Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Provider Focus

Active Work Plan Items

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as give our colleagues and clients 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.

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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Contact an Expert

Nancy Roht
913-207-4329
Nancy.Roht@SunHawkConsulting.com

James Rose
502-445-7511
James.Rose@SunHawkConsulting.com

Jim Rough
602-334-5522
Jim@SunHawkConsulting.com

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Provider

Multiple Providers

[NEW] Medicare Advantage Organizations' Use of Prior Authorization for Post-Acute Care

Expected Issue Date: 2025
Announced or Revised: June 2024

Medicare Advantage plans must cover at least the same services as original Medicare, but Medicare Advantage Organizations (MAOs) may impose additional administrative requirements, such as requiring prior authorization before certain services can be provided. Prior OIG work found that MAOs sometimes denied prior authorization requests for post-acute care after a qualifying hospital stay even though the requests met Medicare coverage rules. OIG will examine selected MAOs' processes for reviewing prior authorization requests for post-acute care in long-term acute care hospitals, inpatient rehabilitation facilities, and skilled nursing facilities. OIG will also review the extent to which the selected MAOs denied requests for post-acute care and examine the care settings to which patients were discharged from the hospital.

Work Plan #: OEI 09-24-00330
Government Program: Medicare Part C

The Role of Patient Selection Criteria in Ensuring Equitable Access to Kidney Transplantation

Expected Issue Date: 2025
Announced or Revised: July 2023

A transplant program at a hospital with a Medicare provider agreement must meet Medicare Conditions of Participation (CoPs) in order to receive CMS approval for providing transplant services. CoPs for transplant programs include a requirement that programs use written patient selection criteria to determine a patient's suitability for placement on the waiting list for a transplant and that patient selection criteria ensure the fair and nondiscriminatory distribution of organs. However, CMS stops short of defining patient selection criteria, and inequities in access to organ transplants persist. This study will evaluate how kidney transplant programs' patient selection criteria and related processes may affect the fair and nondiscriminatory distribution of organs. In addition, this study will assess how CMS monitors programs' compliance with, and takes corrective action regarding, its requirement that each program's patient selection criteria ensure the fair and nondiscriminatory distribution of organs.

Work Plan #: OEI-01-23-00290
Government Program: Medicare Parts A & B

Provider

Audits of Medicare Payments for Spinal Pain Management Services

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-07-21-00618 (March 2023); A-09-22-03006 (March 2023); A-09-21-03002 (December 2021); A-09-20-03010 (February 2021); A-09-20-03003 (October 2020); W-00-21-35825; W-00-22-35825; W-00-20-35825
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: 2024
Announced or Revised: Completed (partial)

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 #: A-09-22-06001 (March 2024); W-00-21-35873; W-00-22-35873
Government Program: Medicare Parts A & B

Provider

- **Multiple 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

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: 2023
Announced or Revised: Completed (partial)

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 #: A-09-21-06001 (September 2022); W-00-21-59060
Government Program: Medicare Parts A & B

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Provider

Hospital

[NEW] Medicare Enrollees Leaving Hospitals Against Medical Advice

Expected Issue Date: 2025
Announced or Revised: June 2024

Hospitals indicate on a claim that a patient left against medical advice (AMA) with a specific patient discharge status code- "07," which stands for "left against medical advice or discontinued care." According to some academic researchers, the AMA designation indicates a higher risk that a patient experienced poor quality health care. The researchers also note that hospital stays coded with the AMA designation may be associated with increased patient morbidity and mortality percentage rates. In addition, the researchers note that historically medically underserved groups of patients are more likely than other groups to receive the AMA designation. The percentage rates that hospitals have been designating that Medicare enrollees left AMA have increased over the past three decades. This data brief will analyze the percentage rates and outcomes for enrollees that hospitals designate as left AMA as well as provide CMS and other stakeholders with information that can be used to address health disparities and improve enrollee outcomes.

Work Plan #: W-00-24-35915
Government Program: Medicare Parts A & B

Medicare Inpatient Hospital Billing for Sepsis

Expected Issue Date: 2025
Announced or Revised: March 2024

Sepsis is the body's extreme response to an infection. It is a life-threatening, emergency medical issue that often progresses quickly and responds best to early intervention. The definition of and guidance for sepsis have changed over the years in attempts to identify it more accurately. The definition of sepsis was updated in 2016 by an international task force to better differentiate sepsis from a general infection. This narrower definition is widely recognized by groups such as the World Health Organization. However, CMS and CDC currently recognize an older, broader definition. Sepsis is a frequently billed diagnosis in Medicare. There are concerns that hospitals may be taking advantage of this broader definition, as they have a financial incentive to do so. This study will analyze Medicare claims to assess patterns in the inpatient hospital billing of sepsis in 2023 and describe how the billing of sepsis varied among hospitals. OIG will also estimate the costs to Medicare associated with using the broader, rather than the narrower, definition of sepsis.

Work Plan #: OEI-02-24-00230
Government Program: Medicare Parts A & B

Provider

- Multiple 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

Patient Safety Organizations: Key Insights, Challenges, and Opportunities

Expected Issue Date: 2025
Announced or Revised: March 2024

Despite nationwide efforts to improve patient safety, patient harm events in hospitals remain a serious concern. The Patient Safety Organization (PSO) program, authorized by the Patient Safety and Quality Improvement Act of 2005, is the flagship Federal program to facilitate patient harm reporting and learning on a national scale. However, in the years since the PSO program was created, OIG work has found consistently high patient harm rates in hospitals and a lack of hospital identification of these events, which are areas that the PSO program was designed to address. OIG work has also found that, although many hospitals find value in PSOs, hospitals find it challenging to navigate the legal protections that surround their work with PSOs. This study will build on previous OIG work by determining the extent to which hospitals participate in the PSO program nationwide and identifying the program's successes and challenges. OIG will also identify opportunities for the PSO program to mitigate these challenges and leverage new strategies to improve patient safety.

Work Plan #: OEI-01-24-00150
Government Program: Medicare Parts A & B

Audit of Medicare Payments for Emergency Department Services Provided in Nonemergency Department Sites of Service

Expected Issue Date: 2024
Announced or Revised: December 2023

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention. Certain Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes should be used only if a Medicare enrollee is seen in the emergency department and the services described by the codes' definitions are provided. Medicare reimburses providers based on the patient's documented service needs at the time of the visit and based on the site of service. This audit will determine whether Medicare appropriately paid hospitals and physicians for emergency department services provided in nonemergency department sites of service.

Work Plan #: WA-23-0041 (W-00-23-35904)
Government Program: Medicare Parts A & B

Hospital Identification of Patient Harm Events

Expected Issue Date: 2024
Announced or Revised: May 2023

Hospitals collect information about patient harm events to meet Medicare requirements to measure, analyze, and track adverse patient harm events. Incident reporting systems enable providers and hospital staff to report information about patient safety incidents when they occur. In addition to general incident reporting systems, hospitals use other surveillance systems to capture events within specific hospital departments, such as the hospital pharmacy, or to capture specific types of adverse events, such as infections. Hospitals analyze this information to identify trends and root causes of safety issues

Provider

to improve care and prevent recurrences of harm events. OIG will determine the extent to which hospitals identify patient harm events and report those events to external entities. OIG will use harm events OIG identified through medical review for the study Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018 (OEI-06-18-00400) as the basis for this review.

Work Plan #: OEI-06-18-00401
Government Program: Medicare Parts A & B

Hospital Price Transparency

Expected Issue Date: 2024
Announced or Revised: September 2022

CMS issued a final rule effective January 1, 2021, to improve transparency in health care costs by requiring hospitals to make their prices readily available for consumers. The rule applies to all hospitals regardless of how they are paid. CMS's final rule provided specific instructions on which items were to be included on the list as well as gross charges for each item or service, payer-specific negotiated charges for each item or service, the discounted cash price, and codes used by a hospital to identify each item or service. CMS has also outlined its monitoring and enforcement plan to ensure hospital compliance. Potential actions CMS may take for noncompliance include providing a written warning listing violations, requiring a hospital to create a corrective action plan, and imposing civil monetary penalties. To evaluate CMS's monitoring and enforcement of the hospital price transparency rule, OIG will review the controls in place at CMS and statistically sample hospitals to determine whether CMS's controls are sufficient to ensure that hospital pricing information is readily available to patients as required by Federal law. Additionally, if hospitals are not in compliance with CMS's rule for listing their charges, OIG will contact the hospitals to determine the reason for noncompliance and determine whether CMS identified the noncompliance and imposed consequences on the hospitals.

Work Plan #: WA-22-0013 (W-00-22-35890)
Government Program: Medicare Parts A & B

Followup Review of Inpatient Claims Under the Post-Acute-Care Transfer Policy (PACT)

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to a hospital that discharges an inpatient beneficiary "to home." However, for certain qualifying MS-DRGs under the post-acute-care transfer policy, Medicare pays hospitals a per diem rate when an inpatient beneficiary is transferred to post-acute care. The per diem payment cannot exceed the full payment that would have been made if the beneficiary had been discharged to home. A prior OIG review identified Medicare overpayments to hospitals that did not comply with the post-acute-care transfer policy (42 CFR Â§ 412.4(c)). OIG's review found that the CMS Common Working File (CWF) edits that detected inpatient claims under the post-acute care transfer policy were working appropriately. However, some Medicare contractors did not receive automatic notifications of improperly billed claims or did not act to adjust those claims. As a result, OIG recommended that CMS recover the identified overpayments in line with its policies and procedures and ensure that the Medicare contractors are receiving the notifications and are acting to recover the overpayments. CMS concurred with all OIG recommendations

and detailed how they were addressed. This followup audit will determine whether CMS's CWF edits are working properly in detecting inpatient claims under the post-acute-care transfer policy and are automatically recovering overpayments, and whether Medicare contractors are receiving the automatic notifications and acting to recover overpayments.

Work Plan #: A-09-23-03016 (September 2023); W-00-22-35885
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2024
Announced or 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: 2024
Announced or Revised: November 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: Medicaid

Provider

Multiple 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 Payments for Inpatient Claims with Mechanical Ventilation

Expected Issue Date: 2024
Announced or Revised: November 2021

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

Audit of Medicare Emergency Department Evaluation and Management Services

Expected Issue Date: 2024
Announced or 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

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

Expected Issue Date: 2023
Announced or Revised: Completed (partial)

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 #: A-09-22-03007 (September 2022); W-00-21-35861
Government Program: Medicare Parts A & B

CMS Oversight of the Two-Midnight Rule for Inpatient Admissions

Expected Issue Date: 2024
Announced or 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: 2024
Announced or 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

Provider

- Multiple 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

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

Expected Issue Date: 2024
Announced or 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: 2024
Announced or Revised: Completed (partial)

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 #: A-05-20-00053 (October 2022); W-00-20-35854
Government Program: Accelerated and Advance Payment Program (AAP)

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Provider

- Multiple Providers
- Hospital
- Long Term Care
- Home Health Service
- Hospice
- Medical Equipment & Supplies
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- Telehealth
- Other Providers and Suppliers

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

Expected Issue Date: 2021
Announced or 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 or 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

Provider

- Multiple 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

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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: 2024
Announced or 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

Provider

- Multiple 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

Selected Inpatient and Outpatient Billing Requirements

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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-04-21-08084 (October 2022); A-04-19-08077 (August 2021); A-02-20-01004 (December 2021); 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-05-17-00026 (February 2019); A-04-17-08057 (October 2018); A-04-17-08055 (February 2018); A-01-15-00515 (February 2018); A-05-16-00064 (January 2018); A-04-16-04049 (January 2018); A-05-16-00062 (November 2017); W-00-23-35538; W-00-20-35538; W-00-17-35538; various reviews
Government Program: Medicare Parts A & B

Medicare Capital Payments to New Hospitals

Expected Issue Date: 2021
Announced or 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

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Provider

Long Term Care

[NEW] Assessment of the Special Focus Facility Program for Nursing Homes

Expected Issue Date: 2025
Announced or Revised: June 2024

CMS established the Special Focus Facility (SFF) Program to improve care in the poorest performing nursing homes. CMS and State survey agencies conduct increased oversight of nursing homes in the SFF Program by surveying these facilities twice per year, about twice as often as required for other nursing homes. In October 2022, CMS updated the SFF Program to shorten the amount of time that nursing homes spend as an SFF and increase the number of nursing homes that go through the program. This study will evaluate CMS's and State survey agencies' implementation of the SFF Program, including implementation of the October 2022 program updates. In addition, this study will identify factors that have aided graduated SFFs with sustaining quality improvements and will assess the extent to which CMS and States incorporate these factors into the SFF Program. Finally, this study will also provide descriptive information about nursing homes that participated in the SFF Program from 2013 through 2022.

Work Plan #: OEI-01-23-00050; OEI-01-23-00052
Government Program: Medicare Parts A & B

Medicaid Nursing Facility Supplemental Payments

Expected Issue Date: 2025
Announced or Revised: April 2024

CMS has approved Medicaid nursing facility upper payment limit (UPL) supplemental payment programs in several States. In these States, nursing facilities may be eligible for supplemental payments that, when combined with a base payment, may not exceed a reasonable estimate of the amount that Medicare would pay for the services. Under the UPL supplemental payment programs, a State may use a variety of financing mechanisms to fund that State's share of supplemental payments. OIG will determine whether payments States claimed under their Medicaid supplemental payment programs complied with Federal and State requirements, and describe how those payments were distributed and used.

Work Plan #: WA-24-0038 (W-00-24-31579)
Government Program: Medicaid

Audit of Nursing Facility Drug Overdoses

Expected Issue Date: 2025
Announced or Revised: March 2024

Drug abuse and overdose deaths are at epidemic levels in the United States. According to the Centers for Disease Control and Prevention, more than 1 million Americans died from an overdose during 1999-2021, with 80,000 of those deaths occurring in 2021. People who have had at least one overdose are more likely to have another. For every drug overdose that results in death, there are many more nonfatal overdoses, each one with its own emotional and economic toll. OIG will

Provider

determine whether selected nursing facilities complied with quality-of-care requirements and reported, investigated, and implemented corrective actions for potential illegal drug usage and significant pain medication errors involving opioid overdoses.

Work Plan #: WA-24-0030 (W-00-24-31578)
Government Program: Medicare Parts A & B

Assessing the Accuracy of Nursing Home Falls Reporting in MDS Assessments

Expected Issue Date: 2025
Announced or Revised: March 2024

In the Medicare and Medicaid programs, nursing homes are required to report resident falls in patient assessments. CMS then uses this information to determine the percentage of residents experiencing falls resulting in major injury for each certified nursing home. These percentages are posted on CMS's Care Compare website to give consumers information about the relative performance of each nursing home. In this study, OIG will assess the accuracy of the patient assessment data used to calculate nursing home fall rates. Specifically, OIG will use claims data to identify hospitalizations due to falls with major injury among nursing home residents that are Medicare enrollees, including people who are dually enrolled in Medicaid. OIG will then use patient assessments to assess the extent to which nursing homes reported those falls. OIG will examine the characteristics of the people who did not have their falls reported. Finally, OIG will examine the characteristics of nursing homes that did not report falls among their residents.

Work Plan #: OEI-05-24-00180
Government Program: Medicare Parts A & B

National Background Check Program for Long-Term Care Providers: A Final Assessment

Expected Issue Date: 2025
Announced or Revised: February 2024

The National Background Check Program (NBCP) provides grants to States to develop programs for conducting background checks of prospective long-term care provider employees. NBCP was launched through legislation enacted in 2010 and included a mandate for OIG to produce an evaluation of NBCP within 180 days of the program's completion. This report will be the final report in a series to fulfill this mandate. When NBCP ends, OIG will determine the extent to which States conducted background checks during and after program participation. OIG will determine the cost of conducting background checks, the number of applicants who received a background check, and those who were disqualified from employment during and after NBCP participation. Additionally, OIG will determine whether States experienced unintended consequences, the program's impact on reducing the number of incidents of neglect, abuse, and misappropriation of resident property, and the long-term impact of the program.

Work Plan #: OEI-07-24-00100
Government Program: Medicare Parts A & B

Provider

Optometrists Billing for Part B Services for Medicare Enrollees in Nursing Facilities

Expected Issue Date: 2024
Announced or Revised: January 2024

Medicare Part B covers many medical services (e.g., optometry services, mobile x rays, and psychological therapy) provided to enrollees, including those residing in nursing facilities (NFs). NFs are required to provide services necessary to ensure their residents attain or maintain sound health. Sometimes, an NF does not have the staff to meet residents' needs and arranges for services to be furnished by outside resources. Some of these services are provided by optometrists who, like many other providers, often visit NFs. Their on-site services include following up on cataract surgeries, treating dry or itchy eyes, and providing annual eye exams because transportation to and from an NF might be difficult for some enrollees. Opportunities for fraudulent, excessive, or unnecessary Part B billing exist because an NF may not be aware of the services for which a provider is billing when submitting a claim to Medicare. OIG will identify line items billed by optometrists for services performed in an NF. OIG will review medical records to determine whether the services were appropriately documented and billed according to Medicare requirements.

Work Plan #: WA-24-0026 (W-00-24-35909)
Government Program: Medicare Parts A & B

Audit of CMS Oversight of States' Use of Third-Party Contractors To Conduct Nursing Home Surveys

Expected Issue Date: 2025
Announced or Revised: January 2024

Prior OIG reviews of nursing homes have identified multiple issues related to the backlog of required nursing home surveys conducted by State survey agencies. To combat this backlog, State survey agencies have increasingly used third-party contractors to conduct surveys. CMS may also rely on these same third-party contractors to conduct comparative surveys to ensure that States meet Section 1864 requirements. OIG will review this area to determine whether CMS provides adequate oversight of States' use of third-party contractors to conduct nursing home surveys in accordance with Federal requirements.

Work Plan #: WA-24-0024 (W-00-24-31576)
Government Program: Medicare Parts A & B

Audit of Nursing Homes' Nurse Staffing Hours Reported in CMS's Payroll-Based Journal

Expected Issue Date: 2025
Announced or Revised: November 2023

Nursing homes are required to electronically submit complete and accurate direct care staffing information to CMS's Payroll-Based Journal (PBJ) system on a quarterly basis. Direct care staff include nurse and non-nurse staff who, through interpersonal contact with nursing home residents or resident care management, provide care and services to residents to allow them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. CMS and other

stakeholders use the staffing information in the PBJ to: (1) measure nursing home performance, (2) better understand the relationship between nursing home staffing levels and the quality of care that nursing homes provide, (3) identify noncompliance with Federal nurse staffing regulations, and (4) facilitate the development of nursing home staffing measures. OIG will review the nurse staffing hours reported in the PBJ to determine whether the reported hours are accurate.

Work Plan #: WA-24-0011 (W-00-24-31575)
Government Program: Medicare Parts A & B

Audit of Nursing Homes' Emergency Power Systems

Expected Issue Date: 2024
Announced or Revised: July 2023

Recent severe weather events have highlighted the need for and importance of emergency power systems for nursing homes. Nursing homes are required to provide an alternate source of energy (usually a generator) to maintain temperatures to protect residents' health and safety, as well as for food storage, emergency lighting, fire protection, and sewage disposal (if applicable), or to evacuate the residents. Nursing homes with generators must have them installed in a safe location and are required to perform weekly maintenance checks. During OIG's onsite inspections of 154 nursing homes in eight States as part of OIG's recent life safety and emergency preparedness audits, OIG found numerous facilities that had generators that were more than 30 years old. OIG will conduct an audit to determine the age of emergency power systems in use by nursing homes and whether those systems are capable of delivering reliable and adequate emergency power, including power to HVAC systems, and whether they have been maintained in accordance with Federal requirements.

Work Plan #: WA-23-0026 (W-00-23-31571)
Government Program: Medicare Parts A & B

State Survey Agency Processes for Overseeing Nursing Home Preparedness

Expected Issue Date: 2025
Announced or Revised: March 2023

Historically, nursing homes have experienced challenges preparing for and responding to emergencies. To address these challenges, HHS has taken steps to bolster nursing home emergency preparedness and response through regulations such as CMS's Conditions of Participation (CoPs). However, prior OIG reviews and continued challenges during recent emergencies have highlighted gaps, including gaps related to State Survey Agency (SA) reviews of nursing home adherence to the CoPs. This evaluation will determine: (1) what processes SAs use to oversee nursing home emergency preparedness; (2) what promising practices, challenges, and/or limitations exist within those processes; and (3) how CMS or other HHS agencies can best support SAs.

Work Plan #: OEI-04-23-00030
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Multiple 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

In-Depth Review of Nursing Home Citations Related to the Use of Antipsychotic Drugs

Expected Issue Date: 2025
Announced or Revised: February 2023

The potentially inappropriate use of antipsychotic drugs among nursing home residents remains concerning despite efforts to decrease their use over the last decade. Antipsychotic drugs were developed to treat schizophrenia—a serious mental disorder that is generally diagnosed before the age of 30. These powerful drugs are known to have severe side effects, particularly among elderly individuals with dementia. In 2008, the Food and Drug Administration issued a boxed warning against the use of all antipsychotic drugs among elderly individuals with dementia because of the increased risk of death. OIG has raised concerns about the high use of antipsychotic drugs among nursing home residents. In response, CMS took steps to discourage the use of these drugs by, for example, developing publicly reported quality measures related to the use of antipsychotic drugs among nursing home residents. More recently, OIG has raised concerns about the potential falsification of schizophrenia diagnoses to make the use of antipsychotic drugs appear appropriate and avoid Federal attention. OIG will conduct an in-depth review of survey reports to: (1) examine the nature of nursing home citations related to the use of antipsychotic drugs and (2) identify vulnerabilities that contribute to the inappropriate use of these drugs.

Work Plan #: OEI-02-23-00200
Government Program: Medicare Parts A & B

Assessment of CMS's Early Use of Payroll-Based Journal Data To Improve Enforcement of Nursing Home Staffing Standards

Expected Issue Date: 2024
Announced or Revised: January 2023

In October 2022, CMS began to provide State Survey Agency surveyors (State surveyors) with extracts of Payroll-Based Journal (PBJ) staffing data for use in annual nursing home certification surveys (also known as “inspections”). CMS instructed State surveyors to use this data to investigate specific instances of noncompliance with hourly staffing standards (for example, the requirement to have a registered nurse on duty for a minimum of 8 hours per day). Additionally, CMS instructed State surveyors to review PBJ data for indications of whether a nursing home has met the requirement to have sufficient staffing. OIG’s objective is to assess the early results of CMS's strategy to use PBJ data to improve the enforcement of Federal nursing home staffing standards by State surveyors. OIG will review CMS's plan for monitoring the success of the strategy and explore State surveyors' experiences with using the data in their surveys.

Work Plan #: OEI-04-22-00550
Government Program: Medicare Parts A & B

Assessment of the Special Focus Facility Program for Nursing Homes

Expected Issue Date: 2024
Announced or Revised: January 2023

CMS established the Special Focus Facility (SFF) program to improve care in the poorest performing nursing homes. CMS and State survey agencies conduct increased oversight of nursing homes in the SFF program by surveying these facilities

Provider

- Multiple 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

twice per year-about twice as often as required for other nursing homes. In October 2022, CMS updated the SFF program to reduce the amount of time a nursing home spends as an SFF and increase the number of nursing homes that go through the program. This study will evaluate CMS's and State survey agencies' implementation of the SFF program, including implementation of the October 2022 updates to the program. In addition, this study will identify factors that have aided graduated SFFs with sustaining quality improvements and assess the extent to which CMS and States incorporate these factors into the SFF program.

Work Plan #: OEI-01-23-00050
Government Program: Medicare Parts A & B

Potentially Preventable Hospitalizations of Medicare-Eligible Skilled Nursing Facility Residents

Expected Issue Date: 2024
Announced or Revised: October 2022

Prior OIG work identified nursing facilities with high rates of Medicaid enrollee transfers to hospitals for a urinary tract infection (UTI), a condition that is often preventable and treatable in the nursing facility setting without requiring hospitalization. The audits disclosed that the nursing facilities often did not provide UTI prevention and detection services in accordance with its residents' care plans, increasing the residents' risk for infection and hospitalization. Previous CMS studies found that five conditions (pneumonia, congestive heart failure, UTIs, dehydration, and chronic obstructive pulmonary disease/asthma) constituted 78 percent of the long-term care resident transfers to hospitals. Additionally, sepsis is often considered a preventable condition when the underlying cause of sepsis is preventable. OIG's review of claims shows that skilled nursing facility (SNF) residents often present with one of these six conditions (pneumonia, congestive heart failure, UTIs, dehydration, chronic obstructive pulmonary disease/asthma, and sepsis) on inpatient hospitalization. OIG will review inpatient hospitalizations of SNF residents with any of these six conditions and determine whether the SNF provided services to residents in accordance with their care plans and professional standards of practice (42 CFR §483.21 and 42 CFR § 483.25).

Work Plan #: WA-23-0002 (W-00-23-35892)
Government Program: Medicare Parts A & B

Skilled Nursing Facilities' Medicare Payments to Related Parties

Expected Issue Date: 2024
Announced or Revised: August 2022

Understanding skilled nursing facilities' (SNFs') costs is crucial to understanding the factors that contribute to nursing home performance and how nursing homes deliver care to beneficiaries. The cost of services, facilities, and supplies furnished to a provider by an organization related to the provider by common ownership or control may be included in the allowable cost of the provider in an amount equal to the related organization's cost. However, such cost must not exceed the price of comparable services, facilities, and supplies that could be purchased elsewhere. Medicare requires that a reported amount be the lower of either the actual cost to the related organization or the market price for comparable services, facilities, or supplies, thereby removing any incentive to realize profits through these transactions. OIG will determine whether SNFs

are reporting related-party costs in accordance with Federal regulations. OIG will also determine whether a SNF's allocation of Medicare funds could impact beneficiary care, such as whether overhead costs might have increased while allocations for patient care decreased, potentially reducing care.

Work Plan #: WA-22-0004 (W-00-22-35887)
Government Program: Medicare Parts A & B

Skilled Nursing Facility Reimbursement

Expected Issue Date: 2024
Announced or 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: 2024
Announced or Revised: Completed (partial)

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 #: A-06-21-02000 (November 2023); W-00-21-31553
Government Program: Medicaid

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Provider

- Multiple 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

Nursing Home Oversight During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced or 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.

Work Plan #: OEI-01-20-00430
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 or 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

Medicaid Nursing Home Life Safety and Emergency Preparedness Reviews

Expected Issue Date: 2025
Announced or Revised: Completed (partial)

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.

Provider

- Multiple 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

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 #: A-07-22-07009 (February 2024); A-06-22-09007 (January 2024); A-09-22-02006 (December 2023); A-04-22-08093 (September 2023); A-02-21-01010 (September 2022); W-00-20-31525; W-00-22-31525; W-00-23-31525;
Government Program: Medicaid

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

Expected Issue Date: 2024
Announced or 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

Managed Long-Term-Care Reimbursements

Expected Issue Date: 2024
Announced or 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

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Provider

Home Health Service

Medicare Payments for Home Dialysis Services

Expected Issue Date: 2024
Announced or Revised: December 2023

Medicare Part B covers outpatient dialysis services for enrollees diagnosed with end-stage renal disease (ESRD). Treatments can be provided in an outpatient or home setting and must be monitored by certified ESRD facilities. Prior OIG work identified inappropriate Medicare payments for dialysis services. Specifically, OIG identified claims for which there were neither dialysis treatment notes for home dialysis sessions nor documentation of the dispensing or administration of medication billed. Additionally, OIG found claims with medication billed exceeding a physician-prescribed amount, as well as other issues with comprehensive assessments, plans of care, and physicians' monthly progress notes. OIG will review claims for Medicare Part B home dialysis services provided to ESRD patients to determine whether such services complied with Medicare requirements. Also, OIG will review the impact of home dialysis services on enrollees and whether enrollees' quality of care could be affected.

Work Plan #: WA-24-0016 (W-00-24-35908)
Government Program: Medicare Parts A &

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-07-21-03247 (March 2023); W-00-20-31543; W-00-21-31543
Government Program: Medicaid

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Provider

Home Health Compliance with Medicare Requirements

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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-02-17-01022 (August 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: 2024
Announced or Revised: Completed (partial)

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 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: 2024
Announced or Revised: Completed (partial)

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-04-22-00134 (March 2023); A-05-17-00030 (October 2018); A-05-16-00044 (October 2017); A-05-17-00009; A-05-17-00028; W-00-20-31503; W-00-22-31503
Government Program: Medicaid

Consumer-Directed Personal Assistance Program

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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-07-20-03243 (February 2023); A-02-16-01026 (June 2018); W-00-16-31035; W-00-20-31035
Government Program: Medicaid

SUNHAWK CONSULTING

Provider

Hospice

Audit of Medicaid's Hospice Inpatient and Aggregate Cap Calculations

Expected Issue Date: 2025
Announced or Revised: January 2024

Under Medicare, CMS requires two annual limits to ensure that hospice care does not exceed the cost of conventional medical care at the end of life: the inpatient cap and the aggregate cap. Under Medicaid, however, CMS only requires States to calculate the hospice inpatient cap, and calculating the aggregate cap is optional for each State. If a State applies the hospice caps, any amount paid to a hospice for its claims in excess of each cap is considered an overpayment and must be repaid to Medicaid. OIG will audit selected States to determine whether the hospice caps were calculated correctly, whether cap overpayments were collected, and whether the Federal share of the collected cap overpayments was properly refunded.

Work Plan #: WA-24-0025 (W-00-24-31577)
Government Program: Medicaid

Audit of Selected, High-Risk Medicare Hospice General Inpatient Services

Expected Issue Date: 2025
Announced or Revised: June 2023

Medicare pays hospices a daily reimbursement rate for each day an individual is enrolled to receive the hospice benefit. The reimbursement rate for hospice general inpatient (GIP) care is the second-highest daily rate that Medicare pays for hospice services. GIP care is provided only for pain control or acute or chronic symptom management that cannot be managed in other settings. It is intended to be short-term care. For this audit, OIG will focus on claims for enrollees who were transferred to GIP care immediately after an inpatient hospital stay for a period during which the enrollee's inpatient stay reached or exceeded the geometric mean length of stay for the assigned diagnosis-related group. These hospice GIP claims are at high risk for inappropriate billing because GIP care may exceed an enrollee's needs or may not be provided. OIG will determine whether hospice providers that billed for GIP care complied with Medicare requirements.

Work Plan #: WA-23-0020 (W-00-23-35897)
Government Program: Medicare Parts A & B

Nationwide Review of Hospice Beneficiary Eligibility

Expected Issue Date: 2024
Announced or 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: 2024
Announced or Revised: Completed (partial)

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 #: A-09-20-03015 (February 2022); A-09-20-03026 (November 2021); W-00-20-35797
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced or 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

Provider

- Multiple 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

Review of Hospices' Compliance with Medicare Requirements

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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-02-20-01001 (September 2022); A-02-19-01018 (July 2022); 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; W-00-18-35783; various reviews
Government Program: Medicare Parts A & B

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Provider

Medical Equipment & Supplies

[NEW] Followup Review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided by Suppliers During Inpatient Stays

Expected Issue Date: 2025
Announced or Revised: July 2024

Overlapping claims can happen when an enrollee receives a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) item during an inpatient stay at an acute-care hospital. In general, certain items, supplies, and services furnished to inpatients are covered under Medicare Part A and should not be billed separately to Medicare Part B (42 CFR §§ 409.10; Medicare Claims Processing Manual, Chapter 3 § 10.4). Therefore, DMEPOS claims for enrollees who received DMEPOS items during an inpatient stay (excluding admission and discharge dates) in a hospital should not be billed to Medicare Part B, and any Medicare payments made on those claims would be considered overpayments. Prior OIG reviews and investigations have identified this area as at risk for noncompliance with Medicare billing requirements. For this followup audit, OIG will review Medicare payments to certain types of inpatient hospitals to determine whether claims billed to Part B for certain DMEPOS items provided during inpatient stays were made in accordance with Federal requirements. Additionally, OIG will review the CMS Common Working File system edits that should deny claims for DMEPOS items furnished during an inpatient stay.

Work Plan #: WA-24-0059 (W-00-24-35919)
Government Program: Medicare Parts A & B

[NEW] Durable Medical Equipment Fraud and Safeguards in Medicare

Expected Issue Date: 2025
Announced or Revised: June 2024

Each year, Medicare payments for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) top more than $7 billion in traditional Medicare alone. Although CMS has a number of safeguards in place to prevent bad actors from billing DMEPOS in Medicare, fraudulent billing for DMEPOS continues to be a major concern. Recent cases demonstrate that DMEPOS continues to be a target of fraudulent billing and that new schemes have developed. OIG's review will provide information about current fraud schemes and the safeguards and monitoring that CMS has to prevent fraud, waste, and abuse. These findings will result in multiple products. The first product will look at billing for DMEPOS in Medicare Advantage, specifically by suppliers that are not enrolled in Medicare fee-for-service.

Work Plan #: OEI-02-24-00310
Government Program: Medicare Parts A & B

Provider

- Multiple 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

Audit of Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program

Expected Issue Date: 2024
Announced or Revised: September 2023

CMS administers a competitive bidding program under which prices for selected durable medical equipment, prosthetics, orthotics, and supplies furnished in specified areas are determined through a competitive bidding process. Federal law requires OIG to assess the process used by CMS to conduct the competitive bidding and subsequent pricing determinations under the first two rounds. Federal law also permits OIG to continue to verify such calculations for subsequent rounds (Medicare Improvements for Patients and Providers Act of 2008, § 154(a)(1)(A)(iv), adding subparagraph 42 U.S.C. § 1395w-3(a)(1)(E)). OIG will review the process used by CMS to conduct competitive bidding and to make subsequent pricing determinations during round 2021 of the competitive bidding program.

Work Plan #: WA-23-0033 (W-00-23-35901)
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2024
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

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

Expected Issue Date: 2024
Announced or 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

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

Expected Issue Date: 2020
Announced or 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; A-05-xx-xxxxx
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: 2024
Announced or 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

Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services

Expected Issue Date: 2021
Announced or Revised: Completed (partial)

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

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Provider

Behavioral Health

Audit of Substance Abuse and Mental Health Services Administration's Behavioral Health Treatment Services Locator

Expected Issue Date: 2024
Announced or Revised: February 2023

Substance use disorders (SUDs) impact the lives of millions of Americans. Drug overdose deaths in the United States increased by 28.5 percent during the 12-month period ending in April 2021. An individual who experiences an SUD may also experience a co-occurring mental disorder and vice versa. Nearly one in five U.S. adults (52.9 million in 2020) lives with a mental illness. In accordance with the 21st Century Cures Act (P.L. 114-255, § 9006), the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains the Behavioral Health Treatment Services Locator, which is a searchable, online database of facility locations where individuals can seek substance use disorder and mental health treatment in the United States and U.S. Territories. We will conduct an audit to determine whether substance use disorder and mental health treatment facilities' information in SAMHSA's Behavioral Health Treatment Services Locator is accurate.

Work Plan #: WA-23-0009 (W-00-23-59476)
Government Program: SAMHSA

States' and MCOs' Compliance With Mental Health Parity Requirements

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) promotes equal access to treatment for mental health and substance use disorder (MH/SUD) by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than medical or surgical benefits. Such limitations could include higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews, as compared to other covered medical treatments. Federal regulations require managed care organizations (MCOs) with plans that provide services to Medicaid enrollees to comply with the parity provisions of MHPAEA. Federal regulations require that States or their MCOs, as applicable, conduct analyses to demonstrate compliance with parity requirements. CMS reviews States' parity analyses as part of its review of States' MCO contracts. We will audit CMS's oversight of States' compliance with Federal parity requirements, including whether States and their MCOs conducted the required parity analyses and whether States ensured that their MCOs complied with certain parity requirements for MH/SUD benefits.

Work Plan #: A-02-22-01016 (March 2024); WA-22-0003 (W-00-22-31565)
Government Program: Medicaid

Provider

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

Expected Issue Date: 2025
Announced or Revised: Completed (partial)

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 (March 2024); OEI-09-21-00410; OEI-02-23-00540
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-02-21-02010 (September 2023); W-00-21-59463
Government Program: Medicare Parts A & B

Provider

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-09-21-03021 (May 2023); A-02-21-01006 (March 2022); A-02-19-01012 (July 2020); A-09-19-03018 (April 2020); A-09-18-03004 (August 2019); 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 or 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: 2024
Announced or Revised: Completed (partial)

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-01-20-00006 (June 2022); A-09-20-02009 (April 2022); 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
Announced or Revised: Completed (partial)

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

Provider

Medicaid Targeted Case Management

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: 07-21-03246 (August 2022); 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

[NEW] Medicare Payments for Clinical Diagnostic Laboratory Tests in 2023

Expected Issue Date: 2025
Announced or Revised: July 2024

Medicare is the largest payer of clinical diagnostic laboratory services in the United States. Medicare Part B covers most lab tests and pays 100 percent of allowable charges without patient cost-sharing obligation. The Protecting Access to Medicare Act of 2014 (PAMA), Pub. L. No. 113-93, requires CMS to set payment rates for lab tests using current charges in the private health care market under Title XVIII of the Social Security Act (PAMA, § 216(a)). On January 1, 2018, CMS began paying for lab tests under a new system mandated by PAMA. PAMA also requires OIG to publicly release an annual analysis of the top 25 laboratory tests by expenditure. (Pub. L. No. 113-93 § 216(c)(2)(A)). In accordance with PAMA, OIG will publicly release an analysis of the top 25 laboratory tests by expenditure for 2023.

Work Plan #: OEI-09-24-00350
Government Plan: Medicare Parts A & B

Medicare Part B Add-On Payments for COVID-19 Tests

Expected Issue Date: 2024
Announced or Revised: May 2022

Laboratory tests are critical for early detection, diagnosis, monitoring, and treatment of disease. Effective testing for COVID-19 is essential to slow its spread by identifying those with the virus and enabling treatment or isolation. On October 15, 2020, CMS announced actions to incentivize prompt COVID-19 test turnaround times by paying more for expedited results. CMS has identified that timelier test results benefit individual patients, their immediate communities, and the public at large. Starting in 2021, the amended Administrative Ruling (CMS 2020-1-R2) lowered the base payment amount for COVID-19 clinical diagnostic laboratory tests (CDLTs) that use high-throughput technology to $75 in accordance with CMS's assessment of the resources needed for those tests. The amended ruling also established an additional $25 add-on payment for a COVID-19 CDLT that uses high-throughput technology if the laboratory: (1) completed the test in 2 calendar days or less and (2) completed a majority of the CDLTs that use high-throughput technology in 2 calendar days or less for all their patients (not just their Medicare patients) in the previous month. For this audit, OIG will review providers' supporting documentation for the COVID-19 CDLT add-on payments to determine whether the documentation complied with Medicare requirements.

Work Plan #: W-00-22-35884
Government Program: Medicare Parts A & B

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Provider

- Multiple 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

Audit of the Centers for Disease Control and Prevention Grants to Recipients for COVID-19 Screening Testing at Schools

Expected Issue Date: 2025
Announced or Revised: Completed (partial)

The Centers for Disease Control and Prevention's (CDC's) Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) program provides strategic investments aimed at reducing infectious disease-related illnesses and death through its cooperative agreement with health departments throughout the United States. Financial resources and technical assistance are provided each year to 64 jurisdictions to support activities related to surveillance, detection, response, and prevention of infectious diseases. The American Rescue Plan (ARP) Act of 2021, enacted March 11, 2021 (P.L. No. 117-2), provides additional relief to address COVID-19's continued impact on the economy, public health, State and local governments, individuals, and businesses. The CDC, through the ELC program, provided $10 billion in ARP funding to States to support COVID-19 screening testing for teachers, staff, and students to assist schools in reopening safely for in-person instruction. The $10 billion, under the ELC reopening school awards, was awarded to the current 64 ELC jurisdictions according to a population-based formula. OIG's first audit will determine whether the CDC provided effective oversight to the ELC recipients in implementing the screening testing programs. OIG's second phase of audits will determine whether select ELC recipients had controls in place to monitor schools in implementing COVID-19 screening testing programs. In addition, OIG will determine whether select ELC recipients and schools used the ARP funding in accordance with Federal requirements and the applicable grant terms.

Work Plan #: A-05-22-00010 (September 2023); W-00-22-59468, W-00-23-59468; W-00-24-59468
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2024
Announced or 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

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Provider

- Multiple 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 Payments for Clinical Diagnostic Laboratory Tests in 2020

Expected Issue Date: 2022
Announced or 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

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-09-21-03004 (November 2022); W-00-21-35867
Government Program: Medicare Parts A & B

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Provider

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

Expected Issue Date: 2021
Announced or 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

Medicare Part B Payments for Laboratory Services

Expected Issue Date: 2025
Announced or Revised: Completed (partial)

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-09-22-03010 (June 2023); A-09-21-03006 (February 2023); 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; W-00-22-35726; W-00-21-35726 various reviews
Government Program: Medicare Parts A & B

Provider

- Multiple 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

Review of Medicare Part B Urine Drug Testing Services

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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

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Provider

Prescriber

Medicare Payments for Stelara

Expected Issue Date: 2024
Announced or 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

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Provider

Telehealth

Medicaid—Telehealth Expansion During COVID-19 Emergency

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-07-21-03250 (May 2023); W-00-20-31548; W-00-21-31548; A-05-21-00035; W-00-20-42021
Government Program: Medicaid

Other Providers & Suppliers

[NEW] Medicare Payments for Lower Extremity Peripheral Vascular Procedures

Expected Issue Date: 2025
Announced or Revised: June 2024

The use of peripheral vascular procedures in an office setting has increased among the Medicare population over the past decade. For CYs 2022 and 2023, Medicare paid approximately $1.16 billion for lower extremity peripheral vascular procedures in office settings. These minimally invasive procedures aim to improve blood flow when arteries narrow or become blocked because of peripheral arterial disease but are generally recommended only after patients have tried medical and exercise therapy and have lifestyle-limiting symptoms. In addition, CMS and whistleblower fraud investigations have identified these procedures as vulnerable to improper payments. OIG will analyze Medicare fee-for-service for peripheral vascular procedures for questionable characteristics and review the program integrity activities of CMS and its contractors to combat fraud, waste, and abuse specific to these procedures. Additionally, OIG will assess whether these procedures complied with CMS requirements and met applicable treatment guidelines.

Work Plan #: W-00-24-35914
Government Program: Medicare Parts A & B

[NEW] Nationwide Audits of Organ Procurement Organizations and Certified Transplant Centers

Expected Issue Date: 2025
Announced or Revised: May 2024

Organ Procurement Organizations (OPOs) are not-for-profit organizations that perform or coordinate the procurement, preservation, and transportation of organs to hospitals for transplantation into patients who are on a waiting list to receive a transplant. Certified Transplant Centers (CTCs) are components within transplant hospitals that provide transplantation of particular types of organs. CTCs are reimbursed by Medicare for certain costs associated with the acquisition of organs from OPOs or other CTCs for transplants involving Medicare patients. Federal regulations (42 CFR part 486, subpart G) include Medicare conditions for coverage for OPOs, and other Federal statutes, regulations, and guidance specify Medicare requirements for the acquisition of organs. Prior OIG audits determined that OPOs did not comply with Medicare requirements for reporting overhead costs, administrative and general costs, and organ statistics. OIG will determine whether costs reported by OPOs and CTCs were allowable, reasonable, and according to Medicare requirements, and whether OPOs met required process performance and outcome measures

Work Plan #: WA-24-0043 (W-00-24-35913)
Government Program: Medicare Parts A & B

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Provider

Audit of Ambulance Services Supplemental Payment Program

Expected Issue Date: 2024
Announced or Revised: July 2023

Some States have implemented uncompensated care payment programs that allow ambulance providers to receive supplemental payments for services provided to Medicaid beneficiaries and uninsured patients. OIG will conduct audits of selected States to determine whether the States' claims for Federal reimbursement for supplement payments to these providers complied with Federal and State requirements.

Work Plan #: WA-23-0024 (W-00-23-31570)
Government Program: Medicaid

Review of Medicare Payments for Trauma Claims

Expected Issue Date: 2024
Announced or Revised: November 2022

There have been concerns about trauma centers improperly billing for trauma team activation that is not medically necessary. In addition, OIG found some providers have received trauma team activation payments without proper designation or verification. Currently, CMS does not track which providers are designated or verified as trauma centers. OIG will determine the amount of Medicare overpayments and Medicare charges that affect future hospital payments, and OIG will identify providers that are not trauma centers or that billed for medically unnecessary trauma team activations.

Work Plan #: WA-23-0004 (W-00-23-35893)
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2024
Announced or 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

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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; W-00-22-30100
Government Program: Medicare Parts A & B

Medicare Part B Payments for Podiatry and Ancillary Services

Expected Issue Date: 2024
Announced or 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

Ambulance Services - Supplier Compliance with Payment Requirements

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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: 2024
Announced or Revised: Completed (partial)

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-03-20-00002 (July 2022); A-03-18-00003 (October 2020); W-00-18-35816; W-00-22-35816; various reviews
Government Program: Medicare Parts A & B

Provider

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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 #: A-05-20-00010 (September 2022); W-00-18-35811
Government Program: Medicare Parts A & B

Transportation Services - Compliance with Federal and State Requirements

Expected Issue Date: 2022
Announced or Revised: Completed (partial)

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-02-21-01001 (September 2022); A-05-16-00021 (June 2018); A-07-16-03209 (March 2017); various reviews
Government Program: Medicaid

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

Expected Issue Date: 2024
Announced or Revised: Completed (partial)

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

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Provider

Multiple 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

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 #: A-09-17-03002 (July 2018); W-00-17-35748; W-00-22-35748
Government Program: Medicare Parts A & B