

# Healthcare Audit and Enforcement Risk Analysis

## HHS OIG Completed Provider-Focused Audits Summary

August 1, 2021 - August 31, 2024



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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. In an effort to promote the value of shared learnings, as well as, give our colleagues and clients focused insights into the over 300 audits, performed by HHS OIG, over the last two years, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

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

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at [SunHawkConsulting.com](https://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.

\*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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## Multiple Providers

### **HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program**

The Provider Relief Fund (PRF) provided funds to eligible hospitals and other health care providers (providers) for health care-related expenses or lost revenue attributable to COVID-19. The Phase 2 General Distribution went to Medicaid, the Children's Health Insurance Program (CHIP), and dental providers and assisted living facilities. From July 3, 2020, through June 21, 2021, the Health Resources and Services Administration (HRSA) distributed about \$4.9 billion to more than 100,000 providers. HRSA calculated each payment based on 2 percent of the provider's patient care revenue. To receive a PRF payment, a provider had to submit an application and supporting documentation, such as a Federal income tax return, to support reported revenue. A provider also had to meet certain requirements, such as not being excluded from participating in Medicaid. This audit was part of the Office of Inspector General's (OIG's) oversight of the Department of Health and Human Services' COVID-19 response and recovery efforts.

OIG's objective was to determine whether PRF payments under the Phase 2 General Distribution were correctly calculated, supported by appropriate documentation, and made to eligible providers.

The audit covered 73,449 tax-filing taxpayer identification numbers (TINs) for Medicaid and CHIP providers, dental providers, and assisted living facilities for which each provider had received a total of \$10,000 or more from July 3, 2020, through June 21, 2021, under the Phase 2 General Distribution. HRSA disbursed \$4.8 billion to these providers. OIG selected a statistical sample of 150 providers (each represented by a TIN).

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for all 150 sampled providers, HRSA made PRF payments to eligible providers. However, for 17 of the 150 sampled providers, HRSA made PRF payments that were not correctly calculated (15 sampled providers) or were not supported by appropriate documentation (2 sampled providers). Specifically, for the 15 sampled providers for which PRF payments were not correctly calculated, HRSA made payments: (1) without subtracting payments that had previously been made to providers' subsidiary organizations, (2) based on incorrectly calculated patient care revenue, (3) based on revenue information that providers incorrectly entered on PRF applications, and (4) based on revenue information for which bad debt was not subtracted. For the remaining two sampled providers, HRSA made payments based on revenue that was not supported by Federal income tax returns.

As a result, HRSA made \$18.4 million in potential overpayments to the 17 sampled providers. On the basis of OIG's sample results, OIG estimated that HRSA made \$159.4 million in potential overpayments to providers (3.3 percent of the total PRF payment amount that OIG audited). These potential overpayments occurred because certain HRSA procedures for processing and reviewing providers' PRF applications and supporting documentation did not ensure that PRF payments were correctly calculated and were supported by appropriate documentation. For example, HRSA's procedures did not include requiring providers to submit documentation supporting the percentage of revenue from patient care.

Provider

**Multiple Providers**

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



## Provider

### Multiple Providers

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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

OIG recommended that, with respect to PRF payments that were already made to providers under the Phase 2 General Distribution, HRSA conduct a review of the 17 sampled providers OIG identified that had potential overpayments of \$18.4 million and determine the amount of and seek repayment of any overpayments. Furthermore, should HRSA need to rapidly disburse similar payments to providers in response to a future national emergency, HRSA consider taking specified steps (to the extent they are applicable) to safeguard taxpayer money, such as requiring providers to submit supporting documentation for all revenue information provided on applications for payments. (The full text of OIG's recommendations is shown in the report.)

**Audit #:** [A-09-22-06001](#) (03/04/2024)

**Government Program:** HRSA

### [A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data](#)

Medicare was an essential part of the Nation's health care system, with 66 million people enrolled. The COVID-19 pandemic brought persistent disparities in health care access and outcomes to the forefront, including in the Medicare program. The Office of Inspector General (OIG) and the Centers for Medicare & Medicare Services (CMS) made advancing health equity a top priority. In order to address health disparities, it was important to assess them using accurate, complete, and comprehensive data. The results of these analyses could be used to tailor interventions aimed at improving disparities. The data could then be used to evaluate the efficacy of these interventions. Ultimately, success in advancing health equity hinged on a thorough understanding of the underlying data.

In June 2022, OIG issued a data brief, (OEI-02-21-00100), analyzing the quality of the race and ethnicity data for people enrolled in Medicare. That data brief made constructive recommendations to CMS for improving the data.

As CMS worked to implement these recommendations, improvements were expected to take several years to yield better data for health disparities research. Until then, the existing data remained a vital source for understanding one of the largest Federal programs and conducting health equity work.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that the race and ethnicity data in Medicare's enrollment data had limitations, but could still be used in important health equity work if those limitations were recognized and accounted for during analysis.

**Evaluation #:** [OEI-02-21-00101](#) (06/27/2023)

**Government Program:** CMS

### [Providers Did Not Always Comply With Federal Requirements When Claiming Medicare Bad Debts](#)

Providers sought reimbursement of nearly \$10 billion for Medicare bad debts on their cost reports with cost reporting periods ending during Federal fiscal years 2016 through 2018. Federal regulations stated that Medicare was to reimburse providers 65 percent of deductible and coinsurance amounts for Medicare beneficiaries that remained unpaid (1) after the provider had made a reasonable effort to collect, (2) the debt was uncollectible, and (3) there was no likelihood of future recovery based on sound business judgment ("Medicare bad debts").



## Provider

### Multiple Providers

#### Hospital

#### Long Term Care

#### Home Health Service

#### Hospice

#### Medical Equipment and Supplies

#### Behavioral Health

#### Laboratory

#### Telehealth

#### Other Providers and Suppliers

OIG's objectives were to determine whether (1) providers complied with Federal requirements when claiming Medicare reimbursement for Medicare bad debts and (2) providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements.

OIG randomly selected 67 cost reports in which providers claimed Medicare bad debts. OIG selected a nonstatistical sample of 148 bad debts and reviewed the providers' documentation of the collection efforts performed.

OIG reviewed the sampled providers' policies and procedures for collecting Medicare bad debts to ensure that the policies and procedures included reasonable collection efforts.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that providers did not always comply with Federal requirements when claiming Medicare reimbursement for Medicare bad debts. Of the 148 Medicare bad debts in the nonstatistical sample, 86 were associated with beneficiaries whom providers had deemed indigent and for whom, therefore, no reasonable collection efforts were required. Providers did not comply with Federal requirements when claiming 18 of the remaining 62 Medicare bad debts. OIG identified four additional bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries. These 22 bad debts resulted in a total of \$29,787 in unallowable Medicare reimbursement. The Centers for Medicare & Medicaid Services (CMS) inappropriately reimbursed these amounts because the Medicare administrative contractors (MACs) did not concentrate on reviewing bad debts when performing audits of cost reports during the audit period.

For the second objective, OIG found that the 67 selected providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. These policies and procedures were similar to the providers' policies and procedures for collecting non-Medicare bad debts.

OIG recommended that CMS consider issuing instructions or guidance to the MACs that required or encouraged more review of Medicare bad debts claimed on cost reports, such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directed the MACs to revise their cost report audit work plans accordingly.

**Audit #:** [A-07-20-02825](#) (12/15/2022)

**Government Program:** CMS



## **Payments Made to Providers Under the Covid-19 Accelerated and Advance Payments Program Were Generally in Compliance with the CARES Act and Other Federal Requirements**

The Centers for Medicare & Medicaid Services (CMS) could provide temporary relief loans through the accelerated payment program for certain Part A providers and through the advance payment program for certain Part B providers and suppliers when these providers and suppliers faced cashflow challenges due to circumstances beyond their control. The Coronavirus Aid, Relief, and Economic Security (CARES) Act, which Congress passed on March 27, 2020, expanded these programs to more providers to relieve pandemic-caused financial strain. CMS referred to this expansion as the COVID-19 Accelerated and Advanced Payments (CAAP) Program and issued eligibility criteria on March 28, 2020. As of September 17, 2020, CMS, through the Medicare Administrative Contractors (MACs), disbursed more than \$100 billion in CAAP Program payments to more than 46,000 providers. These CAAP Program payments were issued in a short period of time, thus increasing the risk of improper payments.

COVID-19 created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for HHS, the Office of Inspector General (OIG) oversaw HHS's COVID-19 response and recovery efforts. This audit was part of OIG's COVID-19 response strategic plan.

OIG's objective was to determine whether CAAP Program payments were made to providers in compliance with the CARES Act and other Federal requirements.

The audit covered \$103.1 billion in total CAAP Program payments made to 46,373 providers. OIG selected a stratified random sample of 109 providers and reviewed CAAP Program payments totaling \$4.1 billion made to those providers. Of those 109 providers, 100 providers were randomly selected, and 9 providers were under bankruptcy when the CAAP Program payments were made.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that CMS generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Of the 109 providers in the sample, CMS appropriately made CAAP Program payments to all 100 providers that were randomly selected. For the nine providers under bankruptcy, CMS did not send a CAAP Program payment to six of the providers; however, CMS did make a CAAP program payment to three of the providers.

The CAAP Program payments made to the three providers under bankruptcy occurred because two MACs did not correctly match the provider's request against their bankruptcy databases, and one MAC did not update its bankruptcy database based on bankruptcy information that was provided by CMS prior to approving the CAAP Program payment request.

For the three CAAP Program payments made to providers under bankruptcy, the MACs immediately identified their errors after the payment and recovered the improper payments.

OIG concluded that CMS and its MACs generally made CAAP Program payments to providers in compliance with the CARES Act and other Federal requirements. Although the MACs erroneously approved CAAP Program payments to nine providers under bankruptcy, the MACs immediately identified their errors, stopped payments to six providers, and recovered improper payments made to the other three providers. Therefore, OIG did not have any recommendations.

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**Audit #:** [A-05-20-00053](#) (10/24/2022)  
**Government Program:** CMS

**[Selected Dialysis Companies Implemented Additional Infection Control Policies and Procedures To Protect Beneficiaries and Employees During the COVID-19 Pandemic](#)**

End-stage renal disease (ESRD) is a medical condition in which a person's kidneys permanently ceased functioning, leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. The Centers for Disease Control and Prevention (CDC) found that beneficiaries with serious underlying medical conditions, such as ESRD, were at a higher risk for severe illness from COVID-19. Health care personnel were also some of the most at-risk essential workers.

OIG's objective was to determine whether selected dialysis companies implemented additional infection control policies and procedures in accordance with Centers for Medicare & Medicaid Services (CMS) and certain CDC guidance to protect high-risk ESRD beneficiaries during the COVID-19 pandemic.

OIG's audit covered 9 dialysis companies that owned 6,451 facilities (83 percent) of the 7,813 ESRD facilities that had a Medicare or Medicaid certification at any point during 2020 in 50 States, the District of Columbia, Guam, and Puerto Rico. OIG's findings were based on responses to a questionnaire and followup interviews that were conducted with nine dialysis companies.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the nine selected dialysis companies surveyed (representing 83 percent of the ESRD facilities that had a Medicare or Medicaid certification at any point during 2020) implemented additional infection control policies and procedures in accordance with CMS and CDC recommendations to protect high-risk ESRD beneficiaries and employees during the COVID-19 pandemic. OIG found all nine companies had infection control policies and procedures in place to protect beneficiaries and employees, and when recommended by CMS and CDC, the companies implemented additional policies and procedures. However, while two companies provided education about the importance of hand hygiene, they did not emphasize the importance of hand hygiene immediately before and after any contact with a facemask or cloth face covering, as recommended by CDC.

OIG concluded that because the nine selected companies implemented additional infection control policies and procedures as recommended by CMS and CDC, this report contained no recommendations.

**Audit #:** [A-05-20-00052](#) (05/24/2022)  
**Government Program:** CMS

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## Hospital

### **[NEW] Medicare Improperly Paid Hospitals an Estimated \$79 Million for Enrollees Who Had Received Mechanical Ventilation**

Prior OIG audits found that hospitals did not fully comply with Medicare requirements for inpatient claims paid with certain Medicare Severity Diagnosis-Related Groups (MS-DRGs) that required enrollees to have received 96 or more consecutive hours (i.e., 4 days or more) of mechanical ventilation. An inpatient claim for mechanical ventilation included the date that a mechanical ventilation procedure started but did not indicate when it ended. CMS implemented an automated process to identify claims that had a mechanical ventilation start date that was 4 days or fewer before an enrollee's discharge from a hospital. Consequently, OIG conducted this audit to evaluate whether claims reporting a mechanical ventilation start date that was 5 to 10 days before the enrollee discharge date were at risk for billing errors.

OIG's objective was to determine whether Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required more than 96 consecutive hours of mechanical ventilation complied with Medicare requirements.

The audit covered \$3.6 billion in payments for 83,359 inpatient claims that had dates of service from October 2015 through September 2021 (audit period), were assigned MS-DRGs 207 or 870, and had a mechanical ventilation start date from 5 to 10 days before the enrollee discharge date. OIG selected for review a stratified random sample of 250 claims with payments totaling \$11 million.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required more than 96 consecutive hours of mechanical ventilation did not fully comply with Medicare requirements. For 233 of 250 sampled claims, Medicare payments to hospitals complied with requirements. However, for the 17 remaining sampled claims, Medicare payments to hospitals did not comply with requirements. Specifically, hospitals used incorrect procedure or diagnosis codes. For eight sampled claims, hospitals incorrectly used the procedure code for more than 96 hours of mechanical ventilation when enrollees had not received more than 96 hours of mechanical ventilation. For nine sampled claims, hospitals used incorrect diagnosis codes or incorrectly used a procedure code that was not related to mechanical ventilation. Consequently, the 17 sampled claims were assigned incorrectly to MS-DRGs 207 or 870, resulting in \$382,032 of overpayments.

On the basis of OIG's sample results, OIG estimated that Medicare improperly paid hospitals \$79.4 million for the audit period. Hospitals confirmed that they used incorrect procedure or diagnosis codes and generally attributed the improper billing to incorrectly counting the hours that enrollees had received mechanical ventilation or to clerical errors in selecting procedure or diagnosis codes.

OIG recommended that CMS: (1) direct the Medicare Administrative Contractors (MACs) to recover from hospitals the portion of the \$382,032 in identified overpayments for the sampled claims during the audit period that were within the 4-year reopening period in accordance with CMS's policies and procedures; and (2) educate hospitals on correctly counting the hours of mechanical ventilation and submitting claims with correct procedure and diagnosis codes, which could have saved an estimated \$79.4 million for the audit period.

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## **ICD Codes Identified in This Audit:**

- J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
- I12.0 - Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

Audit #: [A-09-22-03002](#) (08/09/2024)

Government Program: CMS

## **[NEW] CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays**

Under CMS's two-midnight rule, implemented in fiscal year (FY) 2014, CMS generally considered it inappropriate for hospital stays not expected to span at least two midnights to be billed as inpatient. OIG issued a report about the effect of this rule on short inpatient stays (i.e., stays that lasted less than two midnights) for FY 2014. According to the report, hospitals were still billing for many short inpatient stays that were potentially inappropriate under the two-midnight rule, and Medicare paid almost \$2.9 billion for these stays. Given the high payment amount at risk for noncompliance identified in that report, OIG focused this audit on program safeguards for claims for short inpatient stays for calendar years 2016 through 2020 (audit period).

OIG's objective was to assess program safeguards for ensuring that Medicare claims for short inpatient stays complied with Medicare requirements.

OIG's audit covered \$19.7 billion in Medicare Part A claims with dates of service during the audit period for 2.5 million short inpatient stays at 3,340 acute-care hospitals. OIG interviewed CMS officials and one Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to obtain an understanding of program safeguards for short inpatient stays and policies and procedures for reviewing claims for short inpatient stays.

## **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for the audit period, three weaknesses were identified in the established program safeguards for preventing and detecting improper payments for short inpatient stays and recovering overpayments. Specifically, CMS did not have: (1) adequate information to identify short inpatient stays at risk for noncompliance with the two-midnight rule, (2) prepayment edits for claims at risk for noncompliance with the two-midnight rule, and (3) adequate policies and procedures to review claims at risk for noncompliance with the two-midnight rule and to recover overpayments.

These weaknesses occurred because, among other reasons, CMS relied primarily on post-payment reviews conducted by BFCC-QIOs to ensure compliance with the two-midnight rule. Although BFCC-QIOs reviewed thousands of claims for short inpatient stays and denied \$49.2 million in improper payments during the audit period, these reviews denied only 0.6 percent of the \$7.8 billion in improper payments estimated by CMS's Comprehensive Error Rate Testing reviews. Without strengthening program safeguards, CMS and its contractors might not have been able to prevent or detect improper payments for short inpatient stays and recover overpayments for claims that did not comply with Medicare requirements.



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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

OIG recommended that CMS work with its contractors to:

- add information to inpatient claims indicating any stay that did not span two or more midnights because of an unforeseen circumstance,
- develop a list of inpatient procedure codes associated with the outpatient procedure codes on the inpatient-only procedures list,
- implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule, and
- update policies and procedures for postpayment reviews to focus on claims for short inpatient stays identified as at risk for noncompliance with the two-midnight rule and to focus on overpayment recoveries.

The full text of the recommendations was in the report.

### **ICD Codes Identified in This Audit:**

- Z53 series - Persons encountering health services for specific procedures and treatments, not carried out

**Audit #:** [A-09-21-03022](#) (06/11/2024)

**Government Program:** CMS

### **Medicare Generally Paid Acute-Care Hospitals for Inpatient Stays for Medicare Enrollees Diagnosed With COVID-19 in Accordance With Federal Requirements**

The Coronavirus Aid, Relief, and Economic Security Act increased the payment amount that acute-care hospitals received for Medicare enrollees who were diagnosed with COVID-19 and discharged during the COVID-19 public health emergency (PHE). OIG's previous work related to pneumonia and other diagnosis codes on claims documented aberrant billing by some hospitals. In addition, acute-care hospitals may have had a financial incentive to include a COVID-19 diagnosis on claims to receive additional payments. For these reasons, OIG conducted this audit of Medicare payments to acute-care hospitals for inpatient stays with admission dates from September 1 through November 30, 2020, for enrollees diagnosed with COVID-19.

OIG's objective was to determine whether Medicare paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements.

OIG's audit covered \$2.7 billion in Medicare payments for 166,107 claims billed by acute-care hospitals. OIG selected a random sample of 150 claims and excluded 1 claim because the acute-care hospital did not receive the increased payment. OIG submitted the remaining 149 claims to an independent medical review contractor to determine whether the claims met coverage, medical necessity, and coding requirements.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that of the 149 sampled claims for inpatient stays for enrollees diagnosed with COVID-19, 146 claims complied with Federal requirements; however, the remaining 3 claims did not comply with the requirements. As a result, Medicare improperly paid hospitals \$18,911. These improper payments occurred primarily because the acute-care hospitals made clerical errors when billing claims for inpatient stays. OIG provided the Centers for Medicare & Medicaid Services (CMS) with the billing details and OIG's findings for the three improperly paid claims so that it could evaluate



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these claims and decide whether to recover the improper payments in accordance with the agency's policies and procedures.

At the time of OIG's audit, CMS stated that, with the recent end of the COVID-19 PHE on May 11, 2023, CMS was assessing which actions would be most useful in a future PHE, such as a natural disaster or other emergencies, to: (1) ensure a rapid response to future emergencies, both locally and nationally, or (2) address the unique needs of communities that may experience barriers to accessing health care. CMS also stated that it would use lessons learned from the COVID-19 PHE and assessments of the actions it took in response to the PHE to inform what steps it takes in responding to future emergencies, such as mitigating risk by having a policy in place to ensure that payments are made only for treatments that are reasonable and medically necessary.

OIG concluded that this report did not have any recommendations because Medicare generally paid acute-care hospitals for inpatient stays for enrollees diagnosed with COVID-19 in accordance with Federal requirements. The improper payments OIG identified resulted primarily from clerical errors made by the acute-care hospitals, and Medicare no longer paid hospitals the additional amount for billing a claim for a Medicare enrollee diagnosed with COVID-19.

**ICD Codes Identified in This Audit:**

- U07.1 - COVID-19 diagnosis code
- B97.29 - Other coronavirus as the cause of diseases classified elsewhere
- J69.0 - Pneumonitis due to inhalation of food and vomit
- J96.01 - Acute respiratory failure with hypoxia

**Audit #:** [A-09-21-03009](#) (12/13/2023)

**Government Program:** CMS

**[Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Discharges to Postacute Care](#)**

In a 2022 report, the Trustees of the Part A Hospital Insurance Trust Fund projected a Medicare Part A deficit of \$7.3 billion by 2028 and urged policymakers to take timely and effective action to address this projected deficit. OIG performed this audit because data analysis indicated that significant cost savings could be realized for the Medicare program if the Centers for Medicare & Medicaid Services (CMS) expanded the hospital transfer policy for discharges to postacute care (PAC).

OIG's objective was to determine how the hospital transfer policy for discharges to PAC would financially affect Medicare and hospitals if CMS expanded the policy to include all Medicare Severity Diagnosis-Related Groups (MS-DRGs).

OIG reviewed a stratified random sample of 100 acute-care inpatient hospital claims for Medicare enrollees who were discharged early to PAC from 2017 through 2019. These claims were billed with specified MS-DRGs that were not subject to the hospital transfer policy for discharges to PAC. OIG calculated the savings that the Medicare program would have realized if the hospital transfer payment policy for discharges to PAC had been expanded to include all MS-DRGs. In addition, OIG compared the payments that would have been made under an expanded transfer policy with the hospitals' calculated costs to provide care.



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### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that an expanded hospital transfer policy for discharges to PAC would have resulted in significant cost savings to the Medicare program, and Medicare transfer payments would have exceeded hospital costs to provide care for most of the claims hospitals submitted to Medicare. Of the 100 claims in the sample, 99 could have had transfer payments that were based on a reduced per diem rate (rather than the full payment) that would have resulted in net Medicare cost savings of \$1 million. This amount represented the difference between the amount paid to the hospitals under the current policy for discharges to PAC and the amount that would have been paid if the policy had been expanded to include the MS-DRGs associated with the sampled claims. This policy change might have negatively impacted hospitals' revenues, but the transfer payment would have exceeded hospital costs for an estimated 65 percent of all claims that hospitals submitted to Medicare.

CMS officials stated that CMS had not conducted an updated analysis of claims data since 2005. This analysis could have provided updated information in support of adding MS-DRGs or expanding the hospital transfer policy to include all MS DRGs. On the basis of the sample results, OIG estimated that Medicare could have saved approximately \$694 million, or an average of \$6,407 per claim, from 2017 through 2019 if it had expanded its hospital transfer policy to include all MS-DRGs.

OIG recommended that CMS conduct an analysis of its hospital transfer payment policy for discharges to PAC and expand the policy as necessary.

**Audit #:** [A-01-21-00504](#) (10/06/2023)

**Government Program:** CMS

### **Medicare Improperly Paid Acute-Care Hospitals for Inpatient Claims Subject to the Post-Acute-Care Transfer Policy Over a 4-Year Period, but CMS's System Edits Were Effective in Reducing Improper Payments by the End of the Period**

Prior OIG audits identified over \$563 million in overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). These hospitals transferred patients to certain post-acute care settings, such as skilled nursing facilities (SNFs), but claimed the higher reimbursements associated with discharges to home. Because compliance with the transfer policy had been an issue over a long period, OIG conducted this follow-up audit to evaluate whether Medicare properly paid acute-care hospitals' claims subject to that policy for those claims with dates of service from January 1, 2019, through December 31, 2022 (audit period).

OIG's objective was to determine whether Medicare properly paid acute care hospitals' inpatient claims subject to the transfer policy.

OIG's audit covered \$198 million in Medicare Part A payments for 12,133 inpatient claims subject to the transfer policy. OIG first identified specific inpatient claims for the audit period that had a patient discharge status code indicating a discharge to home or certain types of health care institutions. OIG used the Medicare enrollee information and service dates from those claims to identify services furnished in post-acute-care settings that began: (1) on the same date as the inpatient discharge (e.g., SNF claims) or (2) within 3 days of the inpatient discharge (i.e., home health claims).



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### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for the audit period, Medicare improperly paid \$41.4 million to acute-care hospitals for inpatient claims subject to the transfer policy. These hospitals improperly billed these claims by using the incorrect discharge status codes. Specifically, they coded these claims as discharges to home (6,338 claims) or to certain types of health care institutions (5,795 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. Medicare made the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to an acute-care hospital that discharged an inpatient to home or certain types of health care institutions, but paid an acute-care hospital that transferred an enrollee to post-acute care a per diem rate for each day of the enrollee's stay in the hospital. The total overpayment of \$41.4 million represented the difference between the amount of the full MS-DRG payments and the amount that would have been paid if the per diem rates had been applied.

These improper payments were made because CMS's system edits were not effective in detecting inpatient claims subject to the transfer policy in October and November 2019 and from October 2020 through March 2022. However, after CMS fixed the edits in April 2022, improper payments significantly decreased through the end of the audit period (i.e., through December 2022).

OIG recommended that CMS:

(1) direct the Medicare contractors to recover from acute-care hospitals the portion of the \$41.4 million in identified overpayments for the audit period that were within the 4-year reopening period and

(2) instruct the Medicare contractors to notify appropriate providers so that the providers could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule.

**Audit #:** [A-09-23-03016](#) (09/08/2023)

**Government Program:** CMS

### **Targeted Provider Relief Funds Allocated to Hospitals Had Some Differences with Respect to the Ethnicity and Race of Populations Served**

The COVID-19 pandemic highlighted longstanding inequities, like disparities in funding levels for health care providers by locations and populations served, as well as inequitable access to quality health care. From the beginning of the pandemic, reports indicated that people of color (e.g., Hispanic/Latino and Black Americans) and people from economically disadvantaged communities were at greater risk of COVID-19 exposure, illness, hospitalization, and death than members of predominantly Non-Hispanic White communities. In addition, the Centers for Disease Control and Prevention (CDC) considered Hispanic/Latino ethnicity and Black race to be associated with social vulnerability, along with external stressors such as poverty and poor housing conditions. This meant that communities with greater concentrations of Hispanic/Latino residents, greater concentrations of Black residents, and/or higher rates of people experiencing poverty might be at a greater risk of experiencing long-term financial hardship due to disease outbreaks.

In April 2020, the U.S. Department of Health and Human Services (HHS) began distributing Provider Relief Fund (PRF) payments through the Health Resources and Services Administration (HRSA) to support health care providers, including hospitals, on the front line of the pandemic response. To respond to the urgent need for health care funding, Congress



required HHS to make PRF payments using the most efficient payment systems practicable. HHS had to make decisions quickly about how to allocate money in accordance with statutory criteria associated with the funds.

HHS placed a priority on promoting health equity and reducing health disparities during the COVID-19 pandemic, including in the distribution of resources. While the PRF was not designed with the goal of addressing health disparities, understanding how early PRF Targeted Distributions (Targeted PRF) correlated with racial, ethnic, and economic characteristics of the communities providers served could help to inform decisions for future public health funding and the opportunities they present to advance the health equity goals of HHS.

To analyze hospital funding according to populations served, OIG took allocations to hospitals from the Targeted PRF in 2020 and translated them into estimated "PRF per person" amounts for each U.S. census tract (in this report, OIG also referred to census tracts as "communities"). To do so, OIG used Medicare data about the census tracts served by each hospital, and assigned each hospital's funding allocations to those census tracts proportionately. OIG then determined whether there were statistically significant correlations between PRF per person and the racial, ethnic, and economic composition of the census tracts. To account for other community characteristics that could help explain differences in PRF per person, OIG analyzed rural and nonrural census tracts separately. OIG conducted this analysis for the approximately \$44 billion in Targeted PRF allocated to hospitals in 2020 through the four allotments designated for:

1. COVID-19 High Impact Area Hospitals
2. Safety Net Hospitals
3. Rural Hospitals
4. Indian Health Service and Tribal Hospitals.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that OIG's analysis identified some differences in PRF per person across census tracts with respect to the race and ethnicity of their residents, but not with respect to poverty rates. Specifically, when OIG analyzed all four Targeted PRF allotments combined, it was found that communities with greater concentrations of Hispanic/Latino residents were associated with less PRF per person than communities with smaller concentrations of Hispanic/Latino residents. In nonrural areas, communities with greater concentrations of Non-Hispanic Black residents were associated with more PRF per person than communities with smaller concentrations of Non-Hispanic Black residents, but this pattern did not occur in rural areas. OIG did not find a meaningful association between PRF per person and the proportion of residents experiencing poverty in the community.

When OIG analyzed the four Targeted PRF allotments individually, the most notable trends were found in the allotment targeted to rural hospitals (about \$9.7 billion): Communities with greater concentrations of Hispanic/Latino residents or Non-Hispanic Black residents were associated with less PRF per person than communities with smaller concentrations of Hispanic/Latino Residents or Non-Hispanic Black residents.

OIG concluded that differences in hospital funding with respect to the characteristics of the populations hospitals serve--including race and ethnicity--could potentially have exacerbated pre-existing disparities in health outcomes. If hospitals that served populations experiencing disparate health outcomes were under-resourced, those populations might have been left with less access to high-quality care, which could have widened gaps in health outcomes. Health care funding was an important tool that could have helped HHS contribute to goals of reducing health disparities, both in the context of COVID-19 and more broadly. OIG hoped that this analysis was useful to HHS in planning for future emergency funding scenarios and identifying opportunities to support these goals, to the extent permitted by law.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

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Behavioral Health

Laboratory

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Evaluation #: [OEI-05-20-00580](#) (07/12/2023)  
Government Program: OS

**Crow/Northern Cheyenne Hospital—an IHS-Operated Health Facility—Did Not Timely Conduct Required Background Checks of Staff and Supervise Certain Staff**

The Indian Child Protection and Family Violence Prevention Act established requirements for Federal background investigations for individuals in contact with Indian children as well as supervision of such individuals pending completion of the background investigation. Prior OIG work in this area found that several Tribes and their health programs did not comply with Federal requirements to perform FBI fingerprint background investigations for individuals in contact with Indian children. In this audit, OIG evaluated the background investigation and supervision processes for individuals in contact with Indian children at Crow/Northern Cheyenne Hospital (the Hospital), an Indian Health Service (IHS)-operated health facility located within the IHS Billings Area Office, in Crow Agency, Montana.

OIG's objective was to determine whether the Hospital met Federal requirements for conducting background investigations and supervision of staff in contact with Indian children.

OIG reviewed the background investigation and supervision processes and related documentation at the Hospital for a randomly selected sample of 50 staff in contact with Indian children during calendar year 2020.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the Hospital did not fully comply with Federal requirements for conducting background investigations of staff members in contact with Indian children. Specifically, for 44 of the 50 staff members OIG reviewed, the Hospital did not comply with Federal requirements for conducting background investigations, including failing to initiate or timely initiate and adjudicate certain investigations. Further, the Hospital could not document that it supervised certain staff members with pending background investigations (provisional staff) in accordance with Federal requirements. Specifically, for 47 of the 50 staff members OIG reviewed, the Hospital did not provide evidence documenting compliance with Federal supervision requirements while their background investigations were pending.

These deficiencies generally occurred because the Hospital did not monitor compliance with background check requirements for permanent staff or ensure background checks for temporary staff were performed in accordance with the applicable requirements. Finally, the Hospital could not document supervision in accordance with Federal requirements. As a result, Indian children faced an increased risk of harm and abuse.

OIG recommended that the Hospital, the Billings Area Office, and IHS Headquarters work together to (1) complete and adjudicate necessary background investigations for staff members identified in the report, (2) ensure provisional staff supervision was adequately documented, and (3) update standard operating procedures and establish monitoring systems for background investigations and provisional staff supervision.

Audit #: [A-02-21-02004](#) (04/21/2023)  
Government Program: IHS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

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Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers





## **ASPR Could Improve Its Oversight of the Hospital Preparedness Program To Ensure That Crisis Standards of Care Comply With Federal Nondiscrimination Laws**

In 2020, during the COVID-19 pandemic, individuals with disabilities and their advocates filed complaints with HHS's Office for Civil Rights (OCR) asserting that six States had language in their Crisis Standards of Care (CSCs) that could result in individuals being denied treatment because of their disabilities.

OIG's objective was to determine whether the Administration for Strategic Preparedness and Response's (ASPR's) oversight of the Hospital Preparedness Program (HPP) could be improved with respect to recipients adopting CSCs that comply with Federal nondiscrimination laws.

OIG reviewed complaints filed by individuals with disabilities and their advocates with OCR as well as their subsequent resolutions. OIG also conducted interviews with officials from ASPR and 11 States with a focus on their development of CSC planning documents and their considerations of and compliance with Federal civil rights laws from July 2019 through June 2021. Furthermore, OIG reviewed the HPP cooperative agreements as well as Federal nondiscrimination laws and regulations. Of the States included in the interviews, six had complaints that had been filed and resolved with OCR during the COVID-19 pandemic. OIG judgmentally selected the other five States to provide input from various regions in different stages of CSC planning.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that although ASPR had taken steps to improve its oversight of the HPP by promoting the adoption of nondiscriminatory CSCs that comply with Federal nondiscrimination laws, it could take additional steps. The HPP cooperative agreement did not previously specify that States should consider Federal nondiscrimination laws when developing CSCs because prior to the COVID-19 pandemic, ASPR had not identified CSC compliance with Federal nondiscrimination laws as a high-risk area. Additionally, ASPR stated that it was not required to review CSCs for legal and regulatory compliance. CSCs that did not comply with Federal nondiscrimination laws increased the risk that individuals could be denied access to lifesaving care during a public health emergency.

OIG recommended that ASPR consider additional updates to the current HPP cooperative agreement to promote that HPP recipients adopt CSCs that comply with Federal nondiscrimination laws. OIG acknowledged that ASPR had taken steps in previous HPP updates to promote compliance with Federal nondiscrimination laws; however, OIG believed that additional steps could be taken. Such steps could have included an additional update to the HPP cooperative agreement to encourage recipients to engage with advocacy groups in decision making related to crisis care planning.

**Audit #:** [A-01-21-01502](#) (01/13/2023)

**Government Program:** ASPR

Provider

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## **CMS Can Use OIG Audit Reports To Improve Its Oversight of Hospital Compliance**

During calendar years (CYs) 2016 through 2018, Medicare paid hospitals approximately \$555.2 billion: OIG performed a series of hospital compliance audits to determine whether hospitals were billing appropriately for certain claims. OIG did this audit to determine the Centers for Medicare & Medicaid Services' (CMS's) actions taken regarding recommendations in these 12 audits. OIG also considered the results from the first and second levels of appeals to determine whether identified claims errors were sustained. Finally, OIG wanted to confirm that CMS was making the best use of OIG's reports to enhance its oversight of the Medicare program.

OIG's objectives were to: (1) summarize the results, after considering the status of appeals, of OIG's hospital compliance audits covering Medicare claims paid from 2016 through 2018; (2) identify CMS's actions taken to ensure that OIG's recommendations were implemented; and (3) determine how CMS could improve program oversight using OIG's hospital compliance audits.

OIG summarized the results of the previous 12 audits, determined the appeals status of any improperly paid claims, determined what actions CMS had taken with respect to the recommendations made in these 12 audits, and identified internal controls that CMS had in place to prevent payment of high-risk Medicare claims determined to be in error in these 12 reports.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that of the 387 improperly paid claims identified in OIG's previous 12 hospital compliance audits, 333 were inpatient claims that resulted in \$5,260,147 in net overpayments, and 54 were outpatient claims that resulted in \$53,729 in net overpayments. Of these 387 improperly paid claims, 229 claims were appealed at the first level, of which 22 overpayment determinations were overturned. In addition, 126 claims were appealed at the second level, of which 6 overpayment determinations were overturned. As a result, 359 overpayment determinations remained, resulting in sustained overpayments totaling \$5,041,721. After considering the results of the first and second levels of appeal, OIG determined that the total overpayments received by the 12 hospitals was \$82 million.

OIG found that CMS has taken some actions to ensure that the recommendations in OIG's previous 12 hospital compliance audits were implemented. With respect to OIG's recommendations to repay funds, CMS provided OIG with insufficient information; therefore, OIG could not identify the actions CMS had taken to ensure that OIG's recommendations were implemented. With respect to OIG's recommendations to follow the 60-day rule, CMS provided OIG with insufficient information; therefore, OIG could not ensure that OIG's recommendations were implemented. With respect to OIG's recommendations to strengthen internal controls, CMS acted on most of these recommendations. As a result of CMS's incomplete responses, OIG was not able to verify that some hospitals had repaid funds or implemented OIG's recommendations to follow the 60-day rule and strengthen internal controls. CMS has not used the results from OIG's 12 issued audit reports in its internal control activities. CMS could use OIG's hospital compliance audit reports to enhance its oversight of the Medicare program.

OIG recommended that CMS: (1) continue to follow up on the overpayment recovery recommendations contained in the 12 audits covered by this report and (2) improve tracking and responding on the status of claims identified in OIG's reports as they proceeded through the appeals process. OIG made additional procedural recommendations that were included in the body of the report.

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**Audit #:** [A-04-21-08084](#) (10/26/2022)  
**Government Program:** CMS

## **CMS's System Edits Significantly Reduced Improper Payments to Acute-Care Hospitals After May 2019 for Outpatient Services Provided to Beneficiaries Who Were Inpatients of Other Facilities**

A prior OIG audit found that Medicare inappropriately paid acute-care hospitals \$51.6 million for outpatient services they provided from January 2013 through August 2016 to beneficiaries who were inpatients of long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), inpatient psychiatric facilities (IPFs), and critical access hospitals (CAHs). The overpayments occurred because system edits were not working properly. Because of the large overpayment amount OIG identified, OIG conducted this followup audit to review payments to acute-care hospitals for outpatient services provided from September 2016 through December 2021 (audit period), including determining whether the Centers for Medicare & Medicaid Services (CMS) had corrected the system edits.

OIG's objective was to determine whether Medicare appropriately paid acute-care hospitals for outpatient services they provided to beneficiaries who were inpatients of other facilities.

OIG's audit identified \$39.3 million in Medicare Part B payments to acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of certain other facilities during the audit period. OIG identified inpatient claims from LTCHs, IRFs, IPFs, and CAHs and used the beneficiary information and service dates to identify outpatient claims from acute-care hospitals that overlapped with the identified inpatient claims.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that during the audit period, Medicare inappropriately paid acute-care hospitals \$39.3 million for outpatient services they provided to beneficiaries who were inpatients of other facilities (i.e., LTCHs, IRFs, IPFs, and CAHs). None of the \$39.3 million should have been paid because the inpatient facilities were responsible for payment. Each type of inpatient facility covered by the audit had to: (1) provide directly all services furnished during an inpatient stay or (2) arrange for services to be provided on an outpatient basis by an acute-care hospital and include those outpatient services on its inpatient claims submitted to Medicare.

Before May 2019, the system edits were not working properly. However, after CMS modified the edits in May 2019, only \$3.4 million (less than 9 percent of the \$39.3 million in improper payments for the entire audit period) was inappropriately paid to acute-care hospitals from June 2019 through December 2021.

OIG recommended that CMS: (1) direct the Medicare contractors to recover the portion of the \$39.3 million in improper payments for the audit period that were within the 4-year reopening period, (2) instruct acute-care hospitals to refund beneficiaries up to \$9.8 million in deductible and coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf, (3) direct the Medicare contractors to recover any improper payments after the audit period, and (4) continue to review the system edits to determine whether any refinements were necessary to prevent overpayments to acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities. The report included one other recommendation.

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Hospital

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**Audit #:** [A-09-22-03007](#) (09/22/2022)  
**Government Program:** CMS

### **Medicare Critical Care Services Provider Compliance Audit: Lahey Clinic, Inc.**

Medicare paid approximately \$2.4 billion for critical care services provided to Medicare beneficiaries nationwide from January 1, 2017, through March 31, 2019 (audit period). The 2018 Medicare improper payment error rate for critical care services was 19.7 percent, or about \$198 million. Using computer matching, data mining, and data analysis techniques, OIG identified Lahey Clinic, Inc. as a provider that was at risk for noncompliance with Medicare billing requirements for critical care services.

OIG's objective was to determine whether Lahey complied with Medicare requirements when billing for critical care services performed by its physicians.

Medicare Part B paid \$5.3 million to Lahey for 30,738 critical care services provided during 5,109 inpatient admissions in OIG's audit period. OIG selected a stratified random sample of 100 inpatient admissions that included 1,410 critical care services totaling \$233,797. OIG submitted the medical records for 10 judgmentally selected inpatient admissions to an independent medical review contractor. The 10 selected admissions included 92 critical care services totaling \$14,966.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Lahey complied with Medicare billing requirements for 36 of the 92 critical care services that OIG reviewed. However, Lahey did not comply with Medicare billing requirements for the remaining 56 critical care services. All 10 of the inpatient admissions reviewed included at least 1 critical care service that did not comply with Medicare billing requirements. Specifically, Lahey billed for 54 critical care services for patients whose conditions did not indicate that the critical care services were medically necessary or for which the physician did not directly provide services that were at the level of care required for critical care services. In addition, Lahey billed for two critical care services that were billed using an incorrect Current Procedural Terminology code for the critical care service provided.

These billing errors resulted in Lahey receiving \$6,015 in unallowable Medicare payments. These errors occurred because Lahey did not have adequate policies and procedures to ensure that: (1) physicians correctly documented in the patient's medical record and identified critical care services that met Medicare requirements and (2) coders made correct determinations for critical care services that met Medicare requirements.

OIG recommended that Lahey refund to the Medicare administrative contractor \$6,015 in overpayments for critical care services, and made procedural recommendations for Lahey to strengthen its policies and procedures. The full recommendations were in the report.

OIG commended Lahey for the actions it had taken and planned to take to address the procedural recommendations to strengthen its policies and procedures.

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**CPT Codes Identified in This Audit:**

- 99291 - Used to bill for the first 30 to 74 minutes of critical care on a given date of service by a physician or physician group of the same specialty
- 99292 - Used to bill for additional blocks of time of up to 30 minutes each beyond the first 74 minutes of critical care occurring on the same date
- 99232 - Typically 25 minutes of subsequent hospital care per day
- 99233 - Typically 35 minutes of subsequent hospital care per day

Audit #: [A-03-20-00002](#) (07/19/2022)

Government Program: CMS

**The Reduced Outlier Threshold Applied to Transfer Claims Did Not Significantly Increase Medicare Payments to Hospitals**

The Medicare program paid hospitals for inpatient hospital services based on a Medicare severity diagnosis-related group (DRG) rate per discharge. To protect hospitals from excessive losses due to unusually high-cost cases, the Medicare program supplemented the DRG rate payment by making outlier payments. To avoid giving hospitals an incentive to transfer patients to another health care setting early in a patient's stay, while still receiving the full DRG rate, Congress established the transfer policy. Medicare payment for transfer claims differed from Medicare payment for discharge claims in two ways. First, under the transfer policy, CMS used a graduated per diem rate payment (transfer rate payment), which was less than the full DRG rate payment, to pay a hospital that transferred an inpatient to another health care setting. Second, CMS decreased the outlier threshold (reduced outlier threshold) applied to determine the eligibility for, and the amount of, outlier payments for transfer claims.

OIG's objective was to assess the financial impact that Medicare's transfer policy and reduced outlier threshold had on Medicare total payments for transfer claims compared with what hospitals would have been paid if the beneficiary had been discharged instead of transferred.

During fiscal years 2011 through 2017, Medicare paid approximately \$776 million in outlier payments for transfer claims. OIG reviewed 5,303 transfer claims with outlier payments totaling \$66 million from 30 hospitals. Specifically, using Medicare claim data and information obtained from CMS for the 7-year period, OIG calculated DRG rate amounts and outlier payment amounts without applying the transfer policy for these 5,303 transfer claims, and OIG compared the results with the actual payments that Medicare made for these transfer claims.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare's reduced outlier threshold for transfer claims did not have a significant impact on the total Medicare payments to the 30 hospitals audited by OIG. Of the 5,303 transfer claims, the total Medicare payments for 3,668 transfer claims were less than what Medicare would have paid the hospitals if they had discharged the beneficiaries. However, the total Medicare payments for the remaining 1,635 transfer claims were \$2.9 million more than what Medicare would have paid the hospitals if they had discharged the beneficiaries. Specifically, under the transfer policy, Medicare decreased DRG rate payments by \$10.8 million but, because of the reduced outlier threshold, Medicare increased outlier payments by \$13.7 million, resulting in a net increase of \$2.9 million in total Medicare payments compared to what hospitals would have been paid if they had discharged the beneficiaries.



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The \$2.9 million net increase in total Medicare payments for these 1,635 transfer claims occurred because the outlier payment increase using the reduced outlier threshold was greater than the DRG payment decrease under the transfer policy.

OIG concluded that Medicare's reduced outlier threshold for transfer claims did not have a significant enough impact for OIG to recommend a policy change. Therefore, OIG did not have any recommendations.

**Audit #:** [A-05-19-00019](#) (07/05/2022)

**Government Program:** CMS

### **Medicare and Beneficiaries Paid Substantially More to Provider-Based Facilities in Eight Selected States in Calendar Years 2010 Through 2017 Than They Paid to Freestanding Facilities in the Same States for the Same Type of Services**

Three Medicare Payment Advisory Commission reports to Congress and a previous Office of Inspector General (OIG) report found that hospitals were increasingly purchasing physician practices and operating them as provider-based facilities because of their higher payment rates, and that Medicare payments and beneficiary coinsurance payments were substantially higher for services in provider-based facilities than they were for the same services in freestanding facilities.

OIG's objective was to identify the potential cost savings to both the Medicare program and its beneficiaries by comparing their payments made for certain evaluation and management (E&M) services performed at provider-based facilities in calendar years 2010 through 2017 in eight selected States with what Medicare and beneficiaries would have paid for the same type of services performed at freestanding facilities in the same eight States.

OIG's audit covered \$3.95 billion that Medicare and beneficiaries paid for E&M; services they received at provider-based facilities in the selected States. OIG developed a database of payments made to physicians and provider-based facilities based on outpatient and Physician Fee Schedule (PFS) claims for E&M; services performed in these facilities. OIG then compared those payments to what would have been paid at freestanding facilities.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that both the Medicare program and its beneficiaries could have realized significant savings for E&M; services if those services had been paid as if provided at freestanding facilities. If the physicians in the selected States had been paid at the freestanding PFS nonfacility rate and hospitals paid nothing under the Outpatient Prospective Payment System for the audit period, the Medicare program could have realized cost savings of \$1.3 billion and its beneficiaries could have realized cost savings of \$334 million, for combined savings totaling over \$1.6 billion. In addition, beneficiaries would have been required to make only one coinsurance payment rather than two (as they are currently required to do) and the cost-sharing would generally have been lower because it would have been based only on the freestanding facility rate.

The Centers for Medicare & Medicaid Services (CMS) had taken some steps intended to equalize payments. If these changes had been in effect during the period covered by the audit, the potential cost savings of these changes for E&M;



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services in the selected States for the audit period could have been a combined \$1.4 billion for the Medicare program and its beneficiaries. However, the combined \$1.4 billion in potential cost savings would still have been less than the \$1.6 billion in potential cost savings if E&M; services had been paid at the freestanding PFS nonfacility rate.

OIG recommended that CMS pursue legislative or regulatory changes to lower costs for both the Medicare program and beneficiaries, by equalizing payments as appropriate between provider-based facilities and freestanding facilities for E&M; services.

OIG continued to recommend that CMS pursue legislative or regulatory changes to lower costs by equalizing payments between the two types of facilities.

#### **CPT Codes Identified in This Audit:**

- 99215 - Highest level of care for established patients being seen in the office for E&M; services

#### **HCPCS Codes Identified in This Audit:**

- G0463 - Hospital outpatient clinic visit for assessment and management of a patient

**Audit #:** [A-07-18-02815](#) (06/10/2022)

**Government Program:** CMS

### **Vanderbilt University Medical Center: Audit of Outpatient Outlier Payments**

Medicare made supplemental payments to hospitals, known as outlier payments, which were designed to protect hospitals from significant financial losses resulting from patient-care cases that were extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments were directly influenced by hospital charges. OIG selected Vanderbilt University Medical Center (VUMC) because outpatient outlier payments increased from \$2.7 million in 2017 to \$6.2 million in 2018.

OIG's objective was to determine whether possible billing inconsistencies resulted in improper outpatient outlier payments to VUMC.

OIG's audit covered 2,362 outpatient outlier payments, totaling \$6.2 million, to VUMC for services provided from January 1 through December 31, 2018. OIG selected a stratified random sample of 117 outlier payments totaling \$543,684 for review. Because outlier payments were based on total charges, OIG retrieved the claim detail related to each outlier payment. OIG submitted the claims related to the 117 outlier payments to VUMC for it to review. OIG requested that VUMC verify that charges and codes on the claim were correct. Additionally, OIG reviewed outlier claims data for inconsistencies and claim support documentation for billing errors.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that VUMC properly billed the claims for 34 of the 117 sampled outlier payments totaling \$102,551. However, VUMC did not properly bill the claims related to 81 outlier payments, resulting in improper outlier payments during OIG's audit period. These 81 claims, which had outlier payments totaling \$427,644, contained 110 billing errors. The billing errors primarily occurred because VUMC did not have adequately designed controls or billing system capabilities to prevent coding errors, charge errors, and billing for services not covered by Medicare Part B. VUMC billed another two



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claims with incorrect dates of service that caused the claims to fall outside the scope of this audit (outpatient services longer than 1 day) and so were classified as non-errors.

OIG recommended that the Vanderbilt University Medical Center refund to the Medicare contractor the portion of the \$686,500 in estimated outpatient outlier net overpayments for incorrectly billed claims that were within the 4-year reopening period. OIG also recommended that VUMC improve procedures, provide education, and implement changes to its billing system to ensure that claims billed to Medicare were accurate.

**Audit #:** [A-06-20-04003](#) (05/25/2022)

**Government Program:** CMS

### **Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018**

In 2010, OIG reported the first national incidence rate of patient harm events in hospitals--27 percent of hospitalized Medicare patients experienced harm in October 2008. During that month, hospital care associated with these events cost Medicare and patients an estimated \$324 million in reimbursement, coinsurance, and deductible payments. Nearly half of these events were preventable.

OIG conducted a new study to update the national incidence rate of patient harm events among hospitalized Medicare patients in October 2018. This work included calculating a new rate of preventable events and updating the cost of patient harm to the Medicare program.

The Department of Health and Human Services (HHS) led national efforts to promote quality health care and prevent patient harm. Several agencies shared this responsibility, including AHRQ, which led HHS's efforts to improve health care quality, and CMS, which was the Nation's largest health care payer and oversight entity.

Although HHS agencies reported progress during the past decade toward improving patient safety, protecting the health and safety of HHS beneficiaries remained one of HHS's top management and performance challenges. An increased understanding of the prevalence and nature of patient harm would further assist efforts to reduce patient harm events and the factors contributing to these events.

OIG reviewed medical records for a random sample of 770 Medicare patients who were discharged from acute-care hospitals during October 2018. OIG conducted a two-stage medical record review to estimate a national incidence rate of adverse events and temporary harm events. The review included all causes of patient harm regardless of whether the harm was preventable.

**Stage 1:** Nurses screened the records for possible patient harm events using a "trigger tool" method. A "trigger" is a clinical clue (e.g., documentation of a fall) that may indicate harm. From the Medicare claims data, nurses also reviewed present-on-admission indicators to identify harm that developed after the patient was admitted. Records were automatically referred to Stage 2 when patients were readmitted within 30 days of discharge, regardless of whether the nurse identified harm (these included readmissions in October and November).

**Stage 2:** Physicians reviewed the records flagged during Stage 1 as containing possible harm events.





Physician-reviewers identified harm events and assessed the severity of events, whether events were preventable, and factors that contributed to events.

OIG calculated the potential cost incurred by Medicare and patients as a result of these events. OIG also determined whether events were on CMS's lists of hospital-acquired conditions. Finally, OIG compared the results of this report to the 2010 report and explained the limitations of this comparison.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that twenty-five percent of Medicare patients experienced patient harm during their hospital stays in October 2018. Patient harm included adverse events and temporary harm events.

Twelve percent of patients experienced adverse events, which were events that led to longer hospital stays, permanent harm, life-saving intervention, or death. In addition to the patients who experienced adverse events, 13 percent of patients experienced temporary harm events, which required intervention but did not cause lasting harm, prolong hospital stays, or require life-sustaining measures. Temporary harm events were sometimes serious and could have caused further harm if providers had not promptly treated patients.

- **Categories of Harm Events.** The most common type of harm event was related to medication (43 percent), such as patients experiencing delirium or other changes in mental status. The remaining events related to patient care (23 percent), such as pressure injuries; to procedures and surgeries (22 percent), such as intraoperative hypotension; and to infections (11 percent), such as hospital-acquired respiratory infections.
- **Preventability of Harm Events.** Physician-reviewers determined that 43 percent of harm events were preventable, with preventable events commonly linked to substandard or inadequate care provided to the patient. (The overall harm rate would have been 13 percent if OIG were to include only events that physician-reviewers determined were preventable.) Reviewers determined that 56 percent of harm events were not preventable and occurred even though providers followed proper procedures. Events were determined not preventable for several reasons, including that the patients were found to be highly susceptible to the events because of their poor health status.
- **CMS's Lists of Hospital-Acquired Conditions.** CMS's two policies on hospital-acquired conditions (HACs) created payment incentives for harm prevention by reducing payment for certain HACs. However, because the policies used narrowly scoped lists of HACs and employed specific criteria for counting harm events, they had limited effectiveness in broadly promoting patient safety. The lists did not cover most of the harm events that patients in OIG's study experienced. Of the harm events OIG identified, only 5 percent were on CMS's HAC Reduction Program list and only 2 percent were on CMS's Deficit Reduction Act HAC list.
- **Harm Events Resulting in Costs to Medicare.** Nearly a quarter of Medicare patients who experienced harm events (23 percent), either preventable or non-preventable, required treatment that led to additional Medicare costs. These events also potentially increased patient costs in the form of coinsurance and deductible payments. Costs were incurred during the sample hospital stay or for an additional hospital stay necessary to ameliorate the harm. Combined, OIG estimated the costs for all events to be in the hundreds of millions of dollars for October 2018.

OIG concluded that given the scale and persistence of patient harm in hospitals in the decade since OIG's last report, HHS leadership and agencies had to work with urgency to reduce patient harm in hospitals. Although HHS agencies took steps to improve patient safety in hospitals, including implementing many of OIG's prior recommendations, substantial efforts were still needed. OIG made seven recommendations and received concurrences from CMS and AHRQ on all:

## Provider

### Multiple Providers

### Hospital

### Long Term Care

### Home Health Service

### Hospice

### Medical Equipment and Supplies

### Behavioral Health

### Laboratory

### Telehealth

### Other Providers and Suppliers



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

- OIG made the following three recommendations to CMS: (1) update and broaden its lists of HACs to capture common, preventable, and high-cost harm events; (2) explore expanding the use of patient safety metrics in pilots and demonstrations for health care payment and service delivery, as appropriate; and (3) develop and release interpretive guidance to surveyors for assessing hospital compliance with requirements to track and monitor patient harm.
- OIG made the following four recommendations to AHRQ: (1) with support from HHS leadership, coordinate agency efforts to update agency-specific Quality Strategic Plans; (2) optimize use of the Quality and Safety Review System, including assessing the feasibility of automating data capture for national measurement and to facilitate local use; (3) develop an effective model to disseminate information on national clinical practice guidelines or best practices to improve patient safety; and (4) continue efforts to identify and develop new strategies to prevent common patient harm events in hospitals.

**Evaluation #:** [OEI-06-18-00400](#) (05/05/2022)

**Government Program:** AHRQ, CMS

### **Hospitals Did Not Always Meet Differing Medicare Contractor Specifications for Bariatric Surgery**

Bariatric surgery helped those with morbid obesity to lose weight by making changes to their digestive system. A prior OIG audit found that a hospital's claims for bariatric surgeries performed in 2015 and 2016 did not fully meet a Medicare contractor's eligibility specifications. Because eligibility specifications varied among the Medicare contractors, OIG conducted this nationwide audit of hospitals' inpatient claims for bariatric surgeries performed from January 2018 through July 2019 (audit period), for which Medicare paid approximately \$279 million.

OIG's objective was to determine whether hospitals' inpatient claims for bariatric surgeries met Medicare national requirements and Medicare contractors' eligibility specifications.

OIG's audit covered \$275.2 million in Medicare payments for 24,821 inpatient claims for bariatric surgeries performed during the audit period. OIG stratified the claims into four strata (which OIG referred to as "groups") based on the Medicare contractor jurisdictions that had similar eligibility specifications for bariatric surgery. OIG selected for review a statistical sample of 120 claims to determine whether the claims met Medicare national requirements in the Centers for Medicare & Medicaid Services' (CMS's) national coverage determination (NCD) and eligibility specifications in local coverage determinations (LCDs) or local coverage articles (LCAs).

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that not all hospitals' inpatient claims for bariatric surgeries met Medicare national requirements or Medicare contractors' eligibility specifications. Specifically, of the 120 sampled inpatient claims, 86 met NCD requirements and applicable eligibility specifications for bariatric surgery, and 1 claim was not reviewed but treated as a non-error because it was under review by a CMS contractor. However, of the remaining 33 claims, 32 claims met the NCD requirements but not the eligibility specifications, and 1 claim did not meet the NCD requirements.

Differing eligibility specifications for bariatric surgery contributed to differences in the number of claims that did not meet the specifications among Medicare contractor jurisdiction groups. Jurisdiction groups with more restrictive specifications



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

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and Supplies

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Laboratory

Telehealth

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Suppliers

had more claims that did not meet the eligibility specifications and more specifications that were not met. The Medicare contractors may have issued differing eligibility specifications because CMS's NCD requirements were not specific. On the basis of OIG's sample results, OIG estimated that Medicare could have saved \$47.8 million during the audit period if Medicare contractors had disallowed claims that did not meet Medicare national requirements or Medicare contractor specifications for bariatric surgery.

OIG recommended that CMS: (1) determine whether any eligibility specifications in the Medicare contractors' LCDs and LCAs should be added to the NCD for bariatric surgery and, if so, take the necessary steps to update the NCD; (2) work with the Medicare contractors to review the eligibility specifications in the applicable Medicare contractors' bariatric surgery LCDs and LCAs and determine which, if any, of those additional specifications should be requirements rather than guidance; and (3) educate hospitals on the NCD requirements for bariatric surgeries if the NCD had been updated in response to OIG's first recommendation.

**CPT Codes Identified in This Audit:**

- 619 - Procedures for obesity
- 620 - Procedures for obesity
- 621 - Procedures for obesity

**ICD Codes Identified in This Audit:**

- E66.01 - Morbid obesity

**Audit #:** [A-09-20-03007](#) (02/22/2022)

**Government Program:** CMS

**Medicare and Beneficiaries Pay More for Preadmission Services at Affiliated Hospitals Than at Wholly Owned Settings**

**SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that Medicare's diagnosis related group (DRG) window policy stated that if a beneficiary was furnished outpatient hospital services and was admitted to the hospital shortly afterwards for the same condition, the outpatient services were considered part of the admission and included in the pre-set inpatient payment amount rather than resulting in separate payments for the outpatient services. Since 1990, this policy had covered all settings wholly owned or operated by the admitting hospital.

The DRG window policy did not apply to one common hospital ownership structure that was similar to wholly owned or operated settings: affiliated settings. Affiliated settings were health care settings that were owned by the same affiliated group. OIG found that in 2019, Medicare paid \$168 million and beneficiaries paid approximately \$77 million for 3.3 million admission-related outpatient services provided during the DRG-window-covered days at hospitals affiliated with the admitting hospitals. This total of \$245 million for 2019 was more than 5 times the estimated \$45 million that Medicare and beneficiaries paid for nearly 800,000 outpatient services related to inpatient admissions at affiliated hospitals when OIG examined this issue in 2011. Further, beneficiaries who received admission-related outpatient services at affiliated critical access hospitals paid particularly high amounts for those services—about six times as much as beneficiaries who received similar services at other affiliated hospitals. (Critical access hospitals were a type of small, rural hospital that



### Provider

### Multiple Providers

### Hospital

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### Other Providers and Suppliers

Medicare reimbursed based on the hospital's reasonable costs, which were typically higher than the rates set by prospective payment systems or fee schedules.)

OIG recommended that CMS evaluate the potential impact of updating the DRG window policy to include affiliated hospitals, and that it seek the necessary legislative authority to update the policy as appropriate.

#### **CPT Codes Identified in This Evaluation:**

- 85025 - Complete blood count with auto differential
- 80053 - Comprehensive metabolic panel
- 93005 - Electrocardiogram tracing
- 36415 - Routine venipuncture
- 84484 - Assay of troponin quantification

**Evaluation #:** [OEI-05-19-00380](#) (12/27/2021)

**Government Program:** CMS

#### **Medicare Hospital Provider Compliance Audit: St. Joseph's Hospital Health Center**

This audit was part of a series of hospital compliance audits. OIG selected St. Joseph's Hospital Health Center (the Hospital) for a compliance audit through the use of computer matching, data mining, and data analysis techniques, and in consultation with another OIG component that categorized the Hospital as being a high risk for noncompliance based upon its refusal to enter into a Corporate Integrity Agreement after settling two False Claims Act cases.

OIG's objective was to determine whether the Hospital complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

OIG's audit covered about \$50 million in Medicare payments to the Hospital for 9,742 claims that were potentially at risk for billing errors. OIG selected for audit a stratified random sample of 75 inpatient and 25 outpatient claims with payments totaling \$1.4 million for the 2-year audit period (July 1, 2017, through June 30, 2019).

OIG focused the audit on the risk areas that were identified as a result of prior OIG audits at other hospitals and an OIG analysis of the Hospital's Medicare inpatient and outpatient claims. OIG evaluated compliance with selected billing requirements and submitted records associated with them to a medical review contractor.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the Hospital complied with Medicare billing requirements for 94 of the 100 inpatient and outpatient claims OIG audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining six claims, resulting in overpayments of \$68,897 for the audit period. Specifically, five inpatient claims and one outpatient claim had billing errors.

On the basis of OIG's sample results, OIG estimated that the Hospital received overpayments of at least \$389,000 for the audit period. As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.



## Provider

### Multiple Providers

#### Hospital

### Long Term Care

### Home Health Service

### Hospice

### Medical Equipment and Supplies

### Behavioral Health

### Laboratory

### Telehealth

### Other Providers and Suppliers

OIG recommended that the Hospital: (1) refund to the Medicare contractor \$389,000 in estimated overpayments for the audit period for the claims that it incorrectly billed that were within the 4-year claim reopening period; (2) based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen controls to ensure full compliance with Medicare requirements. The detailed recommendations were listed in the body of the report.

#### **HCCPS Codes Identified in This Audit:**

- 33249 - Hospital-specific outlier code
- 99285 - Hospital-specific outlier code
- C9600 - Hospital-specific outlier code

**Audit #:** [A-02-20-01004](#) (12/16/2021)

**Government Program:** CMS

#### **Medicare Beneficiaries Hospitalized With COVID-19 Experienced a Wide Range of Serious, Complex Conditions**

OIG reviewed hospital inpatient claims and enrollment data to identify all Medicare beneficiaries who were hospitalized in a short-term acute-care hospital at any point from April 1 through July 31, 2020. OIG then identified six localities that experienced a surge in hospitalizations of Medicare beneficiaries with COVID-19 over a 3-week period. OIG analyzed the diagnoses on the claims of beneficiaries hospitalized with COVID-19 in those six selected localities to identify the conditions for which they were treated during their hospital stays. The percentages presented in this report represent averages among the six localities.

#### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that during surges in hospitalizations, hospitals in the six localities treated Medicare beneficiaries with COVID-19 for a wide range of serious, complex conditions. Almost all of these beneficiaries were treated for acute respiratory issues, such as viral pneumonia. Many of these beneficiaries were also treated for other types of serious conditions including:

- almost half were treated for acute kidney failure,
- almost half had acute circulatory issues,
- almost two-thirds were treated for significant endocrine, nutritional, or metabolic issues, and
- more than one-third had sepsis.

OIG found that more than 50 percent of Medicare beneficiaries hospitalized with COVID-19 received intensive care or mechanical ventilation. Additionally, dually eligible, Black, Hispanic, or older beneficiaries were disproportionately hospitalized with COVID-19 relative to the Medicare population in these localities.

OIG concluded that the complex needs of hospitalized Medicare beneficiaries—combined with surges in hospitalizations—may have created substantial challenges in meeting the needs of these patients, particularly in light of the staffing and other problems that hospitals had reported. Gaining a better understanding of Medicare beneficiaries



### Provider

### Multiple Providers

### Hospital

### Long Term Care

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### Laboratory

### Telehealth

### Other Providers and Suppliers

hospitalized with COVID-19—including the conditions for which they were being treated and demographic characteristics—could have assisted Federal, State, and local efforts in the COVID-19 pandemic and may be used to provide additional guidance to hospitals. This information could also have helped hospitals, physicians, and other practitioners better prepare for the complex and resource-intensive care needs of Medicare beneficiaries with COVID-19, which might be particularly important during continued surges of the virus. CMS could also have used this information to identify beneficiaries who were particularly vulnerable to hospitalization as well as to understand the needs of these beneficiaries during their hospitalizations. In addition, this analysis showed that Medicare claims data could be used to enhance knowledge of the treatment of COVID-19 and help inform additional research efforts.

#### **ICD Codes Identified in This Evaluation:**

- U07.1 - COVID-19 diagnosis code
- B97.29 - Prior COVID-19 diagnosis code

**Evaluation #:** [OEI-02-20-00410](#) (08/30/2021)

**Government Program:** CMS

#### **Medicare Hospital Provider Compliance Audit: Jewish Hospital**

This audit was part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, OIG identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2018, Medicare paid hospitals \$179 billion, which represented 47 percent of all fee-for-service payments for the year.

OIG's objective was to determine whether Jewish Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

The audit covered about \$43 million in Medicare payments to the Hospital for 2,453 claims that were potentially at risk for billing errors. OIG selected for review a stratified random sample of 85 inpatient and 15 outpatient claims with payments totaling \$4.9 million for the 2-year audit period (January 1, 2017, through December 31, 2018).

OIG focused the audit on the risk areas that were identified as a result of prior OIG audits at other hospitals. OIG evaluated compliance with selected billing requirements.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the Hospital complied with Medicare billing requirements for 62 of the 100 inpatient and outpatient claims OIG reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 38 claims, resulting in overpayments of \$705,976 for the audit period. Specifically, 34 inpatient claims and 4 outpatient claims had billing errors. On the basis of OIG's sample results, OIG estimated that the Hospital received overpayments of at least \$13.5 million for the audit period.

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



the body of the report.

**Audit #:** [A-04-19-08077](#) (08/18/2021)

**Government Program:** CMS

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

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

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

OIG's audit covered Medicare program payments totaling \$423.2 million for capital costs that were paid to 112 new hospitals under the current (reasonable cost) methodology for Federal fiscal years 2012 through 2018. OIG calculated what the IPPS payments to new hospitals would have been by using the Provider Statistical and Reimbursement Reports, cost report data from the Centers for Medicare & Medicaid Services' (CMS's) Healthcare Cost Report Information System, and inpatient claim data. OIG also compared actual capital costs and utilization reported by 35 of the 112 new hospitals.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

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

With respect to the reasons for the IPPS exemption, OIG compared the first 2 years of operation with the subsequent 2 years of operation of the 35 new hospitals for which such data were available and determined that in the first 2 years of operation, average Medicare-related capital costs were only 3 percent higher and average Medicare utilization was 15 percent lower.

Most of these new hospitals (approximately 59 percent) were also part of chain organizations that might have been able to provide reserve capital to their new hospitals if needed.

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

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers



**Audit #:** [A-07-19-02818](#) (08/13/2021)

**Government Program:** CMS

## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers





Provider

Multiple Providers

Hospital

Long Term Care

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Hospice

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and Supplies

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Suppliers

## Long Term Care

### **[NEW] Certain For-Profit Nursing Homes May Not Have Complied With Federal Requirements Regarding the Infection Preventionist Position**

- More than 1.3 million people lived in nursing homes nationwide. These individuals were susceptible to a high number of health care-associated infections.
- Prior OIG audits found that nursing homes did not always comply with Federal regulations regarding designating an infection preventionist (IP) who met Federal requirements for that position.
- This audit examined whether for-profit nursing homes nationwide complied with Federal requirements pertaining to IPs.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that not all for-profit nursing homes that OIG reviewed met Federal requirements. Seventy-six of the 100 for-profit nursing homes in OIG's sample complied with Federal requirements pertaining to IPs. However:

- 17 potentially did not comply with the requirement that the IP complete specialized infection prevention and control training prior to assuming the role and
- 7 potentially did not comply with the requirement to designate an IP.

On the basis of OIG's sample results, OIG estimated that 2,568 for-profit nursing homes nationwide (approximately 1 in 4) may not have complied with Federal requirements pertaining to IPs during the audit period. As a result, there may have been increased health and safety risks for the residents and staff of these nursing homes.

OIG recommended that the Centers for Medicare & Medicaid Services:

1. instruct the State survey agencies to follow up with the 24 nursing homes that may not have complied with Federal requirements to verify that they had taken corrective actions, and
2. share the results of this audit with the State survey agencies and encourage them to focus their oversight on verifying that nursing homes designated an IP and that the IPs completed specialized training prior to filling that position.

**Audit #:** [A-01-22-00001](#) (08/19/2024)

**Government Program:** CMS

### **Florida Ensured That Nursing Homes Complied with Federal Background Check Requirements**

Background checks for employees in long-term care facilities (nursing homes) were an important safety measure that could help protect some of the most vulnerable populations. Approximately 1.4 million Medicare recipients resided in nursing homes, with more than half of them relying on Medicaid to pay for their long-term care. Oversight and management of nursing homes were crucial to the safety of long-term care residents.

OIG's objective was to determine whether the Florida Agency for Health Care Administration (State agency) ensured, for the period of January 1, 2021, to June 1, 2023, that selected nursing homes in Florida complied with Federal



requirements that prohibited the employment of individuals with disqualifying backgrounds.

As of April 11, 2023, 676 nursing homes in Florida were certified by Medicaid. From this group, OIG selected 30, based on their geographic location and a variety of risk factors.

At each of the selected nursing homes, OIG reviewed background checks for 30 randomly selected employees per nursing home, for a total of 900. In addition, OIG judgmentally selected an additional 119 employees for review based on OIG's review of incident reports during the audit period. The total sample size was 1,019 employees.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the State agency complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds as defined at 42 CFR SS 483.12(a)(3). Specifically, for the 1,019 nursing home employees OIG sampled, all of them had completed a background check by the State agency through the Clearinghouse before working at a nursing home. In addition, the sampled employees who were required to have a license because of their occupation had a current license (as of the time of their employment) and did not have any actions taken against their license related to disqualifying offenses. Finally, none of the sampled employees were listed on the OIG List of Excluded Providers and Entities, which would have precluded them from working in a healthcare setting.

OIG attributed this compliance with Federal requirements to the State agency's internal controls over the background check screening process for nursing home employees.

**Audit #:** [A-04-23-08100](#) (04/26/2024)

**Government Program:** CMS

### **Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes**

- Facility-initiated discharges that did not follow Federal regulations could be unsafe and traumatic, leading to resident harm.
- CMS and State Long-Term Care Ombudsmen had raised concerns about the extent to which nursing homes followed Federal requirements for these discharges.
- This review provided insights into a sample of facility-initiated discharges from nursing homes and the extent to which these discharges followed Federal requirements.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that in most (107 out of 126) of the facility-initiated discharge cases in the review, nursing homes discharged residents for allowable reasons; however, the review raised concerns about nursing homes' understanding of and compliance with notice and documentation requirements for facility-initiated discharges.

- **Nursing homes sometimes fell short in providing required documentation**, such as documentation that the receiving facility could provide services that met residents' needs.
- **Nursing homes often failed to notify residents of their discharges and frequently omitted required information in notices**, which may have compromised residents' rights and abilities to plan for safe transitions.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



## Provider

### Multiple Providers

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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

- **Even when nursing homes provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required**, potentially impeding the Ombudsman's ability to effectively advocate for residents.

OIG also found that nursing homes struggled to identify facility-initiated discharges, which may have presented CMS and State survey agencies with challenges in overseeing these discharges during the survey process.

OIG concluded that:

1. CMS provided a standard notice template to help nursing homes provide complete and accurate information to residents facing discharge and Ombudsmen.
2. CMS required nursing homes to systematically document facility-initiated discharges in information available to CMS and States to enhance oversight.

**Evaluation #:** [OEI-01-18-00251](#) (03/29/2024)

**Government Program:** CMS

### **Nursing Home Residents With Endangering Behaviors and Mental Health Disorders May Be Vulnerable to Facility-Initiated Discharges**

- Facility-initiated discharges that did not follow Federal regulations could be unsafe and traumatic, leading to resident harm.
- CMS and State Long-Term Care Ombudsmen had raised concerns about the extent to which nursing homes followed Federal requirements for these discharges.
- This review provided insights into a sample of facility-initiated discharges from nursing homes, including the reasons cited for discharges, shared characteristics among discharged residents, and the locations to which residents were discharged.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that nursing homes discharged 72 of the 126 residents in OIG's review because of behaviors that endangered them or others in a facility. In most cases, the residents exhibited aggressive or violent behaviors. Prior to discharging these residents, nursing homes most commonly tried changing medications and counseling. Residents discharged due to behaviors shared some characteristics such as a mental health disorder and admission for long-term versus short-term care. Nursing homes also initiated discharges for residents who failed to pay for a stay (33 of 126) or residents whose health improved and no longer needed facility services (13 of 126). Lastly, most residents in OIG's review were discharged to acute-care hospitals, and 10 residents were discharged to an unknown location, a nonspecific location, or a hotel.

OIG concluded that the findings highlighted the challenges that nursing homes faced in caring for residents with mental health disorders as well as raised questions about nursing homes' admissions of and capacities to care for these residents. More research was needed into how to provide safe and effective long-term care for residents with mental health disorders and behaviors, especially as the demand for such care grew. To that end, the new Center for Excellence for Behavioral Health in Nursing Facilities, established by the Substance Abuse and Mental Health Services Administration in partnership with CMS, held promise.



Evaluation #: [OEI-01-18-00252](#) (03/29/2024)

Government Program: CMS

## [Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes](#)

- Nursing home residents and staff had been especially impacted by the COVID-19 pandemic. Now, it is critical to learn from what happened in nursing homes and take steps to better protect residents and staff during future infectious disease outbreaks, emergencies, or other disruptions to the health care system.
- This was the third and final report in a three-part series about the effects of the COVID-19 pandemic on nursing homes. The previous reports found that COVID-19 had a devastating impact on Medicare beneficiaries in nursing homes during 2020, as 2 in 5 residents had or likely had COVID-19 in 2020. Also, more than 1,300 nursing homes had infection rates of 75 percent or higher during surge periods.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that nursing homes faced monumental and ongoing staffing challenges, including a significant loss of staff and substantial difficulties in hiring, training, and retaining new staff. Many nursing homes used outside staffing agencies to fill gaps, which had significant downsides.

Nursing homes continued to struggle with costs, testing protocols, personal protective equipment compliance, and vaccination rates after initial challenges were resolved.

Nursing homes identified challenges with implementing effective infection control practices and opportunities for improvement.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

1. Implement and expand upon its policies and programs to strengthen the nursing home workforce.
2. Reassess nurse aide training and certification requirements.
3. Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic.
4. Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements.
5. Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care.

Evaluation #: [OEI-02-20-00492](#) (02/26/2024)

Government Program: CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

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Other Providers and  
Suppliers



## **Colorado Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Colorado ensured that selected nursing homes in Colorado that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 219 nursing homes in Colorado that participated in the Medicare or Medicaid programs, OIG selected a non-statistical sample of 20 nursing homes for the audit based on location and certain risk factors, including multiple high-risk deficiencies that Colorado reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from September through November 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Colorado could better ensure that nursing homes in Colorado that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control. During OIG's onsite visits, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that were audited, totaling 556 deficiencies. Specifically, OIG identified 165 deficiencies related to life safety requirements, 210 deficiencies related to emergency preparedness requirements, and 181 deficiencies related to infection control requirements. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of inadequate oversight by Colorado and by nursing home management, frequent management and staff turnover at the nursing homes, inadequate oversight by the State survey agency, and frequent State survey agency staff turnover. In addition, the State survey agency had limited resources to conduct surveys of all nursing homes, including those with a history of multiple high-risk deficiencies, more frequently than was required by CMS. Finally, although not required by CMS, Colorado did not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content.

OIG recommended that Colorado follow up with the 20 nursing homes reviewed in this audit to ensure that corrective actions had been taken regarding the life safety, emergency preparedness, and infection control deficiencies OIG identified; work with CMS to develop a risk-based approach to identify nursing homes at which surveys would be conducted more frequently, such as those with a history of multiple high-risk deficiencies or frequent management turnover; and work with CMS to develop standardized life safety training for nursing home staff.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



**Audit #:** [A-07-22-07009](#) (02/02/2024)  
**Government Program:** CMS

## **CDC Has Improved the Nursing Homes Reporting Process for COVID-19 Data in NHSN, but Challenges Remain**

NHSN had served as a critical source for monitoring the effects of the COVID-19 pandemic, and informing the Federal, State, and local pandemic response. In May 2020, the Centers for Medicare & Medicaid Services (CMS) issued a requirement for nursing homes to report COVID-19 data to NHSN. CDC had operated NHSN since 2005, but nursing home reporting had been voluntary, with participation from only a small proportion of facilities. The reporting requirement resulted in the influx of thousands of nursing homes enrolling in and reporting to NHSN in 2020, while they, and CDC, also responded to the pandemic.

This evaluation provided insights into nursing home experiences enrolling in and reporting to NHSN, and CDC efforts to facilitate reporting such as user support for facilities facing difficulties. These insights can help CDC address ongoing challenges, and mitigate potential issues in future updates or expansions.

OIG administered an electronic survey to a simple random sample of 197 nursing homes from a population of 15,324 facilities that had reported COVID-19 data to NHSN, and interviewed a subset of facilities. OIG also interviewed CDC and CMS officials to understand CDC efforts to facilitate nursing home enrollment and reporting to NHSN. OIG based its findings on analysis of survey and interview responses.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that despite CDC efforts, both CDC and nursing homes experienced difficulties during a mass enrollment of more than 12,000 facilities into NHSN to begin reporting COVID-19 data in May 2020.

As the pandemic continued, CDC added data variables to NHSN, including fields with personally identifiable information, in response to emerging data needs and new Federal reporting requirements. Nursing homes had to upgrade their security access levels to report the sensitive data. At this time, CDC experienced a significant backlog of support requests, which also inhibited some facilities from accessing NHSN.

CDC improved the process of nursing home reporting to NHSN throughout the pandemic. Facilities acknowledged this effort and reported that CDC support improved, but some continued to experience difficulty getting assistance. Additionally, a quarter of nursing homes reported lacking confidence in the quality of NHSN data, despite the quality assurance checks CDC conducted on key variables.

After December 2024, CMS reporting requirements for some key variables will expire, but the mandate for reporting vaccination-related data will remain. CDC stated that it will continue to support voluntary reporting of COVID-19 data and other infection and quality measures, and modernize NHSN reporting processes. Stakeholders and CDC expressed that having nursing home participation in NHSN is valuable for public health surveillance, and the agency is exploring opportunities to leverage the current national enrollment for reporting on other health outcomes.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

To continue improvements, OIG recommended that CDC (1) improve the user support the NHSN Help Desk provided to nursing homes, (2) take further steps to ensure the quality of nursing home reporting of COVID-19 data to NHSN, and (3) consider how quality assurance checks could be enhanced to ensure data accuracy, as appropriate.

**Evaluation #:** [OEI-06-22-00030](#) (01/08/2024)

**Government Program:** CDC

### **Oklahoma Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, CMS updated its life safety and emergency preparedness regulations for health care facilities to improve protections for individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. In addition, facilities were required to develop an infection control program.

OIG's objective was to determine whether Oklahoma ensured that selected nursing homes in Oklahoma that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 296 nursing homes in Oklahoma that participated in Medicare or Medicaid, OIG selected a non-statistical sample of 20 nursing homes for the audit based on certain risk factors, including the number of deficiencies Oklahoma reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from October 2022 through January 2023. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Oklahoma could better ensure that nursing homes in Oklahoma that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes audited, totaling 146 deficiencies. Specifically, OIG found 98 deficiencies related to life safety, 16 deficiencies related to emergency preparedness, and 32 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were at an increased risk during a fire or other emergency or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Oklahoma had limited resources to conduct surveys of all nursing homes as required by CMS.

OIG recommended that Oklahoma follow up with the 20 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they had taken corrective actions. OIG also made procedural recommendations for Oklahoma to work with CMS to develop an approach to identifying and conducting more frequent surveys at nursing homes.



**Audit #:** [A-06-22-09007](#) (01/04/2024)  
**Government Program:** CMS

## **Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, CMS updated its life safety and emergency preparedness regulations for health care facilities to improve protections for all Medicare and Medicaid enrollees, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Ohio ensured that selected nursing homes in Ohio that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 949 nursing homes in Ohio that participated in Medicare or Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Ohio reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from August through November 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Ohio could have better ensured that nursing homes in Ohio that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at 18 of the 20 nursing homes that OIG audited, totaling 160 deficiencies. Specifically, OIG found 47 deficiencies related to life safety, 47 deficiencies related to emergency preparedness, and 66 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 18 nursing homes were at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Ohio had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Ohio did not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that Ohio follow up with the 18 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to verify that corrective actions had been taken regarding the deficiencies identified in this report. OIG also made procedural recommendations for Ohio to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers





Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

**HCCPS Codes Identified in This Audit:**

- K354 - Sprinkler System - Out of Service: There are no procedures for "Sprinkler System - Out of Service"
- K325 - Alcohol Based Hand Rub Dispenser: Empty hand sanitizer dispensers
- K372 - Penetrations in smoke/fire barrier: Several ceiling tiles have water damage

Audit #: [A-05-22-00019](#) (12/20/2023)

Government Program: CMS

**Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to develop an infection control program.

OIG's objective was to determine whether Washington State ensured that selected nursing homes in Washington that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 200 nursing homes in Washington State that participated in Medicare or Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies that Washington reported to CMS.

OIG conducted unannounced site visits at each of the 20 nursing homes from September through November 2022. During each site visit, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Washington State did not ensure that selected nursing homes in Washington that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control. During onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that were audited, totaling 525 deficiencies. Specifically, OIG found 91 deficiencies related to life safety, 155 deficiencies related to emergency preparedness, and 279 deficiencies related to infection control. As a result, residents, staff, and visitors at the 20 nursing homes were at an increased risk of injury, significant illness, or death during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because nursing homes lacked adequate management oversight and had frequent management turnover. In addition, although nursing home management and staff were ultimately responsible for ensuring resident safety, Washington had a role in helping nursing homes reduce the risk of resident injury, significant illness, or death through its oversight of nursing homes' compliance with Federal requirements. However, Washington did not consistently identify deficiencies related to life safety, emergency preparedness, and infection control during



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

surveys and take enforcement action to ensure that nursing homes complied with the requirements. Furthermore, Washington did not ensure that nursing home management was educated about life safety and emergency preparedness training resources available to nursing home staff that could be used to train staff on how to comply with Federal requirements.

OIG recommended that Washington State follow up with the 20 nursing homes reviewed in this audit to ensure that these nursing homes had taken corrective actions to address the deficiencies identified. OIG also made procedural recommendations for Washington to provide training to State surveyors and educate nursing home management that training resources were available.

**Audit #:** [A-09-22-02006](#) (12/08/2023)

**Government Program:** CMS

### **Louisiana Should Improve Its Oversight of Nursing Homes' Compliance With Requirements That Prohibit Employment of Individuals With Disqualifying Background Checks**

Background checks for employees are an important safety measure that can help protect some of the most vulnerable populations. Approximately 1.4 million beneficiaries resided in long-term care facilities (nursing homes), with more than half of them relying on Medicaid to pay for their long-term care. Oversight and management of nursing homes were crucial to the safety of long-term care residents.

OIG's objective was to determine whether Louisiana ensured, for the period October 1, 2019, to June 30, 2021, that selected nursing homes in Louisiana complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds.

As of May 2021, 276 nursing homes were licensed in Louisiana. OIG selected for the audit a judgmental sample of 9 of the 276 nursing homes based on a variety of risk factors and based on the need to select nursing homes in urban and rural settings.

From the 9 nursing homes, OIG reviewed background checks for 209 non-licensed employees and verified the licensure status of 77 licensed employees, for a total of 286 employees. The sample size at each nursing home varied depending on the number of employees there, but generally, OIG selected for review individuals who were actively employed at some point between October 1, 2019, and June 30, 2021.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Louisiana ensured, for the period October 1, 2019, to June 30, 2021, that all nine selected nursing homes in the State complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds. In addition, OIG determined that 77 licensed employees whom OIG selected for review from the same 9 selected nursing homes were free from any disciplinary action against their professional license; thus, their licensure statuses were in good standing. Although Federal requirements did not specify the methods or types of information that should be considered for a background check to be regarded as having been satisfactorily completed, OIG identified potential limitations in the nursing homes' background check searches and adjudication methods for 49 of the 209 non-licensed employees OIG reviewed.

## Provider

## Multiple Providers

## Hospital

## Long Term Care

## Home Health Service

## Hospice

## Medical Equipment and Supplies

## Behavioral Health

## Laboratory

## Telehealth

## Other Providers and Suppliers

The limitations that OIG identified occurred because Louisiana did not require the review of nursing homes' compliance with background check requirements as part of its periodic nursing home surveys unless concerns had been identified relative to inadequate staffing; issues of abuse, neglect, exploitation, or misappropriation; or both.

OIG recommended that Louisiana conduct routine monitoring of nursing homes' compliance with background check requirements. OIG made other procedural recommendations to the State in its full report.

**Audit #:** [A-06-21-02000](#) (11/29/2023)

**Government Program:** CMS

### **Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all Medicare and Medicaid enrollees, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether Pennsylvania ensured that selected nursing homes in Pennsylvania that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 701 nursing homes in Pennsylvania that participated in Medicare and Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Pennsylvania reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from July through October 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Pennsylvania could better ensure that nursing homes in Pennsylvania that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control if additional oversight was provided. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes that were audited, totaling 586 deficiencies. Specifically, OIG found 220 deficiencies related to life safety, 288 deficiencies related to emergency preparedness, and 78 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, poor record keeping, combined with an inconsistent application of policies, also contributed to deficiencies. Finally, although not required by CMS, Pennsylvania



## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

did not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.

OIG recommended that Pennsylvania follow up with the 20 nursing homes reviewed as part of this audit to verify that corrective actions had been taken regarding the deficiencies identified in this report. OIG also made seven additional procedural recommendations for Pennsylvania that were included in the report.

**Audit #:** [A-03-22-00206](#) (11/08/2023)

**Government Program:** CMS

### **New Jersey Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, CMS updated its life safety and emergency preparedness regulations related to health care facilities to improve protections for all Medicare and Medicaid enrollees, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Additionally, facilities were required to implement an infection control program.

OIG's objective was to determine whether New Jersey ensured that selected nursing homes in New Jersey that participate in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 356 nursing homes in New Jersey that participated in Medicare and Medicaid, OIG selected a nonstatistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies New Jersey reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from March through May 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies based on requirements listed on CMS surveyor checklists.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that New Jersey could better ensure that nursing homes in New Jersey that participated in Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at all 20 nursing homes audited, totaling 363 deficiencies. Specifically, OIG found 148 deficiencies related to life safety, 152 deficiencies related to emergency preparedness, and 63 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at the 20 nursing homes were at an increased risk during a fire or other emergency, or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, New Jersey had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, New Jersey did not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

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OIG recommended that New Jersey follow up with the 20 nursing homes reviewed as part of this audit to ensure that they had taken corrective actions regarding the deficiencies identified in this report and instruct all nursing homes to install carbon monoxide detectors in accordance with New Jersey requirements. OIG also made procedural recommendations for New Jersey to work with CMS to develop and implement a plan to identify and conduct more frequent surveys at nursing homes and to develop standardized training for nursing home staff.

**Audit #:** [A-02-22-01004](#) (09/29/2023)

**Government Program:** CMS

### **Georgia Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control**

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations for health care facilities to improve protections for individuals enrolled in Medicare and Medicaid, including those residing in long-term care facilities (nursing homes). The updates expanded requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. In addition, facilities were required to implement an infection control program.

OIG's objective was to determine whether Georgia ensured that selected nursing homes in Georgia that participated in the Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control.

Of the 358 nursing homes in Georgia that participated in Medicare and Medicaid, OIG selected a non-statistical sample of 20 nursing homes for the audit based on certain risk factors, including multiple high-risk deficiencies Georgia reported to CMS.

OIG conducted unannounced site visits at the 20 nursing homes from June through September 2022. During the site visits, OIG checked for life safety, emergency preparedness, and infection control deficiencies.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Georgia could better ensure that nursing homes in Georgia that participated in Medicare or Medicaid programs complied with Federal requirements for life safety, emergency preparedness, and infection control if additional resources were available. During OIG's onsite inspections, OIG identified deficiencies related to life safety, emergency preparedness, or infection control at 19 of the 20 nursing homes audited, totaling 155 deficiencies. Specifically, OIG found 71 deficiencies related to life safety, 66 deficiencies related to emergency preparedness, and 18 deficiencies related to infection control. As a result, the health and safety of residents, staff, and visitors at 19 of the 20 nursing homes were at an increased risk during a fire or other emergency or in the event of an infectious disease outbreak.

The identified deficiencies occurred because of frequent management and staff turnover, which contributed to a lack of awareness of, or failure to address, Federal requirements. In addition, Georgia had limited resources to conduct surveys of all nursing homes more frequently than CMS required. Finally, although not required by CMS, Georgia did not require relevant nursing home staff to participate in standardized life safety training programs despite CMS having a publicly accessible online learning portal with appropriate content on life safety requirements.



## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

OIG recommended that Georgia follow up with the 19 nursing homes in this audit that demonstrated life safety, emergency preparedness, and infection control deficiencies to ensure that they had taken corrective actions. OIG also made procedural recommendations for Georgia to work with CMS to address foundational issues to implement a risk-based approach to identifying and conducting more frequent surveys at nursing homes and to develop standardized life safety training for nursing home staff.

**Audit #:** [A-04-22-08093](#) (09/06/2023)

**Government Program:** CMS

### **Nursing Homes Reported Wide-Ranging Challenges Preparing for Public Health Emergencies and Natural Disasters**

OIG had identified emergency preparedness and nursing home safety as priorities. Nursing home failures to adequately plan for and respond to public health emergencies and natural disasters had led to tragic results. Although such outcomes were not typical, they pointed to the need to identify the source of breakdowns and to strengthen nursing home preparedness efforts.

OIG surveyed a random sample of 199 nursing homes located in geographic areas rated by the Federal Emergency Management Agency (FEMA) as having a very high or relatively high risk for natural hazards. OIG received responses from 168 nursing homes and projected the results to all nursing homes in the FEMA risk areas. Respondents rated how challenging each of

49 preparedness activities were for their facility. The activities covered seven topic areas related to emergency preparedness capabilities that are important for ensuring safety of residents during emergency events.

#### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that in June 2022, an estimated 77 percent of nursing homes located in areas at greater risk for natural disasters reported experiencing challenges with emergency preparedness activities. Administrators reported concerns across seven topic areas, with activities related to ensuring proper staffing during emergencies and transporting residents during evacuations being the most problematic. An estimated 62 percent of nursing homes reported at least one challenge regarding staffing and an estimated 50 percent noted at least one challenge regarding transportation. Other challenges reported by some nursing homes related to securing beds for evacuated residents and planning for infection control and quarantine during emergencies.

OIG found that even those nursing homes that met the Federal requirements for emergency preparedness faced challenges with critical aspects of emergency preparedness. Specifically, OIG found that only 24 percent of nursing homes in areas at high risk for disasters received a deficiency for not meeting emergency preparedness requirements established by the Centers for Medicare & Medicaid Services (CMS) during their most recent compliance survey--but an estimated 77 percent of nursing homes reported at least one challenge with preparedness activities.

OIG found that nursing homes reporting challenges had lower community resilience compared to other nursing homes, indicating that availability of community resources may have been a factor in nursing homes' experience with preparedness activities. Further, an estimated one in five nursing homes reported difficulties coordinating preparedness



activities with multiple community partners.

**Evaluation #:** [OEI-06-22-00100](#) (09/01/2023)

**Government Program:** CMS

### **CMS Did Not Accurately Report on Care Compare One or More Deficiencies Related to Health, Fire Safety, and Emergency Preparedness for an Estimated Two-Thirds of Nursing Homes**

On behalf of the Centers for Medicare & Medicaid Services (CMS), State survey agencies performed inspections of Medicare- and Medicaid-certified nursing homes to determine whether they were in compliance with Federal health, fire safety, and emergency preparedness requirements. State survey agency surveyors cited instances of noncompliance as deficiencies and reported inspection results to CMS. CMS made the inspection results available on Care Compare, a CMS website that provides information on health care providers that consumers can use to make informed decisions about health care.

OIG's objective was to determine whether CMS accurately reported on Care Compare the deficiencies related to health, fire safety, and emergency preparedness that were identified during inspections of nursing homes.

OIG selected a random sample of 100 nursing homes from among 15,377 nursing homes nationwide. For each sampled nursing home, OIG compared the deficiencies that had been reported on Care Compare as of December 10, 2020, with the deficiencies that State survey agency surveyors had documented in inspection reports from the three most recent yearly health, fire safety, and emergency preparedness inspections and the results of the most recent 3 years of complaint inspections.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for 67 of the 100 sampled nursing homes, CMS did not accurately report on Care Compare 1 or more deficiencies that surveyors identified during yearly and complaint inspections. The deficiencies consisted of health deficiencies for 34 nursing homes, fire safety deficiencies for 52 nursing homes, and emergency preparedness deficiencies for 2 nursing homes. In addition, for 42 of the 100 sampled nursing homes, CMS did not report on Care Compare the results of all yearly fire safety and emergency preparedness inspections.

On the basis of OIG's sample results, OIG estimated that 10,303 nursing homes had 1 or more deficiencies identified during inspections that were not accurately reported on Care Compare. Specifically, OIG estimated that 5,228 nursing homes had health deficiencies, 7,996 nursing homes had fire safety deficiencies, and 308 nursing homes had emergency preparedness deficiencies that were not accurately reported on Care Compare. In addition, OIG estimated that for 6,458 nursing homes CMS did not report on Care Compare the results of all yearly fire safety and emergency preparedness inspections.

OIG recommended that CMS: (1) correct the inaccurately reported deficiencies that OIG identified for the sampled nursing homes; and (2) strengthen its processes for reviewing inspection results reported on Care Compare by requiring State survey agencies to verify the deficiencies reported, providing technical assistance and additional training to State survey agencies, and verifying that nursing home inspection results were accurately reported. The report had three other procedural recommendations.

## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

Audit #: [A-09-20-02007](#) (04/10/2023)

Government Program: CMS

## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

### [More Than a Thousand Nursing Homes Reached Infection Rates of 75 Percent or More in the First Year of the COVID-19 Pandemic; Better Protections Are Needed for Future Emergencies](#)

Almost every American had been affected in some way by the COVID-19 pandemic. By the end of 2020, COVID-19 had spread throughout the United States. The COVID-19 pandemic had been particularly devastating for Medicare beneficiaries in nursing homes, which was why OIG embarked on a three-part series of evaluations focusing exclusively on the nursing home experience during 2020. The first report in this series found that 2 in 5 Medicare beneficiaries in nursing homes either had or likely had COVID-19 in 2020. Some Medicare beneficiaries in nursing homes seemed to be at greater risk than others. Specifically, Black beneficiaries, Hispanic beneficiaries, and Asian beneficiaries were more likely than White beneficiaries to have or likely have COVID-19. In addition, overall mortality for Medicare beneficiaries in nursing homes increased by almost one-third in 2020 from the 2019 level.

This was the second report in the series and built on the first OIG report by focusing on nursing homes themselves. It looked at the extent to which they had residents who were diagnosed with COVID-19 or likely COVID-19, and the characteristics of nursing homes with extremely high infection rates. The third report will feature specific challenges nursing homes faced and the strategies they used to deal with them.

For the health and safety of residents, nursing homes must be prepared to face current and future health emergencies. Understanding how the COVID-19 pandemic had affected nursing homes can help the CMS, Congress, and other stakeholders learn from what had happened and inform their decisions as they strive to improve care and better protect residents.

OIG used Medicare claims data to determine the extent to which nursing homes had Medicare beneficiaries who were diagnosed with COVID-19 or likely COVID-19. OIG looked at 15,086 nursing homes nationwide and identified nursing homes with extremely high infection rates during the surges of cases during the spring and fall of 2020. These homes had three-quarters or more of their Medicare beneficiaries diagnosed with COVID-19 or likely COVID-19 during a surge period. OIG examined the characteristics of these nursing homes. OIG also examined whether these nursing homes had been cited with any infection control deficiencies and whether their reported nursing hours met minimum Medicare requirements for these hours.

### [SunHawk Summary of OIG Evaluation Findings and Recommendations](#)

OIG found that nursing homes had a surge of COVID-19 cases during the spring of 2020 and a greater surge during the fall, well after they were known to be vulnerable. More than 1,300 nursing homes had extremely high infection rates--75 percent or more of their Medicare beneficiaries--during these surges. These nursing homes were more common and geographically widespread during the second surge. Nursing homes with extremely high infection rates experienced dramatic increases in overall mortality (not limited to deaths of beneficiaries who had or likely had COVID-19). Specifically, these nursing homes experienced an average overall mortality rate approaching 20 percent during these surges--roughly double the mortality rate of other nursing homes during the same time periods. For comparison, in 2019





## Provider

### Multiple Providers

### Hospital

### Long Term Care

### Home Health Service

### Hospice

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### Laboratory

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the average mortality rate in these same nursing homes was 6 percent.

OIG found that for-profit nursing homes made up a disproportionate percentage of the nursing homes with extremely high infection rates during both surges. Other characteristics varied by surge. For example, urban nursing homes were more likely to have extremely high infection rates during the first surge, but rural nursing homes were more likely to have extremely high rates during the second surge.

OIG found that high COVID-19 transmission in a county did not always lead to nursing homes in that county reaching extremely high infection rates. In addition, the survey process did not identify any deficiencies in infection control for the majority of the nursing homes with extremely high infection rates, raising questions about how effective the survey process was in preventing and mitigating the spread of infectious disease in nursing homes. Also, the vast majority of nursing homes with extremely high infection rates reported nursing hours that met or exceeded Medicare's specific minimum requirements for these hours, which may indicate that these requirements were not adequate to keep residents safe from infectious disease.

OIG concluded that these findings made clear that nursing homes in this country were not prepared for the sweeping health emergency that COVID-19 created, nor were they able to stem the devastation once it was evident that nursing homes were especially vulnerable. Virtually all nursing homes experienced infections, and more than 1,300 nursing homes had extreme infection rates of 75 percent or higher during a surge period and an average overall mortality rate close to 20 percent. Significant changes were needed to protect the health and safety of residents and better prepare nursing homes for current and future health emergencies.

The administration recently announced a major initiative to improve safety and quality of care in nursing homes. The findings in this report lent urgency to the administration's initiative. OIG recommended that CMS, as it supported the administration's initiative, take the following actions:

- (1) reexamine current nursing staff requirements and revise them as necessary;
- (2) improve how surveys identified infection control risks to nursing home residents and strengthen guidance on assessing the scope and severity of those risks; and
- (3) target nursing homes in most need of infection control intervention, and provide enhanced oversight and technical assistance to these facilities as appropriate.

#### **ICD Codes Identified in This Evaluation:**

- U07.1 - Confirmed COVID-19 test result
- B97.29 - Other coronaviruses as the cause of diseases
- Z20.828 - Contact with or suspected exposure to other viral communicable diseases

**Evaluation #:** [OEI-02-20-00491](#) (01/12/2023)

**Government Program:** CMS

## Long-Term Trends of Psychotropic Drug Use in Nursing Homes

Nursing home residents and their families relied on nursing homes to provide quality care in a safe environment, and nursing homes were statutorily required to protect residents' rights in this regard. OIG work in 2011 raised quality and safety concerns about the high use of one category of psychotropic drug--antipsychotics--by nursing home residents. CMS began monitoring nursing home residents' use of antipsychotics in 2012, and in May 2021 OIG published a report that determined that CMS's existing methods for monitoring antipsychotic use by nursing home residents did not always provide complete information. Additionally, congressional stakeholders continued to raise concerns that nursing home residents might have been inappropriately prescribed other types of psychotropic drugs and that potentially inappropriate use of those drugs might have been going undetected.

OIG used Minimum Data Set (MDS) assessment data from calendar year 2011 through 2019 to identify long-stay nursing home residents aged 65 and older and reviewed Medicare Part D psychotropic drug claims data for these residents. From these data, OIG identified the number of residents who received a prescription for any of these drugs. OIG then searched for patterns and characteristics in these data correlated with a higher use of psychotropic drugs in nursing homes. OIG's review did not assess the administration or medical necessity of psychotropic drugs for nursing home residents.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that from 2011 through 2019, about 80 percent of Medicare's long-stay nursing home residents were prescribed a psychotropic drug. While CMS focused its efforts to reduce the use of one category of psychotropic drug—antipsychotics—the use of another category of psychotropic drug—anticonvulsants—increased. This increased use of anticonvulsants contributed to the overall use of psychotropics remaining constant.

In 2019, higher use of psychotropic drugs was associated with nursing homes that had certain characteristics. Nursing homes with lower ratios of registered nurse staff to residents were associated with higher use of psychotropic drugs. Nursing homes with higher percentages of residents with low-income subsidies were also associated with higher use of psychotropic drugs.

Additionally, over time the number of unsupported schizophrenia diagnoses increased and in 2019 was concentrated in relatively few nursing homes. Specifically, OIG found that from 2015 through 2019 both the reporting of residents with schizophrenia in the MDS and the number of residents who lacked a corresponding schizophrenia diagnosis in Medicare claims and encounter data increased by 194 percent. In 2019, the unsupported reporting of schizophrenia was concentrated in 99 nursing homes in which 20 percent or more of the residents had a report of schizophrenia in the MDS that was not found in the Medicare claims history.

CMS's long-stay quality measure that tracked antipsychotic use in nursing homes excluded residents who were reported as having schizophrenia in the MDS. Thus, nursing homes could misreport residents as having schizophrenia in the MDS to falsely impact CMS's quality measure.

By not collecting diagnoses on Medicare Part D claims, CMS was limited in its ability to effectively conduct oversight of psychotropic drugs. First, not having diagnoses on claims limited CMS's ability to detect patient risk and patterns of potentially inappropriate drug use. Second, the lack of diagnoses made it difficult for CMS to systematically determine whether claims met the payment requirement that drugs be used for medically accepted purposes.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

OIG recommended that CMS should:

- Evaluate the use of psychotropic drugs among nursing home residents to determine whether additional action was needed to ensure that use among residents was appropriate.
- Use data to identify nursing homes or nursing home characteristics that were associated with a higher use of psychotropic drugs and focus oversight on nursing homes in which trends may signal inappropriate use.
- Expand the required data elements on Medicare Part D claims to include a diagnosis code.

Evaluation #: [OEI-07-20-00500](#) (11/10/2022)

Government Program: CMS

### **Certain Life Care Nursing Homes May Not Have Complied With Federal Requirements for Infection Prevention and Control and Emergency Preparedness**

At the start of the pandemic, the Centers for Disease Control and Prevention indicated that individuals who are aged 65 and older or nursing home residents are at a higher risk for severe illness from COVID-19. In addition, 8 out of 10 COVID-19 deaths reported in the United States in 2020 were adults aged 65 and older. COVID-19 is especially dangerous for the more than 1.3 million residents who live in the 15,450 Medicare and Medicaid certified nursing homes nationwide.

OIG's objective was to determine whether selected Life Care Centers of America (Life Care) nursing homes complied with Federal requirements for infection prevention and control and emergency preparedness.

OIG analyzed State survey agency (SSA) data on Medicare.gov for the most recent standard surveys and the previous 12 months of complaint surveys. OIG identified that 6,622 nursing homes had been cited for infection prevention and control program deficiencies as of February 26, 2020, and Medicare.gov indicated that 24 nursing homes were part of the Life Care nursing home chain. OIG contacted Life Care's corporate office regarding the 24 nursing homes and requested that they provide documentation related to infection prevention and control and emergency preparedness program policies and procedures that were in effect from January 2019 through May 2020.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that selected Life Care nursing homes may not have complied with Federal requirements for infection prevention and control and emergency preparedness. Specifically, 23 of the 24 nursing homes selected had possible deficiencies. Actual deficiencies could only be determined following a thorough investigation by trained surveyors. At 22 nursing homes, OIG found 35 instances of possible noncompliance with infection prevention and control requirements related to annual reviews of the Infection Prevention and Control Program, training, designation of a qualified infection preventionist, and Quality Assessment and Assurance Committee meetings. OIG also found at 16 nursing homes 20 instances of possible noncompliance with emergency preparedness requirements related to the annual review of emergency preparedness plans and annual emergency preparedness risk assessments. Life Care officials attributed the possible noncompliance to:

- leadership turnover,
- staff turnover,



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- documentation issues (i.e., information was not documented or documentation was either lost or misplaced),
  - staff members who were unfamiliar with requirements (i.e., requirements stipulating that there is no grace period for infection preventionists to complete specialized training and that emergency preparedness plans needed to be reviewed annually),
  - qualified personnel shortage, and
  - challenges related to the COVID-19 public health emergency.
- OIG also believed that many of the conditions noted in the report occurred because CMS did not provide nursing homes with communication and training related to complying with the new, phase 3 infection control requirements, or clarification about the essential components to be integrated in the nursing homes' emergency plans.

OIG recommended that CMS instruct SSAs to follow up with the 23 nursing homes that OIG had identified with possible infection prevention and control and emergency preparedness deficiencies to verify that they had taken corrective actions.

**Audit #:** [A-01-20-00004](#) (09/15/2022)

**Government Program:** CMS

### **Certain Nursing Homes May Not Have Complied With Federal Requirements for Infection Prevention and Control and Emergency Preparedness**

The Centers for Disease Control and Prevention indicated that individuals who were aged 65 and older or nursing home residents were at a higher risk for severe illness from COVID-19. In addition, 8 out of 10 COVID-19 deaths reported in the United States in 2020 were adults aged 65 years and older. COVID-19 was especially dangerous for the more than 1.3 million residents who lived in the 15,446 Medicare and Medicaid certified nursing homes nationwide.

OIG's objective was to determine whether selected nursing homes complied with Federal requirements for infection prevention and control and emergency preparedness.

OIG analyzed State survey agency (SSA) data on Medicare.gov for the most recent standard surveys and the previous 12 months of complaint reports. OIG identified 6,830 nursing homes that were cited for infection prevention and control program deficiencies, and Medicare.gov indicated that 39 nursing homes had not provided a plan of correction for the deficiencies as of March 26, 2020. OIG contacted the 39 nursing homes and requested that they provide infection prevention and control and emergency preparedness program documents that were in effect from January 1, 2019, through May 31, 2020.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that selected nursing homes may not have complied with Federal requirements for infection prevention and control and emergency preparedness. Specifically, 28 of the 39 nursing homes had possible deficiencies. OIG found 48 instances at 25 nursing homes of possible noncompliance with infection prevention and control requirements and 18 instances at 18 nursing homes of possible noncompliance with emergency preparedness requirements related to all-hazards risk assessments and strategies to address emerging infectious diseases. The nursing homes attributed the possible noncompliance to: (1) nursing home inadequate internal controls, (2) nursing home inadequate management oversight, (3) nursing home administrative and leadership changes, (4) inadequate communication and training from the Centers for Medicare & Medicaid Services (CMS), and (5) inconsistent and confusing regulations.



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Hospital

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Home Health Service

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OIG recommended that CMS: (1) instruct SSAs to follow up with the 28 nursing homes that OIG had identified with potential infection prevention and control and emergency preparedness deficiencies to ensure that they had taken corrective actions; (2) issue updated phase 3 interpretive guidance as soon as feasible; (3) provide training to SSAs on the updated phase 3 interpretive guidance as soon as feasible; and (4) consider updating the regulation to make clear that nursing homes must include emerging infectious diseases as a risk on their facility- and community-based all-hazards risk assessments.

**Audit #:** [A-01-20-00005](#) (07/26/2022)

**Government Program:** CMS

### **Audits of Nursing Home Life Safety and Emergency Preparedness in Eight States Identified Noncompliance With Federal Requirements and Opportunities for the Centers for Medicare & Medicaid Services to Improve Resident, Visitor, and Staff Safety**

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in nursing homes. These updates expanded requirements related to sprinkler systems and smoke detector coverage. Emergency preparedness planning requirements were also expanded.

As part of its oversight activities, OIG reviewed this area because many residents of nursing homes had limited or no mobility and were particularly vulnerable in the event of a fire or other emergency. Beginning in 2018, OIG conducted a series of audits in eight States to assess compliance with CMS's new life safety and emergency preparedness requirements.

OIG's objective was to summarize the results of its previous audits of eight States' compliance with CMS's life safety and emergency preparedness requirements for nursing homes and to identify opportunities for CMS to improve resident, visitor, and staff safety.

OIG summarized the findings from the previous audits and identified opportunities and developed recommendations to help CMS address deficiencies identified during the audits and improve resident, visitor, and staff safety.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that OIG identified a total of 2,233 areas of noncompliance with life safety and emergency preparedness requirements at 150 of the 154 nursing homes visited. Specifically, OIG identified 1,094 areas of noncompliance with life safety requirements and 1,139 areas of noncompliance with emergency preparedness requirements. These deficiencies occurred because of several factors, including inadequate oversight by management, staff turnover, inadequate oversight by State survey agencies, and a lack of any requirement for mandatory participation in standardized life safety training programs. As a result, residents, visitors, and staff at the nursing homes were at increased risk of injury or death during a fire or other emergency. CMS subsequently followed up with State survey agencies to determine if they had addressed the recommendations included in OIG's prior audits and, according to CMS, the States had already taken acceptable actions to address OIG's recommendations.



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OIG identified several opportunities for CMS to expand on its life safety requirements for nursing homes to improve the safety of residents, visitors, and staff. Among other findings, CMS could propose regulations requiring nursing homes to install carbon monoxide detectors according to national standards. OIG also noted areas in which CMS could improve its support for State survey operations and nursing home training. CMS could work with State survey agencies to address issues preventing more frequent surveys of high-risk facilities and require mandatory participation in standardized nursing home staff training.

OIG recommended that CMS propose regulations requiring nursing homes to install carbon monoxide detectors and work with States to encourage mandatory participation in standardized training for nursing home staff.

**Audit #:** [A-02-21-01010](#) (07/15/2022)

**Government Program:** CMS

### **An Estimated 91 Percent of Nursing Home Staff Nationwide Received the Required COVID-19 Vaccine Doses, and an Estimated 56 Percent of Staff Nationwide Received a Booster Dose**

The COVID-19 pandemic had hit nursing homes particularly hard. To reduce the spread of COVID-19 in nursing homes, the Centers for Medicare & Medicaid Services amended the infection control requirements for nursing homes to include a requirement for nursing homes to ensure that staff received all of the required COVID-19 vaccine doses (i.e., a single-dose vaccine or all required doses of a multidose vaccine) except for individuals granted an exemption from receiving the vaccine or individuals whose vaccination had to be delayed.

OIG's objective was to identify the COVID-19 vaccination status of nursing home staff as of the week ended March 27, 2022.

OIG used a stratified multistage design to select a sample of nursing home staff nationwide. OIG stratified the sampling frame of 15,224 nursing homes nationwide into 10 strata based on the nursing homes' locations and randomly selected 10 nursing homes from each stratum. From each of the 100 sampled nursing homes, OIG obtained a list of staff members who were subject to the vaccination requirements and randomly selected 10 staff members. For each of the 1,000 sampled staff members, OIG reviewed documentation that nursing homes provided to determine whether the staff member had received the required vaccine doses, had received a booster dose, or had requested or had been granted an exemption from receiving the vaccine.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that as of the week ended March 27, 2022, for the 1,000 nursing home staff members in the sample, 884 had received the required vaccine doses (506 of these staff members had also received a booster dose); 78 had been granted an exemption from receiving the vaccine based on a sincerely held religious belief, practice, or observance (religious exemption); 12 were partially vaccinated; 3 had been granted an exemption from receiving the vaccine based on a medical condition (medical exemption); and 3 had applied for an exemption that was being reviewed by a nursing home. For the remaining 20 staff members in the sample, the nursing homes did not provide OIG with documentation related to the staff members' vaccination status, or the documentation provided did not clearly identify the staff members'



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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

vaccination status. As a result, OIG was not able to determine the vaccination status of these staff members.

On the basis of the sample results, OIG estimated that 91 percent of staff nationwide had received the required vaccine doses, 56 percent of staff nationwide had received a booster dose, and 6 percent of staff nationwide had been granted a religious exemption. OIG did not estimate the percentages among the small number of staff members (i.e., 38) in the nationwide sample results who were partially vaccinated, who were granted a medical exemption, who applied for an exemption that was being reviewed, or for whom the vaccination status could not be determined.

In addition, the estimated percentages of staff who received the required vaccine doses, staff who received a booster dose, and staff who were granted a religious exemption varied depending on the locations (i.e., Department of Health and Human Services regions) of the nursing homes in which they worked.

OIG concluded that the results of this audit presented a snapshot of the COVID-19 vaccination status of nursing home staff nationwide at a specific point in time. This report included no recommendations.

**Audit #:** [A-09-22-02003](#) (06/23/2022)

**Government Program:** CMS

### **National Background Check Program for Long-Term-Care Providers: An Interim Assessment**

Background checks for employees of long-term-care facilities were an important safety measure that could help protect some of the facilities' most vulnerable populations. More than 13 million beneficiaries were served by long-term-care facilities each year, including the elderly, individuals in hospice care, and individuals with intellectual disabilities.

The National Background Check Program (Program), enacted by legislation in 2010, provided grants to States and territories (States) to assist them in developing and improving systems to conduct Federal and State background checks of prospective long-term-care employees. Included in this legislation was a mandate that OIG produce an evaluation of the Program within 180 days of Program completion. This report—the fifth in a series to supplement the mandated evaluation—reviewed Idaho and Mississippi, the last two States that were participating in the Program. (Twenty-seven States had completed their participation in the Program.) The interim review allowed for CMS to assist the States in fully implementing Program requirements during participation. In future work, OIG would assess the Program overall.

OIG reviewed grant monitoring documents and financial reports to determine the extent to which Idaho and Mississippi were working towards meeting Program requirements. Specifically, OIG evaluated the States' ability to obtain legislative authority and to coordinate between State-level agencies. Additionally, OIG evaluated States' monitoring documents.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that Idaho and Mississippi lacked State legislative authority to implement some Program requirements. Further, both States encountered challenges with coordination between State-level departments responsible for seeking legislative authority.

OIG found additional concerns with Mississippi. First, Mississippi was unable to submit required data to CMS to calculate determinations of ineligibility. This was despite the fact that Mississippi conducted background checks during the first



years of Program participation. Additionally, Mississippi and Idaho did not consistently report Federal and State funds on required quarterly financial reports; this made it difficult for CMS to determine the ongoing cost of Program implementation.

These report findings were consistent with findings in previous OIG reports about challenges that States experienced during Program participation. Therefore, OIG recommended that CMS continue to implement OIG's prior recommendations for it to take appropriate actions to (1) encourage States to obtain the necessary legislative authority from the State to fully implement Program requirements, and (2) require participating States to consistently submit data that allowed CMS and each State to calculate determinations of ineligibility. In addition, with this report, OIG recommended that CMS ensure that participating States submitted accurate quarterly reports.

**Evaluation #:** [OEI-07-20-00181](#) (05/12/2022)

**Government Program:** CMS

### **Posthospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries in Indiana Generally Met Medicare Level-of-Care Requirements**

To qualify for skilled nursing facility (SNF) services, a Medicare beneficiary must have had a preceding inpatient hospital stay. Centers for Medicare & Medicaid Services (CMS) research had found that many hospital admissions of nursing home residents who were enrolled in both Medicare and Medicaid (dually eligible beneficiaries) could have been avoided because the condition could have been prevented or treated outside of an inpatient hospital setting.

OIG's objectives were to determine whether the posthospital SNF care provided to dually eligible beneficiaries in Indiana between October 1, 2016, and September 30, 2018 (OIG's audit period): (1) was associated with potentially avoidable hospitalizations and (2) met Medicare level-of-care requirements.

The audit covered 20,668 SNF claims with Medicare payments totaling \$119,945,529, where each payment was greater than or equal to \$350 for services provided during the audit period, to dually eligible beneficiaries in Indiana who had a preceding Medicaid-covered stay at the same nursing facility. OIG selected and reviewed a stratified random sample of 100 SNF claims totaling \$667,184.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that posthospital SNF care provided to 98 of the 100 dually eligible beneficiaries in Indiana, on whose behalf the sampled SNF claims were submitted, was not associated with potentially avoidable hospitalizations. For the remaining two beneficiaries, an independent medical review contractor found that the beneficiaries' conditions were potentially preventable and manageable at the NFs, but, because the NFs did not have effective prevention strategies, the beneficiaries were hospitalized and later discharged to SNF care at the same facility.

OIG found that posthospital SNF care provided to 98 of the 100 beneficiaries met the Medicare SNF level-of-care requirements. The remaining two beneficiaries did not meet the Medicare SNF level-of-care requirements because the SNF physicians incorrectly determined that the beneficiaries required skilled nursing or skilled rehabilitation services, or both, on a daily basis.

For all 100 beneficiaries, physicians ordered SNF services. OIG noted that records from the hospitals where 33

Provider

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beneficiaries had a qualifying inpatient stay did not contain a clear and definitive hospital physician discharge order for SNF care. Hospital physicians mainly discharged beneficiaries 'back to nursing facility' without specifying the level of care. In these cases, SNF physicians certified the SNF level of care. The physician order not only affected level-of-care determination but also had a financial impact on the nursing facilities.

OIG concluded that SNF care provided to dually eligible beneficiaries in Indiana during the audit period generally: (1) was not associated with potentially avoidable hospitalizations and (2) met the Medicare level-of-care requirements. As a result, OIG did not have any recommendations. However, the quality of care in nursing facilities remained a concern for OIG. OIG would continue to monitor SNF claims, including those submitted on behalf of dually eligible beneficiaries, to determine whether services were appropriate and met payment requirements.

**Audit #:** [A-05-20-00005](#) (04/07/2022)

**Government Program:** CMS

### **CMS Should Take Further Action To Address States With Poor Performance in Conducting Nursing Home Surveys**

CMS oversaw how State survey agencies (States) conducted surveys of nursing homes to assess the homes' compliance with Federal requirements. Recent work by OIG found problems with performance by some States, which raised questions about the effectiveness of CMS oversight of State performance in conducting nursing home surveys, and the ability of CMS to hold States accountable when problems arose.

OIG analyzed CMS oversight of 52 States (including Puerto Rico and the District of Columbia) during FYs 2015-2018 to identify. OIG conducted interviews with CMS staff at the central office and 10 regional offices during February and March 2020, to learn how they worked with States to address serious problems with survey performance and any challenges that States may have faced. OIG also collected and analyzed documents from CMS about State performance and CMS imposition of remedies and sanctions on States with poor performance.

#### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that just over half of States—28 of 52—failed to meet the same performance measure or measures in three or four consecutive years during FYs 2015-2018. States most commonly missed performance measures related to survey timeliness, which CMS and States often attributed to staffing shortages. Ten percent of States' corrective action plans were missing from CMS files and many others lacked substantive detail. In addition to corrective action plans, CMS relied on other remedies, such as training and technical assistance, to help States improve performance.

Although CMS sometimes imposed financial penalties when States failed to meet the timeliness requirement for surveys, it frequently offset these penalties with one-time funding adjustments. CMS rarely imposed formal sanctions and has never initiated action to terminate any of its agreements with States for conducting surveys.

OIG recommended that CMS: (1) actively monitor States' corrective action plans, (2) establish guidelines for progressive enforcement actions, (3) engage with senior State officials earlier and more frequently to address problems, and (4) revise the State Operations Manual to reflect current CMS oversight practices. OIG also recommended that CMS: (5) disseminate the results of State performance reviews more widely.

**Evaluation #:** [OEI-06-19-00460](#) (01/11/2022)  
**Government Program:** CMS

### **Facility-Initiated Discharges in Nursing Homes Require Further Attention**

Nursing homes could legally discharge residents for certain reasons (known as facility-initiated discharges). Facility-initiated discharges that did not comply with regulations (i.e., inappropriate facility-initiated discharges) could be unsafe and a traumatic experience for the resident; media reports highlighted the rise in these discharges. For example, the police found one resident on the streets after a nursing home discharged the resident to an unlicensed boarding house without notifying the resident's family. In addition, State Ombudsmen cited "discharge/eviction" as the top complaint from 2013 through 2019. Given concerns about inappropriate facility-initiated discharges and the risk to vulnerable nursing home residents, efforts to reduce these discharges warranted OIG's examination.

OIG surveyed State Ombudsmen in all 50 States and the District of Columbia. OIG also analyzed CMS administrative data to determine the number of nursing homes that received a deficiency related to facility-initiated discharge. OIG interviewed officials in ACL, CMS, and all 10 CMS Regional Offices about efforts to reduce inappropriate facility-initiated discharges. OIG also interviewed five State Ombudsmen about the effect of COVID-19 on these discharges.

#### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that the magnitude of facility-initiated discharges in nursing homes remained unknown. Many challenges existed to identifying and addressing inappropriate facility-initiated discharges, including that neither ACL nor CMS collected data on the number of facility-initiated discharges, and many State Ombudsmen did not count or track the notices they received. Nursing homes had to send facility-initiated discharge notices to State Ombudsmen, but ACL did not collect data on these. State Ombudsmen reported facing challenges while responding to facility-initiated discharges, such as nursing homes sending facility-initiated discharge notices that lacked required information. Moreover, the COVID-19 pandemic exacerbated challenges. In addition, Ombudsmen, CMS, and State agencies might have differed in their perspectives on regulations and enforcement of facility-initiated discharges. Following CMS's initiative to review and take appropriate enforcement action in cases of noncompliance with facility-initiated discharge requirements, State agencies cited many more nursing homes for not complying with notice requirements for discharges in 2018. CMS had not yet determined the trends and outcomes of its initiative.

OIG's findings raised concerns about weaknesses in the safeguards to protect nursing home residents from harm that may result from inappropriate facility-initiated discharges. OIG recommended that CMS provide training to nursing homes, assess the effectiveness of its enforcement of inappropriate facility-initiated discharges, and implement its deferred initiatives to address inappropriate facility-initiated discharges. OIG recommended that ACL assist State Ombudsman programs with a data-collection system for facility-initiated discharge notices and establish guidance for analysis and reporting of data from these notices. Finally, OIG recommended that ACL and CMS coordinate to strengthen safeguards to protect nursing home residents and ensure that all State Ombudsmen, State agencies, and CMS ROs had an ongoing venue to share information about facility-initiated discharges.

**Evaluation #:** [OEI-01-18-00250](#) (11/18/2021)  
**Government Program:** ACL, CMS

Provider

Multiple Providers

Hospital

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## **CMS's COVID-19 Data Included Required Information From the Vast Majority of Nursing Homes, but CMS Could Take Actions To Improve Completeness and Accuracy of the Data**

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

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

OIG's audit covered CMS's COVID-19 data for 15,388 nursing homes that reported data to CMS for the 4-week period from June 22 through July 19, 2020. OIG interviewed CMS officials to understand the reporting process for COVID-19 data, reviewed CMS's COVID-19 data and quality assurance process, selected a statistical sample of 120 nursing homes and sent questionnaires to each sampled nursing home, and sent questionnaires to State health departments in 50 States and the District of Columbia.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that CMS's COVID-19 data for nursing homes included the required data from the vast majority of nursing homes (e.g., the number of confirmed COVID-19 cases among residents); however, the data were not complete or accurate for some nursing homes. Specifically, for 775 of the 15,388 nursing homes (about 5 percent), CMS's COVID-19 data: (1) did not include all of the COVID-19 data that nursing homes were required to report and (2) were not complete or accurate after CMS had performed its quality assurance checks (e.g., the number of confirmed COVID-19 cases among residents may have been under- or overreported). These conditions occurred because, in part, CMS's quality assurance checks were not always effective in ensuring the accuracy and completeness of the COVID-19 data for nursing homes.

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

When CMS's COVID-19 data are complete and accurate, Federal and State officials and other stakeholders may be able to more effectively monitor trends in infection rates and develop public health policies when making decisions about how to ensure the health and safety of nursing home residents and staff.

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

Provider

Multiple Providers

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Home Health Service

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**Audit #:** [A-09-20-02005](#) (09/01/2021)

**Government Program:** CMS

## Provider

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## Home Health Service

### **Home Health Agencies Rarely Furnished Services Via Telehealth Early in the COVID-19 Public Health Emergency**

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) expanded telehealth benefits to limit community spread and keep vulnerable patients in their homes while maintaining access to care. In April 2020, CMS revised Medicare regulations on an interim basis to retroactively allow home health agencies (HHAs) to use telehealth services beginning March 1, 2020. In November 2020, CMS finalized changes to those regulations to permanently allow home health services to be furnished via telehealth. While Medicare made payments for some types of telehealth services, the final regulations prohibited payments for home health services furnished via telehealth. At the start of the audit, CMS did not require HHAs to report telehealth services on Medicare claims. Therefore, oversight agencies lacked the ability to effectively identify and monitor those services.

OIG's objective was to determine whether home health services furnished via telehealth early in the COVID-19 PHE were provided and billed in accordance with Medicare requirements.

OIG selected a stratified random sample of 200 home health claims with beginning service dates from March 1 through December 31, 2020. OIG reviewed medical records to evaluate compliance with Medicare regulations for providing and billing telehealth services.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that HHAs rarely furnished services via telehealth early in the COVID-19 PHE; however, for the few claims in the sample with services furnished via telehealth, HHAs did not fully comply with Medicare requirements for providing them. Of the 200 sampled claims, 4 claims had home health services furnished via telehealth, so it was estimated that there were 127,999 claims in the sampling frame with such services. None of the four claims fully complied with Medicare requirements for home health services furnished via telehealth. The errors occurred because the HHAs were unfamiliar with the Medicare requirements for such services, which were new early in the COVID-19 PHE. Of the remaining 196 sampled claims, 194 claims did not have home health services furnished via telehealth. For the remaining two sampled claims, medical records were unable to be obtained, so it could not be determined whether home health services were furnished via telehealth.

Beginning July 1, 2023, CMS now requires HHAs to report the use of telehealth services on home health claims. CMS has instructed HHAs to use one of two G-codes to report the services on claims and to list each service as a separate, dated line item. CMS stated that such reporting will allow it to analyze the characteristics of patients utilizing telehealth and give it a broader understanding of the determinants that affect who benefits most from those services. Furthermore, in their March 2022 Report to the Congress, the Medicare Payment Advisory Commission recommended tracking the use of telehealth on home health claims to improve payment accuracy.

OIG recommended that CMS monitor HHA reporting of the new G-codes to determine whether further updates to regulations or guidance were necessary.

Provider

Multiple Providers

Hospital

Long Term Care

**Home Health Service**

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



Provider

Multiple Providers

Hospital

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Hospice

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Laboratory

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Other Providers and  
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**HCCPCS Codes Identified in This Audit:**

- G0320 - Home health services furnished using synchronous telemedicine rendered via a real-time, two-way audio and video telecommunications system
- G0321 - Home health services furnished using synchronous telemedicine rendered via telephone or other real-time, interactive, audio-only telecommunications system

Audit #: [A-05-21-00026](#) (09/25/2023)

Government Program: CMS

**Home Health Agencies Failed To Report Over Half of Falls With Major Injury and Hospitalization Among Their Medicare Patients**

Starting in 2019, HHAs were required to report that their patients experienced falls with major injury in patient Outcome and Assessment Information Set (OASIS) assessments. CMS used this HHA-reported information to calculate major injury fall rates at the agency level. Beginning in 2022, CMS included these fall rates as one of the Care Compare website's quality measures, which provided consumers with information about HHA performance. The Office of Inspector General (OIG) and others had found problems with using provider-reported information to assess quality in the past. OIG conducted this study to determine the extent of falls reporting by HHAs and implications for the accuracy of the falls information on Care Compare.

OIG identified falls with major injury in Medicare hospital claims for home health patients. Whenever their patients were hospitalized, HHAs had to submit an OASIS assessment. OIG checked whether the falls were reported in those OASIS assessments as required. OIG calculated non-reporting rates for these falls. OIG also examined whether reporting rates differed by patient or HHA characteristics, including whether HHAs had low fall rates on Care Compare.

**SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that fifty-five percent of falls OIG identified in Medicare claims were not reported in associated OASIS assessments as required. Falls reporting on OASIS assessments was worse among younger home health patients (compared to older patients) and patients who identified as Black, Hispanic, or Asian (compared to White). Reporting was also lower among for-profit HHAs as compared to nonprofit and government-owned agencies. Notably, HHAs with the lowest Care Compare major injury fall rates reported falls less often than HHAs with higher Care Compare fall rates, indicating that Care Compare did not provide the public with accurate information about how often home health patients fell. Finally, for many Medicare home health patients who fell and were hospitalized, there was no OASIS assessment at all associated with the hospitalization, which raised additional concerns about potential noncompliance with data submission requirements and its impact on the accuracy of information about falls with major injury on Care Compare.

OIG recommended that CMS (1) take steps to ensure the completeness and accuracy of the HHA reported OASIS data used to calculate the falls with major injury quality measure; (2) use data sources, in addition to OASIS assessments, to improve the accuracy of the quality measure related to falls with major injury; (3) ensure that HHAs submit required OASIS assessments when their patients were hospitalized; and (4) explore whether improvements to the quality measure related to falls could also be used to improve the accuracy of other home health measures.



Evaluation #: [OEI-05-22-00290](#) (09/05/2023)  
Government Program: CMS

## **Mandated Analysis of Home Health Service Utilization From January 2016 Through March 2022**

Medicare paid for home health services provided to beneficiaries who needed skilled care for an illness or injury and were unable to leave their home. When providers furnished these services in rural areas, a percentage increase (rural add-on payment) was added to the standardized home health payment.

Under the Bipartisan Budget Act of 2018, Congress required the Centers for Medicare & Medicaid Services (CMS) to implement a new methodology for applying rural add-on payments beginning on January 1, 2019. Through the same legislation, Congress amended the Social Security Act to require, as a condition of payment, that all home health claims contain the code for the county (or equivalent area) where the service was furnished. Congress further required the Office of Inspector General to complete an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and make recommendations as appropriate.

OIG's audit covered \$109,389,663,042 in Medicare payments to home health agencies (HHAs) for 45,417,624 claims. These claims were for home health services provided January 2016 through March 2022. OIG performed an analysis of service utilization by county and evaluated compliance with selected billing requirements.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that, during the audit period, beneficiary utilization of home health services decreased for urban counties and rural counties in the "high utilization" and "all other" categories, while utilization in the "low population density" category remained steady. OIG further determined that the number of home health episodes decreased for all urban and rural county categories. Many variables during the audit period may have affected utilization of services. Most notably, during calendar years 2020–2022, the Secretary of Health and Human Services declared a public health emergency in response to the COVID-19 pandemic. The pandemic affected utilization of services and presented staffing challenges for HHAs. Therefore, OIG could not determine the cause of any changes in utilization of services during this period.

Lawmakers designed the new rural add-on methodology to provide higher add-on percentages to rural counties in the "low population density" and "all other" categories. OIG determined that, during the audit period, the methodology shifted the distribution of add-on payments from the "high utilization" category to the "low population density" and "all other" categories. OIG originally planned to use Federal Information Processing Standards (FIPS) data to analyze utilization from January 2016 through March 2022 but was unable to do so because the FIPS data was incomplete. This occurred because providers were not always applying the FIPS codes to claims, or the FIPS codes were invalid. Also, Medicare administrative contractors (MACs) did not always return claims with missing or invalid FIPS codes to providers for correction as required.

OIG recommended that CMS take the following steps to improve FIPS code reporting: (1) update the HH Pricer logic to check for missing and invalid FIPS codes on all home health claims and work with MACs to ensure that these claims were returned to providers for correction; and (2) re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

Provider

Multiple Providers

Hospital

Long Term Care

**Home Health Service**

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



**Audit #:** [A-05-20-00031](#) (12/20/2022)  
**Government Program:** CMS

## **Home Health Agencies Used Multiple Strategies To Respond to the COVID-19 Pandemic, Although Some Challenges Persist**

The COVID-19 pandemic required HHAs to adapt their care to respond to COVID-19's infectious nature, as well as other circumstances from the pandemic. HHAs played an important role in caring for Medicare beneficiaries: in 2020, the first year of the COVID-19 pandemic, HHAs cared for over 3 million beneficiaries. CMS required HHAs to prepare for and respond to emergencies and, during those emergencies, CMS could offer regulatory flexibilities and supports (which OIG referred to collectively as regulatory flexibilities) for various requirements. This report provided insights into HHAs' experiences that would help stakeholders continue managing the response to COVID-19 and prepare for future emergencies.

OIG surveyed a nationally representative sample of 400 HHAs, 396 of which participated in Medicare, in fall 2021 to ask about their experiences early in the pandemic and at the time OIG administered the survey. OIG projected the results to the 72 percent of Medicare-participating HHAs represented by the sample. In addition, OIG interviewed 12 HHAs about notable challenges, strategies, or other experiences they identified in their surveys. OIG also interviewed staff at CMS about its support of--and perspectives on--HHAs' provision of care during the pandemic.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that like all health care providers, HHAs had experienced multiple challenges to providing care during the COVID-19 pandemic. HHAs had continued to experience longstanding staffing challenges as well as new ones resulting from the pandemic, such as maintaining staffing despite quarantine and isolation protocols. These staffing challenges persisted for many HHAs despite efforts to address them. In addition, HHAs faced numerous and widespread infection control challenges, including accessing personal protective equipment (PPE) to limit exposure and spread, but these had mostly eased since early in the pandemic.

HHAs' own strategies to respond to the pandemic included offering paid leave to retain staff and finding PPE from nontraditional sources. HHAs had also benefited from government support--including regulatory flexibilities instituted in response to the declaration of a public health emergency--and this support had mitigated some staffing challenges. For example, by the Federal government's allowing new types of providers to certify and order home health services and complete certain patient assessments, HHAs could more efficiently provide care. Telehealth flexibilities under the public health emergency had also helped HHAs provide care while reducing COVID-19 exposure and dealing with staffing shortages. However, HHAs' challenges with telehealth raised questions about its future role in home health care, and--because of limited reporting requirements--CMS had limited insight into HHAs' telehealth use. Finally, the emergency preparedness plans required by CMS guided HHAs' responses to the pandemic but fell short of fully addressing a global emergency such as COVID-19.

CMS had an opportunity to assess how to best help HHAs prepare for and respond to future emergencies, as well as to evaluate how changes to the home health landscape could better serve patients. To that end, OIG recommended that CMS evaluate how HHAs were using telehealth--specifically, the types of services provided via telehealth and the characteristics of patients who benefited from these services. OIG also recommended that CMS--to inform

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## Provider

Multiple Providers

Hospital

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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

decision-making—evaluate how the regulatory flexibilities it had offered in response to the COVID-19 public health emergency affected the quality of home health care. Finally, OIG recommended that CMS—in collaboration with the Administration for Strategic Preparedness and Response's (ASPR's) Technical Resources, Assistance Center, and Information Exchange (TRACIE)—apply lessons learned from the COVID-19 pandemic to update and/or develop emergency preparedness trainings and materials for HHAs on responding to infectious disease outbreaks.

**Evaluation #:** [OEI-01-21-00110](#) (10/14/2022)

**Government Program:** CMS

### **Medicare Could Have Saved Approximately \$993 Million in 2017 and 2018 if It Had Implemented an Inpatient Rehabilitation Facility Transfer Payment Policy for Early Discharges to Home Health Agencies**

In their 2020 report, the Trustees of the Part A Hospital Insurance Trust Fund urged policymakers to take timely and effective action to address projected deficits that could lead to Medicare Part A deficits of \$9.6 billion by 2026. The Trustees stated in their report that the sooner significant reforms were enacted, the more flexible and gradual the reforms could be. OIG performed this audit because an audit regarding the Centers for Medicare & Medicaid Services' (CMS's) early transfer payment policies for hospitals to hospice care indicated that significant savings could be realized for the Medicare program if CMS implemented an inpatient rehabilitation facility (IRF) transfer payment policy for early discharges to home health agencies (HHAs). OIG's prior work resulted in Congress enacting a hospital early discharge to hospice policy that went into effect on October 1, 2018.

OIG's objective was to determine how much Medicare could have saved in calendar years (CYs) 2017 and 2018 if CMS had expanded the IRF transfer payment policy to include early discharges to home health care.

For IRF stays that occurred in CYs 2017 and 2018, 1,152 IRFs submitted 802,275 claims with payments totaling \$16.1 billion. Of these claims, OIG's audit covered 230,725 IRF claims with payments totaling \$4.8 billion for stays that ended in early discharges to home health care (i.e., the length of the IRF stay was more than 3 days but less than the case-mix group average length of stay and the actual HHA claim date of service was within 3 days of the IRF discharge date). OIG calculated the savings CMS would have realized for these claims if the transfer payment policy had covered discharges to home health. OIG used claims with a date of service within 3 days of the IRF discharge date for their calculations to be consistent with CMS regulations for discharges from acute-care hospitals to home health care.

In addition, OIG compared the payments that would have been made under an expanded transfer policy with the IRFs' calculated costs to provide care. To do so, OIG calculated the IRFs' transfer payments and compared them with the IRFs' costs to provide care.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare could have saved approximately \$993 million in CYs 2017 and 2018 if CMS had expanded its IRF transfer payment policy to apply to early discharges to home health care. OIG determined that this payment policy would generally result in payments to IRFs that would cover their costs to provide care. When CMS announced its proposed IRF transfer payment policy in 2001, it stated that it would analyze claims data to compare billing patterns prior to and after its implementation and refine IRF payments in the future, if warranted. For this audit, CMS officials did not



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explain why CMS had not expanded the IRF transfer payment policy to cover discharges to home health care. CMS also did not analyze claims data to compare billing patterns prior to and after the implementation of the PPS for IRFs in January 2002, which could have provided information in support of expanding the IRF transfer payment policy to include early discharges to home health care.

OIG recommended that CMS take the necessary steps to establish an IRF transfer payment policy for early discharges to home health care. If this expanded policy had been in place, Medicare could have saved \$993,134,059 in 2017 and 2018.

**HCCPS Codes Identified in This Audit:**

- C0404 - Traumatic spinal cord injury

Audit #: [A-01-20-00501](#) (12/07/2021)

Government Program: CMS

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

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

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

The audit covered the infection prevention and control policies and procedures for eight HHA providers. OIG reviewed each HHA provider's policies and procedures to determine whether they included:

1. Guidance for following standards of practice
2. A coordinated agencywide infection control program
3. Infection control education for HHA staff, Medicare beneficiaries, and caregivers.

OIG also determined whether the HHA providers' policies and procedures followed CMS COVID-19 guidance for:

1. Screening patients
2. Screening staff
3. Treating patients with known or suspected COVID-19.



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Suppliers

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that six of the eight selected HHA providers had infection control policies and procedures that complied with CMS requirements and followed CMS guidance to safeguard HHA staff, Medicare beneficiaries, and caregivers during the COVID-19 pandemic. However, one HHA provider did not comply with CMS requirements or follow CMS COVID-19 guidance. Specifically, this HHA provider's infection control policies and procedures did not:

1. Require staff to follow one of the standard precautions to prevent the transmission of infections and communicable diseases
2. Include documentation of surveillance methods used for identifying and tracking infections and improvement activities to prevent infection
3. Include COVID-19 screening protocols for staff in accordance with CMS guidance
4. Include information about how to care for patients with known or suspected COVID-19 in accordance with CMS guidance.

In addition, this provider and another HHA provider's COVID-19 screening protocols for patients were not consistent with CMS guidance. As a result, the patients and staff at these two HHA providers were at an increased risk of infection. OIG did not determine whether these HHA providers had infection prevention and control issues related to the implementation of the policies and procedures. However, State survey agencies identified issues with implementation at several of these HHA providers, as indicated by infection prevention and control deficiencies found during surveys conducted in 2019 and 2020.

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

**Audit #:** [A-01-20-00508](#) (09/24/2021)

**Government Program:** CMS

### **Medicare Home Health Agency Provider Compliance Audit: Catholic Home Care**

Under the home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services paid home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary received. The PPS payment covered intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies.

OIG's prior audits of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

OIG's objective was to determine whether Catholic Home Care complied with Medicare requirements for billing home health services on selected types of claims.

The audit covered over \$103 million in Medicare payments to Catholic Home Care for 28,645 claims for home health services provided in calendar years 2017 and 2018 (audit period). OIG selected a simple random sample of 100 claims and submitted records associated with them to an independent medical review contractor to determine whether the services met coverage, medical necessity and coding requirements.



## Provider

### Multiple Providers

### Hospital

### Long Term Care

### Home Health Service

### Hospice

### Medical Equipment and Supplies

### Behavioral Health

### Laboratory

### Telehealth

### Other Providers and Suppliers

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

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

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

**Audit #:** [A-02-19-01013](#) (08/18/2021)

**Government Program:** CMS

## Hospice

### **National Government Services, Inc., Accurately Calculated Hospice Cap Amounts but Did Not Collect All Cap Overpayments**

To ensure that hospice care did not exceed the cost of conventional care at the end of life, there were two annual limits (called caps) to payments made to hospices—the inpatient cap and the aggregate cap. The cap amounts were calculated annually, and any amount paid to a hospice above either cap amount was an overpayment and had to be repaid to Medicare. The Centers for Medicare & Medicaid Services (CMS) contracted with three Medicare administrative contractors (MACs) to calculate cap amounts and recover overpayments. This audit was part of a series of audits regarding MACs' oversight of hospice cap calculations.

OIG's objective was to determine whether NGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.

The audit covered the cap calculation process for all 1,966 hospices in NGS's Jurisdictions 6 and K that participated in the Medicare hospice program in cap year 2019 and 3 prior cap years. For the 2019 cap calculations, NGS calculated aggregate cap overpayments totaling \$186.1 million for 515 hospice providers. For the lookback calculations of 3 prior cap years, NGS calculated additional net lookback aggregate overpayments totaling \$27.3 million for 673 hospice providers. For cap year 2019, NGS calculated overpayments totaling \$213.4 million.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that NGS accurately calculated all cap amounts and collected or attempted to collect \$211.3 million of the \$213.4 million in total cap overpayments in accordance with CMS requirements. However, NGS did not attempt to collect the remaining \$2.1 million in net lookback overpayments because of its internal policy of not pursuing lookback cap calculation amounts that were less than a set threshold.

Additionally, against CMS requirements, NGS instructed hospices to wait to submit the overpayments calculated on their cap determination notices until the hospice received a demand letter from NGS, which took an average of more than 2 months after the due date for hospices to file the cap determination notices. Of 30 judgmentally sampled hospices, 13 reported cap overpayments, totaling \$8.1 million, on their cap determination notices. Nine of those thirteen hospices did not remit their overpayments, totaling \$6.1 million, when they filed their cap determination notices as required. Because of NGS's instructions, the Federal Government lost the benefit of having the overpayment funds for its use for an additional average of more than 2 months.

OIG recommended that NGS (1) collect \$2.1 million in lookback overpayments and return \$22,576 in lookback refunds resulting from 2019 hospice cap calculations for lookback years, (2) discontinue its internal policy of waiving certain overpayment collections related to lookback years and start collecting all hospice cap overpayments and paying refunds in accordance with CMS requirements, and (3) change its instructions on the cap determination notices to follow the CMS requirement that hospices remit overpayments at the time they submit their cap determination notice.

**Audit #:** [A-06-21-08004](#) (11/17/2022)  
**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

**Hospice**

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



## **Medicare Hospice Provider Compliance Audit: Hospice of Palm Beach County, Inc.**

The Medicare hospice benefit allowed providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less and who had elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.

OIG's objective was to determine whether hospice services provided by Hospice of Palm Beach County, Inc. (HPBC), complied with Medicare requirements.

The audit covered 37,121 claims for which HPBC (located in Palm Beach, Florida) received Medicare reimbursement of \$149 million for hospice services provided from April 2017 through March 2019. OIG reviewed a random sample of 100 claims. OIG evaluated compliance with selected Medicare billing requirements and submitted these sampled claims and the associated medical records to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that HPBC received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in OIG's sample, 60 claims complied with Medicare requirements. However, the remaining 40 did not comply with the requirements. Specifically, the clinical record did not support the beneficiary's terminal illness prognosis (30 claims), the clinical record did not support the level of care claimed (9 claims), and services were not supported in the medical record (3 claims). The total exceeded 40 because 2 claims contained more than 1 deficiency.

Improper payment of these claims occurred because HPBC's policies and procedures were not effective in ensuring the clinical documentation it maintained supported the terminal illness prognosis, the appropriate level of care was provided, and that services were supported. On the basis of OIG's sample results, OIG estimated that HPBC received at least \$42.3 million in improper Medicare reimbursement for hospice services.

OIG recommended that HPBC: (1) refund to the Federal Government the portion of the estimated \$42.3 million in Medicare overpayments that were within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return overpayments, in accordance with the 60-day rule; and (3) strengthen its policies and procedures to ensure that hospice services complied with Medicare requirements.

### **HCPCS Codes Identified in This Audit:**

- SIA payment - Service Intensity Add-on payment for direct patient care provided by a registered nurse and/or a social worker during the last 7 days of life

**Audit #:** [A-02-20-01001](#) (09/23/2022)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

**Hospice**

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



## **Medicare Hospice Provider Compliance Audit: Vitas Healthcare Corporation of Florida**

The Medicare hospice benefit allowed providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less and who had elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.

OIG's objective was to determine whether certain hospice services provided by Vitas Healthcare Corporation of Florida (Vitas) complied with Medicare requirements.

The audit covered 50,850 claims for which Vitas received Medicare reimbursement totaling \$210 million for certain hospice services provided during the period April 2017 through March 2019. OIG reviewed and evaluated a stratified sample of 100 claims for compliance with selected Medicare requirements. In addition, OIG submitted medical records associated with the sample to an independent medical review contractor who determined whether the documents supported the hospice services billed.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Vitas did not comply with Medicare requirements for 89 of the 100 claims in the sample. Specifically, the clinical record did not support the continuous home care (CHC) level of hospice care claimed for Medicare reimbursement (68 claims), the clinical record did not support the general inpatient level of hospice care claimed for Medicare reimbursement (28 claims), and CHC services were not documented or supported in the beneficiary's clinical record (23 claims). The total exceeded 89 because 27 claims contained more than 1 error.

These improper payments occurred because Vitas' policies and procedures were not effective to ensure that it maintained documentation to support the level of care and hospice services claimed for Medicare reimbursement. On the basis of the sample results, OIG estimated that Vitas received at least \$140 million in improper Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Vitas refund to the Federal Government the portion of the estimated \$140 million in Medicare overpayments that were within the 4-year claims reopening period; identify, report, and return any overpayments in accordance with the 60-day rule; and strengthen its policies and procedures to ensure that hospice services complied with Medicare requirements.

**Audit #:** [A-02-19-01018](#) (07/14/2022)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

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Behavioral Health

Laboratory

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## **Medicare Payments of \$6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight**

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that OIG's analysis of trends and patterns in payments for items and services provided to Medicare beneficiaries outside the Medicare hospice benefit during a hospice period of care (which OIG referred to as "nonhospice payments") demonstrated an increase in Medicare nonhospice payments for beneficiaries. Nonhospice payments for Medicare Part A services and Part B items and services totaled \$6.6 billion from 2010 through 2019. If providers billed Medicare for nonhospice items and services that potentially should have been covered by hospices, Medicare could have paid for the same items or services twice.

OIG's prior work on Medicare Part D drugs and durable medical equipment, prosthetics, orthotics, and supplies provided to hospice beneficiaries demonstrated that these duplicate payments were, in fact, occurring. In three prior reports, OIG made several recommendations to CMS to establish oversight and scrutiny of Medicare nonhospice payments. Implementing the recommendations from those reports and considering the information in this data brief might help the Centers for Medicare & Medicaid Services (CMS) further evaluate the need to potentially restructure the hospice payment system to reduce duplicate payments for items and services that should have been included in the hospice per diem payment. The information in this data brief might also help CMS determine whether the hospice benefit was operating consistent with its longstanding position that services unrelated to a hospice beneficiary's terminal illness and related conditions should have been exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit.

OIG concluded that because this report contained no recommendations, CMS did not provide written comments on the draft report but did provide technical comments, which OIG addressed as appropriate.

**Audit #:** [A-09-20-03015](#) (02/14/2022)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

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and other legal protections.

## Medical Equipment and Supplies

### **Medicare Remains Vulnerable to Fraud, Waste, and Abuse Related to Off-the-Shelf Orthotic Braces, Which May Result in Improper Payments and Impact the Health of Enrollees**

From calendar years (CYs) 2014 through 2020, Medicare paid approximately \$5.3 billion for orthotic braces provided to Medicare enrollees. The Centers for Medicare & Medicaid Services (CMS) found that orthotic braces were consistently among the top 20 items of durable medical equipment, prosthetics, orthotics, and supplies with the highest improper payment rates. Adequate CMS oversight was critical in ensuring that Medicare enrollees continued to have access to and receive medically necessary braces.

This portfolio provided an overview of vulnerabilities identified in prior Office of Inspector General (OIG) audits, evaluations, and investigations and issues identified in OIG's analysis of Medicare claims data related to off-the-shelf (OTS) orthotic braces from CYs 2018 through 2020.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that, based on OIG's review of the vulnerabilities identified in OIG's prior work and OIG's analysis of Medicare claims data, OIG identified issues related to CMS's oversight of OTS braces, including the following: (1) providers ordered braces for enrollees for whom there was no history of a treating relationship, (2) new suppliers were located in geographic areas with known Medicare fraud, (3) Medicare paid more than private payers for OTS braces, and (4) suppliers used prohibited solicitation to contact enrollees.

These issues continued to put Medicare and its enrollees at risk and demonstrated the need for CMS to strengthen its oversight related to supplier billing requirements, ordering provider requirements, supplier enrollment and monitoring, Medicare allowable amounts for OTS braces, telemarketing to Medicare enrollees, and fraud related to OTS braces. If not addressed, these issues could result in improper payments, potential enrollee harm, and Medicare paying more than non-Medicare payers, such as private insurance companies, for OTS braces.

OIG recommended that CMS strengthen its oversight of Medicare billing for OTS braces by:

- (1) taking steps to prevent payments for claims for replacement OTS braces billed without required modifiers;
- (2) identifying providers who ordered OTS braces for enrollees with whom they had no treating relationships, and using that information to determine whether to provide additional education to or take administrative or legal action against the ordering providers or associated suppliers;
- (3) analyzing supplier billing patterns to determine whether to conduct additional prepayment or postpayment reviews of suppliers;
- (4) ensuring that Medicare allowable amounts were reasonably comparable with payments made by non-Medicare payers;
- (5) educating suppliers and enrollees on telemarketing practices for OTS braces; and
- (6) using predictive data analysis and information from other Federal agencies and from State agencies to identify emerging fraud schemes related to OTS braces, and using CMS's authority to prevent further losses to the Medicare program.



## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

### **HCPCS Codes Identified in This Audit:**

- L1832 - Off-the-shelf knee brace

**Audit #:** [A-09-21-03019](#) (05/24/2024)

**Government Program:** CMS

### **Medicare Paid \$30 Million for Accumulated Repair Costs That Exceeded the Federally Recommended Cost Limit for Wheelchairs During Their 5-Year Reasonable Useful Lifetime**

From January 2016 through December 2021 (audit period), Medicare paid \$91.1 million to durable medical equipment (DME) suppliers nationwide for repairs made to capped-rental wheelchairs (wheelchairs) that were within their 5-year reasonable useful lifetime (RUL) and owned by Medicare enrollees. Two prior OIG reviews found that Medicare paid DME suppliers for repairs made to capped-rental DME items after the accumulated costs of repairs had exceeded 60 percent of the cost to replace the items (federally recommended cost limit), which may have resulted in unallowable payments. Therefore, OIG conducted this nationwide audit to determine the extent to which the issue identified in the prior OIG reviews occurred for wheelchairs during the audit period.

The objective was to determine whether the accumulated costs of repairs paid by Medicare for enrollee-owned wheelchairs that were within their 5-year RUL exceeded the federally recommended cost limit.

The audit covered Medicare Part B claim lines, totaling \$91.1 million, for repairs made to 77,774 enrollee-owned wheelchairs during the audit period that were within their 5-year RUL and were purchased during the same period. OIG analyzed claims data to determine the amount paid for repairing each enrollee's wheelchair and the portion of the accumulated costs of repairs that exceeded the federally recommended cost limit.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the accumulated costs of repairs paid by Medicare for some enrollee-owned wheelchairs that were within their 5-year RUL exceeded the federally recommended cost limit. For 504,794 of the 688,948 repairs (73 percent) that OIG reviewed, Medicare paid suppliers before the accumulated costs of repairing 77,200 wheelchairs had exceeded the federally recommended cost limit. However, the remaining 184,154 repairs (27 percent) were paid after the accumulated costs of repairing 16,962 wheelchairs had exceeded the federally recommended cost limit, resulting in \$30.1 million in potentially unallowable Medicare payments. Enrollee coinsurance associated with the potentially unallowable payments totaled \$7.6 million. Suppliers' billing of these wheelchair repairs may have reflected noncompliance with Medicare requirements. Specifically, the excessive costs for repairing these wheelchairs may have indicated that the repairs were not reasonable or that enrollees were furnished substandard wheelchairs that would not remain serviceable for their entire 5-year RUL.

OIG recommended that CMS work with the DME Medicare administrative contractors (DME MACs) to:

- strengthen Medicare requirements to ensure that DME MACs review accumulated costs of repairs made to wheelchairs during their 5-year RUL that exceeded a certain cost limit and use this cost limit as a basis for determining when wheelchairs furnished by suppliers would not remain serviceable for their entire RUL,



## Provider

Multiple Providers

Hospital

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Medical Equipment and Supplies

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Telehealth

Other Providers and Suppliers

## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

- implement system edits to identify for review claims for repairs made to wheelchairs during their 5-year RUL when the accumulated costs of repairs had exceeded a certain cost limit, and
- take appropriate action for suppliers that consistently billed for repairs made to wheelchairs during their 5-year RUL that exceeded the federally recommended cost limit or the cost limit used as the basis for determining when wheelchairs furnished by suppliers would not remain serviceable for their entire RUL (e.g., by educating suppliers on proper billing and recovering improper payments).

The report contained one other recommendation.

### **HCPCS Codes Identified in This Audit:**

- K0739 - Labor for repair of patient-owned durable medical equipment other than oxygen equipment, per 15 minutes.

**Audit #:** [A-09-22-03003](#) (07/31/2023)

**Government Program:** CMS

### **Reducing Medicare's Payment Rates for Intermittent Urinary Catheters Can Save the Program and Beneficiaries Millions of Dollars Each Year**

A 2018 report by the Medicare Payment Advisory Commission found that Medicare paid substantially more than commercial payers for certain items, including intermittent urinary catheters. The report recommended that Medicare incorporate such items into its competitive bidding program, thereby reducing the rates that Medicare allows. However, Medicare has not done so. In fiscal year (FY) 2020, Medicare Part B and its beneficiaries paid \$407 million for all intermittent urinary catheters. OIG evaluated whether Medicare's payment amounts for these catheters may offer the potential for savings.

OIG sampled 600 Medicare claims from FY 2020, for the three billing categories of intermittent urinary catheters. OIG requested that suppliers provide and document the acquisition cost for each of the catheters in these claims. OIG compared the suppliers' acquisition costs to Medicare payment amounts in three ways: in total, across the three categories, and with regard to three specific features. Additionally, OIG interviewed CMS to better understand the methods available to reduce payment rates while maintaining beneficiaries' access to the catheters that best serve their medical needs.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that from OIG's analysis of data submitted by suppliers, OIG estimated that Medicare payments were 3.4 times suppliers' acquisition costs for intermittent urinary catheters in FY 2020. In total, Medicare allowed \$407 million in payments for these items, while suppliers paid approximately \$121 million to acquire them (see exhibit below). Medicare payments exceeded suppliers' acquisition costs by \$286 million. Each of the three billing categories of intermittent urinary catheters (straight tip, curved tip, and sterile kit) showed large differences between Medicare payments and acquisition costs, which indicated a potential for substantial savings both to Medicare and beneficiaries, who shared responsibility for paying the Medicare-allowed amount.

OIG found potential savings across all categories of catheters. OIG also found potential savings when catheters had one or more of three specific features (hydrophilic coating, grip, or sleeve)—in these cases, there were smaller but still



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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meaningful differences between Medicare payment rates and supplier acquisition costs, reinforcing the potential for savings.

OIG recognized that suppliers faced other costs beyond the cost of acquiring catheters and needed an opportunity to maintain a profit. However, the magnitude of the differences between Medicare reimbursements and suppliers' acquisition costs indicated that Medicare and its beneficiaries could achieve substantial savings while allowing for other costs. To provide an example of the potential for savings, OIG performed an illustrative analysis of suppliers' other costs. In this analysis, OIG used data in a report from the home health care industry (not specific to catheters), which estimated that for every dollar spent on acquisition costs, suppliers spent an additional 72 cents in other costs. OIG applied this same proportion of other costs to the data on acquisition costs in order to obtain an example of suppliers' total costs. This illustrative analysis yielded a total cost of \$209 million, which would allow \$198 million in potential Medicare savings and supplier profits. OIG believed that this analysis likely underestimated potential savings by overstating suppliers' other costs.

OIG recommended that CMS lower Medicare's payment rates for intermittent urinary catheters. As it did so, CMS should have continued to take steps to ensure beneficiaries' access to the catheters that best served their medical needs. When CMS had previously sought to obtain savings for other items, it had used competitive bidding or its "inherent reasonableness" process. Each of these mechanisms had its own methods for ensuring beneficiary access.

**HCPSC Codes Identified in This Evaluation:**

- A4351 - Straight tip catheter
- A4352 - Curved tip catheter
- A4353 - Sterile kit catheter

Evaluation #: [OEI-04-20-00620](#) (08/30/2022)

Government Program: CMS

**Medicare Improperly Paid Durable Medical Equipment Suppliers an Estimated \$8 Million of the \$40 Million Paid for Power Mobility Device Repairs**

From October 1, 2018, through September 30, 2019 (audit period), Medicare Part B paid approximately \$40.1 million for Power Mobility Device (PMD) repairs for Medicare beneficiaries nationwide. For 2006 through 2008, a prior OIG review of claims for capped rental durable medical equipment (DME), which included certain PMDs, found that Medicare paid DME suppliers (suppliers) approximately \$26.8 million for DME repair claims that did not meet Medicare requirements.

OIG conducted this nationwide audit of PMD repairs to determine whether the issues identified in the prior OIG report were still occurring during the audit period.

The objective was to determine whether suppliers complied with Medicare requirements when billing for PMD repairs.

The audit covered Medicare Part B paid claims for 37,013 beneficiaries for whom suppliers submitted charges for 244,667 claim lines, totaling \$40.1 million, for PMD repairs provided during the audit period. The beneficiary coinsurance associated with these PMD repairs totaled \$10.4 million. (A claim line represented one PMD repair for a beneficiary on a single date of service.) OIG selected a stratified random sample of 100 beneficiaries, for whom 52 suppliers submitted



charges for 922 PMD repairs totaling \$170,776.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that not all suppliers complied with Medicare requirements when billing for PMD repairs. For 637 of the 922 PMD repairs associated with the 100 sampled beneficiaries, suppliers complied with those requirements. However, for 261 PMD repairs, suppliers submitted PMD repair charges that did not comply with those requirements. (OIG did not review the remaining 24 PMD repairs but treated them as non-errors because they were under contractor review.) Specifically, documentation did not adequately support the charges for PMD repairs, the labor time associated with PMD repairs was not documented, or PMD repair charges were not reasonable and necessary, resulting in \$41,137 in improper Medicare payments and \$10,494 in associated beneficiary coinsurance payments. OIG also identified questionable charges for 183 PMD repairs associated with 19 sampled beneficiaries. Although the billing of these PMD repairs did not reflect noncompliance with Medicare requirements, suppliers did not meet documentation standards established by guidance or submitted charges that may not have been reasonable and necessary, resulting in \$20,692 in questionable Medicare payments and \$5,278 in associated beneficiary coinsurance payments.

On the basis of the sample results, OIG estimated that \$7.9 million of the \$40.1 million paid for PMD repairs was improperly paid. OIG also estimated that Medicare could have saved as much as an additional \$3.7 million for questionably paid PMD repairs. In addition, OIG estimated that Medicare beneficiaries could have saved as much as \$3 million in coinsurance for the improperly and questionably paid PMD repairs.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) instruct the DME Medicare contractors to:

- recover \$41,137 in overpayments for PMD repairs;
- notify suppliers to refund \$10,494 in coinsurance; and
- based upon the results of this audit, notify appropriate suppliers so that they could exercise reasonable diligence to identify, report, and return any overpayments.

OIG also made four procedural recommendations. The full text of OIG's recommendations was shown in the report.

**HCPSC Codes Identified in This Audit:**

- K0739 - Repair or nonroutine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes

**Audit #:** [A-09-20-03016](#) (05/31/2022)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers



## **Medicare Improperly Paid Suppliers an Estimated \$117 Million Over 4 Years for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Provided to Hospice Beneficiaries**

A prior OIG audit found that Medicare improperly paid suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for DMEPOS items provided to beneficiaries during inpatient stays. However, that audit did not cover payments for DMEPOS items that suppliers provided to hospice beneficiaries.

OIG's objective was to determine whether Medicare properly paid suppliers for DMEPOS items they provided to hospice beneficiaries.

The audit covered \$185.7 million in Medicare Part B payments to suppliers for 1.6 million DMEPOS items provided to hospice beneficiaries from January 2015 through April 2019 (audit period). OIG identified hospice claims with service dates during the audit period and used these claims' beneficiary information and service dates to identify DMEPOS items that had service dates within the hospice service dates. OIG selected 2 stratified samples, with 200 items billed by suppliers. One sample was for 115 items billed without the GW modifier. (This modifier indicated that an item was not related to the beneficiary's terminal illness and related conditions.) Another sample was for 85 items billed with the GW modifier. For each sample, OIG contacted the hospices that provided care to the beneficiaries to have them assess whether the items palliated or managed the beneficiaries' terminal illnesses and related conditions.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for 121 of 200 sampled DMEPOS items, Medicare improperly paid suppliers for DMEPOS items they provided to hospice beneficiaries. Specifically, for 58 percent of the sampled DMEPOS items billed without the GW modifier (67 of 115 items) and 63 percent of the sampled DMEPOS items billed by suppliers with the GW modifier (54 of 85 items), the items were provided to palliate or manage the beneficiaries' terminal illnesses and related conditions. Medicare paid the hospices for the DMEPOS items provided to the beneficiaries as part of the hospices' per diem payments. These items should have been provided directly by the hospices or under arrangements between the hospices and the suppliers.

The improper payments occurred because: (1) the majority of the suppliers were unaware that they had provided DMEPOS items to hospice beneficiaries, (2) the system edit processes that should have prevented the improper payments were not effective or did not exist, and (3) the suppliers inappropriately used the GW modifier. On the basis of OIG's sample results, OIG estimated that Medicare could have saved \$116.9 million in payments during the audit period, and beneficiaries could have saved \$29.8 million in deductibles and coinsurance that may have been incorrectly collected from them or from someone on their behalf.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS): (1) improve the prepayment edit process by instructing the durable medical equipment (DME) Medicare contractors to deny DMEPOS claims submitted by suppliers without the GW modifier for DMEPOS items provided to hospice beneficiaries; (2) implement a postpayment edit process; (3) direct the DME and hospice Medicare contractors, or other contractors as appropriate, to conduct prepayment or postpayment reviews of supplier claims billed with the GW modifier; and (4) study the feasibility of including palliative items and services not related to a beneficiary's terminal illness and related conditions within the hospice per diem.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers



Audit #: [A-09-20-03026](#) (11/16/2021)

Government Program: CMS

## Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment  
and Supplies**

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

**Behavioral Health**

Laboratory

Telehealth

Other Providers and Suppliers

## Behavioral Health

### **A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care**

- Almost half of all Americans will experience a behavioral health condition--which includes mental health disorders and substance use disorders--in their lifetime.
- Without enough behavioral health providers willing to participate in Medicare and Medicaid, enrollees may have experienced difficulty accessing providers or delays in care and may even have forgone treatment altogether.
- The Office of Inspector General (OIG) conducted this review, in part, because of congressional interest in ensuring that enrollees had access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care (hereafter referred to as 'Medicaid').

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees. These providers represented about one-third of the total behavioral health workforce in the counties. Despite unprecedented demand for behavioral health services, treatment rates in all three programs remained relatively low. Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS):

1. Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.
2. Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.
3. Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.
4. Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

### **CPT Codes Identified in This Evaluation:**

- 90839 - Psychotherapy for crisis; first 60 minutes
- 90840 - Psychotherapy for crisis; each additional 30 minutes

**Evaluation #:** [OEI-02-22-00050](#) (03/29/2024)

**Government Program:** CMS





## **Medicare Improperly Paid Providers for Some Psychotherapy Services, Including Those Provided via Telehealth, During the First Year of the COVID-19 Public Health Emergency**

In response to the COVID-19 public health emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) temporarily expanded access to health services provided via telehealth. From March 2020 through February 2021 (audit period), Medicare Part B paid \$1 billion for psychotherapy services, including telehealth services, provided to Medicare enrollees nationwide. Prior Office of Inspector General (OIG) audits of four psychotherapy providers identified high improper payment rates for psychotherapy services furnished before the PHE. OIG conducted this nationwide audit to determine whether compliance issues identified in the prior audits occurred during the audit period. To understand the challenges that providers faced when furnishing telehealth services, OIG also surveyed providers on their experience with providing those services to people enrolled in Medicare.

OIG's objective was to determine whether providers met Medicare requirements and guidance when billing for psychotherapy services, including services provided via telehealth.

OIG's audit covered approximately \$1 billion in Part B payments for more than 13.5 million psychotherapy services provided during the audit period. OIG selected two stratified random samples of psychotherapy services: one sample consisted of 111 enrollee days for telehealth services, and the other consisted of 105 enrollee days for non-telehealth services (i.e., provided in person).

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that providers did not meet Medicare requirements and guidance when billing for some psychotherapy services, including services provided via telehealth. For 84 of the 216 sampled enrollee days, providers met Medicare requirements. However, for 128 sampled enrollee days, providers did not meet these requirements (e.g., psychotherapy time was not documented). In addition, for 54 sampled enrollee days, providers did not meet Medicare guidance (e.g., providers' signatures were missing). (OIG did not review 4 sampled enrollee days and treated them as non-errors because they were already part of other OIG reviews.) Based on the sample results, OIG estimated that of the \$1 billion that Medicare paid for psychotherapy services, providers received \$580 million in improper payments for services that did not comply with Medicare requirements, consisting of \$348 million for telehealth services and \$232 million for non-telehealth services.

OIG also presented the information obtained on providers' experience with providing telehealth services during the PHE for the sampled enrollee days. CMS may be able to use this information when making decisions about how telehealth can be best used to meet the needs of Medicare enrollees in the future. OIG found that some providers reported challenges in furnishing telehealth services and most providers used approved communication technology to provide those services.

OIG recommended that CMS:

- (1) work with Medicare contractors to recover \$35,560 in improper payments for the sampled enrollee days,
- (2) implement system edits for psychotherapy services to prevent payments for incorrectly billed services, and
- (3) strengthen educational efforts to make providers aware of educational materials on meeting requirements and guidance for psychotherapy services.

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

**Behavioral Health**

Laboratory

Telehealth

Other Providers and  
Suppliers

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

The report contained three other recommendations.

**CPT Codes Identified in This Audit:**

- 90837 - 60 minutes of psychotherapy
- 90834 - 45 minutes of psychotherapy
- 90832 - 30 minutes of psychotherapy
- 90833 - 30 minutes of psychotherapy with an E&M; service
- 90836 - 45 minutes of psychotherapy with an E&M; service
- 90838 - 60 minutes of psychotherapy with an E&M; service
- 90785 - interactive complexity add-on service

**Audit #:** [A-09-21-03021](#) (05/02/2023)

**Government Program:** CMS

**National Snapshot of Trends in the National Domestic Violence Hotline's  
Contact Data Before and During the COVID-19 Pandemic**

The COVID-19 pandemic (the pandemic) posed special challenges for victims of domestic violence. Government agencies implemented extensive community mitigation activities, including issuing shelter-in-place orders. Because of economic and other uncertainties surrounding the pandemic and shelter-in-place orders, victims may have been less likely to use crisis hotlines because their abusers were close by. The National Domestic Violence Hotline (the Hotline) provided life-saving resources and safety planning services for victims of domestic violence.

OIG's objectives were to: (1) identify trends in the Hotline's contact data before and during the pandemic and (2) identify challenges that the Hotline faced during the pandemic and actions that it took to address those challenges while continuing to support those affected by domestic violence.

OIG obtained the Hotline's contact data for March 19, 2019, through March 18, 2021, and analyzed the following: contact volume and communication methods; demographic information (ethnicity, age group, and gender); situational information (abuse types, contact needs, barriers in service, and contact type); and referral information. OIG also obtained the Hotline's feedback on the analysis. OIG interviewed Hotline officials to identify challenges the Hotline faced during the pandemic and actions it took to address them.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that although OIG's analysis showed little change in total contact volume from the period before to the period during the pandemic, OIG identified notable changes in the contact data for some subcategories of data that were analyzed. For example, the number of contacts that used online chat to contact the Hotline increased by 19 percent, the number of contacts that identified with the Asian ethnicity group increased by 24 percent, and the need for protective/restraining order assistance increased by 40 percent. Furthermore, OIG's analysis showed notable fluctuations in the number of contacts for some subcategories of data in certain months during the pandemic. Although the Hotline provided explanations for what could have contributed to these fluctuations, it could not determine whether



they were a result of the pandemic. The Hotline believed that the full impact of the pandemic may not be reflected in the contact data until more time has passed.

OIG found that the Hotline identified four challenges that it faced during the pandemic: (1) connecting victims to providers and resources that were operating at a limited capacity because of the pandemic, (2) tracking the unique impact of the pandemic on victims to better serve contacts' needs, (3) addressing a decrease in contact volume from victims who may have needed help but did not contact the Hotline because they were in closer proximity to their abusers as a result of shelter-in-place orders, and (4) fostering meaningful connections among Hotline staff to carry its mission forward. To address these challenges, the Hotline took actions to help ensure that it continued to support those affected by domestic violence.

OIG concluded that considering the information in this report may have helped the Hotline evaluate its emergency response to identify areas in which it could improve and to ensure that it addressed any long-term effects of the pandemic.

**Audit #:** [A-09-21-06000](#) (04/27/2022)  
**Government Program:** ACF

### **Psychotherapy Services Billed by a New York City Provider Did Not Comply With Medicare Requirements**

Medicare paid approximately \$1 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar year 2019. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services. After analyzing Medicare claims data for Part B psychotherapy services provided during 2019, OIG identified a New York City provider that was among the highest reimbursed individual providers in the Nation.

OIG's objective was to determine whether a New York City provider complied with Medicare requirements when billing for psychotherapy services.

The audit covered 15,559 beneficiary days for psychotherapy services for which a New York City provider received Medicare reimbursement totaling \$1.1 million during the period April 1, 2018, through August 31, 2020 (audit period). OIG reviewed a simple random sample of 100 beneficiary days. OIG did not determine whether the services were medically necessary.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the New York City provider did not comply with Medicare requirements when billing for psychotherapy services for all 100 sampled beneficiary days. Specifically, beneficiaries' treatment plans associated with these services were not provided or did not contain required elements (e.g., frequency or duration of services). This heightened the risk that treatments were inappropriate or unnecessary and could have had a significant effect on the beneficiaries' quality of care received. OIG also found that services billed to Medicare did not meet incident-to requirements or were conducted by a therapist that was not licensed or registered in New York State. Also, time spent on psychotherapy services was not documented and treatment notes were not maintained to support the services billed. In addition, for psychotherapy services provided during 96 sampled beneficiary days, there was no evidence that beneficiaries' treatment plans were

Provider

Multiple Providers

Hospital

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signed by the treating physician.

On the basis of OIG's sample results, OIG estimated that the New York City provider received \$1.1 million in Medicare overpayments for psychotherapy services. These deficiencies occurred because the provider did not develop policies and procedures or provide training to its therapists to ensure that psychotherapy services were appropriately billed to Medicare.

OIG recommended that the New York City provider (1) refund to the Medicare program the estimated \$1.1 million overpayment and (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommended that the provider develop policies and procedures and provide training to its therapists to ensure that psychotherapy services comply with Medicare requirements.

**CPT Codes Identified in This Audit:**

- 90832 - Psychotherapy (30 min)
- 90833 - Psychotherapy (30 min + E&M;)
- 90834 - Psychotherapy (45 min)
- 90836 - Psychotherapy (45 min + E&M;)
- 90837 - Psychotherapy (60 min)
- 90838 - Psychotherapy (60 min + E&M;)
- 90853 - Group Psychotherapy
- 90785 - Interactive Complexity

**Audit #:** [A-02-21-01006](#) (03/29/2022)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

## Laboratory

### Potential Vulnerabilities in CMS Oversight of Medicare Add-on Payments for COVID-19 Tests Show That Oversight of Incentive Payments Could Be Improved

OIG understood that CMS had to quickly: (1) establish the payment rates for laboratories to bill for COVID-19 testing and create an add-on payment to incentivize laboratories to promptly complete COVID-19 tests and (2) establish documentation requirements to support the add-on payment. However, OIG believed that it was important for CMS and MACs to provide oversight of add-on payments to prevent fraud, waste, and abuse in the Medicare program. For incentive payments in general, it was important that CMS issue specific guidance on documentation that was expected to be maintained to support incentive payments and provide oversight to ensure that these payments were supported, especially in the event of a future public health emergency.

#### SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the Centers for Medicare & Medicaid Services (CMS) established an add-on payment to incentivize laboratories to promptly complete COVID-19 tests (i.e., within 2 calendar days or less). Based on OIG's analysis of \$339.4 million in Medicare add-on payments made to 9,380 laboratories for COVID-19 diagnostic tests provided to more than 4 million enrollees during the audit period (January 1, 2021, through June 30, 2022), OIG determined that more than two-thirds of laboratories that billed Medicare at least once for the add-on payment during the audit period billed for that payment with all of their COVID-19 tests. OIG also identified the following potential vulnerabilities related to CMS and the Medicare Administrators' (MACs') oversight of add-on payments for COVID-19 tests: (1) CMS requirements related to supporting documentation for add-on payments were vague, and documentation from the laboratories was inconsistent; and (2) CMS and the MACs did not perform adequate reviews of claims for add-on payments. To determine whether the incentive payment achieved the intended result of laboratories' prompt completion of COVID-19 tests, CMS would have had to perform manual reviews of supporting documentation, which could be difficult and costly to perform in the event of an audit or a medical review.

#### HCPCS Codes Identified in This Audit:

- U0005 - Add-on payment for COVID-19 tests completed within 2 calendar days or less from the date the specimen was collected
- U0003 - COVID-19 diagnostic test using a specific technique
- U0004 - COVID-19 diagnostic test using any technique

**Audit #:** [A-09-22-03015](#) (05/08/2024)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and  
Suppliers

## [CMS Could Improve Its Procedures for Setting Medicare Clinical Diagnostic Laboratory Test Rates Under the Clinical Laboratory Fee Schedule for Future Public Health Emergencies](#)

On March 13, 2020, the White House declared the COVID-19 outbreak a national emergency. This emergency posed unprecedented challenges to the delivery of health care including the establishment of sufficient lab testing capacity to help combat COVID-19. In response to the public health emergency (PHE) and these challenges, CMS had to quickly establish billing codes for new clinical diagnostic laboratory tests (CDLTs) and payment rates that would be adequate to cover labs' costs for conducting the tests. OIG's objective was to determine whether CMS's procedures for CDLT rate setting could be improved for future PHEs.

OIG reviewed applicable laws and regulations effective as of January 2018 related to CMS setting rates for new CDLTs. OIG reviewed those principles in the *Standards for Internal Controls in the Federal Government* (Green Book) that were determined to be relevant to the audit objective. OIG also conducted interviews with CMS and Medicare administrative contractor's (MAC's) pricing coordinators to obtain an understanding of the rate setting process that occurred from February 2020 through January 2021. OIG conducted interviews with officials from two laboratory associations to obtain an understanding of the communication they had with CMS and MACs during the PHE rate setting process.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that CMS's procedures for CDLT rate setting could have been improved for future PHEs. Specifically, CMS could have improved its: (1) communication with laboratory associations and the MACs' pricing coordinators, and (2) procedures to provide the MACs with additional flexibility when they set interim CDLT rates to respond to a PHE. Neither the Clinical Laboratory Fee Schedule statute (CLFS) nor its implementing regulations specifically addressed how pricing coordinators could quickly set rates for new CDLTs before the lengthy public consultation rate setting process. Normally, CMS filled that delay by using its longstanding MAC interim rate setting policy. Accordingly, in March 2020, MACs set rates for new COVID-19 viral tests through CMS's interim MAC rate setting policy. However, CMS had to take additional action beyond its standard rate setting procedures to set and adjust rates for CDLTs.

As a result, CMS's standard rate setting procedures did not allow the MACs to set rates that were adequate to cover the cost of conducting COVID-19 viral tests for all laboratories during a time when CMS was working to increase testing capacity. CMS may have missed opportunities to obtain important information that could have improved its response to the COVID-19 pandemic from laboratory associations and the MACs' pricing coordinators when it made decisions about the new CDLT rates.

OIG recommended that CMS: (1) establish procedures to improve communication among all stakeholders involved in setting new CDLT rates during a PHE; and (2) improve its procedures, which may have required seeking legislative authority, for setting and adjusting rates for new CDLTs during a PHE.

### **CPT Codes Identified in This Audit:**

- 87635 - COVID-19 tests involving infectious agent detection by nucleic acid

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

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Provider

Multiple Providers

Hospital

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**HCPCS Codes Identified in This Audit:**

- U0002 - Non-CDC COVID-19 tests
- U0003 - COVID-19 tests involving infectious agent detection by nucleic acid using high-throughput technologies
- U0004 - Non-CDC COVID-19 tests using high-throughput technologies
- U0005 - Add-on payment for high-throughput COVID-19 tests completed within 2 days of specimen collection

**Audit #:** [A-01-21-00506](#) (04/03/2024)

**Government Program:** CMS

**Medicare Part B Spending on Clinical Diagnostic Laboratory Tests in 2022**

To help control lab test spending, PAMA required that Medicare Part B payment rates align with rates paid by private payors. From 2018 through 2020, the Centers for Medicare and Medicaid Services (CMS) implemented new Medicare Part B lab test payment rates. From 2021 through 2023, changes in legislation delayed any rate changes; the next payment rate changes were scheduled for January 1, 2026. Since 2014, OIG had been reporting on lab test spending in Medicare Part B as mandated by PAMA.

In this report, OIG analyzed Medicare Part B claims data for lab tests paid for by CMS under the Clinical Laboratory Fee Schedule in 2022. OIG identified key statistics and trends for total Medicare spending on lab tests, including the top 25 lab tests on the basis of total spending.

**SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that in 2022, Medicare Part B spending on clinical diagnostic laboratory tests (lab tests) decreased by 10 percent from lab test spending in 2021. Medicare Part B spending on lab tests had experienced an upward trend since 2014, the first year OIG began this series of annual analysis required by the Protecting Access to Medicare Act of 2014 (PAMA). Because payment rates for individual lab tests did not change in 2021 and 2022, changes in spending were primarily driven by changes in the volume of tests. Decreases in spending and volume occurred for most, but not all, individual lab tests and for each category of lab tests--COVID-19 tests; genetic tests; and chemistry and other tests. OIG's data snapshot contained no recommendations.

**CPT Codes Identified in This Evaluation:**

- 87798 - Detection test by nucleic acid for organism
- 83036 - Hemoglobin A1C level
- 83970 - Parathormone (parathyroid hormone) level
- 80307 - Testing for presence of drug, by chemistry analyzers
- 87635 - COVID-19 test: Amplified DNA or RNA probe detection of severe acute respiratory syndrome
- 87426 - COVID-19 test: Detection test by immunoassay technique for severe acute respiratory syndrome
- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 81455 - Genetic test: Test for detecting genes associated with cancer
- 82607 - Cyanocobalamin (vitamin B-12) level
- 80048 - Blood test, basic group of blood chemicals (Calcium, total)
- 84153 - PSA (prostate specific antigen) measurement, total.



Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

**HCPCS Codes Identified in This Evaluation:**

- U0005 - COVID-19 test: Infectious agent detection by nucleic acid (DNA or RNA); severe acute
- U0004 - COVID-19 test: Any technique, high-throughput technologies
- G0483 - Drug test(s), definitive, 22 or more drug class(es)
- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- 0241U - COVID-19 test: Respiratory infectious agent detection by RNA for severe acute respiratory
- 0242U - Genetic test: Gene analysis of 55-74 genes associated with solid organ cancer in cell-free

Evaluation #: [OEI-09-23-00350](#) (12/19/2023)

Government Program: CMS

**CMS's Oversight of Medicare Payments for the Highest Paid Molecular Pathology Genetic Test Was Not Adequate To Reduce the Risk of up to \$888 Million in Improper Payments**

Prior OIG work identified increased spending on Medicare Part B genetic testing, as well as fraudulent billing of genetic tests. Although there may have been legitimate reasons for the increased spending, the increases indicated the potential for improper payments. OIG's prior analysis showed that, for 2016 through 2019, Current Procedural Terminology (CPT) code 81408 was the genetic-testing procedure code with the second highest total Part B payments and was the molecular pathology procedure (a type of genetic test) with the highest Medicare payment amount (\$2,000). This CPT code may have been billed when testing for multiple genes associated with rare diseases. Because these diseases generally manifested in childhood, the genes associated with them would not generally have been tested for in the Medicare population, which was predominantly 65 years of age and older. Therefore, there was a risk of Medicare improper payments for this CPT code.

OIG's objective was to determine whether the Centers for Medicare & Medicaid Services' (CMS's) oversight of Medicare payments for CPT code 81408 was adequate to reduce the risk of improper payments.

To determine whether there was a risk of improper payments, OIG analyzed the Medicare Part B claims associated with payments of \$888.2 million for more than 450,000 genetic tests billed under CPT code 81408 that had dates of service from 2018 through 2021 (audit period). OIG also interviewed CMS and Medicare contractor officials.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that CMS and the Medicare Administrative Contractors' (MACs') oversight of Medicare payments for CPT code 81408 did not: (1) ensure that all Medicare enrollees had established relationships with ordering providers; (2) ensure that Medicare payments for CPT code 81408 were related to diseases associated with genes that would generally be tested and billed under that CPT code; and (3) include adequate monitoring of the number of tests billed under CPT code 81408, a Tier 2 molecular pathology procedure (MPP) code, to determine whether that number exceeded the number of tests billed under Tier 1 MPP codes. (Tier 2 MPPs are generally performed in lower volumes than Tier 1 MPPs because the diseases being tested for are rare.) In addition, not all MACs could identify the specific gene tested by laboratories billing CPT code 81408. Finally, although five of the seven MACs had Local Coverage Article





## Provider

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### Hospital

### Long Term Care

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### Hospice

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### Behavioral Health

### Laboratory

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### Other Providers and Suppliers

## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

guidance that prohibited or limited use of CPT code 81408, two MACs' Local Coverage Articles did not limit its use.

Although CMS officials stated that CMS conducted data analysis (e.g., to identify high-risk providers), CMS did not ensure that the MACs provided sufficient oversight over billing of and payments for CPT code 81408. Two of the MACs' payments made up 97 percent of the total payments for CPT code 81408 for the audit period. Because there were no longer payments for this CPT code by the end of the audit period (December 31, 2021), OIG considered the issues identified by this audit corrected. However, based on the results of the audit, up to \$888.2 million in Medicare payments made for CPT code 81408 claims that OIG identified for the audit period were at risk of improper payment.

OIG recommended that CMS direct the appropriate Medicare contractors to:

- review claims billed under CPT code 81408 for the audit period to determine whether they complied with Medicare requirements; and
- determine the amount of improper payments for the claims that did not comply with Medicare requirements and, for those that were within the 4-year claim-reopening period, in accordance with CMS's policies and procedures, recover up to \$888.2 million for claims that were at risk of improper payment during the audit period.

The report contained one other recommendation.

### **CPT Codes Identified in This Audit:**

- 81400 - Level 1 Molecular Pathology Procedure (least complex)
- 81408 - Level 9 Molecular Pathology Procedure (most complex)

### **ICD Codes Identified in This Audit:**

- E7800 - Pure hypercholesterolemia, unspecified
- Z1509 - Genetic susceptibility to other malignant neoplasm
- Z8546 - Personal history of malignant neoplasm of prostate
- E785 - Hyperlipidemia, unspecified
- I429 - Cardiomyopathy, unspecified
- I2510 - Atherosclerotic heart disease of native coronary artery without angina pectoris

**Audit #:** [A-09-22-03010](#) (06/21/2023)

**Government Program:** CMS

## **Medicare Could Have Saved up to \$216 Million Over 5 Years if Program Safeguards Had Prevented At-Risk Payments for Definitive Drug Testing Services**

Drug testing was generally used to detect the presence or absence of drugs in patients undergoing treatment for pain management or substance use disorders. Medicare payments for definitive drug testing services increased based on the number of drug classes tested. The Centers for Medicare & Medicaid Services (CMS) identified overpayments for the definitive drug testing service with the highest reimbursement amount (procedure code G0483, definitive drug testing for 22 or more drug classes) due to noncompliance with Medicare requirements. In addition, a prior OIG report on drug



testing services identified that payments for G0483 were at risk for overpayments.

OIG's objective was to identify Medicare Part B payments for definitive drug testing services that were at risk for noncompliance with Medicare requirements.

OIG's audit covered \$3 billion in Medicare Part B payments for definitive drug testing services with dates of service from January 2016 through December 2020 (audit period). These payments were made to 1,062 "at-risk providers," which routinely billed procedure code G0483 (for 75 percent or more of their definitive drug testing services), and 4,227 "other providers," which did not routinely bill this service. OIG compared characteristics of the at-risk providers and other providers.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that for the 5-year audit period, Medicare paid \$704.2 million for definitive drug testing services that were at risk for noncompliance with Medicare requirements. Specifically, these payments were for the definitive drug testing service with the highest reimbursement amount (procedure code G0483). These payments were made to 1,062 at-risk providers that routinely billed this procedure code and may not have been reasonable and necessary. OIG determined that presumptive drug testing preceded most definitive drug testing services billed by both the at-risk and other providers. However, the at-risk providers may not have always used presumptive testing to determine the number of drug classes that needed to be tested using definitive drug testing, because they routinely billed for testing 22 or more drug classes using G0483 and the other providers did not. Although the at-risk providers billed a significantly higher percentage of definitive drug testing services using G0483 than the other providers, the at-risk and other providers had similar characteristics (such as the types of patients they tested and the frequency of testing). This suggested that the at-risk providers may have been able to bill for definitive drug testing services using primarily procedure codes with lower reimbursement amounts, as the other providers did.

If CMS's program safeguards had focused on at-risk payments to at-risk providers for procedure code G0483, Medicare could have saved up to \$215.8 million for the audit period.

OIG recommended that CMS:

- (1) expand program safeguards to prevent and detect at-risk payments to at-risk providers for procedure code G0483;
- (2) review at-risk payments made to at-risk providers during and after the audit period and recover any overpayments;
- (3) notify appropriate providers to exercise reasonable diligence to identify, report, and return any overpayments; and
- (4) educate providers that received payments that did not comply with Medicare requirements.

### **CPT Codes Identified in This Audit:**

- 80305 - Presumptive drug test, low complexity
- 80306 - Presumptive drug test, moderate complexity
- 80307 - Presumptive drug test, high complexity

Provider

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**HCPCS Codes Identified in This Audit:**

- G0480 - Definitive drug test, 1-7 drug classes
- G0481 - Definitive drug test, 8-14 drug classes
- G0482 - Definitive drug test, 15-21 drug classes
- G0483 - Definitive drug test, 22+ drug classes
- G0659 - Simple definitive drug test for all classes

**ICD Codes Identified in This Audit:**

- Z79.891 - Long term (current) use of opiate analgesic

**Audit #:** [A-09-21-03006](#) (02/27/2023)

**Government Program:** CMS

**Medicare Part B Spending on Lab Tests Increased in 2021, Driven By Higher Volume of COVID-19 Tests, Genetic Tests, and Chemistry Tests**

The Protecting Access to Medicare Act of 2014 (PAMA) changed the way the Medicare program set payment rates for lab tests by aligning Medicare payment rates with rates paid by private payers. The Centers for Medicare & Medicaid Services (CMS) calculated new rates that took effect in 2018, lowering Medicare payment rates for many tests. As part of PAMA, Congress also mandated that the Office of Inspector General (OIG) publicly release an annual analysis of the top 25 tests based on Medicare spending and that it conduct analyses that OIG determined appropriate. OIG issued the first report in 2015, analyzing Medicare Part B payments for lab tests in 2014. This data brief provided an analysis of Medicare payments for lab tests in 2021.

OIG analyzed claims data for lab tests performed in 2021 that CMS paid for under the Clinical Laboratory Fee Schedule (CLFS). These tests were covered under Medicare Part B and did not include tests that Medicare paid for under other payment systems, such as the payment system for critical access hospitals or the Hospital Outpatient Prospective Payment System. OIG identified the top 25 lab tests based on Medicare spending for tests performed in 2021. OIG also identified key statistics and emerging trends, including Medicare spending by procedure code and test category.

**SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that Medicare Part B spending on lab tests increased by \$1.3 billion in 2021, from \$8.0 billion in 2020 to \$9.3 billion in 2021. The 17-percent increase was the biggest change in spending since OIG began monitoring payments in 2014.

In 2021, Medicare Part B spent \$2.0 billion on COVID-19 tests, a 29-percent increase from 2020. Medicare Part B paid for 26 different procedure codes for COVID-19 tests, including code U0005, a new code that incentivized faster test turnaround times. More than 10 million enrollees received at least 1 COVID-19 test paid for by Medicare Part B.

Medicare Part B spending on non-COVID-19 tests also increased. Total spending on four categories of high-priced genetic tests increased by 56 percent, from \$1.2 billion in 2020 to \$1.9 billion in 2021, exceeding pre-pandemic spending levels. Spending on chemistry tests--the largest category of tests by both spending and volume--increased from \$1.9 billion in 2020 to \$2.1 billion, but remained below pre-pandemic levels.

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### Medical Equipment and Supplies

### Behavioral Health

### Laboratory

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### Other Providers and Suppliers

Medicare Part B spent \$5.5 billion in 2021 on the top 25 tests, which accounted for 59 percent of total test spending. The factors that affected overall spending also contributed to the increase in spending on the top 25 tests. These factors were the increased volume for COVID-19 tests, the continued growth of high-priced genetic tests, and the increased volume for panel and chemistry tests.

OIG concluded that the COVID-19 pandemic continued to have an impact on Medicare Part B spending on lab tests. Spending on COVID-19 tests increased in 2021, driven by more people receiving more tests. However, the decline between pre-pandemic levels for chemistry tests and the 2020 and 2021 levels could indicate that people were not seeking the routine or preventive care appointments where these tests were ordered. The second year in a row of low volume for chemistry tests raised questions about the pandemic's long-term impact on Medicare enrollee health.

#### **CPT Codes Identified in This Evaluation:**

- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids
- 84443 - Blood test, thyroid stimulating hormone
- 85025 - Complete blood cell count, automated test
- 81408 - Genetic test: Molecular pathology procedure level 9
- 82306 - Vitamin D-3 level
- 81528 - Genetic test: Gene analysis (colorectal cancer)
- 87798 - Detection test for organism
- 83036 - Hemoglobin A1C level
- 80307 - Testing for presence of drug
- 87635 - COVID-19 test: Amplified probe technique
- 87426 - COVID-19 test: ELISA detection of severe acute respiratory syndrome coronavirus 2 (COVID-19)
- 83970 - Parathormone (parathyroid hormone) level
- 81162 - Genetic test: Gene analysis (breast cancer 1 and 2)
- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 80048 - Blood test, basic group of blood chemicals
- 82607 - Cyanocobalamin (vitamin B-12) level
- 81407 - Genetic test: Molecular pathology procedure level 8

#### **HCPCS Codes Identified in This Evaluation:**

- U0003 - COVID-19 test: Infectious agent detection by nucleic acid for COVID-19, high-throughput
- U0005 - COVID-19 test: Add-on payment for high throughput tests completed within 2 calendar days of specimen collection
- U0004 - COVID-19 test: Any technique, high-throughput technologies
- G0483 - Drug test(s), definitive, 22 or more drug class(es)
- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- G0481 - Drug test(s), definitive, 8-14 drug class(es)



Evaluation #: [OEI-09-22-00400](#) (12/19/2022)  
Government Program: CMS

## **Labs With Questionably High Billing for Additional Tests Alongside COVID-19 Tests Warrant Further Scrutiny**

Medicare Part B spending on COVID-19 lab tests increased steadily between spring 2020--when Medicare first started paying for these tests--and the end of that year. Preliminary analysis of Medicare Part B claims data indicated that some diagnostic testing laboratories billed for other diagnostic tests--such as individual respiratory tests (IRTs), respiratory pathogen panels (RPPs), genetic tests, and allergy tests--along with COVID-19 tests. OIG referred to these four types of tests billed with COVID-19 tests as add-on tests. Although it was not unusual for labs to bill for COVID-19 tests and other diagnostic tests on the same claim, certain billing patterns--such as a high volume of or high payments for add-on tests--raised concerns of potential waste or fraud.

OIG performed outlier analysis to identify labs that billed for add-on tests at questionably high levels compared to other labs that billed for COVID-19 tests. OIG identified two kinds of outlier labs: (1) those for which add-on tests constituted a high proportion of each lab's total *number* of tests, and (2) those for which add-on tests constituted a high proportion of each lab's total *payments* for tests.

OIG examined all Medicare Part B claims paid for COVID-19 tests during 2020, and for the following types of add-on tests: IRTs, RPPs, genetic tests, and allergy tests.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that 378 labs billed Medicare Part B for add-on tests at questionably high levels--in volume, payment amount, or both--compared to the 19,199 other labs. This included 276 labs that billed for high volumes of add-on tests on claims for COVID-19 tests, and 263 labs that billed for high payment amounts from add-on tests on claims for COVID-19 tests. Further, 161 of these labs billed for both high volumes of add-ons and high payment amounts from add-ons on claims for COVID-19 tests. OIG also found a small number of labs that had at least 10 claims where 2 labs had billed for the same enrollee for the same tests on the same day, which may have been an indication of a fraud scheme involving the sharing of enrollee information.

On their claims for COVID-19 tests, some of the 378 labs billed for add-on tests in combinations that had little if any variation across patients. This may have indicated that these tests were not specific to individual patients' needs. The add-on tests significantly increased the per-claim amounts that Medicare Part B paid to these labs. For example, one outlier lab regularly billed for a combination of five add-on respiratory tests on almost all of its claims for COVID-19 tests. As a result, the average per-claim Medicare payment to this outlier lab was \$666, covering both COVID-19 and add-on tests, compared to an average payment of \$89 to all other labs that billed for COVID-19 tests and any add-on tests. Although billing for add-on tests was generally allowable, and Medicare Part B pays for these tests when they are medically appropriate, these patterns of questionably high billing raised concerns that some tests may have been wasteful or potentially fraudulent.

Provider

Multiple Providers

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OIG concluded that further scrutiny of billing by the 378 outlier labs was needed and, therefore, the Office of Inspector General referred these labs to the Centers for Medicare & Medicaid Services for further review. Outlier labs exceeded the thresholds for one or both measures of questionable billing, raising concerns about potential waste or fraud.

**CPT Codes Identified in This Evaluation:**

- 87798 - Detection test by nucleic acid for organism, amplified probe technique. This is a general test code that is used when a specific code is not available, and can be used to indicate tests for measles, mumps, norovirus among others
- 87581 - Detection test by nucleic acid for Mycoplasma pneumoniae (bacteria), amplified probe technique
- 87486 - Detection test by nucleic acid for Chlamydia pneumoniae, amplified probe technique
- 87631 - Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 3-5 targets
- 87633 - Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 12-25 targets

Evaluation #: [OEI-09-20-00510](#) (12/06/2022)

Government Program: CMS

**The Number of Beneficiaries Who Received Medicare Part B Clinical Laboratory Tests Decreased During the First 10 Months of the COVID-19 Pandemic**

Clinical laboratory (lab) tests, when used appropriately, were important because they provided health care providers with information to prevent, detect, diagnose, treat, and manage disease (including managing chronic medical conditions). These conditions had health impacts and economic costs, and prevention could reduce costs. To help contain the spread of COVID-19, Federal, State, Tribal, and local government agencies implemented community mitigation activities, including some issuing orders or advisories to residents to stay at home. These and other factors may have contributed to Medicare beneficiaries receiving fewer clinical services, including lab tests. OIG's preliminary analysis of lab tests billed to and paid by Medicare Part B found decreases in the number of beneficiaries who received lab tests when compared with a similar period before the pandemic.

OIG's objective was to identify changes in the number of beneficiaries who received Medicare Part B lab tests during the first 10 months of the COVID-19 pandemic—specifically, the number of beneficiaries who received: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries.

OIG's audit covered Part B claims for lab tests provided from March through December 2019 ('pre-pandemic period') and from March through December 2020 ('pandemic period').

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that during the pandemic period, the number of beneficiaries who received Medicare Part B lab tests decreased for: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries. From March through December in 2016, 2017, and 2018 and for the pre-pandemic period (in 2019), the number of beneficiaries who received lab tests paid for by Medicare decreased by 1 percent or less in each year. However, for the pandemic period (in 2020), the number of beneficiaries

who received lab tests decreased by about 9 percent compared with the pre-pandemic period.

OIG's comparison of the numbers of beneficiaries who received lab tests during the pandemic and pre-pandemic periods identified the following trends: (1) The number of beneficiaries who received lab tests had the highest percentage decreases during the first 3 months of the pandemic period when compared with the same months during the pre-pandemic period; (2) for almost 90 percent of lab tests for which the number of tests performed had decreased during the pandemic period, the number of beneficiaries who received those tests decreased by more than 10 percent; (3) for the gender and residential location (i.e., rural or urban) demographics, during the pandemic period the number of beneficiaries who received lab tests had similar percentage decreases for each category within the corresponding demographic (e.g., the female and male genders had similar percentage decreases); (4) for the race or ethnicity group demographic, during the pandemic period there was more variation in the percentage decreases in the number of beneficiaries who received lab tests for each category (e.g., the Hispanic or Latino category had a higher percentage decrease than the White category); and (5) the number of beneficiaries with diabetes, kidney disease, and heart disease who received common lab tests for those conditions decreased during the pandemic period. The results of OIG's data analysis suggested that the COVID-19 pandemic contributed to these decreases. Lab tests are important for beneficiaries with chronic medical conditions, which are associated with hospitalizations, billions of dollars in Medicare costs, and deaths.

OIG concluded that the information in this report was provided for informational purposes only and therefore the report did not contain any recommendations.

**CPT Codes Identified in This Audit:**

- 83036 - Hemoglobin A1C level
- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids (cholesterol and triglycerides)
- 85025 - Complete blood cell count (red cells, white blood cell, platelets), automated test
- 82043 - Urine microalbumin (protein) level
- 84443 - Blood test, thyroid stimulating hormone (TSH)
- 82570 - Creatinine level to test for kidney function or muscle injury
- 87186 - Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral)
- 82746 - Folic acid level
- 81002 - Urinalysis, manual test
- 83550 - Iron binding capacity

**HCPCS Codes Identified in This Audit:**

- G0103 - Prostate cancer screening; prostate specific antigen test (psa)

**ICD Codes Identified in This Audit:**

- E11 - Type 2 Diabetes Mellitus
- N18 - Chronic Kidney Disease (Ckd)
- I25 - Chronic Ischemic Heart Disease

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
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Behavioral Health

Laboratory

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Other Providers and  
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**Audit #:** [A-09-21-03004](#) (11/09/2022)  
**Government Program:** CMS

## **COVID-19 Tests Drove an Increase in Total Medicare Part B Spending on Lab Tests in 2020, While Use of Non-COVID-19 Tests Decreased Significantly**

The Protecting Access to Medicare Act of 2014 (PAMA) changed the way the Medicare program set payment rates for clinical diagnostic laboratory (lab) tests by aligning Medicare payment rates with private payment rates. CMS calculated new rates that took effect in 2018. As part of PAMA, Congress also mandated that OIG publicly release an annual analysis of the top 25 tests based on Medicare Part B spending and conduct analyses that OIG determined appropriate. This data brief provided an analysis of Medicare payments for lab tests in 2020.

OIG analyzed claims data for lab tests performed in 2020 that CMS paid for under the Clinical Laboratory Fee Schedule (CLFS). These tests were covered under Medicare Part B and did not include COVID-19 tests provided by community testing programs or tests that Medicare paid for under other payment systems, such as the payment system for critical access hospitals or the Hospital Outpatient Prospective Payment System. OIG identified the top 25 lab tests based on Medicare spending for tests performed in 2020. OIG also identified key statistics and emerging trends, including Medicare spending by procedure code and test category.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that Medicare Part B spending on lab tests in 2020 was affected by significant new spending on COVID-19 tests, a type of test that did not exist before the pandemic. Overall spending increased from \$7.7 billion in 2019 to \$8.0 billion in 2020. This increase in spending was driven by \$1.5 billion in new spending on COVID-19 tests, including \$1.0 billion on a rapid COVID-19 test, which was the number 1 test by spending.

Aside from COVID-19 tests, spending for all other tests, as a group, decreased by about \$1.2 billion in 2020. The decline in spending was driven by a sharp decline in non-COVID-19 tests during the early months of the pandemic, as well as further reductions in payment rates for some of these tests, as required by PAMA.

OIG concluded that the decline in volume for non-COVID-19 tests raised questions about the potential impact on beneficiary health and the COVID-19 pandemic would continue to have an impact on Medicare Part B spending on lab tests beyond 2020. OIG would continue to monitor annual payments for lab tests, including COVID-19 tests.

### **CPT Codes Identified in This Evaluation:**

- 87426 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; COVID-19
- 0225U - Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including COVID-19, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
- 0226U - Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome COVID-19, ELISA, plasma, serum
- 86408 - 86409

Provider

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Behavioral Health

Laboratory

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Other Providers and  
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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

- 86413 - COVID-19: antibody, quantitative
- 0240U - Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (COVID-19, influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected
- 0241U - Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (COVID-19, influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected
- 87636 - 87637
- 87811 - Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group B COVID-19
- 0202U - Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including COVID-19, qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
- 0223U - Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including COVID-19, qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
- 0224U - Antibody, COVID-19, includes titer(s), when performed

### **HCPSC Codes Identified in This Evaluation:**

- U0003 - Infectious agent detection by nucleic acid (DNA or RNA); COVID-19, amplified probe technique, making use of high-throughput technologies as described by CMS-2020-01-R. Payment rate set at \$100 per test by CMS-2020-01-R
- U0004 - COVID-19, any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high-throughput technologies as described by CMS-2020-01-R. Payment rate set at \$100 per test by CMS-2020-01-R
- U0002 - CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel
- G2023 - Specimen collection for COVID-19, any specimen source. Payment rate set at \$23.46
- G2024 - Specimen collection for COVID-19, from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source. Payment rate set at \$25.46.

**Evaluation #:** [OEI-09-21-00240](#) (12/30/2021)

**Government Program:** CMS

### **CMS Needs To Issue Regulations Related to Phlebotomy Travel Allowances**

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

For this audit, OIG focused on two previous audits of phlebotomy travel allowance payments for clinical diagnostic laboratory tests made by two Medicare administrative contractors (MACs) from January 1, 2015, through December 31, 2016, and on current travel allowance guidance. OIG's objectives were to (1) summarize the results of the previous two audits that identified instances in which payments made by two MACs to providers for phlebotomy travel allowances for



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clinical diagnostic laboratory tests did not always comply with Medicare guidance and (2) review Centers for Medicare & Medicaid Services (CMS) guidance related to phlebotomy travel allowances to determine whether there have been any updates.

OIG summarized the results of their prior audits, which covered 753,410 paid claim lines, totaling \$16.4 million, paid by the 2 MACs for phlebotomy travel allowances. OIG also met with CMS to determine whether it had taken steps to clarify how to properly prorate phlebotomy travel allowances.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

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

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

#### **HCPCS Codes Identified in This Audit:**

- P9603 - Used when the average round trip to a patient's home or nursing home is farther than 20 miles, paid on a mileage per trip basis
- P9604 - Used when the average round trip is less than or equal to 20 miles, paid on a flat rate per trip basis.

**Audit #:** [A-06-20-04000](#) (08/25/2021)

**Government Program:** CMS

## Telehealth

### **Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements**

In response to the COVID-19 public health emergency (PHE), CMS temporarily expanded access to health services provided via telehealth. From March 2020 through November 2020 (audit period), Medicare Part B paid approximately \$10.3 billion for Evaluation and Management (E/M) services, including telehealth services, provided to Medicare enrollees nationwide. The telehealth expansion increased the risk of inappropriate payments in the Medicare program due to the extent and speed of the changes. Therefore, CMS's oversight of the telehealth expansion became increasingly important to ensure that enrollees received the appropriate quality of care both during and after the PHE, while protecting the Medicare program from fraud, waste, and abuse.

OIG's objective was to determine whether physicians and other practitioners that provided E/M services via telehealth complied with Medicare requirements.

OIG's audit covered \$1.4 billion in Medicare Part B payments for more than 19 million E/M claim line services that were billed with place of service codes or modifiers indicating telehealth was used to provide the service during the audit period. OIG selected a stratified random sample containing three strata of E/M services provided via telehealth during the audit period. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that physicians and other practitioners that provided E/M services via telehealth generally complied with Medicare requirements. For 105 of the 110 sampled E/M services provided via telehealth, providers complied with Medicare requirements. However, for the remaining five sampled E/M services, providers did not comply with Medicare requirements. Medicare paid \$446 for the five sampled E/M services for which providers did not document or insufficiently documented the services. OIG also identified potential documentation issues in the medical records used to support the sampled E/M services that OIG discussed in the Other Matters section of this report.

This report did not have recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments OIG identified resulted primarily from clerical errors or the inability to access records.

CMS elected not to provide comments on OIG's draft report.

#### **CPT Codes Identified in This Audit:**

- 99213 - Established patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

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- 99214 - Established patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
- 99215 - Established patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
- 99201 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- 99202 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 99203 - New patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 99204 - New patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 99205 - New patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
- 99211 - Established patient office or other outpatient visit. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- 99212 - Established patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Audit #: [A-01-21-00501](#) (02/13/2024)

Government Program: CMS

### [Telehealth During 2020 Helped Ensure End-Stage Renal Disease Patients Received Care, But Limited Information Related to Telehealth Was Documented](#)

In response to the COVID-19 public health emergency (PHE) and pursuant to section 1135 of the Social Security Act, the Secretary of Health and Human Services (HHS) authorized the Centers for Medicare & Medicaid Services (CMS) to temporarily implement waivers and modifications to Medicare program requirements, retroactive to March 2020. From March through December 2020 (audit period), Medicare claims data showed that payments for end-stage renal disease (ESRD)-related telehealth services increased almost 10,000 percent from 2019. Oversight of telehealth expansion was increasingly important to ensure that Medicare enrollees received the appropriate care while protecting the program from fraud, waste, and abuse. OIG conducted this audit of ESRD-related telehealth services provided during the first year of the PHE to verify whether providers complied with Medicare requirements, determine what telehealth-related information was documented in the medical records, and further inform policymakers and other stakeholders as they considered permanent changes to telehealth policies.



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OIG's objectives were to determine, for ESRD-related telehealth services provided during the PHE: (1) what information related to the telehealth services was documented in the medical records and (2) whether the claims met certain Medicare requirements.

OIG's audit covered approximately \$38 million in Medicare Part B payments for 179,952 ESRD-related telehealth services provided during the audit period. OIG selected a stratified random sample: one stratum included 75 claim lines for telehealth services provided to in-center dialysis patients, and the other included 25 claim lines for telehealth services provided to at-home dialysis patients.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that providers documented limited information related to telehealth services in the medical records, but the ESRD-related telehealth service claim lines generally met certain Medicare requirements. Most medical records for sampled claim lines included documentation identifying that the service was provided via telehealth but did not include documentation that would allow OIG to determine whether the services were provided using 1) audiovisual interactive technology and 2) technology that was non-public-facing.

OIG found that CMS did not oversee or enforce whether the telecommunications systems used to provide telehealth services were non-public-facing; the Health and Human Service's Office for Civil Rights (OCR) had responsibility for oversight of this requirement. Any information in this report regarding non-public-facing telecommunications systems used was for informational purposes only.

OIG concluded that it would be beneficial for the medical records to document the type of telecommunications system used to perform the telehealth visit. This information may be beneficial to CMS and OCR when considering future oversight mechanisms or changes regarding remote communication products.

#### **CPT Codes Identified in This Audit:**

- 90951 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90962 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90963 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90966 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90967 - Age-specific and based on the number of visits for less than a month of service, billed per day
- 90970 - Age-specific and based on the number of visits for less than a month of service, billed per day

**Audit #:** [A-05-22-00015](#) (08/01/2023)

**Government Program:** CMS



## **The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls**

In response to the COVID-19 pandemic, health care providers increasingly delivered care using telehealth technologies. These technologies improved access to care, increased patient convenience, and increased service-delivery efficiency.

OIG's objective was to determine whether the Indian Health Service (IHS) implemented select cybersecurity controls to protect its telehealth system.

OIG reviewed applicable IHS and HHS policies and procedures for telehealth technologies, interviewed staff, and reviewed system security documentation to determine whether IHS telehealth technologies were secure. OIG focused on determining whether IHS designed and implemented cybersecurity controls that were essential to securing IHS telehealth systems components before deployment.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that although IHS deployed a national telehealth system, which increased the availability of health care services during the pandemic, it did not complete select IT controls as required prior to deploying its telehealth system nationally. Specifically, IHS did not complete the contingency plan, risk assessment, finalized authorization to operate (ATO), and system security plan. Additionally, after deployment of the telehealth system, IHS did not remediate known vulnerabilities on some telehealth system devices in a timely manner.

OIG recommended that the Indian Health Service develop a strategy for identifying, implementing, and testing cybersecurity controls for new information systems that were deployed in an expedited fashion to meet an urgent, mission-critical need. The strategy should have defined the minimum set of critical controls that must be implemented and tested before the system was deployed, noting the acceptance of risk for not implementing all required controls and stipulating that the full ATO process would be completed within a specific time period. OIG also recommended that the Indian Health Service ensure that adequate policies, procedures, and training were implemented to ensure that known telehealth vulnerabilities were remediated in a timely manner.

**Audit #:** [A-18-21-03100](#) (09/07/2022)

**Government Program:** IHS

## **Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic**

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and from the beneficiary's home.

In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million--about 2 in 5--Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88

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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expanded on that analysis and examined the characteristics of beneficiaries who used telehealth during the first year of the pandemic. This information shed light on how the temporary expansion of telehealth affected different groups of beneficiaries. This information would help CMS, HHS, Congress, and other stakeholders understand who benefited from the expansion and make decisions about whether some of the temporary changes should become permanent. It could also inform efforts aimed at ensuring that all beneficiaries had appropriate access to telehealth.

This data brief included beneficiaries in Medicare fee-for-service and Medicare Advantage. This report was part of a series that examined the use of telehealth in Medicare and identified program integrity concerns related to telehealth during the pandemic.

This analysis focused on Medicare beneficiaries who used telehealth services during the first year of the pandemic, from March 1, 2020, to February 28, 2021. OIG based this analysis on Medicare fee-for-service claims data, Medicare Advantage encounter data, and data from the Medicare Enrollment Database.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that beneficiaries in urban areas were more likely than those in rural areas to use telehealth during the first year of the pandemic. Beneficiaries in Massachusetts, Delaware, and California were more likely than beneficiaries in some other States to use telehealth. Dually eligible beneficiaries (i.e., those eligible for both Medicare and Medicaid), Hispanic beneficiaries, younger beneficiaries, and female beneficiaries were also more likely than others to use telehealth. In addition, beneficiaries almost always used telehealth from home or other non-health-care settings. Furthermore, almost one-fifth of beneficiaries used certain audio-only telehealth services, with the vast majority of these beneficiaries using these audio-only services exclusively. Older beneficiaries were more likely to use these audio-only services, as were dually eligible and Hispanic beneficiaries.

OIG recommended that CMS: (1) take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home, (2) temporarily extend the use of audio-only telehealth services and evaluate their impact, (3) require a modifier to identify all audio-only telehealth services provided in Medicare, and (4) use telehealth to advance health care equity.

### **CPT Codes Identified in This Evaluation:**

- 99441 - Telephone evaluation and management service, 5-10 minutes of medical discussion
- 99442 - Telephone evaluation and management service, 11-20 minutes of medical discussion
- 99443 - Telephone evaluation and management service, 21-30 minutes of medical discussion
- 98966 - Telephone assessment and management service, 5-10 minutes of medical discussion
- 98967 - Telephone assessment and management service, 11-20 minutes of medical discussion
- 98968 - Telephone assessment and management service, 21-30 minutes of medical discussion

**Evaluation #:** [OEI-02-20-00522](#) (08/29/2022)

**Government Program:** CMS

## **Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks**

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. In addition, CMS temporarily paused several program integrity activities, including medical reviews of claims.

In a related report, the OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million Medicare beneficiaries--about 2 in 5--used telehealth services that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

The changes to Medicare telehealth policies, along with the dramatic increase in the use of telehealth, underscored the importance of determining whether providers were billing for telehealth services appropriately and how to best protect Medicare and beneficiaries against fraud, waste, and abuse.

This data brief described providers' billing for telehealth services and identified ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. This information could help CMS, Congress, and other stakeholders determine what safeguards might be needed as they considered permanent changes to telehealth policies in Medicare.

This report was part of a series that examined the use of telehealth in Medicare and the characteristics of beneficiaries who used telehealth during the pandemic.

This data brief was based on an analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic from March 1, 2020, to February 28, 2021. OIG focused the analysis on the approximately 742,000 providers who billed for a telehealth service. Using input from OIG investigators, OIG developed seven measures that focused on different types of billing for telehealth services that may indicate fraud, waste, or abuse. For each of these measures, OIG set very high thresholds to identify providers whose billing posed a high risk to Medicare. Because this data brief focused on specific measures with very high thresholds, it did not capture all concerning billing related to telehealth services that may have been occurring in Medicare. Additionally, this report did not confirm that any particular provider was engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would have required additional investigation.

Further, a Medicare billing practice—known as "incident to" billing—created challenges for oversight because it allowed services provided by clinical staff who were directly supervised by a practitioner to be billed under the supervising practitioner's identification number. It was critical for program integrity efforts to identify the individual who delivered the telehealth service that was billed to Medicare. To address these limitations in the data, OIG developed measures for this report that aimed to minimize the effect of "incident to" billing on the results of the claims analysis.

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### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that 1,714 providers whose billing for telehealth services during the first year of the pandemic posed a high risk to Medicare. These providers billed for telehealth services for about half a million beneficiaries and received a total of \$127.7 million in Medicare fee-for-service payments.

Each of these 1,714 providers had concerning billing on at least 1 of 7 measures OIG developed that may indicate fraud, waste, or abuse of telehealth services. All of these providers warranted further scrutiny. For example, they may have been billing for telehealth services that were not medically necessary or were never provided.

In addition, more than half of the high-risk providers OIG identified were a part of a medical practice with at least one other provider whose billing posed a high risk to Medicare. This may have indicated that certain practices were encouraging such billing among their associated providers. Further, 41 providers whose billing posed a high risk appeared to be associated with telehealth companies; however, there was currently no systematic way to identify these companies in the Medicare data.

OIG concluded that although these high-risk providers represented a small proportion of all providers who billed for a telehealth service, these findings demonstrated the importance of strong, targeted oversight of telehealth services. The findings also offered insight on how Medicare and others could protect beneficiaries against fraud, waste, and abuse. Conducting targeted oversight of telehealth would help ensure the benefits of telehealth were realized while minimizing risk in an effective and efficient manner. Accordingly, OIG recommended that CMS:

- strengthen monitoring and targeted oversight of telehealth services,
- provide additional education to providers on appropriate billing for telehealth services,
- improve the transparency of "incident to" services when clinical staff primarily delivered the telehealth service,
- identify telehealth companies that billed Medicare, and
- follow up on the providers identified in this report.

#### **CPT Codes Identified in This Evaluation:**

- 99304 - Initial nursing facility visit, typically 25 minutes
- 99307 - Subsequent nursing facility visit, typically 10 minutes
- 99318 - Evaluation and management of a patient involving an annual nursing facility assessment

**Evaluation #:** [OEI-02-20-00720](#) (08/29/2022)

**Government Program:** CMS

### **Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic**

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services; it also allowed beneficiaries to use telehealth in different locations, including in urban areas and from the beneficiary's home.

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This data brief provided insight into the use of telehealth in both Medicare fee-for-service and Medicare Advantage during the first year of the COVID-19 pandemic, from March 2020 through February 2021. It was a companion to a report that examined the characteristics of beneficiaries who used telehealth during the pandemic. Another report in this series identified program integrity concerns related to telehealth during the pandemic. Understanding the use of telehealth during the first year of the pandemic could shed light on how the temporary expansion of telehealth affected where and how beneficiaries accessed their health care. This information could help CMS, Congress, and other stakeholders make decisions about how telehealth could be best used to meet the needs of beneficiaries in the future.

OIG based this analysis on Medicare fee-for-service claims data and Medicare Advantage encounter data from March 1, 2020, to February 28, 2021, and from the prior year, March 1, 2019, to February 29, 2020. OIG used these data to determine the total number of services used via telehealth and in-person, as well as the types of services used. OIG also compared the number of services used via telehealth and in-person during the first year of the pandemic to those used in the prior year.

#### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that over 28 million Medicare beneficiaries used telehealth during the first year of the pandemic. This was more than 2 in 5 Medicare beneficiaries. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they used in the prior year. Beneficiaries' use of telehealth peaked in April 2020 and remained high through early 2021. Overall, beneficiaries used telehealth to receive 12 percent of their services during the first year of the pandemic. Beneficiaries most commonly used telehealth for office visits, which accounted for just under half of all telehealth services used during the first year of the pandemic. However, beneficiaries' use of telehealth for behavioral health services stood out. Beneficiaries used telehealth for a larger share of their behavioral health services compared to their use of telehealth for other services. Specifically, beneficiaries used telehealth for 43 percent of behavioral health services, whereas they used telehealth for 13 percent of office visits.

OIG concluded that telehealth was critical for providing services to Medicare beneficiaries during the first year of the pandemic. Beneficiaries' use of telehealth during the pandemic also demonstrated the long-term potential of telehealth to increase access to health care for beneficiaries. Further, it showed that beneficiaries particularly benefited from the ability to use telehealth for certain services, such as behavioral health services. These findings were important for CMS, Congress, and other stakeholders to take into account as they considered making changes to telehealth in Medicare. For example, CMS could use these findings to inform changes to the services that were allowed via telehealth on a permanent basis.

#### **HCPCS Codes Identified in This Evaluation:**

- GT - Modifier indicating the service was delivered via telehealth
- GQ - Modifier indicating the service was delivered via telehealth
- G0 - Modifier indicating the service was delivered via telehealth

**Evaluation #:** [OEI-02-20-00520](#) (03/15/2022)

**Government Program:** CMS



## Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship

In response to the COVID-19 pandemic, both Congress and the Department of Health & Human Services (HHS) expanded access to a wide range of medical services that could be delivered via telehealth (i.e., telehealth services). This expansion enhanced the ability of health care providers to offer care to Medicare beneficiaries remotely during the COVID-19 pandemic. Prior to the pandemic, beneficiaries were only able to receive certain telehealth services from providers with whom they had an established relationship. However, HHS announced that it would use its discretion to not enforce requirements for established relationships during the pandemic.

While the expansion of telehealth had been essential to maintaining beneficiaries' access to care, there had been concerns about the potential for fraud, waste, and abuse associated with expanded telehealth services. This data snapshot provided information to policymakers and other stakeholders about the relationship between beneficiaries and providers for telehealth services. These data were critical to informing decisions about how to structure telehealth services in Medicare on a more permanent basis. Understanding how likely beneficiaries were to receive telehealth services from a provider with whom they had had an established relationship, and the average timeframe between an in-person visit and a telehealth service, could help inform decisions on how frequently in-person care might need to be paired with telehealth services. This snapshot was part of a series of reports on telehealth; the other reports focused on telehealth utilization and program integrity.

OIG reviewed Medicare claims data for telehealth services provided from March through December 2020. OIG determined the proportion of beneficiaries who received telehealth services only from providers with whom they had an established relationship and looked for any differences among the 10 most common types of telehealth services and between beneficiaries enrolled in traditional Medicare and those enrolled in Medicare Advantage. For beneficiaries who had an established relationship with their providers, OIG determined the average amount of time between their first telehealth service and their most recent in-person visit for each of their providers.

### SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that most beneficiaries received telehealth services from providers with whom they had an established relationship. Notably, 84 percent of beneficiaries received telehealth services only from providers with whom they had an established relationship. Those enrolled in traditional Medicare were more likely to receive services from providers with whom they had an established relationship, compared to beneficiaries in Medicare Advantage. This pattern persisted among virtually all of the most common telehealth services. Beneficiaries tended to see their providers in person about 4 months prior to their first telehealth service, on average.

OIG concluded that data on how likely beneficiaries were to receive telehealth services from a provider with whom they had had an established relationship could be used to inform decisions about how to best use telehealth in Medicare and should have been taken into account as policymakers continued to examine telehealth utilization and concerns about telehealth being vulnerable to fraud, waste, and abuse. This included decisions about which services to allow to be delivered via telehealth on a more permanent basis and to what extent Medicare should have required that beneficiaries have had a relationship with their providers prior to receiving certain telehealth services.

**Evaluation #:** [OEI-02-20-00521](#) (10/18/2021)

**Government Program:** CMS

Provider

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## Other Providers and Suppliers

### **Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect \$11 Million in Net Overpayments That Had Been Made to Medicare Providers**

Medicare-certified providers were required to submit an annual cost report to their Medicare administrative contractor (MAC). Cost reports were financial documents that conveyed the provider's costs associated with providing services to people enrolled in Medicare. A MAC could decide to audit a provider's cost report before bringing it to final settlement. If there was an error made in the final settlement, the MAC could reopen and adjust the cost report final settlement to correct the error.

OIG performed this audit to determine whether one MAC, Noridian Healthcare Solutions (Noridian), reopened and corrected cost report final settlements because of audit errors.

OIG's objectives were to determine: (1) how many audited cost reports Noridian reopened to correct the final settlements and (2) whether any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

OIG obtained information for audited cost reports ending in fiscal years 2016 and 2017 and determined whether they had been reopened. OIG obtained workpapers, audit adjustments, and final settlement summaries. After removing cost reports that were outside of OIG's scope, OIG reviewed 12 cost reports for this audit.

#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Noridian reopened 141 audited cost reports to correct the final settlements. Of these, 84 cost reports were reopened based on new information or at the request of the Centers for Medicare & Medicaid Services (CMS). In addition, 45 cost reports were not related to OIG's objectives; OIG excluded these from the review. For the second objective, of the remaining 12 audited cost reports that Noridian reopened and that OIG reviewed, Noridian's audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

These 12 cost reports required reopening because Noridian's auditors and supervisors required additional education on applicable criteria and audit requirements, because Noridian's procedures for multiple levels of review did not detect incorrect audit adjustments, and because of time constraints on Noridian's audits. The reopened cost reports resulted in revised final settlements to providers totaling almost \$11.3 million in net overpayments.

OIG recommended that Noridian: (1) develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements; (2) develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit documents and related actions; and (3) develop and implement enhanced procedures so that supervisors and higher-level reviewers were better qualified to detect incorrect audit adjustments.

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**Audit #:** [A-06-22-05000](#) (11/01/2023)  
**Government Program:** CMS

## **FDA Could Take Stronger Enforcement Action Against Tobacco Retailers With Histories of Sales to Youth and Other Violations**

Youth tobacco use in the United States remained a high public health concern. FDA's Tobacco Retailer Compliance Check Inspection Program was a critical part of its approach to prevent youth access to tobacco. Through that program, FDA inspected tobacco retailers to determine whether they were in violation of tobacco law or regulation. If FDA found a violation, it might issue an advisory action, such as a warning letter, or an enforcement action, such as a civil money penalty. When FDA issued an enforcement action, it had to consider mitigating factors including the nature, circumstances, extent, and gravity of the violation and, with respect to the violator, ability to pay, effect on ability to continue to do business, any history of prior such violations, and the degree of culpability.

OIG analyzed data from FDA on retailer inspections; violations; and advisory and enforcement actions from 2010 through 2019. OIG also analyzed retailer inspection and violation histories for a random sample of retailers that were subject to enforcement actions. To determine whether FDA inspection, advisory, or enforcement actions varied by neighborhood socioeconomic characteristics, OIG compared FDA inspection data to the Area Deprivation Index. OIG also interviewed FDA officials about the agency's direction and management of the retailer compliance check inspection program.

### **SunHawk Summary of OIG Evaluation Findings and Recommendations**

OIG found that FDA conducted more than one million inspections from 2010 through 2019, by inspecting, at least once, 74 percent of tobacco retailers that were in business nationwide as of 2020. FDA almost always returned to inspect retailers where it found violations within 12 months. In some States, inspection activities were correlated with neighborhoods' socioeconomic conditions, raising questions about how FDA and its contractors selected retailers to inspect. Overall, FDA's actions against retailers that violated tobacco laws and regulations were in accord with its policies.

However, retailers with histories of violations were often not subject to the strongest enforcement actions. FDA collected the full amount for only 9 percent of the civil money penalties (CMPs) it issued to retailers with histories of violations compared to 60 percent of CMPs it issued to retailers with fewer violations. Also, retailers in the sample that could have been subject to a no-tobacco-sale order usually did not receive one. However, OIG did not determine the extent to which FDA's consideration of mitigating factors or actions by Administrative Law Judges played a role in these outcomes.

OIG recommended that FDA (1) give greater weight to retailers' past noncompliance when taking enforcement actions against retailers with histories of violations and (2) determine whether variation in inspection activity on the basis of neighborhoods' socioeconomic status was appropriate and the extent to which it was meeting FDA's objective for protecting vulnerable populations.

**Evaluation #:** [OEI-01-20-00240](#) (09/18/2023)  
**Government Program:** FDA

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## **Novitas Solutions, Inc., Claimed Some Unallowable Medicare Nonqualified Plan Costs Through Its Incurred Cost Proposals**

The Centers for Medicare & Medicaid Services (CMS) reimbursed a portion of its contractors' nonqualified plan costs.

The Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services, Region VII pension audit team reviewed the cost elements related to qualified defined-benefit, postretirement benefit, and any other pension-related cost elements claimed by Medicare contractors through Incurred Cost Proposals (ICPs).

Previous OIG audits found that Medicare contractors did not always correctly identify and claim nonqualified plan costs.

OIG's objective was to determine whether the calendar years (CYs) 2016 through 2018 nonqualified plan costs that Novitas Solutions, Inc. (Novitas), claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

OIG reviewed \$1.9 million of Medicare nonqualified costs that Novitas reported on its ICPs for CYs 2016 through 2018.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Novitas claimed Medicare nonqualified costs of \$1.9 million for Medicare reimbursement, through its ICPs, for CYs 2016 through 2018. However, OIG determined that the allowable costs during this period were \$1.8 million. The difference, \$84,291, represented unallowable nonqualified costs that Novitas should not have claimed on its ICPs for CYs 2016 through 2018. This overstatement occurred primarily because Novitas based its claims for Medicare reimbursement on incorrectly calculated Cost Accounting Standards-based nonqualified costs.

OIG recommended that Novitas work with CMS to ensure that its final settlement of contract costs reflected a decrease in Medicare nonqualified costs of \$84,291 for CYs 2016 through 2018.

**Audit #:** [A-07-23-00633](#) (09/12/2023)

**Government Program:** CMS

## **Medicare Paid Independent Organ Procurement Organizations Over Half a Million Dollars for Professional and Public Education Overhead Costs That Did Not Meet Medicare Requirements**

Organ procurement organizations (OPOs) performed or coordinated the procurement and preservation of organs, such as kidneys, as well as transportation of organs to hospitals for transplantation into patients on a waiting list to receive a transplant. Prior OIG audits found that two independent OPOs in California did not comply with Medicare requirements for reporting overhead costs as well as administrative and general costs. Specifically, professional and public education overhead costs accounted for 44 percent and 65 percent of the total amount questioned in each report, respectively. OIG conducted this nationwide audit to determine whether the issues identified in the two prior OIG audits were occurring at independent OPOs nationwide.

The objective was to determine whether independent OPOs' professional and public education overhead costs met

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Medicare requirements.

The audit covered \$101.6 million of professional and public education overhead costs (with Medicare payments of \$50.9 million) reported in the 50 independent OPOs' most recently finalized Medicare cost reports with FY end dates from May 31, 2015, through June 30, 2019 (audit period). The audit covered costs from only 1 FY for each OPO. OIG randomly sampled for review 30 professional and public education overhead costs from each of the 10 randomly selected OPOs (300 sampled costs totaling \$294,692).

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that not all professional and public education overhead costs reported by independent OPOs met Medicare requirements. Of the 300 sampled professional and public education overhead costs, 264 costs met Medicare requirements. The remaining 36 costs, totaling \$15,852 (with Medicare payments of \$6,423), did not meet Medicare requirements and were therefore unallowable. Furthermore, while reconciling the OPOs' general ledgers with the OPOs' Medicare cost reports, OIG determined that OPOs reported an additional \$132,898 of unallowable professional and public education overhead costs (with Medicare payments of \$65,785).

On the basis of the sample results and additional findings OIG identified during the reconciliation, OIG estimated that \$664,295 (consisting of an estimated \$598,510 based on the sample results and \$65,785 for the reconciliation findings) of the \$50.9 million paid for professional and public education overhead costs was unallowable. The OPOs reported unallowable costs because: (1) they misunderstood Medicare requirements and (2) their staff made administrative errors or were not aware that costs did not meet Medicare requirements.

OIG recommended that CMS: (1) instruct the Medicare administrative contractor (MAC) to recover \$72,208 in unallowable Medicare payments by adjusting the applicable OPOs' Medicare cost reports to correct the \$148,750 of unallowable professional and public education overhead costs reported, consistent with relevant laws and the agency's policies and procedures; and (2) update applicable Medicare requirements to clarify which types of professional and public education overhead costs are unallowable, which could have saved Medicare an estimated \$664,295 for professional and public education overhead costs during OIG's audit period.

**Audit #:** [A-09-21-03020](#) (08/09/2023)

**Government Program:** CMS

### **Medicare Improperly Paid Physicians an Estimated \$30 Million for Spinal Facet-Joint Interventions**

Medicare covered pain management procedures, such as facet-joint interventions, to treat neck or back pain resulting from arthritis in or injury to the spinal facet joints. A prior OIG audit found that for 51 of 100 sampled sessions, a Medicare contractor did not pay physicians in 1 jurisdiction for facet-joint injections in accordance with Medicare requirements. Another OIG audit found that Medicare improperly paid for facet-joint denervation sessions. Because facet-joint interventions were at risk for overutilization and prior audits had found improper payments for these services, OIG conducted this audit to determine whether Medicare improperly paid for these interventions from August 1 through October 31, 2021 (audit period).

OIG's objective was to determine whether Medicare paid physicians for spinal facet-joint interventions in accordance



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with Medicare requirements and guidance.

OIG's audit covered Medicare Part B payments of \$62.2 million for 425,843 claim lines for facet-joint interventions, which OIG grouped into 218,421 sessions, with dates of service during the audit period. OIG selected a statistical sample of 120 sessions. For each session, OIG reviewed beneficiaries' medical records to evaluate compliance with Medicare billing requirements and guidance but did not use medical review to determine whether interventions were medically necessary.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare did not pay physicians for some spinal facet-joint interventions in accordance with Medicare requirements and guidance. Of the 120 sampled sessions, 54 complied with Medicare requirements; however, the remaining 66 sessions did not comply with one or more of the requirements. As a result, Medicare made improper payments to physicians of \$18,084. On the basis of OIG's sample results, OIG estimated that Medicare improperly paid physicians \$29.6 million for facet-joint interventions for the audit period.

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least one therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic instead of therapeutic facet-joint injections. This improper billing did not result in improper payments because Medicare pays the same amount for diagnostic and therapeutic facet-joint injections.

The Medicare Administrative Contractors' (MACs') education of physicians and their billing staff varied across their jurisdictions and was not always sufficient to ensure compliance with Medicare requirements and guidance.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) direct the MACs to recover \$18,084 in improper payments made to physicians for the 66 sampled sessions. OIG also recommended that CMS encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions and that were specific to Medicare requirements for facet-joint interventions, which could have saved an estimated \$29.6 million for the audit period; and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education or updating guidance on how each type of injection should be billed. The report contained one other recommendation.

### **CPT Codes Identified in This Audit:**

- 64633 - Denervation of a single facet joint in the cervical/thoracic spine
- 64635 - Denervation of a single facet joint in the lumbar/sacral spine
- 64634 - Denervation of each additional facet joint in the cervical/thoracic spine
- 64636 - Denervation of each additional facet joint in the lumbar/sacral spine
- 64490 - Injection to a single facet-joint level in the cervical/thoracic spine
- 64493 - Injection to a single facet-joint level in the lumbar/sacral spine
- 64491 - Injection to the second facet-joint level in the cervical/thoracic spine
- 64492 - Injection to the third and any additional facet-joint levels in the cervical/thoracic spine
- 64494 - Injection to the second facet-joint level in the lumbar/sacral spine
- 64495 - Injection to the third and any additional facet-joint levels in the lumbar/sacral spine





**Audit #:** [A-09-22-03006](#) (03/22/2023)  
**Government Program:** CMS

## **Medicare Improperly Paid Physicians for Epidural Steroid Injection Sessions**

To address inappropriate billing for and overuse of epidural steroid injections, 10 of the 12 Medicare Administrative Contractors' (MACs') jurisdictions developed coverage limitations, through Local Coverage Determinations (LCDs), for epidural steroid injection sessions. These coverage limitations allowed for physicians to be reimbursed for a maximum number of epidural steroid injection sessions in a 6-month or a 12-month period.

Prior Office of Inspector General audits found that Medicare did not always pay physicians for spinal facet-joint denervation and injection sessions in accordance with Federal requirements.

The objective was to determine whether Medicare paid physicians for epidural steroid injection sessions in accordance with Medicare requirements.

During the audit period (January 1, 2019, to December 31, 2020), the MACs paid physicians \$52.8 million for 303,408 epidural steroid injection sessions. OIG analyzed the 303,408 sessions and identified 80,419 sessions totaling \$13.8 million that exceeded the coverage limitation for the respective MAC jurisdiction.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare did not always pay physicians for epidural steroid injection sessions in accordance with Medicare requirements. For the audit period, Medicare improperly paid physicians \$3.6 million on behalf of beneficiaries who received more epidural steroid injection sessions than were permitted by the coverage limitations in the applicable LCDs. These improper payments occurred because neither the Centers for Medicare & Medicaid Services's (CMS's) oversight nor the MACs' oversight was adequate to prevent or detect improper payments for epidural steroid injection sessions.

After the audit period, all 12 MAC jurisdictions updated their LCDs with revised coverage limitations that were specific to epidural steroid injections.

OIG recommended that CMS:

- (1) direct the MACs to recover the \$3.6 million in improper payments made to physicians for epidural steroid injection sessions;
- (2) instruct the MACs to, based on the results of this audit, notify appropriate physicians (i.e., those for whom CMS determined this audit constituted credible information of potential overpayments) so that the physicians could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;
- (3) assess the effectiveness of oversight mechanisms, put in place after OIG's audit period, that were specific to preventing or detecting improper payments to physicians for more than the allowed number of epidural steroid injection sessions, and modify the oversight mechanisms, if necessary, based on that assessment; and
- (4) direct the MACs (or other designated entities) to review a sample of claims for injection sessions administered after OIG's audit period but before the revised coverage limitations became effective to identify and recover any improper

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payments.

**CPT Codes Identified in This Audit:**

- 62320 - 62321
- 62325 - Injection of anesthetic and/or steroid drug into the cervical or thoracic spinal region with imaging guidance and contrast
- 64479 - 64480
- 64483 - 64484

**Audit #:** [A-07-21-00618](#) (03/10/2023)

**Government Program:** CMS

**Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning**

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals and patients to discuss their wishes if they became unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services. Payments for ACP provided from 2016 through 2019 totaled more than \$340 million. Payments for services provided in an office setting represented 61 percent of all payments.

OIG's objective was to determine whether Medicare providers who received payments for ACP services in an office setting complied with Federal requirements.

The audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of \$70.1 million. OIG selected for review a stratified random sample of 125 beneficiaries. OIG reviewed all 691 paid ACP services for the 125 beneficiaries selected for the sample.

**SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that Medicare providers that billed for ACP services in an office setting did not always comply with Federal requirements. Specifically, of the 691 ACP services associated with the sample, Medicare providers complied with Federal requirements for 225 services totaling \$15,874. However, providers did not comply with Federal requirements for 466 services totaling \$33,332.

On the basis of the sample results, OIG estimated that Medicare providers in an office setting were paid approximately \$42.3 million for ACP services that did not comply with Federal requirements. These payments occurred because the providers did not understand the Federal requirements for billing ACP services.

OIG also identified questionable claims associated with 12 sampled beneficiaries for whom 15 or more ACP services were received. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings did not align with guidance contained in CMS's Frequently Asked Questions.



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## Healthcare Audit and Enforcement Risk Analysis - **OIG Completed Audits Summary**

OIG recommended that CMS educate providers on documentation and time requirements for ACP services to comply with Federal requirements. Had the requirements been followed, Medicare could have saved an estimated \$42.3 million during OIG's audit period. In addition, CMS should instruct the MACs to recoup \$33,332 for ACP services paid in error for claims in OIG's sample. Also, CMS should instruct the MACs to notify appropriate providers so that they could exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule. Finally, CMS should establish Medicare requirements that addressed when it was appropriate to provide multiple ACP services for a single beneficiary and how these services should be documented when required to support the need for multiple ACP services.

### **CPT Codes Identified in This Audit:**

- 99497 - Covers the first 30 minutes of Advance Care Planning (ACP), which includes a face-to-face explanation and discussion of advance directives, such as standard forms, between the provider and the patient, family member(s) or a surrogate, or both
- 99498 - Should be used for each additional 30 minutes of ACP and listed separately in addition to code 99497.

**Audit #:** [A-06-20-04008](#) (11/22/2022)

**Government Program:** CMS

### **Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers**

Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) made a reduced payment to physicians who worked together as co-surgeons to perform a surgical procedure on the same patient during the same operative session. OIG conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier.

OIG's objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

OIG's audit covered \$15.4 million in Medicare Part B payments for services performed during calendar years 2017 through 2019 (audit period) in which two different providers separately billed an identical procedure code for the same beneficiary and on the same day. OIG selected a stratified random sample of 100 services for review that were billed by one of the providers from the sampling frame without a co-surgery or assistant-at-surgery modifier. OIG also identified and reviewed 127 corresponding services that were billed by providers with the same procedure code for the same beneficiary on the same day as the sampled services.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that from OIG's 100 statistically sampled services, 69 did not comply with Federal requirements. Specifically, these statistically sampled services included 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. These statistically sampled service errors resulted in overpayments of \$31,545. Based on the results of OIG's statistical sample, it was estimated that Medicare made \$4.9 million in improper payments for physician surgical services during the audit period. In addition to the statistically sampled services, based on OIG's review of the 127 corresponding



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services, it was further found that 62 of these corresponding services did not comply with Federal requirements. These corresponding service errors resulted in overpayments of \$24,471. Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to identify and prevent such payments.

OIG recommended that CMS: (1) recover the portion of the \$56,016 in Medicare Part B overpayments that were within the 4-year claim reopening period; (2) instruct the Medicare contractors to, based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determined this audit constituted credible information of potential overpayments) so that the providers could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services—which could have saved approximately \$4.9 million during the audit period; and (4) update Medicare requirements and corresponding educational material to improve providers' understanding of the Part B billing requirements for co-surgery procedures.

**CPT Codes Identified in This Audit:**

- 33880 - Thoracic endovascular repair procedure
- 28299 - Bilateral bunion correction procedure
- 19364 - Bilateral breast removal procedure
- 27447 - Bilateral knee replacement procedure
- 22840 - Spinal instrumentation code
- 22848 - Spinal instrumentation code
- 22850 - Spinal instrumentation code
- 22852 - 22854
- 22859 - Spinal instrumentation code
- 63030 - Spinal laminectomy and decompression procedure

**Audit #:** [A-01-20-00503](#) (11/22/2022)

**Government Program:** CMS

**Medicare Dialysis Services Provider Compliance Audit - Dialysis Clinic, Inc.**

Medicare Part B covered dialysis services for beneficiaries with end-stage renal disease (ESRD). Prior OIG reviews identified inappropriate Medicare payments made for ESRD dialysis services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements.

OIG selected Dialysis Clinic, Inc. (DCI), because it ranked among the highest paid providers of dialysis services in the United States, and Medicare surveyors identified various health and safety issues.

OIG's objective was to determine whether dialysis services provided by DCI complied with Medicare requirements.

OIG's audit covered 112,192 claims for dialysis services provided during the audit period (calendar year 2018) for which DCI received Medicare reimbursement totaling \$276,427,841. OIG reviewed a random sample of 100 claims. OIG evaluated the services for compliance with Medicare requirements and submitted them to independent medical review.



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#### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that DCI claimed reimbursement for dialysis services that did not comply with Medicare requirements for 70 of the 100 sampled claims. Specifically, DCI submitted claims for which: (1) comprehensive assessments or plans of care did not meet Medicare requirements, (2) dialysis treatments were not completed, (3) dialysis services were not documented, (4) beneficiaries' height or weight measurements did not comply with Medicare requirements, and (5) the medical record did not have a monthly progress note by a physician or other qualified professional.

While DCI had established corporate-wide internal controls to monitor and maintain complete, accurate, and accessible medical records at all its facilities, these controls were not always effective in ensuring that DCI's claims for dialysis services complied with Medicare requirements.

OIG estimated that DCI received unallowable Medicare payments of at least \$14,193,677 for dialysis services that did not comply with Medicare requirements. Many of the errors OIG identified did not affect DCI's Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have had a significant impact on the quality of care provided to Medicare beneficiaries and could have resulted in the provision of inappropriate or unnecessary dialysis services.

OIG recommended that DCI refund an estimated \$14,193,677 to the Medicare program. OIG also made a series of recommendations to strengthen DCI's internal controls to ensure that dialysis services complied with Medicare requirements.

#### **HCPCS Codes Identified in This Audit:**

- V502 - Comprehensive assessments used with care plans include assessment of all elements covered in V502
- V515 - Comprehensive assessments used with care plans include assessment of all elements covered in V515
- V555 - Rehabilitation Status
- V562 - Education and Training
- V552 - Psychosocial Status
- V550 - Vascular Access Monitoring
- V543 - Dialysis Dose

**Audit #:** [A-05-20-00010](#) (09/28/2022)

**Government Program:** CMS

#### **The District of Columbia's Monitoring Did Not Ensure Child Care Provider Compliance With Criminal Background Check Requirements at 7 of 30 Providers Reviewed**

The Child Care and Development Block Grant Act (CCDBG Act) of 2014 added new requirements for States receiving funding from the Child Care and Development Fund (CCDF) to conduct comprehensive criminal background checks on staff members and prospective staff members of child care providers every 5 years. Criminal background check requirements applied to any staff member who was employed by a child care provider for compensation or whose activities involved the care or supervision of children or unsupervised access to children.

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OIG's objective was to determine whether the District of Columbia's monitoring process ensured provider compliance with District requirements related to criminal background checks established under the CCDBG Act.

The audit covered 113 child development centers and child development homes that received CCDF funding during District fiscal year 2018. OIG used geographic area, total CCDF funding received, and total capacity to select 15 child development centers and 15 child development home providers. In total, OIG reviewed supporting documentation for 541 household members and employees at 30 child care provider locations.

### **SunHawk Summary of OIG Audit Findings and Recommendations**

OIG found that the District's monitoring process did not ensure provider compliance related to criminal background checks for 7 of the 30 child care providers (55 of the 541 individuals requiring background checks) OIG reviewed. In response to the audit, the District took action and completed background checks for 52 of the 55 individuals. The errors OIG found occurred because: (1) providers did not send the in-State child abuse and neglect (Child Protection Register) check results to the District, (2) District law did not allow Child Protection Register check results to be sent directly to the District unless the individual was found not to be suitable for employment, and (3) processing delays resulted in incomplete Federal Bureau of Investigations fingerprint checks and inter-State checks. To ensure the safety of children at these child care providers, the District needed to strengthen its process for conducting criminal background checks for all individuals who supervised or had routine unsupervised contact with children.

OIG recommended that the District:

1. Conduct all required criminal background checks for the three individuals OIG reviewed who did not have the required checks and whose background checks were not resolved during the audit, and
2. Work with District legislators to allow Child Protection Register check results to be sent directly to the District without requiring a signed and notarized consent form from the individual whose records were to be released. The detailed recommendations were in the report.

**Audit #:** [A-03-20-00252](#) (11/03/2021)

**Government Program:** ACF

### **An Ophthalmology Clinic in Florida: Audit of Medicare Payments for Eye Injections of Avastin, Eylea, and Lucentis**

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

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



The audit covered Medicare Part B payments of \$2.1 million for intravitreal injections of Avastin, Eylea, and Lucentis (and for other services provided on the same day as the injections) that the Clinic provided in 2018. OIG reviewed a stratified random sample of 100 beneficiary days, consisting of 543 services and drugs. (A beneficiary day consisted of all services and drugs provided on a date of service to a beneficiary in which intravitreal injections of Avastin, Eylea, or Lucentis were administered.) For each sampled beneficiary day, OIG provided copies of the medical records to an independent medical review contractor to determine whether the services and drugs were properly billed.

**SunHawk Summary of OIG Audit Findings and Recommendations**

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

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

OIG recommended that the Clinic refund to the Medicare contractor \$215,606 in estimated overpayments for other services provided on the same day as intravitreal injections of Avastin, Eylea, and Lucentis. OIG also recommended that the Clinic implement policies and procedures to ensure that it:

- did not bill for services that were not separately payable from intravitreal injections of Avastin, Eylea, and Lucentis
- billed only for services that were reasonable and necessary.

The report contained one other recommendation.

**Audit #:** [A-09-19-03025](#) (09/07/2021)

**Government Program:** CMS

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment  
and Supplies

Behavioral Health

Laboratory

Telehealth

**Other Providers and  
Suppliers**