Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Provider Focus

March 2022

SUNHAWK CONSULTING

Prepared by SunHawk Consulting LLC

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 organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan 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 OIG Work Plan sets forth various projects, including OIG audits and evaluations, that are underway or planned to be addressed during the fiscal year and beyond. The Work Plan item summaries provided herein are referenced by their respective Work Plan numbers at the end of each abstract. SunHawk's report summarizes currently active Work Plan items and sorts relevant Work Plans items into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original Work Plan item summaries.

We review all OIG Work Plan items that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused Work Plan items, 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, we would appreciate any feedback that would make this report more valuable to you or others. 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 offertheir 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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Provider

All Providers

Follow-up Audit on CMS's Use of Medicare Data To Identify Instances of Potential Abuse or Neglect

Expected Issue Date: 2023
Announced/Revised: January 2022

A prior audit (A-01-17-00513) identified 34,664 Medicare claims containing diagnosis codes that indicated Medicare beneficiaries were treated for injuries possibly caused by abuse or neglect from January 1, 2015, through June 30, 2017. It estimated that 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. CMS did not identify the Medicare claims that indicate potential abuse or neglect because, according to CMS officials, it did not extract data consisting of Medicare claims with diagnosis codes related to abuse or neglect. The lack of a data extract impeded the ability of CMS and public and patient safety organizations to pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare beneficiaries. This audit is a follow-up to determine whether CMS improved its use of Medicare data to identify incidents of potential abuse and neglect since OIG issued their previous report. OIG will also determine: (1) the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries in 2019 and 2020, (2) who may have perpetrated those incidents and where they occurred, (3) and whether the incidents were reported to law enforcement.

Work Plan #: W-00-22-35882
Government Program: Centers for Medicare and Medicaid Services

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Audit of Centers for Disease Control and Prevention's Vaccines for Children Program Requirement for Provider Site Visits

Expected Issue Date: 2023
Announced/Revised: December 2021

The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to eligible children through health care providers enrolled in the program. The Centers for Disease Control and Prevention (CDC) has the lead responsibility for policy development and implementation of the VFC program. CDC buys vaccines at a discount and distributes them to grantees-i.e., State health departments and certain local and territorial public health agencies-which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC providers. To ensure the quality of VFC vaccines and the integrity of the VFC program, CDC requires grantees to conduct: (1) an enrollment site visit for all new and re-enrolling VFC providers before they receive VFC vaccines; (2) compliance site visits for all enrolled and active VFC providers every 24 months; and (3) unannounced storage and handling site visits at a minimum of 5 percent of VFC providers during the cooperative agreement budget period. Site visits help determine provider compliance with VFC Program requirements, including adherence to vaccine eligibility screening and documentation, accountability, and management. OIG will conduct an audit to determine whether CDC VFC grantees conducted site visits at enrolled and active VFC program providers that provide routine childhood vaccines (not COVID-19 vaccines) according to program requirements. Due to the COVID-19 pandemic, OIG will identify alternative procedures or approaches that grantees may have taken to complete site visits.

Provider

Work Plan #: W-00-22-59464
Government Program: Centers for Disease Control and Prevention

Accuracy of Place-of-Service Codes on Claims for Medicare Part B Physician Services When Beneficiaries Are Inpatients Under Part A

Expected Issue Date: 2022
Announced/Revised: June 2021

Generally, Medicare makes payments under Part B for physician services and payments under Part A for the costs of inpatient stays at inpatient facilities such as skilled nursing facilities (SNFs) and hospitals. While Medicare pays both SNFs and hospitals through prospective payment systems for the costs of inpatient stays, physician services provided to SNF and hospital inpatients are paid according to the Medicare Physician Fee Schedule. The amount Medicare pays physician service providers (such as physicians, podiatrists, and nurse practitioners, referred to collectively as "physicians") can vary based on where the service is provided (such as a SNF, hospital, or physician's office). Physician services can include medical and surgical procedures, office visits, and medical consultations. Fee schedule payments for physician services are based on three major categories of physician costs: practice expense, physician work, and malpractice insurance. The practice expense is intended to cover overhead costs involved in providing a service. To account for different practice expenses that physicians incur at different settings, Medicare designates a nonfacility rate and a facility rate for each service within the fee schedule. Because physicians generally incur higher practice expenses by performing services in their offices and other nonfacility settings such as independent clinics and urgent care facilities, Medicare generally reimburses physicians at a higher nonfacility rate for services performed in these settings. For services performed at a facility setting such as a SNF or hospital, Medicare generally reimburses physicians for services at a lower facility rate, and the prospective payment system payment to the facility covers the overhead expense. Physicians indicate the applicable place of service on a Medicare claim using a two-digit place-of-service code to ensure that Medicare properly reimburses the physician at either the nonfacility rate or the facility rate. The physical setting where a physician performs a service does not always determine the appropriate place-of-service code. For example, when a beneficiary is a registered inpatient at a hospital or SNF, physician services should always be coded with a facility place-of-service code and paid at the facility rate. This is irrespective of the setting where the patient actually receives the face-to-face encounter. OIG's preliminary data analysis indicates that during 2018 and 2019, Medicare may have paid a significant number of Part B physician service claim lines at the nonfacility rate when the beneficiary was a Part A inpatient at either a hospital or SNF. OIG will determine whether Medicare appropriately paid claims for Part B physician services based on the correct place-of-service code when a beneficiary was an inpatient at a SNF or hospital.

Work Plan #: W-00-21-35872; W-00-22-35872
Government Program: Medicare Parts A & B

Audits of Medicare Payments for Spinal Pain Management Services

Expected Issue Date: 2022

Medicare Part B covers various spinal pain management services including facet joint injections, facet joint denervation sessions, lumbar epidural injections, and trigger point injections. Medicare Part B also covers sedation administered during

these pain management services. OIG will audit whether Medicare payments for spinal pain management services billed by physicians complied with Federal requirements.

Work Plan #: W-00-21-35825; W-00-22-35825; A-09-21-03002 (December 2021)
Government Program: Medicare Parts A & B

Audit of CARES Act Provider Relief Funds-Payments to Health Care Providers That Applied for General Distribution Under Phases 1, 2, and 3

Expected Issue Date: 2022
Announced/Revised: May 2021

The Provider Relief Fund (PRF), a $178 billion program, provides relief funds to hospitals and other health care providers for health-care-related expenses or lost revenue attributable to COVID-19 and to ensure that uninsured Americans can get testing and treatment for COVID-19. For the General Distribution of the PRF, HHS allocated funds in three phases: $50 billion during Phase 1 for Medicare providers; $18 billion during Phase 2 for Medicaid and Children's Health Insurance Program providers, dental providers, certain Medicare providers, and assisted living facilities; and $24 billion during Phase 3 for certain behavioral health providers and newly practicing providers, as well as providers that received a payment under a previous phase. Providers applying for General Distribution funds must meet certain requirements, such as submitting revenue information and supporting documentation to the Health Resources and Services Administration, which uses this information to determine eligibility and payments. OIG will perform a series of audits of funds related to the three phases of the General Distribution to determine whether payments were: (1) correctly calculated for providers that applied for these payments, (2) supported by appropriate and reasonable documentation, and (3) made to eligible providers.

Work Plan #: W-00-21-35873; W-00-22-35873
Government Program: Medicare Parts A & B

Audit of Health Resources and Services Administration's COVID-19 Supplemental Grant Funding for Health Centers

Expected Issue Date: 2023
Announced/Revised: April 2021

The Health Resources and Services Administration (HRSA) awarded nearly $2 billion in supplemental grant funding to 1,387 health centers nationwide in fiscal year (FY) 2020 to respond to the COVID-19 public health emergency. The funding was intended to support the health centers' activities related to the detection, prevention, diagnosis, and treatment of COVID-19, including maintaining or increasing health center capacity and staffing levels during the pandemic, and expanding COVID-19 testing. The performance period for each of these one-time supplemental grant awards, which HRSA began awarding in March 2020, is 12 months. Health centers were permitted to charge to their awards pre-award costs in order to support expenses related to the COVID-19 public health emergency dating back to January 20, 2020. OIG will determine whether health centers used their HRSA COVID-19 supplemental grant funding in accordance with Federal requirements and grant terms.

Work Plan #: W-00-21-59456
Government Program: Medicare Parts A & B

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Provider

Audit of HRSA's Controls Over Medicare Providers' Compliance with the Attestation, Submitted-Revenue-Information, and Quarterly Use-of-Funds Reporting Requirements Related to the $50 Billion General Distribution of the Provider Relief Fund

Expected Issue Date: 2022
Announced/Revised: October 2020

A combined $175 billion in funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act constitutes the Provider Relief Fund (PRF), which provides relief funds to hospitals and other health care providers for health-care-related expenses or lost revenue attributable to COVID-19 and to ensure that uninsured Americans can get testing and treatment for COVID-19. HHS allocated $50 billion for a General Distribution to Medicare providers.

Providers that receive PRF funds are subject to certain requirements for attestation, submission of revenue information, and reporting of quarterly use-of-funds to HHS. A provider that received a PRF payment and retained it for at least 90 days without contacting HHS regarding the payment is deemed to have accepted its terms and conditions. Further, a provider must submit general revenue data after receiving or when applying to receive a payment. Finally, according to the CARES Act, Division B, Title V, Section 15011(b)(2), no later than 10 days after the end of each calendar quarter, a provider that received more than $150,000 in total funds for the coronavirus response and related activities shall submit a report to HHS regarding the use of those funds.

As part of the OIG's oversight of the $50 billion General Distribution of the PRF, OIG will provide a snapshot of the effectiveness of the Health Resources and Services Administration's (HRSA's) controls over Medicare providers' compliance with the attestation, submitted-revenue-information, and quarterly use-of-funds reporting requirements. Specifically, OIG will review HRSA's internal controls and assess its policies and procedures related to these areas.

Work Plan #: W-00-21-59060
Government Program: Medicare Parts A & B

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Provider

Hospital

Hospital's Compliance with the Provider Relief Fund Balance Billing Requirement for Out - of - Network Patients

Expected Issue Date: 2023
Announced/Revised: January 2022

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, Paycheck Protection and Health Care Enhancement Act, and Consolidated Appropriations Act, 2021, appropriated a combined $178 billion in relief funds to hospitals and other health care providers. This funding, known as the Provider Relief Fund (PRF), is administered by the Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) and is intended to reimburse eligible health care providers for health care-related expenses or lost revenue attributable to COVID-19 and to ensure that Americans could get testing and treatment for COVID-19. Under the PRF terms and conditions, hospitals are eligible for PRF distribution payments if they attest to specific requirements, including a requirement that providers, such as hospitals, must not pursue the collection of out-of-pocket payments from presumptive or actual COVID - 19 patients in excess of what the patients otherwise would have been required to pay if the care had been provided by in-network providers. OIG will refer to this limitation on balance billing, commonly referred to as "surprise billing," as the "balance billing requirement." OIG will perform a nationwide audit to determine whether hospitals that received PRF payments and attested to the associated terms and conditions complied with the balance billing requirement for COVID - 19 inpatients. OIG will assess how bills were calculated for out-of-network patients admitted for COVID-19 treatment, review supporting documentation for compliance, and assess procedural controls and monitoring to ensure compliance with the balance billing requirement.

Work Plan #: W-00-22-35878
Government Program: Medicare Parts A & B

Medicaid Inpatient Hospital Claims with Severe Malnutrition

Expected Issue Date: 2023
Announced/Revised: Nov 2021

Malnutrition can result from treatment of another condition, inadequate treatment or neglect, or general deterioration of a patient's health. Hospitals are allowed to bill for treatment of malnutrition on the basis of the severity of the condition (mild, moderate, or severe) and whether it affects patient care. Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a claim can result in an increased payment by causing the claim to be coded in a higher diagnosis-related group. OIG will conduct statewide reviews to determine whether hospitals complied with Medicaid billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims.

Work Plan #: W-00-22-31558
Government Program: Medicare Parts A & B

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Medicare Payments for Inpatient Claims with Mechanical Ventilation

Expected Issue Date: 2023
Announced/Revised: Nov 21

OIG will review Medicare payments for inpatient hospital claims with certain Medicare Severity Diagnosis Related Group (MS-DRG) assignments that require mechanical ventilation to determine whether hospitals' DRG assignments and resultant Medicare payments were appropriate. Mechanical ventilation is the use of a ventilator to take overactive breathing for a patient. For certain MS-DRGs to qualify for Medicare coverage, a beneficiary must have received more than 96 hours of mechanical ventilation. OIG's review will include claims for beneficiaries who received more than 96 hours of mechanical ventilation. Previous OIG reviews identified improper payments made because hospitals inappropriately billed for beneficiaries who did not receive at least 96 hours of mechanical ventilation.

Work Plan #: W-00-22-35879
Government Program: Medicare Parts A & B

Adverse Events: Disparities Among Hospitalized Medicare Patients

Expected Issue Date: 2022
Announced/Revised: Oct 2021

Disparities in the delivery of healthcare and patient outcomes are a significant U.S. public health concern, with communities of color and other disadvantaged groups experiencing poorer health outcomes compared to the U.S. population as a whole. Research on disparities in patient safety and adverse events is limited and this study intends to add to the body of information specific to health outcome disparities. OIG will identify the extent to which disparities in adverse event rates exist and which patient and hospital characteristics are associated with higher adverse event rates (e.g., race/ethnicity, hospital type, and geographic location). OIG uses data collected for an ongoing OIG study of adverse events (OEI-06-18-00400), which includes detailed information about adverse events experienced by a random sample of 770 hospitalized Medicare patients. OIG will analyze these adverse event data in conjunction with demographic information available in the medical record and other information contained in CMS claims data or in publicly available datasets, such as U.S. Census Bureau data. An increased understanding of disparities in patient safety will help medical providers and researchers identify and address the underlying issues that contribute to inequities in the delivery of healthcare.

Work Plan #: OEI-06-21-00040
Government Program: Medicare Parts A & B

Toolkit for Identifying Adverse Events Through Medical Record Review

Expected Issue Date: 2022
Announced/Revised: Oct 2021

OIG has found that patient harm is common among Medicare beneficiaries in a range of inpatient health care settings. Federal regulations require that hospitals and other health care facilities identify harm, such as adverse events, and work to reduce these events. OIG will use guidance materials and tools created for OIG's prior studies of adverse events to develop a web-based toolkit for identifying and measuring adverse events to assist health care facilities, government agencies, and researchers in their efforts to improve care. OIG will share the resources that OIG developed and used in

OIG's adverse event studies to aid hospitals and other researchers in their own efforts to identify and monitor the incidence of adverse events. The toolkit will provide standard definitions for most event types, lists of triggers to flag patient harm, suggested guidance for reviewers, and considerations for clinical decision making.

Work Plan #: OEI-06-21-00030
Government Program: Medicare Parts A & B

Audit of Medicare Emergency Department Evaluation and Management Services

Expected Issue Date: 2022
Announced/Revised: August 2021

An emergency department is defined as an organized, hospital-based facility for providing unscheduled or episodic services to patients who present for immediate medical attention. Certain Current Procedural Terminology (CPT) codes should only be used when a beneficiary is seen in an emergency department and the services described by the health care CPT coding system code definition are provided. Medicare reimburses physicians based on a patient's documented needs at the time of a visit. All evaluation and management (E/M) services reported to Medicare must be adequately documented so that medical necessity is clearly evident. This review will determine whether Medicare payments to providers for emergency department E/M services were appropriate, medically necessary, and paid in accordance with Medicare requirements.

Work Plan #: W-00-21-35877; W-00-22-35877
Government Program: Medicare Parts A & B

Medicare-Related Capital Costs Reported by New Hospitals

Expected Issue Date: 2022
Announced/Revised: May 2021

Hospitals are paid through Medicare Part A for Medicare-related capital costs (such as depreciation, interest, rent, and property-related insurance and tax costs). Most hospitals receive payment for capital costs through the Medicare Inpatient Prospective Payment System (IPPS) whereby a portion of their payment for each patient discharge is intended to cover capital costs. New hospitals can be exempted from the IPPS and be paid on a cost basis for their first 2 years of operation. OIG will determine whether new hospitals claimed Medicare-related capital costs in accordance with Federal regulations.

Work Plan #: W-00-21-35870
Government Program: Medicare Parts A & B

Duplicate Medicare Professional Fee Billing by Both the Critical Access Hospital and the Health Care Practitioner to Medicare Part B

Expected Issue Date: 2022
Announced/Revised: April 2021

Under Section 1834(g)(1) of the Social Security Act and Federal regulations (42 CFR §§ 410.152(k) and 413.70(b)), Critical Access Hospitals (CAHs) are paid under the Standard Payment Method unless they elect to be paid under the Optional

(Elective) Payment Method. Under Section 1834(g)(2) of the Social Security Act and Federal regulation (42 CFR § 413.70(b)(3)(i)), a CAH may elect the Optional (Elective) Payment Method, under which it bills the Part B Medicare Administrative Contractor (MAC) for both Medicare Part B facility services and Medicare Part B professional services for its outpatients. If a physician or other practitioner reassigns his or her Medicare Part B billing rights pursuant to 42 CFR part 424, subpart F, and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective.

The CAH must forward a copy of the completed assignment form (Form CMS 855R) to the MAC and keep the original form on file. Each practitioner must sign an attestation that clearly states that he or she will not bill Medicare Part B for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH (Medicare Claims Processing Manual, Chapter 4, Section 250.2). OIG will determine whether CAHs forwarded a completed Form CMS 855R to the MAC. OIG will determine whether both the CAH and physician billed and were paid by the MAC for the same outpatient professional services. OIG will determine whether the beneficiary paid coinsurance amounts to both the CAH and physician or another practitioner. OIG will also determine whether CMS has an edit in place to ensure that duplicate payments for beneficiary outpatient professional services are not made.

Work Plan #: W-00-21-35869
Government Program: Medicare Parts A & B

Follow-up Review on Medicare Claims for Outpatient Services Provided During Inpatient Stays

Expected Issue Date: 2022
Announced/Revised: December 2020

A prior OIG review conducted in 2017 (A-09-16-02026) identified that Medicare inappropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical-access hospitals). It was found that none of the $51.6 million OIG reviewed, representing 129,792 claims, should have been paid because the inpatient facilities were responsible for payments. In addition, beneficiaries were held responsible for unnecessary deductibles and coinsurance totaling $14.3 million paid to acute-care hospitals for those outpatient services. In addition, it was found that Medicare overpaid acute-care hospitals because the common working file (CWF) edits that should have prevented or detected the overpayments were not working properly.

Work Plan #: W-00-21-35861
Government Program: Medicare Parts A & B

CMS Oversight of the Two-Midnight Rule for Inpatient Admissions

Expected Issue Date: 2022
Announced/Revised: November 2020

Prior OIG audits identified millions of dollars in overpayments for inpatient claims with short lengths of stay. Instead of billing the stays as inpatient claims, they should have been billed as outpatient claims, which usually results in a lower payment. To reduce inpatient admission errors, CMS implemented the Two-Midnight Rule in fiscal year 2014. Under the Two-Midnight

Rule, CMS generally considered it inappropriate to receive payment under the inpatient prospective payment system for stays not expected to span at least two midnights. The only procedures excluded from the rule were newly initiated mechanical ventilation and any procedures appearing on the Inpatient Only List. Revisions were made to the Two-Midnight Rule after its implementation. OIG plans to audit hospital inpatient claims after the implementation of and revisions to the Two-Midnight Rule to determine whether inpatient claims with short lengths of stay were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation. OIG also plans to review policies and procedures for enforcing the Two-Midnight Rule at the administrative level and contractor level. While OIG previously stated that it would not audit short stays after October 1, 2013, this serves as notification that OIG will begin auditing short stay claims again, and when appropriate, recommend overpayment collections.

Work Plan #: W-00-20-35857
Government Program: Medicare Parts A & B

Swing-Bed Services at Nationwide Critical Access Hospitals

Expected Issue Date: 2022
Announced/Revised: August 2020

In 2015, the Office of Inspector General reported that swing-bed usage at Critical Access Hospitals (CAHs) significantly increased from CY 2005 through CY 2010. Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. OIG estimated that Medicare could have saved $4.1 billion over the CY 2005 through CY 2010 period if payments for swing-bed services at CAHs had been made using Skilled Nursing Facility Prospective Payment System rates. OIG will review swing-bed data for CY 2015 through CY 2019 to determine whether: (1) any actions were taken to reduce swing-bed usage at CAHs, (2) Medicare payment amounts were updated for swing-bed services to CAHs, and (3) alternative care was available to Medicare beneficiaries at a potentially lower rate.

Work Plan #: W-00-20-35853
Government Program: Medicare Parts A & B

Audit of Medicare Payments for Inpatient Discharges Billed by Hospitals for Beneficiaries Diagnosed With COVID-19

Expected Issue Date: 2022
Announced/Revised: August 2020

Section 3710 of the Coronavirus Aid, Relief, and Economic Security Act directs the Secretary to increase the weighting factor that would otherwise apply to the assigned diagnosis-related group by 20 percent for an individual who is diagnosed with COVID-19 and discharged during the COVID-19 public health emergency period. OIG will audit whether payments made by Medicare for COVID-19 inpatient discharges billed by hospitals complied with Federal requirements.

Work Plan #: W-00-20-35856
Government Program: Medicare Parts A & B

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Audit of CARES Act Provider Relief Funds—General and Targeted Distributions to Hospitals

Expected Issue Date: 2022
Announced/Revised: August 2020

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act appropriated $175 billion for the Provider Relief Fund (PRF) to support health care providers affected by the COVID-19 pandemic. In April 2020, the Health Resources and Services Administration began distributing the funds through general distributions to Medicare providers based on 2018 net patient revenue and targeted distributions for certain provider types (e.g., providers in areas particularly impacted by COVID-19, skilled nursing providers, and providers in rural areas). Providers such as hospitals may be eligible for PRF payments from the general and targeted distributions. OIG will select for audit a statistical sample of providers that received general and/or targeted distributions. OIG's objective is to determine whether providers that received PRF payments complied with certain Federal requirements, and the terms and conditions for reporting and expending PRF funds.

Work Plan #: W-00-20-35855
Government Program: Medicare Parts A & B

Audit of CMS's Controls Over the Expanded Accelerated and Advance Payment Program Payments and Recovery

Expected Issue Date: 2022
Announced/Revised: July 2020

This work will provide details of the effectiveness of CMS controls over its Accelerated and Advance Payment Program (AAP) payments to providers and payment recovery. OIG will obtain data and meet with program officials to understand CMS's eligibility determination process for AAP payments and the steps CMS will have taken to recover such funds in compliance with the CARES Act and other Federal requirements. The objectives of OIG's work will be to determine whether CMS made AAP payments to eligible providers and implemented controls to recover the AAP payments in compliance with the CARES Act and other Federal requirements. OIG will also evaluate a select group of providers to determine whether they were eligible for AAP payments, and their efforts to repay CMS in compliance with the CARES Act and other Federal requirements.

Work Plan #: W-00-20-35854
Government Program: Accelerated and Advance Payment Program (AAP)

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Hospital Collection Effort for Medicare Bad Debt Basic Health Program Eligibility Determinations

Expected Issue Date: 2022
Announced/Revised: July 2020

Medicare allows providers to claim reimbursement for a portion of these uncollectible deductibles and coinsurance (known as "bad debt") once the provider establishes that reasonable collection efforts were made, that the debt was uncollectible, and that there was no likelihood of future recovery based on sound business judgment. Reasonable collection efforts can include billings, follow-up letters, phone calls, and personal contact. OIG plans to select a random sample of hospitals and review the policies and procedures in place related to collecting deductibles and coinsurance, offering financial assistance, identifying bad debt, and accounting for the receipt of previously reimbursed bad debt. In addition, OIG will select a judgmental sample of claims with high-dollar bad-debt amounts (coinsurance or deductible) and determine how the hospitals adhered to Federal criteria in treating these bad debts. OIG's audit will determine whether hospitals' policies and procedures for collecting Medicare deductible and coinsurance amounts from beneficiaries follow Federal regulations for the reimbursement of bad debt.

Work Plan #: W-00-20-35849
Government Program: Medicare Parts A & B

A Review of Medicare Data to Understand Hospital Utilization During COVID-19

Expected Issue Date: 2021
Announced/Revised: June 2020

Coronavirus disease 2019 (COVID-19) can significantly tax hospitals and disproportionately affect Medicare beneficiaries. COVID-19 can affect much of a state or a locality at the same time, rapidly increasing the demand for hospital resources. Using Medicare claims data, this review will analyze the effects of COVID-19 on hospitalized Medicare beneficiaries and the hospital resources needed to care for them. Specifically, OIG will review utilization of the treatments provided and paid for by Medicare for patients with COVID-19 in selected localities that have known outbreaks. OIG will also describe the extent to which hospital utilization for Medicare beneficiaries changed over time.

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

Review of the Medicare DRG Window Policy

Expected Issue Date: 2022
Announced/Revised: May 2020

Outpatient services related to an inpatient admission are considered part of the inpatient payment and are not separately payable by Medicare. The diagnosis-related group (DRG) window policy defines when CMS considers outpatient services to be an extension of inpatient admissions, and generally includes services that are: (1) provided within the three days immediately preceding an inpatient admission to an acute-care hospital, (2) diagnostic services or admission-related non-diagnostic services, and (3) provided by the admitting hospital or by an entity wholly owned or operated by the admitting

hospital. Building on previous OIG work, OIG will determine the number of admission-related outpatient services that were not covered by the DRG window policy in 2018, including services that were provided prior to the start of the DRG window and services that were provided at hospitals that shared a common owner. OIG will also determine the amounts that Medicare and beneficiaries would have saved in 2018 if the DRG window policy had been updated to include more days and other hospital ownership structures. In addition, OIG will interview CMS staff to identify other payment models that CMS could use to pay for outpatient services related to inpatient admissions.

Work Plan #: OEI-05-19-00380
Government Program: Medicare Parts A & B

CMS's Internal Controls Over Hospital Preparedness for Emerging Infectious Disease Epidemics Such as Coronavirus Disease 2019

Expected Issue Date: 2022

Hospitals that participate in the Medicare program must comply with Federal participation requirements, including requirements that hospitals engage in all-hazards emergency preparedness planning. On February 1, 2019, CMS added planning for emerging infectious diseases to its emergency preparedness guidance. OIG will audit CMS's internal controls over hospital preparedness for an emerging infectious disease epidemic, such as coronavirus disease 2019 (COVID-19). OIG will also audit hospital compliance with CMS's emergency preparedness requirements.

Work Plan #: A-02-21-01003 (June 2021); W-00-20-35845; W-00-21-35845
Government Program: Medicare Parts A & B

Medicare Hospital Payments for Claims Involving the Acute- and Post-Acute-Care Transfer Policies

Expected Issue Date: 2022
Announced/Revised: March 2020

Medicare's acute-and post-acute-care transfer policies designate some discharges as transfers when beneficiaries receive care from certain post-acute-care facilities. The diagnosis-related group (DRG) payment provides payment in full to hospitals for all inpatient services associated with a diagnosis. Because of its transfer payment policies, Medicare pays hospitals a per diem rate for early discharges when beneficiaries are transferred to another prospective payment system hospital or to post-acute-care settings, including skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long-term-care hospitals, psychiatric hospitals, and hospice. This is based on the presumption that hospitals should not receive full payments for beneficiaries discharged early and then admitted for additional care in other clinical settings. Previous Office of Inspector General reviews identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy.

OIG will review Medicare hospital discharges that were paid a full DRG payment when the patient was transferred to a facility covered by the acute and post-acute transfer policies where Medicaid paid for the service. Under the acute- and post-acute transfer policies, these hospital inpatient stays should have been paid a reduced amount. Additionally, OIG will assess the transfer policies to determine if they are adequately preventing cost shifting across healthcare settings.

Work Plan #: W-00-20-35832
Government Program: Medicare Parts A & B

Selected Inpatient and Outpatient Billing Requirements

Expected Issue Date: 2022

This review is part of a series of hospital compliance reviews that focus 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 will review Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements and recommend recovery of overpayments. OIG's review will focus on those hospitals with claims that may be at risk for overpayments.

Work Plan #: A-02-18-01018 (May 2021); A-02-18-01025 (June 2021); A-05-19-00024 (June 2021); A-07-17-05102 (March 2020); A-04-17-08057 (October 2018); A-05-17-00026 (February 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; various reviews
Government Program: Medicare Parts A & B

Medicare Capital Payments to New Hospitals

Expected Issue Date: 2021
Announced/Revised: February 2020

Hospitals are reimbursed through Medicare Part A for Medicare-related capital costs (e.g., depreciation, interest, rent, and property-related insurance and taxes costs). New hospitals are paid on a cost basis for their first two years of operation. Beyond the first two years, hospitals' Medicare-related capital costs are paid through the inpatient prospective payments system under which a portion of their payment for each discharge is intended to cover capital costs. OIG will determine the potential impact for Medicare if capital payments to new hospitals were paid through the prospective payments system for the first two years.

Work Plan #: W-00-20-35843
Government Program: Medicare Parts A & B

Outpatient Outlier Payments for Short-Stay Claims

Expected Issue Date: 2022

CMS makes an additional payment (an outlier payment) for hospital outpatient services when a hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment (Social Security Act (SSA) § 1833(t)(5)). The purpose of the outlier payment is to ensure beneficiary access to services by having Medicare share in the financial loss incurred by a provider associated with extraordinarily expensive individual cases. Prior OIG reports have concluded that hospitals' high charges, unrelated to cost, lead to excessive inpatient outlier payments. OIG will determine the extent of potential Medicare savings if hospital outpatient short stays (same day or over one midnight) were ineligible for an outlier payment. Prior to a

nationwide review, OIG plans to perform several reviews at one or more hospitals to determine whether outpatient outlier payments to hospitals are associated with extraordinarily expensive individual cases.

Work Plan #: A-06-16-01002 (February 2020); W-00-16-35775
Government Program: Medicare Parts A & B

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries - 10-Year Update

Expected Issue Date: 2022
Announced/Revised: June 2019

OIG has conducted studies about adverse events (patient harm) in various healthcare settings since 2008, with 15 reports released or in process through 2019. The series includes a congressionally mandated study released in 2010 that found that 27 percent of Medicare beneficiaries experienced adverse events or temporary harm events while hospitalized in 2008. The current study will replicate the methodology used in the prior work for a sample of Medicare beneficiaries admitted to acute-care hospitals in 2018. OIG will measure the incidence of adverse events and temporary harm events, the extent to which the harms were preventable given better care, and the associated costs to Medicare. OIG will compare the 2018 results with the prior study results to assess progress in reducing harm at the 10-year mark, and identify differences in harm rates, types, contributing factors, preventability, and costs.

Work Plan #: OEI-06-18-00400
Government Program: Medicare Parts A & B

Comparison of Provider-Based and Freestanding Clinics

Expected Issue Date: 2022
Announced/Revised: June 2019

Provider-based facilities often receive higher payments for some services than freestanding clinics. OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures. OIG will also assess the potential impact on Medicare and beneficiaries of hospitals' claiming provider-based status for such facilities.

Work Plan #: W-00-18-30026
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

All Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment & Supplies

Physical and Other Therapies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

Medicare Outpatient Outlier Payments for Claims with Credits for Replaced Medical Devices

Expected Issue Date: 2022
Announced/Revised: January 2019

CMS requires hospitals to submit a zero or token charge when they receive a full credit for a replacement device, but CMS does not specify how charges should be reduced for partial credits. CMS makes an additional payment (an outpatient outlier payment) for hospital outpatient services when a hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment 42 CFR § 419.43(d). Prior OIG reviews focused on finding unreported credits for medical devices and recommended that CMS recoup Medicare funds for the overstated ambulatory payment classification payment only. This audit focuses on overstated Medicare charges on outpatient claims that contain both an outlier payment and a reported medical device credit. OIG will determine whether Medicare payments for replaced medical devices and their respective outlier payments were made in accordance with Medicare requirements.

Work Plan #: W-00-19-35819; W-00-21-35819
Government Program: Medicare Parts A & B

Payment Credits for Replaced Medical Devices That Were Implanted

Expected Issue Date: 2021

Certain medical devices are implanted during inpatient or outpatient procedures. Such devices may require replacement because of defects, recalls, mechanical complication, and other factors. Under certain circumstances, Federal regulations require reductions in Medicare payments for inpatient, outpatient, and ambulatory surgical center (ASC) claims for the replacement of implanted devices due to recalls or failures (42 CFR §§ 412.89, 419.45, and 416.179). Prior OIG reviews have determined that Medicare administrative contractors made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices. OIG will determine whether Medicare payments for replaced medical devices were made in accord with Medicare requirements.

Work Plan #: A-01-18-00502 (November 2020); A-05-16-00059 (March 2018); W-00-16-35745; W-00-18-35745
Government Program: Medicare Parts A & B

Nationwide Medicare Electronic Health Record Incentive Payments to Hospitals

Expected Issue Date: 2022
Announced/Revised: July 2017

Medicare incentive payments were authorized over a five-year period to hospitals that adopted electronic health record (EHR) technology (Recovery Act, 4102). From January 1, 2011, through December 31, 2016, the Centers for Medicare & Medicaid Services (CMS) made Medicare EHR incentive payments to hospitals totaling $14.6 billion. The Government Accountability Office identified improper incentive payments as the primary risk to the Medicare EHR incentive program. A Department of Health and Human Services, Office of Inspector General (OIG) report describes the obstacles that CMS faces in overseeing the Medicare EHR incentive program. In addition, previous OIG reviews of Medicaid EHR incentive payments found that state agencies overpaid hospitals by $66.7 million and would in the future overpay these hospitals an

Provider

additional $13.2 million. These overpayments resulted from inaccuracies in the hospitals calculations of total incentive payments. OIG will review hospital incentive payment calculations to identify potential overpayments that the hospitals would have received as a result of the inaccuracies.

Work Plan #: W-00-17-35795; A-09-17-03020
Government Program: Medicare Parts A & B

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Provider

Long Term Care

[NEW] Nursing Home Capabilities and Collaboration to Ensure Resident Care During Emergencies

Expected Issue Date: 2022
Announced/Revised: February 2022

Nursing homes face a broad range of challenges from public emergencies, such as emerging infectious disease outbreaks and natural disasters. To protect residents and prevent disruption of care during emergencies, nursing homes must develop and maintain an emergency preparedness program that addresses a wide range of issues, from maintaining emergency supplies to collaborating with local emergency responders. Despite these requirements, recent emergencies have exposed weaknesses in nursing home emergency preparedness. This study will survey the challenges nursing homes face in preparing for emergencies, with specific focus on their capabilities for managing resident care during emergencies, as well as their collaboration with community partners (e.g., other health care providers, emergency management agencies). OIG will present the findings in a data brief. OIG will also use a portion of the data collected for this study for a new Key Performance Indicator that will track the prevalence and severity of challenges experienced by nursing homes over time.

Work Plan #: OEI-06-22-00100
Government Program: Medicare Parts A & B

Meeting the Challenges Presented by COVID-19: Nursing Homes

Expected Issue Date: 2022
Announced/Revised: May 2021

Nursing homes have been at the epicenter of the COVID-19 pandemic. Residents in these homes have been particularly affected by the disease, as they are predominantly elderly individuals who have underlying medical conditions and live in close quarters. To prevent and mitigate future outbreaks, it is important that we understand how nursing homes experienced the COVID-19 pandemic. This nationwide, three-part study will examine how the pandemic affected nursing homes. The first part will analyze the extent to which Medicare beneficiaries residing in nursing homes were diagnosed with COVID-19 and describe the characteristics of those who were at greater risk. The second part will describe the characteristics of the nursing homes that were hardest hit by the pandemic (i.e., homes with high numbers of beneficiaries who had COVID-19). The third part will describe the strategies nursing homes used to mitigate the unprecedented challenges of COVID-19. These challenges include procuring critical supplies, testing residents and staff, isolating high numbers of contagious residents, caring for those afflicted, and protecting residents and staff on a scale never before experienced in this country.

Work Plan #: OEI-02-20-00490; OEI-02-20-00491; OEI-02-20-00492
Government Program: Medicare Parts A & B

Skilled Nursing Facility Reimbursement

Expected Issue Date: 2022
Announced/Revised: April 2021

A skilled nursing facility (SNF) is a nursing home that provides skilled nursing care and rehabilitation services such as physical, speech, and occupational therapy to beneficiaries who need assistance after hospitalization. In October 2019, the Centers for Medicare & Medicaid Services (CMS) implemented a new payment system for determining Medicare Part A payments to SNFs. Specifically, CMS implemented the Patient Driven Payment Model (PDPM), a new case-mix classification system for classifying SNF patients in a Medicare Part A covered stay into payments groups under the SNF Prospective Payment System. Under PDPM, payment is determined by factoring in a combination of six payment components.

Five of the components are case-mix adjusted and include a physical therapy component, an occupational therapy component, a speech-language pathology component, a nontherapy ancillary services component, and a nursing component. Additionally, there is a non-case-mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics. OIG will determine whether Medicare payments to SNFs under PDPM complied with Medicare requirements.

Work Plan #: W-00-21-35784
Government Program: Medicare Parts A & B

Background Checks for Nursing Home Employees

Expected Issue Date: 2022
Announced or Revised: January 2021

Federal regulation 42 CFR 483.12(a)(3) provides beneficiaries who rely on long-term care services with protection from abuse, neglect, and theft by preventing prospective employees with disqualifying offenses from being employed by these care providers and facilities. The National Background Check Program was enacted by legislation in 2010 to assist States in developing and improving systems for conducting Federal and State background checks. Prior OIG work has shown that not all States complied with the National Background Check Program for Long-Term Care Providers. OIG will determine whether Medicaid beneficiaries in nursing homes in selected States were adequately safeguarded from caregivers with a criminal history of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property, according to Federal requirements.

Work Plan #: W-00-21-31553
Government Program: Medicaid

Facility and Nursing Home-Initiated Discharges in Nursing Homes

A facility or nursing home-initiated transfer or discharge of a resident from a nursing home can be an unsafe and traumatic experience for the resident and his or her family. To address these concerns, Congress passed the Nursing Home Reform Act of 1987 to protect residents against inappropriate facility-initiated transfer and discharge. However, data from the National Ombudsman Reporting System show that from 2011 through 2016, the Long-Term Care Ombudsman Program, established to advocate for older Americans by the Older Americans Act of 1965, cited complaints related to "discharge/eviction" more frequently than any other concern. In addition, the media has highlighted the rise in nursing home evictions.

Nursing Homes' Compliance with Facility-Initiated Discharge Requirements (OEI-01-18-00251)

Expected Issue Date: 2022
Announced/Revised: November 2020

In this work, OIG will examine the extent to which nursing homes meet CMS requirements for facility-initiated discharges.

Facility-Initiated Discharge in Nursing Homes (OEI-01-18-00250)

Expected Issue Date: 2022
Announced/Revised: November 2020

In this work, OIG will determine the extent to which State long-term care ombudsmen, State survey agencies, and CMS address facility-initiated discharges from nursing homes.

Work Plan #: OEI-01-18-00251; OEI-01-18-00250
Government Program: Medicare Parts A & B

State Compliance with Requirements for Reporting and Monitoring Critical Incidents

Expected Issue Date: 2022

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.

Work Plan #: A-06-17-02005 (June 2021); A-04-17-03084 (April 2021); A-04-17-08058 (March 2021); A-02-17-01026 (February 2021); A-04-17-04063 (July 2020); A-03-17-00202 (January 2020); A-09-17-02006 (June 2019); W-00-17-31040; A-06-17-01003; A-06-17-04003 (July 2020)
Government Program: Medicaid

Nursing Home Oversight During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced/Revised: October 2020

Onsite surveys of nursing homes are a fundamental safeguard to ensure that nursing home residents are safe and receive high-quality care. In response to the coronavirus disease 2019 (COVID-19) pandemic, CMS directed State Survey Agencies (SSAs) to suspend standard onsite surveys and most onsite surveys for complaints. CMS directed SSAs to conduct onsite surveys in response to the most serious complaints (i.e., those involving immediate jeopardy) and complaints related to infection control, and to conduct targeted infection control surveys, which are abbreviated surveys focused on infection control policies and practices within facilities. Using recent complaint and survey data for all nursing homes, this study will examine the extent to which SSAs and CMS are conducting onsite surveys in nursing homes related to serious complaints and targeted infection control, in accord with CMS's recent guidance to suspend certain onsite surveys. OIG will also identify any barriers that CMS and SSAs face in conducting onsite surveys as well as potential solutions.

Provider

Work Plan #: OEI-01-20-00430
Government Program: Medicare Parts A & B

Meeting the Challenges Presented by COVID-19: Nursing Homes

Expected Issue Date: 2022

Nursing homes have been at the epicenter of the COVID-19 pandemic. Residents in these homes have been particularly affected by the disease as they are predominantly elderly individuals who have underlying medical conditions and live in close quarters. To prevent and mitigate future outbreaks, it is important to understand how nursing homes experienced the COVID-19 pandemic. This nationwide, three-part study will examine how the pandemic affected nursing homes.

The first part will analyze the extent to which Medicare beneficiaries residing in nursing homes were diagnosed with COVID-19 and describe the characteristics of those who were at greater risk. The second part will describe the characteristics of the nursing homes that were hardest hit by the pandemic (i.e., homes with high numbers of beneficiaries who had COVID-19). The third part will describe the strategies nursing homes used to mitigate the unprecedented challenges of COVID-19. These challenges include procuring critical supplies, testing residents and staff, isolating high numbers of contagious residents, caring for those afflicted, and protecting residents and staff on a scale previously unexperienced in this country.

Work Plan #: OEI-02-20-00490; OEI-02-20-00491; OEI-02-20-00492
Government Program: Medicare Parts A & B

Audit of Nursing Homes' Reporting of COVID-19 Information Under CMS's New Requirements

Expected Issue Date: 2021
Announced/Revised: June 2020

In response to the coronavirus disease 2019 (COVID-19) public health emergency, CMS added requirements to an existing regulation that requires nursing homes to report to state and local health departments communicable diseases, health care-associated infections, and potential outbreaks. Under one requirement, these facilities must now report COVID-19 data (such as information on suspected and confirmed infections, and deaths among residents and staff) to the Centers for Disease Control and Prevention through its National Healthcare Safety Network system. The data must be reported in a standardized format at least weekly. OIG will assess nursing homes' reporting of CMS-required information related to the COVID-19 public health emergency. Specifically, OIG will determine whether the data reported by nursing homes were complete, accurate, and reliable.

Work Plan #: W-00-20-31546
Government Program: Medicare Parts A & B

Audit of Nursing Home Infection Prevention and Control Program Deficiencies

Expected Issue Date: 2022
Announced/Revised: May 2020

Provider

The Centers for Disease Control and Prevention has indicated that individuals at high risk for severe illness from coronavirus disease 2019 (COVID-19) are people aged 65 years and older and those who live in a nursing home. Currently, more than 1.3 million residents live in approximately 15,450 Medicare and Medicaid-certified nursing homes in the United States.

As of February 2020, State Survey Agencies have cited more than 6,600 of these nursing homes (nearly 43 percent) for infection prevention and control program deficiencies, including lack of a correction plan in place for these deficiencies. To reduce the likelihood of contracting and spreading COVID-19 at these nursing homes, effective internal controls must be in place. OIG's objective is to determine whether selected nursing homes have programs for infection prevention and control and emergency preparedness in accordance with Federal requirements.

Work Plan #: W-00-20-31545
Government Program: Medicare Parts A & B

Medicaid Nursing Home Life Safety and Emergency Preparedness Reviews

Expected Issue Date: 2022
Announced/Revised: March 2020

Previous OIG audits on Medicaid nursing home life safety and emergency preparedness have identified multiple issues that put vulnerable populations at risk and indicated that nursing homes in various states are not complying with these requirements. In 2016, CMS updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care (LTC) facilities.

In addition, in 2019 CMS also issued expanded guidance on emerging infectious disease control to ensure that health care facilities are prepared to respond to threats from infectious diseases. OIG is reviewing this area because residents of LTC facilities are particularly vulnerable to risks such as fires, natural disasters, or disease outbreak (such as COVID-19 and other coronaviruses). OIG's objective is to determine whether LTC facilities that received Medicare or Medicaid funds complied with new Federal requirements for life safety and emergency and infectious disease control preparedness.

Work Plan #: W-00-20-31525
Government Program: Medicaid

Medicaid Nursing Home Life Safety Reviews

Expected Issue Date: 2022

CMS recently updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in LTC facilities. These updates include requirements that facilities install expanded sprinkler and smoke detector systems to protect residents from the hazards of fire and develop an emergency preparedness plan that facilities must review, test, update, and train residents on annually. The plan must include provisions for sheltering in place and evacuation.

OIG is reviewing this area because residents of LTC facilities are particularly vulnerable to the risk of fires since many of these residents have limited or no mobility. OIG's objective is to determine if LTC facilities that received Medicare or Medicaid funds complied with new Federal requirements for life safety and emergency preparedness for the period of May 4, 2016 through November 15, 2017.

Provider

Work Plan #: A-02-17-01027 (August 2019); W-00-17-31525
Government Program: Medicare Parts A & B

Medicare Part B Services to Medicare Beneficiaries Residing in Nursing Homes During Non-Part A Stays

Expected Issue Date: 2022
Announced/Revised: August 2019

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

Work Plan #: W-00-19-35824; W-00-22-35824
Government Program: Medicare Parts A & B

Medicaid Assisted Living Services

Expected Issue Date: 2022
Announced/Revised: August 2019

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

Work Plan #: W-00-19-31541
Government Program: Medicaid

Post-Hospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries

Expected Issue Date: 2022
Announced/Revised: March 2019

Skilled nursing facilities (SNFs) are specially qualified facilities that provide extended care services, such as skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. During previous OIG reviews, OIG noted that some nursing facility residents who were receiving Medicaid-covered nursing home care were admitted to a hospital and returned to the same facility to receive Medicare-covered post-hospital SNF care. In some cases, hospital physicians discharged beneficiaries to "home" rather than "SNF," yet nursing facility physicians certified that skilled care was needed. Because Medicare pays substantially more for SNF care than Medicaid for nursing home care, nursing facilities have financial incentives to increase the level of care to "skilled."

OIG will determine whether the post-hospital SNF care provided to dually eligible beneficiaries met the level of care requirements. Specifically, OIG will determine whether: (1) the SNF level of care was certified by a physician (e.g., a hospital or SNF physician) or a physician extender (i.e., a nurse practitioner, clinical nurse specialist, or physician assistant), (2) the condition treated at the SNF was a condition for which the beneficiary received inpatient hospital services or a condition that arose while the beneficiary was receiving care in a SNF for a condition for which the beneficiary received inpatient hospital services, (3) daily skilled care was required, (4) the services delivered were reasonable and necessary for the treatment of a beneficiary's illness or injury, and (5) improper Medicare payments were made on the claims OIG reviews. OIG will also determine whether any of the hospital admissions in review were potentially avoidable.

Work Plan #: W-00-19-35821
Government Program: Medicare Parts A & B

Managed Long-Term-Care Reimbursements

Expected Issue Date: 2022
Announced/Revised: November 2016

Medicaid managed care plans are subject to Federal requirements (42 CFR Part 438). Some States contract with MCOs to provide long-term services. OIG will review States' reimbursements made to managed long-term-care plans to determine whether those reimbursements complied with certain Federal and State requirements.

Work Plan #: W-00-17-31510
Government Program: Medicaid

SUNHAWK CONSULTING

Provider

Home Health Service

Home Health Agencies' Emergency Communication Plans: Strengths and Challenges Ensuring Continuity of Care During Disasters

Expected Issue Date: 2023
Announced or Revised: July 2021

The COVID-19 pandemic highlighted the importance of emerging infectious disease (EID) preparedness in health care facilities, including home health agencies (HHAs). OIG has ongoing work reviewing HHA preparedness for EIDs. However, HHAs also must prepare for other types of emergencies. Natural disasters such as hurricanes, floods, and fires continue to threaten operations, even as HHAs continue to address the impact of COVID-19. In 2020, the United States experienced a record number of natural disasters, and Federal scientists predict a greater number of hurricanes and storms in 2021. Previous natural disasters highlighted vulnerabilities in HHAs' preparedness for disasters, specifically with regards to communication and continuity of care. Since November 2017, HHAs have had to comply with CMS Emergency Preparedness Conditions of Participation (EP CoPs). As part of these EP CoPs, CMS requires HHAs to develop communication plans that must include information necessary to ensure continuity of care during any emergency. This evaluation will determine selected HHAs' compliance with EP CoPs and will report factors these HHAs identify as hindering and/or supporting continuity of care during a disaster.

Work Plan #: OEI-04-21-00280
Government Program: Medicare Parts A & B

Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency

Expected Issue Date: 2022
Announced or Revised: February 2021

On March 13, 2020, President Trump declared a national emergency in response to the COVID-19 pandemic, which allowed the Centers for Medicare & Medicaid Services (CMS) to take proactive steps to support the response to COVID-19 through the use of section 1135 waivers. By means of this authority, CMS waived certain requirements in order to expand Medicare telehealth benefits to health care professionals who were previously ineligible, including physical therapists, occupational therapists, speech language pathologists, and others. However, the waiver does not allow for payment of telehealth services on home health claims. In the COVID-19 Public Health Emergency Interim Final Rule With Comment, CMS amended regulations on an interim basis to allow home health agencies to use telecommunications systems in conjunction with in-person visits. In the CY 2021 Home Health PPS Final Rule, CMS permanently finalized these changes. The final amended regulations state that the plan of care must include any provision of remote patient monitoring or other services furnished via telecommunications technology or audio-only technology, and that such services must be tied to patient-specific needs as identified in the comprehensive assessment. They further state that telehealth services cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of patient eligibility or payment. OIG will evaluate home health services provided by agencies during the COVID-19 public health emergency to determine which types of skilled services were furnished via telehealth, and whether those services were administered and billed in

accordance with Medicare requirements. OIG will report as overpayments any services that were improperly billed. OIG will make appropriate recommendations to CMS based on the results of OIG's review.

Work Plan #: W-00-21-35864
Government Program: Medicare Parts A & B

Home Health Agencies' Challenges and Strategies in Responding to the COVID-19 Pandemic

Expected Issue Date: 2022
Announced/Revised: January 2021

Home health agencies (HHAs) have faced unprecedented challenges to providing care during the COVID-19 pandemic. Reported challenges include, but are not limited to, procuring necessary equipment and supplies, implementing telehealth to treat patients remotely, and addressing staffing shortages. However, the full spectrum of these challenges, including how challenges have evolved over time, is unknown. HHAs have used strategies to address these challenges, but the array of strategies and the extent to which HHAs found them helpful are also unknown. This nationwide study will provide insights into the strategies HHAs have used to address the challenges presented by COVID-19, including how well their emergency preparedness plans served them during the COVID-19 pandemic.

Work Plan #: OEI-01-21-00110
Government Program: Medicare Parts A & B

Infection Control at Home Health Agencies During the COVID-19 Pandemic

Expected Issue Date: 2022
Announced/Revised: September 2020

The coronavirus that causes the respiratory disease COVID-19 is especially dangerous for adults aged 65 years and older and those with underlying medical conditions. Medicare beneficiaries receiving home health services may be at a high risk of developing severe illness from COVID-19. Home health services are covered for the elderly and disabled under the Medicare program. Home health services may include skilled nursing care, physical therapy, speech-language pathology, occupational therapy, and medical supplies. Home health agencies (HHAs) must meet certain requirements to participate in the Medicare and Medicaid programs, including meeting infection prevention and control standards.

On March 10, 2020, CMS issued a State Survey Directors Letter, "Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Home Health Agencies (HHAs)," to provide HHAs with guidance on addressing the outbreak and minimizing transmission. Home health workers often travel to several homes on a weekly basis, which increases their risk of exposure to the COVID-19 and increases the risk of infection among Medicare beneficiaries. HHAs must maintain a coordinated agencywide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. OIG will interview corporate officers from the three HHA providers with the largest market share in 2019 as well as HHAs that have recently been cited by CMS for infection control and prevention deficiencies to determine the extent to which their infection control and prevention policy and procedures comply with CMS guidance regarding COVID-19.

Work Plan #: A-01-20-00508 (September 2021); W-00-20-35858
Government Program: Medicare Parts A & B

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Provider

Analysis of New Rural Add-On Payment Methodology

Expected Issue Date: 2022
Announced/Revised: July 2020

Section 50208 of the Bipartisan Budget Act of 2018 (the BBA) extended rural add-on payments for home health episodes and visits ending during calendar years (CYs) 2019 through 2022, and mandated implementation of a new methodology for applying those payments. Beginning in CY 2019, rural add-on payments were provided in varying amounts according to classification in one of three rural categories: (1) high utilization, (2) low population density, and (3) all other. The BBA requires home health claims to indicate the code for the county in which the home health service is provided. CMS has instructed providers to use value code 85 to report the county code and will return claims for correction when the code is missing or invalid. The BBA also mandated that, no later than January 1, 2023, HHS-OIG submit to Congress an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and recommendations, as appropriate, based on such analysis. To meet that mandate, OIG will perform an analysis of Medicare home health claims for CYs 2019 through 2021. OIG will trend the claim data and cost reports to determine what impact, if any, the new rural add-on methodology has had on home health agency providers and the utilization of home health services in rural areas.

Work Plan #: W-00-20-35850
Government Program: Medicare Parts A & B

Medicaid-Audit of Health and Safety Standards at Individual Supported Living Facilities

Expected Issue Date: 2022
Announced/Revised: April 2020

State agencies operate home and community-based services programs under a 1915(c) waiver to their respective Medicaid State plans. Some of these waivers allow for providing services to individuals with developmental disabilities. Such waivers include individualized supported living habilitation services, which aid and provide necessary support to achieve personal outcomes that enhance individuals' ability to live in and participate in their communities. To receive approval for a waiver, state agencies must ensure the health and welfare of the beneficiaries of the service. Recent media coverage throughout the United States of deaths of people with developmental disabilities involving abuse, neglect, or medical errors has led to OIG audits in several states. OIG's objective is to determine whether state agencies and providers complied with Federal and state health and safety requirements involving Medicaid beneficiaries with developmental disabilities residing in individualized supported living settings, including infection control for conditions such as coronavirus disease 2019 (COVID-19) and other infectious diseases.

Work Plan #: W-00-20-31543
Government Program: Medicaid

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Provider

Medicaid Health Home Services for Beneficiaries with Chronic Conditions

Expected Issue Date: 2022

Section 1945 of the Social Security Act created an optional Medicaid State Plan benefit for States to establish "health homes" to coordinate care for people with Medicaid who have chronic medical conditions. States receive a 90-percent enhanced Federal Medical Assistance Percentage (FMAP) for health home services valid through the first eight quarters of the program. The State option to provide health home services to eligible Medicaid beneficiaries became effective on January 1, 2011. As of May 2017, CMS has approved Medicaid State plan amendments for 21 States and the District of Columbia for health home programs. More than 1 million Medicaid beneficiaries have been enrolled in these programs. OIG will review Medicaid health home programs for compliance with relevant Federal and State requirements.

Work Plan #: A-07-20-04117 (August 2021); A-02-19-01007 (July 2021); A-02-17-01004 (July 2019); A-02-17-00000; W-00-17-31524
Government Program: Medicaid

Home Health Compliance with Medicare Requirements

Expected Issue Date: 2021

The Medicare home health benefit covers intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational services, medical social worker services, and home health aide services. For CY 2014, Medicare paid home health agencies (HHAs) about $18 billion for home health services. Centers for Medicare & Medicaid Services's Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was 51.4 percent, or about $9.4 billion. Recent OIG reports have similarly disclosed high error rates at individual HHAs. Improper payments identified in these OIG reports consisted primarily of beneficiaries who were not homebound or who did not require skilled services. OIG will review compliance with various aspects of the home health prospective payment system and include medical review of the documentation required in support of the claims paid by Medicare. OIG will determine whether home health claims were paid in accordance with Federal requirements.

Work Plan #: A-03-17-00004 (January 2021); A-04-16-06195 (May 2021); A-03-17-00009 (April 2021); A-02-19-01013 (August 2021); A-06-16-05005 (December 2020); A-02-17-01025 (October 2020); A-02-16-01001 (May 2019); A-05-16-00057 (May 2019); A-05-16-00055 (May 2019); A-01-16-00500 (May 2019); A-07-16-05092 (August 2019); A-07-16-05093 (October 2019); A-05-17-00022 (December 2019); W-00-19-35712; W-00-16-35712; W-00-16-35501; W-00-17-35712; various reviews
Government Program: Medicare Parts A & B

Medicaid Personal Care Services

Expected Issue Date: 2022

Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. Prior OIG reviews identified significant problems with States' compliance with PCS requirements. Some reviews also showed that program safeguards intended to ensure medical necessity, patient safety, quality, and prevent improper payments were often ineffective. OIG will determine whether improvements have been made to the oversight and monitoring

Provider

of PCS and whether those improvements have reduced the number of PCS claims not in compliance with Federal and State requirements.

Work Plan #: A-02-19-01016 (December 2020); W-00-19-31536
Government Program: Medicaid

Health and Safety Standards in Social Services for Adults

Expected Issue Date: 2022

State agencies operate elderly waiver programs under a 1915(c) waiver to their Medicaid State plan. Adult day centers are center-based facilities directly licensed by the State agency. They provide adult day services to functionally impaired adults on a regular basis for periods of fewer than 24 hours during the day in a nonresidential setting. As the licensing agency for adult day care centers, the State agency must ensure that adult day centers follow applicable licensing standards to protect the health and safety of adults receiving services at these facilities. Recent OIG reports have identified numerous instances of noncompliance in regulated childcare facilities and family adult foster care homes. OIG will determine whether regulated adult day centers comply with applicable Federal, State, and local regulations and standards on ensuring the health and safety of adults in their care, including infection control for conditions such as coronavirus disease 2019 (COVID-19) and other coronaviruses.

Work Plan #: A-05-17-00030 (October 2018); A-05-16-00044 (October 2017); A-05-17-00009; A-05-17-00028; W-00-20-31503
Government Program: Medicaid

Consumer-Directed Personal Assistance Program

Expected Issue Date: 2022

Medicaid Consumer-Directed Personal Assistance Programs provide an alternative way of receiving home care services in which consumers have more control over who provides their care and how it is provided. Rather than assigning a home care agency that controls selection, training, and scheduling of aides, the consumer, or the family member, friend, or guardian directing his or her care, performs all these functions usually done by the agency. Eligible individuals include those eligible for services provided by a certified home health agency, a long-term home health care (waiver) program, AIDS home care program, or personal care (home attendant). Prior OIG work has shown vulnerabilities in personal care programs resulting in ineligible beneficiaries and Medicaid payments that do not comply with Federal and State regulations. OIG will determine whether selected States made Medicaid payments for consumer-directed personal assistance program claims in accordance with applicable Federal and State regulations.

Work Plan #: A-02-16-01026 (June 2018); W-00-16-31035;
Government Program: Medicaid

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Provider

Hospice

Nationwide Review of Hospice Beneficiary Eligibility

Expected Issue Date: 2023
Announced/Revised: January 2022

Hospice care can provide comfort to beneficiaries, families, and caregivers at the end of beneficiaries' lives. To be eligible for hospice care, they must be entitled to Medicare Part A and be certified as being terminally ill. The certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group, and the beneficiaries' attending physician, if they have one, regarding the normal course of their illness. OAS has performed several compliance audits of individual hospice providers in recent years, and each of those audit reports identified findings related to beneficiary eligibility. OIG will perform a nationwide review of hospice eligibility, focusing on those hospice beneficiaries that haven't had an inpatient hospital stay or an emergency room visit in certain periods prior to their start of hospice care.

Work Plan #: W-00-22-35883
Government Program: Medicare Parts A & B

Medicare Payments Made Outside of the Hospice Benefit

Expected Issue Date: 2022
Announced/Revised: June 2018

According to 42 CFR 418.24(d), in general, a hospice beneficiary waives all rights to Medicare payments for any services that are related to the treatment of the terminal condition for which hospice care was elected. The hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions. Medicare continues to pay for covered medical services that are not related to the terminal illness. Prior OIG reviews have identified separate payments that should have been covered under the per diem payments made to hospice organizations.

OIG will produce summary data on all Medicare payments made outside the hospice benefit, without determining the appropriateness of such payments, for beneficiaries who are under hospice care. In addition, OIG will conduct separate reviews of selected individual categories of services (e.g., durable medical equipment, prosthetics, orthotics and supplies, physician services, outpatient) to determine whether payments made outside of the hospice benefit complied with Federal requirements.

Work Plan #: W-00-20-35797; A-09-20-03026
Government Program: Medicare Parts A & B

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Provider

Hospice Home Care - Frequency of Nurse On-Site Visits to Assess Quality of Care and Services

Expected Issue Date: 2020
Announced/Revised: November 2016

In 2013, more than 1.3 million Medicare beneficiaries received hospice services from more than 3,900 hospice providers, and Medicare hospice expenditures totaled $15.1 billion. Hospices are required to comply with all Federal, State, and local laws and regulations related to the health and safety of patients (42 CFR § 418.116). Medicare requires that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs (42 CFR § 418.76(h)(1)(i)). OIG will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

Work Plan #: W-00-16-35777
Government Program: Medicare Parts A & B

Review of Hospices' Compliance with Medicare Requirements

Expected Issue Date: 2022

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of and limitations on payment for hospice services (42 CFR Part 418, Subpart G). OIG will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Work Plan #: A-09-18-03024 (July 2021); A-09-18-03009 (July 2021); A-09-18-03028 (June 2021); A-09-20-03035 (June 2021); A-09-20-03034 (May 2021); A-02-18-01001 (May 2021); A-09-18-03016 (May 2021); A-09-18-03017 (May 2021); A-02-16-01023 (November 2020); A-02-16-01024 (December 2020); W-00-16-35783; various reviews
Government Program: Medicare Parts A & B

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Provider

Medical Equipment & Supplies

Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Orthotic Braces

Expected Issue Date: 2022
Announced or Revised: January 2021

Prior OIG work identified inappropriate payments for orthotic braces that were not medically necessary, not documented in accordance with Medicare requirements, or fraudulent. OIG will compile the results of prior OIG audits, evaluations, and investigations of orthotic braces that were paid for by Medicare. OIG will also analyze data to identify trends in payment, compliance, and fraud vulnerabilities, and offer recommendations for improving detected vulnerabilities.

Work Plan #: W-00-21-35863
Government Program: Medicare Parts A & B

Review of Medicare Payments for Power Mobility Device Repairs

Expected Issue Date: 2022
Announced/Revised: October 2019

Medicare Part B covers medically necessary power mobility devices (PMDs), such as power wheelchairs, and PMD repairs that are reasonable and necessary to make the equipment serviceable. For calendar year 2018, Medicare Part B paid approximately $46.7 million for PMD repairs, including replacement parts needed to repair PMDs. Durable medical equipment (DME) suppliers must maintain documentation from the physician or treating practitioner indicating that the PMD being repaired continued to be medically necessary and that the repairs were reasonable and necessary.

DME suppliers must also maintain detailed records describing the need for and nature of all repairs, which includes a justification for the replaced parts and the labor time. In addition, if the expense for repairs exceeds the estimated expense of purchasing or renting another PMD for the remaining period of medical need, no payment can be made for the excess. OIG will audit Medicare payments for PMD repairs to determine whether suppliers complied with Medicare requirements.

Work Plan #: W-00-19-35828; W-00-22-35828
Government Program: Medicare Parts A & B

Supplier Compliance with Medicare Requirements for Replacement of Positive Airway Pressure Device Supplies

Expected Issue Date: 2022
Announced/Revised: October 2019

Beneficiaries receiving continuous positive airway pressure or respiratory assist device (collectively known as positive airway pressure (PAP) devices) therapy require replacement of supplies (e.g., mask, tubing, headgear, and filters) when they wear out or are exhausted. Medicare payments for these replacement supplies in 2017 and 2018 were approximately

$945.8 million. Prior OIG work found that most Medicare claims that suppliers submitted for replacement PAP device supplies did not comply with Medicare requirements.

For supplies and accessories used periodically, orders must specify the type of supplies needed, the frequency of use, if applicable, and the quantity to be dispensed. Suppliers must not automatically ship refills on a predetermined basis (Centers for Medicare & Medicaid Services Medicare Program Integrity Manual, Pub. 100-08, Ch. 5, §§ 5.2.3 and 5.2.8). OIG will review claims for frequently replaced PAP device supplies at selected suppliers to determine whether documentation requirements for medical necessity, frequency of replacement, and other Medicare requirements are met.

Work Plan #: W-00-20-35830; W-00-22-35830
Government Program: Medicare Parts A & B

Medicare Payments of Positive Airway Pressure Devices for Obstructive Sleep Apnea Without Conducting a Prior Sleep Study

Expected Issue Date: 2022
Announced/Revised: August 2019

An OIG analysis of the 2017 Comprehensive Error Rate Testing (CERT) program for positive airway pressure (PAP) device payments shows potential overpayments of $566 million. Claims for PAP devices used to treat obstructive sleep apnea (OSA) for beneficiaries who have not had a positive diagnosis of OSA based on an appropriate sleep study are not reasonable and necessary (Medicare National Coverage Determination Manual, Chapter 1, Part 4, § 240.4 and Local Coverage Determination (LCD) L33718). Medicare will not pay for items or services that are not "reasonable and necessary" (Social Security Act § 1862(a)(1)(A)). OIG will examine Medicare payments to durable medical equipment providers for PAP devices used to treat OSA to determine whether an appropriate sleep study was conducted.

Work Plan #: W-00-19-35823; W-00-22-35823
Government Program: Medicare Parts A & B

Non-invasive Home Ventilators - Compliance with Medicare Requirements

Expected Issue Date: 2022

For items such as non-invasive home ventilators (NHVs) and respiratory assist devices (RADs) to be covered by Medicare, they must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Depending on the severity of the beneficiary's condition, an NHV or RAD may be reasonable and necessary. NHVs can operate in several modes, i.e., traditional ventilator mode, RAD mode, and basic continuous positive airway pressure (CPAP) mode. The higher cost of the NHVs' combination of non-invasive interface and multimodal capability creates a greater risk that a beneficiary will be provided an NHV when a less expensive device such as a RAD or CPAP device is warranted for the patient's medical condition. Prior OIG work identified significant growth in Medicare billing for NHVs in the years since they reached the market. OIG will determine whether claims for NHVs were medically necessary for the treatment of beneficiaries' diagnosed illnesses and whether the claims complied with Medicare payment and documentation requirements.

Work Plan #: A-04-18-04066 (May 2021); W-00-18-35809; W-00-22-35809
Government Program: Medicare Parts A & B

Provider

Ventilation Devices: Reasonableness of Medicare Payments Compared to Amounts Paid in the Open Market

Expected Issue Date: 2020
Announced/Revised: August 2017

Medicare reimbursement for ventilation devices has risen from $51 million in 2011 to $72 million in 2015. However, unlike similar items for which Medicare has seen reduced costs through competitive bidding, ventilation devices have not been competitively bid. OIG will determine the reasonableness of the fee schedule prices that Medicare and beneficiaries pay for ventilation devices compared to prices on the open market to identify potential wasteful spending in the Medicare program.

Work Plan #: W-00-17-35803
Government Program: Medicare Parts A & B

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Provider

Physical and Other Therapies

Medicare Part B Payments for Speech-Language Pathology

Expected Issue Date: 2022
Announced/Revised: October 2019

Outpatient speech therapy services are provided by speech-language pathologists and are necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and swallowing disorders (dysphagia). When Medicare payments for a beneficiary's combined physical therapy and speech therapy exceed an annual therapy spending threshold (e.g., $2,010 in 2018), the provider must append the KX modifier to the appropriate Healthcare Common Procedure Coding System reported on the claim. The KX modifier denotes that outpatient physical therapy and speech therapy services combined have exceeded the annual spending threshold per beneficiary, and that the services being provided are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

OIG will determine whether the claims using the KX modifier adhere to Federal requirements. In addition, OIG will evaluate payment trends to identify Medicare payments for outpatient speech therapy services billed using the KX modifier that are potentially unallowable.

Work Plan #: W-00-19-35827; W-00-21-35827
Government Program: Medicare Parts A & B

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Provider

Behavioral Health

Availability of Behavioral Health in Medicare Fee-For-Service, Medicare Advantage, and Medicaid Managed Care

Expected Issue Date: 2023
Announced/Revised: December 2021

More than half of all Americans will be diagnosed with a behavioral health condition in their lifetime, estimates indicate, and many experts say that the need for behavioral health services has grown dramatically during the COVID-19 pandemic. Medicare and Medicaid beneficiaries often have unmet behavioral health needs and face difficulty accessing appropriate services. To address these concerns, OIG will conduct a three-part study to examine access to behavioral health care in Medicare fee-for-service, Medicare Advantage, and Medicaid managed care. For selected localities, this study will determine: (1) the ratio of behavioral health providers to beneficiaries within each of these three programs; (2) the extent to which behavioral health providers have availability to accept new patients and schedule appointments within each of the three programs; and (3) the extent to which behavioral health providers listed in networks of managed care plans provided services to the plans' beneficiaries. Combined, these studies will provide significant insight into the accessibility of behavioral health providers within each of these three programs.

Work Plan #: OEI-02-22-00050, OEI-09-21-00410
Government Program: Centers for Medicare and Medicaid Services

Audits of SAMHSA's Certified Community Behavioural Health Clinic Expansion Grants

Expected Issue Date: 2023
Announced/Revised: August 2021

Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide comprehensive 24/7 access to: (1) community-based mental health and substance use disorder services, (2) treatment of co-occurring disorders, and (3) physical health care in one location. In Federal fiscal year 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded CCBHC expansion grants totaling approximately $450 million to increase access to and improve the quality of community mental health and substance use disorder treatment services through direct services. This included $250 million appropriated by the Coronavirus Aid, Relief and Economic Security Act. OIG will determine whether SAMHSA followed its policies and procedures for awarding and monitoring CCBHC expansion grants. In a separate audit, OIG will determine whether CCBHCs used expansion grant funds in accordance with Federal requirements and applicable grant terms.

Work Plan #: W-00-21-59463
Government Program: Medicare Parts A & B

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Provider

Medicare Part B Payments for Psychotherapy Services (Including Services Provided via Telehealth During the Public Health Emergency)

Expected Issue Date: 2022
Announced/Revised: December 2020

Medicare Part B covers psychotherapy services. Psychotherapy is the treatment of mental illness and behavioral disturbances in which a physician or other qualified health care professional establishes professional contact with a patient and, through therapeutic communication and techniques, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. In calendar year 2019, Medicare Part B allowed approximately $1 billion for psychotherapy services, including individual and group therapy. A prior OIG review found that Medicare allowed $185 million in inappropriate outpatient mental health services, including psychotherapy services that were not covered and were inadequately documented. Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act and section 1135 of the Social Security Act, and retroactive to March 2020, the Secretary of Health and Human Services authorized CMS to temporarily implement waivers and modifications to Medicare program requirements and conditions of participation for telehealth. Medicare beneficiaries are now able to receive psychotherapy services through telehealth.

OIG's preliminary analysis of psychotherapy services provided during the first 8 months of calendar year 2020 determined that 43 percent of the Medicare payments were for services provided via telehealth (compared to less than 1 percent in calendar year 2019). OIG will conduct multiple audits of Medicare Part B payments for psychotherapy services to determine whether those services were allowable in accordance with Medicare documentation requirements. The nationwide audit of psychotherapy services will be included in phase one of OIG's audits of Medicare Part B Telehealth Services Provided During the Public Health Emergency (work plan number W-00-21-35862) to make an early assessment of whether these services comply with Medicare requirements. OIG will assess the appropriateness of psychotherapy services in general and also include a review of psychotherapy services provided via telehealth.

Work Plan #: W-00-17-35801; W-00-21-35801
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2022
Announced/Revised: February 2021

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.

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

Medicaid Claims for Opioid Treatment Program Services

Expected Issue Date: 2022

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 will determine whether selected state agencies complied with certain Federal and state requirements when claiming Medicaid reimbursement for OTP services.

Work Plan #: A-02-17-01021 (February 2020); A-06-20-08000 (August 2021); A-07-20-04118 (September 2021); W-00-17-31523; W-00-20-31523
Government Program: Medicaid

Assertive Community Treatment Program

Expected Issue Date: 2021

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 will determine 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.

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

Medicaid Targeted Case Management

Expected Issue Date: 2022

The Social Security Act, § 1915(g)(2), defines case management services as those assisting individuals eligible under the state plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other

program authorities for the same service. Prior OIG work in one state identified 18 percent of such claims as unallowable, with an additional 20 percent as potentially unallowable. OIG will determine whether Medicaid payments for targeted case management services in selected States were made in accord with Federal requirements.

Work Plan #: A-07-17-03219 (March 2019); A-07-17-03219 (March 2019); A-07-16-03215 (April 2018); W-00-17-31082
Government Program: Medicaid

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Provider

Laboratory

Audit of CMS Clinical Laboratory Fee Schedule Rate-Setting Process for Public Health Emergencies

Expected Issue Date: 2022
Announced/Revised: June 2021

Medicare Part B pays for most clinical diagnostic laboratory tests (CDLTs) under the Clinical Laboratory Fee Schedule (CLFS). As a result of the Protecting Access to Medicare Act of 2014 (PAMA), beginning in 2018, CMS sets CLFS reimbursement rates based on the weighted median of private payer rates reported to CMS. A rate is set for each CDLT's Healthcare Common Procedure Coding System (HCPCS) code. The data are reported every 3 years, beginning January 1, 2017. (Reporting was postponed from January 1, 2020, to January 1, 2022, because of the pandemic.) For new CDLTs, CMS or its Medicare administrative contractors set reimbursement rates using "cross-walking" or "gap-filling" methodologies. CMS determines the basis (i.e., cross-walking or gap-filling) after it solicits and receives public comments, announces and holds its CLFS annual public meeting regarding new CDLTs, and considers comments and recommendations (and accompanying data) received, including recommendations from an outside advisory panel. The objective of this audit is to determine whether CMS's procedures for clinical diagnostic laboratory test rate-setting could be improved for future public health emergencies.

Work Plan #: W-00-21-35875; W-00-22-35875
Government Program: Medicare Parts A & B

Medicare Payments for Clinical Diagnostic Laboratory Tests in 2020

Expected Issue Date: 2022
Announced/Revised: June 2021

Medicare is the largest payer of clinical laboratory services in the Nation. Medicare Part B covers most laboratory tests and pays 100 percent of allowable charges. Beneficiaries do not have a copay. The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to set payment rates for laboratory tests using current charges in the private health care market, under Title XVIII of the Social Security Act. (Pub. L. No. 113-93 § 216(c)(2)(A)). On January 1, 2018, CMS began paying for laboratory tests under the new system mandated by PAMA. PAMA requires OIG to publicly release an annual analysis of the top 25 laboratory tests by expenditures. In accordance with the Act, OIG will publicly release an analysis of the top 25 laboratory tests by expenditures for 2020.

Work Plan #: OEI-09-21-00240
Government Program: Medicare Parts A & B

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Provider

Audits of Medicare Part B Laboratory Services During the COVID-19 Pandemic

Expected Issue Date: 2022
Announced/Revised: February 2021

Laboratory tests are critically important because they are used for early detection, diagnosis, monitoring, and treatment of disease. COVID-19, the disease caused by a new strain of coronavirus that had not been previously identified in humans, first emerged in China in December 2019, and the first reported U.S. case occurred in January 2020. Because of the rapid worldwide spread of the virus, the World Health Organization declared COVID-19 a global pandemic in March 2020. To protect the health and safety of the American people and to assist the Department of Health and Human Services and its Federal partners, laboratories began to provide COVID-19 testing to identify individuals who had contracted the coronavirus that causes COVID-19. Laboratory testing for both COVID-19 tests and non-COVID-19 tests (i.e., laboratory tests that are not for COVID-19) is important for all Medicare beneficiaries, but may be especially important for beneficiaries with certain medical conditions who are identified to be at increased risk for severe illness from COVID-19. Ensuring individuals receive necessary laboratory tests is critical to improving health care quality and containing long-term health costs.

OIG's preliminary analysis has shown that the number of non-COVID-19 tests billed for Medicare Part B beneficiaries during the COVID-19 pandemic has decreased compared with the 6-month period before the pandemic, and many independent laboratories have encountered challenges in providing COVID-19 testing. OIG will conduct a series of audits on Medicare Part B laboratory services during the pandemic that will initially focus on the effect of the pandemic on non-COVID-19 testing. The series of audits will also focus on aberrant billing of COVID-19 testing during the pandemic.

Work Plan #: W-00-21-35867
Government Program: Medicare Parts A & B

Audit of Health Resources and Services Administration's COVID-19 Uninsured Program

Expected Issue Date: 2022
Announced/Revised: October 2020

To address the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) and the Paycheck Protection Program and Health Care Enhancement Act (PPP) together appropriated $2 billion to reimburse providers for costs associated with conducting COVID-19 testing and testing-related items and services for the uninsured. Additionally, a portion of the $175 billion appropriated to the Provider Relief Fund by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and PPP will be used for treating uninsured individuals with a confirmed COVID-19 diagnosis. HHS, through the Health Resources and Services Administration (HRSA), launched the COVID-19 Uninsured Program Portal, a single electronic claims processing system for health care providers for submitting claims for reimbursements for diagnostic testing and treating uninsured individuals. OIG will determine whether claims for COVID-19 diagnostic testing and treatment services reimbursed by HHS through HRSA's COVID-19 Uninsured Program complied with Federal requirements.

Work Plan #: W-00-20-30053
Government Program: Department of Health and Human Services (HHS)

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Provider

Trend Analysis of Medicare Laboratory Billing for Potential Fraud and Abuse With COVID-19 Add-on Testing

Expected Issue Date: 2022
Announced/Revised: June 2020

The coronavirus disease 2019 (COVID-19) pandemic has led to an unprecedented demand for diagnostic laboratory testing to determine whether an individual has the virus. Beyond the COVID-19 tests, laboratories can also perform add-on tests, for example, to confirm or rule out diagnosis other than COVID-19. However, OIG has program integrity concerns related to add-on tests in conjunction with COVID-19 testing, particularly related to potentially fraudulent billing for associated respiratory pathogen panel (RPP) tests, allergy tests, or genetic tests. The Centers for Medicare & Medicaid Services has relaxed rules related to COVID-19 testing and other associated diagnostic laboratory testing to no longer require an order from the treating physician or nonphysician practitioner (NPP) during the COVID-19 public health emergency. Relaxation of the physician ordering/NPP rules could allow unscrupulous actors more leeway for fraudulent billing of unnecessary add-on testing. This study will examine Medicare claims data for laboratory testing to identify trends in the use of RPP, allergy, and genetic testing and identify patterns of billing by laboratories that may indicate fraud and abuse.

Work Plan #: OEI-09-20-00510
Government Program: Medicare Parts A & B

Medicare Payments for Clinical Diagnostic Laboratory Tests in 2019: Year 2 of the New Fee Schedule Rates

Expected Issue Date: 2021
Announced/Revised: June 2020

Medicare is the largest payer of clinical laboratory services in the Nation. Medicare Part B covers most lab tests and pays 100 percent of allowable charges. The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to set Medicare payment rates for lab tests using private payer rates collected from labs (PAMA, Pub. L. No. 113-93 § 216(a)). On January 1, 2018, CMS began paying for lab tests under the new system mandated by PAMA. PAMA requires OIG to release an annual analysis of the top 25 laboratory tests by expenditures under Title XVIII of the Social Security Act (PAMA, § 216(c)(2)(A)). In addition, PAMA mandates that OIG conduct analyses it determines appropriate with respect to the implementation and effect of the new payment system (PAMA, § 216(c)(2)(B)). In accordance with PAMA, OIG will publicly release an analysis of the top 25 laboratory tests by expenditures for 2019 and analyze the payments made under the new payment system in 2019, the second year of payments made under the new system for setting payment rates.

Work Plan #: OEI-09-20-00450
Government Program: Medicare Parts A & B

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Provider

Medicare Part B Payments for Laboratory Services

Expected Issue Date: 2022

Medicare covers diagnostic clinical laboratory services that are ordered by a physician who is treating a beneficiary and who uses the results in the management of the beneficiary's specific medical problem (42 CFR 410.32(a)). These covered services can be furnished in hospital laboratories (for outpatient or nonhospital patients), physician office laboratories, independent laboratories, dialysis facility laboratories, nursing facility laboratories, and other institutions.

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 (the Social Security Act § 1833(e)). OIG will review Medicare payments for clinical laboratory services to determine laboratories' compliance with selected billing requirements. OIG will focus on claims for clinical laboratory services that may be at risk for overpayments. For example, OIG reviews will focus on the improper use of claim line modifiers for a code pair, genetic testing, urine drug testing services and billing phlebotomy travel allowances. OIG may use the results of these reviews to identify laboratories or other institutions that routinely submit improper claims.

Work Plan #: A-09-20-03027 (December 2021); A-09-19-03027 (May 2021); A-06-17-04002 (December 2019); A-04-18-08063 (November 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 Parts A & B

Review of Medicare Part B Urine Drug Testing Services

Expected Issue Date: 2022

Medicare covers treatment services for substance use disorders (SUDs), such as inpatient and outpatient services, when they are reasonable and necessary. SUDs occur when the recurrent use of alcohol or other drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Medicare also covers clinical laboratory services, including urine drug testing (UDT), under Part B. Physicians use UDT to detect the presence or absence of drugs or to identify specific drugs in urine samples.

A patient in active treatment for a SUD or being monitored during different phases of recovery from a SUD may undergo medical management for a variety of medical conditions. UDT results influence treatment and level-of-care decisions for individuals with SUDs. The 2018 Medicare fee-for-service improper payment data showed that laboratory testing, including UDT, had an improper payment rate of almost 30 percent, and that the overpayment rate for definitive drug testing for 22 or more drug classes was 71.7 percent. OIG will review UDT services for Medicare beneficiaries with SUD-related diagnoses to determine whether those services were allowable in accordance with Medicare requirements.

Work Plan #: A-09-20-03017 (June 2021) ;W-00-20-35829
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Prescriber

Assessing Trends Related to the Use of Psychotropic Drugs in Nursing Homes

Expected Issue Date: 2022
Announced/Revised: July 2020

Previous OIG work found that elderly nursing home residents who were prescribed antipsychotic drugs—a type of psychotropic drug—were at risk for harm. CMS concurred with some OIG's recommendations and developed new initiatives. However, policymakers continue to raise concerns about whether CMS has made sufficient progress in reducing the use of antipsychotic drugs to care for the elderly. OIG will report the changes over time for the following: (1) the use of psychotropic drugs for elderly nursing home residents, (2) citations and civil monetary penalties assessed to nursing homes regarding psychotropic drugs, and (3) the presence of diagnoses that exclude nursing home residents from CMS's measure of the use of antipsychotic drugs.

Work Plan #: OEI-07-20-00500
Government Program: Medicare Parts A & B

Medicare Payments for Stelara

Expected Issue Date: 2023
Announced/Revised: May 2020

Since 2016, total Medicare Part B payments to physicians for Stelara, an expensive drug used to treat certain autoimmune diseases that is often self-injected by patients in their home, have increased substantially. Such a large increase in payments for a drug that would not typically be covered under Part B raises questions about what is driving the growth, including the possibility of improper billing. In this study, OIG will: (1) determine whether versions of Stelara that are typically self-injected meet the criteria for Medicare Part B coverage, (2) identify factors that may be causing the substantial growth in payments, and (3) determine whether claims for Stelara show evidence of improper billing by physicians.

Work Plan #: OEI-BL-19-00500
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Telehealth

Telehealth Services in Select Federal Health Care Programs

Expected Issue Date: 2023
Announced/Revised: December 2021

Throughout the COVID-19 pandemic, the use of telehealth has been critically important. Telehealth has helped ensure access to care while reducing the risk of community spread of the virus. As the effects of the pandemic are still being felt throughout the Nation, there are questions about how telehealth can best be used to meet the needs of beneficiaries in the future. HHS-OIG will work with the other OIG members and leadership of the Pandemic Response Accountability Committee (PRAC) to produce a report describing the types of telehealth services that are available, including those that were expanded during the pandemic, and key program integrity risks associated with the use of telehealth across six selected Federal health care programs. Medicare is the HHS program included in this evaluation. HHS-OIG will conduct this evaluation with OIGs from the departments of Defense, Justice, Labor, and Veterans Affairs, and the Office of Personnel Management. PRAC will issue the resulting report. It will provide policymakers and stakeholders with foundational information about the nature of telehealth across select Federal health care programs and related program integrity risks in order to inform the use of telehealth in the future.

Work Plan #: OEI-02-22-00150
Government Program: Medicare Parts A & B

Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks

Expected Issue Date: 2022
Announced/Revised: October 2020

In response to the COVID-19 pandemic, CMS implemented a number of waivers and flexibilities that allowed Medicare beneficiaries to access a wider range of telehealth services without having to travel to a health care facility. This review will be based on Medicare Parts B and C data and will identify program integrity risks associated with Medicare telehealth services during the pandemic. OIG will analyze providers' billing patterns for telehealth services. OIG will also describe key characteristics of providers that may pose a program integrity risk to the Medicare program.

Work Plan #: OEI-02-20-00720
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Use of Medicare Telehealth Services During the COVID-19 Pandemic

Expected Issue Date: 2022
Announced/Revised: October 2020

In response to the coronavirus disease 2019 (COVID-19) pandemic, CMS made several changes that allowed Medicare beneficiaries to access a wider range of telehealth services without having to travel to a health care facility. CMS is proposing to make some of these changes permanent. This review will be based on Medicare Parts B and C data, and will look at the use of telehealth services in Medicare during the COVID-19 pandemic. It will look at the extent to which telehealth services are being used by Medicare beneficiaries, how the use of these services compares to the use of the same services delivered in-person, and the different types of providers and beneficiaries using telehealth services.

Work Plan #: OEI-02-20-00520; OEI-02-20-00522
Government Program: Medicare Parts A & B

Medicaid—Telehealth Expansion During COVID-19 Emergency

Expected Issue Date: 2022
Announced/Revised: June 2020

As a result of the coronavirus disease 2019 (COVID-19) pandemic, State Medicaid programs have expanded options for telehealth services. Rapid expansion of telehealth may pose challenges for State agencies and providers, including state oversight of these services. OIG's objective is to determine whether state agencies and providers complied with federal and state requirements for telehealth services under the national emergency declaration, and whether the states gave providers adequate guidance on telehealth requirements.

Work Plan #: W-00-20-31548
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Other Providers & Suppliers

Intimate Partner Violence Screening and Referral by Primary Care Providers for Patients Enrolled in Medicaid

Expected Issue Date: 2023
Announced/Revised: August 2021

Intimate partner violence—which includes physical, sexual, and psychological abuse—is a serious, preventable public health problem that affects millions of Americans. Primary care providers play a critical role in screening patients for intimate partner violence and referring patients who screen positive to support services. The U.S. Preventive Services Task Force (USPSTF) has a recommendation that clinicians screen for intimate partner violence in women of reproductive age and provide or refer women who screen positive to ongoing support services. Despite this recommendation, primary care providers may encounter barriers to screening—including lack of knowledge, time constraints, and lack of adequate compensation. Medicaid expansion programs must provide coverage of certain preventive services recommended by USPSTF including screening for intimate partner violence, and States may opt to cover this preventive service in their traditional Medicaid programs. However, there are no specific procedure codes for providers to bill for time spent screening for intimate partner violence and making referrals to support services. This evaluation will determine whether and how primary care providers who serve Medicaid enrollees screen for intimate partner violence and make referrals to support services. OIG also expects this work to identify opportunities to improve these screening and referral practices.

Work Plan #: OEI-03-21-00310
Government Program: Medicare Parts A & B

Audit of Independent Organ Procurement Organizations' Organ Acquisition Overhead Costs

Expected Issue Date: 2022
Announced/Revised: June 2021

OIG will review Medicare payments made to independent organ procurement organizations (OPOs). An OPO is an organization that performs or coordinates the procurement, preservation, and transport of organs and maintains a system for locating prospective beneficiaries for available organs. Medicare reimburses OPOs under 42 CFR § 413.200 according to a cost basis method set out at 42 CFR § 413.24. Prior OIG audits determined that OPOs did not comply with Medicare requirements for reporting overhead costs and administrative and general costs and for reporting organ statistics. OIG will determine whether payments to OPOs for selected overhead costs complied with Medicare requirements and guidance.

Work Plan #: W-00-21-35874
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Dermatologist Claims for Evaluation and Management Services on the Same Day as Minor Surgical Procedures

Expected Issue Date: 2022
Announced/Revised: April 2021

Medicare covers an Evaluation and Management (E/M) service when the service is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Generally, Medicare payments for global surgery procedures include payments for necessary preoperative and postoperative services related to surgery when furnished by a surgeon. Medicare global surgery rules define the rules for reporting E/M services with minor surgery and other procedures covered by these rules. In general, E/M services provided on the same day of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for a minor surgical procedure and must not be reported separately as an E/M service.

An E/M service should be billed only on the same day if a surgeon performs a significant and separately identifiable E/M service that is unrelated to the decision to perform a minor surgical procedure. In this instance, the provider should append a modifier 25 to the appropriate E/M code. In 2019, about 56 percent of dermatologists' claims with an E/M service also included minor surgical procedures (such as lesion removals, destructions, and biopsies) on the same day. This may indicate abuse whereby the provider used modifier 25 to bill Medicare for a significant and separately identifiable E/M service when only a minor surgical procedure and related preoperative and postoperative services are supported by the beneficiary's medical record. OIG will determine whether dermatologists' claims for E/M services on the same day of service as a minor surgical procedure complied with Medicare requirements.

Work Plan #: W-00-21-35868
Government Program: Medicare Parts A & B

Infection Control and Emergency Preparedness at Dialysis Centers During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced/Revised: August 2020

The CDC has stated that beneficiaries with serious underlying medical conditions, such as end-stage renal disease (ESRD), are at higher risk for severe illness from COVID-19. Regardless of the current pandemic, dialysis patients are at high risk of infection because of weakened immune systems, coexisting conditions such as diabetes, and treatments requiring frequent use of catheters or insertions of needles to access the bloodstream. ESRD facility conditions for coverage regarding infection control and emergency preparedness are defined in 42 CFR 494 Subpart B. On March 30, 2020, CMS issued a revised memorandum providing guidance for infection control and prevention of COVID-19 in dialysis facilities.

OIG will interview corporate officers from the three ESRD service companies covering more than 75 percent of CY 2018 Medicare reimbursements and 71 percent of dialysis clinics. OIG's objective is to determine whether ESRD facilities implemented additional infection control and emergency preparedness procedures in accordance with CMS and CDC guidance to safeguard high risk ESRD beneficiaries during the COVID-19 pandemic.

Work Plan #: W-00-20-35852
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

End Stage Renal Disease Networks' Responsibilities During COVID-19

Expected Issue Date: 2022
Announced/Revised: July 2020

The CDC has stated that beneficiaries with serious underlying medical conditions, such as end stage renal Disease (ESRD), are at higher risk for severe illness from COVID-19. As per the CDC, prompt detection, triage, and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients and health care personnel at dialysis facilities. ESRD treatment facilities are organized into groups called Networks.

Network Organizations under CMS contracts develop relationships with dialysis professionals, providers, and patients, and create a collaborative environment to improve patient care. The Network Organizations' contracts include statutory responsibilities and quality improvement activities that could be important in protecting ESRD beneficiaries during the COVID-19 pandemic. In addition to Network Organizations, the ESRD National Coordinating Center (NCC) supports and coordinates activities for the ESRD program on a national level. OIG will interview Network Organizations, NCC, and CMS officials to identify the actions Network Organizations are taking to aid dialysis clinics and patients in response to COVID-19 and keep CMS abreast of quality-of-care issues resulting from COVID-19.

Work Plan #: W-00-20-35851; W-00-22-35851
Government Program: Medicare Parts A & B

Advanced Care Planning Services: Compliance with Medicare Requirements

Expected Issue Date: 2022
Announced/Revised: June 2020

In 2016, Medicare began paying for Advanced Care Planning (ACP), which is a face-to-face service through which a Medicare physician (or other qualified health care professional) and a patient discuss the patient's wishes for health care if he or she becomes unable to make decisions about care. It allows Medicare beneficiaries to make important decisions, giving them control over the type of care they receive and when they receive it. Previous reviews have shown improper payments due to a lack of clinical documentation to support face-to-face services, clinical documentation of the time spent discussing ACP, or both. OIG plans to perform a nationwide audit to determine whether Medicare providers for ACP services complied with Federal regulations.

Work Plan #: W-00-20-35848
Government Program: Medicare Parts A & B

Medicare Part B Payments to Physicians for Co-Surgery Procedures

Expected Issue Date: 2022
Announced/Revised: March 2020

Under Medicare Part B, when the individual skills of two surgeons are necessary to perform a specific surgical procedure or distinct parts of a surgical procedure (or procedures) simultaneously on the same patient during the same operative session (co-surgery), each surgeon should report the specific procedure(s) by billing the same procedure code(s) with a modifier “62.” By appending modifier “62” to the procedure code(s), the fee schedule amount applicable to the payment for

each co-surgeon is 62.5 percent of the global surgery fee schedule amount. OIG plans to audit a sample of claim line items specifically where different physicians billed for the same co-surgery procedure code, for the same beneficiary, on the same date of service. OIG's objective is to determine whether Medicare Part B payments to physicians for co-surgery procedures were properly made.

Work Plan #: W-00-20-35844; W-00-22-35844
Government Program: Medicare Parts A & B

Review of Medicare Facet Joint Procedures

Expected Issue Date: 2022
Announced/Revised: August 2019

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

Work Plan #: W-00-19-35825; W-00-22-35825
Government Program: Medicare Parts A & B

Review of Medicare Part B Claims for Intravitreal Injections of Eylea and Lucentis

Expected Issue Date: 2022

Medicare Part B covers ophthalmology services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Ophthalmology services include intravitreal injections of Eylea and Lucentis to treat eye diseases such as wet age-related macular degeneration. Medicare pays for an intravitreal injection (which is considered a minor surgery) as part of a global surgical package that includes the preoperative, intraoperative, and postoperative services routinely performed by the physician.

Medicare pays for Eylea and Lucentis separately from the intravitreal injection. Chapter 12, section 40.1 of the Centers for Medicare & Medicaid Services' Medicare Claims Processing Manual states that separate payment can be made for other services provided by the same physician on the same day as the global surgery if the services are significant and separately identifiable or unrelated to the surgery. OIG will review claims for intravitreal injections of Eylea and/or Lucentis and the other services billed on the same day as the injection, including evaluation and management services, to determine whether the services were reasonable and necessary and met Medicare requirements.

Work Plan #: A-09-19-03025 (September 2021); A-09-19-03022 (March 2021); W-00-19-30100
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Review of Monthly ESRD-Related Visits Billed by Physicians or Other Qualified Healthcare Professionals

Expected Issue Date: 2022

Most physicians and other practitioners (e.g., clinical nurse specialists, nurse practitioners, or physician's assistants) who manage the care of patients who receive outpatient dialysis services at end-stage renal disease (ESRD) facilities are paid a monthly capitation payment (MCP) for ESRD-related physician services. The MCP amount is based on the number of visits provided within each month and the age of the ESRD beneficiary. The physician or other practitioner can bill only one of three current procedural terminology (CPT) codes for ESRD-related visits of one per month, two to three per month, or four or more per month (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, chapter 8, § 140.1).

The Comprehensive Error Rate Testing program's special study of the Healthcare Common Procedure Coding System codes for ESRD-related services found that for some codes, approximately one-third of the payments for ESRD-related services were improper payments due to insufficient documentation, incorrect coding, or no documentation submitted (CMS, Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors, volume 5, issue 3, April 2015). OIG will review whether physicians or other qualified healthcare professionals billed monthly ESRD-related visits in accordance with Federal requirements (Social Security Act, §§ 1815(a) and 1833(e)).

Work Plan #: A-07-19-05117 (May 2021); W-00-19-35822; W-00-22-35822
Government Program: Medicare Parts A & B

Medicare Part B Payments for Podiatry and Ancillary Services

Expected Issue Date: 2022
Announced/Revised: February 2019

Medicare Part B covers podiatry services for medically necessary treatment of foot injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Part B generally does not cover routine foot-care services such as the cutting or removal of corns and calluses or trimming, cutting, clipping, or debridement (i.e., reduction of both nail thickness and length) of toenails. Part B may cover these services however, if they are performed: (1) as a necessary and integral part of otherwise covered services, (2) for the treatment of warts on the foot, (3) in the presence of a systemic condition or conditions, or (4) for the treatment of infected toenails.

Medicare generally does not cover evaluation and management (E&M) services when they are provided on the same day as another podiatry service (e.g., nail debridement performed as a covered service). However, an E&M service may be covered if it is a significant separately identifiable service. In addition, podiatrists may order, refer, or prescribe medically necessary ancillary services such as x-rays, laboratory tests, physical therapy, durable medical equipment, or prescription drugs. Prior OIG work identified inappropriate payments for podiatry and ancillary services. OIG will review Part B payments to determine whether podiatry and ancillary services were medically necessary and supported in accordance with Medicare requirements.

Work Plan #: W-00-19-35818; W-00-21-35818
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Ambulance Services - Supplier Compliance with Payment Requirements

Expected Issue Date: 2021

Medicare pays for emergency and nonemergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation would endanger the beneficiary (SSA § 1861(s)(7)). Medicare pays for different levels of ambulance service, including basic life support, advanced life support, and specialty care transport (42 CFR § 410.40(b)). Prior OIG work found that Medicare made inappropriate payments for advanced life support emergency transports. OIG will determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements.

Work Plan #: A-02-16-01021 (December 2018); A-09-17-03018 (July 2018); W-00-17-35574; W-00-22-35574; various reviews
Government Program: Medicare Parts A & B

Physicians Billing for Critical Care Evaluation and Management Services

Expected Issue Date: 2022

Critical care is defined as the direct delivery of medical care by a physician(s) for a critically ill or critically injured patient. Critical care is usually given in a critical care area such as a coronary, respiratory, or intensive care unit, or the emergency department. Payment may be made for critical care services provided in any location if the care provided meets the definition of critical care. Critical care is exclusively a time-based code. Medicare pays physicians based on the number of minutes they spend with critical care patients. The physician must spend this time evaluating, providing care, and managing the patient's care and must be immediately available to the patient. This review will determine whether Medicare payments for critical care are appropriate and paid in accordance with Medicare requirements.

Work Plan #: A-03-18-00003; W-00-18-35816; W-00-22-35816; various reviews
Government Program: Medicare Parts A & B

Medicare Part B Payments for End-Stage Renal Disease Dialysis Services

Expected Issue Date: 2022
Announced/Revised: June 2018

Medicare Part B covers outpatient dialysis services for beneficiaries diagnosed with end-stage renal disease (ESRD). Prior OIG work identified inappropriate Medicare payments for ESRD services. Specifically, OIG identified unallowable Medicare payments for treatments not furnished or documented, services for which there was insufficient documentation to support medical necessity, and services that were not ordered by a physician or ordered by a physician that was not treating the patient (Social Security Act §§ 1862(a)(l)(A) and 1833(e), 42 CFR §§ 410.32(a) and (d), 42 CFR §§ 410.12(a)(3), 424.5(a)(6), and 424.10). Additionally, prior OIG reviews identified claims that did not comply with Medicare consolidated billing requirements (the Act § 1881(b)(14), Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 8 and Medicare Benefit Policy Manual, Pub. No. 100-02, Ch. 11). OIG will review claims for Medicare Part B dialysis services provided to beneficiaries with ESRD to determine whether such services complied with Medicare requirements.

Work Plan #: W-00-18-35811

Government Program: Medicare Parts A & B

Transportation Services - Compliance with Federal and State Requirements

Expected Issue Date: 2022

Federal regulations require States to ensure necessary transportation for Medicaid beneficiaries to and from providers (42 CFR § 431.53). Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. OIG will determine the appropriateness of Medicaid payments by States to providers for transportation services.

Work Plan #: A-05-16-00021 (June 2018); A-07-16-03209 (March 2017); W-00-16-31121; various reviews
Government Program: Medicaid

Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services

Expected Issue Date: 2021

Medicare Part B covers outpatient cardiac and pulmonary rehabilitation services. For these services to be covered, however, they must be medically necessary and comply with certain documentation requirements. Previous OIG work identified outpatient cardiac and pulmonary rehabilitation service claims that did not comply with Federal requirements. OIG will assess whether Medicare payments for outpatient cardiac and pulmonary rehabilitation services were allowable in accordance with Medicare requirements. OIG will also determine whether potential risks in outpatient cardiac and pulmonary rehabilitation programs continue to exist.

Work Plan #: A-02-18-01026 (May 2021); W-00-18-35808
Government Program: Medicare Parts A & B

Review of Medicare Payments for Bariatric Surgeries

Expected Issue Date: 2022
Announced/Revised: October 2017

Bariatric surgery is performed to treat comorbid conditions associated with morbid obesity. (A comorbid condition exists simultaneously with another medical condition.) Medicare Parts A and B cover certain bariatric procedures if the beneficiary has: (1) a body mass index of 35 or higher, (2) at least one comorbidity related to obesity, and (3) been previously unsuccessful with medical treatment for obesity (CMS, Medicare National Coverage Determinations Manual, Pub. No. 100-03, chapter 1, part 2, § 100.1). Treatments for obesity alone are not covered.

The Comprehensive Error Rate Testing program's special study of certain Healthcare Common Procedure Coding System codes for bariatric surgical procedures found that approximately 98 percent of improper payments lacked sufficient documentation to support the procedures (CMS, Medicare Quarterly Provider Compliance Newsletter, "Guidance to Address Billing Errors," volume 4, issue 4, July 2014). OIG will review supporting documentation to determine whether the bariatric services performed met the conditions for coverage and were supported in accordance with Federal requirements (Social Security Act, §§ 1815(a) and 1833(e)).

Provider

Work Plan #: W-00-17-35226
Government Program: Medicare Parts A & B

Payments for Medicare Services, Supplies, and DMEPOS Referred or Ordered by Physicians Compliance

Expected Issue Date: 2022
Announced/Revised: November 2016

Centers for Medicare & Medicaid Services requires that physicians and nonphysician practitioners who order certain services, supplies, and/or durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be Medicare-enrolled physicians or nonphysician practitioners and be legally eligible to refer and order services, supplies, and DMEPOS (Patient Protection and Affordable Care Act § 6405). If the referring or ordering physician or nonphysician practitioner is not eligible to order or refer, then Medicare claims should not be paid. OIG will review select Medicare services, supplies, and DMEPOS referred or ordered by physicians and nonphysician practitioners to determine whether the payments were made in accordance with Medicare requirements.

Work Plan #: W-00-17-35748; W-00-22-35748
Government Program: Medicare Parts A & B