E-BRIEF SERIES

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July 2024 OIG Work Plan Updates

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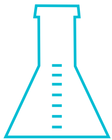
The OIG added many new items to their work plan in July. We've highlighted a select number of them below.



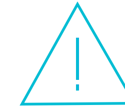
CLINICAL LABORATORY TESTS

Can you guess who the largest payer of clinical diagnostic laboratory services in the United States is? If you guessed Medicare, you would be right. In fact, Medicare Part B covers most lab tests and pays 100% of allowable charges without requiring patients to have any cost-sharing responsibilities.

A 2014 law called the Protecting Access to Medicare Act (PAMA) requires CMS to set their payment rates for lab tests based on current charges in the private health care market. Then in 2018, PAMA required CMS to begin paying for lab tests under a new system. CMS is not the only government agency required to act under PAMA. The OIG must annually analyze the top 25 lab tests (by expenditure) and publicly release their analysis.

This OIG Work Plan item is meant to meet that obligation for the top 25 lab tests for 2023.

Do you audit DMEPOS payments? Well, the OIG has added this item to their Work Plan with the intent to perform a follow up audit.



OVERPAID DMEPOS CLAIMS

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are paid for by Medicare in two different ways. If the person is an inpatient at an acute care hospital, usually DMEPOS services are included in Medicare Part A payments. Some exceptions exist, such as on admission and discharge dates. If the patient is not an inpatient, then Medicare Part B pays for DMEPOS.

Consequently, if Medicare Part B is billed and they pay for DMEPOS when a patient was an inpatient, then this Part B payment would be considered an overpayment because, generally speaking, DMEPOS should not be billed to Part B for an inpatient.

The OIG has examined this area of potential overpayment in the past and found there to be noncompliance risks with billing under these circumstances. In one previous report, OIG concluded that for a specific time period, Medicare should not have paid suppliers for any of the $34 million for DMEPOS that were provided during inpatient stays. In that same audit, OIG concluded beneficiaries were held responsible for unnecessary deductibles and

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coinsurance of $8.7 million paid to the suppliers for the DMEPOS items. For more on this previous report, click here.

Given this risk, the OIG has added this item to their Work Plan with the intent to perform a follow up audit. With this audit, they will review Medicare payments to certain types of inpatient hospitals to determine whether claims billed to Part B for specific DMEPOS items provided during inpatient stays were made in accordance with Federal requirements. Additionally, they plan to review the CMS Common Working File system edits that should deny claims for DMEPOS items furnished during an inpatient stay.

Learn more about DMEPOS billing for inpatients at this Medicare Learning Network publication.

MEDICAID MANAGED CARE

The U.S. Department of Health and Human Services oversees the Medicaid program. There are certain types of payments in the Medicaid Managed Care program that States are allowed to make to providers. These are called State directed payments. CMS is the entity responsible for establishing the criteria and circumstances when States are allowed to make these directed payments. States do so while working within certain parameters the Federal government creates.

In this OIG Work Plan item, the OIG will review certain activities related to State directed payments. Their objective is to determine if the State:

- Obtained CMS approval for the directed payment proposal.
- Complied with CMS-approved requirements and outcomes in the approved proposal.
- Ensured that directed payments were made according to the approved proposal.

MEDICAID MANAGED CARE CAPITATION PAYMENTS

Medicaid managed care organizations contract with States to provide certain services to Medicaid beneficiaries. Usually there is an expectation that in return a predetermined payment is periodically made. This is called a capitation payment.

Various laws, regulations, and guidance from CMS state that Federal financial participation is generally not available for services provided to adult inmates of public institutions. There are exceptions. One is when the individual is not in a prison setting and becomes an inpatient in a medical institution.

The OIG plans to determine if certain States made capitation payments to Medicaid managed care organizations that they should not have made for people incarcerated in State prisons.

The KFF, a healthcare policy and research organization, has written previously on considerations for Medicaid enrollees who become incarcerated. To read more visit this link.

In addition, certain state auditors have also identified improper capitation payments made to Medicaid managed care organizations. In one report from the Ohio Auditor of State, state auditors found millions of dollars of capitation payments that should have been recouped because individuals were ineligible during certain periods of incarceration.

CONCLUSION

Compliance professionals should monitor OIG Work Plan items and determine if the planned activity might affect their own organizations.

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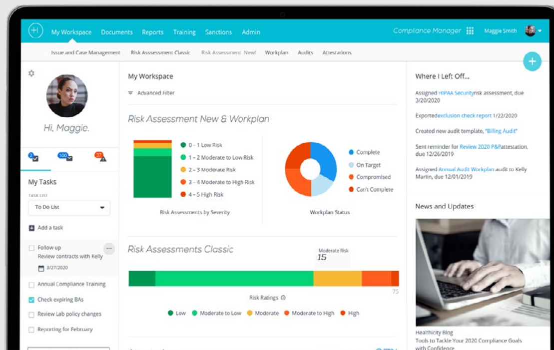
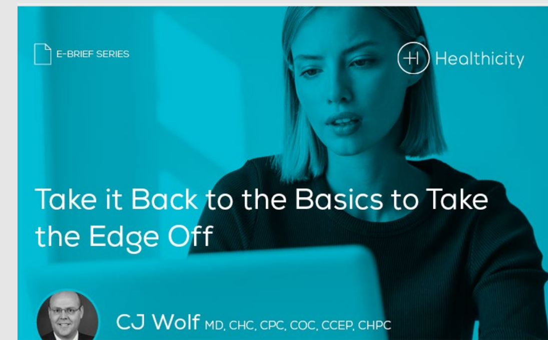
COMPLIANCE MANAGER



WATCH ON-DEMAND DEMO

RESOURCE CENTER



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