficiaries.

What You Need to Know:

The SUPPORT for Patients and Communities Act became public law on October 24, 2018. Multiple provisions in this bill address the opioid crisis regarding access to continued coverage and services for a broad base of the Medicaid population. The Act increases options for provider treatment capacities,
establishes drug review, outlines utilization requirements with safety measures, and requires Medicare medication therapy management programs, along with annual disclosures from drug plans regarding risks of prolonged opioid use. The Act also addresses the facilitation and improvement of access to prescription drug monitoring programs (PDMPs) for Medicaid providers and managed care entities, as well as the expansion of shared access information as permitted by State law. The list is long, and there are many actions for providers to combat this substance abuse crisis.

Misunderstandings about HIPAA protections, obligations of covered healthcare providers, and the circumstances in which covered providers can share information “create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation such as an opioid overdose.” Mental health and substance use disorder treatment information is highly sensitive information with regard to patient privacy. The Office of Civil Rights (OCR) provides guidance addressing the HIPAA privacy protections that allow healthcare professionals to respond to the opioid crisis by permitting some health information disclosure without a patient’s permission under certain circumstances.

What You Need to Do:

The government is addressing the opioid crisis from many angles. Providers and pharmacists must be diligent about checking their State’s prescribing database before writing and filling prescriptions for opioid and other controlled substances, and should seek ways to offer alternate treatment plans to assist with abuse treatments. Insurers can clear that pathway for patient coverage by expanding treatment options and opening services lines to address this national crisis. The OIG will first start by identifying beneficiaries and trace them back to providers and pharmacists, then ultimately to the distributors, to find a solution to this crisis.

Use of Telehealth to Provide Behavioral Health Services in Medicaid Managed Care (CMS)

According to the OIG Work Plan update:

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth can increase beneficiaries’ access to healthcare and reduce healthcare spending. All 50 States and the District of Columbia currently provide some coverage under Medicaid of telehealth; however, limited information is available about how States use telehealth to provide behavioral health services to Medicaid managed care enrollees. This review will focus on selected States. It will analyze how these States and managed care organizations (MCOs) use telehealth to provide behavioral healthcare. It will also review selected States’ monitoring and oversight of MCOs’ behavioral health services provided via telehealth. Finally, it will identify States’ and MCOs’ practices on how to maximize the benefits and minimize the risks of providing behavioral healthcare via telehealth.

What You Need to Know:

Information about States’ use of telehealth medicine to provide mental and behavioral health services to Medicaid and Managed Care Organizations (MCOs) is scarce. The OIG is currently auditing these plans and expects to find a “mixed bag of telemental programs and State laws governing them.” According to Medicaid.gov, “…telemedicine seeks to improve a patient’s health by permitting two-way, real time
interactive communication between the patient, and the physician or practitioner at the distant site.”

Medicaid guidelines require that all providers practice within the scope of their State Practice Act. Some States may require that, in order for telemedicine to be used across State lines, the telecommuting provider(s) must have a “valid State [medical] license in the same State the patient is located.” To obtain reimbursement from Medicaid for telemedicine services, “Federal requirements of efficiency, economy, and quality of care” must be met. As this technology advances and telemedicine expands, providers would be prudent to remember that “the general Medicaid requirements of comparability, stateliness [sic], and freedom of choice do not apply with regard to telemedicine services.” Reimbursement methodologies, including what is and is not covered, are optional and offer a wide range of flexibility.

What You Need to Do:

As the effectiveness of telehealth services continues to grow, providers considering telemedicine should conduct due diligence on several facets of this service line. Such due diligence includes:

- Understanding State requirements for medical licensure in and across State lines.
- Having a comprehensive vendor management process that ascertains telehealth technology use, communication, storage, interface, and exchange capabilities to meet HITECH and HIPAA privacy and security requirements.
- Monitoring and conducting audits to evaluate all aspects of telehealth patient interaction and care, as well as billing and coverage requirements to ensure your organization doesn’t fall into any “gaps” for meeting evidence-based medicine practices and is delivering the quality care you expect.

Review of Medicare Facet Joint Procedures (CMS)

According to the OIG Work Plan update:

Facet joint injections are an interventional technique used to diagnose or treat back pain. Several previous reviews found significant billing errors in this area, including a prior OIG review. We will review whether payments made by Medicare for facet joint procedures billed by physicians complied with Federal requirements (Social Security Act, § 1833(e), 42 CFR § 424.32(a)(1), and 42 CFR §414.40).

What You Need to Know:

Coding errors for facet joint injection services identified by the Department of Health and Human Services (HHS) OIG involved bilateral injections. The findings indicated that physicians inappropriately reported a bilateral injection by listing the base code for the first side to code for the primary procedure and the add-on code for the second side at the same level. CPT coding for a bilateral single-level lumbar facet block should not be coded as 64493 and 64494, but rather 64493-50 indicating that the same vertebral level was injected (64493) on bilateral sides (modifier 50). If a second level is injected bilaterally, report the add-on code (64491 or 64494) with the added modifier 50.

What You Need to Do:

Appropriate CPT codes should be reported once per vertebral level, with modifier 50 indicating the
injection was bilateral. Physicians should indicate a bilateral injection by using billing modifier 50 and the appropriate CPT code, and single-side, multi-levels using the base and add-on CPT codes. MLN Matters Number: MM6518 clarifies that “[p]hysicians who perform facet joint injections on multiple levels on the same side of the spine must use the CPT add-on codes to represent these additional levels injected, instead of using modifier 50.” Providers may not bill separately for the image guidance when reporting facet joint codes whether the provider uses fluoroscopy or computed axial tomography guidance. Providers should review a sample of their facet joint injection claims to ensure the claim services are coded appropriately, are medically necessary, and have been paid appropriately.

**Medicaid Assisted Living Services (CMS)**

According to the OIG Work Plan update:

Medicaid may provide assisted living services to beneficiaries who are medically eligible for placement in a nursing home but opt for a less medically intensive, lower-cost setting. These services may include personal care (e.g., assistance with dressing and bathing), homemaker services (e.g., housecleaning and laundry), personal emergency response services, and therapy services (i.e., physical, speech, and occupational). A 2018 Government Accountability Office report indicated that improved Federal oversight of beneficiary health and welfare is needed in States’ administration of Medicaid assisted living services. We will determine whether assisted living providers are meeting quality-of-care requirements for Medicaid beneficiaries residing in assisted living facilities and whether the providers properly claimed Medicaid reimbursement for services in accordance with Federal and State requirements.

**What You Need to Know:**

Assisted living providers are preparing to identify quality improvement metrics and align their goals with the Federal government’s priorities for quality measurement. The objectives are to reduce direct care staff turnover rates, reduce hospital readmissions, improve patient satisfaction, and reduce off-label use of antipsychotics. Currently, quality reporting is not mandated for assisted living facilities, but providers are encouraged to document, monitor and track, and analyze their internal data to address these objectives. Given the increased focus on long-term, post-acute, and assisted living care services, providers can expect State and Federal mandates to increase and intensify. Organizations will need to show value and demonstrate progress in tracking their improvement activities.

Payments vary for assisted living benefits and are based on the State of residence and the State-specific Medicaid program in which a beneficiary is enrolled. According to the American Council on Aging, “Some States cover personal care assistance, others use home and community-based services (HCBS) waivers. Other States may utilize both a State plan and a waiver. Some assisted living residences do not accept Medicaid at all.”

**What You Need to Do:**

Providers can concentrate on key areas that enhance the lives of their assisted living residents, including:

- Focusing on patient-centered initiatives that contain quality metrics and measurable goals.
- Implementing monitoring and audit processes that track and trend antipsychotic medications and
safety improvements.
- Evaluating readmission rates and factors to identify ways to decrease incidents and episodes of emergent care.
- Setting up a survey to capture residents and family satisfaction experiences.

These results can lead to great insight for effecting change. If staff turnover is high, conduct a behavioral and cultural assessment of the organization and consider making changes that may include an overhaul of the hiring and benefit package. Lastly, know your State’s Medicaid coverage rules and make sure your billing practices are compliant. Be transparent, and assist your residents in understanding what is and is not covered under their plans.

**Medicare Part B Services to Medicare Beneficiaries Residing in Nursing Homes During Non-Part-A Stays (CMS)**

According to the OIG Work Plan update:

Medicare pays physicians, non-physician practitioners, and other providers for services rendered to Medicare beneficiaries, including those residing in nursing homes (NHs). Most of these Part B services are not subject to consolidated billing; therefore, each provider submits a claim to Medicare. Since the 1990s, OIG has identified problems with Part B payments for services provided to NH residents. An opportunity for fraudulent, excessive, or unnecessary Part B billing exists because NHs may not be aware of the services that the providers bill directly to Medicare, and because NHs provide access to many beneficiaries and their records. We will determine whether Part B payments to Medicare beneficiaries in NHs are appropriate and whether NHs have effective compliance programs and adequate controls over the care provided to their residents.

**What You Need to Know:**

An overview from CMS states that for skilled nursing facility (SNF) consolidated billing, “Medicare beneficiaries can either be in a [Part-A-covered SNF stay,] which includes medical services as well as room and board, or they can be in a [Part-B-non-covered SNF stay,] in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.” CMS continues by stating, “For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing (CB). All other covered SNF services for these beneficiaries can be separately billed to and paid by the Medicare contractor.” Under the CB requirement, a SNF itself must submit all Medicare claims for the services that its residents receive (except for some specifically excluded services).

The OIG has also published in the Federal Register Compliance Program Guidance for Nursing Facilities, which will serve as a positive step toward helping facilities establish internal controls to effectively monitor adherence to applicable statutes, regulations, and compliance program requirements. The OIG believes a comprehensive compliance program provides a mechanism that brings the public and private sectors together to reach mutual goals of reducing fraud and abuse, enhancing operational functions, improving the quality of healthcare services, and decreasing the cost of healthcare.

**What You Need to Do:**
Providers should reference their region’s Medicare Administrative Contractor (MAC) updates and billing information for SNF CB. The MAC’s billing guidance will outline categories of services that are excluded and beyond the scope of SNF CB. Evaluating and implementing edits in the claim system in order to capture coding and billing accuracy and appropriateness can alert providers to errors, omissions, and questionable coding relationships that require further investigation and correction.

Integrating a compliant process over CB, as well as establishing a compliance program for a SNF are key. Outlining the avenues for compliance with laws, regulations, standards, and ethical practices can help prevent and detect violations and save organizations from fines and lawsuits.

There are several services excluded from SNF CB. Although separately billed to Part B when furnished by an outside supplier, these excluded services are outside the prospective payment system (PPS) bundle. Billing for these excluded services requires that the SNF’s Medicare provider number be included on the claim. Providers should read MLN Matters Number SE0431 and the SNF Consolidated Billing requirements carefully to understand which services are bundled into Part A inpatient services and which are excluded, yet billable, to Part B when furnished to a SNF resident.

Additionally, the OIG’s Compliance Program Guidance for Nursing Facilities outlines elements that an effective compliance program should contain:

- Policies, procedures, and standards of conduct.
- A designated compliance officer and compliance committee.
- Training and education.
- Effective communication.
- Enforced disciplinary standards.
- Internal monitoring and auditing.
- Prompt response to detected offenses and implementation of corrective action.

Obstructive Sleep Apnea Without Conducting a Prior Sleep Study (CMS)

According to the OIG Work Plan update:

An OIG analysis of the 2017 Comprehensive Error Rate Testing (CERT) program for positive airway pressure (PAP) device payments shows potential overpayments of $566 million. Claims for PAP devices used to treat obstructive sleep apnea (OSA) for beneficiaries who have not had a positive diagnosis of OSA based on an appropriate sleep study are not reasonable and necessary (Medicare National Coverage Determination (NCD) Manual, Chapter 1, Part 4, § 240.4 and Local Coverage Determination (LCD) L33718).

Medicare will not pay for items or services that are not “reasonable and necessary” (Social Security Act § 1862(a)(1)(A)). We will examine Medicare payments to durable medical equipment providers for PAP devices used to treat OSA to determine whether an appropriate sleep study was conducted.

What You Need to Know:

Continuous positive airway pressure (CPAP) therapy is considered reasonable and necessary and is a covered benefit for adult patients with a positive diagnosis of OSA. According to the Social Security Act § 1862(a)(1)(A), payment will be made for Part A or B expenses incurred for items or services considered “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve
the functioning of a malformed body member.” To identify and diagnose OSA, coverage is first limited to a 12-week period and is subsequently covered after a diagnosis is confirmed. A positive OSA diagnosis must include a face-to-face clinical evaluation with documentation that OSA symptoms are improved with the use of CPAP therapy. The treating practitioner must document findings that the beneficiary used the PAP more than four hours per night on 70% of the nights during a consecutive 30-day period anytime during the first three months of initial use.

In addition to the clinical evaluation, [NCD 240.4](#) and [LCD L33718](#) outline criteria that cover a PAP device for the positive diagnosis and treatment of OSA therapy. The NCD and LCD state that coverage must have a previous order by the beneficiary’s treating physician and be based on a sleep test. The sleep test must be one of the following: a polysomnography (PSG) (Type 1 study) conducted by a facility-based sleep lab that follows all applicable State and regulatory requirements, or an inpatient hospital-based or unattended home-based sleep test (HST) Type II or Type III home sleep monitoring device, or an unattended HST with a Type IV home sleep device that measures at least three channels. The beneficiary and/or caregiver must receive instruction on the proper use and care of the CPAP equipment.

What You Need to Do:

Providers should consistently reference the Medicare NCDs and LCDs for coverage and documentation guidance. In order to help providers and patients avoid payer denials, oversight monitoring and auditing activities should be implemented to ensure order entry, diagnosis assignment, admission screening, and authorization, along with complete certification processes, supported medical necessity within the clinical evaluations, and a clear connection to a definitive diagnosis at each stage of care. Documenting these processes and looking for areas of improvement will enhance the experience for all.

How PYA Can Help

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