Health Law Alert: OIG Releases 2013 Work Plan; Holder, Sebelius Warn Hospitals on Misuse of Electronic Health Records

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The Department of Health & Human Services (HHS) Office of Inspector General (OIG) recently published its 2013 "Work Plan"—the agency's roadmap for fighting fraud and abuse during the coming year. Meanwhile, HHS Secretary Kathleen Sebelius, and U.S. Attorney General Eric Holder issued a joint letter to five major health care organizations, including the American Hospital Association and the Association of American Medical Colleges, warning of "troubling indications" of abuse in the way hospitals use electronic health records (EHR) to bill for Medicare and Medicaid reimbursement. This joint letter follows CMS' recently released final rule specifying Stage 2 meaningful use requirements for the Medicare and Medicaid Electronic Health Record Incentive Program. We published an alert last month on the new meaningful use regulations, which can be read here.

2013 OIG Work Plan

In announcing its goals for 2013, the OIG first outlined its recent successes in fighting health care fraud. The agency noted, for instance, that it recovered $5.2 billion alone in fiscal year 2011. The agency excluded 2,662 individuals and organizations from participating in Medicare, Medicaid, and other federal health care programs and reported 723 criminal health care fraud actions and 382 OIG-led civil actions. The Work Plan reports on ongoing initiatives, as well as new programs for 2013. The OIG's new targets for 2013 include the following:

- Compliance with the "provider-based" rules by hospitals and physicians. The OIG is concerned that organizations are taking advantage of increased reimbursement in provider-based status without following the appropriate billing rules.
- Whether the diagnosis related group (DRG) "window" should be expanded. The DRG window currently bundles outpatient services provided within 3 days of admission to a hospital, but OIG is analyzing whether it should be expanded to 14 days.
- Analyzing whether home health agencies are meeting the requirement that physicians have face-to-face visits with beneficiaries prior to certification for home health services, as well as whether HHAs are meeting criminal background check requirements.

- Potential expansion of unannounced pre-enrollment site visits as part of Medicare enrollment process. The OIG referenced a study indicating that one-third of DME suppliers in South Florida did not maintain a physical location, a problem which can be addressed by verifying practice locations during the Medicare enrollment process.
- Whether providers continued to bill Medicare after CMS referred them to Department of Treasury for collections due to the providers' failure to return overpayments. CMS is concerned that providers with overpayments are shifting their billing to a different provider number as a way of continuing to submit claims.
- Reviewing whether claims for anesthesia services are properly billed as personally performed or medically directed.
- Nursing home administration of atypical antipsychotic drugs in light of CMS regulation requiring that nursing home residents' drug regimens be free of unnecessary drugs.
- Reviewing whether CMS' Medicare program integrity strategy is effective or should be expanded. OIG noted that many providers are enrolling their practice locations with addresses that are nothing more than commercial mailboxes.
- Whether drug manufacturers are using copayment coupons in a way that violates the anti-kickback statute.
- Compliance with Medicaid waiver rules regulating payment for supported employment services, adult day care services, and unallowable room and board costs.
- Compliance with Medicaid billing rules for dental services.

All of this builds upon dozens of ongoing OIG projects, including a review of physician-owned distributors of medical devices; whether diagnostic sleep labs are billing for tests that are not reasonable and necessary, questionable billing for clinical lab service and a range of initiatives related to durable medical equipment suppliers and imaging providers. The full OIG Work Plan is available here.

Joint Letter Warning of Fraud and Abuse Using Electronic Health Records

Meanwhile, with CMS' meaningful use program up and running, it was only a matter of time before EHRs took on a position as a new front in the war against fraud and abuse. The Joint Letter (which is located through a link at the end of the alert) warns that regulators will not tolerate what it described as attempts to "game the system" and vowed to vigorously prosecute doctors and hospitals involved in such fraud.

Attorney General Holder and Secretary Sebelius reiterated that "electronic health records have the potential to save money and save lives" but that "[t]here are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal." The letter notes specific concerns about "cloning" of medical records, where information about one patient is repeated in other records, to inflate reimbursement. "There are also reports that some hospitals may be using electronic health records to facilitate ‘upcoding' of the intensity of care or severity of patients' condition as a means to profit with no

commensurate improvement in the quality of care," the letter continues.

Addressing the government's resolve to prevent and prosecute health care fraud, the letter states that CMS is "reviewing billing through audits," "initiating more extensive medical reviews," including "comparative billing reports," and addressing "inappropriate increases in coding intensity in its payment rules." While not unprecedented, the letter is particularly terse and is delivered when the issue of Medicare costs is being hotly debated in the presidential campaign.

The Joint Letter coincides with other initiatives found in the 2013 Work Plan that target EHRs, including improper evaluation and management billing related to EHR documentation; fraud vulnerabilities created through EHRs; and whether providers are receiving improper payments under the Medicare or Medicaid meaningful use programs (because they have not met the underlying meaningful use core or objective measures that trigger receipt of those payments). The OIG has also indicated that it will evaluate what CMS is doing to recoup improper meaningful use incentive payments.

If you have any questions about the 2013 OIG Work Plan or the EHR incentive program, please contact Jeremy Johnson (jeremy.johnson@lathropgpm.com, 612.632.3035) or Jesse Berg (jesse.berg@lathropgpm.com, 612.632.3374).