Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

October 2021

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as, give our colleagues and clients focused insights into the over 300 audits, performed by HHS OIG, over the last 12 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 12 months and sorts relevant audits into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

We review all OIG completed audits that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused completed audits, SunHawk has identified other audit items which we determined relevant to a limited number of Providers and Payers. We plan to publish a summary of these items in January 2021.

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

[1] HHS OIG's Semi-annual reports to Congress for the April 1, 2019 to March 31, 2020 periods reported 304 new Audits and Evaluations which was an increase of 111 more issued reports during the same prior year period.

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Noridian Healthcare Solutions, LLC, Made Improper Medicare Payments of $4 Million to Physicians in Jurisdiction E for Spinal Facet-Joint Injections

Facet-joint injections of an anesthetic with or without a steroid are used to diagnose or treat chronic neck and back pain. A prior OIG review found that 47 percent of Medicare payments to physicians for facet-joint injections nationwide in calendar year (CY) 2006, or approximately $96 million, did not meet Medicare requirements. In addition, Noridian Healthcare Solutions, LLC (Noridian), the Medicare Administrative Contractor for Jurisdiction E, identified during audits performed in CYs 2016 through 2018 various errors in which physicians did not bill for facet-joint injections in accordance with Medicare requirements. OIG's objective was to determine whether Noridian paid physicians in Jurisdiction E for spinal facet-joint injections in accordance with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Noridian did not pay physicians in Jurisdiction E for spinal facet-joint injections in accordance with Medicare requirements. Of the sampled 100 beneficiary days, 51 beneficiary days did not comply with 1 or more of the requirements. As a result, Noridian improperly paid physicians $12,546.

According to OIG, these improper payments occurred because Noridian's education of physicians and their billing staff was not sufficient to ensure that they complied with billing requirements for spinal facet-joint injections. Based on OIG sample results, OIG estimated that Noridian improperly paid physicians $4.2 million for facet-joint injections for OIG's audit period.

OIG recommended that Noridian: (1) recover $12,546 in improper payments made to physicians; (2) based upon the results of this audit, notify appropriate physicians (i.e., those for whom Noridian determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation and (3) provide annual training to physicians and their billing staff in Jurisdiction E specific to Medicare requirements for billing of facet-joint injections, which could have saved an estimated $4.2 million for OIG's audit period.

Work Plan #: A-09-20-03010 (February 2021)
Government Program: Medicare Parts A & B

Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period

To address inappropriate billing for pain management tied to overuse of spinal facet-joint injections, the Medicare Administrative Contractors (MACs) developed a limitation of coverage that allows physicians to be reimbursed, during a

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rolling 12-month period, for a maximum of five sessions in which facet-joint injections are delivered to the lumbar region of the spine (lumbar spine) or the cervical and thoracic regions of the spine (cervical/thoracic spine). (OIG refers] to injection sessions in the two spinal areas during a rolling 12-month period as "selected facet-joint injection sessions"). However, one of the MACs' audits found that Medicare improperly paid for more than five injection sessions related to the lumbar or cervical/thoracic spines during a rolling 12-month period. OIG's objective was to determine whether Medicare paid physicians for selected facet-joint injection sessions in accordance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that MACs in the 11 jurisdictions with a coverage limitation made improper payments of $748,555. During OIG's audit period, the Centers for Medicare & Medicaid Services' (CMS's) oversight was not adequate to prevent or detect these improper payments. In addition, if the remaining MAC jurisdiction had kept in place during OIG's audit period the coverage limitation, Medicare could have saved $513,328.

OIG recommended that for the 11 MAC jurisdictions with a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, CMS: (1) direct the MACs that oversee the 11 jurisdictions to recover $748,555 in improper payments made to physicians; (2) instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) develop oversight mechanisms for the MACs to implement to prevent or detect payments to physicians for more than 5 facet-joint injection sessions received by beneficiaries during a rolling 12-month period in the lumbar spine or cervical/thoracic spine; and (4) direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections after OIG's audit period to identify instances in which Medicare paid physicians for more than 5 injection sessions received by beneficiaries during a rolling 12-month period and recover any improper payments identified.

Work Plan #: A-09-20-03003 (October 2020)
Government Program: Medicare Parts A & B

Medicare Contractors Were Not Consistent in How They Reviewed Extrapolated Overpayments in the Provider Appeals Process

When an overpayment is identified in Medicare Part A or Part B, providers have the right to contest the overpayment amount using the Medicare administrative appeals process. If a statistical estimate of an overpayment (an extrapolated overpayment) is overturned during the administrative appeals process, then the provider is liable for the overpayment identified in the sample but not the extrapolated amount. Given the large difference between overpayment amounts in the sample and extrapolated amounts, it is critical that the process for reviewing extrapolations during an appeal is fair and reasonably consistent. In the first and second levels of the appeals process, such extrapolated overpayments are reviewed by Medicare administrative contractors (MACs) and qualified independent contractors (QICs), respectively. OIG's objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured that MACs and QICs reviewed appealed extrapolated overpayments consistently and in a manner that conforms with existing CMS requirements.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that, although MACs and QICs generally reviewed appealed extrapolated overpayments in a manner that conforms with existing CMS requirements, CMS did not always provide sufficient guidance and oversight to ensure that these reviews were performed in a consistent manner. The most significant inconsistency OIG identified involved the use of a type of simulation testing that was performed only by a subset of contractors. The test was associated with at least $42 million in extrapolated overpayments that were overturned in fiscal years 2017 and 2018. If CMS did not intend that the contractors use this procedure, these extrapolations should not have been overturned. Conversely, if CMS intended that contractors use this procedure, it is possible that other extrapolations should have been overturned but were not. In addition, CMS's ability to provide oversight over the extrapolation review process was limited because of data reliability issues in the Medicare Appeals System (MAS). Of the 39 appeals cases OIG reviewed that were listed in the MAS as involving extrapolation, 19 cases did not actually involve statistical sampling. Improving the accuracy of the information in the MAS would potentially assist CMS with ensuring that extrapolated overpayments are reviewed by the MACs and QICs in a consistent manner.

OIG recommended that CMS: (1) provide additional guidance to contractors to ensure reasonable consistency in procedures used to review extrapolated overpayments during the first two levels of the Medicare Parts A and B appeals process; (2) take steps to identify and resolve discrepancies in the procedures contractors use to review extrapolations during the appeals process; (3) provide guidance regarding the organization of extrapolation related files that must be submitted in response to a provider appeal; (4) improve system controls to reduce the risk of contractors incorrectly marking the extrapolation flag field in the MAS; and (5) update the information in the MAS to accurately reflect extrapolation amounts challenged as part of an appeal, whether the extrapolation was reviewed by a contractor, and the outcome of any extrapolation review.

Work Plan #: A-05-18-00024 (August 2020)
Government Program: Medicare Parts A & B

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[NEW] Medicare Beneficiaries Hospitalized With COVID-19 Experienced a Wide Range of Serious, Complex Conditions

Coronavirus disease 2019 (COVID-19) has affected millions of Americans, resulting in more than 600,000 deaths. Medicare beneficiaries have been particularly affected and remain vulnerable to new variants and additional surges of the virus. Clinicians and researchers are still working to fully understand the damage to the body from the disease and what underlying chronic conditions potentially lead to more severe complications or hospitalization.

Understanding the types of conditions for which Medicare beneficiaries with COVID-19 are being treated and who was more likely to be hospitalized with COVID-19 can help hospitals and health officials better prepare for and address the wide-ranging and extensive needs of COVID 19 patients, particularly in the event of localized surges of cases. Such knowledge will also assist in the Federal, State, and local response to the pandemic by providing a better picture of the needs of these hospitalized beneficiaries.

This report describes the complex care needs of beneficiaries hospitalized with COVID-19. It focuses on surges in COVID-19 hospitalizations in six localities and builds upon prior OIG work that describes the extent to which hospitals have been strained by COVID-19. As OIG noted in the 2021 report about hospital experiences during the pandemic, hospitals have been operating in "survival mode" for an extended period of time. They have also experienced difficulty balancing the complex and resource-intensive care needed for COVID-19 patients with efforts to resume routine hospital care.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that, during surges in hospitalizations, hospitals in the six localities treated Medicare beneficiaries with COVID-19 for a wide range of serious, complex conditions. Almost all of these beneficiaries were treated for acute respiratory issues, such as viral pneumonia. Many of these beneficiaries were also treated for other types of serious conditions including kidney failure, acute circulatory issues, endocrine, nutritional or metabolic issues and sepsis. More than 50 percent of Medicare beneficiaries hospitalized with COVID-19 received intensive care or mechanical ventilation. Additionally, dually eligible, Black, Hispanic, or older beneficiaries were disproportionately hospitalized with COVID-19 relative to the Medicare population in these localities.

Work Plan #: OEI-02-20-00410 (September 2021)
Government Program: Medicare Parts A & B

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Medicare Paid New Hospitals Three Times More for Their Capital Costs Than They Would Have Been Paid Under the Inpatient Prospective Payment System

Medicare regulations require that established hospitals be paid for capital costs through the Inpatient Prospective Payment System (IPPS). These regulations also allow new hospitals to be exempt from the IPPS payment methodology for capital costs and, instead, to be paid for these costs on a cost reimbursement basis for their first 2 years of operation. The stated rationale for this IPPS exemption is that new hospitals may not have adequate Medicare utilization in those initial 2 years and may have incurred significant start-up costs.

OIG's objective was to determine the potential cost savings to Medicare if the IPPS exemption were removed such that capital payments to new hospitals would be paid under the IPPS.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG identified significant potential cost savings to Medicare if the IPPS exemption were removed and capital payments to new hospitals were made through the IPPS. For the 112 new hospitals that OIG reviewed, Medicare paid a total of $283 million more for capital costs than it would have paid if these hospitals had been paid through the IPPS. The IPPS exemption resulted in new hospitals being paid three times more-or an average of almost $1.3 million more per cost report-under the reasonable cost methodology than if they had been paid for their capital costs under the IPPS.

OIG recommended that CMS review the findings in this report and, if it determines that a separate payment methodology for capital costs at new hospitals is no longer warranted, change its regulations to require new hospitals to have their Medicare capital costs paid through the IPPS with an option for payment adjustments or supplemental payments if necessary.

Work Plan #: A-07-19-02818 (August 2021)
Government Program: Medicare Parts A & B

Medicare Hospital Provider Compliance Audits

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, OIG identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals $206 billion, which represents 55 percent of all fee-for-service payments for the year.

SunHawk Summary of OIG Audit Findings and Recommendations

Jewish Hospital (A-04-19-08077)

OIG found that Jewish Hospital did not fully comply with Medicare billing requirements for 38 claims, resulting in overpayments of $705,976 for the audit period. Specifically, 34 inpatient claims and 4 outpatient claims had billing errors. Based on OIG's sample results, OIG estimated that Jewish Hospital received overpayments of at least $13.5 million for the audit period.

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OIG recommended that the Jewish Hospital: (1) refund to the Medicare contractor $13.5 million in estimated overpayments for the audit period for claims that it incorrectly billed; (2) exercise reasonable diligence to identify, report, and return any additional similar overpayments received outside of OIG's audit period, in accordance with the 60-day rule; and (3) strengthen controls to ensure full compliance with Medicare requirements.

Ohio State Hospital (A-05-18-00042)

OIG found that Ohio State Hospital did not fully comply with Medicare billing requirements for 47 claims, resulting in net overpayments of $335,832 for the audit period. Specifically, 26 inpatient claims had billing errors, resulting in overpayments of $291,998, and 21 outpatient claims had billing errors, resulting in overpayments of $43,834. Based on OIG sample results, OIG estimated that Ohio State Hospital received overpayments of at least $3.7 million for the audit period.

OIG recommended Ohio State Hospital refund to the Medicare contractor $3.7 million in estimated overpayments for incorrectly billed services that are within the four-year claim reopening period; exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Texas Health Presbyterian Hospital (A-04-18-08068)

OIG found that Texas Health Presbyterian Hospital did not fully comply with Medicare billing requirements for the 41 claims, resulting in net overpayments of $500,323 for the audit period. The 40 inpatient claims had billing errors, resulting in net overpayments of $500,232 and one outpatient claim had a billing error, resulting in an overpayment of $91. Specifically, Texas Health Presbyterian Hospital incorrectly billed:

- 27 inpatient rehabilitation claims that either did not meet coverage or documentation requirements,
- Eight inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation
- One outpatient and Five inpatient claims that were incorrectly coded.

Based on OIG's sample results, OIG estimated that Texas Health Presbyterian Hospital received overpayments of at least $10.7 million for the audit period. During OIG's audit, Texas Health Presbyterian Hospital submitted 13 of these claims for reprocessing, and OIG verified those claims as correctly reprocessed. Accordingly, OIG have reduced the recommended refund by $114,415.

OIG recommended Texas Health Presbyterian Hospital refund to the Medicare contractor $10.6 million ($10.7 million less $114,415 that the Hospital has already repaid) in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG's audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Northwest Medical Center *(A-04-18-08064)*

OIG reported that Northwest Medical Center did not fully comply with Medicare billing requirements for the 20 claims, resulting in overpayments of $201,624 for the audit period. 13 inpatient claims had billing errors, resulting in overpayments of $200,495, and 7 outpatient claims had billing errors, resulting in overpayments of $1,129. Specifically, Northwest Medical Center incorrectly billed:

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- nine inpatient rehabilitation claims that did not meet coverage requirements,
- two inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, and
- two inpatient and seven outpatient claims that were incorrectly coded.

Based on OIG's sample results, OIG estimated that Northwest Medical Center received overpayments of at least $1.2 million for the audit period. During OIG's audit, Northwest Medical Center submitted six of these claims for reprocessing, and OIG verified those claims as correctly reprocessed. Accordingly, OIG have reduced the recommended refund by $4,024.

OIG recommended the Hospital refund to the Medicare contractor at least $1.2 million in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Carolinas Hospital (A-04-18-08063)

OIG found that Carolinas Hospital did not fully comply with Medicare billing requirements for the 45 claims, resulting in overpayments of $431,757 for the audit period. 41 inpatient claims had billing errors, resulting in overpayments of $431,431, and four outpatient claims had billing errors, resulting in overpayments of $326. Specifically, the Hospital incorrectly billed: 22 inpatient rehabilitation claims that did not meet coverage requirements, 15 inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, four inpatient claims and one outpatient claim that were incorrectly coded, and three outpatient claims that were subject to the consolidated billing requirements. Based on OIG sample results, OIG estimated that the Hospital received overpayments of at least $3.4 million for the audit period.

OIG recommended that Carolinas Hospital refund to the Medicare contractor at least $3.4 million in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Work Plan #: A-04-19-08077 (August 2021); A-05-18-00042 (May 2020); A-04-18-08068 (December 2019); A-04-18-08063 (November 2019); A-04-18-08064 (November 2019)
Government Program: Medicare Parts A & B

OIG Conducts Audit of Medicare Payments for Polysomnography Services in Medical Centers

Medicare administrative contractors nationwide paid approximately $885 million for selected polysomnography (a type of sleep study) services provided to Medicare beneficiaries from January 1, 2017, through December 31, 2018 (audit period). Previous OIG audits of polysomnography services found that Medicare paid for some services that did not meet Medicare requirements. These audits identified payments for services with inappropriate diagnosis codes, without the required supporting documentation, and to providers that exhibited questionable billing patterns. OIG's objective was to determine

whether Medicare claims that Medical Centers submitted for polysomnography services complied with Medicare requirements.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Michigan Health System (A-04-20-07088)

OIG found that, of the 100 randomly selected beneficiaries in OIG's sample, University of Michigan submitted Medicare claims for the four beneficiaries associated with five lines of service that did not comply with Medicare requirements, resulting in overpayments of $3,127.

Based on OIG's sample results, OIG estimated that University of Michigan received overpayments of at least $12,520 for polysomnography services during OIG's audit period. The errors occurred because University of Michigan's policies and procedures did not address the processing of Medicare claims for polysomnography services to ensure that services billed to Medicare were adequately documented and coded correctly.

OIG recommended that University of Michigan (1) refund to the Medicare program the estimated $12,520 overpayment for claims that it incorrectly billed that are within the 4-year reopening period; (2) based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) implement policies and procedures to ensure that Medicare claims for polysomnography services comply with Medicare requirements.

Peninsula Regional Medical Center (A-04-19-07087)

OIG found that, of the 100 randomly selected beneficiaries, Peninsula submitted Medicare claims for polysomnography services that complied with Medicare billing requirements for 90 beneficiaries associated with 157 lines of service. However, Peninsula submitted Medicare claims for the remaining 10 beneficiaries associated with 12 lines of service that did not comply with Medicare requirements, resulting in net overpayments of $17,499.

On the basis of OIG's sample results, OIG estimated that Peninsula received overpayments of at least $66,647 for polysomnography services provided during the audit period. The errors occurred because Peninsula's policies and procedures did not address the processing of Medicare claims for polysomnography services to ensure that services billed to Medicare were adequately documented and coded correctly.

OIG recommended that Peninsula Regional Medical Center: (1) refund to the Medicare program the estimated $66,647 overpayment for claims that it incorrectly billed, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, and (3) implement policies and procedures to ensure that Medicare claims for polysomnography services comply with Medicare requirements.

North Mississippi Medical Center (A-04-19-07086)

OIG found that, of the 100 randomly selected beneficiaries, North Mississippi submitted Medicare claims for polysomnography services that complied with Medicare billing requirements for 88 beneficiaries associated with 155 lines of service. However, North Mississippi submitted Medicare claims for the remaining 12 beneficiaries associated with 13 lines of service that did not comply with Medicare requirements, resulting in overpayments of $7,624. On the basis of OIG's sample results, OIG estimated that North Mississippi received overpayments of at least $67,038 for polysomnography services provided during the audit period.

OIG recommended that North Mississippi Medical Center: (1) refund to the Medicare program the estimated $67,038 overpayment for claims that it incorrectly billed, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, (3) educate its staff on properly billing for polysomnography services, and (4) revise policies and procedures to ensure that claims are coded correctly and that sleep technicians have the required credentials before billing claims for polysomnography services to ensure full compliance with Medicare requirements.

Work Plan #: A-04-20-07088 (June 2021); A-04-19-07087 (March 2021); A-04-19-07086 (March 2021)
Government Program: Medicare Parts A & B

Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery

This review provides a national snapshot, from the perspective of front-line hospital administrators, on how responding to the COVID-19 pandemic has affected their capacity to care for patients, staff, and communities. This is not a review of the HHS response to the COVID-19 pandemic. OIG conducted its first pulse survey of challenges that hospitals reported facing in response to COVID-19 during the early weeks of the pandemic (Click here to view March 2020 pulse survey). This snapshot from February 22-26, 2021 provides HHS and other decision makers with updated information on hospital perspectives.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG spoke with representatives from 320 hospitals that were part of their random sample of 397 hospitals, for an 81-percent rate of contact. The text below provides a summary of OIG's findings:

Health Care Delivery:

- Hospitals reported significant challenges in meeting the needs of COVID-19 patients and uncertainty about future COVID-19 caseloads
- Hospitals reported that the pandemic led to delayed care and feared that an erosion of trust in hospital safety would continue to keep patients from seeking needed care
- Hospitals expressed concern about meeting the increased need for mental and behavioral health care that has emerged as an outgrowth of the pandemic
- Rural hospitals reported that longstanding operational challenges have worsened during the pandemic
- Hospital administrators raised concerns that the COVID-19 pandemic has worsened existing disparities in access to care and health outcomes
- Hospitals reported the adoption and use of telehealth was beneficial and a change they want to retain despite some challenges

Staffing:

- Hospitals reported that increased workloads and the stress of treating seriously ill and dying COVID-19 patients have led to staff burnout and, in some cases, trauma

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- Hospitals reported that high turnover and competition for medical staff have created staffing shortages that in some cases affect patient care

Vaccinations:

- Hospitals reported that vaccination efforts were positive steps toward pandemic recovery but exacerbated challenges with clinical staff shortages and hospital finances
- Differences in government guidelines regarding vaccine eligibility and prioritization created challenges for hospitals
- Hospitals reported that some hospital staff and members of the community were hesitant to get vaccinated
- Hospitals reported challenges in ensuring access to vaccinations for rural, senior, and low-income populations Hospitals reported frustration with the unpredictable and insufficient supply of vaccines

Supplies:

- Hospitals reported difficulty maintaining a steady supply of affordable, high-quality PPE

Finances:

- Hospitals reported that their operational costs have risen dramatically while their revenues have declined, threatening their financial stability
- Hospitals expressed uncertainty about rules on repayment of prior Federal loans

Work Plan #: OEI-09-21-00140 (March 2021)
Government Program: Medicare Parts A & B

Government Program: Medicare Parts A & B Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged Before COVID-19 and Warrants Further Scrutiny

Hospitals have long been essential providers in OIG healthcare system. Medicare payments reflect their importance: nearly one-fifth of all Medicare payments are for inpatient hospitalizations. In fiscal year (FY) 2019-prior to the COVID-19 pandemic-Medicare spent $109.8 billion for 8.7 million inpatient hospital stays. Trends in inpatient hospitalizations from FY 2014 through FY 2019 provide important lessons for improving the accuracy of inpatient hospital billing. From this information, stakeholders can gain a better understanding of how hospitals bill Medicare and of vulnerabilities that Medicare should address. The pandemic has placed unprecedented stress on the country's health care system, making it more important than ever to ensure that Medicare dollars are spent appropriately.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that Hospitals are increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from FY 2014 through FY 2019, ultimately accounting for nearly half of all Medicare spending on inpatient hospital stays. The number of stays billed at each of the other severity levels decreased. At the same time, the average length of stay decreased for stays at the highest severity level, while the average length of all stays remained largely the same. Stays at the highest severity level

are vulnerable to inappropriate billing practices, such as upcoding-the practice of billing at a level that is higher than warranted. Specifically, nearly a third of these stays lasted a particularly short amount of time and over half of the stays billed at the highest severity level had only one diagnosis qualifying them for payment at that level. Further, hospitals varied significantly in their billing of these stays, with some billing much differently than most.

OIG recommended that CMS conduct targeted reviews of MS-DRGs and stays that are vulnerable to upcoding, as well as the hospitals that frequently bill them. CMS did not concur but acknowledged that there is more work to be done to determine conclusively which changes in billing are attributable to upcoding. OIG also thinks more work needs to be done. Therefore, OIG will continue to recommend that CMS conduct targeted reviews to identify stays involving upcoding and hospitals with patterns of upcoding.

Work Plan #: OEI-02-18-00380 (February 2021)
Government Program: Medicare Parts A & B

Hospitals Did Not Comply with Medicare Requirements for Reporting Cardiac Device Credits

Prior OIG audits with audit periods ranging from 2005 through 2016 found that hospitals did not always comply with Medicare requirements for reporting credits received from manufacturers for medical devices that were replaced. Specifically, hospitals did not always report to CMS device manufacturer credits that they received. One prior review estimated that services related to the replacement of seven recalled and prematurely failed cardiac medical devices cost Medicare $1.5 billion during calendar years 2005 through 2014. OIG's objective was to determine whether hospitals complied with Medicare requirements for reporting manufacturer credits associated with recalled or prematurely failed cardiac devices.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for 3,233 of the 6,558 Medicare claims, hospitals likely did not comply with Medicare requirements associated with reporting manufacturer credits for recalled or prematurely failed cardiac medical devices. Device manufacturers issued reportable credits to the hospitals for recalled or prematurely failed cardiac medical devices, but the hospitals did not adjust the claims with proper condition and value codes to reduce payments as required. As a result, 911 hospitals received payments of $76 million rather than the $43 million they should have received, resulting in $33 million in potential overpayments. Medicare contractors made these overpayments because they do not have a post payment review process that would ensure that hospitals reported manufacturer credits for cardiac medical devices.

OIG recommended that CMS: (1) instruct Medicare contractors to recover the portion of the $33 million in identified Medicare overpayments that are within the reopening period, (2) notify hospitals associated with potential overpayments outside the reopening period so that they can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule, (3) require hospitals to use condition codes 49 and 50 on claims, (4) instruct Medicare contractors to implement a post payment review process, (5) obtain device credit listings from manufacturers and determine whether providers reported credits as required, (6) direct Medicare contractors to determine whether hospitals, which OIG have identified as having billed incorrectly in both this audit and OIG's prior audit (A-05-16-00059), have engaged in a pattern of incorrect billing after OIG's audit period and, if so, take appropriate action in accordance with CMS policies and procedures, and (7) consider eliminating the current Medicare requirements for reporting device credits by reducing the payments for cardiac device replacement procedures.

Work Plan #: A-01-18-00502 (November 2020)
Government Program: Medicare Parts A & B

CMS Did Not Ensure That Medicare Hospital Payments for Claims That Included Medical Device Credits Were Reduced in Accordance with Federal Regulations, Resulting in as Much as $35 Million in Overpayments

Medicare regulations and guidance require hospitals and ambulatory surgical centers (ASCs) to report the occurrence of credits received from manufacturers for replaced medical devices. OIG's audit focused on the risk that reported medical device credits may have been processed in a manner that resulted in Outpatient Prospective Payment System (OPPS) overpayments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS did not ensure that OPPS payments for claims that included medical device credits were reduced in accordance with Federal regulations. These regulations require the use of the device offset amount - 100 percent of the device offset amount for each without cost or full credit replacement device and 50 percent of the device offset amount for each partial credit replacement device - when calculating the reduced OPPS payment amount. By following the Medicare Claims Processing Manual (the Manual) instructions, Medicare administrative contractors (MACs) did not comply with these regulations when calculating the claims that OIG reviewed. As a result, Medicare made estimated overpayments of as much as $35.4 million to hospitals for OIG's audit period. This error occurred because as part of Federal rulemaking in CY 2014, CMS announced its intention to update Federal regulations to reduce OPPS payments for replaced medical devices. This intended update was not finalized in the text of the Federal regulations. However, CMS revised the relevant language in its guidance Manual.

OIG recommended that CMS: (1) work with the MACs to recover from hospitals Medicare OPPS overpayments, which total as much as an estimated $35.4 million, (2) work with the MACs to recover Medicare OPPS overpayments from hospitals for any additional claims that included medical device credits and that were outside of OIG's audit period, and (3) revise the OPPS regulations or the Manual instructions to resolve the conflict between these requirements for OPPS claims with medical device credits.

Work Plan #: A-07-19-00560 (November 2020)
Government Program: Medicare Parts A & B

Cedars-Sinai Medical Centre: Audit of Medicare Payments for Bariatric Surgeries

Medicare paid hospitals $372 million for bariatric surgeries provided to Medicare beneficiaries in calendar years 2015 and 2016. Bariatric surgery helps those with morbid obesity to lose weight by making changes to their digestive system. Although OIG has not conducted an audit in this area, the Centers for Medicare & Medicaid Services' (CMS's) study of certain bariatric surgery procedure codes found that 98 percent of improper payments lacked sufficient documentation to support the procedures. After analyzing Medicare claim data for bariatric surgery claims with dates of service from January 2015 through December 2016 (audit period), OIG selected for audit Cedars-Sinai Medical Center (Cedars-Sinai), located in Los Angeles,

California. OIG's objective was to determine whether Cedars-Sinai complied with Medicare requirements and the Medicare contractor's local coverage determinations (LCDs) and local coverage article (LCA) when billing for bariatric surgeries.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for 25 claims, Cedars-Sinai did not comply with Noridian's specifications. Specifically, Cedars-Sinai did not provide adequate documentation of the beneficiaries' multidisciplinary medical evaluations or participation in a weight management program. Cedars-Sinai did not comply with the specifications in the LCDs for 12 claims, with payments totalling $154,074, and did not comply with the specifications in the LCA for 13 claims, with payments totalling $175,199. As of the publication of this report, these payments include claims outside of the 4-year reopening period.

OIG recommended that Cedars-Sinai: (1) refund to Medicare the portion of the $154,074 in overpayments for bariatric surgery claims that did not comply with the specifications in the LCDs and that are within the 4-year reopening period, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60 day rule, (3) work with Noridian to take action deemed necessary by CMS or Noridian, or both, regarding $175,199 in payments for bariatric surgery claims with dates of service on or after the effective date of the LCA, (4) update its patient checklist to include all of Noridian's specifications for billing bariatric surgeries, and (5) obtain supporting medical record documentation from other providers, such as primary care physicians, mental health providers, or dietitians, before performing any future bariatric surgeries.

Work Plan #: A-09-18-03010 (October 2020)
Government Program: Medicare Parts A & B

Medicare Critical Care Services Provider Compliance Audit: Clinical Practices of the University of Pennsylvania

Medicare paid approximately $1.6 billion for critical care services provided to Medicare beneficiaries nationwide from October 2016 through March 2018 (audit period). A previous OIG review of critical care services found that few problems existed and concluded that those problems could be corrected by Medicare contractors. However, that review did not utilize medical review to determine whether the critical care services were appropriate and medically necessary. OIG selected for audit Clinical Practices of the University of Pennsylvania (Clinical Practices) because it was one of the 10 highest-paid providers of critical care services during OIG's audit period. OIG's objective was to determine whether Clinical Practices complied with Medicare requirements when billing for critical care services performed by its physicians.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Clinical Practices did not comply with Medicare billing requirements for 14 critical care services, and these errors resulted in Clinical Practices receiving $1,399 in unallowable Medicare payments. These errors occurred because Clinical Practices incorrectly identified and billed critical care services for physician services that did not meet Medicare requirements. Based on OIG's sample results, OIG estimated that Clinical Practices received overpayments of at least $151,588 for the audit period.

OIG recommended that Clinical Practices: (1) refund to the Medicare administrative contractor $151,588 in estimated overpayments for critical care services, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments

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as having been made in accordance with this recommendation, and (3) strengthen policies and procedures to ensure that critical care services billed to Medicare are adequately documented and correctly billed.

Work Plan #: A-03-18-00003 (October 2020)
Government Program: Medicare Parts A & B

Baylor Scott & White—College Station: Audit of Outpatient Outlier Payments

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges. OIG selected Baylor Scott & White-College Station (College Station) based on outpatient outlier payments increasing from $82,555 in 2015 to $2.6 million in 2016. OIG's objective was to determine whether outpatient outlier payments received by College Station were based on properly billed claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that College Station did not properly bill the claims related to 82 outlier payments which resulted in improper outlier payments during OIG's audit period. These 82 claims, which had outliers totaling $474,282, contained 174 billing errors. The billing errors primarily occurred because College Station did not have adequate controls to prevent errors related to overcharged observation time, charge errors, and coding errors.

OIG recommended that College Station refund to the Medicare contractor $189,276 in estimated overpayments for incorrectly billed claims that are within the reopening period. OIG also recommended that College Station improve procedures, provide education and implement changes to their billing system to ensure claims billed to Medicare are accurate.

Work Plan #: A-06-18-04003 (September 2020)
Government Program: Medicare Parts A & B

Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payment Program

Delivery System Reform Incentive Payment (DSRIP) Program payments are incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and increase the health of patients and families served. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost $10 billion for five years. OIG's objective was to determine whether Texas used permissible funds as the state share of DSRIP Program payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that $146.6 million in funds that Texas used as the state share of DSRIP Program payments was funded through impermissible provider-related donations that did not meet Federal requirements. Those funds were derived from

impermissible provider-related donations because the providers made donations that benefited the IGT entity, the funds the IGT entity transferred resulted from those donations, and the providers' donations were part of a hold-harmless practice. Texas did not decrease its Medicaid expenditures by the $146.6 million as required under federal requirements. As a result, Texas inappropriately received $83.8 million in federal funds.

OIG recommended that Texas: (1) refund the $83.8 million it inappropriately received because it used intergovernmental transfers (IGTs) derived from impermissible provider-related donations as the state share of DSRIP Program payments, (2) provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations, such as those outlined in the Centers for Medicare & Medicaid Services' (CMS's) clarifying letter, and (3) request that its IGT entities disclose whether similar arrangements exist and provide Texas with action plans on ending the arrangements.

Work Plan #: A-06-17-09002 (August 2020)
Government Program: Medicaid

Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services

Prior OIG audits identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). CMS generally concurred with OIG recommendations, but subsequent analysis that OIG conducted indicated that CMS's system edits were still not properly designed and that hospitals may be using condition codes to bypass CMS's system edits to receive higher reimbursements for inpatients transferred to home health services. OIG's objective was to determine whether Medicare properly paid acute-care hospital inpatient claims subject to the transfer policy when hospitals: (1) did not code the claims as a discharge to home with home health services when the beneficiary resumed home health services within three days of discharge, (2) applied condition code 43 indicating that the home health services were not provided within three days of discharge, or (3) applied condition code 42 indicating that the home health services were not related to the inpatient hospital services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Medicare improperly paid most inpatient claims subject to the transfer policy when beneficiaries resumed home health services within three days of discharge, but the hospitals failed to code the inpatient claim as a discharge to home with home health services or when the hospitals applied condition codes 42 (home health not related to inpatient stay) or 43 (home health not within 3 days of discharge). Of the 150 inpatient claims in OIG's sample, Medicare improperly paid 147 with $722,288 in overpayments. Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full payment. Based on OIG's sample results, OIG estimated that Medicare improperly paid $267 million during a two-year period for hospital services that should have been paid a graduated per diem payment.

OIG recommended that CMS direct its Medicare contractors, for the claims that are within the four-year reopening period, to: (1) recover a portion of the $722,288 in overpayments identified in OIG's sample, (2) reprocess the remaining inpatient claims in OIG's sample frame with an incorrect patient discharge status code or condition code 43 to recover a portion of the estimated $225.7 million in overpayments, and (3) analyze the remaining inpatient claims in OIG's frame with condition code 42 and recover a portion of the estimated $40.6 million in potential overpayments. Also, OIG recommended that CMS correct its related system edits, improve its provider education related to the Medicare transfer policy, and use data analytics

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to identify hospitals disproportionally using condition code 42. Finally, OIG recommended that CMS consider reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy by taking the necessary actions, including seeking legislative authority if necessary, to deem any home health service within three days of discharge to be "related."

Work Plan #: A-04-18-04067 (August 2020)
Government Program: Medicare Parts A & B

Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims

Previous OIG audits of severe malnutrition found that hospitals had incorrectly billed Medicare by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. Diagnosis codes E41 and E43 (severe malnutrition diagnosis codes) are each classified as a type of major complication or comorbidity (MCC). Adding MCCs to a Medicare claim can result in a higher Medicare payment. OIG's objective was to determine whether hospitals complied with Medicare billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that hospitals did not correctly bill Medicare for the 173 claims audited. For nine of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the error did not change the DRG or payment. For the remaining 164 claims, hospitals used severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all, resulting in net overpayments of $914,128. Based on OIG's sample results, OIG estimated that hospitals received overpayments of $1 billion for FYs 2016 and 2017.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) collect the portion of the $914,128 for the incorrectly billed hospital claims that are within the reopening period and, based upon the results of this audit, notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule. Additionally, OIG recommended CMS review all claims that were not part of OIG's sample but were within the reopening period.

Work Plan #: A-03-17-00010 (July 2020)
Government Program: Medicare Parts A & B

Selected Inpatient and Outpatient Billing Requirements

This review was part of a series of hospital compliance reviews that focused on hospitals with claims that may be at risk for overpayments. Prior OIG reviews and investigations have identified areas at risk for noncompliance with Medicare billing requirements. OIG reviewed Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements and recommended recovery of overpayments. OIG's review focused on those hospitals with claims that may be at risk for overpayments.

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Saint Francis Health Center (A-07-17-05102)

OIG found that Saint Francis Health Center did not fully comply with Medicare billing requirements for 51 claims, resulting in overpayments of $707,118 for calendar years 2015 and 2016. Based on OIG sample results, OIG estimated that the Hospital received overpayments of at least $5.5 million for the audit period.

OIG recommended that Saint Francis Health Center refund to the Medicare contractor $5.5 million of the estimated overpayments for the claims incorrectly billed that are within the Medicare reopening period; for the remaining portion of the estimated $5.5 million overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

Community Hospital (A-05-17-00026)

OIG found that Community Hospital did not fully comply with Medicare billing requirements for 86 claims, all of which were inpatient, resulting in net overpayments of $1,266,758 for calendar years 2015 and 2016. These errors occurred primarily because Community Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. Based on OIG sample results, OIG estimated that Community Hospital received overpayments of at least $22 million for OIG's audit period.

OIG recommended that Community Hospital refund the Medicare contractor $22 million (of which $1,266,758 was net overpayments identified in OIG sample) in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Work Plan #: A-07-17-05102 (March 2020); A-05-17-00026; (February 2019); A-04-17-08057 (October 2018); A-04-17-08055 (February 2018); A-01-15-00515 (February 2018); A-05-16-00064 (January 2018); A-04-16-04049 (January 2018); A-05-16-00062 (November 2017); W-00-17-35538
Government Programs: Medicare Parts A & B

Health-Care-Acquired Conditions - Prohibition on Federal Reimbursements

As of July 1, 2011, Federal payments to states are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions. Federal regulations prohibit Medicaid payments by states for services related to health-care-acquired conditions and for provider preventable conditions as defined by Centres for Medicare & Medicaid Services or included in the Medicaid State Plan. OIG determined whether selected states made Medicaid payments for hospital care associated with health-care-acquired conditions and provider preventable conditions and quantify the amount of Medicaid payments for such conditions.

SunHawk Summary of OIG Audit Findings and Recommendations:

Texas (A-06-16-01001)

OIG found that Texas did not ensure that its Managed Care Organizations (MCOs) complied with federal and state requirements prohibiting payments to providers for inpatient hospital services related to treating certain Provider Preventable Conditions (PPCs). For OIG's audit period, OIG identified Medicaid claims totaling $29.4 million that contained PPCs for five MCOs. Of this amount, OIG determined that claims totaling $12.7 million followed federal and state regulations regarding nonpayment of PPCs. However, claims totaling $16.7 million were not in compliance. Texas' internal controls were not adequate to ensure that its MCOs complied with federal and state requirements. Specifically, Texas (1) did not have policies and procedures to determine whether its MCOs complied with Federal and State requirements and provisions of the managed-care contract relating to the nonpayment of PPCs and (2) did not ensure that the MCOs' payment rates were based only on services that were covered in the State plan.

OIG recommended that Texas work with the five MCOs to determine what portion of the $16.7 million is unallowable for Federal Medicaid reimbursement and that portion's impact on current- and future-year capitation payment rates. OIG also made procedural recommendations to Texas that it strengthen its monitoring of all MCOs to ensure compliance with federal and state requirements and its managed-care contracts relating to the nonpayment of PPCs.

Pennsylvania (A-03-16-00205)

OIG found that Pennsylvania did not ensure that its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. PPCs are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. For OIG's audit period, OIG identified that MCOs paid providers approximately $43.5 million for 576 claims that contained PPCs. Pennsylvania's policies and procedures were not adequate to ensure its MCOs complied with Federal and State requirements. As a result, unallowable payments for services related to treating PPCs might have been included in the calculation of capitation payment rates.

OIG made several recommendations to Pennsylvania, including: (1) work with the MCOs to determine the portion of the $43.5 million that was unallowable for claims containing PPCs and its impact on current- and future-year capitation payment rates, (2) include a clause in its managed-care agreements with the MCOs that would allow Pennsylvania to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met—a measure that, if incorporated, could result in cost savings for Medicaid, and (3) enforce the provisions in its managed-care agreements that allow sanctions or penalties to be imposed for noncompliance with or failure to meet performance and program standards indicated in the contract and subsequent related contracts.

New York (A-02-16-01022)

OIG was unable to determine whether New York complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs because New York did not provide sufficient evidence that it properly identified claims containing PPCs or determined whether the payments for the related services should have been reduced. Without such evidence, OIG could not verify whether New York's payments for claims containing PPCs were appropriately reduced.

OIG made a series of recommendations to New York, including that it provides CMS with sufficient documentation to determine whether any portion of the $50.3 million Federal Medicaid reimbursement was unallowable and refund to the Federal Government the unallowable amount. In written comments on OIG draft report, New York generally agreed with OIG recommendations; however, it disagreed with OIG's finding. Although New York asserts that it is appropriately reducing payments in accordance with Federal and State requirements, OIG maintained that, without sufficient evidence to support its assertion, OIG cannot objectively determine whether it complied with requirements prohibiting Medicaid payments for

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inpatient hospital services related to treating certain PPCs. Therefore, OIG maintained that OIG finding and related recommendations are valid.

Work Plan #: A-06-16-01001 (October 2019); A-03-16-00205 (August 2019); A-02-16-01022 (May 2019); A-06-16-08004 (March 2018); A-07-16-03216 (May 2018); A-06-16-02003 (December 2018); W-00-16-31452
Government Program: Medicaid

Review of Hospital Wage Data Used to Calculate Medicare Payments

Hospitals report wage data annually to Centers for Medicare & Medicaid Services, which is then used to calculate wage index rates to account for different geographic area labor market costs. Prior OIG wage index work identified hundreds of millions of dollars in incorrectly reported wage data and resulting in policy changes by Centers for Medicare & Medicaid Services regarding how hospitals report deferred compensation costs. OIG reviewed hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Rhode Island Hospital did not always comply with Medicare requirements when reporting its wage data used by CMS for the FFY 2019 hospital wage index calculation. As a result, Rhode Island Hospital overstated its wages and wage-related costs.

OIG recommended that Rhode Island Hospital: (1) ensure that all personnel involved in the process are fully trained to comply with Medicare wage data reporting requirements, (2) annually review all software scripts and manual procedures to ensure compliance with Medicare wage data reporting requirements, and (3) implement more effective quality controls over the entry of contract labor data into its accounting system.

Work Plan #: A-01-17-00509 (October 2019); A-01-17-00510 (May 2019); A-01-17-00500 (November 2018); W-00-16-35452; W-00-17-35725
Government Program: Medicare Parts A & B

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[NEW] CMS's COVID-19 Data Included Required Information from the Vast Majority of Nursing Homes, but CMS Could Take Actions To Improve Completeness and Accuracy of the Data

The United States currently faces a nationwide public health emergency because of the COVID-19 pandemic. Federal regulations, effective May 8, 2020, required nursing homes to report COVID-19 information, such as the number of confirmed COVID-19 cases among residents, at least weekly to the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network. Each week, CDC aggregates the reported information and sends the data to the Centers for Medicare & Medicaid Services (CMS) for posting to the CMS website. These data are used to assist with national surveillance of COVID-19 in nursing homes and to support actions to protect the health and safety of nursing home residents.

OIG's objective was to determine whether CMS's COVID-19 data for nursing homes were complete and accurate.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for 775 of the 15,388 nursing homes (about 5 percent), CMS's COVID-19 data: (1) did not include all of the COVID-19 data that nursing homes were required to report and (2) were not complete or accurate after CMS had performed its quality assurance checks (e.g., the number of confirmed COVID-19 cases among residents may have been under- or overreported).

Additionally, OIG identified two areas in which CMS could take additional actions to help ensure that its COVID-19 data are complete and accurate. First, CMS could provide technical assistance to all nursing homes that fail its quality assurance checks. Second, CMS could make additional efforts to ensure that: (1) CMS's and States' COVID-19 data elements (e.g., confirmed COVID-19 cases among residents) are comparable (i.e., CMS and States could use the same data elements) and (2) the reported data are not substantially different.

OIG recommended that CMS assess the costs and benefits of implementing the six recommendations listed in OIG's report (e.g., our recommendations that it revise its quality assurance checks and contact nursing homes that fail quality assurance checks to verify the accuracy of reported data or to correct inaccurate data), and if CMS determines that the benefits outweigh the costs, take action to implement the recommendations.

Work Plan #: A-09-20-02005 (September 2021)
Government Program: Medicare Parts A & B

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Onsite Nursing Home Surveys During Covid-19

Nursing home residents are particularly vulnerable to infectious diseases such as COVID-19, and infection control has been a persistent problem for most nursing homes. As of November 8, 2020, more than 67,000 nursing home residents had died of COVID-19-related illnesses, which represented almost 30 percent of all COVID 19 deaths in the United States at that time. Because of this, CMS changed survey practices in response to the pandemic. These changes—together with nursing home residents' high-risk status and the importance of the State surveys—warranted close examination to assess the sufficiency of this oversight. From March 2020 – May 2020, OIG analyzed CMS administrative data to determine the number of focused infection control and complaint surveys and published their findings in December of 2020.

OIG's December 2020 report found that States faced backlogs of standard surveys of nursing homes early in the COVID-19 pandemic, with 8 percent of nursing homes having gone at least 16 months without a standard survey as of June 2020. CMS authorized States to resume standard surveys in August 2020 "as soon as they have the resources (e.g., staff and/or Personal Protective Equipment) to do so."

SunHawk Summary of OIG Evaluation Findings and Recommendations

States' Backlogs of Standard Surveys of Nursing Homes Grew Substantially During the COVID-19 Pandemic (OEI-01-20-00431)

OIG found that States' backlogs grew substantially during the COVID-19 pandemic. Nationally, 71 percent of nursing homes (10,913 of 15,295) had gone at least 16 months without a standard survey as of May 31, 2021. By State, the backlogs for standard surveys ranged from 22 percent to 96 percent.

Additionally, OIG found that backlogs of standard surveys of nursing homes need CMS's attention. OIG's updated analysis underscores the importance and urgency of OIG's previous recommendation to CMS to clarify expectations for States to complete backlogs of standard surveys, including by issuing guidance on prioritization of surveys and required timeframes to complete these backlogs.

Onsite Surveys of Nursing Homes During the COVID-19 Pandemic: March 23-May 30, 2020 (OEI-01-20-00430)

OIG found that States conducted onsite surveys at 31 percent of nursing homes during March 23-May 30, 2020; however, States varied significantly. During the same time period in 2019—when States and CMS were under normal operations and conducting standard and other surveys—53 percent of nursing homes received an onsite survey. The infection control surveys conducted during this timeframe in 2020 resulted in few deficiencies, in part because of their limited scope and less surveyor time onsite. State officials reported ongoing challenges to securing adequate personal protective equipment (PPE) and surveyors to complete onsite surveys. States provided guidance and other support—such as training—to nursing homes outside of the survey process. State officials reported concerns about mounting backlogs of standard and complaint surveys, as the pandemic continues.

OIG recommended that CMS assess the results of the focused infection control survey and revise the survey as appropriate. OIG also recommended that CMS work with States to help overcome challenges with PPE and staffing, and that it clarify expectations for States to complete backlogs of surveys.

Work Plan #: OEI-01-20-00431 (July 2021); OEI-01-20-00430 (December 2020)
Government Program: Medicare Parts A & B

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States Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of OIG Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities. Nursing facility residents are at increased risk of abuse and neglect when healthcare professionals and caregivers fail to report abuse, or when incidents of potential abuse or neglect are not acted upon in a timely manner. OIG's objective was to determine whether States ensured that incidents of potential abuse or neglect of Medicaid beneficiaries residing in nursing facilities in States were properly reported and investigated in accordance with applicable Federal and state requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

California (A-09-19-02005)

OIG found that, of 37 incidents they reviewed, 8 incidents were the result of potential abuse or neglect and should have been reported to the State: 2 were reported in a timely manner, 4 were not reported in a timely manner, and 2 were not reported to the State by the nursing facilities. Although the State issued guidance to nursing facilities on the proper reporting of potential abuse or neglect, facilities did not always report incidents or report them in a timely manner. For the other 29 incidents, nursing facilities provided documentation that did not contain sufficient information to determine whether the incidents were the result of potential abuse or neglect; therefore, the State was unable to determine whether the requirements for reporting potential abuse or neglect were met.

OIG recommended that California: (1) strengthen guidance to nursing facilities on reporting incidents of potential abuse or neglect of Medicaid beneficiaries and (2) ensure that its staff are regularly trained on updated Federal and State requirements to ensure that appropriate priorities are assigned to allegations of abuse or neglect.

Georgia (A-04-17-03084)

OIG found that Georgia generally ensured that nursing facilities reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of 117 sampled claims with emergency department visits, 101 associated incidents were not reportable. Of the remaining 16 incidents, the nursing facilities reported 9 timely, reported 3 late, reported 2 that OIG could not determine had been reported timely, and did not report 2 that they should have reported. In addition, Georgia generally complied with Federal and State requirements for assigning a priority level, investigating, and recording allegations of potential abuse or neglect. Finally, Georgia generally operated its complaint and incident report program effectively.

OIG recommended that the Georgia Department of Community Health: (1) remind nursing facilities of Federal and State requirements for reporting incidents of potential abuse or neglect, (2) strengthen its procedures for monitoring nursing facilities and follow up with those that may not be following required policies and procedures, (3) ensure that it documents actions it takes when nursing facilities fail to report incidents and fail to report incidents on time, and (4) ensure that it assigns a priority level to all incidents or complaints by the mandatory deadline.

In written comments on OIG's draft report, Georgia concurred with OIG recommendations and described actions that it has taken to address them. Such actions included: (1) educating nursing facilities about State and Federal reporting requirements, (2) strengthening its procedures for monitoring nursing facilities, (3) strengthening its process for documenting

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actions when nursing facilities do not report incidents as required, and (4) strengthening its procedures for intake and triage of incidents and complaints.

Florida (A-04-17-08058)

OIG found that Florida did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Additionally, OIG could not determine whether Florida complied with Federal requirements for assigning a priority level, initiating onsite surveys, and recording allegations of potential abuse or neglect. Lastly, Florida's incident report program may not have been effective in accomplishing the program's goal and objectives. Certain internal control deficiencies and practices could limit the effectiveness of Florida's complaint and incident program. Specifically, Florida lacked written policies and procedures for processing incident reports, had inadequate intake staffing, had inadequate incident report processing, lacked written policies and procedures for managing late incident report filings, and lacked written policies and procedures for managing APS abuse and neglect investigation notifications.

OIG recommended that Florida: (1) work with CMS to provide clear guidance to nursing facilities regarding what constitutes a reportable incident, (2) establish procedures to require assessment start and end dates and priority level assignments, and (3) establish and implement written policies and procedures for incident report processing. OIG made further recommendations to improve the effectiveness of the complaint and incident report process.

Iowa (A-07-19-03238)

OIG reported that Iowa did not ensure that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness. During OIG's onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes. OIG found 122 instances of noncompliance with life safety requirements related to building exits, fire detection and suppression systems, hazardous storage, smoking policies, and electrical equipment maintenance, among others. OIG also found 133 instances of noncompliance with emergency preparedness requirements related to written plans, emergency power, emergency communications, and training, among others. As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency.

OIG reported the alleged areas of noncompliance occurred because Iowa did not have a standardized life safety training program for all staff (not currently required by CMS). In addition, Iowa did not adequately follow up on deficiencies previously cited or require nursing homes or inspection contractors to (1) tag systems that are critical to the health and safety of nursing home residents when these systems may not work as required and (2) notify the State.

OIG recommended that Iowa follow up with the 20 nursing homes to ensure corrective actions have been taken regarding the deficiencies identified in this report. OIG made other procedural recommendations to Iowa regarding the development of standardized life safety training for nursing home staff, the conduct of more frequent surveys and follow up at nursing homes with a history of multiple high-risk deficiencies, and the tagging of critical systems.

New Jersey (A-02-18-01006)

OIG reported that 10 claims in OIG's sample were the result of potential abuse or neglect that should have been reported to the state. However, five of the ten claims were not properly investigated and reported to the state. For 14 claims, nursing facilities did not provide documentation, or their records did not contain sufficient documentation for state officials to determine whether the incident should have been investigated and reported. These deficiencies occurred because nursing facility staff did not follow requirements for investigating and reporting potential incidents of abuse or neglect. In addition, New Jersey did not have adequate survey procedures for ensuring that nursing facilities documented all such incidents.

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Based on OIG's sample results, OIG estimated that 311 Medicaid hospital claims with selected diagnosis codes resulted from incidents of potential abuse or neglect at a nursing facility in New Jersey during CY 2016. Of this amount, OIG estimated that 220 claims were the result of potential abuse or neglect that the nursing facilities did not investigate and report to the state. In addition, OIG estimated that, for 616 claims, the associated beneficiary's nursing facility did not have records to sufficiently document the circumstances of the beneficiary's injuries or condition that led to the hospital transfer so that state officials could determine whether the incident was the result of potential abuse or neglect.

OIG recommended that New Jersey: (1) reinforce guidance to nursing facilities for ensuring potential incidents of abuse or neglect are reported in accordance with Federal and state requirements, and (2) develop additional procedures for its survey site visits, including reviewing nursing facilities' records related to hospital transfers for certain beneficiary injuries or conditions that could be the result of potential abuse or neglect.

Work Plan #: A-09-19-02005 (June 2021); A-04-17-03084 (April 2021); A-04-17-08058 (March 2021); A-07-19-03238 (February 2021); A-02-18-01006 (August 2020)
Government Program: Medicaid

CMS Could Improve the Data It Uses To Monitor Antipsychotic Drugs in Nursing Homes

CMS has oversight of Medicare- and Medicaid-certified nursing homes that are responsible for the health and safety of vulnerable residents. CMS is required to monitor nursing home activities, including how nursing homes use antipsychotic drugs to treat residents' various conditions. These drugs can be effective in treating a range of conditions, but they carry risk and must be prescribed appropriately. CMS uses the Minimum Data Set (MDS)—i.e., data that nursing homes self-report—as its sole data source to count the number of nursing home residents receiving antipsychotic drugs. CMS has acknowledged the risk for inappropriate use of antipsychotic drugs. CMS has taken important steps to reduce the use of antipsychotic drugs in nursing homes and could further that progress by collecting more complete data on residents' use of these drugs.

Nursing home residents and their families rely on nursing homes to provide quality care in a safe environment; however, there are reasons for concern specific to the use of antipsychotic drugs. Previous OIG work in 2011 raised quality and safety concerns regarding the high use of antipsychotic medications among nursing home residents. Since then, CMS has taken important steps to monitor the use of these drugs in nursing homes. However, CMS has acknowledged the potential for inconsistencies in the data—self-reported by nursing homes—that it uses to monitor quality and the safe use of antipsychotic drugs.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that CMS's use of the MDS as the sole data source to count the number of nursing home residents using antipsychotic drugs may not always provide complete information. This means some residents' use of antipsychotics may not have been detected by CMS's quality measure intended to monitor these drugs. By analyzing a separate data source—Medicare claims—OIG found that using the MDS did not always result in a complete assessment of the number of residents who are prescribed antipsychotic drugs. Specifically, in 2018, 12,091 Part D beneficiaries who were long-stay residents age 65 and older—5 percent of all such beneficiaries—had a Part D claim for an antipsychotic drug but were not reported in the MDS as receiving an antipsychotic drug. Further, nearly one-third of residents who were reported in the

MDS as having schizophrenia—a diagnosis that excludes them from CMS's measure of antipsychotic drug use—did not have any Medicare service claims for that diagnosis. Finally, even for those residents included in the MDS counts, the MDS does not provide important details about the drug use (e.g., which antipsychotic drugs were prescribed; at what quantities and strengths; and for what durations).

So that CMS can enhance the information it uses to monitor antipsychotic drugs in nursing homes, OIG recommended that CMS (1) take additional steps to validate the information reported in MDS assessments and (2) supplement the data it uses to monitor the use of antipsychotic drugs in nursing homes. CMS concurred with both recommendations.

Work Plan #: OEI-07-19-00490 (May 2021)
Government Program: Medicare Parts A & B

Louisiana Appropriately Claimed Most Balancing Incentive Payment Program Funds

The Patient Protection and Affordable Care Act of 2010 established the State Balancing Incentive Payment Program (BIPP), which authorized a $3 billion Federal appropriation over the program's 4-year period. The purpose of the BIPP was to move States' long-term care programs away from institutional care and toward community-based care. As such, States were required to use the BIPP funding to provide new or expanded community-based long-term services and supports (LTSS). The Centers for Medicare & Medicaid Services (CMS) awarded funds to approved States through an increase in their Federal Medical Assistance Percentage (FMAP) for eligible Medicaid community-based LTSS.

OIG's objective was to determine whether Louisiana claimed its BIPP expenditures in accordance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Louisiana appropriately claimed most of its BIPP expenditures in accordance with Federal requirements. Specifically, of the $1.59 billion claimed by Louisiana, $1.53 billion (96 percent) was for eligible noninstitutional LTSS expenditures under the BIPP. Accordingly, Louisiana appropriately received $30.5 million of BIPP funding at the enhanced FMAP rate. However, $66.3 million (4 percent) was not related to noninstitutional LTSS because Louisiana mistakenly included ineligible procedure codes as noninstitutional LTSS expenditures on the CMS-64. As a result, Louisiana inappropriately received more than $1.3 million at the enhanced FMAP rate for ineligible expenditures. OIG recommended that Louisiana refund $1.3 million to the Federal Government in BIPP funding that it received for ineligible expenditures.

In written comments on OIG's draft report, Louisiana concurred with OIG's finding and recommendation and described actions that it has taken and plans to take to address OIG's finding. These actions include refunding $1.3 million in BIPP funding to the Federal Government, implementing a process to review expenditures before submission of the CMS-64 report, and continuing to train the reporting staff.

Work Plan #: A-06-19-02000 (March 2021)
Government Program: Medicare Parts A & B

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CMS Use of Data on Nursing Home Staffing: Progress and Opportunities to Do More

In April 2018, CMS began updating staffing information on Nursing Home Compare, which was a public website, with a new source for staffing data. In December 2020, CMS moved these data to a new website, called Care Compare, that contains the same staffing information for consumers that Nursing Home Compare did. Specifically, consumers can search nursing homes based on location and compare quality of care and staffing. The usefulness of this information to consumers depends on the extent to which it is complete and accurate. Additionally, CMS works with State survey agencies to monitor nursing home compliance with Federal requirements, including those for staffing.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS has taken important steps to build a new source for data on nursing home staffing and to use these data to better inform consumers and improve nursing home oversight. CMS provides the public with some of this staffing information on the Care Compare website. There, consumers can use Staffing Star Ratings to compare nurse staffing between nursing homes. Additionally, CMS has implemented a robust process to ensure the reliability of this nurse staffing information. However, CMS has opportunities to better use the staffing information that nursing homes report. Specifically, the staffing information that CMS provides on Care Compare could be more useful to consumers if it included data on nurse staff turnover and tenure, as required by Federal law. CMS reported that the COVID-19 pandemic delayed its progress to implement these requirements. Additionally, CMS can take steps to increase the reliability of the non-nurse staff information (i.e., information on physical therapists) that CMS publicly reports on Care Compare. Non-nurse staff play a critical role in providing quality care.

Additionally, OIG found that CMS has taken an important step to target its oversight of nurse staffing by sharing information with State survey agencies. Specifically, to help State survey agencies target weekend inspections, CMS now informs the agencies as to which nursing homes reported lower weekend staffing. However, CMS can take additional steps to improve the effectiveness of State survey agencies' weekend inspections and strengthen oversight of staffing in nursing homes.

OIG recommended that CMS: (1) provide data to consumers on nurse staff turnover and tenure, as required by Federal law, (2) ensure the accuracy of non-nurse staffing data used on Care Compare; (3) consider residents' level of need when identifying nursing homes for weekend inspections, and (4) take additional steps to strengthen oversight of nursing home staffing.

Work Plan #: OEI-04-18-00451 (March 2021)
Government Program: Medicare Parts A & B

New York Did Not Fully Comply with Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

OIG have performed audits in several States, including New York, in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. Federal waivers permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. CMS requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

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OIG's objective was to determine whether New York ensured that community-based providers complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that New York did not ensure that providers fully complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Of the 30 incidents of potential abuse and neglect in OIG's sample, 23 incidents were properly reported and investigated; however, 7 incidents were not. Specifically, providers did not properly report three incidents and, for all seven incidents, providers did not meet investigation requirements (four incidents were not investigated on time and three were not investigated adequately).

These incidents of potential abuse and neglect were not properly reported because the individuals responsible for reporting them either initially reported them to the wrong authority or erroneously believed that another provider was responsible for reporting them. Investigations were not adequately conducted because: (1) some incidents were not reported on time, thereby delaying initiation of the investigations, and (2) providers' internal policies and procedures for investigating internal incidents were either inadequate or were nonexistent. Because incidents of potential abuse and neglect were not properly reported or investigated, beneficiaries were put at an increased risk of harm.

Of the 48 reported and substantiated incidents of abuse and neglect in OIG's judgmental sample, OIG found that the associated providers complied with the critical incident reporting and monitoring requirements.

Work Plan #: A-02-17-01026 (February 2021)
Government Program: Medicare Parts A & B

States Should Improve their Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care facilities (commonly known as nursing homes). The updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency plan that is reviewed, trained on, tested, and updated at least annually, and provisions for sheltering in place and for evacuation. OIG's objective was to determine whether States ensured that selected nursing homes in the state that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness.

SunHawk Summary of OIG Audit Findings and Recommendations

North Carolina (A-04-19-08070)

OIG reported that, of the 20 North Carolina nursing homes that OIG visited, 18 had deficiencies in areas related to life safety or emergency preparedness. Specifically, 18 nursing homes had 64 instances of noncompliance with life safety requirements related to building exits, smoke barriers, and smoke partitions, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment power cords. Furthermore, 14 nursing homes had 124 instances of noncompliance with emergency preparedness requirements related to written emergency

plans, emergency power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training and testing.

The instances of noncompliance occurred because nursing homes had inadequate management oversight and high staff turnover. In addition, North Carolina did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 8 to 15 months, even at these higher risk nursing homes.

OIG recommended that North Carolina: (1) follow up with the 18 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies.

Illinois (A-05-18-00037)

OIG reported that Illinois did not ensure that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness. During OIG site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 15 nursing homes that OIG reviewed. Specifically, OIG found 53 instances of noncompliance with life safety requirements and 184 instances of noncompliance with emergency preparedness requirements. As a result, residents at the 15 nursing homes were at increased risk of injury or death during a fire or other emergency.

The identified deficiencies occurred because the existing life safety training program for nursing home management could not educate all Illinois nursing home management in a timely manner, and the State did not offer an emergency preparedness training program for nursing home management. (Currently, CMS requires neither of the two training programs.) Further, Illinois performed abbreviated surveys of emergency preparedness plans and had insufficient personnel for its workload. In addition, Illinois did not determine whether carbon monoxide alarms were installed in accordance with State law.

OIG recommended that Illinois: (1) follow up with the 15 nursing homes to verify that corrective actions have been taken regarding the deficiencies that OIG identified, (2) conduct more thorough emergency preparedness reviews for the safety and protection of nursing home residents and staff, (3) work with CMS to develop emergency preparedness training and expand life safety training sessions to accommodate all nursing home management, (4) consider increasing staffing levels to address caseload thresholds for State surveyors, and (5) consider modifying its survey procedures to check for carbon monoxide alarms required by Illinois law.

Florida (A-04-18-08065)

OIG reported that all 20 nursing homes that OIG visited had deficiencies in areas related to life safety or emergency preparedness. Specifically, 19 nursing homes had 100 areas of noncompliance with life safety requirements related to building exits and smoke barriers, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment. Furthermore, 16 nursing homes had 87 areas of noncompliance with emergency preparedness requirements related to written emergency plans, emergency supplies and power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training. The instances of noncompliance occurred because of several contributing factors, specifically inadequate management oversight and staff turnover at the nursing homes. In addition, OIG reported Florida did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 12 to 15 months, even at these higher risk nursing homes.

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OIG recommended Florida: (1) follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies and follow up to ensure that corrective actions have been taken.

Missouri (A-07-18-03230)

During OIG's onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes. OIG found 178 areas of noncompliance with life safety requirements related to building exits, fire detection and suppression systems, hazardous storage, smoking policies, and electrical equipment maintenance, among others. OIG also found 149 areas of noncompliance with emergency preparedness requirements related to written plans, emergency power, emergency communications, and training, among others. As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified areas of noncompliance occurred because Missouri did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, Missouri did not adequately follow up on deficiencies previously cited.

OIG recommended Missouri follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the identified deficiencies. OIG made other procedural recommendations to Missouri regarding the development of standardized life safety training for nursing home staff, the conducting of more frequent surveys and follow-up at nursing homes with a history of multiple high-risk deficiencies, and updates of facility-specific plans.

Texas (A-06-19-08001)

OIG reported that during OIG's onsite inspections, OIG identified deficiencies in areas related to life safety or emergency preparedness at 18 nursing homes. Specifically, OIG found 235 deficiencies with life safety requirements related to building exits and smoke partitions, fire detection and suppression systems, hazardous storage areas, fire drills and smoking policies, and electrical equipment and elevator inspection and testing. OIG found 55 deficiencies with emergency preparedness requirements related to written emergency plans, emergency supplies and power, emergency communications plans, and emergency plan training. As a result, residents at the 18 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because management oversight at nursing homes was inadequate, and nursing homes had high maintenance and administrative staff turnover. In addition, maintenance personnel at some of the nursing homes indicated that building maintenance is challenging because of the advanced age of some buildings.

OIG recommended Texas follow up with the 18 nursing homes to verify that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report.

California (A-09-18-02009)

During OIG's site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 19 nursing homes that OIG reviewed. Specifically, OIG found 137 instances of noncompliance with life safety requirements related to building exits, smoke barriers, smoke partitions, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment testing and maintenance. OIG also found 188 instances of noncompliance with emergency preparedness requirements related to written emergency plans, emergency power, plans for evacuation, sheltering in place, and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training and testing. As a result, nursing home residents at the 19 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because nursing homes lacked adequate management oversight and had high staff turnover. In addition, California did not

adequately follow up on deficiencies previously cited, ensure that surveyors were consistently enforcing CMS requirements, or have a standard life safety training program for all nursing home staff (not currently required by CMS).

OIG recommended California: (1) follow up with the 19 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) conduct more frequent site surveys at nursing homes to follow up on deficiencies, (3) ensure that all surveyors consistently enforce CMS requirements, and (4) work with CMS to develop life safety training for nursing home staff.

Work Plan #: A-04-19-08070 (September 2020); A-05-18-00037 (September 2020); A-04-18-08065 (March 2020); A-07-18-03230 (March 2020); A-06-19-08001 (February 2020); A-09-18-02009 (November 2019)
Government Program: Medicare Parts A & B

States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018

The nursing home complaint process is a critical safeguard to protect the vulnerable residents of nursing homes. CMS relies on the States' respective survey agencies to serve as the front-line responders to address health and safety concerns raised by residents, their families, and nursing home staff. State survey agencies (hereinafter, States) must conduct onsite investigations within certain timeframes for the two most serious levels of complaints-those that allege serious injury or harm to a nursing home resident and require a rapid response to address the complaint and ensure residents' safety. A previous OIG report found that a few States fell short in the timely investigation of the most serious nursing home complaints between 2011 and 2015. To follow-up on this report, OIG examined the extent to which States met required timeframes for investigating the most serious nursing home complaints from 2016 through 2018.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that the rate of nursing home complaints per 1,000 nursing home residents increased from 45 in 2015 to 52 in 2018. Twenty-one States failed to meet CMS's timeliness threshold for the second-most serious level of complaints in all three years from 2016 through 2018, and ten of these States did not meet the threshold for eight consecutive years, from 2011 through 2018. Of the five States that fell short in timely investigation of the most serious nursing home complaints from 2011 through 2015, Georgia had limited improvement, while Arizona, Maryland, New York, and Tennessee continued to fall short through 2018. Furthermore, OIG found that from 2016 through 2018, trends in late investigations of complaints in New Jersey, Illinois, and Texas raise concerns.

OIG reported that the analysis raises questions about some States' ability to address serious nursing home complaints and also about the effectiveness of CMS's oversight of States. OIG found that many States are consistently failing to meet required timeframes for investigating the most serious nursing home complaints. States that OIG communicated with face challenges with receiving a high volume of complaints, triaging complaints, and having adequate human resources to investigate complaints. CMS has worked with States to address these challenges, yet few States have made progress. To ensure that States conduct timely investigations, OIG recommended that CMS should ensure that all States receive training on the triage guidance it plans to update. Furthermore, CMS should also identify new approaches to address States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints.

Work Plan #: OEI-01-19-00421 (September 2020)
Government Program: Medicare Parts A & B

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Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns and Consumer Transparency Could Be Increased

Nurse staffing is a key contributor to the quality of care provided in nursing homes. This review, initiated before the COVID-19 pandemic emerged, focuses on staffing data from 2018. However, the 2020 pandemic reinforces the importance of adequate staffing for nursing homes, as inadequate staffing can make it more difficult for nursing homes to respond to infectious disease outbreaks like COVID-19. Consumers need meaningful information about nurse staffing at nursing homes to make informed care decisions. CMS created the Payroll-Based Journal (PBJ)-a system containing self-reported provider data-to collect nursing homes' daily staffing hours. CMS uses the PBJ data to calculate Staffing Star Ratings reported on the public Nursing Home Compare website. CMS requires a minimum number of daily hours for different types of nurses (nursing homes must have a registered nurse (RN) on staff at least eight hours each day and licensed nurses on staff around the clock). However, CMS does not use PBJ data to enforce these daily Federal staffing requirements, nor does it regularly publish day-to-day nurse staffing on Nursing Home Compare.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that seven percent (943) of nursing homes reported 30 or more days in 2018 on which staffing was below at least one required staffing level. Additionally, another seven percent of nursing homes (900) reported between 16 and 29 days with staffing below required levels in 2018. This raise concerns that some nursing homes may not have fully met their residents' needs in 2018. CMS implemented a policy in 2018 to downgrade nursing homes' Staffing Star Ratings to one Star for having at least seven total days within a quarter with no reported RN time. Following CMS's announcement of this policy, 27 percent fewer nursing homes reported days with no RN time. At the same time, seven percent more nursing homes reported days with some RN time, although less than the required eight hours per day. These trends suggest overall improvements in staffing levels. Finally, OIG found that daily staffing levels reported by individual nursing homes often did not match their Staffing Star Rating published on Nursing Home Compare. While some nursing homes' reported staffing levels varied considerably from day to day, other nursing homes' daily staffing levels were more consistent.

OIG recommended that CMS: (1) enhance efforts to ensure nursing homes meet daily staffing requirements, and (2) explore ways to provide consumers with additional information on nursing homes' daily staffing levels and variability.

Work Plan #: OEI-04-18-00450 (August 2020)
Government Program: Medicare Parts A & B

State Compliance with Requirements for Reporting and Monitoring Critical Incidents

The Centers for Medicare & Medicaid Services requires states to implement an incident reporting system to protect the health and welfare of the Medicaid beneficiaries who receive services in community-based settings or nursing facilities. During prior audits, OIG found that some states did not always comply with Federal and state requirements for reporting and monitoring critical incidents such as abuse and neglect. OIG will review additional State Medicaid Agencies to determine whether the selected states follow the requirements for reporting and monitoring critical incidents. OIG's work will focus on Medicaid beneficiaries residing in both community-based settings and nursing facilities.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that North Carolina did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. In addition, it did not always fully comply with Federal requirements for assigning a priority level to reported allegations of potential abuse and neglect or for correctly recording the associated dates. Finally, North Carolina's complaint and incident report program may not have been effective in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services.

OIG recommended that North Carolina continue working with the Centers for Medicare & Medicaid Services (CMS) to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report and revise its policies and procedures to require that it: (1) assign a priority level to incident reports even if the nursing facilities' investigations are not complete, (2) enter into CMS's automated tracking system the date that North Carolina first receives incident reports, and (3) manage employee absences to better prevent them from interfering with assigning priority levels to allegations within appropriate timeframes. OIG also made procedural recommendations, including recommendations to address OIG's concerns with the effectiveness of North Carolina's complaint and incident report program.

Work Plan #: A-04-17-04063 (July 2020); A-03-17-00202 (January 2020); A-09-17-02006 (June 2019); W-00-17-31040; A-02-17-01026; A-04-17-03084; A-04-17-08058; A-06-17-01003; A-06-17-02005; A-06-17-04003
Government Program: Medicaid

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Home Health Service

[NEW] Six of Eight Home Health Agency Providers Had Infection Control Policies and Procedures That Complied With CMS Requirements and Followed CMS COVID-19 Guidance To Safeguard Medicare Beneficiaries, Caregivers, and Staff During the COVID-19 Pandemic

Medicare beneficiaries receiving home health services may be at a high risk of developing severe illness from COVID-19. Home health agencies (HHAs) must comply with the Centers for Medicare & Medicaid Services' (CMS's) infection prevention and control requirements and follow CMS guidance by having policies and procedures to protect HHA staff, Medicare beneficiaries, and caregivers during the pandemic.

OIG's objective was to determine whether eight selected HHAs had infection control policies and procedures that complied with CMS requirements and followed CMS guidance to safeguard HHA staff, Medicare beneficiaries, and caregivers during the COVID-19 pandemic.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that one HHA provider did not comply with CMS requirements or follow CMS COVID-19 guidance. Specifically, this HHA provider's infection control policies and procedures did not: (1) require staff to follow one of the standard precautions to prevent the transmission of infections and communicable diseases, (2) include documentation of surveillance methods used for identifying and tracking infections and improvement activities to prevent infection, (3) include COVID-19 screening protocols for staff in accordance with CMS guidance, and (4) include information about how to care for patients with known or suspected COVID-19 in accordance with CMS guidance. In addition, this provider and another HHA provider's COVID-19 screening protocols for patients were not consistent with CMS guidance. As a result, the patients and staff at these two HHA providers were at an increased risk of infection. OIG did not determine whether these HHA providers had infection prevention and control issues related to the implementation of the policies and procedures. However, State survey agencies identified issues with implementation at several of these HHA providers, as indicated by infection prevention and control deficiencies found during surveys conducted in 2019 and 2020.

OIG recommended that CMS develop and share with the HHA industry information on COVID-19 infection prevention and control best practices that HHA providers can use to comply with CMS requirements and follow CMS guidance.

Work Plan #: A-01-20-00508 (September 2021)
Government Program: Medicare Parts A & B

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States Claimed Federal Reimbursement for Payments to Health Home Providers That Did Not Meet Medicaid Requirements

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model in which providers work together to coordinate and manage beneficiaries' care at a reasonable cost. For Federal fiscal year 2019, States claimed Federal Medicaid reimbursement for health home services totaling $611 million ($408 million Federal share).

OIG's objective was to determine whether States' claims for Medicaid reimbursement for payments made to health home providers complied with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Missouri (A-07-20-04117)

OIG found that Missouri improperly claimed Federal Medicaid reimbursement for 14 of 150 payments. These 14 improper payments primarily involved deficiencies in documentation. Specifically, Missouri's health home providers did not always document core services, but all other requirements were met. The improper payments occurred because Missouri did not adequately monitor providers for compliance with Federal and State requirements regarding the maintenance of medical records that documented the health home services that the providers furnished to beneficiaries.

On the basis of OIG's sample results, OIG estimated that Missouri improperly claimed at least $3.4 million in Federal Medicaid reimbursement for payments made to health home providers.

OIG recommended that Missouri refund $3.4 million to the Federal Government and improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received payments.

New York (A-02-19-01007)

OIG found that New York improperly claimed reimbursement for 9 payments. Specifically, New York's health home providers did not provide a comprehensive patient-centered care plan covering the sampled date of service for enrolled beneficiaries (five payments) and did not document health home services (four payments). The improper payments occurred because New York did not adequately monitor health home providers for compliance with certain Federal and State requirements for providing, documenting, and billing services.

OIG found that home health providers' failure to develop comprehensive patient-centered care plans and provide health home services could have resulted in beneficiaries not getting the services that they needed and may have put their health and safety at risk. On the basis of OIG's sample results, OIG estimated that New York improperly claimed at least $6 million in Federal Medicaid reimbursement for payments made to health home providers for services provided to beneficiaries diagnosed with serious mental illness or substance use disorder.

OIG recommended that New York refund $6 million to the Federal Government. New York should also strengthen its monitoring of the health home program to ensure that health home comply with Federal and State requirements for (1)

providing services according to a comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

Work Plan #: A-07-20-04117 (August 2021); A-02-19-01007 (July 2021)
Government Program: Medicare Parts A & B

Medicare Home Health Agency Provider Compliance Audits

Under the Medicare home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. OIG's prior audits of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

SunHawk Summary of OIG Audit Findings and Recommendations

Catholic Home Care (A-02-19-01013)

OIG found that Catholic Home Care did not comply with Medicare billing requirements for 17 of the 100 home health claims that they reviewed. For these claims, Catholic Home Care received overpayments of $25,742 for services provided during OIG's audit period. Specifically, Catholic Home Care incorrectly billed Medicare for services provided to beneficiaries who did not require skilled services and for some dependent services that did not meet coverage requirements. On the basis of OIG's sample results, OIG estimated that Catholic Home Care received overpayments of at least $4.2 million for the audit period.

OIG recommended that Catholic Home Care: (1) refund to the Medicare program the portion of the estimated $4.2 million overpayment for claims incorrectly billed that are within the reopening period; (2) exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen its procedures for billing home health services.

Caretenders of Jacksonville, LLC (A-04-16-06195)

OIG found that Caretenders received overpayments of $92,345 for services provided during OIG's audit period. Specifically, Caretenders incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) payment codes. These errors occurred primarily because Caretenders did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas. On the basis of OIG's sample results, OIG estimated that Caretenders received overpayments of approximately $4.4 million for the audit period. All 100 claims in OIG's sample are outside of the Medicare 4-year claim-reopening period.

OIG recommended that Caretenders: exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this

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recommendation. OIG also recommended that Caretenders ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, and (3) the correct HIPPS payment codes are billed.

VNA of Maryland (A-03-17-00009)

OIG found that VNA did not comply with Medicare billing requirements for 19 of the 100 home health claims that OIG audited. For these claims, VNA received overpayments of $25,295 for services provided in calendar years 2015 and 2016. Specifically, VNA incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) services that were not delivered in accordance with the beneficiary's plan of care, and (4) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) payment codes. On the basis of our sample results, OIG estimated that VNA received overpayments of at least $2.1 million for the audit period. All 100 claims in our sample are outside of the Medicare 4-year claim-reopening period.

OIG recommended that VNA exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation. OIG also recommended that VNA ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, (3) services are provided in accordance with beneficiaries' plans of care, and (4) the correct HIPPS payment codes are billed.

In written comments on OIG's draft report, VNA stated that it disagreed with the majority of OIG's findings. VNA concurred with OIG's finding regarding the homebound determination for one claim and also concurred that an incorrect HIPPS payment code was assigned to two sampled claims identified in our draft report. VNA stated that it would promptly make a repayment for those three claims but also stated that it did not have any repayment obligation with respect to the other claims that OIG found were paid in error. VNA retained a health care consultant to review the claims OIG questioned and challenged OIG's independent medical review contractor's decisions, maintaining that nearly all of the sampled claims were billed correctly. To address these concerns, OIG had its independent medical review contractor review VNA's written comments on OIG's draft report as well as the spreadsheet prepared by VNA's consultant. Based on the results of that review, OIG reduced the sampled claims incorrectly billed from 36 to 19 and revised the related finding and recommendations. OIG maintains that its remaining findings and recommendations, as revised, are valid.

Southeastern Home Health (A-03-17-00004)

OIG reported that Southeastern did not comply with Medicare billing requirements for 18 of the 100 home health claims that OIG reviewed. For these claims, Southeastern received overpayments of $46,404 for services provided in calendar years 2015 and 2016. Specifically, Southeastern incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) codes. On the basis of OIG's sample results, OIG estimated that Southeastern received overpayments of at least $1.8 million for OIG's audit period. All 100 claims within OIG sample are outside of the Medicare 4-year claim-reopening period.

OIG recommended that Southeastern exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommend that Southeastern strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as

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homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, and (3) the correct HIPPS payment codes are billed.

Total Patient Care Home Health (A-06-16-05005)

OIG reported that TPC did not comply with Medicare billing requirements for 32 of the 100 home health claims that OIG reviewed. For these claims, TPC received overpayments of $75,461 for services provided during OIG's audit period, October 1, 2014, through September 30, 2016. Specifically, TPC incorrectly billed Medicare for services provided to beneficiaries who were not homebound or did not require skilled services. On the basis of OIG's sample results, OIG estimated that TPC received overpayments of at least $1.7 million for OIG's audit period.

OIG recommended that TPC exercise reasonable diligence to identify, report and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommended that TPC strengthen its procedures to ensure that; (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (2) beneficiaries are receiving only reasonable and necessary skilled services.

The Palace at Home (A-04-17-07067)

OIG reported that The Palace did not comply with Medicare billing requirements for 20 of the 100 home health claims that OIG audited. For these claims, The Palace received overpayments of $30,387 for services provided during OIG's audit period. Specifically, The Palace incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that it assigned with incorrect Health Insurance Prospective Payment System codes. These errors occurred primarily because The Palace did not have adequate controls to prevent the incorrect billing of Medicare claims. Based on OIG's sample results, OIG estimated that The Palace received overpayments of at least $731,304 for OIG's audit period. All the incorrectly billed claims are outside of the four-year reopening period.

OIG recommended that The Palace exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommend that The Palace strengthen its procedures to ensure full compliance with requirements for billing home health services.

VNA of Central Jersey (A-02-17-01025)

OIG reported that VNA of Central Jersey did not comply with Medicare billing requirements for 14 of the 100 home health claims that OIG reviewed. For these claims, VNA of Central Jersey received overpayments of $21,553 for services provided during OIG audit period. Specifically, VNA of Central Jersey incorrectly billed Medicare for services provided to beneficiaries who were not homebound or did not require skilled services. It also inappropriately received reimbursement for claims for some services that were not provided, not reasonable or necessary, and incorrectly billed. Based on OIG's sample results, OIG estimated that VNA of Central Jersey received overpayments of at least $2 million for the audit period.

OIG made several recommendations to VNA of Central Jersey, including that it: (1) refund to the Medicare program the portion of the estimated $2 million overpayment for claims incorrectly billed that are within the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures for billing home health services.

Gem City Home Care (A-05-18-00011)

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OIG reported that Gem City received overpayments of $40,621 for services provided in fiscal years (FYs) 2016 and 2017. Specifically, Gem City incorrectly billed Medicare for services provided to beneficiaries who: (1) were not homebound, or (2) did not require skilled services. Based on OIG's sample results, OIG estimated that Gem City received overpayments of at least $2.67 million during this period.

OIG made several recommendations to Gem City, including that it: (1) refund to the Medicare program the portion of the estimated $2.67 million in overpayments for incorrectly billed claims that are within the 4-year reopening period, (2) for the remaining portion of the estimated $2.67 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures to ensure that the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and beneficiaries are receiving only reasonable and necessary skilled services.

Mercy Health Visiting Nurse Services (A-05-18-00035)

OIG reported that Mercy did not comply with Medicare billing requirements for 23 of the 100 home health claims that OIG reviewed. For these claims, Mercy received overpayments of $42,466 for services provided in calendar years (CYs) 2016 and 2017. Specifically, Mercy incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, or (2) services provided to beneficiaries who did not require skilled services. Based on OIG's sample results, OIG estimated that Mercy received overpayments of approximately $1.1 million for CYs 2016 and 2017.

OIG made several recommendations to Mercy, including that it: (1) refund to the Medicare program the portion of the estimated $1.1 million in overpayments for claims incorrectly billed that are within the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period.

Mission Home Health of San Diego, Inc. (A-09-18-03008)

OIG reported that Mission Home Health did not comply with Medicare billing requirements for 32 home health claims that OIG audited. For these claims, Mission Home Health received overpayments of $61,718 for services provided during OIG's audit period. Specifically, Mission Home Health incorrectly billed Medicare for; (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) claims that were assigned incorrect payment codes, and (4) claims for which documentation was inadequate to support the services provided. These errors occurred primarily because Mission Home Health did not have adequate procedures to prevent the incorrect billing of Medicare claims. Based on OIG's sample results, OIG estimated that Mission Home Health received overpayments of at least $5.9 million for OIG's audit period.

OIG recommended that Mission Home Health: (1) refund to the Medicare program the portion of the estimated $5.9 million overpayment for claims incorrectly billed that are within the reopening period, (2) for the remaining portion of the estimated $5.9 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, and (4) strengthen its procedures to ensure the correct billing of Medicare claims.

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Condado Home Care Program, Inc. (A-02-17-01022)

OIG reported that Condado did not comply with Medicare billing requirements for 14 home health claims that OIG audited. Specifically, Condado incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) incorrect Health Insurance Prospective Payment System payment codes, or (4) services provided under a plan of care that did not meet Medicare requirements. These errors occurred because Condado did not have adequate procedures in place to prevent the incorrect billing of Medicare claims within selected risk areas. Based on OIG's sample results, OIG estimated that Condado received overpayments of at least $97,210 for the audit period.

OIG made several recommendations to Condado, including that it: (1) refund to the Medicare program the portion of the estimated $97,210 in overpayments for claims incorrectly billed that are within the four-year claim reopening period, (2) exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and (3) exercise reasonabl e diligence to identify and return any additional similar overpayments outside the reopening period.

Residential Home Health (A-05-16-00063)

OIG reported that Residential did not comply with Medicare billing requirements for 11 of the 100 home health claims that OIG reviewed. For these claims, Residential received overpayments of $16,927 for services provided in calendar years (CYs) 2014 and 2015. Specifically, Residential incorrectly billed Medicare for beneficiaries who: (1) were not homebound, or (2) did not require skilled services. Based on OIG's sample results, OIG estimated that Residential received overpayments of at least $2 million in CYs 2014 and 2015. All the incorrectly billed claims are now outside of the Medicare reopening period.

OIG recommended Residential exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG's recommendations. OIG also recommended that Residential strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (2) beneficiaries are receiving only reasonable and necessary skilled services.

Palos (A-05-17-00022)

OIG found that Palos did not comply with Medicare billing requirements for 16 home health claims. For these claims, Palos received overpayments of $22,428 for services provided in calendar years (CYs) 2015 and 2016. Specifically, Palos incorrectly billed Medicare for; (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries that did not require skilled services, or (3) incorrect Health Insurance Prospective Payment System payment codes. Based on OIG's sample results, OIG estimated that Palos received overpayments of at least $680,884 for CYs 2015 and 2016.

OIG made several recommendations to Palos, including: (1) refund the portion of the estimated $680,884 in overpayments for claims incorrectly billed that are within the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period.

Angels Care Home Health (A-07-16-05093)

OIG found that Angels Care did not comply with Medicare billing requirements for 29 of the 72 home health claims paid in CYs 2014 or 2015 that OIG reviewed. For these claims, Angels Care received overpayments of $57,148. Specifically, Angels Care incorrectly billed Medicare because; (1) beneficiaries were not homebound, (2) beneficiaries did not require skilled services, or (3) claims were assigned with incorrect Health Insurance Prospective Payment System payment codes. Based

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on OIG's sample results, OIG estimated that during CYs 2014 and 2015 the Angels Care received overpayments totaling $3.8 million.

OIG recommended that Angels Care: (1) refund to the Medicare program the portion of the $3.8 million in estimated overpayments received during CYs 2014 and 2015 for claims incorrectly billed and within the reopening and recovery periods, (2) for the rest of the $3.8 million in estimated overpayments for claims that are outside the 4-year reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, and (4) strengthen controls to ensure full compliance with requirements for billing home health services.

Mederi Caretenders (A-07-16-05092)

OIG found that Mederi Caretenders did not comply with Medicare billing requirements for 21 home health claims paid in CYs 2014 or 2015. For these claims, Mederi Caretenders received overpayments of $31,428. Specifically, Mederi Caretenders incorrectly billed Medicare because; (1) beneficiaries were not homebound, (2) beneficiaries did not require skilled services, (3) one claim was assigned with an incorrect Health Insurance Prospective Payment System billing code, or (4) one claim was not adequately documented. Based on OIG's sample results, OIG estimated that during CYs 2014 and 2015 the Mederi Caretenders received overpayments totaling at least $1.26 million.

OIG recommended that Mederi Caretenders: (1) refund to the Medicare program the portion of the $1.26 million in estimated overpayments received during CYs 2014 and 2015 for claims incorrectly billed that are within the reopening and recovery periods, (2) exercise reasonable diligence to identify and return any additional similar overpayments outside of the 4-year claim-reopening period, in accordance with the 60-day rule, and (3) strengthen its controls to ensure full compliance with Medicare requirements for billing home health services.

Metropolitan **(**A-02-16-01001)

OIG found that Metropolitan did not comply with Medicare billing requirements for 11 of the 100 home health claims that OIG reviewed. For these claims, Metropolitan received overpayments of $34,514 for services provided during CYs 2013 and 2014. Specifically, Metropolitan incorrectly billed Medicare for beneficiaries that were not homebound or did not require skilled services. In addition, Metropolitan received reimbursement for claims for which the services were not supported by documentation. Based on OIG's sample results, OIG estimated that Metropolitan received overpayments of at least $2.9 million for the audit period. All the incorrectly billed claims are now outside of the Medicare reopening period; therefore, OIG did not recommend recovery of the overpayments.

OIG recommended that Metropolitan exercised reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG recommendations. OIG also recommended that Metropolitan strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, and (3) reimbursement for services comply with Medicare documentation requirements.

Great Lakes (A-05-16-00057)

OIG found that Great Lakes did not comply with Medicare billing requirements for 38 of the 100 home health claims that OIG reviewed. For these claims, Great Lakes received overpayments of $64,114 for services provided in calendar years (CYs) 2014 and 2015. Specifically, Great Lakes incorrectly billed Medicare for beneficiaries who: (1) were not homebound,

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and (2) did not require skilled services. Based on OIG sample results, OIG estimated that Great Lakes received overpayments of $10.5 million in CYs 2014 and 2015.

OIG made several recommendations to Great Lakes, including that it: (1) refund to the Medicare program the portion of the estimated $10.5 million in overpayments for claims incorrectly billed for the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures.

EHS (A-05-16-00055)

OIG reported that EHS did not comply with Medicare billing requirements for 35 of the 100 home health claims that OIG reviewed. For these claims, EHS received overpayments of $55,303 for services provided in calendar years (CYs) 2014 and 2015. Specifically, EHS incorrectly billed Medicare for beneficiaries who: (1) were not homebound, or (2) did not require skilled services. Based on OIG sample results, OIG estimated that EHS received overpayments of at least $7.5 million in CYs 2014 and 2015.

OIG made several recommendations to EHS, including that it: (1) refund to the Medicare program the portion of the estimated $7.5 million in overpayments for claims incorrectly billed for the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures.

Excella (A-01-16-00500)

OIG found that Excella did not comply with Medicare billing requirements for 41 of the 100 home health claims that OIG reviewed. For these claims, Excella received overpayments of $129,520 for services provided in calendar years (CYs) 2013 and 2014. Specifically, Excella incorrectly billed Medicare because beneficiaries: (1) were not homebound, or (2) did not require skilled services. Based on OIG sample results, OIG estimated that Excella received overpayments of at least $6.6 million for the CY 2013 and CY 2014 period. All the incorrectly billed claims are now outside of the Medicare reopening period; therefore, OIG did not recommend recovery of the overpayments.

OIG recommended that Excella exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG recommendations. OIG also recommended that Excella strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (2) beneficiaries are receiving only reasonable and necessary skilled services.

Work Plan #: A-02-19-01013 (August 2021); A-04-16-06195 (June 2021); A-03-17-00009 (April 2021); A-03-17-00004 (January 2021); A-06-16-05005 (December 2020); A-04-17-07067 (November 2020); A-02-17-01025 (October 2020); A-05-18-00011 (October 2020); A-05-18-00035 (September 2020); A-09-18-03008 (August 2020); A-02-17-01022 (August 2020); A-05-16-00063 (April 2020); A-05-17-00022 (December 2019); A-07-16-05093 (October 2019); A-07-16-05092 (August 2019); A-02-16-01001 (May 2019); A-05-16-00057 (May 2019); A-05-16-00055 (May 2019); A-01-16-00500 (May 2019); W-00-19-35712; W-00-16-35712; W-00-16-35501; W-00-17-35712
Government Program: Medicare Parts A & B

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CMS Could Have Saved $192 Million by Targeting Home Health Claims for Review

Under the prospective payment system (PPS), Medicare pays home health agencies (HHAs) for each 60-day episode of care that a beneficiary receives, called a payment episode. During OIG's audit period, if an HHA provided four or fewer visits in a payment episode, Medicare paid the HHA a standardized per-visit payment. Claims for these types of payments are called Low Utilization Payment Adjustment (LUPA) claims. Once a fifth visit was provided during the payment episode (i.e., above the LUPA threshold), Medicare paid an amount for the services provided that was, in general, substantially higher than the per-visit payment amount. Because of the large payment increase starting with the fifth visit, HHAs have an incentive to improperly bill claims with visits slightly above the LUPA threshold.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for 4 claims there was no documentation available to make a compliance determination. Another 25 claims did not comply with requirements. As a result, Medicare improperly paid HHAs for a portion of the payment episode (14 claims) and for the full payment episode (11 claims), totaling $41,613. These improper payments occurred because the Medicare administrative contractors (MACs) did not analyze claim data or perform risk assessments to target for additional review for those claims with visits slightly above the LUPA threshold of four visits. Based on OIG's sample results, OIG estimated that Medicare overpaid HHAs nationwide $191.8 million for OIG's audit period. OIG recommended that CMS: (1) direct the MACs to recover the $41,613 in identified overpayments made to HHAs for the sampled claims, (2) require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review, and (3) instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold, which could have saved Medicare as much as $191.8 million during OIG's audit period.

Work Plan #: A-09-18-03031 (July 2020)
Government Program: Medicare Parts A & B

Hospice

Medicare Hospice Provider Compliance Audit

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of six months or less and who have elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet Medicare requirements. OIG's objective was to determine whether hospice services complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Professional Healthcare at Home, LLC (A-09-18-03028)

OIG found that, of the 100 hospice claims in OIG's sample, 21 claims showed that the clinical record did not support the beneficiary's terminal prognosis. In addition, for 1 of these 21 claims, there was no documentation that a hospice physician or hospice nurse practitioner had a required face-to-face encounter with the beneficiary. Improper payment of these claims occurred because Professional Healthcare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. Based on OIG's sample results, OIG estimated that Professional Healthcare received at least $3.3 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Professional Healthcare: (1) refund to the Federal Government the portion of the estimated $3.3 million in Medicare overpayments that are within the 4-year claims reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Alive Hospice, Inc. (A-09-18-03016)

OIG found that, for 16 claims, the clinical record did not support the beneficiary's terminal prognosis, and for the remaining 8 claims, the clinical record did not support the level of care claimed for Medicare reimbursement. Improper payment of these claims occurred because Alive's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis and that the appropriate level of care was provided. Based on OIG's sample results, OIG estimated that Alive received at least $7.3 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Alive: (1) refund to the Federal Government the portion of the estimated $7.3 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

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Ambercare Hospice, Inc. (A-09-18-03017)

OIG found that, for 52 claims, the clinical record did not support the beneficiary's terminal prognosis. Improper payment of these claims occurred because Ambercare's policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis. Based on OIG's sample results, OIG estimated that Ambercare received at least $24.6 million in unallowable Medicare reimbursement for hospice services.

OIG recommended that Ambercare: (1) refund to the Federal Government the portion of the estimated $24.6 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Suncoast Hospice (A-02-18-01001)

OIG found that, for 49 claims in the sample, Suncoast claimed Medicare reimbursement for hospice services for which the clinical record did not support the beneficiary's terminal prognosis or the level of care claimed and for services that were not provided.

These improper payments occurred because Suncoast's policies and procedures for ensuring that claims for hospice services met Medicare requirements were not always effective. Based on OIG's sample results, OIG estimated that Suncoast received at least $47.4 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Suncoast: (1) refund to the Federal Government the portion of the estimated $47.4 million in Medicare overpayments that are within the 4-year claims reopening period; (2) exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Tidewell Hospice, Inc. (A-02-18-01024)

OIG reported that Tidewell did not comply with Medicare requirements for 18 of the 100 claims in OIG's sample. For these claims, Tidewell claimed Medicare reimbursement for hospice services for which the clinical record did not support the beneficiary's terminal illness prognosis or the level of care claimed and for services that were not eligible for Medicare reimbursement. These improper payments occurred because Tidewell's policies and procedures for ensuring that claims for hospice services met Medicare requirements were not always effective. On the basis of OIG's sample results, OIG estimated that Tidewell received at least $8.3 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Tidewell: (1) refund to the Federal Government the portion of the estimated $8.3 million in Medicare overpayments that are within the 4-year claims reopening period, (2) exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule, and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.

Hospice Compassus, Inc. (A-02-16-01023)

OIG reported that Compassus did not comply with Medicare requirements for 39 of the 100 claims in OIG sample. For these claims, Compassus claimed Medicare reimbursement for hospice services: (1) for which the associated beneficiary did not

meet eligibility requirements, (2) that were not documented, and (3) at a reimbursement rate associated with a level of care higher than what the associated beneficiary required. These improper payments occurred because Compassus's policies and procedures for ensuring that claims for hospice service met Medicare requirements were not always effective. Based on OIG's sample results, OIG estimated that Compassus received at least $1.8 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Compassus exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and based on the results of OIG's audit, identify, report, and return any additional overpayments as having been made in accordance with OIG's recommendations. OIG also recommended that Compassus strengthen its procedures to ensure that hospice services comply with Medicare requirements.

Work Plan #: A-09-18-03028 (June 2021); A-09-18-03016 (May 2021); A-09-18-03017 (May 2021); A-02-18-01001 (May 2021); A-02-18-01024 (February 2021); A-02-16-01023 (November 2020)
Government Program: Medicare Parts A & B

Office of Inspector General's Partnership with the Office of the New York State Comptroller: Improper Medicaid Payments for Individuals Receiving Hospice Services Covered by Medicare

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to individuals who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and localities (the City of New York and counties) funded the remaining 43.5 percent. The Department uses two methods to pay health care providers for Medicaid services: fee-for-service (FFS) and managed care.

Hospice is a coordinated program of home and/or inpatient care that treats terminally ill individuals and their families. Hospice provides palliative care that can help manage the pain and symptoms of illness with a focus on comforting the recipient rather than curing the terminal illness. In addition to delivering services, hospice providers are responsible for developing a comprehensive plan of care and coordinating care and services needed by patients.

Many of the State's Medicaid recipients are also eligible for Medicare, the federal health insurance program for people age 65 or older and people under 65 with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligible." When dual-eligibles elect hospice under Medicare, Medicare pays a daily rate to hospice providers for hospice services. In these cases, Medicare is the primary payer for services covered under Medicare, while Medicaid is the payer of last resort. Also, when dual-eligibles who reside in nursing homes elect hospice, Medicare will pay for hospice services while Medicaid pays for nursing home room and board.

Medicaid Managed Long-Term Care (MLTC) plans are MCOs that serve people who require nursing home or long-term home health care. MLTC plans develop plans of care, coordinate care, and authorize and pay for services such as durable medical equipment (DME), medical supplies, and home health care (including personal care services) for their enrollees. Some Medicaid services are excluded from the MLTC benefit package and may be paid separately by Medicaid FFS. Many dual-eligibles in Report 2018-S-71 7 hospice are enrolled in MLTC plans. When a recipient is enrolled in a MLTC plan, the plan is required to coordinate care with other providers, including hospice providers, to avoid duplicative or excessive services and payments.

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When a recipient is enrolled in Medicaid FFS, Local Departments of Social Services (LDSS) and/or Medicaid providers are generally responsible for authorizing appropriate services and for coordinating care with other providers, including hospice providers, to avoid inappropriate Medicaid payments. OIG reviewed records obtained from hospice providers, MLTC plans, LDSS, and Medicaid providers for 50 cases where recipients were enrolled in Medicare hospice and also received large amounts of personal care services or DME and supplies from Medicaid. OIG reviewed records obtained from hospice providers, MLTC plans, LDSS, and Medicaid providers for 50 cases where recipients were enrolled in Medicare hospice and also received large amounts of personal care services or DME and supplies from Medicaid.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Department has not established sufficient controls to ensure Medicaid payments (made via FFS and managed care) are appropriate for dual-eligibles receiving care under the Medicare-funded hospice benefit (herein referred to as Medicare hospice). For the period January 1, 2015 through July 31, 2019, OIG identified about $50 million in payments that need the Department's review, as follows:

- $4.3 million in actual and potential overpayments for services not allowed in conjunction with hospice or that overlap with hospice-covered benefits
- $1.2 million ($1,093,617 + $74,693) in potential overpayments for services that likely should have been covered by hospice providers
- $370,506 in actual and potential overpayments for unnecessary personal care services; $35.7 million in questionable payments for personal care services
- $4.1 million in questionable payments for DME and supplies
- $4.3 million in unnecessary payments for nursing home room and board under managed care

Medicare pays hospice providers a daily rate that covers the establishment of a comprehensive plan of care, coordination of care with non-hospice providers, and direct provision of all care for a patient's terminal illness and related conditions. According to guidance from the Centers for Medicare & Medicaid Services (CMS), services unrelated to the terminal illness should be exceptional, unusual, and rare. Medicare requires non-hospice providers who bill Medicare for services to document the diagnoses or conditions the hospice provider has determined are unrelated to the terminal illness. However, Medicaid does not specifically require providers to document why services are provided outside of the hospice benefit. In addition, the Department does not have a process to identify, track, or monitor dual-eligibles who elect the Medicare hospice benefit. In recent years, the Department issued guidance stating hospice providers must notify MLTC plans when recipients have elected hospice and coordinate care to prevent the duplication of services.

MLTC plans were also urged to monitor encounters for potential hospice services that should be denied. However, the Department has not taken any additional steps to verify that all involved parties are adequately coordinating care with hospice providers to ensure Medicaid is paying only for services completely unrelated to the terminal illnesses for which Medicaid recipients entered hospice care. Developing a comprehensive plan of care and coordinating care and services needed by patients are primary responsibilities of hospice providers. Nonhospice entities such as MLTC plans, LDSS, and Medicaid providers also have responsibilities, including: maintaining up-to-date care plans, authorizing services, and coordinating care.

OIG found there was generally no delineation of the specific services needed for certain conditions unrelated to the terminal illness, such as delineation of the amount of personal care services required for non-terminal illness conditions (versus the amount required for the terminal illness). This information is necessary as part of the hospice provider's comprehensive

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plan of care and to ensure adequate coordination of care, which are primary responsibilities of hospice providers. Additionally, when MLTC plans, LDSS, or other Medicaid providers were responsible for authorizing services, maintaining care plans, or coordinating care, OIG found there was a lack of evidence of coordination between parties in the Medicaid program and hospice providers. The absence of a tracking system to identify dual-eligibles who elect Medicare hospice; details in the hospice, MLTC plan, and other provider records regarding the provision of, and coordination of, services unrelated to the terminal illness; and a specific requirement for non-hospice providers to document the reason a service is provided outside of the hospice benefit, create barriers to Department oversight.

Work Plan #: A-02-21-01008 (April 2021)
Government Program: Medicare Parts A & B

Protecting Medicare Hospice Beneficiaries from Harm

OIG produced this study as a companion to *Trends in Hospice Deficiencies and Complaints* (also included in this SunHawk summary) in which OIG determined the extent and nature of hospice deficiencies and complaints and identify trends. For this study, OIG used the survey reports to provide more detail about poor-quality care that resulted in harm to beneficiaries. Additionally, OIG described specific instances of harm to Medicare hospice beneficiaries and identified the vulnerabilities in Medicare's process for preventing and addressing harm.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Protecting Medicare Hospice Beneficiaries from Harm (OEI-02-17-00021)

OIG's reported that featured 12 cases of harm to beneficiaries receiving hospice care caused by multiple vulnerabilities including insufficient reporting requirements for hospices, limited reporting requirements for surveyors, and barriers that beneficiaries and caregivers face in making complaints. Also, these hospices did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm and hospices' plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

OIG recommended that CMS seek statutory authority to establish additional, intermediate remedies for poor hospice performance. OIG also recommended that CMS should: (1) strengthen requirements for hospices to report abuse, neglect, and other harm, (2) ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm, (3) strengthen guidance for surveyors to report crimes to local law enforcement, (4) monitor surveyors' use of immediate jeopardy citations, and (5) improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

Trends in Hospice Deficiencies and Complaints (OEI-02-17-00020)

OIG reported that over 300 hospices had at least one serious deficiency or at least one substantiated severe complaint in 2016, which OIG considered to be poor performers. These hospices represent 18 percent of all hospices surveyed nationwide in 2016.

OIG recommended CMS should: (1) expand the deficiency data that accrediting organizations report to CMS and use this data to strengthen its oversight of hospices, (2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices, (3) include on Hospice Compare the survey reports from state agencies, (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained, (5) educate hospices about common deficiencies

and those that pose particular risks to beneficiaries, and (6) increase oversight of hospices with a history of serious deficiencies.

Work Plan #: OEI-02-17-00021 (July 2019); OEI-02-17-00020 (July 2019)
Government Program: Medicare Parts A & B

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Medical Equipment & Supplies

Sleep Management, LLC: Audit of Claims for Monthly Rental of Noninvasive Home Ventilators

A previous OIG review found that medical equipment suppliers could bill Medicare for a non-invasive home ventilator (NHV) as if it were being used as a ventilator, when use of a lower cost respiratory assist device or basic continuous positive airway pressure device was indicated by the patient's medical condition.

Sleep Management, LLC (Sleep Management), was among the top three suppliers of NHVs in calendar years (CYs) 2016 and 2017. Medicare paid Sleep Management $36.8 million for NHVs during OIG's audit period. OIG's objective was to determine whether Medicare claims submitted by Sleep Management for the monthly rental of NHVs complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that, of the 100 sampled claim lines with payments totalling $75,694, 98 claim lines with payments totalling $74,288 did not comply with Medicare requirements. Based on OIG's sample results, OIG estimated that Medicare made overpayments to Sleep Management of at least $29.1 million for the monthly rental of NHVs that did not comply with Medicare requirements. These overpayments occurred because Sleep Management did not follow its policies and procedures to ensure that it obtained sufficient documentation to support the medical necessity of the NHV or discontinued service for lack of beneficiary usage.

OIG recommended that Sleep Management: (1) refund the portion of the estimated $29.1 million in Medicare overpayments for claim lines incorrectly billed that are within the 4-year reopening period; (2) exercise reasonable diligence to identify, report, and return any similar overpayments in accordance with the 60-day rule; and (3) follow existing policies and procedures to help ensure that it complies with Medicare requirements.

Work Plan #: A-04-18-04066 (May 2021)
Government Program: Medicare Parts A & B

Medicare Advantage Organizations Are Missing Opportunities To Use Ordering Provider Identifiers To Protect Program Integrity

National Provider Identifiers (NPIs) for ordering providers are essential for safeguarding the program integrity of what OIG refer to in this issue brief as high-risk services in Medicare - i.e., durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); clinical laboratory services; imaging services; and home health services. For these services, NPIs are critical for identifying patterns of inappropriate billing and ordering among providers and investigating fraud and abuse. Both CMS and OIG rely on ordering provider NPIs (hereafter ordering NPIs) to conduct oversight and pursue fraud investigations. However, prior OIG work found that these NPIs were largely absent from CMS's MA encounter data, despite evidence that many MAOs can-and do-already collect this information. As a result, OIG recommended that CMS establish and enforce

requirements for MAOs to submit ordering NPIs for high-risk services. Findings from this issue brief may be useful as CMS considers requiring MAOs to collect and use ordering NPIs for MAOs' program integrity oversight activities.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that almost half of the MAOs that lack ordering NPIs on at least some MA encounter records raised concerns that this hinders their data analysis for program integrity. Among MAOs that collect any ordering NPIs, most use these NPIs to conduct oversight activities-such as analyses that detect potential fraud schemes-but one in five of these MAOs does not perform program integrity oversight using ordering NPIs, despite having the data to do so. Furthermore, when MAOs collect ordering NPIs on MA encounter records, most do not validate these NPIs against CMS's NPI registry.

OIG recommended that CMS encourage MAOs to perform program integrity oversight using ordering NPIs. CMS neither concurred nor non-concurred with this recommendation and stated that it would consider whether additional education is needed for MAOs regarding the role that ordering NPIs can play in program integrity oversight.

Work Plan #: OEI-03-19-00432 (April 2021)
Government Program: National Provider Identities (NPI)

Medicare-Allowed Charges for Non-invasive Ventilators Are Substantially Higher Than Payment Rates of Select Non-Medicare Payers

Medicare-allowed charges for noninvasive ventilators increased from $279.9 million in 2016 to $424.4 million in 2018, an increase of 52 percent. OIG is concerned about the relationship of these increased costs to prices per noninvasive ventilator, and specifically concerned about whether Medicare-allowed charges are comparable with payment rates of select non-Medicare payers. OIG's objective was to determine whether Medicare-allowed charges for noninvasive ventilators were comparable with payment rates of select non-Medicare payers.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for CYs 2016 through 2018, OIG estimated that Medicare and beneficiaries could have saved $86.6 million if Medicare-allowed charges were comparable with payment rates of select non-Medicare payers on HCPCS code E0466. Of this payment difference, OIG estimated that Medicare paid $69.3 million and Medicare beneficiaries paid $17.3 million. Generally, Medicare-allowed charges are higher than select non-Medicare payer payment rates because the Centers for Medicare & Medicaid Services (CMS) does not routinely evaluate pricing trends for noninvasive ventilators or payment rates of select non-Medicare payers. Rather, CMS uses statutorily mandated fee schedule payments that have an economic update factor applied to them annually. In 2016, CMS was required to adjust certain fee schedule amounts for durable medical equipment, prosthetics, orthotics, and supplies using information from the competitive bidding program. But this change did not affect the noninvasive ventilator HCPCS code reviewed for this report.

OIG recommended that CMS review Medicare-allowed charges for noninvasive ventilators HCPCS code E0466, for which Medicare and beneficiaries could have potentially saved an estimated $86.6 million in CYs 2016 through 2018 and add noninvasive ventilators HCPCS code E0466 to the competitive bidding program as soon as practicable.

Work Plan #: A-05-20-00008 (September 2020)
Government Program: Medicare Parts A & B

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CMS Generally Met Requirements for the DMEPOS Competitive Bidding Program Round 1 Recompete

The Medicare Improvements for Patients and Providers Act of 2008 contains a broad mandate requiring OIG to assess, through a post-award audit, survey, or otherwise, the process used by the Centers for Medicare & Medicaid Services (CMS) to conduct the competitive bidding and subsequent pricing determinations that are the basis for the pivotal bid amounts and single-payment amounts (SPAs) under Rounds 1 and 2 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (the Program). OIG's objective was to determine whether CMS selected DMEPOS suppliers, calculated the SPAs, and monitored the suppliers for the Round 1 Recompete in accordance with its established Program procedures and applicable Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS did not consistently follow its established procedures and applicable Federal requirements for selecting suppliers during the bid process for 6 of the 225 winning suppliers. This inconsistency affected 3 of the 30 sampled SPAs. Specifically, CMS awarded contracts to five suppliers that did not meet financial statement requirements and one supplier that did not have the applicable state license in one competition. Additionally, CMS did not monitor suppliers in accordance with established procedures and federal requirements for another seven suppliers that did not maintain the applicable license, as required by their contracts for the first six months of 2014. On the basis of OIG's sample, OIG estimated that CMS paid suppliers $24,054 more than they would have received without any errors, or less than 0.03 percent of the $73 million paid under the Round 1 Recompete during the first six months of 2014.

OIG recommended that CMS take specific actions, as described in this report, to ensure that suppliers meet financial documentation requirements and obtain and maintain the required licenses.

Work Plan #: A-05-16-00051 (August 2020)
Government Program: Medicare Parts A & B

Audits of Medicare Payments for Orthotic Braces

From January 1, 2016, through May 31, 2018 (audit period), Medicare paid $1.5 billion for knee, back, and ankle-foot braces (selected orthotic braces) provided to Medicare beneficiaries. Prior OIG audits and evaluations found that some suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) billed for orthotic braces that did not comply with Medicare billing requirements. During OIG's audit period, the Centers for Medicare & Medicaid Services found that orthotic braces were among the top 20 DMEPOS items with the highest improper payment rates.

SunHawk Summary of OIG Audit Findings and Recommendations

Visionquest Industries, Inc. (A-09-19-03010)

OIG found that Visionquest did not fully comply with Medicare requirements when billing for selected orthotic braces. For 67 sampled beneficiaries, Visionquest billed for orthotic braces that were not medically necessary. Based on OIG's sample results, OIG estimated that Visionquest received at least $2.5 million in unallowable Medicare payments for orthotic braces. OIG recommended that Visionquest: (1) refund to the durable medical equipment Medicare administrative contractors the portion of the $2.5 million in estimated overpayments for claims that are within the four-year reopening period, (2) exercise

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reasonable diligence to identify and return any additional similar overpayments, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

Desoto Home Health Care, Inc. (A-09-19-03021)

OIG reported that Desoto did not comply with Medicare requirements when billing for orthotic braces. For all 100 sampled beneficiaries, with payments totaling $143,714, Desoto billed for orthotic braces that were not medically necessary. These deficiencies occurred because Desoto did not obtain sufficient information from the beneficiaries' medical records to assure itself that the claims for orthotic braces met Medicare requirements for medical necessity. Based on OIG's sample results, OIG estimated that Desoto received at least $2.8 million in unallowable Medicare payments for orthotic braces.

OIG recommended that Desoto: (1) refund to the durable medical equipment Medicare administrative contractors $2.8 million in estimated overpayments for orthotic brace, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

Freedom Orthotics, Inc (A-09-19-03012)

OIG found that for all 100 sampled beneficiaries, with payments totaling $165,306, Freedom billed for orthotic braces that were not medically necessary. These deficiencies occurred because Freedom did not obtain sufficient information from the beneficiaries' medical records to assure itself that the claims for orthotic braces met Medicare requirements for medical necessity. Based on OIG's sample results, OIG estimated that Freedom received at least $6.9 million in unallowable Medicare payments for orthotic braces.

OIG recommended that Freedom: (1) refund to the durable medical equipment Medicare administrative contractors $6.9 million in estimated overpayments for orthotic braces, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

Work Plan #: A-09-19-03010 (August 2020); A-09-19-03021 (August 2020); A-09-19-03012 (July 2020)
Government Program: Medicare Parts A & B

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Accountable Care Organizations (ACOs)

CMS's Monitoring Activities for Ensuring That Medicare Accountable Care Organizations Report Complete and Accurate Data on Quality Measures Were Generally Effective, but There Were Weaknesses That Could Be Improved

Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if the ACOs reduce health care costs and satisfy the MSSP quality performance standard for their assigned beneficiaries. As part of the standard, ACOs must report to CMS complete and accurate data on all quality measures. For performance year (PY) 2017, ACOs were required to report data on 31 quality measures through 3 methods of submission: a patient survey, claims and administrative data, and the designated CMS web portal. If ACOs do not report complete and accurate data, shared savings payments could be affected. Previous OIG audits of two selected ACOs assessed whether they reported complete and accurate data on selected quality measures. OIG's objective was to determine whether CMS's monitoring activities were effective for ensuring that ACOs report complete and accurate data on quality measures.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS's monitoring activities were generally effective for ensuring that ACOs report complete and accurate data on quality measures through claims and administrative data and the CMS web portal. (For example, ACOs report data through the web portal on whether beneficiaries received preventive care, such as depression screenings.) However, OIG identified weaknesses in CMS's monitoring activities that could lead to ACOs reporting incomplete or inaccurate data through the patient survey. Specifically, CMS did not ensure that its contractor; (1) verified survey vendors' correction of identified issues even though the issues were directly related to the collection or reporting of data, and (2) provided feedback reports in time for survey vendors to include in their Quality Assurance Plans (QAPs) all of the changes implemented to address identified issues. (A QAP describes a survey vendor's process for performing the patient survey and complying with the CMS Quality Assurance Guidelines.) In addition, CMS did not ensure that its contractor reviewed survey instruments (e.g., mail survey packages) translated into other languages. As a result of these weaknesses, ACOs may not report complete and accurate data on quality measures, which could affect the ACOs' overall quality performance scores and ultimately the shared savings payments.

OIG recommended to improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, that CMS update the Statement of Work to require its contractor to; (1) verify that survey vendors have corrected identified issues that directly relate to the collection or reporting of data, (2) confirm that all implemented changes to address the identified issues are included in QAPs before they are approved, and (3) review the translated survey templates, mail survey packages, and telephone survey scripts to ensure that they are consistent with the English versions.

Work Plan #: A-09-18-03033 (September 2020)
Government Program: Medicare Parts A & B

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Sunshine ACO, LLC, Generally Reported Complete and Accurate Data on Quality Measures Through the CMS Web Portal, but There Were a Few Reporting Deficiencies That Did Not Affect the Overall Quality Performance Score

The Affordable Care Act established the Medicare Shared Savings Program (MSSP). Accountable Care Organizations (ACOs) in the MSSP may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if they reduce healthcare costs and satisfy the quality performance standard for their assigned beneficiaries. As part of the standard, ACOs must report to CMS complete and accurate data on all quality measures. For performance year (PY) 2016, ACOs reported more than half of the quality measures using the designated CMS web portal. If the reported data were not complete and accurate, the shared savings payments could have been affected. This vulnerability led OIG to select two ACOs that had consistently received shared savings payments to perform an initial risk assessment of ACOs' reporting of data on quality measures through the CMS web portal.

SunHawk Summary of OIG Audit Findings and Recommendations

Sunshine ACO, LLC. (A-09-18-03019)

OIG reported that for 11 sampled beneficiary-measures, Sunshine did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the measure population based on the exclusion criteria or (2) satisfied the conditions of the quality measures. Further, the medical records did not support the reported measurement values or that the reported measurement values were the most recent for the beneficiaries. Instead, the records supported different measurement values that would have still satisfied the conditions of the quality measures. These reporting deficiencies, which did not affect Sunshine's overall quality performance score, occurred because according to Sunshine officials, the ACO staff made clerical errors when entering the data and did not perform a thorough review of the beneficiaries' medical records to confirm that (1) the beneficiaries should have been included in or removed from the measure population for the Colorectal Cancer Screening measure or (2) the reported measurement values were the most recent for the Controlling High Blood Pressure measure and the Diabetes: Hemoglobin A1c Poor Control measure.

This report contains no recommendations.

West Florida ACO, LLC. (A-09-18-03003)

OIG reported that for 13 sampled beneficiary-measures, West Florida did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the measure population based on the exclusion criteria or (2) satisfied the conditions of the quality measures. Further, the medical records did not support the reported measurement values or the reported "Patient Reason" exception. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a "Medical Reason" exception that would have still removed the beneficiary from the measure population. These reporting deficiencies, which did not affect West Florida's overall quality performance score, occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2) presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according

to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception or the "Medical Reason" exception may apply.

OIG recommend that West Florida (1) ensure that it accurately reports all data on quality measures through the CMS web portal and (2) clarify with CMS its understanding of the exclusion criteria for a beneficiary to be removed from the measure population and the difference between the "Patient Reason" exception and the "Medical Reason" exception.

Work Plan #: A-09-18-03019 (October 2019); A-09-18-03003 (August 2019)
Government Program: Medicare Parts A & B

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Behavioral Health

[NEW] Use of Telehealth to Provide Behavioral Health Services in Medicaid Managed Care

Telehealth generally involves the use of electronic information and telecommunication technologies to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. States have significant flexibility to provide telehealth services and all 50 States and the District of Columbia currently provide some Medicaid coverage of telehealth; however, limited information is available about how States use telehealth to provide behavioral health services to Medicaid enrollees. This review will describe: (1) the challenges that States face using telehealth to provide behavioral health services to Medicaid enrollees, (2) the extent to which States assess the effects of telehealth on access, cost, and quality and monitor telehealth to provide behavioral health services, and (3) how States use telehealth to provide behavioral health services in Medicaid managed care. OIG collected data for these products prior to States' expanding telehealth in response to the COVID-19 pandemic; however, this information continues to be valuable in future decisions to strengthen telehealth on a more permanent basis.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Opportunities Exist to Strengthen Evaluation and Oversight of Telehealth for Behavioral Health in Medicaid (OEI-02-19-00401)

OIG found that, while most States can identify which services are provided via telehealth, a few reported being unable to, limiting their ability to evaluate and oversee telehealth. In addition, only a few States have evaluated the effects of telehealth in their State; these States found increased access and reduced costs. Based on their own experiences, other States believe that telehealth increases access, has uncertain impacts on costs, and raises concerns about quality. Further, despite concerns about fraud, waste, and abuse, many States do not conduct monitoring and oversight specific to telehealth.

OIG recommended that CMS: (1) ensure that the three States that are unable to distinguish telehealth from in-person services implement indicators to identify which services are provided via telehealth; (2) conduct evaluations, and support State efforts to evaluate the effects of telehealth on access, cost, and quality of behavioral health services; and (3) conduct monitoring for fraud, waste, and abuse, and support State efforts to oversee telehealth for behavioral health services.

States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees (OEI-02-19-00400)

OIG found that most States reported multiple challenges with using telehealth, including a lack of training for providers and enrollees, limited internet connectivity for providers and enrollees, difficulties with providers' protecting the privacy and security of enrollees' personal information, and the cost of telehealth infrastructure and interoperability issues for providers. Some States also reported other challenges, including a lack of licensing reciprocity and difficulties with providers obtaining informed consent from enrollees. These challenges limit States' ability to use telehealth to meet the behavioral health needs of Medicaid enrollees.

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OIG recommended that CMS share information to help States address the challenges they face with using telehealth. This information could include examples from States that describe how they have responded to these challenges. It could also include best practices from States and information about working with other State and Federal partners. Further, CMS could collect information from States detailing their experiences and lessons learned in response to the COVID-19 pandemic that address these challenges.

Work Plan #: OEI-02-19-00401 (September 2021); OEI-02-19-00400 (September 2021)
Government Program: Medicaid

On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services

Medicare paid approximately $2.2 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar years 2017 and 2018. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services.

SunHawk Summary of OIG Audit Findings and Recommendations

On-Site Psychological Services, P.C. (A-02-19-01012)

OIG reported that 111 claims for psychotherapy services did not comply with Medicare billing requirements. Specifically, OIG reported that beneficiaries' treatment plans did not comply with Medicare requirements, therapeutic maneuvers were not specified in beneficiaries' treatment notes (9 claims), and treatment notes did not support services billed (5 claims). OIG also identified potential quality-of-care issues related to all 120 claims for psychotherapy services: beneficiaries' treatment plans did not document if a beneficiary's condition improved or had a reasonable expectation of improvement (111 claims) and treatment notes were "signed" with digital images of clinicians' signatures (109 claims). Based on OIG's sample results, OIG estimated that On-Site received at least $3.3 million in Medicare overpayments for psychotherapy services. These deficiencies allegedly occurred because On-Site's management oversight did not ensure that treatment plans were maintained or contained all required elements, therapeutic maneuvers utilized by clinicians were properly documented in treatment notes, and reliable treatment notes were maintained to support services billed. In addition, on-site also did not have controls in its electronic recordkeeping system to allow for electronic signatures.

OIG recommended that On-Site (1) refund to the Medicare program the estimated $3.3 million overpayment; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its management oversight to ensure that it properly maintains treatment plans that contain all required elements, therapeutic maneuvers utilized by clinicians are properly documented in treatment notes, and it properly maintains reliable treatment notes to support services billed; and (4) implement controls for authenticating signatures on treatment notes.

Grant Desert Psychiatric Services (A-09-19-03018)

OIG reported that 99 services did not comply with the requirements (the total below exceeds 99 because 29 services had more than 1 deficiency): As a result, Grand Desert received $5,173 in unallowable Medicare payments. On the basis of

OIG's sample results, OIG estimated that at least $421,272 were unallowable for Medicare reimbursement, or 93 percent of the $450,663 paid to Grand Desert for psychotherapy services.

OIG recommended that Grand Desert (1) refund to the Medicare contractor $421,272 in estimated overpayments for psychotherapy services; (2) implement policies and procedures to ensure that psychotherapy services billed to Medicare are adequately documented, including the time spent on those services; (3) strengthen management oversight and review Medicare claims to ensure that psychotherapy services billed to Medicare meet incident-to requirements; (4) improve its billing system to ensure that Medicare claims identify the correct provider of psychotherapy services; and (5) strengthen management oversight to ensure that psychotherapy services billed to Medicare were actually provided and have supporting documentation.

Oceanside Medical Group (A-09-18-03004)

OIG reported that Oceanside did not comply with Medicare requirements when billing for psychotherapy services. Specifically, none of the 100 sampled beneficiary days, consisting of 103 psychotherapy services, complied with Medicare requirements: psychotherapy was not provided (52 services), psychotherapy time was not documented (49 services), and adequate supporting documentation was not provided (2 services). As a result, Oceanside received $5,317 in unallowable Medicare payments. Based on OIG's sample results, OIG estimated that Oceanside received at least 2.6 million in unallowable Medicare payments for psychotherapy services. These overpayments occurred because Oceanside did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were provided, adequately documented, and correctly billed.

OIG recommended that Oceanside (1) refund to the Medicare program the portion of the estimated $2.6 million overpayment for claims that are within the reopening period; (2) for the remaining portion of the estimated 2.6 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and (4) implement policies and procedures and strengthen management oversight to ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed.

Work Plan #: A-02-19-01012 (July 2020); A-09-19-03018 (April 2020); A-09-18-03004 (August 2019)
Government Program: Medicare A & B

An Estimated 87 Percent of Inpatient Psychiatric Facility Claims with Outlier Payments Did Not Meet Medicare's Medical Necessity or Documentation Requirements

Under the inpatient psychiatric facility (IPF) prospective payment system (PPS), Medicare pays IPFs a standard per diem rate for inpatient services, modified for patient- and facility-level characteristics and length of stay. In addition, the IPF PPS includes an outlier payment policy that makes an additional payment in cases with unusually high costs to limit financial losses to IPFs. For this audit, OIG focused on claims that resulted in outlier payments because the number of

those claims increased by 28 percent from fiscal year (FY) 2014 to FY 2015, and total Medicare payments for those claims (including the outlier payment portion) increased from $450 million to $534 million (19 percent).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS paid 25 claims that did not meet Medicare medical necessity requirements for some or all days of the stay. Based on OIG sample results, OIG estimated that Medicare overpaid IPFs $93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. However, if the patients had been treated in different settings, Medicare might have covered those treatments. In addition, 142 claims had missing or inadequate medical record elements, including physician certifications. Of those 142 medical records, 12 did not clearly support that the IPF had protected the patient's right to make informed decisions regarding care. OIG estimated that 87 percent of IPF claims for FYs 2014 and 2015 with outlier payments did not meet Medicare medical necessity or medical record requirements. CMS oversight activities were not adequate to prevent or detect the IPFs' errors. Finally, OIG identified three additional areas of concern: (1) outlier payments may have been made for stays that were not unusually costly, (2) beneficiaries used lifetime reserve days to help pay for days when they no longer required inpatient hospitalization but for the unavailability of appropriate posthospitalization placements, and (3) CMS did not track patient falls or fall rates at IPFs.

OIG made recommendations to (1) increase the number of post-payment reviews to provide more feedback to IPFs, (2) promulgate regulations on the patient's right to make informed decisions regarding care, (3) study the accuracy of the outlier payment methodology, (4) consider tracking patient falls or fall rates, (5) research whether the physician certification requirements are useful in preventing inappropriate payments and then take appropriate follow up action, (6) CMS require certifications to be in a specific format to aid in auditing, and (7) study the lifetime reserve day issue.

Work Plan #: A-01-16-00508 (April 2020)
Government Program: Medicare Parts A & B

Medicaid Claims for Opioid Treatment Program Services

Medicaid is a significant source of coverage and funding for behavioral health treatment services, including treatment of substance abuse. Some Medicaid State agencies provide payment for Opioid Treatment Program (OTP) services. Services can be provided at freestanding and hospital-based OTPs. OIG determined whether selected State agencies complied with certain Federal and State requirements when claiming Medicaid reimbursement for OTP services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that New York claimed Federal Medicaid reimbursement for OTP services that did not comply with federal and state requirements. 115 claims complied with Medicaid requirements, but 35 claims did not. In addition, 299 claims totaling $8,905 ($5,830 Federal share) were billed in error. Specifically, 220 claims were duplicate claims, and 79 claims were for services that the providers stated were not provided. Based on OIG sample results, OIG estimated that New York improperly claimed at least $39.3 million in Federal Medicaid reimbursement for OTP services during OIG audit period.

OIG recommended that New York (1) refund $39.3 million to the Federal Government, (2) ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and (3) implement procedures to detect and prevent duplicate claims for OTP services.

Work Plan #: A-02-17-01021 (February 2020); W-00-17-31523
Government Program: Medicaid

Assertive Community Treatment Program

The Assertive Community Treatment (ACT) program offers treatment, rehabilitation, and support services using a person-centered, recovery-based approach to individuals who have been diagnosed with severe and persistent mental illness. Individuals receive ACT services including assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support from a mobile, multidisciplinary team in community settings. Prior OIG work has shown vulnerabilities in states' mental health programs and their rate-setting methodologies, resulting in Medicaid payments that do not comply with federal and state requirements. OIG determined whether (1) Medicaid payments for ACT services complied with Federal and State requirements and (2) the payment rate for ACT services met the Federal requirement that payment for services be consistent with efficiency, economy, and quality of care.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that 50 of New Jersey's sampled claims did not comply with federal and state requirements. Of the 100 claims, 21 contained more than 1 deficiency. OIG found PACT program services provided were not adequately supported or documented (36 claims), plan of care requirements were not met (17 claims), PACT teams did not include staff from required clinical disciplines (8 claims), and providers did not obtain prior authorization for beneficiaries (5 claims), among other findings. OIG also identified potential quality-of-care issues related to PACT services. Specifically, PACT team psychiatrists associated with 33 of OIG sample claims did not provide the minimum amount of face-to-face psychiatric time required for their caseload. Also, despite defining the PACT program as rehabilitative, New Jersey did not require periodic reauthorizations or reevaluations of beneficiaries' program eligibility.

OIG recommended that New Jersey (1) refund $14.9 million to the Federal Government, (2) reinforce program guidance to PACT providers, (3) improve its monitoring of the PACT program, and (4) consider developing regulations for periodic reassessments to determine whether beneficiaries continue to require PACT services. maintain that OIG findings and recommendations, as revised, are valid.

Work Plan #: A-02-17-01020 (January 2020); A-02-17-01008 (October 2018); A-02-17-01009; W-00-17-31521
Government Program: Medicaid

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Provider

Laboratory

CMS Needs To Issue Regulations Related to Phlebotomy Travel Allowances

Medicare pays a specimen collection fee when it is medically necessary for a clinical laboratory technician to draw a specimen for a clinical diagnostic laboratory test. In addition, when a technician travels to a nursing home or to a homebound patient's residence and a specimen collection fee is payable, the Social Security Act provides for payment of a phlebotomy travel allowance.

For this audit, OIG focused on two previous audits (see A-06-17-04005 and A-06-17-04002 and **Medicare Part B Payments for Laboratory Services** on page #) of phlebotomy travel allowance payments for clinical diagnostic laboratory tests made by two Medicare administrative contractors (MACs) from January 1, 2015, through December 31, 2016, and on current travel allowance guidance. OIG's objectives were to (1) summarize the results of our previous two audits that identified instances in which payments made by two MACs to providers for phlebotomy travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare guidance and (2) review Centers for Medicare & Medicaid Services (CMS) guidance related to phlebotomy travel allowances to determine whether there have been any updates.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the two MACs paid providers for phlebotomy travel allowances that did not comply with Medicare guidance. Specifically, in OIG's 2 MAC audits, 93 of the 202 sampled paid claim lines we reviewed complied with Medicare guidance, but 109 paid claim lines did not. (Some lines did not comply for more than one reason.) Errors identified in those audits were related to incorrect prorated mileage, incorrect payment rates, and inadequate documentation. On the basis of the sample results, OIG estimated that the two MACs paid providers a combined $2.7 million in phlebotomy travel allowance payments that were not in accordance with Medicare guidance. In addition, we spoke with CMS in June 2020 and, at that time, it had not begun the notice and comment rulemaking process necessary to clarify provider guidance related to prorating mileage on claims for phlebotomy travel allowances or issue further guidance.

OIG recommended that CMS (1) work with the MACs to educate providers about the documentation requirements for phlebotomy travel allowances, (2) instruct the MACs to identify and adjust any paid claims that incorrectly used the previous year's rate, and (3) issue regulations related to phlebotomy travel allowances.

Work Plan #: A-06-20-04000 (August 2021)
Government Program: Medicare Parts A & B

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Opportunities Exist for CMS and Its Medicare Contractors To Strengthen Program Safeguards To Prevent and Detect Improper Payments for Drug Testing Services

Patients in active treatment for substance use disorder may also be treated for a variety of medical conditions. Medicare Part B covers these patients' drug testing services when reasonable and necessary. For 2019, Medicare paid $180 million for such services provided to 274,000 beneficiaries with substance use disorders nationwide. Although the 2019 Medicare fee-for-service improper payment rate was 7.3 percent, the improper payment rate was 58.9 percent for the drug test with the highest Medicare fee schedule amount. OIG conducted this audit to evaluate how the Centers for Medicare & Medicaid Services (CMS) and its Medicare contractors addressed the risk for improper payments for drug testing services.

OIG's objective was to assess the Medicare contractors' program safeguards for ensuring that Medicare claims for drug testing services for beneficiaries with substance use disorders comply with Medicare requirements.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG identified three weaknesses in the Medicare contractors' established program safeguards for preventing and detecting improper payments for drug testing services and promoting provider compliance with Medicare requirements. Specifically, the contractors did not have: (1) clear and consistent requirements or guidance for laboratories to use when determining the number of drug classes to bill for definitive drug testing services, (2) procedures for identifying or limiting the frequency of drug testing services (e.g., the number of drug tests performed per year) for each beneficiary across all Medicare jurisdictions, and (3) consistent requirements in their LCDs or any procedures for identifying claims for direct-to-definitive drug testing. If CMS and its contractors cannot ensure that laboratories' claims for drug testing services comply with Medicare requirements, laboratories may receive improper payments, and beneficiaries with substance use disorders may receive medically unnecessary drug testing services.

OIG recommended that CMS work with its Medicare contractors to: (1) take the necessary steps to determine whether clinical evidence exists to support a single, specific reasonable and necessary standard for drug testing services, and if such evidence exists, establish a National Coverage Determination or develop LCDs with more consistent requirements for drug testing services; (2) clearly indicate in LCDs, Local Coverage Articles, or other instructions how laboratories should determine the number of drug classes for billing definitive drug testing services; (3) implement a system edit or procedure to identify and limit the frequency of drug testing services per beneficiary across all Medicare jurisdictions; (4) determine whether a postpayment medical review is necessary for laboratories that have been paid for excessive definitive drug tests (e.g., more than one test) in a 1-week period for the same beneficiary; and (5) consider adding a modifier to claims for definitive drug tests indicating whether a test was based on results obtained from a presumptive drug test.

Work Plan #: A-09-20-03017 (June 2021)
Government Program: Medicare Parts A & B

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Provider

Medicare Laboratory Test Expenditures Increased in 2018, Despite New Rate Reductions

Effective in 2018, the Medicare program changed the way it sets payment rates for clinical diagnostic laboratory tests. CMS replaced the previous payment rates with new rates based on private payer data collected from labs. This is the first reform in three decades to Medicare's payment system for lab tests. As part of the same legislation reforming Medicare's payment system, Congress mandated that OIG monitor Medicare payments for lab tests as well as the implementation and effect of the new payment system for those tests.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that Medicare spent $7.6 billion for lab tests in 2018, a $459 million increase from $7.1 billion for 2017. Although payment rates for most tests decreased in 2018, savings that resulted from lower rates were overtaken by increased spending on other tests. Spending on genetic tests increased from $473 million in 2017 to $969 million in 2018 because of new and expensive tests entering the Clinical Laboratory Fee Schedule (CLFS), as well as an increase in the volume of existing genetic tests. Spending on certain chemistry tests also increased by $82 million in 2018 following the end of a discount on these tests. Finally, a one-time spending increase on some tests occurred in cases in which the national rate was higher than the local payment rates that it replaced.

OIG recommended that CMS seek legislative authority to establish a mechanism to control costs for automated chemistry tests. Although CMS does not currently have statutory authority to restore the discount that it had previously used to ensure efficient pricing for these tests, CMS should seek legislative change to regain such authority.

Work Plan #: OEI-09-19-00100 (August 2020)
Government Program: Medicare Parts A & B

Medicare Part B Payments for Laboratory Services

Previous OIG audits, investigations, and inspections have identified areas of billing for clinical laboratory services that are at risk for noncompliance with Medicare billing requirements. Payments to service providers are precluded unless the provider furnishes on request the information necessary to determine the amounts due. OIG reviewed Medicare payments for clinical laboratory services to determine laboratories' compliance with selected billing requirements. OIG focused on claims for clinical laboratory services that may be at risk for overpayments. For example, OIG's review focused on the improper use of claim line modifiers for a code pair, genetic testing, and urine drug testing services. OIG may use the results of these reviews to identify laboratories or other institutions that routinely submit improper claims.

SunHawk Summary of OIG Audit Findings and Recommendations

Novitas (A-06-17-04002)

OIG reported that payments made by Novitas to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, 17 of the 93 claim lines in OIG stratified random sample complied with Medicare requirements, but 76 claim lines did not (some lines had multiple deficiencies). Novitas made

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payments to providers for (1) claims with incorrectly calculated prorated mileage, (2) claims using the incorrect clinical laboratory fee schedule rate, and (3) claims without sufficient documentation to support payment. Based on OIG sample results, OIG estimated that Novitas paid providers $2.4 million in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

OIG recommended that Novitas (1) work with the Centers for Medicare & Medicaid Services to clarify guidance to providers, which could have resulted in savings totaling an estimated $2.4 million during OIG audit period; (2) educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments; (3) educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the incorrect payment rate; and (4) educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

ProLab (A-06-16-02002)

OIG reported that ProLab generally did not comply with Medicare requirements for billing travel allowances. Specifically, 35 claim lines complied with Medicare requirements and 65 claim lines did not (some lines had multiple deficiencies). ProLab did not (1) support prorated miles with documentation when multiple patients were served on a single trip, (2) resubmit claims when there was a retroactive change in the clinical laboratory fee schedule, and (3) have documentation to support specimen collections.

OIG recommended that ProLab (1) refund to the Medicare program the portion of the estimated $319,277 overpayment for claims incorrectly billed that are within the reopening period; (2) for the remaining portion of the estimated $319,277 overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation; and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.

Work Plan #: A-09-19-03027 (May 2021); A-06-17-04002 (December 2019); A-06-16-02002 (October 2018); A-09-16-02034 (February 2018); W-00-17-35726; W-00-20-35726; various reviews
Government Program: Medicare Part B

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Provider

Telehealth

OIG Determines Telemedicine Services Require Improved Documentation

Medicaid telemedicine services are health services delivered via telecommunication systems. A Medicaid patient located at a patient site uses audio and video equipment to communicate with a physician or licensed practitioner located at a distant site. Medicaid views telemedicine services as a cost-effective alternative to the more traditional face-to-face way of providing medical care. OIG's objective for these audits was to determine whether selected states complied with federal and state requirements when claiming federal reimbursement for telemedicine services.

SunHawk Summary of OIG Audit Findings and Recommendations

Illinois (A-05-18-00028)

OIG reported that 28,647 Medicaid fee-for-service telemedicine payments in OIG's population, 6,260 payments were unallowable. For 6,205 of the unallowable payments, the same provider was paid for both the originating site and distant site fee. Fifty-three claims were inaccurately coded as both originating and distant site fees. The remaining two unallowable payments were payments for the same originating site fee in the same day. This noncompliance occurred because Illinois did not give providers formal training on telemedicine billing requirements or adequately monitor compliance. Based on OIG's testing, OIG determined that Illinois made unallowable payments of $198,124 ($124,812 federal share) during OIG's audit period.

OIG recommended that Illinois refund $124,812 to the Federal Government, give providers formal training on telemedicine billing requirements, and enhance the monitoring of provider compliance by conducting periodic reviews of telemedicine payments for compliance with billing requirements.

Texas (A-06-18-05001)

OIG reported that the provider submitted a claim for a professional service with the telemedicine modifier, however, OIG determined that it was a face to face visit and not a telemedicine service. OIG reported that this reportedly incorrect billing did not affect the Medicaid payment amount that the provider received.

This OIG report included no recommendations.

South Carolina (A-04-18-00122)

OIG reported that South Carolina made 97 telemedicine payments that were not in accordance with Federal and State requirements and were therefore unallowable. For 95 unallowable payments, the providers documented neither the start and stop times nor the consulting site location of the medical service. The remaining two unallowable payments were for in-office consultations, not telemedicine services. This noncompliance occurred because South Carolina did not give providers formal training on telemedicine documentation requirements or adequately monitor compliance. Based on OIG's sample results, OIG estimated that 96 percent of South Carolina's Medicaid fee-for service telemedicine payments were unallowable. OIG also estimated that unallowable payments totaled at least $2.1 million ($1.5 million Federal share) during OIG audit period.

Provider

OIG recommended that South Carolina refund $1.5 million to the Federal Government, give providers formal training on telemedicine documentation requirements, and enhance the monitoring of provider compliance by conducting periodic reviews of telemedicine payments for compliance with documentation requirements.

Work Plan #: A-05-18-00028 (August 2020); A-06-18-05001 (June 2020); A-04-18-00122 (April 2020)
Government Program: Medicaid

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Provider

Other Providers and Suppliers

[NEW] An Ophthalmology Clinic in Florida: Audit of Medicare Payments for Eye Injections of Avastin, Eylea, and Lucentis

Prior OIG work found that Medicare inappropriately paid for services that were billed as being distinct or significant and separately identifiable from other services provided on the same day. OIG's analysis showed that in 2018, an ophthalmology clinic in Florida (the Clinic) frequently billed for other services as being distinct from or significant and separately identifiable from intravitreal (inside the eye) injections of the drugs Avastin, Eylea, and Lucentis.

OIG's objective was to determine whether the Clinic complied with Medicare requirements when billing for intravitreal injections of Avastin, Eylea, and Lucentis and for other services provided on the same day as the injections.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Clinic did not always comply with Medicare requirements when billing for other services provided on the same day as the intravitreal injections (e.g., injections of an anesthesia drug). All 100 sampled beneficiary days included at least 1 service that did not comply with Medicare requirements. For 317 of the 543 services and drugs associated with the 100 sampled beneficiary days, the Clinic complied with Medicare requirements. However, for the remaining 226 services, the Clinic did not comply with the requirements: 156 services were not separately payable, and 70 services were not reasonable and necessary.

The Clinic did not have policies and procedures to ensure that it: (1) did not bill for services that were not separately payable from intravitreal injections of Avastin, Eylea, and Lucentis and (2) billed only for services that were reasonable and necessary. On the basis of OIG's sample results, OIG estimated that at least $215,606 of the $2.1 million paid to the Clinic for intravitreal injections of Avastin, Eylea, and Lucentis and for other services provided on the same day as the injections was unallowable for Medicare reimbursement.

OIG recommended that the Clinic refund to the Medicare contractor $215,606 in estimated overpayments for other services provided on the same day as intravitreal injections of Avastin, Eylea, and Lucentis. OIG also recommend that the Clinic implement policies and procedures to ensure that it: (1) does not bill for services that are not separately payable from intravitreal injections of Avastin, Eylea, and Lucentis and (2) bills only for services that are reasonable and necessary. The report contains one other recommendation.

Work Plan #: A-09-19-03025 (September 2021)
Government Program: Medicare Parts A & B

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Provider

Medicare Continues to Make Overpayments for Chronic Care Management Services, Costing the Program, and Its Beneficiaries Millions of Dollars

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established a policy for Medicare to pay under the Medicare Physician Fee Schedule for chronic care management (CCM) services rendered to beneficiaries whose medical conditions meet certain criteria. Effective January 1, 2017, CMS unbundled complex CCM from noncomplex CCM and began paying separately for complex CCM. Although scope of service and billing requirements are the same for noncomplex CCM as for complex CCM, the two types of services differ as to clinical staff time, medical decision making, and care planning. CCM services are a relatively new category of Medicare-covered services and are at higher risk for overpayments. This audit expands on the findings of a previous Office of Inspector General audit.

OIG's objective was to determine whether payments made by CMS to providers for noncomplex and complex CCM services rendered during calendar years (CYs) 2017 and 2018 complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all payments made by CMS to providers for noncomplex and complex CCM services rendered during CYs 2017 and 2018 complied with Federal requirements, resulting in $1.9 million in overpayments associated with 50,192 claims. OIG identified 38,447 claims resulting in $1.4 million in overpayments for instances in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period. OIG also identified 10,882 claims that resulted in $438,262 in overpayments for instances in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods. Further, OIG identified 863 claims that resulted in $52,086 in overpayments for incremental complex CCM services that were billed along with complex CCM services that OIG identified as overpayments. For these 50,192 claims, beneficiaries' cost sharing totaled up to $540,680.

OIG recommended that CMS direct the Medicare contractors to: (1) recover the $1.9 million for claims that are within the reopening period, and instruct providers to refund up to $540,680, which beneficiaries were required to pay; (2) based on the results of this audit, notify appropriate providers so that they can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) implement claim system edits to prevent and detect overpayments for noncomplex and complex CCM services. OIG also recommended that CMS implement claim system edits at its level.

Work Plan #: A-07-19-05122 (August 2021)
Government Program: Medicaid

Medicare Made Millions of Dollars in Overpayments for End-Stage Renal Disease Monthly Capitation Payments

Recovery Audit Contractors (RACs) assist the Centers for Medicare & Medicaid Services (CMS) by performing audits of monthly capitation payments (MCPs) for end-stage renal disease (ESRD) patients receiving four or more visits per month.

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These audits have identified claims with improper payments. An MCP is a monthly payment made to physicians for dialysis-related physician services provided to Medicare ESRD patients. Only one physician may receive an MCP for all ESRD-related services provided to a Medicare beneficiary during a calendar month. The RAC audits found that this was not always the case: some of these audits identified claims that were improperly paid, because they reflected more than one MCP for ESRD-related services provided to the same beneficiary for the same calendar month.

OIG's objective was to determine whether CMS made Medicare MCPs to physicians for monthly ESRD-related services provided in calendar years (CYs) 2016 through 2018 in accordance with Federal requirements. OIG's audit covered $12.2 million in Medicare MCPs to physicians for 53,608 claims for monthly ESRD-related services with dates of service in CY 2016, CY 2017, or CY 2018 that OIG identified as at risk for noncompliance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 23,695 claims were for services for which physicians reported monthly ESRD-related billing codes more than once for the same beneficiary for the same month. These claims consisted of 21,763 claims that resulted in $4 million in overpayments for instances in which different physicians reported codes for services and 1,932 claims that resulted in $291,813 in overpayments for instances in which the same physician reported codes for services. Beneficiaries were responsible for up to $1.1 million in cost sharing related to these 23,695 claims. OIG is setting aside potential overpayments related to an additional 1,598 claims totaling $289,169 and $74,563 in beneficiary cost sharing for CMS's review and determination. CMS did not have adequate claims processing controls in place, to include system edits, to identify and prevent these overpayments.

OIG recommended that CMS direct the Medicare contractors to: (1) recover the $4 million for claims that are within the reopening period; (2) recover the $291,813 for claims that are within the reopening period; (3) instruct the physicians to refund the $1.1 million in beneficiary cost-sharing amounts; (4) review the 1,598 claims for potentially duplicate claims, determine which should have been denied, and take follow up actions; (5) based on the results of this audit, notify physicians so that they can exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule and identify any returned overpayments as according with this recommendation; and (6) implement improved claims processing controls, including improved system edits, to prevent and detect overpayments.

Work Plan #: A-07-19-05117 (May 2021)
Government Program: Medicare Parts A & B

CMS Needs to Strengthen Regulatory Requirements for Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services to Ensure Providers Fully Meet Coverage Requirements

Previous OIG work identified Medicare claims for cardiac and pulmonary rehabilitation services that did not comply with Federal requirements. Preliminary work reviewing one provider's compliance identified broader, significant concerns with Centers for Medicare & Medicaid Services (CMS) regulations; therefore, OIG determined that an audit of CMS's Medicare cardiac and pulmonary rehabilitation programs could identify potential areas for improvement and reduce provider errors as well as result in monetary savings. OIG's objective was to determine whether CMS regulatory requirements contained

sufficient information to ensure that claims for outpatient cardiac and pulmonary rehabilitation services complied with Medicare coverage requirements.

OIG selected for review the third highest-paid provider in the country in combined Medicare reimbursement for both outpatient cardiac and pulmonary rehabilitation services. OIG reviewed a random sample of 100 beneficiary-days. OIG submitted 10 beneficiary-days to an independent medical review contractor and evaluated all 100 beneficiary-days for compliance with applicable requirements and to determine whether services complied with Medicare coverage and documentation requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS regulatory requirements related to Medicare outpatient cardiac and pulmonary rehabilitation services did not contain sufficient information to ensure that claims for these services met Medicare coverage requirements. Specifically, the requirements lacked details related to what patient-specific information should be contained in a beneficiary's medical record and how this information should relate to their individualized treatment. As a result, for all 100 sampled beneficiary-days, OIG determined that medical record documentation obtained from the selected provider did not contain sufficient evidence to support whether Medicare coverage requirements for reimbursement of cardiac and pulmonary rehabilitation services were met. Based on OIG's sample results, OIG estimated that $2.7 million in Medicare payments made by CMS to the selected provider for outpatient cardiac and pulmonary rehabilitation services may not have met Medicare coverage requirements, as intended. Further, based on OIG's review, OIG believes that Medicare payments totaling approximately $626 million made by CMS to all providers for outpatient cardiac and pulmonary rehabilitation services during OIG's audit period may not have met the requirements.

OIG recommended that CMS revise its regulations to provide sufficient guidance to ensure that providers meet coverage requirements for outpatient cardiac and pulmonary rehabilitation services.

Work Plan #: A-02-18-01026 (May 2021)
Government Program: Medicare Parts A & B

States Claimed Medicaid Reimbursement for Services that did not Comply with Federal and State Requirements

The Medicaid program pays for nonemergency medical transportation (NEMT) services that a state determines to be necessary for beneficiaries to obtain care. Prior OIG audit reports have consistently identified NEMT services as vulnerable to fraud, waste, and abuse. OIG's objective was to determine whether States claimed Federal Medicaid reimbursement for NEMT service claims in accordance with federal and state requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

Massachusetts (A-01-19-00004)

OIG reported that Massachusetts claimed Federal Medicaid reimbursement for 86 of 100 sampled lines of service submitted by transportation providers that did not comply with certain Federal and State requirements. The improper claims for unallowable services were made because the State's monitoring and oversight of the NEMT program did not

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Other Providers and Suppliers

ensure that NEMT services were for qualifying medical services and were adequately documented. In addition, for all 100 sample items, driver qualifications and vehicle inspection, registration, and maintenance policies or schedules were not adequately documented.

OIG recommended that Massachusetts: (1) refund $7,071,365 million to the Federal Government, (2) perform data matches to all claims billed on the day of an NEMT service to ensure only NEMT claims are paid when there is a corresponding qualifying medical service, (3) work with its brokers to ensure that documentation contains all necessary elements to support the NEMT service, (4) evaluate opportunities to better monitor transportation services, and (5) work with its brokers to implement controls that ensure drivers and vehicles used to provide NEMT services can be directly and clearly traced to the correct driver qualifications and vehicle records.

Indiana (A-05-18-00043)

OIG reported that at least 113,086 Medicaid claims, totaling $3.5 million (federal share), did not comply with federal and state regulations. The claims for unallowable services were made because Indiana's monitoring and oversight of the Medicaid program did not ensure that providers complied with federal and state requirements for documenting and claiming NEMT services. After OIG's audit period, Indiana took additional steps to increase the oversight and monitoring of the NEMT program by contracting with a broker to administer the NEMT program.

OIG recommended that the State agency: (1) refund $3.5 million to the Federal Government, and (2) require its broker to have procedures in place to strengthen the monitoring and oversight of the NEMT program to ensure that providers document all services in accordance with federal and state requirements and maintain the correct documentation to support the services provided and provider qualifications.

Work Plan #: A-01-19-00004 (January 2021); A-05-18-00043 (August 2020)
Government Program: Medicaid

Medicare Dialysis Services Provider Compliance Review: Bio-Medical Applications of Arecibo, Inc.

Medicare Part B covers dialysis services for beneficiaries with end-stage renal disease (ESRD). Prior OIG reviews identified inappropriate Medicare payments made for ESRD (dialysis) services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements. OIG selected Bio-Medical Applications of Arecibo, Inc. (BMA), for review because it ranked among the highest-paid providers of dialysis services in Puerto Rico and Medicare surveyors identified various health and safety issues. OIG's objective was to determine whether dialysis services provided by BMA complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that BMA claimed reimbursement for dialysis services that did not comply with Medicare requirements during 96 sampled beneficiary-months. Specifically, BMA submitted claims for which (1) plans of care and/or comprehensive assessments did not meet Medicare requirements, (2) beneficiaries' height and/or weight measurements did not comply with Medicare requirements, (3) there were no valid physicians' orders, (4) dialysis treatments were not completed, (5) ESRD measurements were not supported and (6) home dialysis services were not documented. While

Provider

BMA had internal controls to monitor and maintain complete, accurate, and accessible medical records, these controls were not always effective or followed to ensure that its claims for dialysis services complied with Medicare requirements. OIG estimated that BMA received unallowable Medicare payments of at least $96,185 for dialysis services that did not comply with Medicare requirements. Most of the errors OIG identified did not affect BMA's Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have a significant impact on the quality of care provided to Medicare beneficiaries and could result in the provision of inappropriate or unnecessary dialysis services

OIG recommended BMA refund an estimated $96,185 to the Medicare program.

Work Plan #: A-02-17-01016 (March 2020)
Government Program: Medicare Parts A & B